RULES AND REGULATIONS
OF THE
MEDICAL STAFF OF
THE MEDICAL CENTER OF AURORA/
CENTENNIAL MEDICAL PLAZA

2016

The Medical Center of Aurora
Medical Staff Rules and Regulations
2016

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ARTICLE I. ADMISSION OF PATIENTS

1.1 GENERAL

The Hospital accepts acute medical, surgical, obstetrical, and psychiatric patients for care and treatment within the limitations stated here and in the Hospital's policies and procedures. Admission of any patient to the Hospital is contingent upon adequate facilities and personnel being available for the patient. Only Medical Staff members with admitting privileges may admit patients to the Hospital.

1.2 ADMISSION OF PATIENTS WITH INFECTIOUS DISEASES/CONDITIONS

Patients with suspected infectious conditions or diseases shall be admitted to their rooms minimizing the time these patients spend in public areas such as the Admissions Office, the Hospital lobby, or waiting rooms. Standard precautions shall be utilized to prevent disease transmission per Infection Control Policy.

1.3 PSYCHIATRIC AND SUBSTANCE ABUSE PATIENTS

The Hospital will provide medical care to psychiatric and substance abuse patients in accordance with the Hospital Policy regarding 72-hour mental health and short-term certification

1.4 USE OF ANCILLARY SERVICES BY NON-STAFF PRACTITIONERS

A practitioner who is not a Medical Staff member and who has not been granted clinical privileges may order outpatient ancillary services providing the following requirements are met:

- The Practitioner's current licensure shall be verified in accordance with HealthONE policy.
- The practitioner's eligibility to participate in federal and state health programs shall be verified through the OIG Sanction Report and GSA List in accordance with HealthONE policy.
- The orders shall be confined to those for outpatient laboratory, radiology, rehabilitation services, diagnostic cardiopulmonary or electrodiagnostic testing.
- All diagnostic tests that require an interpretation by a practitioner with a delineated clinical privilege to do so shall be subject to interpretation by a member of the Medical Staff with such privileges, and the interpretation shall be provided to the non-staff practitioner.

ARTICLE II. ASSIGNMENT OF PATIENTS

2.1 ASSIGNMENT OF SERVICE

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the patient's condition to the referring Practitioner.

Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

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

ARTICLE III. GENERAL RESPONSIBILITY FOR CARE

3.1 GENERAL

Care for patients is the nucleus of activity around which all Hospital functions revolve. Members of the Medical Staff are intricately involved in carrying out and providing leadership in all patient care functions conducted by individuals with clinical privileges.

The attending Practitioner is responsible for the medical care and treatment of each patient, except when transfer of responsibility is affected pursuant to transfer of patients hereof.

In the event that an attending practitioner determines that it would be appropriate for another practitioner to assume attending responsibilities for a particular patient, the current attending may transfer care of the patient to such other practitioner provided that:

1. The current attending communicates directly with the successor attending and there is mutual agreement to the transfer of attending responsibilities. Such conversation must be documented in the chart;
2. The current attending notifies the patient of the proposed change in attending and documents the patient's assent or objection in the chart;
3. The current attending notifies the successor attending of any clinical information reasonably necessary to allow the successor attending to assume the care of the patient.

In the event that a practitioner performs a procedure upon, provides care to, or issues orders for a patient for whom he or she is not currently the attending practitioner, the practitioner shall provide such follow-up as is reasonably necessary to ensure the safety and continuity of patient care. Responsibility for such follow-up care may be assumed by the attending practitioner upon mutual agreement between the attending and the physician who performed the procedure or provided the care.

Inpatients shall be seen within 24 hours of admission with the exception of intensive care patients who shall be seen within four (4) hours of admission to an intensive care unit or sooner if the patients' condition warrants. [Neonatal Intensive Care Unit (NICU) is excluded.] Inpatients shall be seen a minimum of one (1) time each calendar day thereafter with the following exceptions: well babies remaining in the Hospital due to maternal complications, well mothers with baby(s) complications or patients who no longer meet inpatient criteria (i.e., awaiting transfer, stable newborns).

3.2 ALTERNATE COVERAGE

Whenever a Member of the Medical Staff will be out of town or otherwise unavailable to provide for the continuing care of his patients, he must indicate, or have his designee indicate, the name and telephone number of the Practitioner with whom the Medical Staff Member has made prior arrangements for assuming responsibility for the care of his patients during his absence. Such indication may consist of a written order in the patient's record of who will be providing care to the patient during the Medical Staff Member's period of unavailability or it may be given to the nursing staff by other means. It will, however, be the responsibility of the Medical Staff Member to insure that this information regarding coverage is documented and available to the nursing staff. This section shall not apply to routine coverage or day to-day call provided by a partner or associate in a designated call group; however, the covering physician must be a member of the Medical Staff.

In the absence of designation of alternative coverage, and when the Medical Staff Member does not respond to calls, the following have the authority to call any member of the Medical Staff qualified to care for the patient:

Department Chair or designee; President or President-Elect of the Medical Staff; the Hospital Administrator on-call. (See Facility Policy – Chain of Command).

3.3 STUDENTS, INTERNS, AND RESIDENTS

The Medical Center of Aurora recognizes the value of medical education and acknowledges the benefits that undergraduate students (defined as but not limited to medical students, physician assistants, and nurse practitioners), interns, and residents provide to both patients and clinical staff. The Hospital desires to assist students, interns, and residents in achieving their medical education objectives by making available the use of clinical and other facilities within the Hospital.

The Hospital and the HealthONE Governing Board require that an agreement exist between the Hospital and the medical school before assigned students, interns and residents are able to participate in clinical activities at the Hospital. Students, interns, and residents shall be enrolled in a medical school accredited by the Liaison Committee on Medical Education.

The responsibility of the students', interns', and residents' involvement and activities in the clinical practice of medicine at the Hospital will be under the supervision, direction, and control of their faculty member (preceptor) or the attending physician who is on the Medical Staff at the Hospital. Clinical activities of students, interns, and residents include taking patient histories, participation in diagnostic and therapeutic procedures, and the preparation of patient summaries.

Students, interns, and residents will provide the Hospital with the following:

1. A letter from the dean of students or program director, including:
    a. confirmation of the applicant's status as a student, intern or resident
    b. indication that this clinical experience is an approved rotation
    c. confirmation that malpractice insurance coverage for the student/intern/resident is provided for the student/intern/resident through the college or university
    d. a statement outlining the school of medicine's expectations of the student/intern/resident and facility during the clinical rotation
    e. a statement of affiliation and release and hold harmless agreement from the college or university.
2. An agreement to observe and abide by the Hospital Bylaws, Medical Staff Bylaws and Rules and Regulations, and Hospital policies.
3. An attending physician/preceptor must be appointed to assume responsibility for the student's, intern's or resident's clinical activities/actions in the Hospital.
4. Responsibilities are delegated to the student/intern/resident by the attending physician/preceptor and the student/intern/resident may not treat or prescribe for Hospital patients except under the direct supervision of the attending physician/preceptor.
5. Interns and residents may perform history and physical examinations; history and physical exams must be countersigned by the attending physician/preceptor. Medical Students may not perform history and physical examinations.
6. Students may write orders and progress notes, state tentative diagnoses, propose diagnostic and therapeutic procedures, recommend a course of treatment, and complete a discharge summary with the supervision and co-signature of the attending physician/preceptor. Orders by medical students must be countersigned by the attending physician/preceptor before being executed. Orders by interns/residents must be countersigned within 24 hours by the attending physician/preceptor.
7. Students/interns/residents may not a) assume any responsibility for making final diagnosis or directing

patient care; b) admit patients; c) hold Medical Staff membership or specific clinical privileges.

8. Interns/residents' history and physical, progress notes, and discharge summaries, when properly edited and countersigned by the attending physician, will become the official chart copy.
9. Students/interns/residents may assist in surgery under the direct supervision of the attending physician/preceptor according to their level of training and experience; the attending physician/preceptor must be present in the room at all times, and the patient must give consent.

The authority of students, interns and residents to observe and/or participate in the care and treatment of patients in the Hospital may be terminated at any time by the President or the CEO. The student, intern or resident shall not be entitled to any procedural rights outlined in Article VIII of the Credentials Manual and any other Medical Staff or Hospital Bylaws, rules and regulations, manuals or policies.

3.4 ADVANCED PRACTICE PROFESSIONAL (APP)

3.4.1 Responsibilities of the Practitioner:

3.4.1.1 The Practitioner supervising an APP shall maintain membership as a member of the Medical Staff of the Hospital. Further, the Practitioner shall maintain licensure to practice medicine within the State of Colorado without restrictions. If any restrictions have been or are placed on the Practitioner's state licensure or Medical Staff membership or clinical privileges, the Practitioner shall obtain the written approval of the Medical Staff to continue to serve as the responsible practitioner for the APP, despite such restrictions.

3.4.1.2 The Practitioner accepts responsibility for the care rendered by the APP, to the extent provided by applicable law.

3.4.2 Responsibilities of the APP:

3.4.2.1 The APP shall maintain current licensure or other regulatory authorization necessary to practice APP's profession in Colorado, and shall perform only those services, which are consistent with such licensure and/or authority.

