

MEDICAL STAFF RULES & REGULATIONS MANUAL

**Wesley Medical Center
Wichita, Kansas**

Approved:

**Medical Staff – November 16, 2015
Board of Trustees - November 19, 2015**

RULES AND REGULATIONS MANUAL

Table of Contents

DEFINITIONS	1
1.0 MEDICAL STAFF ORGANIZATION	1
1.1 Medical Staff Meetings	1
1.2 Medical Staff Dues	1
1.2.1 <u>Date Payable</u>	1
1.2.2 <u>Amount</u>	1
1.2.3 <u>Expenditure</u>	1
1.3 Leave of Absence	1
1.3.1 <u>Request</u>	1
1.4 Board Certification	2
1.5 Medical Staff Conduct Policy	2
1.5.1 <u>Physician Support Committee</u>	2
1.5.2 <u>Disciplinary Action</u>	2
1.5.3 <u>Appropriate Access Enforcement & Discipline</u>	2
1.5.4 <u>Privacy Violations Enforcement & Discipline</u>	4
1.5.5 <u>Self-Treatment or Treatment of Immediate Family Members</u>	5
1.6 Summary Suspension For Impairment	6
2.0 MEDICAL COVERAGE OF PATIENTS	6
2.1 General	6
2.2 Proximity	6
2.3 Wesley Clinics	6
2.4 Unassigned Patients	6
2.5 Private Patients	7
2.6 Admitting Physician	7
2.7 Emergency Alternate	7
2.8 On-Call Coverage (for assigned patients)	7
2.9 Emergency On-Call Coverage (for unassigned patients)	7
2.9.1 <u>Obligation</u>	7
2.9.2 <u>Back-up Call</u>	8
2.9.3 <u>Scheduling</u>	8
2.9.4 <u>Exemption from Call</u>	8
2.9.5 <u>Medical Screening Exam</u>	8
2.9.6 <u>Sanctions for Non-Compliance</u>	9
2.10 Frequency & Timeliness of Physician Visits	9
2.11 House Staff/Resident Privileges	9
3.0 ADMISSION OF PATIENTS	10
3.1 Admitting Physician	10
3.2 Provisional Diagnosis	11
3.3 Infectious/Contagious Diseases	11

3.4	Dental Services	11
4.0	CONSULTATIONS	11
4.1	Guidelines	11
4.1.1	<u>Qualifications</u>	11
4.1.2	<u>Levels of Consultation</u>	11
4.1.3	<u>Essentials of a Consultation</u>	11
4.1.4	<u>Suggestions for Consultations</u>	11
5.0	PHYSICIANS' ORDERS FOR TREATMENT	12
5.1	Writing of Orders	12
5.1.1	<u>Acceptable Orders</u>	12
5.1.2	<u>Narcotic Number</u>	13
5.1.3	<u>Do No Resuscitate/No Code Blue Orders</u>	13
5.1.4	<u>Discharge Orders</u>	13
5.1.5	<u>Outpatient Orders</u>	13
5.2	Standing Orders	14
5.2.1	<u>Department/Clinical Service/House-Wide</u>	14
5.2.1.1	<u>Formulation</u>	14
5.2.1.2	<u>Change</u>	14
5.2.1.3	<u>Adherence</u>	14
5.2.1.4	<u>Use in Lieu of Specific Orders</u>	14
5.2.1.5	<u>Suspension</u>	14
5.2.1.6	<u>Revisions/Updates</u>	15
5.2.2	<u>Individual Physician/Physician Group Standing Orders</u>	15
6.0	LABORATORY	15
6.1	Tissue Examination	15
6.1.1	<u>Exempt from Examination by Pathologist</u>	15
6.1.2	<u>"Gross Only" Examination by Pathologist</u>	15
6.2	Autopsies	15
6.2.1	<u>Grounds and Permission for Autopsy</u>	15
6.2.2	<u>Reports</u>	16
6.2.3	<u>Definition of a Coroner's Case</u>	16
7.0	PATIENT CONSENT	16
7.1	Informed Consent	16
7.1.1	<u>Blood Transfusions</u>	16
7.1.2	<u>Administration of Anesthesia</u>	16
7.1.3	<u>Investigational Drugs/Research</u>	17
7.1.4	<u>Operative/Invasive/Diagnostic Procedures Requiring Written Consent</u>	17
7.1.5	<u>Documentation Guidelines for Informed Consent</u>	17
7.2	Patient Notification of Healthcare Errors	17

8.0	HEALTH INFORMATION (MEDICAL RECORD)	18
8.1	General	18
8.1.1	<u>Ownership of the Health Information/Medical Record</u>	18
8.1.2	<u>Patient Access to Health Information/Medical Records</u>	18
8.1.3	<u>Abbreviations</u>	18
8.1.4	<u>Authentication of the Medical Record</u>	18
	8.1.4.1 <u>Electronic Signature</u>	18
8.1.5	<u>Retirement of Medical Records</u>	18
8.1.6	<u>Organized Health Care Arrangement (OHCA)</u>	18
8.2	The Medical Record Content and Timeframes for Completion	19
8.2.1	<u>General Guidelines</u>	19
8.2.2	<u>History and Physical Examination</u>	20
8.2.3	<u>Progress Notes</u>	20
8.2.4	<u>Physician Orders</u>	21
8.2.5	<u>Consultations</u>	21
8.2.6	<u>Operation Reports/Procedure Notes</u>	21
8.2.7	<u>Anesthesia Documentation</u>	22
8.2.8	<u>Diagnostic and Therapeutic Tests/Procedures</u>	22
8.2.9	<u>Discharge Summary</u>	22
8.2.10	<u>Final Diagnosis</u>	22
8.4	Failure to Complete Medical Records	22
8.4.1	<u>Vacation/Illness</u>	23
8.4.2	<u>Delinquent Medical Records – Medical Staff</u>	23
8.4.3	<u>Suspension/Notification Process</u>	23
8.4.4	<u>Medical Record Suspension</u>	24
9.0	PERFORMANCE IMPROVEMENT ACTIVITIES	24
10.0	RISK MANAGEMENT REPORTING REQUIREMENTS	25
11.0	PLAN FOR CARE OF PSYCHIATRIC, DRUG AND ALCOHOL ABUSE PATIENTS	25
12.0	SURGERY FIRST ASSISTS	26
13.0	NON-PHYSICIANS WHO CAN ORDER DIAGNOSTIC AND LABORATORY TESTS AND THERAPEUTICS	26
14.0	APPROVAL/AMENDMENT OF RULES & REGULATIONS	26
14.1	Amendment	26

DEFINITIONS

Please see the Medical Staff Bylaws for all definitions.

1.0 MEDICAL STAFF ORGANIZATION

The Medical Staff Organization is fully described in the Medical Staff Bylaws, Certain Rules & Regulations not covered in the Medical Staff Bylaws are described in this Manual.

