RULES AND REGULATIONS OF THE MEDICAL STAFF

January 28, 2020

Heart of the Rockies Regional Medical Center
Rules and Regulations of the Medical Staff

Table of Contents

Heart of the Rockies Regional Medical Center
Rules and Regulations of the Medical Staff

Table of Contents

Heart of the Rockies Regional Medical Center
RULES AND REGULATIONS OF THE MEDICAL STAFF

1. Purpose

These Rules and Regulations of the Medical Staff (the "Rules") implement more specifically the general principles found within the Medical Staff Bylaws. They relate to the proper conduct of Medical Staff organizational activities and embody the level of practice that is required of each member of the Medical Staff and Advanced Practice Professional Staff in the Medical Center and within the Medical Center's facility based clinics and HRRDC, its ESRD Facility. These Rules and Regulations are an integral part of the Medical Staff Bylaws and apply to all members of the Medical Staff and Advanced Practice Professional Staff. The terms used herein are the same as those defined in the Bylaws.

2. Admissions and Discharges

A. Authority to Admit Patients. A patient may only be admitted to the Medical Center by a Physician (member of the Medical Staff with admitting privileges in good standing. All admissions are subject to the admitting policies of the Medical Center, the Medical Staff Bylaws and these Rules and Regulations, as in effect from time-to-time. The admission order should clearly indicate that the patient is being admitted either for "observation" or as an "inpatient."

B. Non-Discrimination. The Medical Center shall accept for care and treatment patients with either acute or chronic illness without regard to race, religion, age, gender, gender identity, sexual orientation, national origin, disability, or any other basis prohibited by applicable law or ability to pay. The admission of any patient is contingent on the availability of adequate facilities and personnel to care for the patient.

C. Limitation on Admissions. Whenever bed availability is limited, it may not be possible to accommodate all admissions scheduled for a specific day. In that event, the Chief of Staff or his/her designee shall prioritize the cases by condition and will make the decision regarding admission. In making that decision, the Chief of Staff or designee will seek input from the attending Physician, consult with the nursing supervisor, and give due consideration to the inconvenience caused the patient and/or his/her family.

D. Purpose of Admission. Except in an emergency, a patient shall not be admitted to the Medical Center as an inpatient or for observation until a provisional diagnosis or valid reason for admission has been provided by the Admitting Physician. The Admitting Physician shall provide, if known, patient information concerning communicable disease or infection, behavioral issues that might disturb or endanger others, incompetence to consent to treatment, and such additional information relevant to the admission. For patients requiring psychiatric or substance-abuse services a written treatment plan shall be clearly documented by the Admitting Physician identifying how these issues will be addressed during admission or following discharge. For Medicare patients, the Admitting Physician shall certify at the time of admission that the patient may reasonably be expected to be discharged or transferred to a hospital within ninety-six (96) hours after admission to the Medical Center.

E. Patient Choice of Physician. A patient presenting for admission who has no personal Physician may request care by any Physician member of the Medical Staff with appropriate clinical privileges. When the patient does not request a specific Physician, or when the selected Physician cannot or will not assume care of the patient, a member of the Medical Staff with the requisite privileges shall be assigned to the patient according to the on-call schedule of the

applicable Service.

F. Clinical Appraisal Following Admission. The Admitting or attending Physician, or his or her designee, shall observe and conduct a clinical evaluation of the patient within twelve (12) hours of admission, unless a shorter time frame is warranted by the patient's condition. The clinical evaluation shall include a physical examination. All patients admitted to the Medical Center's Intensive Care Unit must be seen by the Admitting Physician within four (4) hours of admission.

G. Discharge or Transfer. The attending Physician shall determine that a patient is stable for discharge or transfer. Patients shall be discharged or transferred only on the order of the attending Physician or his/her designee with appropriate clinical privileges.

H. Discharge Against Medical Advice. In the event that a patient leaves the Medical Center against the advice of the attending Physician or without a proper discharge, a notation of the occurrence shall be made in the patient's Medical Record and the patient will be asked to sign a form approved by the Medical Center acknowledging that the departure is against medical advice.

I. Patient Deaths. In the event of a death of a Medical Center patient, the deceased shall be pronounced dead by the attending Physician or his/her designee within a reasonable time. For deaths which are expected and occur after a Physician's normal office hours, pronouncement of death may be made by the Emergency Department Physician and at the discretion of the attending Physician. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law and shall be in accordance with the Coroner's Policy on file at the Medical Center for coroner's cases.

J. Emergency Medical Treatment and Active Labor Act ("EMTALA"). For purposes of complying with EMTALA and the Medical Center's EMTALA policies, all Physician members of the Active, Active Outpatient, Courtesy and Consulting Medical Staff are authorized to conduct a medical screening examination ("MSE") to determine if an emergency medical condition exists or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. Physician Assistant and Advance Practice Nurse members of the Advanced Practice Professional Staff, acting within the scope of their license and/or certification, may also be credentialed to perform MSEs and/or to determine, after a reasonable period of observation, whether a woman experiencing contractions is in false labor. All such Practitioners shall be considered Qualified Medical Personnel ("QMP") under EMTALA.

