

The Medical Staff is responsible to the Stanford Healthcare (SHC) Board of Directors for the professional medical care performed at SHC and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional care are hereby adopted. Individual Clinical Services may adopt Service-specific Rules governing both practice in the Service and the professional medical care to be rendered by members of the Service. These documents are complementary.

1. PATIENT TYPES AND ADMISSION OF PATIENTS

A. Description

The Hospital is a general acute care hospital that responds to the medical needs of patients who present for care. In addition, the Hospital manages a set of primary care and specialty clinics. The Hospital accepts for care patients suffering from all types of disease and clinical needs dependent upon available facilities, personnel, and licensure.

B. Definitions

Patient encounters at SHC fall into three general categories: inpatient, emergency, and outpatient. These are based on the service provided as well as on specific regulatory requirements such as Title 22 of the California Code of Regulations and the Medicare Conditions of Participation.

- 1). Inpatient: A person who has been admitted to the hospital for bed occupancy for purposes of receiving care. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight. (Medicare's two midnight rule applies for reimbursement of these patients.)
- 2). Emergency: The provision of emergency medical care in specifically designated areas of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting with urgent medical conditions.
- 3). Outpatient: A person who has not been admitted to the hospital as an inpatient and who is not receiving emergency services but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.
 - a. Hospitalized Episodes for Outpatients
 - (1) Ambulatory Care Procedure: Outpatient procedures that are generally invasive, including same-day surgeries, invasive diagnostic imaging and therapeutic procedures, bronchoscopies, and endoscopies
 - (2) Observation: Those services furnished on the hospital's premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition.
 - b. Other Outpatient Episodes/Services
 - (1) Clinic Visits: Encounters during which diagnoses, and other related information are provided by the attending physician who performs the examination or who is overseeing the activities of an Advanced Practice Provider or housestaff.

- (2) Diagnostic and Treatment Services: Services such as laboratory and radiological studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified physician who is also responsible for providing the patient's diagnosis and other clinical justification for the test or therapy.
- (3) Referred Specimen Services: Services rendered when a specimen is sent by an external (SHC or non-SHC) physician's office, hospital, or other institution for evaluation or consultation when the patient does not present to SHC for service

C. Admission Criteria

Patients may be admitted to the Hospital as inpatients, accepted for outpatient hospital registration, or accepted for observation services or ambulatory care procedures only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the Hospital or order procedures in accordance with state law and criteria for standards of medical care established by the Medical Staff. All patients must be under the direct care or supervision of a member of the Medical Staff.

- 1). Only those practitioners authorized in accordance with the Bylaws of the Medical Staff may admit patients to the Hospital. The patient's attending physician will execute, or cause to be executed, all physician responsibilities related to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admitting and discharging of patients from the Hospital.
- 2). The admit order must specify the admission type: (a) Observation, (b) Outpatient Surgery, or (c) Inpatient.
- 3). A change in admission type requires a new order; however, a patient's status cannot change from Inpatient to Observation without consultation with Case Management.
- 4). Except in emergencies, no patient may be admitted to the Hospital without a recorded provisional diagnosis. In the case of an emergency, a diagnosis must be recorded as soon as possible.
- 5). Patients who are treated at Stanford Health Care for diseases diagnosed based on histological sections or the morphological assessment of fine needle aspirates, bone marrow aspirates, or peripheral blood, and when the proposed treatment depends on the interpretation of these specimens, must have such diagnoses confirmed by a Medical Staff member with Pathology privileges. This must be done before initiation of therapy, except when urgent therapy is indicated. Where the clinician can document clinical or radiologic findings that would justify performance of the procedure regardless of the prior pathology, or in situations where the diagnosis is made radiographically, this rule would not apply. If the pathology specimens cannot be obtained because they have been destroyed, no longer exist, or have been irrevocably lost or cannot be obtained through reasonable efforts, this should be documented in the medical record.
- 6). It is the responsibility of the Medical Staff member to ensure reporting of all cases of reportable diseases in accordance with Title 17 of the California Code of Regulations for the control of communicable diseases, and SHC Infection Control Procedures and Policies.