1.1 Medical Staff Meetings

- (a) The Medical Staff will meet as defined in the Medical Staff Bylaws.
- (b) Clinical Service Meetings shall be held as determined by the Clinical Service Executive Committee and Clinical Service Executive Committee should meet at least quarterly or may meet more often if needed or at least during the months the clinical service does not meet.
- (c) Meeting attendance for clinical service and general staff meetings is not required but is recommended for members of the Provisional and Active staff.

1.2 Medical Staff Dues

1.2.1 Date Payable

Dues for Medical and Advance Practice Staff members shall be due and payable before January 31 of each year. If dues are not paid by this date, the member will receive a second notice that if not paid within thirty (30) days, will be considered as a voluntary resignation from the staff.

1.2.2 Amount

Annual dues for each classification of Staff membership shall be determined by the Medical Executive Committee at its meeting in November of each year and written notice given to the Staff, no later than the end of December. Members appointed after July 1st of each year shall pay one-half (1/2) of the dues for that year. Members who are appointed in November or December will be assessed the annual amount and this will be applied to the next year's dues.

1.2.3 Expenditure

Funds of the Staff shall be in the charge of the Medical Executive Committee and shall be used for the benefit of the Staff of medically related, educational, charitable, medical research, or for direct operational needs of the Medical Staff, as the Medical Executive Committee shall designate. Annual financial statements shall be prepared. An annual audit may be performed.

1.3 Leave Of Absence

1.3.1 Request

A Staff member may request voluntary leave of absence, as defined in the Medical Staff Bylaws.

1.4 Board Certification

The Board certification requirements are outlined in the Medical Staff Bylaws.

1.5 Medical Staff Conduct Policy

It is the policy of this hospital that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, Wesley Medical Center requires all individuals, employees, physicians, and other independent practitioners to conduct themselves in a professional and cooperative manner in the Medical Center. If an employee fails to conduct himself or herself in the required manner, the matter shall be addressed in accordance with Medical Center employment policies. If a practitioner appointed to the medical staff or recognized as an Advance Practice Professional fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with the Medical Staff Bylaws.

1.5.1 Physician Support Committee (The Peer Review Committee acts as the Physician Support Committee)

If such behavior continues, the CMO will refer to the Physician Support Committee. The practitioner will be notified of the identification of a trend and requested to appear before the Physician Support Committee.

- (a) The initial approach should be collegial and designed to be helpful to the practitioner.
- (b) Committee shall invite other practitioners and Medical Center supervisory and ancillary staff to be interviewed regarding the incident(s) which warranted referral to the Physician Support Committee.
- (c) Meeting shall be documented, with a full report of findings to the Medical Executive Committee for determination of the necessity for further action.
- (d) The practitioner shall be given the opportunity to review (with the Physician Support Committee Chairperson) the written report prior to submission to the Medical Executive Committee and given the opportunity to submit written rebuttal to be included in presentation to the Medical Executive Committee.
- (e) In the event that the Physician Support Committee recommends ongoing review and/or follow-up, the practitioner shall be given an opportunity to comply with the committee's recommendation prior to the Medical Executive Committee's review of the report. Such agreement must be submitted in writing, through the Medical Staff Services.

1.5.2 Disciplinary Action

A single additional incident could result in initiation of formal disciplinary action pursuant to the Medical Staff Bylaws, Rules & Regulations. Suspension may be deemed appropriate pending this process and may be initiated by the CMO in accordance with the Medical Staff Bylaws, Rules & Regulations.

1.5.3 Appropriate Access Enforcement & Discipline

- (a) Physicians, Advance Practice Professionals, and physician office staff may have access to one or more forms of electronic media and services (computers, electronic mail, telephones, voice mail, fax machines, external electronic bulletin

boards, wire services, on-line services, the Internet and the World Wide Web). The security of data through this access is the responsibility of the Director of Information Systems.

- (b) The company reserves the right, in its discretion, to review any user's electronic files and messages and usage to the extent necessary to ensure that electronic media and services are being used in compliance with the law and with this and other company policies.
- (c) When a breach of confidentiality is identified, disciplinary action will be taken according to the level of the violation and the type of user.

Recommended Violation Levels		
Level and Definition of Violation	Examples of Violations	Recommended Action
<p>Level I</p> <p>Accidental and/or due to lack of proper education.</p>	<ul style="list-style-type: none"> ▪ Failing to sign off a given computer terminal when not using it. ▪ Accessing a member of your family's medical record in PCI without written authorization. 	<ul style="list-style-type: none"> ▪ Retraining and re-evaluation. ▪ Discussion of policy and procedures. ▪ Oral warning or reprimand.
<p>Level II</p> <p>Purposeful break in the terms of the Confidentiality Agreement or an unacceptable number of previous violations.</p>	<ul style="list-style-type: none"> ▪ Accessing a patient's records without having a legitimate reason to do so. ▪ Using another employee's access code. ▪ Allowing another employee to utilize CPCS via his/her password. 	<ul style="list-style-type: none"> ▪ Retraining and re-evaluation. ▪ Discussion of policy and procedures. ▪ Written warning and acknowledgment of consequences of subsequent infractions.
<p>Level III</p> <p>Purposeful break in the terms of the Confidentiality Agreement or an unacceptable number of previous violations and accompanying verbal disclosure of patient information regarding treatment and status.</p>	<ul style="list-style-type: none"> ▪ Accessing a patient's record without having a legitimate reason to do so. ▪ Using another employee's access code. ▪ Allowing another employee to utilize CPCS via his/her password. ▪ Disclosure of confidential patient information. 	<ul style="list-style-type: none"> ▪ Termination of employment.

- (d) If a member of the medical staff or advance practice professional breaches confidentiality, they will be contacted by the chair of their section, Medical Staff President, or Chief Medical Officer. Depending on the level of violation; a warning, discontinuance of user privileges, suspension of medical staff privileges, or termination from the medical staff may occur. If a warning is issued, a letter will be sent to the practitioner and placed in his or her file. Repeat breaches will be reported to the executive committee of the practitioner's section or department for action. If a suspension or termination from the medical staff is recommended, the corrective action process will be followed.

- (e) If physician office staff members breach confidentiality, disciplinary action will include immediate discontinuance of user privileges and the evaluation of any additional sanctions or actions warranted by the situation.

1.5.4 Privacy Violations Enforcement and Discipline

To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, Administrative Requirements and, to establish guidelines for sanctions for violations of the Company Privacy Policies (HIM.PRI.001 through HIM.PRI.009) and the facility's Privacy Policies.

- (a) Physicians, Advance Practice Professionals:
1. Violations are identified and will be communicated to the Chief Medical Officer.
 2. Next steps will be determined in consultation with the appropriate medical staff leader.
 3. Violations of privacy policies by a physician or advance practice professional will be communicated to the individual by a member of the executive staff.
 4. Disciplinary action will be based on guidelines established in the Medical Staff Bylaws and Rules and Regulations.