3. On-Call Requirements

A. On-Call Responsibility. All Active Staff members shall be familiar with and shall comply with the requirements of the Medical Center's "Medical Staff Emergency Room Call Coverage" policy as it may be amended from time-to-time. .

B. Conflicting Obligations While On-Call. Notwithstanding an on-call Physician's obligation to respond when on-call, the on-call Physician may perform elective surgery or other patient care services at the Medical Center while on call, and may be on-call at another hospital, provided the on-call Physician notifies and receives approval of the Service Chief, or his/her designee and the Chief Executive Officer, or a designee of the Chief Executive Officer.

C. Participation of Advanced Practice Professional Staff in Monthly Call Schedule. Members of the Advanced Practice Professional Staff may be required to participate, within the scope of their clinical privileges, in the monthly call schedule, if deemed appropriate by their Service and subject to the Service's ability to provide Physician back up wherever necessary.

4. Orders

A. General Requirements. All orders for treatment, diagnostic tests, admission or discharge shall be authenticated, dated, timed and signed in a timely manner by the prescribing Practitioner. Orders shall be clearly written, legible and complete. Advanced Practice Professional Staff may enter orders only to the extent, if any, allowed by their professional license/certification Illegible orders or orders which nursing has difficulty interpreting shall not be carried out until rewritten or understood by nursing.

B. Verbal Orders. Verbal orders are not encouraged and should be used infrequently. A verbal order may be given to Medical Center staff (e.g. a registered nurse, licensed practical nurse, registered respiratory therapist, registered rehabilitation therapist, registered pharmacist, registered dietician, imaging services technician, or laboratory technicians) functioning within his/her scope of practice and who are authorized by law to receive and record verbal orders. When communicating a verbal order, the ordering Practitioner shall identify himself/herself and the patient.

Authentication of a verbal order shall occur within forty-eight (48) hours after the time the order is made unless a read-back and verify process is used. The individual receiving a verbal order shall record in writing the date and time of the verbal order, and sign the verbal order in accordance with hospital policies or medical staff bylaws.

A read-back and verify process is allowed and shall require that the individual receiving the order immediately read back the order to the ordering Practitioner, who shall immediately verify that the read-back order is correct. The individual receiving the verbal order shall record in writing that the order was read back and verified. If the read-back and verify process is followed, the verbal order shall be authenticated within thirty days (30) after the date of the patient's discharge.

C. Do Not Resuscitate Orders. When indicated, a Do Not Resuscitate ("DNR") order shall be documented in the Medical Record in accordance with Medical Center Policy. Limiting an existing DNR or Advance Directive Status is the responsibility of the Physician performing a surgery/procedure involving anesthesia care. After discussion/review with the patient and/or the patient's representative, the Physician shall:

1. Clarify or modify the DNR or Advance Directive status and indicate the findings in the chart; and
2. Indicate in the chart, in the plans for postoperative care, if or when the original/pre-existing directive to limit the use of resuscitative procedures will be reinstated.

D. Patient Restraint. All orders requiring patient restraint or seclusion shall conform to the Medical Center's Policy on Patient Restraint or Seclusion.

E. Formulary. 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, and A.M.A. Drug Evaluations.

5. Medical Records

A. General Requirements. A medical record shall be prepared for every patient receiving care at the Medical Center and will contain information to justify inpatient and outpatient services and continued hospitalization, support the diagnoses, and describe the patient's progress and response to medications and services, and should demonstrate continuity of care among providers. Each Practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides. All medical record entries shall be dated and authenticated.

B. Authority to Make Medical Record Entries. Only individuals authorized by licensure, certification and clinical privileges at the Medical Center are authorized to sign, date and time entries in medical records and the identity of the author shall be set forth in the record and authenticated.

C. Authentication. Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for electronic entries. The Practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Medical Center policy. Hand written signatures or initials must be legible.

D. Forms and Templates. All forms and templates used for medical record documentation, both printed and electronic, shall be approved by the Clinical Forms Committee or the Informatics Advisory Committee or designee. Modifications of current forms and templates, which often result from changes in state and federal regulations, shall be handled expeditiously by the committees.

E. Symbols and Abbreviations. Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations may be used in the medical record. An official record of approved symbols and abbreviations is available in the Medical Staff Library. In general, the use of abbreviations and dose expressions on the "Do Not Use" list is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

F. Correction of Errors. Corrections to the medical record shall be added with a single line through the entry; the author shall time, date and sign this correction in accordance with Medical Center policy. When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial report. Any error made while entering an order in the Computerized Physician Order Entry (CPOE) should be corrected by writing another order.

G. Copying and Pasting. Copying and pasting between notes is not encouraged. In any instance where text copies from a prior note, it must be properly updated.

