STRAUB CLINIC AND HOSPITAL

dba: Straub Medical Center

888 South King Street
Honolulu, HI 96813
(808) 522-4000

MEDICAL STAFF RULES AND REGULATIONS

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STRAUB MEDICAL CENTER

RULES AND REGULATIONS

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MEDICAL STAFF RULES & REGULATIONS

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The hospital shall accept patients for care and treatment except for maternity patients and infants.

2. A patient may be admitted to the hospital only by a practitioner who is a member of the medical staff with admitting privileges. All practitioners shall be governed by the official admitting policy of the hospital.

3. As part of the admission process, all providers must enter Patient Class and Level of Care orders in the electronic medical record (EMR).

4. A member of the medical staff (attending physician) shall be responsible for the medical care and treatment of each patient in the hospital. Any patient admitted to the hospital must be seen by the attending physician or his designee on a daily basis. The attending physician shall be responsible for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the EMR.

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

6. In any emergency case in which it appears that patient will have to be admitted to the hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

7. For emergency admissions, the history and physical examination must clearly justify that the patient is being admitted on an emergency basis and these findings must be recorded in the EMR within 24 hours of admission.

8. Each Active and Courtesy Member and Independent Allied Health Professional who admits patients shall designate one or more alternates with comparable privileges/practice prerogatives to provide continuous coverage for patients. Whenever a designated alternate is not available, the Department Chair or the Chief of Staff shall have the authority to call any member of the staff to arrange for coverage.

9. The medical staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.

10. During high census, admitting/bed control clerk will admit patients on the basis of the following order of priorities:

    a. <u>Emergency Admissions</u>

       Emergency admissions are patients requiring immediate hospitalization and treatment**.** The attending physician shall indicate the need for this emergency admission in the patient's record, which will be reviewed by the hospital case managers. Failure to furnish this information or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Utilization Review Committee for appropriate action.

b. Urgent Admissions

This category includes those so designated by the attending physician and shall be reviewed as necessary by the Utilization Review Committee to determine priority when all such admissions for a specific day are not possible.

c. Pre-Operative Admissions

This includes patients scheduled for surgery. If it is not possible to handle all such admissions, the Department Chair may decide the urgency of any specific admission.

d. Routine Admissions

This will include elective admissions involving all services.

11. Patients diagnosed as having a communicable disease shall only be admitted when isolation facilities can be provided. The attending physician shall be responsible for furnishing information and ordering the patient to be isolated. Proper isolation procedures must be carried out on all patients with infectious diseases or conditions, as specified in the Infection Control Policy: Isolation Precautions.

12. Resident physicians assigned to the hospital may not admit patients.

13. Patient Transfers: Transfer priorities shall be as follows:

a. Emergency Room to appropriate patient bed.
b. From Intensive Care Unit to general care area.
c. From CCIU/Burn Unit to general care area.
d. From temporary placement in an inappropriate geographic area to the appropriate area for that patient.

Patients will be transferred only upon approval by the responsible practitioner.

14. The admitting practitioner shall be responsible for providing information as may be necessary to protect the patients from self-harm and to protect others whenever his patients might be a source of danger.

15. Any patient known or suspected to be suicidal shall be admitted to appropriate beds for close observation. Other measures including one-to-one observation or restraints may be used as needed for protection. A psychiatric/psychological consultation is recommended in order to assess the appropriate protective environment, the seriousness of the suicide risk, and to assist in discharge planning. When the patient is medically cleared but remains a serious danger to himself or others, arrangement shall be made for transfer to a psychiatric facility for further treatment. Refer to hospital policy: Psychiatric/Suicidal Patient Management.

16. Admissions to Intensive Care Unit: If any question as to the validity of admission to or discharge from the intensive care unit should arise, that decision is made through consultation with the designated physician leader for Critical Care or Chief of Staff.

17. The attending physician shall document the need for continued hospitalization in the EMR Concurrent utilization review will be conducted by the hospital case manager for medical necessity and appropriate level of care. Utilization concerns will be discussed with the attending physician and referred, as needed, to the Utilization Review Committee.

18. Patients shall be discharged only on order of the attending physician. Should a patient leave

the hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be placed in the patient's medical record and the patient or his/her guardian shall be required to sign release of responsibility. Should he/she refuse to sign a release, a witnessed statement to that effect shall be placed in the patient's record.

