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Trinity Health Specialty Hospital – Grand Haven

MEDICAL STAFF

RULES AND REGULATIONS

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

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ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general principles contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

The specific responsibilities of each individual Practitioner are to render specific professional services at the level of quality and efficiency equal to, or greater than, that generally recognized and accepted among Practitioners of the same profession, in a manner consistent with licensure, education and expertise, and in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources, and case management/utilization standards in effect in the Hospital.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts patient approved by Insurance for admission to long term acute care with expected length of stay of at least 25 days.

- a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.
- b. **Admitting Diagnosis:** No patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record.
- c. **Admission Procedure:** Admissions must be scheduled through the Hospital's designated admitting process. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. The attending practitioner or designee shall contact the admitting department to ascertain whether there is an available bed.

2.1.2 Admission Criteria

Admission/Registration personnel will admit/register patients on the basis of the following order of priorities:

Elective Admissions: Only elective admission patients who meet the medical necessity criteria for hospitalization at long term acute care as approved by the Insurance may be admitted on a first-come, first-serve basis. A waiting list may be kept and each patient will be admitted as soon as a bed becomes available.

2.2 TRANSFERS

2.2.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

- a. The patient must be medically stable for transfer;
- b. The patient's condition must meet medical necessity criteria;
- c. The patient must require, and this hospital must be able to provide the level of care needed at LTAC after approval by the insurance. Responsibility for the patient must be accepted by a physician with appropriate privileges at this Hospital; and
- d. The transfer must be approved by the Hospital representative with authority for accepting transfers.

2.2.3. Transfers to Another Hospital

Patients who are transferred to another hospital must follow the Hospital policy on transfers to ensure EMTALA compliance.

2.3 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending practitioner, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners who have patients who are a danger to themselves and/or others should follow the hospital “Suicide Precautions” policy.

2.4 PROMPT ASSESSMENT

All new admissions are expected to be personally assessed by a provider within the following timeframes:

- Routine admissions within four (4) hours

All new admissions will have a history and physical examination completed and on the record within twenty-four (24) hours.

2.5 INTERDISCIPLINARY TEAM CONFERENCES

Attendance at Interdisciplinary Weekly Team Conferences is required.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or privileged designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient’s care. These instructions should include, if appropriate:

- a. A list of all medications the patient is to take post-discharge;
- b. Dietary instructions and modifications;
- c. Medical equipment and supplies;
- d. Instructions for pain management;
- e. Any restrictions or modification of activity;
- f. Follow up appointments and continuing care instructions;
- g. How to seek emergent care if the patient’s condition deteriorates;
- h. Referrals to rehabilitation, physical therapy, and home health services; and
- i. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice. Although no discharge order is necessary for patients who leave against medical advice, a discharge summary is required.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to ensure a complete and legible medical record for each patient.

In order to practice medicine, all healthcare providers who exercise privileges in the facility are required to utilize the electronic health record (EHR) in order to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All healthcare providers will undergo appropriate EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

Handwritten entries in the medical record are not permissible except for specific documents (e.g., consent forms), in certain clinical areas without access to the THM electronic medical record or during downtime documentation. If handwritten entries are required, all such handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible.

Orders which are, in the opinion of the authorized individual responsible for executing the order, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and document the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.1.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid

repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record. These will include at a minimum:

- U for Units
- IU for International Units
- QD for Daily
- QOD for Every Other Day
- Trailing Zero (X.0)
- Lack of Leading Zero (.X)
- MS or MSO4 for Morphine Sulfate

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses, on informed consents, or on operative procedures.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the history and physical examination are noted in the medical staff bylaws and Section 2.5 here.

3.5.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the medical staff bylaws.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination is required for all admissions. A complete history and physical examination report must include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;

- c. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
- d. An age-appropriate social history;
- e. A pertinent family history;
- f. A review of systems;
- g. Cardiorespiratory exams and other relevant physical findings;
- h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Admitting Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the admitting physician, or designee.

