

MERCY MEDICAL CENTER REDDING
RULES & REGULATIONS OF THE MEDICAL STAFF
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ACCESSORY DOCUMENT
to the
MEDICAL STAFF BYLAWS
MERCY MEDICAL CENTER REDDING

RULES AND REGULATIONS OF THE MEDICAL STAFF

1. **Admissions:** All patients in the hospital shall have a member of the Medical Staff as attending physician and all such admissions shall contain an admitting diagnosis. For complex cases involving multiple providers, the attending physician is the physician of record and responsible for coordinating and overseeing a patient's care unless/until it is documented in the medical record that a patient has been signed off and accepted by another physician who shall then be the attending physician.

Comment [j1]: JCAHO Tip of the Week 7/6/04 from CHW

Clear identification of the physician who is currently responsible for the primary management of every patient is necessary to ensure quality of care. To meet this need, when the responsibility for primary management of a patient changes from one physician to another, this information must be clearly communicated to those involved in the patient's care. It is the responsibility of the current physician to give the transfer of care information in the form of a physician's order in the patient's chart. Nursing shall then have this information readily available for all care providers. The physician transferring care to another must communicate pertinent patient information to the physician assuming care and include an opportunity to ask pertinent questions.

Emergency Physicians: Once the Emergency Physician and admitting physician have agreed that a patient is to be admitted to the hospital, and agree upon the type of bed needed, either the admitting physician will immediately give telephone orders for the admission or the Emergency Physician (on behalf of the admitting physician) will write brief "holding orders" to admit the patient to the agreed upon bed type. In addition, in order to facilitate accurate transcription of orders, patient safety, and nursing care, when telephone admitting orders are given they should be given to a nurse on a standard form and kept to a minimum for appropriate patient care.

Comment [j2]: Developed at the request of the ER physicians and approved by the MEC 8/08.

Dentists and Podiatrists: Dentist and podiatrist members of the medical staff may admit patients for diagnosis and treatment of conditions within the scope of their licensure. The medical history and physical examination of the patient, evaluation of operative risk, and responsibility for the treatment of specific concomitant medical disease throughout the period of hospitalization are the responsibility of a consulting physician, except that qualified oral and maxillofacial surgeons may do their own H&Ps.

Comment [j3]: MS.6.2.2.2 & MS.6.2.2.3

2. **Medical Records:** The attending physician shall be responsible for the preparation of a complete medical record for his/her patient. This shall include a history and physical, appropriate progress notes, and an appropriate discharge summary (discharge summary not required for uncomplicated admission of less than 48 hours or normal OB deliveries).

No medical record shall be filed until it is complete except on order of the Quality Improvement & Assessment Committee.

- a. **TIMING OF THE MEDICAL RECORD** – All patient medical records must be legible, complete, dated, timed and authenticated in writing or electronic format.
- 1) An H&P or its equivalent shall be completed by a hospital credentialed or non-credentialed licensed practitioner* on any patient requiring surgery or any potentially hazardous diagnostic procedure(s), or admission. A brief, handwritten note will be placed in the progress notes on admission if the history and physical is not available. The appropriately complete history and physical will be

completed within 24 hours of admission. If an H&P exam has been performed within 30 days before admission, that report may be used in the patient's record provided an interval note* is entered into the record No later than 24-hours of admission or prior to the surgical procedure.

Comment [J4]: JCAHO

Comment [J5]: Title 22: 70717 (d)

* LIPs, Nurse Practitioners, Physician Assistants, or Nurse Midwives.

- 2) Patients going to surgery must have a complete H&P or its equivalent within 30 days of surgery and an interval note* or progress note recorded 24-hours prior to surgery. A preoperative diagnosis must be completed prior to surgery.

Comment [J6]: (Title 22: 70223)

* An interval note should compliment the original H&P and specify any changes to the original document/findings (vital systems, organs or areas of the body that will be having procedure or surgery, pertinent negatives, etc.) This note must be dated and timed to correspond with the time the review of the patient occurred.

Comment [J7]: Per Dr. Way of DHS 8/04

- 3) Indicated diagnostic tests shall be completed within 72-hours prior to the operative episode.

Comment [J8]: (Title 22: 70223)

- 4) Progress notes may vary in frequency and should be appropriate for the degree of illness. As a minimum, progress notes will be written once per day unless the patient is on administrative days waiting SNF placement.

- 5) Surgical cases will have a brief dictated or handwritten post-operative note written immediately after surgery and an appropriate dictated operative note must be completed within 24 hours after surgery/procedure.

Comment [J9]: (IM.7.3)

- 6) Post-op/post procedural documentation should include a description of the findings, the technique used, the tissue removed or altered, the post-operative diagnosis and estimated blood loss and complications.

- 7) A discharge summary shall be dictated or written and authenticated within fourteen (14) days after discharge. A discharge summary shall include all of the required elements as summarized below (see paragraph c).