19. Patients may be discharged by resident physicians only with the approval of the attending physician.

20. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable time. The body shall not be removed until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Policies with respect to release of dead bodies shall conform to State law.

21. It shall be the duty of medical staff members to secure autopsies whenever possible. Refer to Medical Staff Policy: Autopsy Criteria. In particular, an autopsy should be requested for:

    a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications
    b. Deaths in which the cause of death is not known with certainty on clinical grounds
    c. Cases in which autopsy may help to allay the concerns of the family or public and to provide reassurance
    d. Unexpected or unexplained deaths occurring during or following any dental, medical, surgical or diagnostic procedures or therapies
    e. Death of patients who have participated in clinical trials (protocols) approved by the Institutional Review Board
    f. Deaths resulting from high risk infectious and contagious disease
    g. Deaths of patients of any age where it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs
    h. Deaths known or suspected to have resulted from environmental or occupational hazards

22. An autopsy may be performed only with written consent, signed in accordance with state law. All autopsies shall be performed by the pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours and the complete protocol should be made a part of the record within fourteen (14) days.

    Resident physicians may secure permission for an autopsy.

B. MEDICAL RECORDS

1. The EMR or copies of records shall not be released from the custody of Straub Medical Center, except by court order, on order of a subpoena or as defined in hospital policy. Un-authorized release of records by a provider is grounds for suspension of the provider for a period to be determined by the Medical Executive Committee. No portion of a medical record may be removed, replaced, obliterated or altered under any circumstances except as outlined in Medical Records policies and procedures.

2. All clinical entries, including orders, in the patient's medical record shall be legible (if paper based), dictated, dated, and timed**.** If two licensed healthcare professionals are unable to read the entry, this is considered to be an illegible entry.

3. The attending physician will be responsible for the preparation of an accurate, timely and complete record for each patient. Its contents will be pertinent and current.

4. Corrections in the medical record, whether handwritten or dictated, will be corrected in ink with a single line drawn through the incorrect information. In the EMR, correction will be made by editing and saving the corrected document as an addendum. The person making the correction will time and date the corrected information.

5. The supervising/attending physician will authenticate reports recorded/dictated by residents, medical students, or physician assistants. These reports include but are not limited to:

    - Clinic Note
    - History and Physical
    - Discharge Resume/Summary
    - Transfer Summary
    - Death Summary
    - Consultation Report
    - Operative Report
    - Emergency Room Record
    - Progress Notes

6. All entries in the EMR including history and physical examination, operative report, consultations, discharge summary, nursing observations, progress notes, and other professional care notes will be dated, timed and authenticated by the author, with the first name or initial, the full surname and professional title or initial indicating the professional credential. Authentication can be through electronic signature, written signature or computer key.

7. Abbreviations, acronyms and symbols which are not to be used shall be approved by the medical staff. An official record of Do Not Use abbreviations is available on the Straub intranet and in the National Patient Safety Goals website.

8. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

9. Upon written request for and approval by Administration, medical records will be made available for research purposes. The material contained within a medical record is of confidential nature and release of such information for reasons other than proper management of a case or for research will require the patient's written authorization.

10. Individuals authorized to make entries in the medical record: Refer to the "Authorized Personnel to Make Clinical Entries in the Medical Record" policy in the Patient Care Manual.

11. Information transmitted via facsimile, including orders, shall be considered as original document and may be included in the medical record. Once the hospital begins to process the order or prescription, the implementation of the order or prescription is promptly dated and timed.

12. <u>History and Physical:</u>

An admission History and Physical examination will be completed by a provider who has privileges to perform a history and physical. History and physical examination shall be performed no more than twenty-four (24) hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services. The report will include all pertinent findings resulting from an assessment of the patient.

<u>Delegation of History and Physical</u>:

History and Physical examination may be delegated to Physician Assistants (except for Emergency admissions) and Nurse Practitioners. These Allied Health Professionals shall comply with the requirements in the Medical Records section of the Rules and Regulations of the medical staff. When performed by a Sponsored Allied Health Professional, the History and Physical examination shall be performed under the supervision of, or through appropriate delegation by, a qualified practitioner who countersigns and retains accountability for the examination.