3.6 PROGRESS NOTES

The attending service will record a progress note each day, and for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued hospitalization. Where cosignature is required (e.g., daily progress notes documented by residents and fellows) must be completed within one (1) calendar day.

3.7 OPERATIVE / PROCEDURE REPORTS

Full operative reports will be completed no later than twenty-four (24) hours after the end of the procedure, and the report promptly made a part of the patient's current medical record and signed by the surgeon. In the event the full operative/procedure report is not documented immediately after surgery, a brief operative/procedure note must be completed immediately after surgery/procedure consistent with Section 3.9.

Operative/procedure reports will include:

- a. name and hospital identification number of the patient,
- b. date and times of the surgery,
- c. the name of the surgeon(s) who performed the procedure and any assistants and a description of their tasks,
- d. the pre-operative and post-operative diagnoses,
- e. the name of the procedure performed,

- f. a description of the procedure performed,
- g. the type of anesthesia administered,
- h. findings of the procedure,
- i. complications, if any,
- j. any estimated blood loss,
- k. any specimen(s) removed, and
- l. any prosthetic devices, transplants, grafts, or tissues implanted.

3.8 POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. This note needs to be finalized prior to transfer out of the Post Anesthesia Care Unit (PACU) or in an intensive care unit if the surgeon accompanies the patient to the intensive care unit. Operative/procedure notes will include:

- a. the name of the surgeon(s) who performed the procedure and any assistants,
- b. the name of the procedure performed,
- c. findings of the procedure,
- d. any estimated blood loss,
- e. any specimen(s) removed,
- f. type of anesthesia administered,
- g. any complications, and
- h. the pre-operative/procedure and post-operative/procedure diagnosis.

3.9 PRE-SEDATION ASSESSMENTS

3.9.1 Pre-sedation assessments

Patients who will be receiving moderate sedation must be monitored and evaluated before, during and after a procedure by a trained practitioner, however a pre-anesthesia evaluation is not required because moderate sedation is not considered to be “anesthesia”. The pre-sedation assessment shall follow the guidelines in the “Sedation Policy.”

3.10 POST-SEDATION NOTES

3.10.1 Post-sedation notes

A post-sedation note shall be placed in the record within forty-eight (48) hours after the completion of a procedure involving deep sedation. The note shall contain the requirements in the “Sedation Policy.”

3.11 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated

by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report is expected to be completed and entered in the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours after receipt of notification of the consult request. If a full consult note is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. If a consultation is performed by a non-physician, the consulting physician must cosign the consultation or enter their own note.

If the report is not in the record within the prescribed time, an explanatory note should be recorded in the record. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.12 FINAL DIAGNOSES

The final diagnoses will be recorded in full, without the use of symbols or abbreviations dated and signed by the discharging physician in the discharge summary, transfer note, or death summary of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record.

3.13 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries are the responsibility of the discharging physician on the day of discharge, or privileged designee.

- a. **Content:** A discharge summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the discharging physician and will contain:
 1. Reason for hospitalization;
 2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
 3. Condition of the patient at discharge;
 4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
 5. Final diagnoses.
- b. **Deaths:** A discharge summary is required on all inpatients who have expired and will include:
 - a. Reason for admission;
 - b. Summary of hospital course; and
 - c. Final diagnoses.

- c. **Timing:** A Discharge Summary must be entered and signed in the medical record within 24 hours of the start of the next clinical shift, after discharge, transfer, or death of the patient. A maximum of 7 days is allowed to complete this task in the event a provider is off work.

3.14 DIAGNOSTIC REPORTS

Diagnostic reports must be read and reported within timeframes defined in the Trinity Health System “Medical Records Delinquency Policy.”

3.15 ADVANCED PRACTICE PROFESSIONALS

No Advanced Practice Professional may order chemotherapy or radiation therapy. Advanced Practice Professional documentation will require physician co-signature in accordance with Hospital policies and/or procedures.

