ARTICLE XV: RULES AND REGULATIONS

All Medical Staff members agree to abide by the Medical Staff Rules and Regulations or they may be referred to their Department Chair, Unit Medical Director, President of the Medical Staff and/or the V.P. of Medical Affairs or they may be referred to the appropriate committee for corrective action.

There shall be no policy, procedure or regulation for St Mary’s Hospital which is contrary to written Medical Staff policy, hospital policy or ethics and professional standards of the American Medical Association, Catholic Healthcare Association, and Federal EMTALA/COBRA statute.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. It is the intent of the Medical Staff to comply with all Federal/State laws and regulations (i.e. COBRA/EMTALA, HIPAA).

2. A patient may be admitted to the hospital only by a member of the Active Medical Staff and Midwives on the Allied Health Staff. All practitioners shall be governed by the official admitting policy of the hospital.
3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instruction, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. The Medical Staff member who admits the patient shall be considered the responsible, designated medical staff practitioner. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the order sheet of the medical record.

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

5. In any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall when possible first contact the hospital personnel responsible for bed allocation to ascertain whether there is an available bed.

6. A patient to be admitted on an emergency basis who does not have a private practitioner will be assigned to the hospitalist or family practice teaching service. Internal Medicine and Family Practice departments will maintain a backup call list in the event the hospitalist service and family practice teaching service are unable to handle the volume of unassigned patients. It is the understood intent of this rule that the use of the backup call list would be a rare event. If an assigned medical staff member is unable to take assignment when scheduled, it shall be that medical staff member's responsibility to arrange for a qualified substitute. Failure to respond to an emergency call shall be reported to the Unit Medical Director, Department Chairperson or the V-P. of Medical Affairs and, if not resolved, referred to the Chairpersons of the Credentials and Executive Committees. Failure of the assigned medical staff member to respond to an emergency call may result in disciplinary action up to and including loss of staff privileges. A reasonable explanation for such failure is expected and will be trended.

In those situations in which care may be more appropriately handled by subspecialists, patients may be admitted directly to a subspecialty service.

7. Each practitioner must provide appropriate professional care for his/her patients in the hospital by being available or having available through his/her office coverage by an eligible alternate
practitioner with appropriate clinical privileges with whom prior coverage arrangements have been made. Failure of practitioners to meet these requirements may result in the loss of clinical privileges.

8. Timely response is defined as a phone response within 15 minutes and personal appearance of the provider or an appropriately credentialed designee within 30 minutes of request. Failure of timely response may initiate Chain of Command Policy.

9. The Hospital and Medical Staff shall provide an appropriate medical screening examination to any individual who comes to the Hospital for examination or treatment of a medical condition. The purpose of the examination is to determine whether the individual has an emergency medical condition. When the hospital does not provide the services required by a patient, or for any reason the hospital cannot provide the medically necessary services, the hospital and the attending physician shall arrange for transfer/referral to an alternate facility in compliance with existing Federal/State law.

10. No patient will be transferred without approval by the responsible practitioner. Transfers shall go to the appropriate care areas. The attending practitioner is required to document the need for continued hospitalization. Should disagreement arise regarding transfer, resolution is made through consultation with Resource Management, Department Chair, Unit Medical Director and/or Vice President Medical Affairs.

11. If any question as to the validity of admission to or discharge from the Intensive Care Services (ICU, CCU, CCW) should arise, that decision is to be made through consultation with the Medical Director of the Critical Care Service.
12. Patients shall be discharged only by order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. A form stating that the patient is leaving against medical advice will be presented by the attending physician, or in the absence of the attending physician, by the nurse, for signature by the patient.

13. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner, his/her designee or the hospitalist within a reasonable time not to exceed two hours. Cases of expected death may be handled per the Affirmation of Determination of Death Policy. Policies with respect to release of dead bodies shall conform to local law and hospital policy.

14. It shall be the duty of all staff members to secure autopsies whenever appropriate. An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed by the hospital Pathologist or local medical examiner. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the record within 60 days. The criteria in which consent for an autopsy will be sought are as follows: 1. Cases of an unanticipated death, 2. Cases involving an intra-operative or intra-procedural death, 3. Cases where death occurs within 24 hours after surgery or an invasive procedure, 4. Cases involving death incident to pregnancy or within 7 days following delivery, 5. Cases where death occurs on the psychiatric service, 6. Cases of death of infants and children with congenital malformations when clinically indicated, 7. Cases where practitioners involved in the patient’s care feel an autopsy is appropriate, 8. Cases with unexplainable causes of death, including stillborns, when indicated.
B. MEDICAL RECORDS

1. All health care providers involved in patient care may write in the medical record.

2. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Legibility concerns will be handled per the Medical Staff Policy: Legibility of Entries into the Medical Record.