H. Ownership of Record. Medical records are the physical property of the Medical Center and shall not be removed from the premises except with the approval of the Vice President of Clinics in consultation with the Medical Records custodian, by a subpoena, court order or in accordance with federal and state law and Medical Center policy. Unauthorized removal of Medical Center patient records from the Medical Center facilities is grounds for suspension of the Practitioner for a period to be determined by the Medical Executive Committee.

I. Permanent Filing of Medical Records. A medical record will not be permanently filed until it is completed by the responsible Practitioner, or it is ordered filed by the Medical Executive Committee. In the event that a medical record remains incomplete by reason of death,

resignation, or other inability or unavailability of the responsible Practitioner to complete the record, the Medical Executive Committee shall consider the circumstances and may enter such reasons in the record and order it filed. Except in rare circumstances, and only when approved by the Medical Executive Committee, no Physician or Practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

J. Medical Record Completion. The attending Physician, or his/her representative shall be responsible for the preparation of a complete medical record for each patient. The final obligation for completion of the medical record rests with the attending Physician of record.

K. Timeliness. All entries in the medical record shall be made in a timely manner so as not to impair appropriate continuity of care for the patient and in accordance with Medical Center policy. Medical records shall be completed no later than fifteen (15) days from discharge/registration unless otherwise approved by the Chief Executive Officer. Each Medical Center Department may, subject to approval by the Chief Executive Officer, establish policies defining acceptable timeframes within which certain medical records shall be completed; provided, however, that such timeframes shall be no longer than the specific timeframes set forth in these Rules and Regulations. Moreover, the Medical Center may require, as a contractual matter with contracted Practitioners, specific timeframes for completion of medical records; provided, however, that the length of those timeframes shall be no longer than the specific timeframes set forth in these Rules and Regulations. Such contractually imposed timeframes shall take precedence over timeframes established by the applicable Department.

The following documents must be available in the medical record and authenticated within the following timeframes and will be considered delinquent if not completed within fifteen (15) days of discharge/registration:

1. History and physical: within 24 hours of admission or Observation Stay
2. Brief operative/procedure note: before patient moves to the next level of care (not required if full operative/procedure note is transcribed and available before the patient moves to the next level of care)
3. Full operative/procedure note: within twenty-four (24) hours of surgery/procedure.
4. Emergency department provider clinical report: at the time of service but no later than seventy two (72) hours following discharge/transfer of the patient from the Emergency Department, unless otherwise approved by the Chief Executive Officer.
5. Discharge/Death summary: Should be completed on the day of discharge but in no event later than fifteen (15) days after discharge or up to thirty (30) days after discharge if approved by the Chief Executive Officer.

L. Demographic Content. The medical record shall contain the following demographic information, the patient's:

1. Name,
2. Address,
3. Date of birth,
4. Legally authorized representative, if any,
5. Gender,
6. Legal status if receiving behavioral health services, and
7. Any language and/or communication needs.

M. Advance Healthcare Directive. As needed to provide care, treatment or services, the patient's

advance healthcare directive, if any, shall be included in the medical record.

N. Clinical Content.

1. History and Physical ("H&P"). The Admitting or attending Physician shall document a comprehensive H&P in the medical record of each patient admitted to the Medical Center. An H&P is also required for all patients undergoing surgeries and invasive procedures as outlined below. A H&P may be delegated to and performed by a Physician Assistant or Nurse Practitioner who is a member of the Advanced Practice Professional Staff, provided that the Admitting or attending Physician reviews and authenticates the H&P, including the date and time of authentication, within the timeliness requirements.

   a. Inpatient Admissions/Observation Status.

      1) A comprehensive History and Physical examination must be performed and documented in the medical record no more than 30 days before or 24 hours after admission/observation.
      2) When the History and Physical examination is completed prior to the admission/observation and within 30 days, an update to the patient's condition, including any changes in the patient's condition since the date of the original History and Physical, must be recorded within 24 hours after admission/observation. If there are no changes, it must be documented.
      3) A History and Physical examination completed over 30 days prior to admission/observation is invalid. A new comprehensive History and Physical examination must be performed and documented within 24 hours after admission/observation.

   b. Obstetrical.

      1) A History and Physical for an obstetrical patient will consist of the prenatal record, and will be updated by the Physician, confirming review of the prenatal record, examination of the patient, and documentation of no change, or documentation of changes noted.
      2) The History and Physical update must occur, and be in the medical record, within 24 hours of admission/observation and prior to the performance of a non-emergent surgery or procedure requiring anesthesia services.

   c. Swing Bed.

      1) A comprehensive History and Physical examination must be performed and documented in the medical record for each patient admitted to Swing Bed status.