Recommended Violation Levels		
Level and Definition of Violation	Examples of Violations	Recommended Action
<p>Level I</p> <p>Accidental and/or due to lack of proper education.</p>	<ul style="list-style-type: none"> ▪ Improper disposal of PHI. ▪ Improper protection of medical records of other PHI. <ul style="list-style-type: none"> ▪ Leaving records on counters or where otherwise accessible by unauthorized individuals. ▪ Leaving any documents that contain PHI in inappropriate areas. ▪ Not properly verifying individuals by phone, in person or in writing. ▪ Not accounting for disclosures outside of treatment, payment, or health care operations within the correct system or manual process. 	<ul style="list-style-type: none"> ▪ Retraining and re-evaluation. ▪ Discussion of policy and procedures. ▪ Oral warning or reprimand.
<p>Level II</p> <p>Purposeful violation of privacy policy or an unacceptable number of previous violations.</p>	<ul style="list-style-type: none"> ▪ Accessing or using PHI without having a legitimate need to do so. ▪ Not forwarding appropriate information or requests to facility privacy official (FPO) for processing. 	<ul style="list-style-type: none"> ▪ Retraining and re-evaluation. ▪ Discussion of policy, procedures, and requirements. ▪ Written warning and acknowledgment of consequences of subsequent infractions.

<p>Level III</p> <p>Purposeful violation of privacy policy with associated potential for patient harm.</p>	<ul style="list-style-type: none"> ▪ Disclosure of PHI to unauthorized individual or company. ▪ Sale of PHI to any source. ▪ Any uses or disclosures that could invoke harm to a patient. 	<ul style="list-style-type: none"> ▪ Termination of employment. ▪ Revocation of medical staff privileges. ▪ Termination of vendor contract.
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5. Documentation of the disciplinary action must be placed in the credentials file of the physician or advance practice professional.
 - (b) Physician Office Staff, Vendors, External Entities:
 1. Violations of the Privacy Policy by physician office staff, vendors, or any other external entity will be communicated to the individual by the CEO or designee.
 2. Disciplinary action will be based on the severity and/or frequency of the violation and may result in the termination of user privileges or termination of the contract. Documentation of the disciplinary actions must be placed in the vendor file.

1.5.5 Self-Treatment or Treatment of Immediate Family Members

The American Medical Association's position on self-treatment or treatment of immediate family members, E-8.19, has been accepted as the policy for the Medical Staff of Wesley Medical Center.

AMA E-8.19 Position:

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician. Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care. It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. 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 should not serve as 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 (I, II, IV)

Issued by the American Medical Association in June 1993 and was last updated on August 26, 2005.

1.6 Summary Suspension For Impairment

When a member of the Medical or Dental Staff appears in the Medical Center and there is a question of impairment, the individual physician's Clinical Service Chairperson or designee or the President of the Medical Staff or designee shall be immediately notified to ascertain as to whether the attending is so impaired as to prevent the appropriate care of the patient. (See Medical Staff Bylaws for further details)

2.0 MEDICAL COVERAGE OF PATIENTS

2.1 General

Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the Medical Staff, or have been granted special emergency, temporary or interim privileges in the Medical Staff Bylaws.

2.2 Proximity

Each practitioner must practice and live within a reasonable distance of the Hospital to assure availability within an appropriate time period.

- (a) Reasonable distance is defined as the practitioner must practice and/or reside within 30 miles of the medical center. This requirement does not apply for practitioners who provide services contractually with the medical center by way of electronic communication (telemedicine)
- (b) Availability is defined, as the physician must be available to respond for patient care within 30 minutes.

2.3 Wesley Clinics

All patients shall be attended by a member of the Medical Staff, and shall be assigned to the service concerned in the treatment of disease which necessitated admission.

2.4 Unassigned Patients

Patients presenting to the Emergency Department for treatment, shall be treated by a member of the Emergency Department staff. If a patient is to be admitted as an inpatient, then the patient is assigned an attending physician according to the schedule approved by the Medical Staff. If the patient is seen by the Emergency Department physician, treated, and discharged, but requires an office visit, a referral shall be made to the EMTALA on call doctor for the visit. All patients referred to the EMTALA on call doctor on an outpatient basis will be seen at least one time in their office regardless of their ability to pay. The EMTALA on call doctor shall be available for at least one outpatient appointment as clinically appropriate for patients seen in the Emergency Department. The EMTALA on call doctor shall arrange the

outpatient follow-up appointment. Appointments need to be available on a timely basis. If the patient requires a follow-up appointment within the next 48 hours, a call notifying the on call physician will be made by the Emergency Department physician. If the patient fails to make a follow up appointment within 15 days then the physician no longer has this obligation. Referrals for follow up to the Wesley Outpatient Clinics for medical conditions from the Emergency Department shall be for one required visit only.

2.5 Private Patients

Private patients shall be attended by their own private physician. In the case of a patient applying for admission who has no attending physician or has indicated no preference, shall be assigned to a member of the medical staff.

2.6 Admitting Physician

The admitting physician is defined as the person designated on the admission record as the admitting physician unless a transfer has been noted in the physicians' orders.

2.7 Emergency Alternate

Each member of the medical staff not resident in the city or immediate vicinity shall name a member of the medical staff, who is resident in the metropolitan area, who may be called to attend his/her patients in an emergency.

2.8 On Call Coverage (for assigned patients)

When a member of the medical staff is unavailable for medical coverage of their patients, the medical staff member must provide the following:

- (a) The name of an appropriate member of the medical staff to provide the medical care for his/her patients.
- (b) The medical staff member providing coverage must have the privileges to appropriately care for the patients assigned.
- (c) It is the responsibility of the medical staff member who is checking out to another medical staff member to notify the Medical Center of that coverage.
- (d) The medical staff member shall not sign out to a non-physician or to a physician who is not a member of the Wesley Medical Center's Medical Staff.
- (e) As long as the physician is available within 30 minutes when needed, a physician's calls may be screened by their designee who has immediate access to the physician.

2.9 Emergency On-Call Coverage (for unassigned patients)

2.9.1 Obligation

Each practitioner assigned to a category of medical staff has an obligation to participate in the emergency (unassigned) call schedule commensurate with his/her clinical privileges. All practitioners appointed to the medical staff shall cooperate to the fullest extent in order to provide screening and stabilizing treatment to emergency patients within the services and facilities available at the medical center and in compliance with federal guidelines. However, service on-call is neither a clinical privilege nor a right of medical staff appointment.