3.16 STUDENTS, RESIDENTS AND FELLOWS IN TRAINING

Students, and residents and fellows in training, who are not moonlighting outside of their training program, must have their:

- a. History and physical examinations, progress notes, operative notes, operative reports, and discharge summaries cosigned within one (1) calendar day by the attending physician, or their physician designee;
- b. admission order and chemotherapy orders cosigned. Other orders of the resident or fellow do not need to be cosigned;

Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Designated Institutional Officer, or designee, in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident’s progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

3.17 ACCESS AND CONFIDENTIALITY

A patient’s medical record is the property of the Hospital. If requested, personal health information (PHI) contained in the record will be made available to any member of the Medical Staff attending the patient, to members of medical staffs of other hospitals, and to others in accordance with HIPAA. Records must be retained pursuant to the Trinity Health System medical record retention policies.

- a. **Access to Old Records:** In case of readmission of a patient, all records still maintained will be available to the attending practitioner whether the patient was attended by the same practitioner or by another practitioner.
- b. **Unauthorized Removal of Records:** Unauthorized transmission or deletion of medical records from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.
- c. **Access for Medical Research:** Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.
- d. **Access for Former Members:** Former members of the Medical Staff will be permitted access to PHI from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.18 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the MEC.

3.18.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the “Medical Records Delinquency Policy.”

3.18.2 Policy on Incomplete Records

The “Medical Records Delinquency Policy” define the parameters of action to be taken on practitioners with medical records delinquencies.

3.19 ELECTRONIC RECORDS AND SIGNATURES

“Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.20 CUT AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter. “Cut and Paste” or “Copy and Paste” of entries in the Medical Record that are not updated with current information is prohibited. The Hospital requires that its practitioners accurately and concisely document the services provided and information gathered during each patient encounter, regardless of whether or not health information is generated electronically or manually entered. Please see the applicable Hospital policy.

3.21 ORGANIZED HEALTH CARE ARRANGEMENT

- a. For the purposes of complying with provisions of the federal Health Insurance Portability and Accountability Act (“HIPAA”), the Medical Staff of [Hospital] are deemed to be members of, and a part of, an *Organized Health Care Arrangement* (“OHCA”) as that term is defined within HIPAA. This designation is required to comply with the privacy regulations promulgated pursuant to HIPAA based upon the fact that the members of the OHCA operate in a “clinically integrated care setting.” As such, members of Medical Staff shall, upon acceptance to membership, become part of the OHCA with the Hospital and the hospital’s medical staff. No member shall be liable for any actions, inactions, or liabilities of any other member. Each

member of the OHCA shall be responsible for its own HIPAA compliance requirements related to services and activities performed outside the clinical setting of the OHCA.

- b. The members hereby adopt the Hospital Notice of Privacy Practices that will be distributed by the Hospital to all patients of the Hospital, and agree to comply with all requirements contained in the joint Notice of Privacy Practices.
- c. The members of the Medical Staff shall have access to protected health information of the patients of other members of the OHCA for purposes of treatment, payments and healthcare operations, as those terms are defined by HIPAA and the HIPAA Privacy Regulations; Provided that any member of the Medical Staff that downloads, saves or otherwise stores any protected health information, or has access to any Hospital electronic data systems, through any portal that is not solely operated by the Hospital, shall enter into a Colleague Agreement, which shall require that member of the Medical Staff to observe certain requirements, and to assume responsibility for anyone who accesses any Hospital information through a portal maintained by the member.
- d. Members of the Medical Staff shall be entitled to disclose protected health information of a patient to other members of the OHCA for any health care operations of the OHCA, including peer review, mortality and morbidity meetings, tumor board, and other similar health care operations of the OHCA, as permitted in the HIPAA Privacy Regulations.

ARTICLE IV. STANDARDS OF PRACTICE

4.1 ADMITTING, ATTENDING AND DISCHARGING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges.

The admitting physician, or designee, is responsible for completion of the history and physical examination and admission orders.