      2) Timeliness and Content.

         a) Patients admitted from the Medical Center acute care facility:
            1. A comprehensive History and Physical examination must be performed and recorded no more than 30 days before or 24 hours after admission.
            2. If the History and Physical examination is completed prior to the admission to Swing Bed Status and within 30 days, an

update to the patient's condition, including any changes in the patient's condition since the date of the original History and Physical, must be recorded within 24 hours after admission. If there are no changes, it must be documented. The update must include at minimum:

a. Diagnosis,
b. Prognosis,
c. Rehabilitation potential,
d. Patient's awareness of his/her diagnosis,
e. Oral assessment, and
f. Course of treatment in acute care.

b) Patients admitted from outside the Medical Center acute care facility require a comprehensive History and Physical examination performed and recorded within 14 days after admission to Swing Bed Status.

d. Surgical and Invasive Procedures involving general, spinal, or other major regional anesthesia.

1) A comprehensive History and Physical examination must be performed and documented in the medical record prior to the surgical/invasive procedure.
2) When the History and Physical examination is older than 24 hours but was completed within 30 days before the planned procedure, an update to the History and Physical must be entered into the medical record. The update to the History and Physical must occur, and be in the medical record, within 24 hours prior to the performance of a non-emergent surgery or procedure requiring anesthesia services.
3) The standardized Medical Center "History and Physical Examination" form may be used to document the update to the original History and Physical and to denote interval changes.
4) A History and Physical examination completed over 30 days prior to the procedure is invalid. A new comprehensive History and Physical examination must be performed and documented in the medical record within 24 hours prior to the procedure.

e. Surgical and Invasive Procedures performed under moderate or deep sedation, and for diagnostic and therapeutic invasive vascular procedures, needle biopsy of an intra-abdominal or intra-thoracic organ and normal vaginal deliveries or otherwise healthy patients (ASA classification 1 and 2).

1) A brief History and Physical examination must be performed and documented in the medical record prior to a surgical and/or invasive procedure performed under moderate or deep sedation, and for diagnostic and therapeutic invasive vascular procedures, needle biopsy of an intra-abdominal or intra-thoracic organ and normal vaginal deliveries or otherwise healthy patients (ASA classification 1 and 2).
2) When the History and Physical examination is older than 24 hours but was completed within 30 days before the planned procedure, an update to the History and Physical must be entered into the medical record. The update to the History and Physical must occur, and be in the medical record,

within 24 hours prior to the performance of a non-emergent surgery or procedure requiring moderate or deep sedation and additional services listed in 5.

3) The standardized Medical Center "History and Physical Examination" form may be used for documenting the brief H&P and/or documenting the update to the original History and Physical.

4) A History and Physical examination completed over 30 days prior to the procedure is invalid. A new brief History and Physical examination must be performed and documented in the medical record within 24 hours prior to the procedure.

In addition to the demographic information required by Section 5.L of these Rules, a comprehensive H&P shall contain the following information:

a) Chief complaint and history of present illness,
b) Past medical history of disease and injury,
c) Current medications (including over the counter and herbal),
d) Drug allergies,
e) Food allergies,
f) Past family, social and personal history,
g) Review of systems,
h) Physical exam (i.e. HEENT, hair and skin, cardiovascular, abdominal, chest and lungs, height and weight, neurological, musculoskeletal and current vital signs),
i) Assessment of the health status and healthcare needs of the patient,
j) Reports of diagnostic test results, including clinical laboratory services and consultative findings,
k) Diagnosis, including acuteness and severity of condition, and
l) Reason for admission/procedure including treatment plan and planned interventions and procedures.

In addition to the demographic information required by Section 5.L of these Rules, a brief H&P shall contain the following information:

a) Chief complaint and history of present illness,
b) Past medical history of disease and injury,
c) Current medications (including over the counter and herbal),
d) Drug allergies,
e) Food allergies,
f) Clinically pertinent, positive and negative finding(s) relevant for the system directly related to the history of present illness as well as assessment of cardiovascular, chest and lungs, and abdomen,
g) Clinically appropriate evaluation of vital signs, and
h) Impression and plan of care.

f. Update to History and Physical Examination.

1) The update to the History and Physical must include, at a minimum:
   a) Review of the original History and Physical, examination of the patient and either confirmation of no changes, or documentation of such changes.

b) The Physician must also confirm that the necessity for the procedure or care is still present.

2) The standardized Medical Center "History and Physical Examination" form may be used to document the update to the original History and Physical and to denote interval changes, and must be completed within 24 hours prior to admission/observation or within 24 hours of the performance of a non-emergent surgery or procedure requiring anesthesia services.

g. History and Physical - Cancellations, Delays, and Emergency Situations.

When the history and physical examination is not recorded in the medical record before a surgical or invasive procedure, the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending Physician states in writing that an emergency situation exists.

In an emergency situation, when there is no time to record either a complete or an abbreviated history and physical, the attending Physician will document immediately prior to the procedure, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending Physician is then required to complete and document an appropriate history and physical examination.

2. Informed Consent. Informed consent is required for surgery and for special diagnostic or therapeutic procedures including blood transfusion in accordance with Medical Center policy except in those situations wherein the patient's life is in jeopardy and suitable signature cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient for which consent cannot be immediately obtained from parents, legal guardians or the next of kin, such circumstances should be explained in the patient's medical record. It is the responsibility of the Physician to discuss with the patient the risks and benefits of the procedure, including any risks associated with performing the procedure and document this discussion in the patient's medical record before the Physician is permitted to perform any procedure that requires consent. The patient's signature on the consent form indicates understanding of the discussion.