3. Admission history and physical examination including a plan of action, shall be recorded within 24 hours of the admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. When a patient is readmitted within 30 days for the same or related problem, an interval history and physical reflecting any subsequent changes may be used in the medical record, provided the original information is readily available. In the event that the obstetrical patient does not require surgery, the current obstetrical record including a complete prenatal record may stand as the admission history and physical. The prenatal record may be a legible copy of the attending practitioner’s office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

4. Pre-procedure documentation as required by the Moderate Sedation Policy and Ambulatory Documentation Review will be followed. When the history and physical examination are not recorded, the procedure may be canceled by the Department Chairperson, the President of the Medical Staff, or the Vice President of Medical Affairs unless the attending practitioner documents an emergency medical situation.

5. The attending physician is responsible for all care by Family Practice Residents, as delineated in the Family Practice Residency Program Reporting Requirements and Guidelines.

6. Approved Medical Students will be allowed to record the history and physical examination but not the discharge summary on any hospitalized patient. All medical student entries must be countersigned by the attending physician. Orders may be written but must be countersigned prior to enactment.

7. Progress notes shall be recorded by any medical staff practitioner actively involved in the care of a patient, at the time of
observation, sufficient to permit continuity of care and transferability. Progress notes shall be written at least daily, and shall be dated. Recording time of entry is strongly encouraged. Appropriate documentation of patient’s active clinical problems is expected.

8. Operative/procedural reports shall be written/dictated immediately following surgery/procedure, as outlined in Surgical Procedural Records of this document.

9. Physicians are encouraged to initiate consultation by personal contact between practitioners, and the request recorded in the medical record. Failure to comply may result in disciplinary action. Consultations shall be timely as determined by the clinical and resource management circumstances. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note should, except in emergency situations so verified on the record, be recorded prior to the operation.

10. All clinical entries in the patient's medical record shall be dated and signed. Recording time of entries is encouraged.

11. Symbols and abbreviations listed in dangerous abbreviation list will not be used.

12. A discharge summary shall be written or dictated on all medical records of patients hospitalized for more than 48 hours. All summaries shall be authenticated by the responsible practitioner.

13. The medical staff will comply with the HIPPA Compliance Standard of St. Mary’s Hospital, HIPAA Workforce Responsibilities Overview Standard, Administration Manual, O-1.

14. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Hospital. The only exception is authorized off-site storage of records. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner.

15. Previous medical records should be provided for the use of the attending practitioner as available.
16. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee of the Medical Staff.

17. Routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner, recording time of order is encouraged.

18. Discharge summary shall be complete no later than 28 days post discharge. All other contents of the medical record shall be recorded by the time of discharge.

At time of transfer, an immediate discharge summary is required.

19. All restraints require a time limited physician's order. Restraint orders for a PRN basis are not allowed. (See Restraint/Seclusion Standard, Patient Care Manual, B.12.3).

20. Contents of Medical Records:

(1) A complete medical record shall include the relevant details of:
Identification data, including the patient's name, address, the date of birth, and next of kin, as well as a single unit number that identifies the patient and the patient's medical record; evidence of an advance directive when appropriate.

(2) Date of admission and discharge;

(3) Medical history, including:

(a) the chief complaint,

(b) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status,

(c) relevant past, social and family histories;

(d) relevant menstrual and obstetrical history

(e) a review of body systems and
(f) medications and allergies:

(4) Provisional admitting diagnosis;

(5) Report of a physical examination, including but not limited to vital signs, head, chest, abdomen and extremities, or a note as to the contraindications for such an examination or valid reasons why the examination was not performed;

(6) A statement of the conclusions or impressions drawn from the admission history and physical examination;

(7) Diagnostic and therapeutic orders;

(8) Evidence of appropriate informed consent;

(9) Clinical observations, progress notes, nursing notes, consultation reports;

(10) Reports of procedures, tests and the results, including operative reports;

(11) Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures; and

(12) Conclusions at termination of hospitalization, including the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses, the clinical resume or final progress note, and, when appropriate, the autopsy report.

(b) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Medical Records Committee.

(c) Pursuant to Colorado Law, CRS 25-4-1404 HIV Public Health Reports are not "Medical Records" but strictly confidential information.
Refer to Colorado State Statute (Section 27-10-101 et seq., C.R.S) for specific handling of psychiatric patient information.


21. Surgical/Procedural Records: (to include inpatient and outpatient procedures, invasive cardiac procedures, invasive radiologic procedures, ECT, endoscopy and any other procedure done under moderate sedation)

Surgical/Procedural reports shall be dictated or written in the medical record immediately after the procedure and shall contain:

1. the procedure, description of technique, and a detailed account of the findings;
2. a description of the specimens removed;
3. the post procedure diagnosis;
4. the complications encountered;
5. gross pathology observed visually or by palpation;
6. the names of the primary procedural physician and any and all assistants.

The completed surgical/procedural report shall be authenticated by the procedural physician and filed in the medical record as soon as possible.

A handwritten surgical/procedural progress note to include anesthesia used and pertinent findings must also be entered in the inpatient/observation patient medical record immediately after the procedure.