2.9.2 Back-up Call

- (a) If the responsible practitioner is unavailable, the designated back-up practitioner will be called to handle the care of the patient. The back-up practitioner must have privileges similar to the practitioner to appropriately care for the patient.
- (b) If a responsible practitioner cannot be available to provide care in his or her specialty appropriate back up in a related specialty will be provided or the patient will be transferred to the appropriate specialist at an outside facility. Physician to physician contact will occur and appropriate transfer forms will be completed. All such transfers will be recorded on a central log.
- (c) It is the responsibility of the medical staff member, who is checking out to another medical staff member, to notify the medical center communications department of that coverage. The covering practitioner shall handle the Emergency On-Call Coverage for unassigned patients
- (d) Physicians' must provide a direct pager or telephone number to the medical center communications department. The number of an answering service is not acceptable.

2.9.3 Scheduling

The Medical Executive Committee will have the authority to approve an emergency on-call coverage schedule, which will be the responsibility of the clinical services to develop. The call schedule shall include the following elements:

- (a) Must be prospective. The schedule needs to be available by the 1st of the preceding month for the next month and must be a full month's schedule.
- (b) All specialties and sub-specialties needed to stabilize the patient must be on the schedule.
- (c) Physician's name, not a group name, must be on the schedule.
- (d) Only physicians (and oral surgeons) can be listed on the call schedule.
- (e) Call schedule may require response to both inpatient and outpatient care.
- (f) Call schedules must be retained for five (5) years.
- (g) All call schedules will be coordinated through Medical Staff Services. Any changes to the call schedule during the month will be maintained by the Communications Department and the revised schedule/schedule changes will be sent to Medical Staff Services at the end of each month.

2.9.4 Exemption from Call

Practitioners who are at least 60 years old, and who have been on the medical staff for ten (10) years, may make a written request for exemption from the emergency on-call schedule. Consideration of such requests by their respective department/clinical service chair and the Medical Executive Committee shall include assessment of whether the request would cause hardship to others on that specialty call rotation. There is no right to exemption.

2.9.5 Medical Screening Exam

A medical screening exam shall be performed by a qualified medical individual on all patients who present for emergency care or are in labor. The exam will include a history,

physical examination, and ancillary studies and procedures to determine that an emergency condition does or does not exist or that the patient is stable or can be transferred appropriately. A log of patients who present and who are transferred shall be maintained by the hospital.

A medical screening exam shall be performed by a licensed physician or by:

- (a) A registered nurse/APP in perinatal and newborn areas or SANE/SART.
- (b) An APRN or physician assistant for low acuity Emergency Department patients per their protocol
- (c) A registered nurse or an APRN/PA for ground or air transport

2.9.6 Sanctions for Non-Compliance

A refusal or failure to respond within a reasonable time when called shall be referred to the appropriate peer review process for consideration of whether a letter of reprimand, suspension, or other disciplinary action may be warranted.

2.10 Frequency & Timeliness of Physician Visits

- (a) Patients admitted to a general medical/surgical/pediatric/newborn unit must be seen by the attending/ admitting physician within 24 hours after admission.
- (b) The admitting physician must see an unstable patient admitted to a critical care unit within two (2) hours of the patient admission or delegate the visit to another attending.
- (c) An admitting physician must see their patient every twenty four (24) hours or designate another attending to do so. Documentation of the visit should be present in the progress notes (medical record).
- (d) A consulting physician must see the patient within twenty four (24) hours of the consult, unless other time period is specified between the attending and consulting physician and is documented in the chart, or decline the consult.
- (e) An APRN/PA supervised by an attending physician, who is acting as a consultant, may visit the patient in lieu of the consultant physician up to 72 hours except: at the time of the new consult; or if a significant change in patient condition; or if a significant change in the plan of care occurs, the supervising physician must see the patient and sign off the APRN/PA's notes within twenty four (24) hours of the APRN/PA's visit.

2.11 House Staff/Resident Privileges

- (a) Members of the teaching staff may allow a resident/fellow to perform diagnostic and/or treatment procedures which, in the teaching staff member's judgment, the resident/fellow is competent to perform, based upon evidence of experience and capacity of the resident/fellow, in compliance with the Bylaws, Rules & Regulations of the Medical Staff and Kansas Statutes and Regulations. The resident may give informed consent for the treatment or procedure. The teaching staff member is, therefore, the supervisor of clinical activity. Supervision may be direct or indirect as deemed appropriate by the teaching staff member, who is contacted by the resident/fellow before the procedure is done. The supervising physician, however, is responsible for supervision of all patient care activities performed by the resident/fellow. The UKSM-W residency programs are responsible for monitoring and delineating clinical competencies of residencies.

- (b) Residents/fellows are not allowed to be assigned as the attending physician for the patient. A member of the teaching staff is always assigned as the attending physician.
- (c) The Graduate Medical Education Committee (GMEC) shall monitor all UKSM-W residency/fellowship program activities conducted within Wesley Medical Center, but UKSM-W shall be responsible for such activities. All residency/fellowship policies which impact patient care at Wesley must be submitted to the GMEC for review and approval.
- (d) Residents/fellows may be employed as contract physicians by physician groups who provide medical coverage for the Medical Center in certain areas, i.e., Emergency Department, Anesthesia, etc. The employing physician group shall be responsible for the supervision of the Resident/Fellow and shall ensure the Resident/Fellow has professional liability coverage to practice as an independent physician. The resident/fellow must be credentialed by the Medical Staff as provided in the Medical Staff Credentialing Procedures Manual.

3.0 **ADMISSION OF PATIENTS**

3.1 **Admitting Physician**

Only Active physician members of the Medical Staff & Podiatrists approved for admitting privileges may admit patients to Wesley Medical Center. This order must be authenticated by the admitting physician prior to the patient's discharge.

- 1) Inpatient Status – defined as “required when a patient has been brought to a hospital for bed occupancy for purposes of receiving inpatient hospital services”. The admitting physician decision to place the patient in the hospital as an inpatient is a complex medical judgment based on the physician's expectation the patient will require care that crosses two (2) midnights or the patient will undergo a procedure on the_CMS list of Inpatient Only Surgical Procedures, which must be performed in an Inpatient status.
- 2) Observation Status –defined as “those services furnished on the hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, ordered when the physician expects the patient to need care for a limited amount of time which does not cross two (2) midnights.
- 3) Outpatient Procedure – defined as a “person who has not been placed in the hospital as an inpatient but is registered for a procedure which does not require the patient to be lodged in the medical center at midnight”.

Orders which lack a clear statement of the level of care or status of admission will be considered invalid.

Following placement of a patient in observation; if the patient condition does not improve and the patient is expected to stay two (2) midnights or more, an order must be done to change the patient's level of care to inpatient.

3.2 Provisional Diagnosis

Except in an emergency, no patient shall be admitted to the hospital without a provisional diagnosis. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

3.3 Infectious/Contagious Diseases

- (a) Patients with contagious disease shall be admitted according to the rules of the hospital as established by the Infection Prevention Committee and approved by the medical staff.
- (b) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of infection for any cause whatever, i.e., potential TB patients.