2. MEDICAL RECORDS

A. Definitions

A medical record consists of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Services Department. The information contained in the medical record, and any other patient-specific information, must be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access

Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or other specifically authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored as follows:

- a. Traditional Paper Chart: legal record prior to 1/29/97. These charts are stored off-site and are retrievable by HIMS.
- b. Electronic Record: legal record from 1/29/97 to present. All (electronic and/or handwritten) documents generated during a patient's stay that have been scanned or directly entered (from 4/25/08). The Electronic Record is stored in EPIC.
- c. HIPPA-compliant web-based data storage, approved by Stanford Healthcare and Stanford School of Medicine (e.g., Box)
- d. HIPPA-compliant encrypted USB drives provided by Stanford Health Care

C. Required Medical Record Elements

Elements required in a medical record include identification data; appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent Forms.

D. Documentation Rules

- 1). Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record must be as stated in the Hospital's Policies and Procedures governing medical records.
- 2). Entries must be legible and authenticated by the individual making the entry. Authentication is defined as a written or electronic signature, timed, and dated.
- 3). The attending physician is responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within two weeks following the patient's discharge
- 4). Medical student entries must include identification of student status and be counter-signed by a supervising physician.

- 5). All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed using the 24-hour clock. The following entries must be timed using 24-hour clock:
 - a. Orders
 - b. Post-operative notes immediately following surgery
 - c. Forms that specify a time documentation requirement
 - c. Administration of medications
 - e. Restraint and/or seclusion application and removal
 - f. Emergency Room log of patient arrival, discharge
 - g. Anesthesia note immediately prior to induction

- 6) Symbols and abbreviations may not be used on the face sheet or in the final diagnosis but may be used within the medical record when approved by the Medical Staff.

- 7) A list of approved and unapproved symbols and abbreviations has been approved by the Medical Staff. Use of unapproved symbols and abbreviations has the potential to negatively impact patient care. No order for medications will be completed if the order contains a symbol or abbreviation on the **unapproved** list until the physician has been contacted for order clarification. The Pharmacy and Therapeutics Committee and the HIMS Committee will monitor compliance with these requirements.

- 8) A clinic note should be entered into the medical record or dictated for each visit or consult within 24 hours of the encounter.

- 9) Effective 2021, outpatient New and Established patient clinic visit documentation, must conform with the Centers for Medicare and Medicaid Services (CMS) requirements (regardless of payer), including:
 - a. Chief complaint or reason for visit
 - b. Medically appropriate history
 - c. Medically appropriate exam
 - d. Assessment and plan
 - e. Time (if billing based on time)

All **other** outpatient clinic visit documentation (i.e., consultation), must conform with the CMS 95 or 97 Documentation Guidelines for Evaluation and Management Services (regardless of payer), including:

 - a) Chief complaint or reason for visit
 - b) History of present illness
 - c) Review of systems and pain evaluation
 - d) Past family and social history
 - e) Physical examination
 - f) Assessment and plan

- 10) A focused medical assessment by any attending, house staff or APP member of the treatment team or teams must be documented prior to or at the time of an invasive procedure or moderate sedation, and should include:
 - a. Presenting diagnosis/condition
 - b. Description of symptoms
 - c. Significant past medical history
 - d. Current medications
 - e. Any drug allergies
 - f. Indications for the procedure
 - g. Focused physical exam as indicated

- h. Proposed treatment or procedures
- 11) Orders:
- a. Orders for ancillary and diagnostic services must include the diagnosis (ICD code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service / treatment.
 - b. An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and **not** permitted in medication orders, both generally and for specific types of medications.
 - c. For treatment orders, an explanation must be provided as appropriate.
- 12) Documentation of phone consultations must be included in the medical record.
- 13) All clinical e-mail correspondence with patients must be maintained with the legal, medical record in accordance with SHC policy "Electronic Mail Use Between Provider and Patient". This should include the patient's initial question and the clinical response.
- 14) The summary lists will be revised when the medical condition/diagnosis changes, medications are discontinued or changed, the patient has undergone additional surgical procedures and/or when there is a change in allergy status.
- 15) Education and instructions provided to the patient and family should be documented in the record.