3.4.3 Mutual Obligations:

3.4.3.1 Both the Practitioner and APP are responsible for adhering to the generally accepted standards of health care applicable to their practices.

3.4.3.2 Both the Practitioner and APP agree that the APP may not provide services in a manner, which exceeds the scope of the APP's license, certificate or other legal credential. In addition, the APP may not provide services~~,~~ which exceed the practice prerogatives/privileges.

3.4.3.3 As applicable, the APP and Practitioner will cooperate in the development and implementation of a program for supervision and collaboration acceptable to them. The program shall set forth the following:

- APP and Practitioner practice specialty
- Obligation of the APP and Practitioner for providing and managing the care of patients

- Requirements for consultation between the parties, including the types of patients/conditions which require consultation
- Criteria for when patients will be referred to the Practitioner for care
- Appropriate response times for the Practitioner and APP
- Mechanisms for supervision and collaboration (e.g., chart reviews, patient care conferences, direct observations, etc.)
- Any other issues requested by the Hospital or reasonably necessary to assist the APP and Practitioner in reaching decisions about appropriate health care for specific clinical circumstances. If the APP is employed by the Hospital, and the Practitioner is the Medical Director of the Department in which the APP practices, the supervision/collaborative program shall describe the communication that shall be required with any other Practitioner who is responsible for care of a particular patient.

3.4.3.4 The Practitioner and APP shall provide sufficient written notice to one another and to the HealthONE Credentialing Verification Office prior to termination of the sponsoring relationship, in order to provide for safe and effective transition of patient care. Absent unusual circumstances, such notices shall be provided at least thirty (30) days in advance of termination.

3.5 GUIDELINES FOR USE OF PATIENT RESTRAINTS/SECLUSION

3.5.1 The use of restraints or seclusion requires a written order by a licensed independent practitioner (LIP) prior to the application of restraint. Restraints/seclusion may not be ordered on a PRN basis or with a protocol. Restraint usage is based on behaviors exhibited by the patient. For the non-violent or non-self destructive patient who is disoriented or confused and does not understand treatment needs of maintaining supportive lines, catheter, or tubes and are unable to follow safety directions, etc. for the patient exhibiting violent or self destructive behavior that presents an immediate, serious danger to themselves or to others.

3.5.2 Restraint with Non-Violent or Non-Self Destructive Behavior

Orders for restraint with non-violent or non-self destructive behavior are not to exceed twenty-four (24) hours for the initial order and must include clinical justification for the restraint, the date and time ordered, the type of restraint and behavior-based criteria for release. To continue restraint use beyond the initial order duration, the LIP must see the patient, perform a clinical assessment and determine if continuation of restraint is necessary and an order for the continuation of restraints may be renewed each calendar day.

3.5.3 Restraint with Violent or Self Destructive Behavior

Orders for restraint with violent or self destructive behavior are time limited, and must specify clinical justification for the restraint or seclusion, the date and time ordered, duration of restraint or seclusion use, the type of restraint, and behavior based criteria for release. A face-to-face assessment by the physician must be done within one hour of the restraint or seclusion initiation or administration of medication to manage violent or self-destructive behavior. (Note: a telephone call or telemedicine methodology does not constitute face-to-face assessment.)

3.5.4 Violent or Self Destructive Behavior Restraints/Seclusion

Time limited: Four (4) hours for adults, 18 years and older Two (2) hours for children 9-17 years of age One (1) hour for children under 9 years of age	Renewal of restraint: May be renewed after RN evaluation and call to physician for order continuance and may not exceed: Four (4) hours for adults Two (2) hours for children 9-17 years 1 (1) hour for children under 9 years of age A face-to-face evaluation with the physician required after the renewal based on RN evaluation.

Orders may be renewed according to time limits above for a maximum of 24 consecutive hours. Every 24 hours an LIP responsible for the patient's care sees and evaluates the patient before writing a new order for restraint or seclusion.

3.6 CONSULTATIONS

3.6.1 Consultation Requirements

Consultations shall be required from a licensed independent practitioner with appropriate clinical privileges in any case when the patient's care needs exceeds the clinical privileges and expertise of the Practitioners currently attending the case. Except in emergencies, consultations are recommended in the following situations:

A. When the diagnosis is obscure after ordinary diagnostic procedures have been completed.
B. When there is doubt as to the choice of therapeutic measures to be utilized.
C. In unusually complicated situations when specific skills of other Practitioners may be needed.
D. When the patient exhibits severe psychiatric symptoms (not currently under psychiatric care).
E. When requested by the patient in accordance with discussion with the primary attending physician.
F. When the patient's condition does not improve as expected.
G. Consultation must be obtained when required by the Bylaws, the Medical Staff and Department/Division Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical or psychiatric conditions require consultation.

3.6.2 Inpatient Consultations

Inpatient consultations may be performed by supervised Advanced Practice Professionals (APPs). Supervisors must be physicians and members of this Medical Staff. The following stipulations outline the requirements of consultation by licensed independent practitioners and APPs:

A. Consultations must include a note in the electronic medical record or an electronic dictation. The APPs note in the medical record must be co-signed by the supervising physician the same day that the consult was performed. This co-signature should also include a note by the supervising physician that reflects that the patient has been examined, the database reviewed, and the plan agreed upon.
B. Daily notes by APPs must be co-signed within 24 hours until the consultant has signed off the case.
C. Verbal communication is highly recommended with the attending/requesting practitioner after the initial evaluation and with any significant changes in the patient's condition or management.
D. APPs may not order additional diagnostic testing or additional consultations without directly contacting their supervisors and the attending physician.

E. The attending physician has the discretion of requesting that the consultation be solely provided by a licensed independent practitioner (physician) and not by an APP.

3.6.3 Consultation Requests

The responsibility for obtaining a specialist to perform an inpatient or observation consultation lies with the practitioner requesting the consult. Consultations have different degrees of urgency. Same day consultations must be called by the requesting physician either directly to the consultant or to the consultant's office.

A. The requesting physician's progress note should reflect that a call for the consultation has been made.

B. An order requesting a "next day" consult must be present in the "orders" section of the chart and identify the consultant, group/physician, and phone number if available. Next day consultations are called to the consultant's office by the requesting physician, or the nursing staff caring for the patient on the same day the order is written.

C. It is understood that any urgent or emergent consultation should involve direct communication between the attending physician and the consultant so that timeliness and appropriate medical information are discussed.

D. The primary attending may ask a consultant to relinquish care at any time, as long as appropriate medical care is being provided to the patient. When multiple consultants are on the case the attending physician shall coordinate care.

3.6.4 Inability to Obtain Requested Consultations

If a consultant is unable to provide the requested consultative service, then this must be directly communicated to the requesting physician. It is then the requesting physician's responsibility to solicit the consultation from another qualified physician. If a consultant cannot be found in a timely manner to perform an essential inpatient or observation consultation and the patient's medical care could be compromised because of this, then transfer to a facility where a consultation can be obtained shall be considered by the attending physician.

ARTICLE IV. TRANSFERS

4.1 TRANSFER OF PATIENTS

4.1.1 **Transfer of patients with an unstablized emergency medical condition will be done according to Hospital policy (See EMTALA Policy).**

4.2 DISCHARGE OF PATIENTS WITH STABILIZED EMERGENCY MEDICAL CONDITIONS

A patient may be discharged if the emergency medical condition is stable. A patient is stable for discharge, when within a reasonable clinical confidence, it is determined that the patient has reached the point where his continued care, including diagnostic work up and/or treatment could reasonably be performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions.

4.3 TRANSFER OF INPATIENTS

1. Phone Order for Transfer: The transferring physician shall personally examine and evaluate the

patient before an attempt to transfer is made. If, however, after receiving a report on the patient's condition from the Hospital's nursing staff by telephone or radio, the physician on call determines that an immediate transfer of the patient is medically appropriate, and that the time requirements to conduct a personal examination and evaluation of the patient will unnecessarily delay the transfer to the detriment of the patient, the physician on call may order the transfer by telephone or radio.

2. Physician Certification: If the physician on call issues orders for the transfer of a patient by telephone or radio, those orders shall be documented in writing in the patient's medical record, signed by the Hospital personnel receiving the order, and countersigned by the physician authorizing the transfer as soon as possible. In addition, a patient transfer form must be signed by the Hospital personnel affecting the transfer and the transferring physician. (Use Reason for Transfer Form and Patient Transfer Form.)

3. Behavioral Health Patients: An order for discharge shall not be made over the telephone or radio unless the discharging Practitioner has seen and evaluated the patient within twenty-three (23) hours preceding the time the discharge order is given.

4.4 TRANSFER OF SUICIDAL PATIENTS

For the protection of suicidal patients, the medical and nursing staffs, and the Hospital, certain principles shall be met in the care of the potentially suicidal patient:

1. Any patient known or suspected to be suicidal in intent shall be referred or transferred to an appropriate psychiatric institution, if feasible. When transfer is not possible, the patient shall be in ICU until a psychiatric consultation has been obtained and a decision made on precautions needed. After the psychiatric consultation, admission location shall be to the most appropriate unit with precautions, assessed by the psychiatric consultation, to meet the patient's psychiatric needs.