Comment [J10]: (IM.7.2, IM.7.8 & Title 22: 70751)

- a. A completed discharge summary (handwritten or transcribed) will be available at the time of transfer for all patients going to **another acute care facility or a long term care facility (LTAC)**.
- b. Patients being **transferred to a skilled nursing facility (SNF) or convalescent facility** must have at a minimum (in addition to the H&P) the progress notes with one last note up to the date of transfer specifying the plan of care and updating the patient's status or confirming there was no change in their condition. This may be verbally communicated to the receiving facility, but documentation that such has been done shall be documented in the medical record.
- c. Discharge summaries for patients pending transfer or placement may be completed the day prior to transfer (no greater than 24-hours) with an update note the day of transfer.

- 8) All inpatients require a post anesthesia note by the person who administered the anesthesia within 48-hours of surgery.

Comment [J11]: (COP: 482.52 (b) (3))

b. **ALTERATIONS OF MEDICAL RECORDS**

If changes are made in the medical record, no sheet or parts of sheets may be removed. Unwanted portions may be lined out signed and dated. Additions or changes should be similarly signed and dated.

c. **DISCHARGE SUMMARY**

Comment [J12]: (CC6.1.1, PF.3.9 & Title 22 70749)

A provisional discharge diagnosis is required prior to the patient's departure. The discharge diagnosis will be noted on the discharge summary. For those patients who don't require a discharge summary, the discharge diagnosis will be noted on the final progress note, with the discharge order, or on the face sheet. For outpatient surgery patients, this may be documented on the Operative Report as the "final diagnosis". "Post-op diagnosis" is inadequate, the words "final diagnosis" must be used.

Patients shall be discharged or transferred from the facility only upon order of the attending or covering physician.

- 1) Patients will be informed in a timely manner of the plan for discharge or transfer and informed of at a minimum and where appropriate,
 - Conditions that may result in transfer;
 - Alternatives to transfer;
 - Clinical basis for discharge;
 - Anticipated need for continued care.

- 2) A discharge summary shall be completed for all patients discharged or transferred from the facility and documented in the medical record. Included shall be at a minimum and where appropriate,
 - Date of admission and date of discharge;
 - Admitting diagnosis and history;
 - Significant clinical findings;
 - Hospital course (including procedures performed and treatment rendered);
 - Complications;
 - Discharge instructions and plan for follow-up care (including activity, diet, and medications);
 - Disposition (if transferred);
 - Principal discharge diagnosis (written at the time the discharge order is given).

- 3) It is the physician's responsibility to pronounce a patient dead. It is not necessary for the decedent's own physician to perform this function if another physician is available. State Law requires that a second physician independently confirm a patient's brain death.

- 4) The attending physician (i.e. who admitted or provided the majority of the care) or physician who pronounced a patient will within 15 hours after the death complete the death certificate.

Comment [J13]: (CA Health & Safety Code 7181)

Comment [J14]: (CA Health & Safety Code Article 2: §102825)

d. TNM STAGING

TNM staging for all cancer patients is required by the managing physician. Staging is to be filled out on the designated TNM form, including physician signature. Cases may be clinically or pathologically staged.

e. LEGIBILITY

All written documentation within the medical record, including but not limited to nursing notes, progress notes, consultation records, physician orders, treatment orders, medication orders, etc., shall be legible. All healthcare providers who make entries into the medical record shall follow approved hospital and medical staff policies.

Comment [J15]: (MS.8.2.3)

The process for addressing legibility concerns shall be as follows:

- Medication errors that result from an illegible order shall be reported using the Event Report System and forwarded to the Risk Management.
- Unresolved legibility issues with physicians and allied health professionals shall be reported to the Medical Staff Executive Committee.
- If more than three (3) legibility issues are identified in a three-month period, intensive review of the provider involved will be performed with appropriate action taken.

3. Consent:

- a. Informed Consent:** It shall be the treating physician's exclusive responsibility to obtain and document the informed consent from the patient or his/her legal representative or surrogate decision-maker for any procedure or treatment that is complex and is not covered by the consent obtained at admission. Generally, it is necessary to obtain informed consent for any surgery or for any treatments or procedures that are complex and are not simple or common (excludes PICC lines). Obtaining informed consent when the patient is a minor especially if the minor is over the age of 14 or a minor and incompetent is especially problematic. If there

Comment [J16]: Clarified by MEC 3/09

are questions, legal advice should be sought.

1. **Surgical Procedures:** An invasive procedure shall be performed only on informed consent of the patient or his legal representative, except in emergency. Prior to obtaining informed consent, a discussion including the following elements shall occur with the patient and/or family:
 - The proposed care, treatment, and services ~~intervention/procedure~~, potential benefits, risks, side effects including death, the likely problems that might occur during ~~potential~~ recuperation ~~problems~~, and likelihood of achieving goals.
 - Reasonable alternatives to the patient's proposed care, treatment, and services and the relevant risks related to not receiving the proposed care, treatment, and services.
 - *Reasonable alternatives*
 - Limitations on confidentiality of PHI.The primary ~~physician surgeon~~ will validate in the medical record that the informed consent has been obtained.