3. CONSENT AND DISCLOSURE

A. *Informed Consent*

Unless an emergency exists, no care or treatment may be rendered to any patient in the Hospital, Emergency Department, or Clinics without a written consent signed by the patient or his/her properly designated representative. In an emergency situation, when immediate services are required to alleviate or prevent severe pain, disability, or death, and the patient lacks capacity to give consent for the services required, the physician recommending treatment to the patient must follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable. Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment that is considered complex based on medical judgment, and includes, but is not limited to the following situations:

1. Operative procedures
2. Invasive procedures that have the potential for serious risks and adverse reactions
3. Blood transfusions or other use of blood products
4. Planned use of moderate sedation
5. Electroconvulsive therapy

The informed consent discussion should include at least information about the specific procedure or treatment, the reasonably foreseeable risks and benefits of the treatment, and the reasonable alternatives for care and treatment. Further information on what is required in the discussion and what must be documented is found in the Administrative Manual Policy *Informed Consent*.

In all surgical procedures, the physician in whose name the permission for the operation is obtained must participate in person or as a member of the operating team and must be present during the critical portion(s) of the procedure. Such participation may not be delegated without the informed consent of the patient or the patient's properly designated representative.

B. *Disclosure of Unanticipated Outcomes and Medical Errors*

1) Definitions:

- a) Adverse Event: A detrimental effect from a diagnostic test, defect, failure and/or error within the healthcare system, medical treatment, or surgical intervention
- b) Unanticipated Outcome: A result that differs significantly from the anticipated result of a treatment or procedure

2) Disclosure

The attending physician responsible for the patient's care, or his/her designee as appointed by the Chief of Staff, will serve as the primary communicator of an unanticipated outcome or adverse event to the patient and/or family/legal guardian. The person designated as the primary communicator with the patient/family must document in the progress notes of the patient's medical record what was communicated to the patient/family and any response or other discussion.

C. *Sterilization*

Sterilization procedures are to be performed only in accordance with applicable federal and State law and must adhere to the procedures outlined in the SHC Informed Consent for Sterilization or Hysterectomy policy. Physicians planning to perform sterilization procedures must carefully reference these requirements and should seek advice from Risk Management to ensure that all elements of the consent process are met whenever there are any concerns about the consent process.

4. RESEARCH

- A. Any research project conducted in the Hospital or Clinics involving human subjects must be approved by the Administrative Panel on Human Subjects in Medical Research (the Investigational Review Board or "IRB") of Stanford University School of Medicine.
- B. The Medical Staff Member who is participating as a Principal Investigator in a research protocol involving human subjects is responsible for submitting the research protocol for approval to the IRB of Stanford University School of Medicine and complying with all IRB requirements relating to the provision of care and treatment of a patient under an approved research protocol.
- C. All research projects must be conducted in accordance with the Medical Staff Policy on Clinical Research, and any applicable SHC policy. Confidentiality is maintained in accordance with SHC HIPAA Research policy.
- D. If there is uncertainty as to whether a proposed plan of care should be designated as research (vs. "innovative care"), the SUMC Innovative Care Guidelines should be consulted.

5. PATIENT ASSESSMENT

- A. *H&P Requirements* (Must be documented by a member of the SHC medical staff, housestaff, or an Advanced Practice Provider with the appropriate privileges.)
1. A history and physical examination (H&P) must be completed no more than 30 days before or 24 hours after inpatient or outpatient admission. If the H&P was completed within 30 days before admission, an updated examination, also known as an H&P Interval, must be completed, and documented within 24 hours after admission.
 2. The H&P must be completed for every patient prior to surgery, or a procedure requiring anesthesia services, except in emergencies. In all cases, except for emergencies, the H&P and/or H&P Interval must be completed and documented before the surgery or procedure takes place, even if that surgery occurs less than 24 hours after admission or registration.
 3. The History and Physical will include, at minimum, the following components and any other information deemed to be relevant by the examining provider:
 - Chief Complaint
 - History of Present Illness
 - Medications and Medication Allergies
 - Review of Systems
 - Physical Examination
 - Assessment Including Provisional Diagnosis
 - Treatment Plan
 4. The H&P Interval will indicate that the H&P was reviewed, the patient was examined, any changes that have occurred, or that “no changes” have occurred in the patient’s condition. In the case of a surgical update, it will also confirm that indications for the procedure are still present.
 5. In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a Pre-Anesthesia Assessment. The assessment is performed and documented prior to the induction of sedation/anesthesia and considers data from other assessments.
 6. The H&P requirement does not apply for Emergency Surgery; however, an H&P must be documented as soon as possible after surgery.