3.4 Dental Services

- (a) Patients admitted for dental services shall be admitted on the Surgical Clinical Service, and shall be the responsibility of the Chairperson of that Clinical Service.
- (b) An adequate medical assessment by a physician or a qualified Oral Surgeon with Wesley privileges shall be performed on each patient before dental surgery.
- (c) Consultations shall be sought in complicated cases.

4.0 CONSULTATIONS

Consultations are subject to the discretion of the primary care/attending physician.

4.1 Guidelines

4.1.1 Qualifications

A consultant must be a member of the medical staff, who is qualified to give an opinion in the field in which the opinion is sought.

4.1.2 Levels of Consultation

Unless indicated, all orders to request consultation will be for opinions and recommendation(s) by the consulting physician including orders and workup, as needed. If the physician ordering the consult wants a different level of involvement from the physician, then he/she must indicate the level of involvement at the time the order is given. Those levels are:

- (a) Opinion and recommendation only.
- (b) Assume care and management for this particular situation.
- (c) Accept in referral and assume total care of the patient.

4.1.3 Essentials of a Consultation

- (a) A consultation shall include examination of the patient and the medical record.
- (b) A written opinion signed by the consultant must be included in the patient's medical record.
- (c) When operative procedures are involved, the consultation notes, except in emergencies, should be recorded prior to the operation.
- (d) All Consultation reports, dictated or handwritten, to be completed within 24 hours of consult notification.

4.1.4. Suggestions for Consultations

Except in an emergency, consultations with another qualified physician may be utilized in cases in which, according to the judgment of the physician:

- (a) The patient is not a good risk for operation or treatment.
- (b) The diagnosis is obscure.
- (c) There is doubt as to the best therapeutic measures to be utilized.
- (d) When the condition of the patient goes beyond the privileges granted to the attending physician.

5.0 PHYSICIANS' ORDERS FOR TREATMENT

5.1 Writing of Orders

Physician orders for inpatient and outpatient treatment or services shall be in writing, timed, and dated and signed by the physician who gave the order

5.1.1 Acceptable Orders

All orders for treatment shall be in writing in one of the following forms:

- (a) By handwriting and signature of the physician, APRN, PA or Resident.
- (b) By dictation or by telephone to a Registered Nurse.

All verbal/telephone orders will be authenticated, signed/timed/dated, by the prescribing or covering practitioner within seventy-two (72) hours of the patient's discharge or thirty (30) days, whichever occurs first. Verbal orders should not be given when a practitioner is physically present. All verbal/telephone orders must be read back to a practitioner for verification by the authorized hospital employees.

Who can sign for each other.

Telephone Order Given By:	Can be co-signed by: APRN/PA	Can be co-signed by: Resident	Can be co-signed by: Attending Physician
APRN/PA	Yes	Yes	Yes
Resident	Yes	Yes	Yes
Attending Physician	Yes, in some instances	Yes	Yes

The following personnel may transcribe orders in their field of expertise and sign their name as well as that of the physician giving the order:

Physical Therapist
Respiratory Therapist
Occupational Therapist
Registered Dietitian
EEG Technician
Registered Pharmacist
Social/Care Coordinator
Laboratory Technician
Radiologic Technologist
Speech Therapist
Admissions Clerk
Unit Clerk
Medical Technologist
M.I.C.T. (Cardiac Cath Specialists)

Diagnostic or therapeutic verbal/telephone orders **posing potential hazards to patients** must be authenticated by the physician /LIP/APP on his/her next visit, but no later than twenty-four (24) hours of the issuance of the order. Do Not Resuscitate may be given by attending physician or moonlighting residents acting as an attending physician or if there is an established DNR order, by an APP.

Electronic signature as entered by the physician is acceptable. There shall be no delegation of the use of the physician's electronic signature to another individual.

5.1.2 Narcotics

The physician's narcotic number is a matter of record with the Medical Center and will be utilized whenever narcotics are ordered.

5.1.3 Do No Resuscitate/No Code Blue Orders

"No Code Blue" or "Do Not Resuscitate" orders will be written only by the attending physician, or their resident, or moonlighting residents, acting as an attending physician or designated staff physician. An established DNR order, written by a licensed physician, which includes a DNR from a nursing home, may be entered as an order by an APP or Resident, without co-signature. A patient being transferred from one unit or department to another or from floor to floor will have an active DNR throughout the hospital course, once it has been placed in the record, unless the order is discontinued by an attending physician. Refer to the "Do Not Resuscitate" Policy for Wesley Medical Center.

5.1.4 Discharge Orders

A patient shall be discharged by order of the attending physician or physician's designee.

5.1.5 Outpatient Orders

- (a) A signed practitioner order or requisition is required for outpatient tests performed with reason for performing the test, ICD diagnosis/symptom code, and patient demographic information.

- (b) Orders for recurring patients will be updated at a minimum of every 6 months.

5.2 Standing Orders

Standing Orders may be formulated for use in the Medical Center by a Department, Clinical Service, and Medical Executive Committee for hospital-wide use or by an individual physician or physician group.

5.2.1. Department/Clinical Service/House-Wide

5.2.1.1 Formulation

Standing orders for a clinical service may be formulated in collaboration with the appropriate Medical Staff Committees, and the Administration of the Medical Center.

5.2.1.2 Change

Standing orders may be changed only after conference with the appropriate Medical Staff committee.

5.2.1.3 Adherence

These orders shall be followed insofar as proper treatment of a patient will allow.

5.2.1.4 Use in Lieu of Specific Orders

When specific orders are not written by the attending physician, standing orders shall constitute the orders for treatment.

5.2.1.5 Suspension

A routine order may be suspended by the direct order of an attending physician when in his/her judgment, the care of the patient will thus be improved.

5.2.1.6 Revisions/Updates

Standing orders will be reviewed/revise by the appropriate Medical Staff Committees and Administration as practice changes. These standing orders should be reviewed and updated at least every three (3) years or more frequently as needed.

5.2.2 Individual Physician/Physician Group Standing Orders

Printed standing orders may be provided by the attending physician for his/her patients but in each instance when so used the physician must be verified by his/her signature.

All standing/routine orders will be reviewed and updated to reflect actual practice at least every two (2) years by the responsible physician.

The responsible physician will:

- (a) Approve the orders as printed, or
- (b) Note any necessary changes, or
- (c) Indicate that the orders are no longer necessary.

The standing/routine orders will be revised, retained or deleted as directed by the responsible physician.

6.0 LABORATORY

6.1 Tissue Examination

Tissues removed during a procedure shall be sent to the Pathology Department for examination by a pathologist unless those tissues have been exempted from examination or have been identified for "Gross Examination Only" by the Medical Executive Committee.

6.1.1 Exempt from Examination by Pathology

Refer to the Pathology Department Policy for the listing of exempt tissues.