Comment [J17]: (TX.5.1, IM.7.2, RI.1.2.1)

2. **Emergency Situations:** In the case of emergency where delay would result in immediate danger to the life and health of the patient, and where it is impossible to obtain the consent of the patient or his/her legal representative, the attending physician should specifically document in the medical record that such an emergency exists, and surgery or procedure to correct or treat the **emergency condition only** may be performed without prior consent.

3. **Blood Transfusion:** The physician shall document in the medical record that discussion with the patient and/or family about the need for, risks of, benefits, potential complications, and alternatives of blood transfusion has been performed, for all appropriate non-emergent ~~procedures~~.

Comment [J18]: (TX.5.2)

4. **Incompetent Adult:** Where the patient is temporarily or permanently incompetent and the emergency situation exception does not apply, the physician should determine if the patient has an Advanced Directive to determine whom the patient has appointed to make medical decisions on his/her behalf.

If there is no Advance Healthcare Directive, the law recognizes that the closest relative may make medical decisions on the patient's behalf. Hospital policies should be consulted to determine who the proper individual is to make such decisions. Please note that a conservator may not have the authority to make medical decisions unless the court order or letters of conservatorship specifically provide the conservator with the authority to make medical decisions.

5. **Hysterectomy/Sterilization Procedures:** Particular attention must be made to make sure proper consent has been obtained prior to the hysterectomy given that it will result in a sterilization. Any procedure that results in sterilization must be performed according the Hospital policies and procedures and consent to such procedures must be carefully documented with the proper consent forms executed. State and Federal law provides particular consent forms that must be explained by the physician and signed by the physician and patient.
- b. **Hospital Form:** The hospital form must state the name of the attending physician and/or treating or operating surgeon and the name of the proposed procedures and describe the nature of the treatment. The hospital staff's role is limited to verifying with patient or family/agent that the physician has obtained informed consent. If informed consent cannot be verified, the hospital will not allow the physician to perform the procedure. The hospital form "Consent to Surgery or Special Procedure" is used **after** the physician obtains informed consent. The patient's signature on this form acknowledges that his/her physician has adequately explained the procedure and the patient agrees to treatment.

4. **Consultations:** Except in emergency, consultations with another qualified physician are required when, according to the judgment of the physician:
- The patient is at unusual risk;
 - The diagnosis is obscure;
 - Patient not responding to treatment as expected;
 - Patient requests clinical consultation or a second opinion;
 - The primary physician does not hold privileges for certain aspects of the patient's care.

Consultation on any procedure may be required of any staff member when, in the judgment of the division chair, unit medical director, or chief of staff such action seems warranted on the basis of division chair, unit medical director, or chief of staff findings.

The attending physician is responsible for requesting a consultation. All requests for consultations will be initiated and/or modified by direct physician-to-physician contact between the attending physician and the consulting physician. The only exception to this rule is for Advanced Practice Providers. When consultation is requested and there is question about timeliness or type of study to be conducted, the consulting physician will directly communicate with the attending physician for clarification. Consultations for inpatients are to be completed within 24-hours of request, unless as mutually agreed upon by the attending and consultant.

Comment [J19]: September 2003
MEC

Consultant: A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The requested consultation must be within a reasonable period of time as dictated by the clinical circumstances of the patient.

Essentials of a Consultation: A satisfactory consultation includes examination of the patient and the record. A written opinion appropriate for the problem will be included in the patient's medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation. A "curbside" or telephone consult is not recognized as formal consultation.

5. **Medical Record Completion:** In-house patients will have the medical record monitored by nursing staff and Case Managers.

It is highly desirable that medical records be completed at the time of the patient's discharge; however, it is recognized that Section 70751 (g), Title 22, California Administrative Code provides:

"Medical records shall be completed promptly and authenticated or signed by a physician, dentist or podiatrist within two weeks following patient's discharge."

Chart Completion: Charts must be completed, including signatures, within 14 days of discharge. Failure to complete charts within 14 days will result in suspension.

Failure to complete history and physical, operative reports, discharge summaries, and incomplete records in accordance with these Rules and Regulations will result in suspension of privileges. This shall be defined as follows:

- Suspended physicians cannot admit *or transfer* any new patients directly to the hospital. If a true emergency exists, the physician may proceed as indicated by the patient's condition but all such events will be reported to the Medical Staff Services Department for review by the Chief of Staff or his/her designee.
- Suspended physicians cannot schedule any new inpatient or outpatient surgeries or procedures (i.e. radiology, cardiology, endoscopy, etc.)
- Suspended physicians cannot provide consultations to inpatients or outpatients.
- The suspended physician may continue to provide care for those inpatients directly under his/her care prior to the suspension.
- The suspended physician may continue with any surgery or procedure that was scheduled prior to the suspension.