2. Any patient known or suspected to be suicidal must have psychiatric consultation.

3. Suicidal patients should be transferred to a facility more appropriately staffed and equipped to handle the special requirements of their care as soon as practical.

4.5 REFUSAL TO CONSENT TO TREATMENT OR TRANSFER

1. Refusal to Consent to Treatment. If a patient refuses to consent to examination or treatment, after being informed of the risks and benefits and the Hospital's obligations under these rules, reasonable attempts shall be made to obtain a written refusal to consent to treatment or examination on the form provided for that purpose. (Use Informed Consent to Refuse Form.) The patient's medical record shall contain a description of the examination, treatment, or both, if applicable, that was refused by or on behalf of the patient.

2. Refusal to Consent to Transfer. If the Hospital offers to transfer the patient to another medical facility by appropriate means and the individual or person acting on the patient's behalf refuses to consent to transfer after being informed of the risks and benefits of the transfer, reasonable attempts shall be made to secure the individual's written refusal to consent to transfer. The patient's medical record shall contain a description of the proposed transfer that was refused by or on behalf of the patient.

ARTICLE V. DISCHARGE OF PATIENTS

5.1 LEAVING AGAINST MEDICAL ADVICE

The Hospital's written policies regarding leaving against medical advice should be consulted and followed whenever a patient desires to leave the Hospital, including the Emergency Department, against the advice of any Practitioner.

5.2 DISCHARGE OF MINOR OR INCOMPETENT PATIENT

When the responsible Practitioner is not personally present to make the decision to discharge an outpatient surgery patient or does not sign the order, the name of the Practitioner responsible for the discharge is recorded in the patient's medical record and relevant discharge criteria approved by the Medical Staff are rigorously applied to determine the readiness of the patient for discharge.

5.2.1 MINOR PATIENT

An unemancipated minor or a minor who was not authorized to consent to his treatment shall only be discharged to the custody of the minor's parent(s), legal guardian(s) or to a person authorized in writing by the parent(s) or legal guardian(s), to accept the minor upon discharge. Any such written instructions concerning a minor's discharge should be made a part of the patient's medical record.

5.2.2 INCOMPETENT PATIENT

An incompetent patient shall be discharged only to the custody of the patient's authorized representative and/or appropriate family member, as set out in the medical record, or to the legal guardian or other individual/agency appointed by a court of competent jurisdiction. Where no authorized representative, family member, legal guardian, other court appointee is available, a qualified Hospital designee can coordinate the discharge with the appropriate county, state or federal agency, and/or with the courts.

ARTICLE VI. MEDICAL RECORDS

6.1 OWNERSHIP AND ACCESS

All patient medical records, including but not limited to, electronically stored patient information, radiographic studies, pathological specimens or slides, and fetal heart monitor tracings, are owned by and are the property of the Hospital. No patient record will be removed from the Hospital except pursuant to court order, subpoena, or with the express permission of the Hospital's Administration. Unauthorized removal or inappropriate access of all or any portion of a medical record by a Practitioner may result in the initiation of disciplinary action as determined by the Medical Executive Committee (See hospital policy). This includes, but is not limited to, inappropriately accessing electronically stored patient information, knowingly sharing the Practitioner's user ID and/or password, or inappropriate access to electronically stored information by the Practitioner's office staff.

Patient medical records are confidential and access to and release of such records is limited. The Hospital's policies on use of and access to such records should be consulted and followed. Practitioners are granted access for review or copies of medical records of patients they have treated in the hospital. All other practitioner access requires the explicit consent and authorization of the patient. In the case of patient's readmission to the Hospital, all relevant information of the patient shall be made available upon request of the attending Practitioner.

Access to medical records for bona fide study and research will be granted on approval from the Director of Health Information Management.

6.2 REQUIRED MEDICAL RECORD CONTENT

The attending Practitioner is responsible for the timely and legible completion of their patient's medical record from the time of admission through discharge. Each medical record contains, as applicable, the following clinical/case information:

- Emergency care, treatment, and services provided to the patient before his or her arrival, if any
- Documentation and finding of assessments
- Conclusions or impressions drawn from medical history and physical examination
- The admitting diagnosis, diagnostic impression, or conditions
- The reason(s) for admission or care, treatment, and services
- The goals of the treatment and treatment plan
- Diagnostic and therapeutic orders
- All diagnostic and therapeutic procedures, tests, and results
- Progress notes made by authorized individuals
- All reassessments and plan of care revisions, when indicated
- Relevant observations
- The response to care, treatment, and services provided
- Consultation reports
- Allergies to foods and medications
- Every medication ordered or prescribed
- Every dose of medication administered, including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and any adverse drug reaction including reactions to anesthesia and blood
- Every medication dispensed or prescribed on discharge
- All relevant diagnosis/conditions established during the course of care, treatment and services
- The patient's name, sex, address, date of birth, and authorized representative, if any
- Legal status of patient receiving behavioral health care services
- Evidence of known advance directives
- Evidence of informed consent for patient care
- Records of communication with the patient regarding care, treatment, and services for example, telephone calls or e-mail, if applicable
- Patient –generated information (for example, information entered into the record over the Web or in previsit computer systems), if applicable
- Complications, if any
- Hospital-acquired infections

Records of patients who received emergency care, treatment, and services contain the following information:

- Time and means of arrival
- Whether the patient left against medical advice
- The conclusions at termination of treatment, including final disposition, condition, and instructions for

follow-up care, treatment, and services
- A copy of the record that is available to the practitioner or medial organization providing follow-up care, treatment, and services

Medical record thoroughly documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia to include:
- A provisional diagnosis documented prior to the operative or other high risk procedures by the licensed independent practitioner responsible for the patient
- Anesthesia record, including post-anesthetic condition signed by the anesthesiologist, anesthetist, CRNA, or surgeon within 48 hours after anesthesia as per these Rules and Regulations

6.3 AUTHENTICATION

All clinical entries (transcribed, handwritten, or computer generated) in the patient's medical record must be accurately dated, timed, and authenticated by the responsible Practitioner within 30 days of discharge unless otherwise stated herein. The acceptable methods for authentication include the following:

- Practitioner's written signature
- Electronic authentication is acceptable only under the following conditions:
  - The Practitioner uses his own sign-on identification and individually selected password as programmed by the Information Systems Department.
  - The Practitioner selects and uses the PIN number programmed by the Health Information Management Department.
  - The Practitioner has provided the Health Information Management Department with a signed statement to the effect that he is the only one who has possession of, knows of, or will use the PIN number.

6.4 USE OF SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used in the medical record only when they have been previously approved by the Hospital. An official record of approved symbols and abbreviations is available in the Health Information Management Department. The following abbreviations are not approved: U, IU, QD, QOD, trailing zero, lack of leading zero, MS, MSO4, and MgSO4.

6.5 HISTORY AND PHYSICAL EXAMINATIONS

6.5.1 Completeness and Timeliness of History and Physical Exams

The attending Practitioner must document a comprehensive history and physical examination to be filed in the medical record within 24 hours after admission of the patient. The history and physical exam (H&P) may be dictated or legibly handwritten.

If a Practitioner has obtained a complete history or has performed a complete physical examination within thirty (30) days prior to the patient's admission to the Hospital, then a durable, legible, copy of the report may be used in the patient's Hospital medical record in lieu of the admission history and physical. However, H&Ps completed prior to admission, but less than 30 days may be used provided an interval note recording updates to the patient's condition is documented on admission on or attached to the history and physical or the admission progress report. The interval note should include

whether or not there are changes, content of changes if applicable, and the date, time and signature of the physician. History and physicals greater than 30 days of admission will have exceeded the time limit and require a new H&P.

The history and physical must be prepared by a Practitioner or credentialed licensed supervised Advanced Practice Professional (employee or non-employee). A history and physical completed by a licensed physician who is not a member of the Medical Staff may be used provided that an LIP (licensed independent practitioner) or other individuals who have been authorized/privileged by the organization:

- Review the history and physical examination document
- Conduct a second assessment to confirm the information and findings and document results
- Update any information and findings as necessary (including a summary of the patient's condition and course of care during the interim period)
- Documentation of the current physical/psychosocial status; and
- Sign, date and time the information as an attestation to it being current.

A history and physical examination performed and recorded by licensed supervised Advanced Practice Professional (employee or non-employee) must be authenticated by including date/time by the supervising Practitioner before any high-risk diagnostic or therapeutic intervention or within 24 hours, whichever is earlier. Any patient converted to inpatient status from Observation status will require a full history and physical.

Medical Staff will monitor the quality of H&Ps by performing a review of H&Ps on the medical records involved in peer review cases and as a part of the concurrent medical record review process. Data obtained will be aggregated and analyzed and presented to the MEC on a regular basis.

6.5.1.1 Minimum Requirements for History and Physical Exams:

The following outlines the minimum requirements for history and physical (H&P) exams. The extent of the H&P obtained is dependent on the physician's clinical judgment and the nature of the presenting problem(s) or the reason for the encounter.