6.1.2 "Gross Only" Examination by Pathology

The following tissues removed during procedures require a "Gross Only" examination by the pathologist unless the surgeon requests additional examination and/or the pathologist determines additional examination is necessary after a gross examination has been performed:

Hernia sacs

Trauma specimens

The surgeon may request complete pathological examination of any of the exempt and/or gross only specimens at any time.

All other tissue specimens removed during a procedure require examination by a pathologist.

6.2 Autopsies

Every member of the medical staff shall be active in securing autopsies whenever possible.

6.2.1 Grounds and Permission for Autopsy

Permission for autopsy should be sought when death is:

- (a) Unexpected;
- (b) Within 48 hours of an invasive surgical or radiologic procedure;
- (c) Associated with a drug reaction;
- (d) Associated with an adverse event;
- (e) Associated with experimental treatment;
- (f) Incident to pregnancy (within seven (7) days of delivery);
- (g) Secondary to a disease process so obscure that completion of the death certificate is delayed;
- (h) In a child, birth to 18 years of age.

Efforts to obtain autopsy permission should be documented in the medical record.

6.2.2 Reports

Autopsy reports must be completed within thirty (30) days of the autopsy. Provisional anatomic diagnoses shall be recorded in the medical record within two (2) working days of the autopsy.

NOTE: If a death is deemed a Coroner's Case, an autopsy is automatically performed by the Coroner's Office unless the coroner determines it unnecessary.

6.2.3 Definition Of A Coroner's Case: Statute KSA 19-2031

"When any person shall die, or human body found dead in any county of the state and the death is suspected to have been a result of violence, or by suicide, or by casualty, or suddenly when the deceased was in apparent good health, or when unattended by a licensed physician, or in any suspicious manner, or when the determination of the case of a death is held to be in the public interest, the coroner of the county in which such death occurs or dead body is found shall be notified by the physician in attendance, by a law enforcement officer, by the undertaker, by an person who is, or may be in the future required to notify the coroner, by an other person."

7.0 PATIENT CONSENT

7.1 Informed Consent

Informed Consent is obtained from the patient and/or legal guardian, except in emergencies, for any operative and invasive procedures or any potentially hazardous diagnostic or therapeutic procedure including the administration of anesthesia or blood and blood products.

It is the responsibility of the attending physician and/or surgeon to provide information to the patient and/or the patient's legal representative, the risks, benefits, and potential complications associated with the procedure prior to obtaining informed consent. Alternative treatment options should be presented to the patient.

If the patient's condition does not allow for such discussion, appropriate documentation is provided in the medical record.

7.1.1 Blood Transfusions

The need for, risk of, and alternatives to blood transfusions when blood or blood components may be needed are discussed with the patient and family. The patient/family will be provided with a patient information sheet for elective transfusions, if possible.

A written consent form for blood transfusions is required.

7.1.2 Administration of Anesthesia

Anesthesia options and risks are discussed with the patient and family prior to administration.

7.1.3 Investigational Drugs/Research

Any experimental surgical or diagnostic procedure shall require a specific informed and properly signed consent for the patient or his legal representative.

The investigational drug or research must be approved by the Institutional Review Board of Wichita Medical Research and Educational Foundation.

The name of the person who provided the information and the date the form as signed should be documented in the patient's medical record.

7.1.4 Operative/Invasive/Diagnostic Procedures Requiring Written Consent

The Medical Staff will identify a list of operative/ invasive/diagnostic procedures that should have a signed consent form, unless there is an emergency.

The list is not all-inclusive. There may be other procedures, treatments, etc., that may warrant a written consent. The physician should use his/her judgment as to when a written consent is needed.

7.1.5 Documentation Guidelines for Informed Consent

The medical record should contain evidence of the patient's informed consent for any procedure or treatment for which informed consent is appropriate.

Information found in the medical record should include:

- (a) Identify of the patient;
- (b) Date;
- (c) Procedure or treatment to be rendered (in layman's terminology when possible);
- (d) Name(s) of the individual(s) who will perform the procedure or administer the treatment;
- (e) Authorization for anesthesia, if indicated;
- (f) Indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient;
- (g) Authorization for disposition of any tissue or body parts, as indicated;
- (h) Signature of the patient or legal representative;
- (i) Name and signature of witnesses;
- (j) Practitioner with clinical privileges who informs the patient and obtains the consent should be identified in the medical record.

7.2 Patient Notification of Healthcare Errors

When a significant, unanticipated outcome occurs in patient care, the admitting physician has a responsibility to notify and discuss with the patient and his or her family the event and its possible sequelae, which could impact short-term or long-term care.

8.0 HEALTH INFORMATION (MEDICAL RECORD)

8.1 General

The Protocol for Patient-Specific Data and Information provides the guidelines for the medical staff to follow for meeting the medical staff and regulating agency requirements for documentation. Members of the medical staff shall abide by the policies included in the Protocol for Patient Specific Data and Information as well as the policies in the Rules and Regulations Manual.

8.1.1 Ownership of the Health Information/Medical Record

All records are the property of the hospital and may not be removed from the hospital premises except by court order, subpoena, state statute, for copying purposes, for storage or for completion.

8.1.2 Patient Access to Health Information/Medical Records

Patients have the right of access to the information contained in their medical record unless there are specific contraindications.

8.1.3 Abbreviations

Narrative Documentation Abbreviations: Abbreviations that are widely recognized are acceptable for use in the medical records. Exception: Abbreviations listed on the "Unacceptable Abbreviations, Symbols, and Dose Designations" may not be used.

Operative Consent Form: Abbreviations will not be used on the operative consent to identify a procedure or the site.

8.1.4 Authentication of the Medical Record

All entries in the medical record must be recorded in ink, dated, timed and authenticated by the individual making the entry.

8.1.4.1 Electronic Signature

Electronic signatures as entered by the physician are acceptable. There shall be no delegation of the use of the physician's electronic signature to another individual.

8.1.5 Retirement of Medical Records

A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered to be filed incomplete by the Health Information Committee (HIC). Before a medical record is filed incomplete, all attempts shall be made to have the attending physician complete the record.

8.1.6 Organized Health Care Arrangement (OHCA)

Each member of the Medical Staff, as well as every Practitioner with clinical privileges or Advance Practice Professional with practice parameters and each practitioner with temporary privileges (collectively herein referred to as the "Provider" in this paragraph) shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. 164.520 (which is part of what is commonly known as the HIPAA

Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care 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 during the registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners with clinical privileges, Advance Practice Professionals with practice parameters, and Practitioners with temporary privileges. This arrangement also allows for physicians to participate in the appropriate Health Care Operations (as defined by HIPAA) in accordance to the roles and responsibilities of the Medical Staff and each physician's specialty and/or clinical service.

8.2 The Medical Record Content and Timeframes for Completion

An adequate medical record is maintained for each individual who is evaluated or treated in the facility.