- f. Suspended physicians may only participate in ER call on the approval of the Chief of Staff or his/her designee.
- g. Once the incomplete reports or charts are completed, the physician's admitting privileges will be restored.
- h. If physicians complete all medical records available to them in a weekly manner, they will not be placed on suspension for at least one week.
- i. Any physician reaching 90-days of suspension for incompleteness of medical records will be placed on a 10-day administrative leave. This leave will be in effect without right of appeal regardless of when records are completed. At 120 days, another 10-day administrative leave will be in effect. If at the end of the administrative leave the affected physician has still not completed the records, the MEC will consider summary suspension of all privileges subject to the Medical Staff Bylaws, Fair Hearing Procedure.
- j. When corrective action is necessary for chronic offenders, refer to Medical Staff Bylaws, Fair Hearing Procedure.

Comment [j20]: (MEC 11/03)

6. **Access to Medical Records:** Access to the patient's medical record is limited to those engaged in that patient's care. Exceptions are listed below:
- a. Medical record information may be disclosed to public agencies, clinical investigators, health care research organizations, and accredited public or private nonprofit educational or health care institutions for bona fide research purposes upon prior approval by and upon such terms as may be imposed by the Executive Committee. No such information shall be further disclosed by the recipient in any way which would permit identification of the patient.
 - b. Medical information may be provided for any other purpose authorized by law in the discretion of the Chief Executive Officer of the hospital or his designee.
 - c. Subject to the discretion of the Administrator and the Chief of Staff, former members of the medical staff shall be permitted free access to information from medical records of their patients covering all periods during which they attended such patients in the hospital. In case of re-admission of a patient, all previous records shall be available for the use of professionals providing care to the patient. This shall apply whether the patient be attended by the same physician or not.

Any member of the medical staff who, in violation of this rule, obtains access to the medical records of a patient shall be subject to corrective action. The prohibitions of the rule shall not apply to medical staff committee members reviewing patient records in the course of their responsibilities as committee members and when authorized by the appropriate committee.

7. **Form of Orders:** All orders for medications, care, treatment or services (including diagnostic studies) shall be in writing and shall be legible.

A verbal order shall be considered to be in writing if dictated to a practitioner authorized to receive a verbal order. The use of verbal orders shall be minimized and should be limited to those situations in which it is impossible or impractical for the prescriber to write the order or entry into a computer.

- Verbal Orders (V.O.) are any orders transmitted verbally rather than in writing.
- Telephone Orders (T.O.) are verbal orders received over the telephone.

A faxed written order or an order entered directly into an electronic system by the prescriber is considered a valid, written order. A faxed signature or an electronic signature has the same effect as a hand-written original signature.

Who May Receive Verbal Orders:

The following categories of care providers are authorized to accept telephone/verbal orders for any medication with which they are familiar.

- a. Registered Nurse
- b. Licensed Vocational Nurse
- c. Pharmacist
- e. Physician's Assistant

The following categories of care providers are authorized to accept telephone/verbal or telephone orders for medications related to their practice within the hospital (consistent with their job description and state law):

- f. Respiratory Care Practitioner
- g. Nuclear Medicine Technologist
- h. Radiation Technologist

Nursing may accept a telephone/verbal order for all non-medication care, treatments, and services (including diagnostic studies). Other disciplines may accept telephone/verbal orders for non-medication care, treatments and services (including diagnostic studies) which they or their department provides. For example, dieticians may accept telephone/verbal diet orders, physical or occupational therapists may accept telephone/verbal orders for physical or occupational therapy, etc.

DNR: Only a registered nurse may accept a telephone/verbal order for the withholding or withdrawal of life support. In addition, a second registered nurse must validate the order by overhearing the transmission of the order or by a separate conversation with the ordering provider.

Restraint Orders (See Rule & Regulation #21):

Med/Surg Restraints:

- Restraints must not exceed 24-hours.
- A physician must be contacted within 12 hours to issue a telephone/verbal or written order covering the emergency use of restraint.
- Continuation of restraints beyond a 24-hour period must be on written physician order based on a face-to face assessment of the patient.
- An order continuing a restraint must be obtained no less often than once each calendar day.

Behavioral Management Restraints:

- Each written order for restraint is limited to, 4 hours for adults age 18 and older, 2 hours for children and adolescents age 9-17, or 1 hour for patients under age 9.
- If a telephone order was received, the physician must perform a face-to-face evaluation of the patient **within one (1) hour** of the initiation of the restraint.
- Subsequent orders may be obtained following an assessment by the physician or RN. The physician must conduct an in-person reevaluation at least every 8-hours for patients age 18 and older or 4 hours for patients 17 or younger.

Read Back:

All verbal medication orders shall be written on a piece of paper or entered into a computer and then read back, word for word, to the prescriber before it is acted upon. The person taking the order need **not** document the read back process.

Exception: in some situations it is not practical for the person receiving the order to write it before carrying it out. Such situations may include emergency resuscitation or during invasive procedures where the person administering the medications has "scrubbed in." In such cases, it is acceptable for the person receiving the order to repeat the order to the prescriber rather than first writing the order down and reading it back. Repeat back rather than read back should be minimized and used only when a true "read back" is not possible.

Format of Telephone/Verbal Orders:

A telephone/verbal order shall be complete (as defined elsewhere in hospital policy) and shall include the date and time of transcription, the person recording the verbal order, and the person issuing the order.