A. In-patients and patients receiving general anesthesia require a comprehensive H&P.

B. Outpatients undergoing invasive procedures receiving moderate to deep sedation analgesia will have an expanded problem focused H&P.

C. Outpatients undergoing a minimally invasive procedure under local or patients receiving non-invasive medical evaluation and treatment, require a problem focused H&P.

D. For provider-based clinic patients, if there is no current comprehensive history and physical, discussion will take place at that time with the patient as to the need for a complete history and physical examination, and the patient will be requested to schedule an appointment within an interval of time appropriate to gender, age and co-morbidity. Documentation of this discussion is to be recorded in the patient's chart.

6.5.1.2 Comprehensive History and Physical

A comprehensive history and physical includes:

- History - chief complaint and/or reason for encounter/admission, history of

present illness (HPI), allergies, medications (including herbal and over the counter), past medical and surgical history, family and social history, review of systems.

- Physical - general, hair and skin, HEENT, cardiovascular, chest and lungs, abdominal, musculoskeletal, neurological, vital signs, height, weight; and, as appropriate, breasts, urogenital, and anorectal
- Impression and plan of care

6.5.1.3 Expanded Problem Focused History and Physical

An expanded problem focused history and physical includes:

- History - chief complaint and/or reason for encounter/admission, HPI, allergies, medications (including herbal and over the counter)
- Physical - clinically pertinent, positive and negative finding(s) relevant for the system directly related to the HPI as well as assessment of cardiovascular, chest and lungs, abdomen, mental status, vital signs, height, and weight
- Impression and plan of care

6.5.1.4 Problem Focused History and Physical

A problem focused history and physical includes:

- History - HPI and/or reason for encounter, allergies, medications (including herbal and over the counter)
- Physical - clinically pertinent, positive and negative finding(s) relevant for the system directly related to the HPI
- Impression and plan of care

6.5.2 Surgical History and Physical

A current, thorough history and physical must be recorded on the patient's medical record prior to operation or invasive procedure. Surgery/invasive procedure is cancelled if a history and physical is not documented prior to the scheduled procedure. In an emergency in which any delay would cause harm to the patient, the operating surgeon shall record a brief note, including the pre-operative diagnosis and appropriate physical findings. The note must include a statement that the procedure was emergent. A full history and physical will be required to be dictated immediately following the procedure.

6.5.3 Obstetrical Record

The prenatal course of care is a planned, systematic updating of the history and physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record can be utilized as the history and physical, provided it is updated to reflect the patient's condition upon admission and according to 6.5.1. The prenatal record must be a durable, legible copy of the attending Practitioner's office or clinic record transferred to the Labor and Delivery Unit before admission.

6.5.4 Dental and Podiatric History and Physical

Dentists and podiatrists may treat patients under the conditions provided in the Medical Staff Bylaws. The dentist or podiatrist is responsible for securing a history and physical examination performed by a qualified Physician member of the Medical Staff. The qualified Physician shall confirm or endorse the

findings, conclusions, and assessment of risk prior to major, high-risk diagnostic or therapeutic interventions. This requirement that a history and physical examination be performed by a qualified Physician does not apply to qualified oral and maxillofacial surgeons who have been granted the clinical privileges to perform a history and physical examination.

Dentists are responsible for that part of the patient's history and physical examination related to dentistry. Podiatrists are responsible for that part of the patient's history and physical examination related to podiatry. The history and physical examination shall include:

- A detailed dental/podiatric history and description of the dental/podiatric problem documenting the necessity for hospitalization and for any surgery; and
- A detailed description of the examination of the oral cavity/foot.

6.5.5 Geropsych History and Physical

A completed history and physical, as well as, a psychiatric evaluation, are required as per 6.5.1.

6.5.6 History and Physical Performed by a Licensed Supervised Advanced Practice Professional

A history and physical can be performed with the appropriate practice prerogatives, under the supervision of the attending physician, with appropriate co-signatures as defined by their practice prerogatives.

6.6 CONSULTATION REPORTS

Each consultation report must include a note in the medical record and an electronic dictation and include the opinions and conclusions reached, and where appropriate, documentation of an actual examination of the patient and a review of the patient's medical record. Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

6.7 PHYSICIAN ORDERS

6.7.1 Writing Orders

All orders for treatment, diagnostic tests, admission or discharge must be clearly written, legible and complete, dated, timed, and signed by the ordering Practitioner or assigned teaching Practitioner. All written orders must include a printed identifier along with the signature. The identifier can be full printed name (First, Middle Initial and Last Name), a stamp with full printed name or Colorado license number. An order by a medical student must be co-signed by the supervising Practitioner before being executed. Orders by interns and residents must be countersigned by the supervising Practitioner.

In some instances, Advanced Practice Professionals are credentialed to write certain orders without having the order co-signed by a Practitioner. If the Advanced Practice Professional is not credentialed to write orders without having the order co-signed by a Practitioner, such orders must also be co-signed by the attending or responsible Practitioner before being executed.

Before issuing orders for a patient, the attending or responsible Practitioner must review and be familiar with the patient's current condition and all other orders in effect for the patient.

Any requested consultations shall be documented by a consult order in the medical record by the requesting physician. This designation is necessary to establish the consultant as a physician of record in accordance with Hospital Appropriate Access policies and procedures.

6.7.2 Carrying Out Orders

Orders that are illegible, improperly written, or which the nursing staff has difficulty interpreting, may not be carried out until rewritten or understood by the nurse. Orders for diagnostic tests that necessitate the administration of test substances or medications will be considered to include the order for such administration unless otherwise specified.

6.7.3 Telephone and Verbal Orders

The use of telephone and verbal orders are to be kept at a minimum. All telephone and verbal orders from a Medical Staff member must be given to a Registered Nurse or, in specialized departments, to Registered or otherwise Certified Personnel in accordance with their scope of practice, i.e., respiratory therapist, physical therapist. All orders for treatment shall be in writing.

Verbal orders should be utilized only in emergency situations where the physician cannot write the order due to an urgent need by the patient.

All telephone and verbal orders must be written on the appropriate order form by the appropriate personnel, read back to the prescribing practitioner and indicate Verbal Order Read Back (VORB) or Telephone Order Read Back (TORB), noting date, time, practitioner name/title and first initial, last name, and title of authorized individual receiving the order.

Verbal or telephone orders must be authenticated with a physician signature, date and time and in accordance with Section 6.3.

Telephone orders are to be signed by the prescribing practitioner or partner as soon as possible, but in no case to exceed thirty (30) days post discharge, in compliance with Colorado State law. A verbal order should be authenticated following the resolution of the emergency in which it was given.

Verbal or telephone orders for Mental Health holds, DNR/limited DNR, investigational drugs and cancer chemotherapy may not be accepted.

When the prescribing Practitioner is not able to authenticate his or her verbal/phone order, it is acceptable for a covering physician to co-sign the order for the physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate, and final. An Advanced Practice Professional (APP) cannot co-sign a physician's verbal/phone order.

6.7.4 Automatic Cancellation of Orders

Upon transfer of a patient to or from special care areas such as ED, critical care, Labor & Delivery, geropsych, and/or surgery, new orders must be written. The order "Continue Previous Orders" or "Resume Previous Orders" is not acceptable.

All previous orders are cancelled when a patient goes to surgery or is transferred to or from a special care area, or other Hospital. In such cases, all orders must be rewritten. "Continue previous orders" is not acceptable.

In accordance with the Hospital's "Do Not Resuscitate/CPR Directive Policy and Procedure", DNR orders are not canceled when a patient is transferred to or from a special care area. When a patient with a DNR order or CPR Directive requires procedural/surgical intervention, which requires informed consent:

a. At least one physician (attending of record or consulting physician) shall discuss and document with the patient or surrogate decision-maker whether the DNR order or CPR Directive should be honored or suspended during all or a part of the perioperative/procedural period.
b. When a physician's views are irreconcilable with the patient's request regarding care options any physician has the option to find a physician who is willing to treat the patient within a reasonable time frame. If this alternative is not feasible to prevent further morbidity or suffering, care should proceed with adherence to the patient's directives regarding resuscitation, being mindful of the patient's goals, values, religion, philosophy and best interests.
c. Communication must take place among relevant staff regarding plans to honor or suspend the DNR order.
d. The Perioperative/Procedural Do Not Resuscitate Status form shall be completed, and
e. The DNR identification shall not be removed during this period.

6.7.5 Pre-Printed Orders, Protocols, Clinical Pathways, Guidelines, Clinical Algorithms, Standing Orders

Pre-printed order (predefined, pre-written order set that lists all the possible orders usually favored by a particular LIP or group of LIPs for a particular episode of care…) orders Protocols, Clinical Pathways, Guidelines, Clinical Algorithms and Standing Orders for each clinical area(s) may be formulated by the Medical Staff membership of a clinical department, the nursing service, and/or Pharmacy. All proposed orders in their final draft must be approved by the Medical Executive Committee. All of the types of orders listed above must be reviewed at least annually and revised as necessary, by the originator, the appropriate Medical Staff and Nursing Department(s), or special clinical committees and the Pharmacy Department.