<u>History and Physical Report Components</u>:

- Medical history, including, chief complaint
- Details of the present illness
- Relevant past social and family histories (appropriate to patient's age)
- Review of systems
- Physical examination
- Impression
- Treatment plan (plan of care)

<u>History and Physical Examination: Ambulatory Services</u>

History and physical examination may vary by setting, level of care, treatment or services. Assessment should be sufficient to provide the necessary information to plan for appropriate care of the patient. At a minimum, the report shall include:

- Medical history, including, chief complaint
- Details of the present illness
- Physical examination
- Impression
- Treatment plan (plan of care)

There is no requirement for minimum documentation prior to invasive procedures that do not involve moderate or deep sedation or general anesthesia or which do not involve high risk diagnostic or therapeutic intervention.

13. If a complete history and physical examination was performed within thirty (30) days prior to the patient's admission or registration, an interval note is entered into the medical record within 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services, whichever comes first, noting that the H&P was reviewed, the patient re-examined and documenting any change or lack of change in the patient's condition.

History and physical examination performed within thirty (30) days prior to the patient's admission by a provider who is not a member of the medical staff may be included in the patient's medical record if it meets the requirements of the hospital and a provider on staff with privileges to perform history and physical examination reviews, confirms the

findings and authenticates the document. Any changes that may have occurred are recorded in the medical record at the time of admission.

14. Before surgery, the patient's physical examination and medical history, any indicated diagnostic tests and a preoperative diagnosis are completed and recorded in the patient's medical record except in emergencies. If there is no history and physical on record, the procedure will be canceled, unless the attending physician states in writing that such delay would be detrimental to the patient.

    Medical record of a patient receiving emergency, urgent or immediate care notes the conclusions at termination of treatment, including final disposition, condition at discharge and instructions for follow-up care.

15. Pertinent progress notes sufficient to permit continuity of care and transferability will be recorded at the time of observation. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes will be recorded by the attending physician daily on all patients at an acute level of care.

    For patients who are below an acute care level, whose condition is stable and who are wait-listed for long-term care facilities, progress notes will be recorded by the attending physician at least every third day.

16. Operative or High Risk Procedure Report

    An operative or other high risk procedure report is written or dictated upon completion of the operative or other high risk procedure and before the patient is transferred to the next level of care. Exception to this requirement occurs when an operative or other high risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within 72 hours following the procedure or operation. If the practitioner performing the operation or high risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

    The operative or other high risk* procedure report includes the following information:

    - The name of the licensed independent practitioner(s) who performed the procedure and his/her assistants
    - Name of procedures(s) performed
    - Description of the procedure
    - Findings of the procedure
    - Any estimated blood loss
    - Any specimens removed
    - The postoperative diagnosis

    *****High risk is defined as procedures, with or without sedation, that place patients at greater than minimal risk**.** Refer to Immediate Post Procedure Note (IPPN) Policy.

17. Consultations

    Consultation report shall contain an opinion of the examination in the patient's medical record. When operative procedures are involved, the consultation note will be recorded prior to the operation except in emergency situations.

    The attending physician is primarily responsible for documenting the request for a

consultation, when indicated, and calling in a qualified consultant.

18. Discharge Summary or Final Progress Note

A discharge summary or final progress note will be entered in the EMR on all patients hospitalized. Any hospitalization that exceeds forty-eight (48) hours requires a discharge summary. Medical records must be completed and signed within fourteen (14) days of discharge.

The discharge summary or progress note will include:

- Reason for hospitalization
- Final diagnosis
- Procedures performed
- Care, treatment and services provided
- Condition and disposition on discharge
- Information provided to the patient and/or family
- Discharge medications
- Provisions for follow-up care

19. When an inpatient must be referred to another health care facility for special tests or treatment, only copies of the pertinent medical record data will be sent with the patient upon transfer to another facility. In case of readmission of a patient, all previous records will be available to the attending physician. This applies whether the patient is attended by the same practitioner or by another.

20. A provider's routine orders, when applicable to a given patient, will be reproduced in detail on the order sheet of the patient's record, dated and authenticated by the provider.

21. Inpatient Medical Records: The inpatient record will include, if applicable:

- Identification data;
- Complaint or reason for admission;
- Personal history, including allergies;
- Family history;
- History of present illness;
- Physical examination;
- Treatment plan;
- Consultation report;
- Provisional diagnosis;
- Medical and surgical treatment;
- Operative report
- Anesthesia record;
- Informed consent;
- Pathological findings;
- Progress notes;
- Final diagnosis;
- Condition on discharge;
- Discharge summary;
- Autopsy report;
- Provider's orders;
- Ancillary reports (i.e. lab, radiology, nuclear medicine, EKG, EEG).