Countersignatures:

Telephone/verbal orders shall be countersigned, dated and timed by the prescriber, or another physician if the prescriber is not available, within forty-eight (48) hours. Faxed or electronic signatures may be used to authenticate a verbal order. Verbal orders for the withholding ("DNR") or withdrawal of life support shall be countersigned within twenty-four (24) hours. **Verification of Timeliness of Countersignature:** The timeliness of the countersignature may be verified either by dating and timing the countersignature or through administrative mechanisms.

Effect of Countersignature: By countersigning a telephone/verbal order, the practitioner merely indicates his or her review of the order. The countersignature does not signify that the order was accurately transcribed or that the person countersigning to order agrees with it. However, the person countersigning the order shall be responsible for reacting to any obviously inappropriate or dangerous aspects of the order.

8. **Orders for Drugs:** No drugs shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illness. All such orders shall be in writing and signed, dated, and timed by the person giving the order. Verbal orders for medications may be given only to a licensed pharmacist or licensed nurse and shall be immediately recorded in the patient's medical record and shall be signed, dated, and timed by the prescriber within 48 hours. It is acceptable for a covering physician to co-sign the verbal order of an ordering physician who is "off duty".

Comment [j21]: (42 CFR 482.23 ©(2)(iii))

The blanket reinstatement of orders (i.e. "resume all meds") is not permitted. Each medication order must be individually re-instated when a patient:

- *Transfers from one level of care to another (e.g. ICU to a Medical/Surgical Unit);*
 - *Transitions from post-operative care;*
 - *If orders were held prior to the performance of an invasive and/or diagnostic procedure.*
- Transfer orders will be printed out and available to the physicians prior to any change in patient status.

9. **Stop Order on Drugs:** Certain medications, such as narcotics, sedatives, and antibiotics, shall be discontinued after a given period of time as determined by the Pharmacy & Therapeutics Committee, unless otherwise ordered by reorder stamp on the order sheet. If the order expires in the night, it shall be called to the attention of the physician the following morning. Drugs shall not be discontinued without notifying the physician.

10. **Vacant**

11. **Autopsies:** An autopsy shall be performed after appropriate consent is obtained from the legally authorized representative. Physicians should refer to the following list of situations which may suggest the performance of an autopsy:

Comment [j22]: (MS.8.5) (College of American Pathologists)

- a. Death is determined to be a Coroners Case (Admin. Policy #X.C.0)
- b. Cause of death or other significant medical diagnosis is in doubt
- c. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
- d. Cases in which autopsy may help to allay concerns of, and provide reassurance to, the family and/or the public regarding the death.
- e. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
- f. Deaths in patients who have participated in clinical trials (protocols) approved by Institutional Review Boards.
- g. Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.
- h. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at the hospital; deaths occurring in the hospital within 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- i. All obstetric deaths.
- j. All perinatal and pediatric deaths.
- k. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.
- l. Deaths known or suspected to have resulted from environmental or occupational hazards.

The practitioner in charge of the case will be notified that the autopsy will occur.

12. **Committee Requests:**

- Committee requests for written responses from physicians must be answered by the next scheduled committee meeting or within 30-days, whichever is sooner.
- Failure to respond in this time frame will result in a second letter that must be answered within two weeks after receipt of the request.
- A lack of response to the second request will result in a personal call from the Division chairman.
- If no response is received by the second scheduled committee meeting or within 60-days, whichever is sooner, the committee will make an initial disposition on a case without input of the physician. A letter of the committee's determination will be sent to the physician with an opportunity to request that the committee revisit the disposition. No response by the next scheduled meeting will be deemed as acceptance of the disposition.

13. **Primary Physician in the E.R.:**

The E.R. physician is initially responsible for the patient until a second physician he/she has contacted has accepted the responsibility for care. This physician may be chosen by the E.R. physician, except in cases of multiple trauma, who shall be designated by the on call trauma surgeon.

14. **E.R. Call Responsibilities:**

- a. Physicians wishing to participate on the voluntary back-up E.R. call roster will notify the chief of the division to which he belongs.
- b. Physicians newly appointed to the Provisional/Active Staff will participate in the call roster but no more than one day in four during their first twelve months of service. Specialties where there is no formal call schedule or needed coverage will be excluded. Any disagreement or conflict will need to be addressed by medical staff leadership. Said twelve months begins as follows:
 1. Medical Specialties - Upon appointment to the Provisional/Active Staff.
 2. Surgical Specialties - Upon satisfactory completion of the monitoring/proctoring program (see Monitoring Process, Credentialing Policy Manual, Section 8).
- c. The division chief, or his designee, is responsible for providing the E.R. with call rosters for his service(s) and will notify the E.R. in advance if there are "holes" in coverage.
- d. The On-Call Physician who provides his/her name to the Emergency Room shall be responsible for personally providing coverage during his/her scheduled time or for arranging for coverage by another equally qualified Medical Staff member with appropriate clinical privileges. On-call physicians must respond to the Emergency Room within 30 minutes of the call from the Emergency Room in non-level one trauma cases. The notification of an on-call physician shall be documented in the medical record and any failure or refusal of an on-call physician to respond to call shall be reported to the Medical Staff Executive Committee. (Reference MEC Policy/Procedure "Compliance with EMTALA".)