6. PLANNING CARE, TREATMENT AND SERVICES

A. *Orders*

All orders for treatment must be in writing or entered into the electronic medical record, dated, and timed. Orders written by an individual who is not a medical staff member, housestaff member, or Advanced Practice Provider (NP or PA) authorized to enter orders must be cosigned by the supervising physician prior to implementation.

B. *Verbal/Telephone Orders*

Verbal/telephone orders may be issued by members of the medical staff, housestaff, or Advanced Practice Providers authorized to write orders to licensed nursing personnel (RN’s) and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech-language pathologist, registered laboratory technologist, registered MRI

technologist, registered nuclear medicine technologist, registered sonographer, registered x-ray technologist, or dietician.

Verbal/telephone orders may be issued only if the circumstances are such that an immediate order is required, and it would be impractical for the prescriber issuing the order to do so in writing or to directly enter the order into the electronic medical record.

- 1) Verbal/telephone orders are appropriate in the following situations:
 - a. Emergency
 - b. If person placing the order is physically unavailable and does not have access to the Electronic Medical Record system
 - c. If the physician/clinician is performing a procedure
- 2) The ordering provider must identify him/herself, and the person receiving the verbal order will read back this identifier as a part of the order transcription process.
- 3) For Electronic Medical Record, the provider must remain on the phone if asked by the person receiving the verbal order while the order is entered to ensure that the desired order is available in the system and that any alerts are addressed.
- 4) Verbal/telephone orders must be signed within 48 hours by the prescribing practitioner or by attending or covering physician. The physician to whom the verbal order is attributed should cosign it, authenticating authorship and confirming the accuracy, content, and patient identifiers. Members of a Physician Team may cosign verbal orders for any other member of that team if they are sufficiently familiar with the clinical circumstances and appropriateness of the order. (See SHC Order Policy).

7. MEDICATIONS

An order for medication must comply with the Medical Staff approved Medication Policies and Procedures which govern the content of abbreviations and nomenclature permitted in medication orders, both generally and for specific types of medications.

- A. Complete medication orders must include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There should be a documented diagnosis, condition, or indication for each medication ordered.
- B. Orders documented by medical students must be reviewed and counter-signed by a physician prior to implementation.
- C. Medications brought by or with the patient to SHC may not be administered to the patient unless all of the following conditions are met:
 - 1) The drugs have been specifically ordered by the patient's physician or APP and the order entered in the patient's medical record. The order must include the drug name, dosage, frequency, and route.
 - 2) The drugs have been positively identified and examined for lack of deterioration by the pharmacist or physician and have been re-labeled, if necessary, by the pharmacist to provide adequate identification for those responsible for administering the drug.
 - 3) The drugs are approved agents for in-hospital use as described in the Patient's Own Medication Policy.

- D. Upon transfer of the patient to the Operating Room, all medication orders are canceled and must be rewritten. It is not acceptable to write a statement such as "Resume all medications orders"; complete orders for each medication must be documented. If there is a change in Service (e.g., Medicine, Surgery) and/or the physician responsible for the patient, all orders for the patient must be reviewed by the new Service and/or physician and reaffirmed or discontinued via order documented in the patient's chart.
- E. Only those drugs listed in the SHC Drug Formulary may be administered to inpatients, with the exception of (1) those obtained by the Non-Formulary Drug Procedure; (2) those employed in research protocols approved by Stanford University Medical Center's Administrative Panel on Human Subjects in Medical Research; (3) those employed for purposes of direct therapeutic benefit to a particular patient in an emergency, when approved by the Chief of Staff or the Chief's designee, or (4) those brought by or with the patient to SHC, if all of the conditions in 7.C above have been met. Investigational drugs may be used in accordance with applicable State and federal laws and regulations as well as policies adopted by the Pharmacy and Therapeutics Committee. (See Stanford Health Care Administrative Manual for detailed procedures and policy for the handling and administration of investigational drugs).
- F. Medication ordering and administration must comply with all the Medication Administration Requirements Procedures such as using patient specific information, monitoring the effects of the medications, not using SHC unapproved abbreviations, etc.
- G. The Physician or APP is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

8. PROVIDING CARE, TREATMENT AND SERVICES

A. *Daily Care of Patients*

A hospitalized patient must be seen by the attending physician or a member of the housestaff, APP, or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status at the time of observation.