Except in emergencies, the following data shall be collected and available prior to the procedure or the procedure shall be canceled:

1. verification of patient identity;
2. medical information regarding allergies and drug sensitivities, symptoms/indications for
procedure, other pertinent facts, and evaluation of the capacity of the patient to withstand sedation/anesthesia and the procedure;

(3) physical:
   a. no anesthesia; topical, local, or regional
      . vital signs
      . assessment of mental status
      . exam specific to procedure
   b. IV sedation: all of above plus exam of heart and lungs by auscultation;
   c. general, spinal, epidural: all of the above plus written assessment of patient’s general condition;

(4) provisional diagnosis;

(5) laboratory test results, x-ray and ancillary reports as appropriate to patient’s history and procedure to be performed;

(6) relevant consultation reports;

(7) consent form signed by the procedural physician and the patient or the patient’s legal representative (informed consent for anesthesia must be documented by the anesthesiologist in the patient’s chart)

In an emergency situation, the record will be completed immediately after the procedure.
22. Anesthesia Note:

In cases involving an anesthesiologist, a pre and post anesthesia note shall be documented in the medical record of all patients undergoing procedures and shall specifically include, but not be limited to, information relative to the choice of, risks of, and consent for anesthesia for the anticipated procedure.

23. Pathology Report:

(a) All specimens to be sent to Pathology shall be properly labeled, packaged in preservative as designated, identified as to patient and sent to the laboratory for examination by the pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information.

24. Discharge Summaries:

(a) The discharge summary shall include:

(1) the reason for hospitalization; reference to History & Physical

(2) the significant findings; including co-morbidities

(3) complications;

(4) the procedures performed and treatment rendered;

(5) the condition of the patient on discharge; and

(6) any specific, pertinent instructions given to the patient or the patient's representative.

(7) Medication List

(8) Patient condition at the time of discharge.
When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate and a copy of the preprinted instruction sheet used should be on file in Health Records Information Services.

All discharge summaries shall be authenticated by the attending physician.

(b) All relevant diagnoses established by the time of discharge, as well as all procedures performed and complications experienced, shall be recorded in the discharge summary, using acceptable disease and procedural terminology that includes topography and etiology as appropriate ("Standard Nomenclature of Diseases and Operations").

(c) A short stay record may be used in lieu of a discharge summary in uncomplicated hospitalizations of less than forty-eight (48) hours.

25. Failure to Complete Medical Record

If the record remains incomplete at 28 days post discharge, the physician may be suspended. Notification of delinquent medical records will be sent the second week and third week post discharge and 72 hours prior to suspension per Health Records Information Services procedures. (See Monitoring Overdue Patient Records Documentation Standard, Administrative Manual, H.1.)

In order to facilitate continuity of patient care, medical record suspensions will begin six (6) weeks post discharge (specific timing specified in Health Records Information Services policy). Suspension is for a minimum of 7 days and will extend until medical records are complete. Suspension beyond 30 days are reportable to the National Practitioner Data Bank and will require reapplication to the Medical Staff.

Greater than 2 suspensions in a credentialing cycle will be referred to the Credentials Committee for consideration of further disciplinary action.

Failure to document admission History and Physical Examination within 24 hours of admission, failure to record pre-procedure documentation, failure to dictate or write operative/procedure notes immediately post operation/procedure, shall be grounds for disciplinary action as determined by Medical Staff governance.
C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, shall be obtained at the time of admission. In addition to obtaining the patient's general consent form for treatment, a specific consent form will be signed prior to: any non-emergent surgical/invasive procedure. A specific consent will be obtained for non-emergent transfusions. Consent forms will be approved by the Medical Executive Committee and by the Board of Directors and may be changed from time to time in order to conform to Federal/State laws.

2. The practitioner's chart entries must be written completely, clearly, legibly, dated and authenticated. Orders which are illegible or unclear will not be carried out until clarified.

3. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. "Off-label" use of pharmaceuticals will be in accordance with generally accepted standards of care and is subject to review of the Medical Executive Committee. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration, and the Hospital's Institutional Review Board.

4. All practitioners with clinical privileges in this hospital will provide continuous coverage for their inpatients. Such coverage can be fulfilled by prearranged cross coverage by physicians of similar expertise (See Admission and Discharge of Patients, Section A subparagraph 7 of the Medical Staff Rules and Regulations).

5. All practitioners with clinical privileges in this hospital will provide emergency call and inpatient consultation coverage within their defined clinical privileges as needed. Such mandated coverage shall not exceed one day in four or the equivalent.

6. Except in an emergency, consultation when applicable, is recommended:

   (a) When the patient is not a good risk for operation or treatment;
(b) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

(c) Where there is doubt as to the choice of therapeutic measures to be utilized.

(d) In unusually complicated situations where specific skills of other practitioners may be needed;

(e) When requested by the patient or his/her family;

(f) When any treatment or operative procedure that might interrupt a known or suspected viable pregnancy is contemplated.

(g) Prior to initiation of any oncologic therapy histologic confirmation by the St Mary’s Hospital Department of Pathology should be obtained.

7. The attending practitioner is responsible for contacting and obtaining consultation when indicated and for contacting a qualified consultant. (See Medical Records, #9, of the Medical Staff Rules and Regulations).