15. **Allied Health Personnel (AHP)**

- a. The written orders of the physician shall designate, by name, the AHP to provide the services, unless the provider is an employee of the hospital.
- b. It is the supervising physician's responsibility to ensure that AHPs are working within their scope of practice and not functioning autonomously in their roles.
- c. The supervising physician shall be available in person or by electronic communication at all times when an AHP is caring for a patient.
- d. All entries into a medical record by an AHP must be countersigned/dated/timed by the supervising physician **within 24-hours** of the entry. The only exception will be for the Employee Health Practitioner or Mercy Family Health staff in which written protocols for oversight shall be in place and at least 10% of all orders will be countersigned and timed by a supervising physician **within 30-days** of entry.

- e. H&Ps completed by an authorized AHP for patients undergoing surgery or high-risk diagnostic or therapeutic intervention must be co-signed by the supervising physician prior to the case.
- f. All patients are to be examined by the supervising physician **the same day as** care is provided, excluding patients seen by the Employee Health Practitioner or Mercy Family Health staff.
- g. It is the physician's responsibility to obtain informed consent from patients.
- h. Any medication ordered by an authorized AHP is only done so on behalf of the supervising physician **whose name must also be included** with the order.

Allied Health Personnel are further described in the Medical Staff Bylaws and Interdisciplinary Practice Committee Procedure Manual.

16. **Attempted Suicide, Emotionally Ill, or Substance Abuse Patients:**

Comment [J23]: (MS.6.7)

For the protection of patients, the medical and nursing staffs and the hospital, appropriate precautions are to be taken in the care of the emotionally ill, alcoholic, drug overdosed, and the potentially suicidal patient.

In the event of attempted suicide, a psychiatric consultation shall be offered to the patient and the patient's response to the referral shall be documented. In the event that a patient admitted to the hospital is then or later suspected of being suicidal, he/she should be transferred to an appropriate facility.

When a patient is difficult to handle, the attending physician, family, Social Services, and nursing are to determine the most appropriate means to assure the safety and comfort of all concerned. In all instances, the attending physician will make all decisions necessary for the care and handling of the patient.

Primary Psychiatric Diagnoses: Patients with a primary psychiatric diagnosis should not be admitted to the hospital. If such a patient is admitted, the attending physician should make arrangements for consultation and transfer to an appropriate institution within a reasonable period of time.

17. **Physician Behavior/Disruptive Conduct:**

Expectations:

All physician behavior and actions are consistent with Catholic Healthcare West's core values of:

- ❖ Dignity – Respecting the inherent value and worth of each person.
- ❖ Collaboration – Working together with people who support common values and vision to achieve shared goals.
- ❖ Justice – Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
- ❖ Stewardship – Cultivating the resources entrusted to us to promote healing and wholeness.
- ❖ Excellence – Exceeding expectations through teamwork and innovation.

It is the policy of Mercy that all persons within its facilities be treated with courtesy, respect, and dignity. The purpose of this policy is to ensure optimum patient care by promoting a safe, cooperative and professional health care environment. Disruptive behavior prevents cooperation and adversely affects patient care. The Medical staff has a zero-tolerance policy toward disruptive behavior. Members who engage in a pattern, or even one egregious instance, of disruptive conduct shall be subject to disciplinary action in accordance with the Mercy Medical Staff Bylaws. This policy is a supplement to the Corrective Action procedures under the Bylaws and serves as a guideline.

Unprofessional behavior

Unprofessional behavior may include, but is not limited to:

- Demeaning or disrespectful behavior toward others,
- Using abusive language,
- Inappropriate touching or physical assault,
- Sexual harassment,
- Criticizing staff in an inappropriate setting or manner,
- Intimidating or threatening behavior,
- Throwing instruments or other objects in a patient care setting,
- Impaired behavior resulting from alcohol or other substance abuse,
- Inappropriate comments written in the medical record,
- Retribution toward employees for reporting inappropriate behavior.

Awareness

To promote awareness of the policy, all new applicants to the Medical Staff and all current members applying for reappointment will be given a statement of behavioral expectations with their medical staff application forms and will be asked to sign a statement that they have read them. The signed statement will be retained in the Medical Staff member's credentials file. In addition, all members applying for reappointment will receive notice of any occurrence reports involving their behavior that have been written since their last appointment.

Procedure

Unprofessional behavior must be documented—especially patterns. Directly involved individuals are encouraged to fill out an occurrence report or write a letter to the administration and/or medical staff. Reports concerning medical staff members will be reviewed by the Vice President of Medical Affairs and the appropriate Division Chair, and, if necessary, the Chief of Staff. Reports will be acted upon in a timely manner, based on the severity of the event. The report may be investigated by the Division Chair and then, if appropriate, brought to the full committee. Further investigation may take place, as deemed by the committee. Before any punitive action is taken, the committee should receive input from the physician involved, either personally or in writing. If after documented adequate notice, the physician does not choose to respond, the committee may take punitive action without his/her input. Additional information from the instigator of the report may also be warranted.