B. *Follow-Up on Outpatient Test*

An attending physician who orders medical tests on an SHC outpatient must ensure that the results of such tests are reviewed (by a physician or appropriated Advanced Practice Provider) no later than 2 business days after those results appear in the electronic medical record (or are made available via fax, mail, or other means).

C. *Consultations*

- 1). It is the responsibility of the Medical Staff through the Chiefs of Services and Medical Directors to see that members obtain timely consultations when appropriate and when requested by the Chiefs of Services, Medical Directors, or Chief of Staff. Services may specify the minimum criteria as to when a consultation is required. Consultations must show evidence in the Medical Record of the consultant's review of the patient's record, his/her pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. In case of emergencies, a nurse is authorized to seek appropriate medical consultation if the responsible attending or housestaff physician is not available.

- 2). Two types of consultations may be obtained. Each involves different levels of patient care management and overall responsibility on the part of the consultant.
 - a. “Consultation only” is ordered when the attending physician wishes the consultant to review the patient’s records and pertinent findings to render an opinion and make treatment recommendations. The consultant is not directly involved in patient management, does not place orders in the chart, or have overall responsibility for the patient’s care.
 - b. “Consultation and management” are ordered when the requesting attending physician wishes the consultant to place orders in the chart and participate directly in patient care management.

- 3). Patients who exhibit significant psychiatric illness with acute exacerbation of symptoms or new onset of symptoms while hospitalized will be referred for an evaluation by a psychiatrist on the medical staff as outlined in the Service Rules and Regulations and hospital policy, if the attending physician believes that management of the patient is beyond his/her scope of practice. Patients with alcohol/drug abuse/intoxication/dependence will be referred for psychiatric evaluation if the attending physician believes management of the patient is beyond his/her scope of practice. Consultation will involve diagnostic evaluation, acute management suggestions and assistance, and referral for outpatient treatment as indicated.

E. Sedation and Anesthesia

- 1). Prior to sedation and anesthesia, a pre-anesthesia evaluation must be completed, including:
 - a. A focused H&P with particular attention to
 - (1) Any history of adverse or allergic drug reactions with anesthesia or sedation
 - (2) NPO status
 - (3) Level of consciousness
 - (4) Airway assessment
 - (5) Brief description of the planned procedure(s)
 - (6) Planned anesthesia type, including risks, benefits, and alternatives
 - b. Determination of ASA classification

- 2). At the time of sedation and anesthesia:
 - a. Prior to induction of anesthesia or sedation vital signs and oxygen saturation must be updated.
 - b. Immediately prior to the use of moderate or deep sedation or the induction of anesthesia, re-evaluation of the focused H&P must be done.
 - c. Physiological parameters including (but not limited to) vital signs and oxygen saturation must be measured and assessed throughout anesthesia and documented on the anesthesia record or procedure room record.

- 3). A post anesthesia follow-up report by the individual who administered the sedation or anesthesia must be documented within 48 hours after the procedure that necessitated sedation or anesthesia and should

- (a) Be recorded on the Anesthesia Assessment Form.
- (b) Specifically document any intra-operative or postoperative anesthesia complications.

F. Operative Care of Patients

- 1) Either a full operative or procedure report, or a brief operative or procedure note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care. If a brief operative or procedure note is written prior to transfer of the patient to the next level of care, a full operative or procedure report must be documented or dictated within 24 hours after the procedure.