22. Verbal/Telephone Orders

Verbal or telephone orders or telephonic reporting of critical test results require verification of the complete order or test result by having the person receiving the information record and "read back " the complete order or test result.

Verbal or telephone orders shall be recorded with date and time, identifies the names of the individuals who gave, received and implemented the order and authenticated by the prescribing provider or another provider who is responsible for the care of the patient within forty-eight (48) hours.

a. Medications: Straub Medical Center shall minimize the use of verbal and telephone medication orders. Verbal or telephone orders for medications shall be given only by a provider and shall be accepted only by a licensed nurse, physician assistant, pharmacist or provider and authenticated by the prescribing provider or another provider who is responsible for the care of the patient within twenty-four (24) hours. Registered respiratory therapists and certified respiratory therapists may receive and transcribe verbal orders for drugs directly related to the provision of respiratory care.

   Orders for medication shall include:
   - Name of medication
   - Dose and dosage form
   - Strength
   - Route of administration
   - Dosage regimen (frequency)

b. Blanket orders which are written as "resume preoperative orders", "continue previous medications", "discharge on current medications" or p.r.n. orders are not acceptable.

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c. Restraints: All verbal or telephone orders for restraints will be verified by a practitioner within twenty-four (24) hours of initiation of the restraint. Practitioner order is required for each episode of restraint use. Refer to hospital policy: Restraints and Seclusion.

   Restraint orders will only be accepted by:
   - Registered Nurse
   - Licensed Practical Nurse
   - Physician Assistant

23. All diagnostic and therapeutic orders for inpatients will be documented and accepted by a duly authorized person functioning within his/her sphere of competence and authenticated by a licensed independent practitioner. "Duly authorized person" for non-medication orders is defined as: Ward Clerks (limited to diet, activity, and diagnostic tests), Respiratory Therapists, Dietitians, Physical Therapists, Discharge Planners and Social Workers (limited to: travel, placement arrangements, level of care).

24. Informed Consent:
The medical record shall contain clear evidence of informed consent for procedures and treatments for which a consent is required in accordance with hospital policy and legal requirements.

25. A medical record will not be permanently filed until it is completed by the responsible provider.

26. Incomplete Medical Records:

Members of the medical staff must complete their patient's medical records within fourteen (14) days of each patient's discharge and/or clinic visit. Medical records that the member fails to complete within fourteen (14) days will be considered delinquent. In unusual and extenuating cases, a waiver of the requirement may be considered by the Chief of Staff, Vice Chief of Staff, Chief Medical Officer, Chief Executive Officer or Chief Operating Officer.

Notification Procedures Pertaining to Incomplete Medical Record:

a. Provider will be notified of incomplete records via the EPIC in basket in the designated chart completion folder upon discharge of the patient.

b. Failure to comply within nine (9) calendar days thereafter will result in intervention by the Department Chair, Chief of Staff or Vice Chief of Staff for the provider.

c. Automatic suspension will be imposed if records remain incomplete five (5) calendar days thereafter. Suspension will be lifted as soon as records are complete.

d. The suspended provider may:

- Continue to care for his/her patient(s) already hospitalized;
- Refer his patients, including emergencies, to another provider for admission to the hospital. The admitting provider then is responsible for the total care of the patient;
- Not perform scheduled procedures;
- Not treat patient(s) in the Emergency Room;
- Not serve as a consultant;
- Not accept transfer patients for care.

e. Upon completion of the delinquent records, Health Information Management Department will notify the Admitting Department, Operating Room, and other appropriate departments that the suspension has been lifted.