6.7.6 Admit Order

A patient must have a clear admission order as to the patient's admission status and supporting clinical diagnosis. The attending physician must write one of the following orders:

- "Admit to inpatient for….."
- "Admit to observation for….."

Anytime there is a change in patient admission status from outpatient to inpatient, an order by the attending Practitioner must be documented.

6.7.7 Discharge Order

A patient may be discharged only on the order, written or verbal, of the attending Practitioner or his designee.

6.8 PROGRESS NOTES

A daily visit and note that is dated, timed, and authenticated by the attending Practitioner or his designee is required for each inpatient. Pertinent progress notes should be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending Practitioner. Whenever 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.

Daily visit notes may be written by interns and residents and should be countersigned by the supervising physician within 24 hours.

6.9 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

6.9.1 Definitions of Operative Progress Note/Dictated Operative Report:

Written Operative Progress Note contents include:

- Date of Surgery
- Name of surgeon and assistant
- Findings
- Procedures performed
- Estimated blood loss, specimens removed
- Post-op diagnosis
- Fluids
- Anesthesia
- Pre-op Diagnosis
- Name and Patient Hospital ID#
- Time of surgery
- Prosthetic devices or implants used, if any
- Complications, if any

Dictated Operative Report contents include:

- Date of surgery
- Name of surgeon and assistant and/or other practitioners performing significant tasks
- Pre-operative and post-operative diagnoses
- Name of specific surgical procedure(s) performed
- Type of anesthesia administered
- Estimate blood loss
- Complications, if any
- A detailed, narrative description of techniques, findings, and the tissues removed or altered and their disposition
- Prosthetic devices or implants used, if any
- Patient name and hospital ID #
- Time of surgery
- Description of the specific tasks conducted by practitioners other than the primary surgeon.

6.9.2 Complete written operative progress note (as defined above) will be present on the chart upon transfer to the next level of care, e.g.:

Cath Lab to Cath Recovery
OR to PACU
GI Lab to Day Surgery Recovery
Operating Room to ICU

A comprehensive operative report (as defined above) will be dictated within 24 hours of completion of the procedure.

6.9.3 A dictated operative report is required for all assisted deliveries.

6.9.4 Failure to comply with section 6.9 will result in disciplinary action. See section 6.12.2 Delinquent Medical Records.

6.10 ANESTHESIA/SEDATION RECORD

6.10.1 A pre-anesthesia evaluation by an individual qualified and credentialed to administer anesthesia or sedation will be completed within forty-eight (48) hours prior to inpatient or outpatient surgery, or moderate/deep sedation. This evaluation shall include:

- Allergies and drug history
- Previous patient and family history of adverse reactions to sedation or anesthesia
- Anesthesia risk such as ASA classification
- Results of diagnostic studies, if any
- Plan (choice) of anesthesia or sedation
- Patient's appropriateness for anesthesia or sedation
- Consent for anesthesia or sedation
- Immediately prior to sedation/anesthesia, the patient is reassessed to determine if the patient remains a candidate for the planned procedure and choice of sedation. This assessment is to include, at a minimum, vital signs, cardiac, pulmonary, and airway.

An appropriately credentialed Advanced Practice Professional may document the evaluation provided the physician supervises the evaluation and signs the note signifying review and agreement. While the choice of a specific anesthetic agent or technique may be left up to the individual administering the anesthesia (if different from the individual performing the evaluation), the medical record entry should refer at least to the use of general, spinal, or other regional anesthesia. When a Physician or Nurse Anesthetist does not conduct the initial evaluation, the responsible Practitioner should make reference in the medical record to the use of spinal, regional, topical, or local anesthesia. This re-evaluation should be performed and documented before pre-operative medication has been administered.

6.10.2 Intraoperative anesthesia record includes at a minimum:

- Name of Practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner
- Name, dosage, rout and time of administration of drugs and anesthesia agents
- IV fluids, blood or blood products, if applicable
- Oxygen flow rate

- Continuous recording and documentation of patient status noting blood pressure, heart and respiration rate as per department policies
- Any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment

6.10.3 Post-Anesthesia Evaluation

A post anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation is required any time general, regional or monitored anesthesia has been administered to the patient. The post anesthesia evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia; this need not be the same practitioner who administered the anesthesia to the patient. The evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. The evaluation may occur in the PACU/ICU or other designated recovery locations. The post-anesthesia evaluation should be clearly documented and contains the following:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
- Cardiovascular function, including pulse rate and blood pressure;
- Mental status;
- Pain;
- Nausea and vomiting; and
- Postoperative hydration.

For those patients who are unable to participate in the post anesthesia evaluation (e.g., postoperative sedation, mechanical ventilation, etc.), a post anesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate. This documentation should include the reason for the patient's inability to participate as well as expectations for recovery time, if applicable. For those patients who require long-acting regional anesthesia to ensure optimum medical care of the patient, whose acute effects will last beyond the 48-hour timeframe, a post anesthesia evaluation must still be completed and documented within 48 hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.

6.11 CONCLUSION OF HOSPITALIZATION

6.11.1 Discharge Diagnosis

The discharge diagnosis or diagnoses must be written or dictated in full at the time of the patient's discharge. Additional information may be requested for accurate code assignment.

6.11.2 Discharge Summary

A discharge summary must be recorded for all patients and is recommended to be dictated or written at discharge, but may not exceed 30 days from discharge. The summary must include the following:

- The reason for hospitalization, including final diagnosis
- Significant findings

- Procedures performed and treatment rendered
- Condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission
- Specific discharge instructions given to the patient and family

6.11.2.1 A final progress note may be substituted (as an exception) for the discharge summary in the case of the following categories of patients:

6.11.2.1.1 Patients with problems of a minor nature who require less than 48 hours of hospitalization;

6.11.2.1.2 Patients admitted as Outpatient with Observation Services;

6.11.2.1.3 Normal newborn infants;

6.11.2.1.4 Patients with uncomplicated vaginal deliveries.

6.11.3 Discharge Instructions

Specific discharge instructions shall be provided to the patient or to their significant other at the time of departure. The instructions shall include information regarding physical activity, specific medications and dosage, diet, and follow-up care to include instructions on when to return to the office. These instructions shall be documented in the medical record in laymen's terms.

6.11.4 Discharge Disposition

The condition of the patient at discharge must be stated in a manner allowing specific comparison to the condition of the patient upon admission.

6.12 INCOMPLETE MEDICAL RECORDS

6.12.1 Incomplete Medical Records

A medical record is considered incomplete if any of the information as described in the preceding Sections 6.2 through 6.11 is omitted, not present, or not authenticated by the author of the entry.

6.12.2 Delinquent Medical Records

A delinquent medical record is defined as any medical record, which has an omission of documentation or signature as defined in Section 6.12.1 and has remained incomplete for thirty (30) days past the date of discharge or date of registration for an outpatient visit.

The following are considered delinquent when not done within the stated timeframes:

- A written operative progress note must be done immediately after surgery.
- Dictated operative report must be within 24 hours of completion of the procedure.
- History and physical must be done within 24 hours of admission and/or prior to a procedure.
- Medication verbal/phone orders must be authenticated within 48 hours of transcription unless a read-back and verify process is followed and documented. If a read-back and verify process is followed, the order may be authenticated within thirty (30) days after the date the order was made.

6.12.3 Notification Process for 30-day delinquency

Failure to complete delinquent medical records after appropriate notification from the Health Information Management Department will result in the loss of admitting privileges and the ability to schedule cases until all of the delinquent medical records are complete. The Health Information Management Department will notify Practitioners by email or fax within one (1) week of a record becoming delinquent so that the Practitioner shall receive appropriate notice.

Three (3) automatic suspensions of admitting privileges and the ability to schedule cases within a calendar year for failure to timely complete or prepare records will be deemed a voluntary resignation of Medical Staff appointment and clinical privileges. Practitioners who are deemed to have voluntarily resigned Medical Staff appointment and clinical privileges are not entitled to the procedural rights and processes outlined in Article VIII of the Credentials Manual of the Bylaws. Practitioners who so resign may immediately submit an application for appointment. Any such application shall be treated and processed as an application for initial appointment. All information relating to the Practitioner's actions and conduct during his previous appointments to the Medical Staff may be considered.

These guidelines apply to all Hospital locations.

a) Practitioners are notified of incomplete records biweekly. Notification letters are generated n every other week. The notification is sent one (1) week prior to suspension.

b) When records are not completed after thirty (30) days from initial record analysis, the physician receives a notification of the loss of admitting/scheduling privileges.

c) Practitioners whose admitting and scheduling privileges are automatically suspended due to delinquent medical records will be automatically reinstated upon completion of all delinquent medical records.

d) Practitioners may incur fines and/or voluntarily relinquish Medical Staff appointment and privileges as outlined in the "Delinquent Medical Records" Policy. The Practitioner will receive a certified letter from the President of the Medical Staff notifying him of his voluntary relinquishment of Medical Staff appointment and privileges.