3. Operative/High Risk Procedure Reports. The attending Physician or designee shall document a provisional diagnosis in the patient's medical record before an operative or high risk procedure is performed.

4. Post-Operative Report. A Post-Operative Report for both inpatients and outpatients shall be written or dictated upon completion of any operative or other high risk procedure and before the patient is transferred to the next level of care, unless a Progress Note is written immediately after the procedure and the full report is written or dictated within twenty-four (24) hours of the procedure. A Post-Operative Report shall be included in the medical record. The report shall contain the following information:
   a. The name(s) of the Practitioner(s) who performed the procedure and his/her assistant(s),
   b. The name of the procedure performed,
   c. A description of the procedure,

d. Findings of the procedure,
e. Any estimated blood loss,
f. Any specimen(s) removed,
g. The postoperative diagnosis,
h. The patient's vital signs and level of consciousness,
i. A list of any medications, including intravenous fluids and any administered blood, blood products, or blood components, and
j. Details of any unanticipated events or complications (including blood transfusion reactions) and the management of those events.

The report shall also include information indicating that the patient was discharged from the post-sedation or post anesthesia care area either by the Practitioner responsible for his/her care or according to the Medical Center's approved discharge criteria that determined the patient's readiness for discharge.

5. Anesthesia Care Record:
   a. Pre-anesthesia Evaluation. Except in cases of emergency, the pre-anesthesia evaluation should be recorded prior to the patient's transfer to the operating area and before any pre-operative medication has been administered. All patients scheduled for surgery shall be examined pre-operatively by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) no more than twenty four (24) hours prior to the scheduled surgery.

   b. Intra-operative Anesthesia Record. There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. The anesthetic record shall indicate the state of consciousness of the patient on arrival in the operating room and shall include all events occurring during the administration of the anesthetic.

   c. Post-Anesthesia Evaluation. A post-anesthesia evaluation completed and documented by an individual qualified and credentialed to administer anesthesia no later than twenty four (24) hours after surgery or a procedure requiring anesthesia services. The calculation of the forty-eight (48) hour timeframe begins at the point the patient is moved into the designated recovery area.

   d. Discharge from Post Anesthesia Care Unit. An anesthesiologist or CRNA shall be responsible for the discharge of the patient from the Post Anesthesia Care Unit (PACU). Whenever anesthesia services and post anesthesia care is provided outside the operating room, the level of care must be comparable to the care provided in the operating room suite. Any patient who has received anesthesia, other than local anesthesia, should be examined before discharge unless they meet established criteria for discharge ("discharge by criteria") and must be accompanied home by a designated person. The examination, when required, is performed by an anesthesiologist or CRNA. The anesthesiologist or CRNA will insure that the patient is given adequate post-anesthesia recovery instructions, and will provide the patient or responsible party with a contact number for post-operative problems or questions which may arise after the patient has left the hospital.

6. Consultation Reports. Except in emergency situations, consultations with an appropriate and qualified member of the Medical Staff shall be obtained when services needed by the patient are outside the scope of privilege of the attending; when diagnosis remains

unknown despite appropriate evaluations; when the stay is prolonged beyond usual length; or when there has been no response to treatment ordered. The Attending Physician, or representative, shall arrange the consultation and specify the level of involvement of the consultant. Direct communication between the Attending Physician and consultant is recommended for all consultations in order to accomplish proper coordination of care.

All consultation reports must be included in the medical record. The report shall include the opinions and conclusions reached by the consulting Practitioner, and if relevant, documentation of an examination of the patient and a review of the patient's medical record. Consultative reports will be completed and available in the medical record within twenty-four (24) hours of the request if the consultant is on call for the next 24 hours. Otherwise, the consultative report will be available within 24 hours of the commencement of the consultant's next on call period.

7. Progress Notes. Progress Notes shall be recorded at the time of observation, and shall be sufficient to permit continuity and transferability of care. The patient's clinical issues should be clearly identified in the Progress Notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the patient's clinical issues. For Swing Bed patients, a progress note shall be written at least every thirty (30) days, but may be written more often as may be deemed necessary.

8. Additional Medical Record Information. The medical record shall also contain the following information, wherever relevant to the care, treatment or services provided to the patient:

   a. Any findings, assessments or reassessments of the patient's condition,
   b. Any diagnoses or conditions established during the patient's course of care, treatment and services,
   c. Any observations relevant to care, treatment and services provided including the patient's response,
   d. All orders,
   e. All medications ordered or prescribed,
   f. All medications administered including the strength, dose, route, date and time of administration,
   g. Any access site for medication, administration devices used, and rate of administration,
   h. Any adverse drug reactions,
   i. Treatment goals, plan of care, and revisions to plan of care, and
   j. Results of diagnostic and therapeutic tests and procedures.