8. Consultations will be considered to be routine or emergent.

(a) **Routine Consultations Requests:** Consult requests designated as “routine” indicate that the requesting clinical provider wishes to present a patient to the on-call physician for the hospital, but that the patient’s condition does not require emergency consultations. The hospital on-call physician response time should be no greater than 12 hours, unless the requesting physician agrees to a longer timeframe.

(b) **Emergent Consultation Requests:** Consult requests designated as “emergent “ indicate that the requesting clinical provider wishes to present a patient to the on-call physician for the hospital and that the patient’s condition requires the hospital on-call physician’s prompt response. Since patient outcome in emergent cases may be directly related to care provided
by the hospital on-call physician, that physician shall respond by telephone within 15 minutes of receiving a call from hospital clinical staff and present in the hospital within 30 minutes (see also Section D.5.2.D.3). Any alternate in-person response time will be between the treating physician present in the hospital and the on-call physician. If the physicians are unable to reach an agreement as to the appropriate in-person response time for the on-call physician, then the opinion of the treating physician present in the hospital shall govern.

9. Medical Staff will follow the HIPAA Workforce Responsibilities Overview Standard, Administrative Manual, O-1.

D. Medical Staff Section Specific Rules and Regulations

1) Surgery

Except in emergency cases, an informed consent for: the operation, administration of anesthetics, and the rendering of other medical services will be completed on all patients to undergo surgery in this hospital. The exact content of the operative permit may change from time to time, but will be based on recommendations from the Executive Committee to the governing Board.

The provisional diagnosis shall be recorded prior to the performance of an operation.

Except in cases of an emergency, no patient will be admitted to the Operating Room for surgery unless the history and physical examination, consent, and pertinent lab data are recorded.

Surgical/Procedural reports shall be dictated or written in the medical record immediately after the procedure. (See Medical Records, Surgical Procedural Records section B-21)

All surgical procedures shall, at the discretion of the operating surgeon, have a surgical assistant appropriately credentialed for the procedure.

All general anesthetics are to be administered by or under the direct supervision of physicians with special training and with appropriate clinical privileges in anesthesiology as determined by the department of Anesthesiology.
The anesthesiologist shall record a pre-anesthesia assessment note prior to administration of the anesthetic. Following the operation, the anesthesiologist shall record and sign within 3 to 24 hours after the patient leaves the operating room, a post-anesthetic note describing the condition of the patient.

Specimens

Specimens removed during a surgical procedure shall ordinarily be sent to the pathologist for evaluation. Every gross specimen sent to the laboratory shall be examined by a pathologist. Exemptions to sending specimens removed during a surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exemption, when another suitable means of verification of the removal has been routinely employed, and where there is an authenticated operative or other official report that documents removal. All specimens not exempted must be sent to the Pathology Department for examination by a pathologist. Irrespective of exemptions, microscopic examinations will be performed whenever the surgeon requests it, or at the discretion of the pathologist when such an examination is indicated by the gross findings or clinical history. The categories of specimens that may be exempted from the requirement to be examined by a pathologist include the following:

A. General Surgery/Plastic Surgery

- Bezoars; calculi; clinically normal tissue removed during procedures (e.g. blepharoplasty); debridement for recent trauma; debridement from decubitus ulcer; fat contents from liposuction; fecaliths; foreign bodies removed at surgery (including foreign bodies that are medical legal evidence, such as bullets given directly to law enforcement personnel); hernia sacs in adults; medical devices not contributing to patient illness, injury, or death; panniculectomy tissue; portions of rib removed only to enhance operative exposure; scars from recent burns and trauma, or old scars from non-neoplasm surgery; subcutaneous tissue excess removed incidental to surgery approach; therapeutic radioactive sources; tissue expander implants; tissue from cosmetic repair of nose, ear and face; toenails and fingernails that are grossly unremarkable; traumatically amputated parts of extremities and traumatized digits.
B. **Gynecology**

Placentas from routine and uncomplicated pregnancies as well as C-Sections that appear normal at the time of delivery; vaginal tissue and vulvar skin removed during repair of rectocele and cystocele.

C. **Ophthalmology**

Cornea, not otherwise specified; extraocular tissue and tendon removed during strabismus surgery; iris removed at the time of peripheral iridectomy; lens cataracts; ophthalmologic plastic surgical tissues; scleral tissue removed at the time of trabeculotomy.

D. **Oral Surgery**

Teeth, where there is no attached soft tissue; bone associated with extracted tooth; dental appliances and restorations hardware.

E. **Orthopedics**

Bone from osteotomies; bone segments removed as part of corrective or reconstructive orthopedic procedures (e.g., rotator cuff repair, synostosis repair, spinal fusion); bone spurs; bunions; carpal tunnel tissue; femoral heads; knee joint removed for degenerative disease (excludes fracture); menisci; orthopedic appliances; osteocartilaginous loose bodies; patellar shavings; synovium from reconstructive surgery; tendons; toes removed for functional deformity (e.g., hammer toes and claw toes.)