6.12.4 Notification process for written operative progress note, dictated operative report and H&P delinquencies.

HIM department will call the Practitioner when progress notes and reports are not completed with the timeframe. For the dictated operative report, a faxed notification will be sent at this time. The call will be documented and incorporated into the suspension protocol. If the report is not dictated within 24 hours, the subsequent faxed notification will be a suspension notice. Three incidents resulting in phone calls on any given month will result in auto suspension and/or 5 incidents in 1 year will result in auto suspension.

Failure to complete the written operative progress note as defined in 6.9.2 also results in the above disciplinary actions.

6.12.5 Filing of Incomplete Medical Records

No medical records shall be filed until it is complete and properly authenticated. 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 Staff President or designee shall consider the circumstances and may enter such reasons in the record and order it filed.

6.12.6 Alterations/Correction of Medical Record Entries

Only the original author of a medical record entry is authorized to correct or alter the entry (with the exception of the teaching practitioner). The person making the correctional/alteration must authenticate any correction/alteration. Original medical record entries should never be erased or otherwise obliterated, including the use of "white-out".

If a correction/alteration is made, the individual should cross out the original entry with a single line, ensuring that it is still readable, write the word "error", enter the correct information, sign with legal signature and enter the time and date the correction was made. When the correction requires more space than is available, the individual should write "addendum" and enter the correct information into the record.

Any alteration in the medical record after the patient record has been completed is considered to be an addendum and should be dated, signed, and identified as such.

If alterations are made to the record, which do not reflect an amendment or proper correction method, the individual responsible for the entry may be subjected to disciplinary action by the Medical Executive Committee.

ARTICLE VII. DRUGS

7.1 STOP ORDER POLICY ON DRUGS AND MEDICATIONS

7.1.1 The ordering of certain drugs for patients without placing a definite time limitation may lead in some instances to harm and great expense to patients. Drugs listed below, ordered for patients without specific limitation as to dosage and time, shall be called to the attention of the attending physician by an "automatic stop notice" attached to the patient's chart at three (3) days, two (2) days, and one (1) day prior to automatic discontinuation of the medication. (This is a Meditech-generated notice.)

7.1.2 Categories of drugs under the Stop Order Policy include:

a) Narcotics: ten (10) days.
b) Sedatives: ten (10) days.
c) Antibiotics: thirty (30) days.
d) All other drugs: thirty (30) days.
e) Ketorolac: five (5) days.

7.1.3 The Stop Orders notification will be invoked unless:

a) The order indicates an exact number of doses to be administered.
b) An exact period of time for medications to be given is specified.
c) The practitioner reorders the medication.

7.1.4 Discontinuance of a medication because of the Stop Order Policy will be called to the attention of the patient's physician to allow an opportunity to renew or discontinue the order. No medication will be

discontinued without the approval of the physician.

a) The automatic cancellation of orders will be invoked unless:
   1) The order indicates an exact number of doses to be administered.
   2) An exact period of time for medication to be given is specified.
   3) The physician reorders the medications post-operatively.

7.2 SPECIAL ORDERS

7.2.1 PATIENT'S OWN DRUGS AND SELF-ADMINISTRATION

Patients own medications are not to be used, unless the medication is a bulk item such as eye drops and inhalers, or if the medication is a Non-Formulary drug and a suitable Formulary substitution cannot be made. In order for the patient to use his own medication, the physician must specify the name, dosage, frequency, and route of administration of each medication. “May use own medication” will not be an accepted order. The pharmacist or nurse will interview the patient, call the physician to verify the medications the patient is taking and then write a clarification or order in the chart. The patient’s own medication should be kept in the patient’s medication bin unless it is specifically ordered to be self-administered. Patients own controlled (narcotic/hypnotic) medication may not be used unless there are unusual circumstances. Patients are not to self-administer any of their own controlled (narcotic/hypnotic) medication.

7.2.2 SELF-ADMINISTRATION OF MEDICATION

Self-administration of medication is discouraged. Only the following types of medication are allowed for self-administration and may be kept at the bedside in a cabinet or drawer:

- Topicals such as ointment, cream or lotion
- Oral hygiene products such as mouth wash
- Oral contraceptives/vaginal medications
- Preparations for perineal care
- Ophthalmic, oral inhalers or nasal products (excluding Stadol Inhaler)
- Terbutaline for tocolytics
- Investigational drugs

7.2.3 NON-FDA APPROVED PHARMACEUTICAL/PRODUCTS

All formulary pharmaceuticals currently used for the treatment of patients are FDA approved products which meet many required criteria including but not limited to: efficacy, safety and toxicity, bioequivalence, risks for adverse reactions, propensity to induce errors, and cost, etc. It is acknowledged that the use of non-traditional products (e.g., herbal remedies, extracts, certain vitamin components) which do not have FDA approval is controversial. Because these non-FDA approved products do not meet the above standards within the primary literature, in general, their use is not supported without factual documentation and are not available from the Hospital's pharmacies. However, should the patient request to utilize these products for his own use, the attending Practitioner may support this practice by writing an order in the patient's chart requesting the patient utilize his personal supply.

7.3 FORMULARY DRUGS

7.3.1 The formulary system is the accepted method whereby the Medical Staff, working through the Pharmacy and Therapeutics Committee, evaluates, approves, and selects from among the numerous medicinal agents available, those that are considered most useful in patient care. Under the formulary system, each member of the Medical Staff agrees that in each instance in which he prescribes a drug by proprietary (trade) name, he expressly authorizes the pharmacist to dispense, and the nurse to administer, the same drug under its "therapeutic equivalent" irrespective of whether it is or is not the same brand referred to in the prescription or order. If for any medical reason, a Practitioner wants a patient to receive a specific brand name of drug, they must specifically indicate by writing on the Physician's Order form or the Outpatient Prescription Blank, the words, "Dispense as Written." Only then will the pharmacist dispense that particular brand. All "Dispense as Written" orders are subject to evaluation by the Pharmacy and Therapeutics Committee.

7.3.2 Those drugs which have been reviewed and recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee are designated formulary drugs. The formulary system does not specify brand names. It is the responsibility of the Pharmacy Department to maintain a safe and therapeutically efficacious brand of each formulary drug. The brand stocked in the Pharmacy will be dispensed for prescription orders for any brand unless otherwise indicated by the prescribing Practitioner.

7.3.3 Requests for additions to or deletions from the formulary should be submitted on a Formulary Drug Request Form, available from the Pharmacy Department, to the Director of Pharmacy for presentation to the Pharmacy and Therapeutics Committee. These requests are researched and evaluated by the Pharmacy and Therapeutics Committee. The Pharmacy and Therapeutics Committee is composed of pharmacists and Medical Staff Members. All drugs are admitted to the formulary on a non-proprietary name basis. No drug of unknown or secret composition will be admitted.

7.3.4 When a non-formulary drug is requested from the Pharmacy Department, the pharmacist will inform the prescribing Practitioner of those formulary drugs which are pharmacologically similar. If the Practitioner has a medical reason for using the non-formulary drug, the Pharmacy will obtain the medication for that particular patient. Since non-formulary drugs are not stocked within the Pharmacy, there may be a time delay in obtaining the medication up to twenty-four (24) hours. The pharmacy will keep a written account of all honored requests for non-formulary drugs and will present these to the Pharmacy and Therapeutics Committee for their consideration.

7.3.5 Certain medications may be therapeutically interchanged with a therapeutically equivalent product as determined and approved by the Pharmacy and Therapeutics Committee. Such interchanges will be communicated to the Medical Staff prior to implementation. The interchanges will be automatic.

7.3.6 All medication orders must be written with the degree of accuracy, completeness, and discrimination necessary for their intended use. These orders must be legible and complete, along with a legible prescribers' signature. For unclear orders, the Pharmacy Department will call for clarification to ensure patient safety.

7.3.7 Blanket orders for medications such as "continue previous meds", "resume preoperative meds", or "discharge on current meds" are not acceptable. New, complete and accurate orders must be written.

7.3.8 Double range orders are discouraged. If a physician writes an order for a dose and frequency range, the range for dosage will remain the same and the frequency will be entered with the lowest frequency.

7.3.9 ALL PRN medication orders require an indication for the PRN medication be included in the written order. PRN medications which have a broad range of dosages, multiple indications, or greater than one route of administration must include additional information, qualifications, or indications on how the medication is to be administered.

7.3.10 The Formulary is available on the Hospital intranet.

ARTICLE VIII. CONSENTS

8.1 GENERAL

8.1.1 Upon admission, the Hospital should obtain a general consent for treatment during the hospitalization. This general consent does not, however, eliminate the need for each Practitioner to obtain informed consent from the patient or the patient's authorized representative for specific treatments or procedures.

8.1.2 Where Hospital policies require written consents, such consents must be obtained by the Practitioner. Hospital personnel, including but not limited to the nursing staff, shall not be responsible for or be asked to secure written informed consents from patients, nor shall they complete consent forms nor present them to patients for signature unless specifically allowed under a policy approved by the Medical Executive Committee.