9. Emergency or Urgent Care Records. The medical record of a patient who receives urgent or immediate care, treatment, and services shall contain the following information:

   a. The time and means of arrival,
   b. Indication that the patient left against medical advice, if applicable,
   c. Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services, and
   d. A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

10. EKG Interpretations. A formal interpretation of an EKG by a Practitioner holding privileges in good standing to provide a formal interpretation shall be completed and documented within seventy-two (72) hours of performance of the EKG.

11. Treatment Plan for Patients Requiring Psychiatric or Substance Abuse Services. For patients requiring psychiatric or substance-abuse services either at the time of admission or during admission, the medical record shall include a written treatment plan that clearly identifies and documents how these issues will be addressed during admission or following discharge.

12. Treatment Plan for Patients Admitted through the Colorado Department of Corrections. For patients admitted through the Colorado Department of Corrections, a written treatment plan shall clearly document required follow-up care.

13. Change of Attending Physician. The attending Physician shall be responsible for the management of the patient's general medical care and treatment while in the hospital, and for the prompt completeness and accuracy of the medical record. When these responsibilities are transferred to another medical staff member, an order shall be written transferring care.

14. Discharge Order. Patients shall be discharged only upon the order of the attending Physician or another Physician acting as his/her representative. A discharge order is required on all patients with the exception of patients choosing to leave against medical advice.

15. Final Diagnosis. The final diagnosis shall be recorded in the medical record and dated and signed by the responsible practitioner at the time of discharge. The use of symbols or abbreviations is discouraged.

16. Discharge Summary. A discharge summary shall be completed, authenticated, dated and timed for all inpatients and outpatient stays over forty-eight (48) hours. Patients admitted or observed for less than forty-eight (48) hours and seen for minor problems or interventions and for normal obstetrical deliveries and normal newborn infants shall have a final summation progress note which shall contain the outcome of hospitalization, final diagnoses, disposition of the case, and provisions for follow-up care. A discharge summary is also required for patients discharged from Swing Bed.

    The discharge summary shall briefly recapitulate the significant physical and laboratory findings, the reason for hospitalization, events of hospitalization, the procedures performed, the care, treatment and services provided, the patient's condition and disposition at discharge, final diagnoses, description of any medications dispensed on discharge, information provided to the patient and family, provisions for follow-up care, and with respect to swing bed residents, and indication of where the resident plans to reside. In all instances, the discharge summary shall sufficiently justify the diagnosis and warrant the care, treatment and services provided during the admission.

    Discharge summaries shall be completed by the Attending Physician and included in the medical record promptly, but in any event within fifteen (15) days of discharge, in order to provide information to other caregivers and facilitate the patient's continuity of care. If the Attending Physician has made other arrangements, it is his/her responsibility to contact the other provider and arrange for a timely completion of the discharge summary.

17. Discharge Information for Swing Bed Patients. At discharge or transfer of a swing bed resident the resident, and in the event of a transfer the receiving organization, shall be provided with discharge information. It shall include the following information: the reason for the transfer, discharge, or referral, treatment provided, diet, medication orders, and orders for the resident's immediate care, referrals provided to the resident, the referring licensed independent practitioner's name, the name of the licensed independent practitioner who has agreed to be responsible for the resident's medical care and treatment, if it is someone other than the referring independent practitioner, medical findings and diagnoses, a summary of the care, treatment and services provided, the progress reached toward goals, information about the president's behavior, ambulation, nutrition, physical status, psychosocial status and potential for rehabilitation, nursing information that is relevant in the resident's care, any advance directives, instructions given to the resident before discharge and attempts to meet the resident's needs. It shall also include documentation by a Physician if the resident is being discharged or transferred because the safety of other residents would otherwise be endangered.

18. Queries. A query from the Medical Records Office will be sent to the Physician requesting clarification if the documentation in the medical record is not clear or if the discharge summary is not clear regarding the final diagnoses. The Physician shall submit the reply in writing a soon as possible.

19. Autopsy Report. When an autopsy is performed, a provisional anatomic diagnosis should be documented in the medical record within three (3) days and the complete report should be made part of the medical record within thirty (30) business days unless extenuating circumstances require additional time for toxicology studies, special pathologic procedures, etc.

20. Ambulatory Care. For patients receiving ambulatory care services, the medical record will contain a summary list of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. Clinical documentation should be completed on the day of the patient visit but no later than seventy two (72) hours, or as otherwise approved by the Chief Executive Officer, from the visit. This documentation will be the joint responsibility of the practitioners and the Medical Center.