27. Clinic Records

a. The Clinic record will contain:

i. Identification data;
ii. Allergies
iii. Medical history
iv. Physical examination
v. Pre and postoperative diagnosis
vi. Diagnostic and therapeutic orders
vii. Clinical observations
viii. Operative report, if applicable
ix. Anesthesia documentation, if applicable
x. Medication
xi. Summary lists
xii. Physician orders
xiii. Diagnostic and therapeutic results
xiv. Patient/Family Education

b. The progress note shall require:

i. Date of visit
ii. Chief complaint or purpose of visit
iii. Clinical findings, including follow-up on significant problems and/or abnormal lab or radiological findings
- Nutritional status is assessed when warranted by the patient's needs or condition
- Functional status is assessed when warranted by the patient's needs or condition

iv. Diagnosis or medical impression
v. Treatment plans and recommendations
- When appropriate, an assessment of the patient's and family's ability to comprehend, use and apply information is taught

c. Medical record contains a problem/summary list for each patient who receives continuing ambulatory care services by the third visit and will include:

i. Any significant medical diagnoses and conditions
ii. Any significant operative and invasive procedures
iii. Any adverse and allergic drug reactions
iv. Current medications, including clinically significant over-the-counter medications and herbal preparations

The patient's problem/summary list is updated whenever there is a change in diagnoses, medications or allergies to medications, and whenever a procedure is performed.

d. All entries and diagnostic and therapeutic orders will be documented in the clinic record and signed by the ordering provider.

28. Department or Specialty-Specific Records

Department or specialty-specific records or notes may not be filed with the clinic record. Appropriate documentation for interdepartmental sharing of information must be included in a progress note for each visit.

C. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer shall notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

2. Provider's orders must be documented clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until understood by the nurse. Postoperative and transfer orders between units of different acuity (i.e. intensive care, progressive care and general floor) must be re-ordered in total.

3. All previous orders, are canceled when patients go to surgery with the exception of these diagnostic procedures:
a. Cystoscopy
b. Esophagogastroscopy and Duodenoscopy

c. Bronchoscopy
d. Cardiac Catheterization
e. Myelography and discography
f. Hysterosalpingography
g. Diagnostic nerve block
h. Angiography and/or Interventional Radiology

4. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations.

   Drugs for bona fide 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.

   All drugs brought into the hospital by patients shall be dispensed only upon orders of the attending physician.

5. The attending physician is primarily responsible for deciding whether or not consultations are indicated and for calling in a qualified consultant. He will provide authorization to permit another attending physician to attend or examine his patient, except in an emergency.

6. Any practitioner with privileges in this hospital can be called for consultation within his area of expertise at the discretion of the attending physician.

7. Consultation may be advisable in the following situations:

   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. In instances in which the patient exhibits severe psychiatric symptoms;

   f. When the medical needs of the patient exceed the scope of the clinical privileges of the attending physician or when requested by the patient, family or guardian;

   g. A medical record will not be permanently filed until it is completed by the responsible provider;

   h. The records of discharged patients, including the discharge summary, shall be completed within thirty (30) days following discharge.

D. GENERAL RULES REGARDING SURGICAL CARE

1. General Considerations:

   Surgeons must be on the hospital premises and ready to commence surgery 15 minutes prior to the time scheduled. In no case will the operating room be held longer than 15 minutes past the scheduled time. Such cases shall either be canceled or deferred to the end of the day's surgery schedule. Anesthesia shall not be started on any patient until the surgeon is on the hospital premises.

2. For all surgical patients, the preoperative diagnosis, indication for surgery, type of surgery contemplated, history and physical examinations, necessary consultations, indicated laboratory and x-ray examinations shall be recorded in the EMR before the patient is moved to the operating suite.

3. A patient admitted for dental or oral surgical care is a dual responsibility involving the dentist or oral surgeon and a physician member of the medical staff.

   a. Dentist's/Oral Surgeon's Responsibilities

      i. A detailed dental/oral surgery history justifying hospital admission.

      ii. A detailed description of the examination of the oral cavity or operative area and a preoperative diagnosis.

      iii. 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. All tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination.

      iv. Progress notes as are pertinent to the oral/operative condition;

      v. Resume or summary sheet.

      vi. A qualified oral surgeon who admits a patient without medical problems may complete an admission history and physical examination and assess the medical risks of the procedure to the patient. Criteria to be used in identifying such a qualified oral surgeon shall include:

         a) Successful completion of an accredited postgraduate program in Oral and Maxillofacial Surgery

         b) Evidence (as determined by the Credentials Committee) that the oral surgeon is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the proposed oral surgical procedure.

   b. Provider Responsibilities

      i. Medical history pertinent to the patient's general health.

ii. Physical examination to determine the patient's condition prior to anesthesia and surgery.