8.2.1 General Guidelines

The medical record contains sufficient information to identify the patient; support the diagnosis/condition; justify the care, treatment, and service; document the course and results of care, treatment, and service; and promote continuity of care among providers.

The attending physician is responsible for the completion of a medical record for each patient within 30 days following discharge.

House staff: All records must be completed within seven (7) days of being made available. See also Medical Education Department Guidelines for Resident and Medical Students.

All entries should be legible, complete, signed and dated in ink or electronically signed.

Corrections to the medical record are made according to the Addendum/Late Entry/Corrections to the Medical Record policy – see Administrative Policy manual.

- (a) Original documentation may not be obliterated
- (b) Unsigned documents may be corrected manually or electronically, signed and dated.
- (c) Signed documents may not be removed.
 - (1) Corrections may be made manually or electronically, by addendum or late entry.
 - (2) Corrections, late entry, and addenda's are to be signed and dated.

The Health Information Committee must approve content and format of the medical record.

8.2.2 History & Physical Examination

A history and physical examination should be completed for all inpatients, ambulatory surgery patients and patients undergoing invasive procedures and/or procedural sedation.

Minimum contents of a history and physical include: History of present illness; past medical history; current medications; allergies; physical examination; impression and plan of care.

- (a) The history and physical examination must be completed within 24 hours after admission.
- (b) The history and physical examination with the pre-procedure/surgery update, must be on the medical record prior to operative and invasive procedures, and/or procedural sedation.
- (c) A history and physical examination performed within 30 days prior to admission is acceptable with an update of patient condition completed upon admission.

An interval history and physical is acceptable for use in cases when a patient is readmitted within 30 days for the same or related problems.

8.2.3 Progress Notes

An admission (progress) note is to be written or electronically completed at the time the patient enters the hospital. At a minimum, daily progress notes are written. Additional progress notes are to be written as frequently as indicated by the reassessment of the patient's condition.

In addition to physicians, oral surgeons, dentists, and podiatrists, the following disciplines may document in the progress notes:

Certified Dietary Manager
Chaplains
Clinical Research Assistants
Dietitians
*Medical Students
Nurses (on approved units)
Nurse Anesthetists
Pharmacists

Social Workers
* requires co-signature

Physician Assistants
Psychologists
Rehabilitation Medicine
Therapists
(i.e. physical therapists, speech therapists, occupational therapists, etc.)
Respiratory Therapists

8.2.4 Physician Orders

Physician orders for inpatient and outpatient treatment or services shall be in writing or electronically entered, timed, and dated and signed by the physician who gave the order or alternate physician. An alternate physician is someone who has a group association or a specialty specific or a covering physician association with the ordering physician.

8.2.5 Consultations

A consultation by another physician must be documented in the medical record within 24 hours of completion of the consult.

8.2.6 Operation Reports/Procedure Notes Policy

1. A provisional diagnosis is recorded before the operative procedure.
2. An immediate/post-operative progress note is entered in the medical record immediately following the procedure or before the patient moves to the next level of care to communicate to the next caregiver.
3. Immediate/Post-Operative progress note includes at a minimum:
 - a. The name of the primary surgeon and assistants;
 - b. Findings;
 - c. Procedures performed;
 - d. Description of procedure;
 - e. Estimated blood loss, as indicated;
 - f. Specimens removed;
 - g. Postoperative diagnosis.

Guidelines

1. Approved forms (or format) which categorizes the essentials of an immediate/post-operative progress note are available for use include but are not limited to.
 - ai. Upper GI Endoscopy
 - b. Lower GI Endoscopy
 - c. Fiberoptic Bronchoscopy
 - d. Preliminary Cardiovascular Laboratory Report
 - e. OB Delivery Record
 - f. Physician Procedural Report
 - g. Post-operative Progress Note
2. Detailed operative report describing the procedure performed is completed within 24 hours after the procedure.
3. The detailed operative report includes at a minimum:
 - a. Patient identification
 - b. Date and times of surgery
 - c. Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks
 - d. Pre-operative and post-operative diagnosis
 - e. Procedure(s) performed

- f. Type of anesthesia administered
- g. Complications, if any
- h. Description of techniques, findings, and tissues removed or altered
- i. Description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon, and
- j. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

8.2.7 Anesthesia Documentation

Anesthesia reports should be completed for all patients receiving anesthesia except when local anesthesia is administered.

A pre- and post-anesthesia note should also be documented.

Pre-anesthesia assessment is completed within 48 hours prior to procedure.

Re-evaluation is performed immediately prior to moderate or deep sedation or anesthesia induction. Post-anesthesia assessment is completed within 48 hours after an inpatient procedure.

Outpatients will have a post-op anesthesia note and will be dismissed when they meet rigorous dismissal criteria as defined by the Anesthesia Executive Committee.

8.2.8 Diagnostic and Therapeutic Tests/Procedures:

All diagnostic and therapeutic tests or procedures performed (inpatient and outpatient) shall be fully described by the physician who performed or supervised the procedure within 24 hours following the procedure.

8.2.9 Discharge Summary

A discharge summary must be completed as soon as possible, but no later than 30 days after discharge on all patients who remain hospitalized over 48 hours. For patient stays less than 48 hours to include Same Day Care and Observation, in lieu of discharge summary the physician must document the outcome of hospitalization, the case disposition, instructions to the patient/family, and provisions for follow up care. The discharge summary should document final diagnoses, which include principle, secondary, comorbidity and complications, reason for hospitalization, significant findings, procedures performed, care, treatment and services provided patient's condition on discharge and discharge instructions. Discharge summary can be dictated, handwritten or entered electronically by the responsible provider as a Physician Documentation (PDoc.note)

8.2.10 Final Diagnosis

Final Diagnoses including principle diagnosis, secondary diagnoses, complications and comorbidities at the conclusion of the patient's stay may be documented in the discharge progress notes, discharge summary, or facesheet or the operative report for patient types in observation and same day care.

- (a) Coding Summary
A coding summary form is generated for all registered patients.
- (b) Coding Query Form
Coding Query forms are generated to clarify ambiguous, incomplete or conflicting information contained within the medical record. The Coding Query form will be submitted to the attending physician. The attending physician should mark the question on the query, sign and date form. The physician should also provide additional supporting documentation within the traditional body of the medical record when appropriate.

8.4 Failure to Complete Medical Records

Failure to complete the medical records within the specified time period shall result in incomplete records being counted as delinquent unless the physician has given prior notice to the Health Information Management Department of a vacation, illness or other valid reason for not completing the records.

8.4.1 Vacation/Illness

It is the physician's responsibility to notify the Health Information Management personnel of any scheduled vacation or leave of absence. A physician's absence must be at least one (1) full week in length to warrant a delay in completing records. Completion of records will only be delayed by the amount of time the physician is absent from the hospital.