    a. identification data, including the patient's name, sex, address, date of birth, marital status, religious preference and name of authorized representative,
    b. date and time of arrival,
    c. date and time of departure,
    d. service date,
    e. known significant medical diagnoses and conditions,
    f. known significant operative and invasive procedures,
    g. known adverse and allergic drug reactions,
    h. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations,
    i. principal and other diagnoses,
    j. treatment plan,
    k. procedures performed,
    l. expected source of payment,
    m. disposition of patient.
    n. Medical history, including: Immunization record, screening tests, allergy record, nutritional evaluation, neonatal history for pediatric patients,

o. Physical examination report,
p. consultation reports,
q. clinical notes, including dates and times of visits,
r. treatments and instructions, including: Notations of prescriptions written, Diet instructions, if applicable, Self-care instructions,
s. reports of all laboratory test performed,
t. reports of all X-Ray examinations performed,
u. written record of preoperative and postoperative instructions,
v. operative report on outpatient surgery, including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if appropriate,
w. anesthesia record, including preoperative diagnosis, if anesthesia is administered,
x. pathology report, if tissue or body fluid was removed,
y. clinical data from other providers.
z. referral information from other agencies, and
aa. all consent forms

21. Outpatient Therapeutic and Diagnostic Services. Orders for outpatient therapeutic and diagnostic services will be the responsibility of the ordering provider. All orders for outpatient services must include adequate clinical information to verify the purpose and appropriateness of the requested service. Confirmed diagnoses, symptoms, or the correct ICD code must be entered on the requisition order. "Rule out", "suspected", "probable" and "possible" will not be accepted.

22. Delinquent Medical Records.

a. General Requirements.
It is the responsibility of any Practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these rules and regulations and other relevant policies of the Medical Center. If the patient care and/or discharge happened when another Practitioner was covering then the ultimate responsibility for record completion resides with the supervising Physician.

If the completion of the medical record does not comply with the documentation and timeframe requirements, the Physician will be notified in writing of the delinquency and that his/her medical staff privileges will be automatically relinquished. The relinquishment will remain in effect until all of the Physician's records are no longer delinquent.

b. Notification.
Practitioners who have not completed their medical records fifteen (15) days post-discharge/registration will be notified in writing that his/her clinical privileges are at risk of automatic suspension. Such notice shall be given to the Practitioner seven (7) days in advance of such suspension. Failure to complete medical records shall result in automatic suspension of the Practitioner's privileges to perform non-emergent procedures and admit new patients to the hospital or schedule any new procedures/surgeries to be performed in the hospital, nor submit orders for outpatient procedures and testing and which shall be effective until all delinquent medical records are completed in accordance with Bylaws, Section 8.4.C. The Chief Executive Officer may temporarily stay imposition of the suspension in order to meet a patient care need.

c. Automatic Relinquishment.
In the event automatic relinquishment occurs, the Chief of Staff, Emergency Department, nursing administration, Medical Center administration, and other key departments will be notified via email. The Practitioner will be responsible for transferring care of any patients her or she may have at the Medical Center to a Practitioner who has appropriate clinical privileges. If the Practitioner is unable or fails to appropriately transfer care of his or her patient, the Chief of Staff will assign the care of such patients to a Practitioner who has appropriate clinical privilege.

Three such suspensions of privileges within any twelve (12) month period shall be reviewed by the Medical staff Executive Committee according to the Medical Staff Bylaws.

6. Privacy and Security

A. Access to Medical Records by Medical Staff and Advanced Practice Professional Staff. Members of the Medical Staff or Advanced Practice Professional Staff shall not access patient information through the Medical Center's health information system or medical records, unless required to access such information in connection with their obligation to provide care to a patient or for *bona fide* research or educational purposes, if prior approval of the Medical Executive Committee is obtained. Medical Records may also be accessed by individuals directly involved in conducting Professional Review Actions or carrying out utilization review or performance improvement activities.

B. Password and User Identification Security. No member of the Medical Staff or Advanced Practice Professional Staff shall share his/her password or other user identification with another person even if the other person is an authorized user. Each Medical Staff or Advanced Practice Professional Staff member acknowledges that his/her password or other user identification is his/her legal signature and shall be accountable for the use of such password or user identification.

7. Consultations

A. Consulting Responsibility. Any Practitioner with Medical Center clinical privileges may be called for consultation within the Practitioner's area of expertise.

B. Required Consultations. Appropriate care, treatment and services includes the proper and timely use of consultations. Judgments as to the serious nature of the patient's illness, and any doubt as to diagnosis and treatment, are the responsibility of the Practitioner responsible for care of the patient. Except in an emergency, consultation is required for curettage or other procedures by which a known or suspected pregnancy may be interrupted. Additionally, consultation is recommended in the following instances:

1. When a patient is not a good risk for surgery or treatment,
2. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed,
3. Where there is doubt as to the choice of therapeutic measures to be utilized,
4. In unusually complicated situations where specific skill of other Practitioners may be needed, or
5. When requested by the patient or his/her family.

C. The Attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.

8. General Conduct of Care

A. Surgical Care.

Except in emergencies, the preoperative diagnosis and required laboratory tests must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, the procedure shall be postponed. In an emergency, the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

A History and Physical (H&P) shall be documented prior to surgery whether the case is inpatient or outpatient surgery. The H&P for an outpatient procedure should include all of the same elements and guidelines as for an inpatient admission, as detailed in Section 5.H.1 of these Rules. The scope of the H&P may be further defined by policy of the specific Service.