8.2 INFORMED CONSENT

8.2.1 WHEN REQUIRED

A. The Hospital has several policies outlining when, how and from whom specific consents must be obtained for surgical and medical treatments and procedures. All Practitioners are responsible for being familiar and complying with the provisions of these policies.

B. The Hospital's policies require that informed consent be obtained and documented in writing by the Practitioner on at least the following procedures:

(1) Procedures usually requiring general or regional anesthesia or sedation;
(2) All surgical or invasive procedures;
(3) All sterilization procedures;
(4) All research procedures or treatments;
(5) Blood transfusions;
(6) AIDS and HIV testing;
(7) Organ and tissue donations; and
(8) All other procedures designated by the Hospital or any of its clinical Departments.

8.2.2 DOCUMENTATION

8.2.2.1 Evidence of the informed consent must be obtained and filed in the patient's medical record prior to proceeding with the surgery or other procedure or treatment in accordance with the Hospital's policies.

8.2.2.2 Consents shall be valid for 30 days. The consent shall not extend beyond the present

admission unless it is for a continuous course of treatment. A new consent shall be obtained when it is decided to perform a substantially different operation or to administer a substantially different treatment with greater or different risks than with the original procedure.

8.2.3 EMERGENCIES

A. If a patient who presents with an emergency medical condition is unable to give consent and no other person who is authorized to act on behalf of the patient is available for consultation, the Practitioner may elect to proceed in accordance with the Hospital's policies with such surgery or treatment as is necessary to address the emergency. In all such cases the Practitioner will thoroughly document the patient's condition, including the immediate threat to the patient and all efforts made to obtain a valid consent.

B. If a minor or other incompetent patient presents with an emergency medical condition and the parent(s) or guardian refuses consent for a surgery, procedure or treatment which, in a Practitioner's opinion, is necessary to address the emergency, such emergency care as may be necessary to address the emergency may be administered in accordance with the Hospital's policies. In all such cases, appropriate judicial proceedings should be promptly thereafter initiated.

8.2.4 INABILITY TO OBTAIN CONSENT

If a patient who is not suffering from an immediate life-threatening condition is unable or is incompetent to give consent for a surgery, treatment, or procedure which a Practitioner believes should be performed or administered, or if the parents or other legal guardians or authorized representatives of such a patient refuse to give such consent, approval for the treatment, surgery or procedure should be sought through appropriate judicial proceedings before any treatment is initiated.

ARTICLE IX. SURGICAL INVASIVE PROCEDURES

9.1 INFORMATION PROVIDED UPON SCHEDULING

When scheduling an elective case, the attending surgeon/proceduralist or his designee must provide the following information:

9.1.1 Name, age and sex of patient.

9.1.2 Pre-operative diagnosis and complete procedure planned.

9.1.3 Name of first assistant.

9.1.4 Type of anesthesia requested.

9.1.5 Any additional information required by the Hospital.

9.2 PATIENT SAFETY PROCEDURES

Prior to any procedure, the patient's identification, the procedure, and the site, if applicable are to be verified during a "time out" procedure outlined in Hospital policy.

Patient Identification:
For patient safety, patients will be identified using two patient identifiers prior to any surgery, procedure or test to include the patient's name and date of birth or social security number. Ask the patients to state these while looking at the armband.

Procedure Verification:
Verification of the consented procedure is to occur through patient interview, review of consent, physician orders, H&P, procedure schedule, and diagnostic studies as applicable.

Site Verification:
The practitioner performing the procedure must verify the site marking with their initials prior to the procedure and again verbally during the time out process.

- Digits must be marked individually
- Marking should be visible after prep and drape
- General area of spinal procedures should be marked preoperatively with imaging as final confirmation
- If the site cannot be marked or the patient refuses to be marked, appropriate alternative marking documents should be utilized.

Marking may be omitted in an emergency situation where the physician has accompanied the patient from decision to incision. Site should be verified during the time out.

Time out:
The time out, initiated by the physician performing the procedure, will be conducted in the location where the procedure will be performed, immediately prior to beginning the procedure and after draping, if appropriate, has occurred. The entire procedural team, including the person performing the procedure, will pause, all team members should introduce themselves and take a "time out" and verbally verify the following:

- Patient identification
- Procedure to be performed
- Side and/or site of incision/procedure
- Correct patient position, as applicable
- Correct implants and any special equipment or special requirements, as applicable.

A debriefing should be conducted at the end of the procedure, prior to the physician leaving the room. During this time, closing counts results are announced, the procedure and diagnosis are confirmed, specimen(s) are confirmed and key concerns are addressed.

9.3 SURGICAL SPECIMENS

9.3.1 Category I: These specimens probably do not require examination by a pathologist:

Orthopedic appliances
Prosthetic devices
Pacemakers
Catheters
Intrauterine Contraceptive devices
Toenails/Fingernails
Teeth and tooth fragments (except from bite marks)
Ocular lens (cataracts)
Foreign bodies (except bullets, knives)
Skin and subcutaneous tissue (cosmetic)
Foreskin (pediatric and adult)

9.3.2 Category II: These specimens should be submitted to pathology for gross examination, verification, and documentation by a written pathology report and, if requested, photographs. A microscopic examination may be performed at the discretion of the pathologist, if indicated.

Calculi
Nasal bone, cartilage and mucosa
Varicose veins
Bunions**
Meniscus (knee)**
Stapes
Hernia sacs
Abortion by amniocentesis
Tonsils and adenoids
Intervertebral disc**

**(*Orthopedic Department voted 4/96 to leave submission of these specimens to the discretion of the surgeon.)*

9.3.3 Category III: All other specimens should be submitted to pathology for both gross and microscopic examinations.

9.3.4 Physicians may not take any patient tissue specimens, removed during surgery, from the Operating Room. Tissue specimens must either be submitted to the Pathology Department as per protocol, or be disposed of by authorized Operating Room personnel.

9.4 POST ANESTHESIA CARE UNIT (PACU):

All patients are to be recovered in the PACU with the following exceptions:

- A patient having received a local anesthetic and who is alert and stable, may be sent directly to his room if the surgeon or the anesthesiologist writes a specific order to that effect.
- At the discretion of the anesthesiologist, a patient who has received IV sedation analgesics who is awake and alert with stable vital signs may be directly admitted to the nursing unit.
- A patient having had open heart surgery may be admitted directly to ICU.
- Any patients who remain ventilator-dependent following surgery may be admitted directly to ICU.

Prior to the removal of the patient from the recovery room suite, the surgeon shall, in addition to any post-operative orders, add to the outpatient record a descriptive statement of the pathological state encountered and the procedures performed.

9.5 PRIVILEGES

The operating room supervisor shall have access to the operative privileges granted to each and every surgeon and dentist and notify the Chairperson of the Surgery Department whenever, in his opinion, any surgeon is undertaking or scheduling procedures in excess of those described in the aforementioned copy of privileges.

9.6 ASSISTANTS

Guidelines for required surgical assistants are as follows:

- A scrub nurse may assist on occasions during an operation, but his assisting must not detract from his functions as a scrub nurse;
- The surgeon will be the final judge as to the need for assistants.

9.7 STARTING TIME FOR OPERATIONS AND CANCELLATION

Any practitioner who is more than thirty (30) minutes late and has not notified the OR control desk may have his case canceled and rescheduled at the end of the day or worked into another area of the schedule if possible. Practitioners with three (3) or more unexcused latenesses in any month which exceeds thirty (30) minutes will be reviewed at the next Surgical Services Function Committee meeting and appropriate action will be taken. Such action may include:

1. No action at all.
2. Verbal and/or written reprimand. Copy of written reprimand filed in the practitioner’s peer review file.
3. Loss of morning scheduling for a specified time.
4. Recommended loss of surgical privileges up to two (2) weeks to the Credentials Committee for action.

9.8 ATTIRE

All personnel entering the operating room are to be dressed in the proper scrub suits, caps and masks. Boots are optional. Operating room attire shall be changed if it becomes soiled.

9.9 TRAFFIC PATTERNS

Operating room traffic patterns must be strictly observed. Personnel not working in the operating suite are to refrain from entering the area.

9.10 VISITORS

A visitor is an individual who is not directly involved with the care of a patient or support of the operative team. Courtesy requires that the surgeon be informed when students are to be present during an operation. Visitors may be present in the operating room only with the consent of the patient, surgeon, anesthesiologist, and nurse manager. There may be times when visitors may be present immediately outside the operating room, as in the case of a cesarean delivery where members of the patient's family may be present. Such visitors are allowed as

long as they do not interfere with the operating team, the function of the operating suite or the patients undergoing operative procedures. Medical students, interns and residents who are not in a program affiliated with the Hospital are considered visitors, and, in addition to the other requirements for visitors, must present to the Medical Staff Office letters verifying their participation in the medical school or residency program, as appropriate, and professional liability insurance coverage. Should any dispute arise regarding visitors, the Department Chairman of Surgery shall have the final say whether a visitor is permitted.