Action

After investigation of the complaint, the committee may do any or all of the following:

- a. Take no action (allegation not confirmed or substantiated).
- b. Issue a warning, written or verbal, to the referred physician, with tracking.
- c. Request written apology by member to the affected party.
- d. Refer member to the Well-Being Committee for review.
- e. Request member to attend meetings with involved individuals, supervisors, etc.
- k. Recommend monitoring by another individual in a certain setting or at certain times where behavior is most likely or most disruptive.
- l. Recommend restriction or removal of privileges.
- h. Refer member to the Medical Executive Committee for consideration of disciplinary action as deemed appropriate by the Committee.

Guidelines

- a. Confidentiality. All persons will maintain strict confidentiality involved in an investigation or proceeding involving alleged disruptive behavior of a medical staff member.
- b. Physicians who require ongoing monitoring will be monitored under a written Agreement, the terms and conditions of which will be set forth in a written document, and agreed to by the affected member and the Committee. The Agreement will be enforced by the Committee according to these terms and conditions, until, in the judgment of the Committee, the rehabilitation process is stabilized. At such time, the member may be released from the Agreement.

- c. The goal of the process is rehabilitation, whenever possible, but patient and employee safety must be paramount.

18. **Ethical and Religious Directives:** The medical staff, acknowledging that the hospital operates as an extension of the religious works of the Sponsoring Congregations of Catholic Healthcare West, agrees that the actions of the medical staff and its members, within the facilities, departments and programs of the hospital, shall conform to the Ethical and Religious Directives for Catholic Healthcare Services as promulgated, from time to time, by the National Conference of Catholic Bishops. A copy of the Ethical and Religious Directives shall be maintained in the Medical Staff Office and may be reviewed and/or copied by any member or applicant for medical staff membership at any time during normal business hours.

19. **Dues/Assessments:**

Dues: All medical staff members and allied health professional are responsible for paying annual dues payable in March of each year. Fees are as follows:

- Active and Provisional/Active Staff Members \$250.00
- Affiliate and Provisional/Affiliate Staff members \$100.00
- Allied Health Professional Staff members \$ 50.00

** Dues can be reduced by a maximum of \$100.00 annually through participation in the medical staff process (Active and Provisional/Active Staff members only).

- ⇒ Committee of the Membership meeting attendance = 25 pts/mtg
- ⇒ Division, Peer Review or other Medical Staff meeting attendance = 5 pts/mtg

Every 5 points earned is equivalent to a \$5.00 reduction and participation in a minimum of 50% of the meeting is needed to be considered "attendance".

Dues may be waived only on the approval of the Medical Staff Executive Committee. Providers who do not pay dues as required are subject to immediate termination from the medical staff as outlined in Article V Section 1(c) and Section 5 (a) of the Bylaws.

Application Fees: A one-time fee is required for processing of any new application. This one fee covers application to one, two, or all three of the hospitals in the North State Service Area. Fees are as follows:

- Full Medical Staff membership (Active, Affiliate, Telemedicine) \$ 300.00
- Fast Track Applications* (approval needed within 30-days) \$ 600.00
- *Applications must meet category 1 criteria.
- Privileges to provide Locum Tenens Coverage \$ 50.00
- Privileges for One Time Surgical Assist Waived
- Privileges for Emergency Situations Waived
- Allied Health Professional Staff membership \$ 50.00

20. **Medical Screening Exam (MSE)**

An MSE must be performed by a qualified medical professional (QMP) or a physician on:

- All patients presenting to the hospital requesting examination or treatment.
- All patients presenting by ambulance.
- All patients presenting in a condition of pregnancy. Some patients may require a portion and/or completion of the MSE in the Labor and Delivery Department.
- Hospital employees presenting to the Employee Health Department, Occupational Health Department, or the Emergency Room will be include in the term "patients".

Depending on the patient's presenting symptoms, the MSE represents a spectrum ranging from a simple process involving only a brief H&P examination to a complex process that involves the performance of ancillary studies and procedures, such as but not limited to, lumbar punctures, clinical laboratory tests, CT scans, diagnostic tests and procedures, etc. **Triage is not equivalent to a medical screening examination.** (Reference MEC Policy/Procedure "Compliance with EMTALA".)

21. **Restraints**

Restraints refers to the use of any physical device used to restrain a patient who is attempting to dislodge a tube or dressing or attempting to get out of bed/chair against the directions of caregivers, after determining alternatives to restraint use have been ineffective. Restraints will not be used as a means of punishment or for staff convenience.

Comment [J24]: (Title 22 Section 700059)

Any use of a restraining device shall be per the order of a licensed independent practitioner as permitted by State Law and hospital policy. The type of restraint implemented shall be the least restrictive manner appropriate. Standing and PRN orders are NOT acceptable. Order will be time limited.