If the practitioner performing the operation or procedure accompanies the patient the next area of care, the note or report can be written in the next level of care area. If the practitioner accompanies the patient when they are transferred from the procedure room to the next area of care, the report may be written in the next area of care. Documentation may be performed by any member of the housestaff or an APP who was present and directly participated during the entire procedure. Documentation must include the following

- a. The **brief** immediate operative or procedure note *must* include *all* the following elements without omission or reference to a record not yet available at time of documenting the note
 1. The name(s) of the practitioner(s) who performed the procedure and his or her assistant(s)
 2. The name of the procedure(s) performed
 3. Complications/findings of the procedure, or indicate "none", if there were no complications/findings
 4. Any estimated blood loss, or indicate "none", if there was no blood loss
 5. Any specimen(s) removed, or indicate "none", if there were no specimens removed.
 6. The postoperative diagnosis
 - b. The **full** operative or procedure report must include **all** of the elements of the brief operative or procedure note, *plus* the following:
 1. Pre-op diagnosis
 2. Post-op diagnosis
 3. Type of anesthesia or sedation
 4. Description of the procedure
 5. Date and time of procedure
- 3) The documentation of reports required by this section may be delegated to a member of the housestaff or an APP who was present and directly participated during the entire surgery or procedure. The level of involvement of the attending physician (e.g., "was present and directly participated during the entire procedure") must be clearly documented by either the housestaff or by the attending physician. If the housestaff provides the documentation, the attending physician must document an attestation statement confirming his/her level of involvement.
 - 2) The documentation of reports required by this section may be delegated to a member of the housestaff or an APP who was present and directly participated

during the entire surgery or procedure. The level of involvement of the attending physician (e.g., “was present and directly participated during the entire procedure”) must be clearly documented by either the housestaff or by the attending physician. If the housestaff provides the documentation, the attending physician must document an attestation statement confirming his/her level of involvement.

9. COORDINATING CARE AND TREATMENT

A. *Discharge/Death*

- 1). Patients may be discharged only on the order of the responsible physician or allied health practitioner or his/her designee. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible practitioner is obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients who have been in the hospital for a period of more than 48 hours, the patient’s discharge summary should either be documented in the medical record or dictated within 48 hours of discharge. For patients with a stay less than 48 hours the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. All inpatient deaths must have a death summary regardless of length of stay. The discharge or death summary must be completed by the discharging practitioner within fourteen (14) days of discharge.
- 2) If a patient leaves SHC against medical advice, this must be documented in the patient’s medical record and the patient should be asked to sign the appropriate release form.
- 3) Discharge Summary
 - a. The Discharge Summary can be directly entered in the electronic health record or dictated for transcription.
 - b. The content of the discharge summary should be consistent with the rest of the record and includes:
 - (1) Admitting date and reason for hospitalization
 - (2) Discharge date
 - (3) Final diagnoses
 - (4) Succinct summary of significant findings, treatment provided and patient outcome
 - (5) Documentation of all procedures performed during current hospitalization and complications (if any)
 - (6) Condition of patient upon discharge and to where the patient is discharged
 - (7) Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential
- 4) Death Summary
 - a. The Death Summary is entered in the electronic health record or dictated for transcription.
 - b. The content of the death summary should be consistent with the rest of the record and includes:

- (1) Admitting date and reason for hospitalization
- (2) Date of Death
- (3) Final diagnoses
- (4) Succinct summary of significant findings, treatment provided and patient outcome
- (5) Goals of Care – if patient was placed on DNR/palliative/comfort/hospice care status
- (6) Documentation of all procedures performed during current hospitalization and complications (if any)

B. Patient Death

In the event of death, the patient must be pronounced dead by a licensed physician or APP. The physician pronouncing the death is responsible for determining whether the death is reportable to the County Coroner's Office and must make such reports in accordance with the applicable California laws. The body may not be released from SHC until an appropriate entry by a licensed physician has been made and signed in the patient's medical record. Policies with respect to the release of bodies must conform to California law.

10. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

A. Autopsy

Unless otherwise required by the coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. In the event of a patient death in the Hospital, the physician/Service is expected to attempt to obtain permission to perform an autopsy from the appropriate legally authorized person.

Autopsies are performed by the SHC Pathology Department. The Medical Staff, and specifically the attending physician, should be notified of the time and place an autopsy is performed. The complete post-mortem report should be made part of the medical record within three (3) months.