The attending service will be responsible for:

- a. the medical care and treatment of each patient in the Hospital;
- b. making daily rounds;
- c. ordering consultations, if appropriate;
- d. the prompt, complete, and accurate preparation of the medical record;
- e. necessary special instructions regarding the care of the patient; and
- f. completing the discharge summary

The discharging physician, or designee, is responsible for the discharge orders.

4.1.2 Identification of Attending Service

At all times during a patient's hospitalization, the identity of the attending service shall be clearly documented in the medical record.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending service are transferred to another Medical Service, a note covering the transfer of responsibility will be entered in the medical record by the attending service and must also include a note from the accepting service to this effect.

4.2 COVERAGE AND CALL SCHEDULES

Each practitioner shall identify one or more Hospital Medical Staff Member(s) who have privileges in the same or like specialties who shall be responsible for the care of their patients in the Hospital when the practitioner is not available.

4.3 ATTENDING, ADMITTING AND DISCHARGING PHYSICIANS RESPONDING TO CALLS AND PAGES

- a. Telephonic Response. Practitioners are expected to respond within thirty (30) minutes.

- b. Physical Response: Practitioners are expected to respond within one (1) hour, if requested.

4.4 ORDERS

4.4.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible for the practitioner to write the order or enter it in a computer. Verbal orders are given directly practitioner-to-hospital staff; telephone orders are given practitioner-to hospital staff via telephonic communication means. Verbal/telephone orders must comply with the following criteria:

- a. The order must be given to an authorized individual as defined in hospital policy.
- b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written/electronic orders, should be conveyed in plain English without the use of prohibited abbreviations.
- c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.
- d. All verbal orders must be signed the next time the provider sees the patient, but no later than seven (7) days by the ordering practitioner or another practitioner involved in the patient's care.
- e. Orders for cancer chemotherapy may not be given verbally.
- f. Verbal/telephone orders may be given only by practitioners privileged at the hospital or working under training protocols.

4.4.2 Facsimile Orders

If orders need to be transmitted by facsimile, such orders shall be considered properly authenticated and executable provided that:

- a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;
- b. The order is legible, clear, and complete
- c. The identity of the patient is clearly documented with two patient identifiers within the order; and

- d. The facsimile contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law.

4.4.3 Cancellation of Orders Following Surgery or Transfer

All previous orders are canceled when the patient:

- a. is transferred to, and readmitted from, another hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to “resume previous orders” will not be accepted.

4.4.4 Drugs and Medications

Orders for drugs and medications must follow Hospital Pharmacy policy “Medication Orders”.

4.5 CONSULTATION

- a. Indications for consultation include, but is not limited to: whenever patients in their care require services that fall outside their scope of delineated clinical privileges, whenever a patient is not a good risk for operation or treatment, when the diagnosis is obscure, when severe psychiatric symptoms are exhibited or when there has been an attempted suicide, or when requested by the patient or family.
- b. Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending service will provide written authorization in the EMR requesting the consultation, and permitting the consulting practitioner to attend or examine their patient. This request shall specify:
 1. the reason for the consultation, and
 2. the urgency of the consultation (urgent or emergent– in a timeframe determined by conversation between the referring physician and the consultant; routine – within 24 hours).
- b. All consultations will be for “consultation and treatment” unless otherwise noted as “consultation and recommendation”.
- c. Consultants should not order consultations with other specialties without informing the attending physician, unless the need is urgent/emergent.

- d. APRNs and physician assistants may perform the consultation, including ordering diagnostics or therapeutics, with the knowledge and collaboration of their collaborating/supervising physician. There should be discussion with the collaborating/supervising physician before any therapeutics or significant diagnostics are ordered.
- e. Residents and fellows may perform the consultation, including ordering diagnostics or therapeutics, with the knowledge of their attending physician.
- f. The attending physician may utilize consultants of their choice. In general, if a patient has chronic consultative care by a consultant prior to this episode of care, that physician should be consulted if that medical issue is unstable.
- g. If nurses have any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to their manager to be addressed through the chain of command. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

4.6 DEATH IN HOSPITAL

4.6.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a physician, PA, or NPs 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. Policies with respect to the release of dead bodies shall conform to local law. Patients under Comfort Measures Only or Do Not Resuscitate status may be pronounced by nursing staff.