Surgical procedures performed under general, spinal, epidural, deep sedation and/or regional block anesthesia require a complete H&P, as defined in Section 5.N.5 of these Rules.

Whenever possible, the pre-operative H&P for outpatient surgery should be available to the surgical team the day prior to the scheduled surgery. Consultation by an anesthesia provider member of the Medical Staff or Advanced Practice Professional Staff is required prior to all surgical or invasive procedures for any patient at high risk for anesthesia or surgical complication.

In urgent situations, a brief admission note that documents the reason for the procedure and giving a brief H&P on the patient shall be sufficient documentation for the procedure to be performed.

1. Anesthesia Care Record. The Anesthesia Practitioner's scope of practice shall include management of patients while the patient is in the pre-anesthetic phase of a procedure. The anesthesia provider shall maintain a complete anesthesia record including evidence of pre-anesthetic evaluation, intra-operative monitoring, and post-anesthetic follow-up of the patient's condition.

2. Pre-Anesthesia Evaluation. Except in cases of emergency, this pre-anesthesia evaluation should be recorded prior to the patient's transfer to the operating area and before any pre-operative medication has been administered. All patients scheduled for surgery shall be examined pre-operatively by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) no more than 24 hours prior to the scheduled surgery.

3. Intra-Operative Anesthesia Record. There must be an intraoperative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. The anesthetic record shall indicate the state of consciousness of the patient on arrival in the operating room and shall include all events occurring during the administration of the anesthetic.

4. Post-Anesthesia Evaluation. A post-anesthesia evaluation completed and documented by an individual qualified and credentialed to administer anesthesia no later than 24 hours

after surgery or a procedure requiring anesthesia services. The calculation of the 24 hour timeframe begins at the point the patient is moved into the designated recovery area.

5. Discharge from Post Anesthesia Care Unit. An anesthesiologist or CRNA shall be responsible for the discharge of the patient from the Post Anesthesia Care Unit (PACU). Whenever anesthesia services and post anesthesia care is provided outside the operating room, the level of care must be comparable to the care provided in the operating room suite. Any patient who has received anesthesia, other than local anesthesia, should be examined before discharge unless they meet established criteria for discharge ("discharge by criteria") and must be accompanied home by a designated person. The examination, when required, is performed by an anesthesiologist or CRNA. The anesthesiologist or CRNA will insure that the patient is given adequate post-anesthesia recovery instructions, and will provide the patient or responsible party with a contact number for post-operative problems or questions which may arise after the patient has left the hospital.

6. Presence in the Operating Room. Surgeons should be in the operating room and ready to begin at the time scheduled. Every effort will be made to contact the surgeon if he/she is not in the operating room prior to the scheduled start time. If the surgeon fails to respond within a reasonable time frame, the case will be cancelled.

7. Specimens. Specimens removed during a surgical procedure shall be sent to the pathologist in accordance with the Medical Center Pathology Department's Surgical Specimen Submission Policy, as may from time-to-time be amended.

8. Post-Operative Transfer of Care. When the surgeon is unable to attend the patient during the post-operative period, he/she must make arrangements with an appropriately credentialed Physician member of the Medical Staff to manage the patient post-operatively. These arrangements are required for both inpatient and outpatient procedures and must be documented in the Post-Operative Report.

B. Obstetrical Care.

1. Consultation. Consultations are encouraged in the following situations at the discretion of the attending Physician:
   a. Severe toxemia of pregnancy,
   b. Obstetrical hemorrhage, either antepartum, intrapartum, or postpartum,
   c. Fetal malposition and/or malpresentation,
   d. Prolonged labor, or
   e. Any other condition threatening the life or future well- being of the patient.

2. Induced Labor. Only a Physician with appropriate clinical privileges shall be allowed to induce labor.

C. Dental Care. A patient admitted for dental care is the dual responsibility of the Dentist and the admitting Physician.

1. Dentist's responsibilities:
   a. Care of the patient's dental condition,
   b. A detailed dental history justifying admission to the Medical Center,
   c. A detailed description of the examination of the oral cavity and a pre-operative diagnosis,

d. A complete Operative Report describing the findings and technique used,
e. In cases of extraction of teeth the Dentist shall clearly state the number of teeth and, fragments removed,
f. Progress Notes as are pertinent to the oral condition, and
g. Discharge Summary specific to the patient's dental care.

2. Physician's responsibilities:
   a. General care of the patient while hospitalized other than the patient's dental condition,
   b. Admission of the patient and writing of admission orders,
   c. An H&P pertinent to the patient's general health,
   d. A physical examination to determine the patient's condition prior to anesthesia and surgery, and
   e. Entering an order to discharge of the patient from the Medical Center.

ADOPTED by the Full Medical Staff at its meeting on January 9, 2020.

Daniel A. Wardrop, MD, Chief of Staff

ADOPTED by the Board of Directors at its meeting on January 28, 2020.

Debbie Farrell, Chairman, Board of Directors