Any notification of incomplete medical records by Health Information Management personnel to the physician must be completed prior to his/her vacation or leave of absence. It is the physician's responsibility to notify Health Information Management personnel of any scheduled vacations or leave of absence.

In the case of illness, notification should be made to Health Information Management as soon as possible in order to avoid delinquent episodes.

If a physician will be absent for one month or more the physician must complete all records prior to beginning the vacation or leave of absence.

8.4.2 Delinquent Medical Records Physician Suspension and Notification

A delinquent episode is defined as the failure to complete one or more medical records greater than 30 days old from date available or failure to complete one or more key documents with required completion within 24 hours of event (i.e. H&P, Op report dictation).

8.4.3 Suspension/Notification Process

Physician Notification Letters are mailed, faxed or emailed at a minimum of once per month.

- a) All status letters/notices (aged 01-29 days) – Physicians with incomplete medical records will receive a Courtesy Letter via mail, fax or email.

- b) Delinquent letters/notices (aged 30 days or more) – Physicians with delinquent medical records that are over 30 days or more will receive a Delinquent Letter via mail, fax, or email. The delinquent notification gives the physician one (1) week to complete their delinquent records before they are placed on suspension. The notification will specify the date & time the suspension will be effective.
- c) Suspension Letters/Notices – Providers who are on Precautionary Suspension will receive a letter via mail, fax, or email notifying them that they will remain on Precautionary suspension until ALL records are completed. Physicians on Precautionary Suspension will also be called at least weekly to remind them of their suspension status.

8.4.4 Medical Record Suspension

Providers who have had their privileges suspended for incomplete medical records will not be able to admit or treat new patients. However, they may continue to treat currently admitted patients and emergency patients.

The Health Information Management Department is responsible for notifying applicable departments of providers who are suspended.

All incomplete and delinquent records must be completed before privileges are reinstated. This includes the dictated report being transcribed and signed. The Health Information Management Department is responsible for notifying applicable departments of when providers privileges have been reinstated.

8.4.5 Multiple & Extended Suspensions

- a) Health Information Management Department will keep track of the physicians receiving suspension notices.
- b) Any physician who remains on Precautionary Suspension for more than twenty-nine (29) days will be referred to the Medical Executive Committee for further action, up to and including, termination of staff membership.
- c) A provider who has been suspended four (4) times in a rolling 12 month period will be reported to the Executive Committee of their Clinical Service. The Clinical Service Chair/Department Committee will send provider a certified letter.
- d) A provider with six (6) suspensions in a rolling 12 month period will be reported to the Medical Executive Committee. The provider will have to appear before the Medical Executive Committee.
- e) A record of each suspension imposed under this Section shall be made a permanent part of the staff member's credentials file as required by state law. A practitioner suspended pursuant to this sub-section may request review of the suspension as provided in the Medical Staff bylaws.

9.0 PERFORMANCE IMPROVEMENT ACTIVITIES

The Performance Improvement Committees review all performance improvement activities of the medical staff and report their findings to the Medical Performance Improvement Committee.

The Medical Performance Improvement Committee determines which findings will be reported to the Medical Executive Committee. Any findings shall also be reported to the appropriate clinical chairperson.

The clinical chairperson shall inform the appropriate physician or physicians of the investigation and provide such information as may be indicated. The chairperson shall decide whether involvement of the clinical executive committee is or is not indicated, with the provision that the physician(s) involved may request a hearing before such committee. The chairperson shall report his/her findings and recommendations to the Medical Executive Committee where a final determination of action to be taken is made.

10.0 RISK MANAGEMENT REPORTING REQUIREMENTS

The *Kansas Risk Management Law* (KSA 65-4921, et seq.) requires reporting to appropriate state licensing agencies of certain acts by medical staff members.

If a health care provider or a hospital agent or employee directly involved in the delivery of health care services has knowledge that a medical staff member has committed an act with the hospital that may be a "reportable incident," such person shall report the act to the President of the Medical Staff or the Medical Center President or his/her designee.

The President of the Medical Staff or Medical Center President, as the case may be, shall refer the report to the Medical Executive Committee for appropriate investigation and action pursuant to the Medical Staff Bylaws

Upon conclusion of the Corrective Action, and having accorded the medical staff member appeal rights pursuant to the Medical Staff Bylaws, the Medical Executive Committee shall determine if the staff member's act is a "reportable incident."

A "reportable incident," as defined by the *Kansas Risk Management Law*, means an occurrence involving a health care provider which is or may be below the applicable standard of care and has a reasonable probability of causing injury to a patient or any act that is or may be grounds for disciplinary action by the Kansas State Board of Healing Arts.

The Medical Executive Committee shall determine whether an act comes within the "reportable incident" definition or is grounds for disciplinary action and, as such, must be reported to the Board of Healing Arts, or other appropriate Kansas State Agency which licenses the health care provider involved.

11.0 PLAN FOR CARE OF PSYCHIATRIC, DRUG AND ALCOHOL ABUSE PATIENTS

Psychiatric patients or patients under the influence of drugs or alcohol, including suicidal patients, shall receive careful consideration of both physical and psychological needs.

The patient shall receive an initial physical and psychological assessment to determine the patient's immediate needs.

A follow-up plan to ensure the safety of the patient shall be formulated for each patient, and admission to an appropriate facility shall be arranged as needed.

Referral to a psychiatrist or psychologist for consultation is determined by the Emergency Department and/or Attending Physician of the patient.

Emergency Department personnel and the Department of Social Work are available to assist in transferring patients with psychiatric problems, drug and alcohol abuse to facilities equipped to treat these patients.

Patients may be transferred to a psychiatric facility only after medical stabilization and treatment.

12.0 SURGERY FIRST ASSISTS

It is the responsibility of the operating surgeon to obtain a first assistant as needed.

A first assistant is defined as an M.D. or D.O. with medical staff privileges at Wesley Medical Center or a resident in training. Obtaining a first assistant is the responsibility of the operating surgeon.

Physicians requesting to assist at surgery who do not have medical staff privileges at Wesley, may be allowed to "observe only", but may not participate in the actual procedure.

- (a) Permission of the operating surgeon must be obtained.
 - (b) The operating surgeon should notify the Operating Room prior to the procedure when a physician has been approved to observe a procedure.
 - (c) The observing physician should sign the guest book in surgery upon their arrival.
- Approved: Surgery Executive Committee 2/13/96

13.0 NON-PHYSICIANS WHO CAN ORDER DIAGNOSTIC AND LABORATORY TESTS AND THERAPEUTICS

A licensed chiropractor may be allowed to order diagnostic and laboratory tests and therapeutics if the conditions are met as outlined in the Medical Staff Bylaws.

14.0 APPROVAL/AMENDMENT OF RULES AND REGULATIONS

The Rules and Regulations may be amended or repealed, as outlined in the Medical Staff Bylaws.