For inpatients, the attending physician or other privileged physician is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner, in accordance with law.

4.6.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.7 AUTOPSY

As detailed in “Autopsy Ordering and Performance.”

4.8 DEATHS REPORTABLE TO THE MEDICAL EXAMINER

Deaths will be reported to the Medical Examiner when required by state law.

4.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, which includes Advance Practice Registered Nurses (nurse midwives, CRNAs, anesthesia assistants, nurse practitioners, and clinical nurse specialists providing direct patient care) and Physician Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision/collaboration of a physician(s) who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership.

4.9.2 Guidelines for Supervising Advanced Practice Professionals

- a. The physician(s) is(are) responsible for managing the health care of patients in all settings.
- b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision/collaboration must be within the scope of each practitioner's authorized practice, as defined by state law.
- c. The physician(s) is(are) ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.
- d. The role of the Advanced Practice Professional in the delivery of care shall be defined in the delineations of privileges.
- e. The physician(s) must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means. A physician must be able to respond telephonically and or physically in a timely manner when needed by the Advanced Practice Professional.
- f. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician(s).
- g. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.
- h. The physician(s) and Advanced Practice Professional should review all delegated patient services on a regular basis, as well as the delineations of privileges.
- i. The supervising/collaborating physician(s) is(are) responsible for clarifying and familiarizing the Advanced Practice Professional with supervising methods and style of delegating patient care.
- j. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and any alternate supervising physician(s), as applicable.

4.9.3 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Office written Supervision/Collaboration Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice

Professional. This document must be signed by the Advanced Practice Professional and the supervising/collaborating physician.

4.9.4 Supervising/Collaborating Physician

An Advanced Practice Professional may provide services to patients only if the supervising/collaborating physician, or alternate physician, is within normal backup coverage range. A physician may not supervise more APPs than is allowed by state law.

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of or collaboration with an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.9.5 Medical Record Documentation

Advanced Practice Professionals medical record documentation is noted in Section 3.18.

4.9.6 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not provide a medical service that exceeds the clinical privileges granted to the supervising/collaborating physician.

4.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties, including hand hygiene.

4.11 EVIDENCE-BASED ORDER SETS

Evidence-based order sets provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Evidence-based order sets assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions.

The Medical Executive Committee may adopt evidenced-based order sets, protocols, and standing orders upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital "Informed Consent" policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital policies on "Withdrawing and Withholding Life Sustaining Medical Treatment" delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital policy on "Do Not Attempt Resuscitation" delineates the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital policy on "Disclosure of Unanticipated Outcomes" delineates the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Hospital policy on "Use of Restraints" delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Hospital policy on "Advance Directives and Advanced Instruction for Mental Health Treatment" delineates the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI. SURGICAL CARE

SURGICAL CARE**6.1 SURGICAL PRIVILEGES**

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures will cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE



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The physician/surgeon/proceduralist has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. The Hospital policy on "Time Out" shall be followed.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Trinity Health policy on “Code of Conduct” and the Medical Staff Standards of Excellence and Conduct policy shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff policy on practitioner health and impairment.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*’ Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include: spouses, domestic partners, parents, parents-in-law, children, stepchildren, siblings, siblings-in-law, grandparents, aunts, uncles, nieces and nephews.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the Trinity Health system policy “Viewing of Medical Records” regarding access to medical records of themselves or family members to maintain compliance with HIPAA.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on TB testing, influenza vaccination, and any testing/vaccinations as noted in policy.

7.6 COMMUNICATION

All practitioners must maintain one primary current accessible e-mail address on file in the Medical Staff Office.

All practitioners must use the accepted method of communication determined by the MEC, which, at the time of adoption for administrative matters relative to the Medical Staff Services, is email.