F. **Otolaryngology**

Cartilage or bone removed during septoplasty or rhinoplasty; endoscopically removed foreign bodies.

G. **Pediatrics**

Foreskin from circumcision of a child; hernia sacs other than inguinal hernia sacs; supernumerary digits.
H. **Urology**

Foreskin, elective circumcision; penile implants.

I. **Vascular Surgery**

Artificial heart valve; mammary artery/vein excess from cardiac or peripheral bypass; pacemaker devices; saphenous vein segments harvested for coronary artery bypass; vascular graft material.

The following specimens, when submitted to Pathology, will ordinarily undergo gross examination and are exempt from routine microscopic examination:

1. Tonsils and adenoids from children less than 18 years of age; breast implants; items submitted from the above list of specimens where the pathologist will document a gross examination.

**2) Oral Surgery** is that part of dental practice which deals with the diagnosis and surgical and adjunctive treatment of diseases and injuries of the human jaw and immediate supporting structures. It is understood to include:

(a) Removal of teeth.

(b) Corrective hard and soft palate surgery including surgeries of the mandible and temporomandibular joint, including condylectomy and arthroplasty.

(c) Maxillary and mandibular fractures and associated soft tissue trauma, including open and closed reduction of fractures of the maxilla, mandible and zygomatic complex. Major facial fractures, including fractures involving the frontal sinuses and orbits must have appropriate preoperative physician consultation.

(d) Oral and maxillary infections, including the intra and extra oral incision and drainage, sequestrectomies and saucerization of osteomyelitis of odontogenic origin.

(e) Maxillary sinus disease of odontogenic origin, including closure of oroantral and oronasal fistulas.

(f) Surgical correction of congenital, developmental and acquired zygomaticomaxillary complex and mandibular deformities.
(g) Preprosthetic surgery including skin grafts involving oral tissues.

Patients may be admitted and discharged by members of the Oral Surgery Sub-Section.

Oral surgeons who admit patients for elective procedures without medical problems may perform the admission medical history and physical examination and assess the medical risks of the procedure to the patient, if they have been granted privileges to do so. Patients with medical problems or serious injuries admitted to the hospital by qualified oral surgeons and all patients admitted for dental care by dentists who are not qualified oral surgeons shall receive the same basic medical appraisal as patients admitted for other surgical services. For these patients a physician member of the medical staff must be responsible for performing the medical history and general physical examination and for caring for any medical problems or injuries which may be present upon admission or arise during hospitalization. The responsible dentist or oral surgeon shall take into account the recommendations of this physician and the overall assessment of the specific procedure proposed and the effect of the procedure on the patient. It is the physician's responsibility to determine the extent to which he/she will be involved in the care of each patient upon whom he/she performs a consulting history and physical upon admission. When significant medical abnormality or injury is present, the decision to perform the procedure or not must be a joint responsibility of the dentist or oral surgeon and the medical consultant. The dentist or oral surgeon is responsible for that part of the history and physical examination related to dentistry or oral surgery.

The physician member of the medical staff shall be responsible for the care of any medical problem or injury that may be present upon admission or that may arise during hospitalization of these patients. Certain patients cared for by oral surgeons at St. Mary's Hospital will have diseases and injuries with significant implications beyond the oral region. In such cases, these patients should have the overall supervision and medical care administered by an appropriately privileged physician.

Oral Surgeons dealing with lesions of the oral region, suspected of being malignant, must seek appropriate preoperative consultation. Malignant oral lesions which can be removed by an excisional biopsy and closed, primarily may be handled by Oral Surgeons. However, definitive treatment of major malignant disease is not considered to be within the realm of Oral Surgery at St. Mary's Hospital. Therefore, patients suspected of being in this category should be under the overall supervision of a physician with an Oral Surgeon acting as consultant when requested to do so.
Diseases and surgeries of the parotid gland (except for removal of parotid stones) are not considered to be within the realm of Oral Surgery at St. Mary's Hospital.

3) Dentistry

Patients admitted for dental care are the dual responsibility involving the dentist and the physician member of the Member Staff.

a. Dentists' responsibilities:

1. A detailed dental history justifying hospital admission;

2. A detailed description of the examination of the oral cavity and preoperative diagnosis;

3. A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

4. Progress notes as are pertinent to the oral condition;

5. Clinical resume (or summary statement).

b. Physicians’ responsibilities:

1. Medical history pertinent to the patient's general health;

2. A physical examination to determine the patient's condition prior to anesthesia and surgery;

3. Supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of the attending physician.

d. All oral reconstructive pre-prosthetic patients should have appropriate preoperative dental consultation.
4) OBSTETRICS AND GYNECOLOGY

1. Physicians with limited obstetrical privileges shall be required to call in a designated consultant in the following cases:

   (a) Prolonged labor, that is, after 24 hours of labor or obstructed labor.

   (b) All cases where the use of mid forceps is contemplated.

   (c) Severe hemorrhage.

   (d) Eclampsia, or severe Pregnancy Induced Hypertension

   (e) Malpresentation or dystocia.

   (f) Significant abnormality on the Fetal Monitor pattern.