Comment [J25]: (COP: 482.13)

Requirements for orders for all forms of restraint are as follows:

Med/Surg Restraints:

- Restraints must not exceed 24-hours.
- In an emergency, physical restraint may be initiated by a Registered Nurse (RN) without prior order by a physician, based on an appropriate assessment of the patient.
 - A physician must be contacted within 12 hours to issue a telephone or written order covering the emergency use of restraint.
 - If initiation of the restraint was based on a significant change in the patient's condition, the RN is to notify the treating physician immediately.
- Continuation of restraints beyond a 24-hour period must be on written physician order based on a face-to face assessment of the patient.
 - An order continuing a restraint must be obtained no less often than once each calendar day.

Behavioral Management Restraints:

- Restraints used for behavioral management may be placed at the discretion of an RN in an emergency, but a telephone or written order must be obtained from a physician within one hour following initiation. Any physician may issue this order following a report from the RN caring for the patient and a review of alternatives attempted/considered.
 - If the initial order is not obtained from the patient's treating physician, consultation with the treating physician will occur as soon as possible.
 - Each written order for restraint is limited to:
 - 4 hours for adults age 18 and older
 - 2 hours for children and adolescents age 9-17
 - 1 hour for patients under age 9
- If a telephone order was received, the physician must perform a face-to-face evaluation of the patient **within one hour** of the initiation of the restraint.
- Subsequent orders may be obtained following an assessment by the physician or RN. The physician must conduct an in-person reevaluation at least every
 - 8-hours for patients age 18 and older
 - 4 hours for patients 17 or younger.

22. **Care to Family Members:**

Providers shall not participate in the delivery of medical care, act as primary physician, assist or be present during invasive procedures to immediate family members (1st degree relatives). Exceptions may be made in the cases of support member at C-Section and induction of anesthesia for pediatric cases.

23. **Participation in Peer Review:**

Meaningful peer review is vital to maintaining quality care in the hospital. All members of the medical staff are expected to participate in peer review, as defined by their respective division.

24. **Pronouncement of Death:**

It is the physician's responsibility to pronounce a patient dead. It is not necessary for the decedent's own physician to perform this function if another physician is available. It is the physician's responsibility to contact another physician to pronounce a patient if unavailable. If pronouncement has not occurred in 1 hour, nursing will contact the attending who shall assume responsibly.

Comment [J26]: (Health & Safety Code: 7181)

For patients who have been made a DNR a nurse who has been trained and competency validated may pronounce death.

In the case of brain death, State law requires that a second physician independently confirm a patient's brain death.

25. **Termination from Care:**

In the event that a hospitalized patient refused treatment by a physician, the affected physician will assist in locating another attending to provide care. If no attending is available/willing to accept patient, the physician will immediately notify the Chief of Staff or designee of the situation and to request assistance. If the affected physician is acting as a consultant, the attending physician will find another consultant, absent an emergency situation. The attending physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

Comment [J27]: (MEC 12/03)

26. **Smoking and Tobacco Use:** Smoking by patients is NOT encouraged but exceptions may be made based on medical or clinical reasons per written physician order and under the following criteria:

- The patient has indicated a desire to smoke and has refused (or is not indicated for) treatment related options such as nicotine gum/patches.
- The patient has been discouraged from smoking and has been educated on options regarding smoking cessation.
- The adverse effects of smoking are less than the potential impact on the patient receiving necessary care in a safe environment by not allowing him/her to smoke (i.e. leaving the hospital, illicit smoking, etc.).

27. **Transfer of Patients**

- a. MSICU or STICU: Patients with normal vital signs, not on ventilators or pressors, such as a suicide watch, must be seen within the same day if admitted before midnight or in the morning if admitted after midnight. All other patients must be seen within 2-hours of admission to the unit.
- b. CCU: Patients who have had chest pain but on admission are free of chest pain with no ST elevations or life-threatening arrhythmias, will be seen within 8 hours. All other patients (i.e. unresolved chest pain, life-threatening arrhythmias and/or ECG changes) will be seen promptly which will usually be within 30 minutes.
- c. Telemetry: Patients will be assessed in person within 12-hours of admission to the Telemetry Unit, unless the patient's condition warrants more urgent assessment.
- d. NICU: Patients will be seen as soon as possible, and within 1-hour, regardless of route of admission to the NICU as outlined in the Structure Standards.

Comment [J28]: Prior wording revised 3/09.

28. **PPD Testing:** All members of the medical staff and allied health professional staff are required to provide documentation of annual PPD testing. Verification of testing shall be submitted to the Medical Staff Services Department annually.

Comment [J29]: Title II 70723

29. **Influenza Screening:** The California Department of Public Health (CDPH) recommends that all hospital personnel and clinical staff receive an influenza vaccination. Per CDPH requirements attestation of vaccination or reasons for declination shall be submitted annually. Documentation shall be submitted to the Medical Staff Services Department.

Comment [J30]: 9/1/2008 CDPH SB 739, Title 22 §70739)

30. **Parliamentary Procedure:** Sturgis Standard Code of Parliamentary Procedure shall govern meetings of the Medical Staff, Divisions, and of the committees thereof.