9.11 SURGEONS LEAVING THE OPERATING SUITE

Surgeons should not leave the surgery suite during procedures, except to take breaks during long procedures and in case of illness, or other activity relating to care of that patient (to talk with relatives, etc.). If the surgeon is needed outside the operating suite to care for another patient or for other issues after the patient has been anesthetized and the procedure has not been started, then the anesthesiologist and surgeon shall consult on whether or not the patient should be awakened.

ARTICLE X. WAIVED TESTING

Waived Testing, as defined by the CLIA regulations, may be performed by Physicians and Advanced Practice Professionals, as long as it falls within their specific scope of practice.

Waived Testing may also be performed by Physicians and Advanced Practice Professionals, if the appropriate competencies, as mandated by the Laboratory Department, have been completed and are current. Competency Records shall be maintained by the Ancillary Services Coordinator.

ARTICLE XI. DEATH AND AUTOPSY

11.1 In the event of a Hospital death, the deceased shall be pronounced dead by the attending Practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. 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.

11.2 It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital pathologist or by a Practitioner delegated this responsibility. The complete protocol should be made a part of the record within sixty (60) days 90% of the time, per College of American Pathologists (CAP) standards.

11.3 Guidelines upon patient death:

11.3.1 An autopsy should be requested under the following conditions:

11.3.1.1 An unanticipated death for which there is no known medical or surgical condition which can account for or explain the death;

11.3.1.2 A death in which there is an unexplained medical or surgical finding(s) for which an autopsy might potentially yield useful information;

11.3.1.3 A death in which there is significant medical information to be gained for the family, community, or as part of a medical education program (e.g., confirmation of suspected pathologic process(es), evaluation of new or experimental therapeutic regimens, investigation of ante mortem diagnostic maneuvers, etc.).

11.3.2 Criteria for reporting death to the coroner. Contact the nursing supervisor for assistance:

B. All patients that die within 24 hours of admission to the hospital
C. All deaths that occur in the emergency room
D. All deaths resulting from accident, suicide or homicide
E. Any death in the operation room
F. Any death thought to be related to a therapeutic procedure
G. Deaths resulting from thermal, chemical or radiation injury
H. All deaths due to unexplained causes or under suspicious circumstances
I. Deaths resulting from a disease which may be hazardous or contagious
J. All causes when trauma may be associated with the death

11.4 Any request for an autopsy and family response to that request should be documented in the medical record. Consent for autopsy must be received from the legal "next of kin" prior to autopsy. The physician performing the autopsy shall notify the attending practitioner when an autopsy is being performed.

11.5 Autopsy results shall be used for performance monitoring and improvements.

11.5.1 Autopsy results shall be received and reviewed for discrepancies by a staff Pathologist. If remarkable discrepancies exist, then the results shall be forwarded to the appropriate Department Chair for review. If the Department Chair determines that there is a significant discrepancy, then the case shall be forwarded to the Facility Peer Review Committee for review.

ARTICLE XII. EMERGENCY MEDICAL SERVICES

12.1 SCOPE OF SERVICE

12.1.1 The Emergency Department shall provide services and procedures commensurate with standards and criteria. Procedures requiring general anesthesia or major surgery shall not be performed in the Emergency Department except in the instance where life-saving measures are mandatory.

12.1.2 Any patient who comes to the hospital property or premises requesting emergency services is entitled to and shall receive a medical screening examination performed by an individual qualified to perform such examination to determine whether an emergency medical condition exists. All patients with an emergency medical condition shall receive stabilizing treatment.

12.1.3 All admissions to, diversions, discharges or transfers from the Hospital's Emergency Departments shall be accomplished in conformity with the written policies of the Hospital.

12.2 EMERGENCY MEDICINE

12.2.1 The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department. This shall be in accord with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all practitioners who render emergency care.

12.2.2 An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists.

12.3 MEDICAL STAFF COVERAGE

12.3.1 The Emergency Department shall be staffed with appropriately privileged physicians.

12.3.2 An on-call schedule of specialists and general Practitioners shall be promulgated by the respective clinical Departments or services in accordance with their policies and procedures or rules and regulations and will thereafter be posted or otherwise available in the Emergency Department. All such schedules shall be updated as required by Hospital policy.

12.3.3 Practitioners who are on call to the Emergency Department shall be available to respond to the Emergency Department Physicians by telephone or in person, as appropriate. On call Practitioners shall respond to a call from the Emergency Department no later than twenty (20) minutes by telephone and shall personally appear in the ED within 60 minutes of receiving the call to come in. However, a shorter response time may be required as appropriate for the clinical presentation. If a Practitioner will be unavailable to take call, it is his responsibility to provide for appropriate backup and notify the Medical Staff Office of his unavailability and to identify the Practitioner taking call. Failure to comply with this provision may result in disciplinary action in accordance with the Medical Staff Bylaws and/or policies.

12.3.4 All Practitioners who are on call to the Emergency Department shall be available for at least one outpatient follow-up appointment as clinically appropriate for patients seen in the Emergency Department. The initial contact for the follow-up appointment must be made by the patient within fifteen (15) days of the ED visit. The on-call physician has no obligation to accept an appointment for follow-up after this time.

12.4 INSTRUCTIONS TO PATIENTS DISCHARGED

Patients seen in the Emergency Department and not admitted to the Hospital or transferred out shall be given written instructions regarding their follow-up care ("After Care Instructions"). The patient or authorized representative shall sign a receipt acknowledging delivery of said instructions. A signed copy of the general instructions shall become a part of the Emergency Department record. Where additional printed, standardized or computer generated instructions are given, a notation to that effect should be entered in the record.

ARTICLE XIII. TELEMEDICINE SERVICES

Practitioners who wish to provide Telemedicine services, as defined in the Medical Staff Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws. The Medical Staff has approved the following services delivered through a telemedicine medium at this Hospital, according to commonly accepted quality standards: Teleradiology, PICU, Stroke and Trauma Telemedicine. Consideration of appropriate utilization of Telemedicine equipment by the Telemedicine Practitioner shall be encompassed in clinical privileging decisions.

ARTICLE XIV. NOTICE OF PRIVACY PRACTICES

Each member of the Medical Staff will be part of the Organized Health Care Arrangement with the Hospital, which is defined in USC 164.520(d)(1) (HIPPA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. This arrangement allows the Hospital to share information with the provider and the provider's practice for purposes of the provider's payment and practice operations. The patient will receive one Notice of Privacy Practices in Admissions, which will include information about the Organized Health Care Arrangement with the Medical Staff.

ARTICLE XV. POLICIES AND PROCEDURES

15.1 SCOPE OF POLICIES AND PROCEDURES

Clinical areas of the Hospital may, with approval of the Medical Executive Committee as appropriate, promulgate written policies and procedures regulating any aspect of the care of patients or operations provided that no portion of any such policy or procedure conflicts with any provision of these Rules and Regulations, Bylaws, or the Credentials Manual and Hearing and Appellate Review Policy and Procedure of the Medical Staff. Any such policy or procedure shall have the same force and effect as these Rules and Regulations.

15.2.1 POLICIES/PROCEDURES/PLANS DEVELOPED BY THE MEDICAL STAFF

15.2.1 Emergency Department Call Policy
15.2.2 Disruptive Practitioner Policy
15.2.3 Harassment Policy
15.2.4 Impaired Physician Policy
15.2.5 Advanced Practice Professionals Credentialing Plan

ARTICLE XVI. REVIEW, REVISION, ADOPTION AND AMENDMENT

These Rules and Regulations may be amended or repealed, in whole or in part, in accordance with Article XI of the Medical Staff Bylaws.

Approved by the Medical Staff on June 1999
Adopted by the Board on July 1999
Amended January 11, 2001; October 11, 2001; January 10, 2002; March 14, 2002; January 21, 2003; March 18, 2003; Amended July 14, 2003; August 24, 2004; September 28, 2004; December 14, 2004, October 25, 2005, January 22, 2008 Deleted 6.9.3 re: cancer staging form 4/2009, Consultation reports 6.6 changes November, 2009, Telephone and Verbal Orders updated August 2010, PRN meds 7.3.9 changes February 2010. Med students may not do H & P April 2011, ED response time changes for EMTALA compliance June 2011; November 2011 removal of reference to signature stamp; January 2012 change to Guidelines for Use of Patient Restraint/Seclusion; January 2012 Change to Pre-Anesthesia (delete Hospital employee); January 2012 Addition of 6.10.3 Post-Anesthesia Evaluation; 7/13 added printed identifier to 6.5 Physician Orders; 4/14 Changed Allied Health Professional to Advanced Practice Professional; 6/14 changed "physician" to "practitioner" in 3.1 General, changed to "Inpatients shall be seen a minimum of one (1) time each calendar day thereafter" from "every 24 hours", added "well mothers with baby(s) complications".
Amended February 25, 2015: Surgical H & P added "In an emergency in which any delay would cause harm to the patient and deleted "brief history" Amended March 2015 Changes to autopsy criteria. Amended April 2015 to include site verification and debriefing process to Article IX., 5/15 Changes to Incomplete Medical Records (6.12.1) to reflect current Delinquent Medical Record policy. 2/16 Added 6.11.2.1 Final progress note may be substituted for discharge summary