2. A consultation with a designated obstetrical consultant shall be required in all cases involving operations which may interrupt a known or suspected viable pregnancy, unless a negative pregnancy test from St. Mary’s Hospital is included in the medical record.

3. A physician or Neonatal Nurse Practitioner qualified to care for the infant including intubation must be in attendance for all Cesarean Sections.

4. In cases of severe complications of the newborn, the attending physician shall call the appropriate consultant at once.

5. Maternal Rh factor shall be established no later than 24 hours after delivery, this may be done by producing previous documentation or a concurrent laboratory study. All Rh negative mothers will have cord blood tested.

6. An attending physician will have seen and evaluated the patient within 6 hours before oxytocic drugs are started for the induction or maintenance of labor pursuant to current policy adopted and approved by the Obstetrics and Gynecology Department. (See Induction & Augmentation of Labor Standard, Labor and Delivery Manual)
5) EMERGENCY SERVICES DEPARTMENT POLICIES, PROCEDURES AND REGULATIONS

1. The Emergency Department Physician (EDP) will be Board Certified or Board Prepared in Emergency Medicine.

2. PATIENT CARE IN THE EMERGENCY DEPARTMENT

   A. The following information shall be obtained from each patient presenting to the Emergency Area for medical assistance AFTER appropriate triage:

      1. Time of arrival;

      2. Chief complaint and brief summary of injury or illness;

      3. Authorization for treatment and responsibility;

      4. Standard admitting information; per COBRA/EMTALA

   B. Each patient presenting for treatment shall be evaluated by a triage nurse and categorized as to medical priority before being asked to submit to the outpatient admitting procedure. All patients arriving in the Emergency Department shall be evaluated and treated as soon as possible within the constraints of volume and acuity of patients in the department.

   C. Triage nurses shall be responsible for the initial appraisal, vital signs and preparation of the patient for treatment. The patient will be evaluated in accordance with COBRA/EMTALA Regulations. The EDP shall evaluate and initiate appropriate treatment and will be responsible for contacting the personal physician as to the nature of the case.

      1. Patients who are emergent shall be treated prior to notification of private physician if the situation is life-threatening. Care will be coordinated with a patient’s private physician at the appropriate time.
2. The patient will receive a medical screening exam by the Emergency Physician, appropriately credentialed allied health provider or by the patient’s private physician. The department will make a reasonable attempt to honor a patient’s request for evaluation and treatment by physician of patient’s choice.

3. The Emergency Department Physician shall after evaluation make a clinical judgment as to the nature of the problem and refer to the appropriate physician.

4. The patient shall be referred to his/her own physician following treatment, or if hospitalized, he/she shall be admitted by his/her private physician. In the event that another physician is "covering" for the patient’s private physician, the admitting physician will assume care responsibility until transfer back to patient’s primary physician is possible. The admitting physician shall be responsible for writing admitting orders.

5. In case of life-threatening emergencies, the EDP may provide immediate care irrespective of the lists and coverage.

D. All physicians on staff at the Hospital are subject to the Multi-Specialty Call List. The Multi-Specialty Call List identifies physicians who are expected to be available for emergent care in the Emergency Department and for in-hospital consultations. Failure to accept or comply with such call assignment will be referred to the Credentials Committee. Such mandated call shall not exceed an average frequency of one (1) 24 hour call day in four (4).

All physicians on the Active or Provisional Active Medical Staff of St. Mary’s Hospital shall serve on at least one of the call lists (unless excused as approved by the Credentials Committee/MEC to perform this service because of health or administrative reasons.) Patients who do not have a private physician will be
referred to the appropriate physician at the discretion of the EDP.

1. Any attending physician may take the call on any list for which he/she qualifies by virtue of his/her staff privileges.

2. If mutually agreeable, a physician on any list may assign his/her call to another physician who is qualified to serve on that list. The Emergency Department must be notified of the change. The physician will do his/her own arranging. It is understood that call for the day extends from 7:00 a.m. to 7:00 a.m.

3. A physician on the call list must respond by phone within 15 minutes and present to the Emergency Department or Hospital for consult within 30 minutes when requested.

4. Should a physician be unable to provide his/her call coverage, it is the responsibility of said physician to obtain coverage for his/her assigned call shift by a physician on the medical staff who has appropriate privileges at St. Mary’s Hospital.

5. If the call physician is unable to see the patient for any reason, it is their responsibility to provide an alternative method of care that is reasonable and acceptable to the requesting physician.

E. For all minors admitted to the Emergency Department, emergency care shall be started immediately if required. The signature of a parent or guardian will be required for treatment of any nonemancipated minor less than eighteen (18) years of age in all nonlife-threatening situations. If the circumstances make it impossible for parent or guardian to give written permission, telephone permission with two witnesses will be accepted. In the absence of parent or guardian, the Court shall be contacted immediately. (Minors may now receive treatment as required covered by State Law Statute C.R.S. #13-22-10, 18-6-101 and 25-4-402) In the
cases of emancipated minors, per State Law, parental consent will not be required.