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

4. Written, signed, informed surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and consent cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully documented in the EMR. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

5. All operations performed shall be recorded as stated in Section B, #15 of these Rules and Regulations.

6. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

7. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

8. All tissues removed at the operation**,** unless on the approved specimen exempt list, shall be sent to the hospital pathologist who shall make such examination, as he may consider necessary to arrive at a tissue diagnosis. The signed report shall be made a part of the patient's medical record.

9. Privileges in the Operating Rooms or hospital diagnostic suites shall be restricted to those providers and dentists having clinical delineated privileges in the specialty representing the proposed procedure.

E. RESIDENT SUPERVISION: Refer to Medical Staff Policy: Graduate Education Program

F. EMERGENCY SERVICES

1. The medical staff shall adopt a method of providing medical coverage for the emergency services in the Emergency Department. This shall be in accord with the hospital's basic plan for the delivery of such services.

2. The duties and responsibilities of all personnel serving patients with the emergency service shall be defined in a procedure manual relating specifically to this outpatient department. The contents of such a manual shall be developed by a multispecialty committee of the medical staff, including representatives from nursing service and administration.

3. Individuals who come to the Emergency Department seeking examination or treatment of a medical condition shall be provided a medical screening examination (MSE), under the direction of a qualified medical physician or qualified designee, to determine if the individual has an emergency medical condition.

   Personnel qualified to complete the MSE may include Physicians, Physician Assistants and Nurse Practitioners. Registered Nurses who have demonstrated the knowledge and skills necessary may also perform the MSE. Qualifications and criteria needing to be met by the Registered Nurse performing the MSE are outlined in the RN Medical Screening Examination Process Policy.

A MSE is the process required to reach, with reasonable clinical confidence, appropriate to the individuals presenting signs and symptoms, a determination about whether a medical emergency does or does not exist. It is not a complete medical examination and does not include making a medical diagnosis or the prescription of therapeutic or corrective measures.

4. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. The record shall include:

   a. Adequate patient identification;

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

   c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;

   d. Description of significant clinical, laboratory and roentgenologic findings;

   e. Diagnosis;

   f. Treatment given;

   g. Condition of the patient on discharge or transfer; and

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

5. Each patient's medical record shall be completed by the provider in attendance who is responsible for its accuracy.

6. There shall be an Emergency Management Plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by an Emergency Management Planning Committee which includes members of the medical staff, the director of nursing services or designee, and a representative from hospital administration. The plan shall be approved by the Medical Executive Committee and governing body.

7. The Emergency Management Plan shall make provision for:

   a. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical supportive materials;

   b. An efficient system of notifying and assigning personnel;

   c. Unified medical command under the direction of a designated physician or designated substitutes;

   d. Conversion of all usable space into clearly defined areas for efficient triage, patient observation and immediate care;

   e. Prompt transfer, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate in providing definitive care;

   f. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved;

g. Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy;

h. Maintaining security in order to keep relatives and other individuals out of the triage area;

i. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual and advance arrangements with communications media to disseminate information.

8. All providers shall be assigned to posts and it is their responsibility to report to their assigned stations. The chief of the clinical services in the hospital and the chief executive officer of the hospital will work as a team to coordinate activities and direction. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the Department Chairs or Chief of Staff will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Department Chair or Chief of Staff and the Chief Executive Officer of the hospital. In their absence, the Chief Operating Officer, Chief Medical Officer and alternate in administration are next in line of authority respectively.

9. The Emergency Management Plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. There should be a written report and evaluation of all drills.

G. SPECIAL CARE UNITS

For special care units such as recovery rooms, and intensive care units, appropriate designated physician leaders and nursing staff shall adopt specific regulations. These regulations should be subject to approval of the Medical Executive Committee and the governing body.

H. ALLIED HEALTH PROFESSIONALS

1. Sponsored Allied Health Professionals shall document in the EMR services provided to patients of their sponsor and shall make entries containing pertinent, meaningful observations and information as to the extent of such services provided. Entries into the medical record shall follow hospital and medical staff policies.

2. Verbal or telephone orders may be given by sponsored Allied Health Professionals under the authority of sponsoring physicians.

3. Allied Health Professionals shall participate, as appropriate, in patient care audit and other quality review, evaluation and monitoring activities required of the medical staff.