F. No patient needing emergency treatment who presents in the Emergency Department shall be refused treatment.

3. CALL FOR ASSISTANCE

A. In the event that a number of patients have presented themselves in the Emergency Department and the Emergency Department Physician needs assistance, the call to staff physicians will be in the following order:

(1) Those physicians who in the judgement of the EDP are best suited to care for the patient or those physicians on the Multi-Specialty Call Lists for that particular day will be contacted.

(2) The Disaster Plan will be followed in case of a major disaster.

4. STAFF PHYSICIAN'S PRIVILEGES AND RESPONSIBILITIES IN THE EMERGENCY DEPARTMENT

A. Each attending physician may treat their patients in the Emergency Department, within the constraints of COBRA/EMTALA.

B. Each staff physician may complete an Emergency Department Preference Request which will be kept on file in the Emergency Department.

C. Patients presenting for care, or referred by their physicians, will be evaluated in every case.

(1) A diligent effort will be made to contact the patient's physician per the physician's preference request.

(2) A timely Medical Screening Examination in accordance COBRA/EMTALA Regulations will be performed by the Emergency Physician,
appropriately credentialed allied health provider or by the patient’s private physician. Staff physicians may order treatment in writing or by telephone which will be reviewed by the EDP when performing the Medical Screening Examination and coordinated with the staff physician by the EDP.

D. It shall be noted on the ED Record for all patients admitted to the hospital through the Emergency Department that the attending physician has been notified. In the event that the attending physician cannot be reached, the patient shall be admitted to the attending physician's designated alternate or to a physician of the Emergency Department Physician's choice. In every instance in which a patient having an attending physician is admitted through the Emergency Department, the attending physician or his/her alternate shall be informed of such admission.

5. IN-PATIENT EMERGENCY

A. The Emergency Department Physician shall be available for all "in-patients" in the event that an emergency arises, until the patient's physician can reassume care and insofar as such cases do not compromise the care of the Emergency Department patients.

6. EMERGENCY PHYSICIAN/PATIENT RELATIONSHIPS

A. Each patient shall be given instructions for further follow-up after care. Disposition will be documented on the patient's chart along with care instructions.

B. Law enforcement officers will be given the opportunity to interview the patient, with consent of the patient, as soon as possible. Generally, the Charge Nurse will control this access. If there is any doubt, the Emergency Department Physician on duty will make the final decision. The patient's health and personal rights shall not be compromised in any case.
C. All requests for information by the news media shall be referred to the authorized hospital personnel.

D. The ED record will be completed within 24 hours by the physician responsible for the ER care.

6. REHABILITATION –

I. The patient's attending physician and consulting physician will be determined at the time of admission/transfer. Responsibilities are for medical and rehabilitative care. All patients on the rehabilitation unit not admitted by a rehabilitation physician will have a rehabilitation consultation.

A. Attending Physician Responsibility:

1. History/physical on admission or a copy of the acute hospital's history/physical and discharge summary, with an update note. In the absence of an accompanying discharge summary, current medical and rehabilitation problems and goals should be outlined.

2. Admission orders.

3. Routine and ongoing medical care.

4. Availability by telephone at all times or have an assigned call-physician for coverage and notify the hospital of the coverage.

5. Write discharge order, dictate discharge summary and follow-up recommendations.

6. Three (3) attending or designee physician visits per week minimum.

B. Rehabilitation Responsible Physician

1. Documentation in the medical record of the physician's review of the rehabilitation
process; attend team/family conference as needed; participate in discharge plan.

2. The Medical Director of Rehabilitation shall provide direction to the team in quality evaluation.

7. CONTINUING MEDICAL EDUCATION REQUIREMENTS

All members of the medical staff are encouraged to have earned 60 hours of Category I (or equivalent) CME credit every two years.

Certain sub sets of the medical staff, (e.g., trauma service, physicians reading mammography, etc.) must meet CME requirements to maintain hospital certification.

8. MEDICAL ORDERS

1. GENERAL REQUIREMENTS:

(a) Orders must be written clearly, legibly and completely with date, and signature/authentication. Recording the time of orders is encouraged. Orders which are illegible or improperly written shall not be carried out until they are clarified by the attending physician and are understood by the nurse.

(b) The use of the terms "renew", "repeat", "resume" and "continue" standing alone on orders is not acceptable.

© Any patient changing level of care shall have order sets redone. (e.g., patients going to surgery, transferring into or out of critical care areas, rehab etc.) The medication reconciliation process should be used to reorder medication.

(d) All medications and treatments for all patients shall be reviewed by the attending physician to assure discontinuance when no longer needed. Orders for daily tests shall be renewed after three (3) days.
(e) No order shall be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

2. WHO MAY WRITE ORDERS:

(a) Medical staff physicians and allied health practitioners shall have the authority to write orders only as permitted by their clinical privileges and scope of practice.

(b) All orders must be entered in the patient's record, dated and signed by the responsible practitioner.

(c) Resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the attending physician responsible for the patient's care.

3. VERBAL ORDERS:

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence and signed by the responsible practitioner (Registered Nurse not LPN may take any orders, Physical Therapist may take physical therapy order, Pharmacist may take drug orders, Dieticians may take diet orders, etc.). The order shall include the date and signature of the person to whom the verbal order has been given. All verbal/telephone orders shall be authenticated according to Federal/ State law.

4. ORDERS FOR SPECIFIC PROCEDURES:

(a) All requests for radiological or other special examinations and services shall contain a statement of the reason for the examination.
(a) An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series.

5. Admitting Orders

At a minimum, admitting orders will include

- Admitting Diagnosis
- Activity Level
- Diet
- IV fluids if needed
- Medications
- Identification of Admitting Physician
- Cor Status

9. INFORMED CONSENT

1. Responsibility for obtaining informed consent:

(a) The hospital's admission consent form must be signed by the patient or the patient's representative at the time of admission. The admitting office shall notify the attending physician, and nursing director whenever such consent has not been obtained.

(b) After hospital admission, it shall be the responsibility of the physician to obtain informed consent from the patient: For example:

(1) the surgeon shall obtain the patient's informed consent to any surgical procedure to be undertaken, including ambulatory surgery;

(2) the practitioner performing a medical procedure which presents a substantial risk to the patient shall obtain the patient's informed consent for such procedure;

(3) the anesthesiologist shall obtain the patient's informed consent for the administration of anesthesia;

(4) the physician performing electroconvulsive therapy shall obtain the patient's informed consent to
the electroconvulsive treatment on the standard informed consent form provided by the Colorado Department of Human Services;

(5) The physician ordering the testing of any specimen of any patient for HIV infection shall obtain the patient's informed consent to such testing, except:

(i) where a health care provider or custodial employee of the Department of Corrections or the Department of Human Services is exposed to blood or other bodily fluids that may be infectious with HIV;

(ii) when the testing is done as part of seroprevalence surveys if all personal identifiers are removed from the specimens prior to testing;

(iii) when the patient to be tested is sentenced to and in the custody of the Department of Corrections or the Colorado Mental Health Institute at Pueblo and confined to the forensics ward of such institute;

(iv) and when a person is bound over for trial of a sexual offense.

(6) transfusion of blood or blood components.

(c) Except in emergencies, failure to include a completed informed consent form in the patient's medical record prior to the performance of surgery or diagnostic procedure shall cancel the surgery or procedure.

(d) Whenever the patient's condition prevents the obtaining of a consent, every effort shall be made and documented to obtain the consent of the patient's legal representative prior to the procedure or surgery. Any emergencies involving a minor or otherwise incompetent/incapacitated patient in which consent for surgery cannot be immediately obtained from parents, legal guardian or proxy decision maker in the absence of medical power of attorney should be fully explained on the patient's medical record. When deemed appropriate, a consultation
shall be obtained before any non-emergent operative procedure is undertaken which confirms the medical necessity for the procedure.

(e) Should a second operation be required during the patient's stay at the hospital, a second informed consent shall be obtained. If two (2) or more specific procedures are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

2. Definitions

The following definitions shall be applied when obtaining informed consent to treatment:

(a) Informed Consent - Consent obtained from the patient or the patient's legal representative after being informed by the attending physician of: 1. Nature of the ailment, 2. Nature of the operation, treatment or procedure, 3. Alternative treatments if any, 4. The substantial risks in undergoing the operation, treatment or procedure and, 5. The substantial risks, if any, involved in undergoing any alternative treatment. 6. Risks of refusal to undergo proposed treatment.

(b) Emergency - A situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent would further jeopardize the life, health or safety of the patient.

(c) Emancipated Minor - Any minor fifteen (15) years of age or older who is living separate and apart from his or her parent(s) or legal guardian, and is managing his or her own financial affairs, regardless of the source of his or her income, or who has contracted a lawful marriage. (In accordance with current Colorado State Law-13-22-103)


4. INCOMPETENT/INCAPACITATED PATIENTS:
Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a patient has been declared incompetent by a court, an informed consent form signed by the court appointed legal guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the informed consent of the patient's surrogate decision maker shall be obtained.

5. **UNUSUAL CASES:**

   (a) When questions arise regarding patient informed consent or when unusual circumstances occur not clearly covered by these rules and regulations, the attending physician shall promptly confer with hospital administration concerning such matters. The hospital will make every effort to assist the attending physician in obtaining the required consent and to provide information relative to such matters. However, it is the ultimate responsibility of the attending physician to comply with the requirements contained in these rules and regulations.

   (b) Clinical departments may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such form shall become effective when approved by the Executive Committee.

6. **REFUSAL TO CONSENT:**

   A patient or, if incompetent, the patient's representative retains the right to refuse medical treatment, even in an emergency situation. If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, a non-emergent refusal of treatment form and appropriate release or responsibility form should be executed, and, if possible, signed by the patient. Such form(s) should be kept in the patient's medical record.
APPROVED:

Roy Cromer, M.D. 06/29/2004

President - Medical Staff  Date

_________________________________ _______________
Chair- Board of Directors  Date

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