B. Suicidal Patient

For the protection of patients, the Medical and Nursing Staffs, and SHC, the following standards are to be met in the care of the patient who is determined to be potentially suicidal:

- 1) Psychiatric consultation must be obtained immediately (or as soon as the patient's condition permits if the suicide attempt has rendered him/her unconscious) after a patient has threatened suicide or made a suicide attempt.
- 2) Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders which might include one or more of the orders described in the SHC "Emotionally Distressed/Suicidal/Alcohol and/or Substance Abuse Patient Plan of Care" policy.
- 3) If a patient's medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician is encouraged to seek information and/or consultation regarding alcohol and drug treatment services to assist with detoxification, referral to community resources or treatment sources, and other support.

C. *Restraints and Seclusion*

A restraint or seclusion may only be used if needed to improve the patient's well-being or to protect the safety of other persons, and less restrictive interventions have been determined to be ineffective.

A member of the medical staff, housestaff, or an Advanced Practice Provider with the appropriate privileges may order restraints.

The order for restraint or seclusion must comply with the medical staff approved Hospital policy on restraints and seclusion. Standards for restraint and seclusion care exist in the SHC policy for Restraint and Seclusion. Seclusion may only be used in the psychiatry unit and the Emergency Department.

The use of restraints and seclusion to manage violent or self-destructive behavior requires the practitioner to evaluate the individual in person within *one hour* of restraint or seclusion application.

The use of restraints for safety concerns in the delivery of the patient's medical-surgical care (i.e., for non-violent patients or patients who are not self-destructive) requires a physician, APP, or LIP order prior to application of restraints. If a physician, APP, or LIP is unavailable, and an RN who has successfully demonstrated competence in assessment for restraint has applied restraints for patient protection, a verbal or written order must be placed within 12 hours of the application of the restraint. The patient must be examined by a physician within 24 hours of the initiation of the restraint, and a written order entered into the medical record.

Hospital policy specifies the time within which an order must be obtained after each use of restraint or seclusion and the maximum time for the use of either intervention. PRN orders are not allowed. Restraints are time-limited to no more than one calendar day or 24 hours from the original order. The physician, APP, or LIP must do a face-to-face examination of the patient and renew the order at least once each calendar day or 24-hour period from when the order was initiated that the restraint is required.

D. *Organ and Tissue Donation*

Members of the Medical Staff are expected to follow the SHC Organ and Tissue Donation for Brain Dead Patients Policy and the Organ Donation after Cardiac Death Policy. These policies state that the California Tissue Donation Network is to be contacted for assessment and potential discussion of donation with the patient's family at or near the time of imminent brain death.

E. *Tissue Specimens*

All tissue specimens that are clinically relevant to the indication for the procedure during which they were removed, or to subsequent therapy, must be examined by a Medical Staff member with privileges to examine such specimens at SHC to the extent necessary to arrive at a tissue diagnosis. The findings of that examination must be documented by the medical staff member in the patient's medical record.

11. **TRANSFER OF PATIENT**

If the attending physician transfers the care of a patient to another SHC Medical Staff member, the transferring attending physician, house staff or APP member should clearly document the transfer of responsibility in the medical record to the accepting attending physician.

12. CLINICAL SERVICE POLICIES AND PROCEDURES

Each Clinical Service may develop policies and procedures to be administered routinely to all patients admitted to their Service. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be administered to all patients admitted to the Hospital. Where clinical service and medical staff rules appear inconsistent, medical staff rules will supersede service rules.

13. EMERGENCY SERVICES

- A. The provision of emergency medical services occurs through the Emergency Department of SHC, which is organized and directed by a member of the Medical Staff who is trained and experienced in Emergency Medicine. The Emergency Department is staffed by housestaff and members of the Medical Staff.
- B. A Medical Screening Examination (MSE) must be conducted by physicians or Qualified Medical Personnel (QMP), as approved by the Medical Executive Committee, to determine whether an emergency medical condition exists. A QMP is an individual who is licensed or certified and has demonstrated current competence in the performance of the medical screening exam. In particular, the following categories of individuals are QMPs and may perform MSEs provided they are acting within their scope of practice and under the appropriate physician supervision, subject to any limitations set forth in the privileges granted such individuals:
 - 1) Registered Nurses (“RNs”) and Nurse Practitioners provided such licensed individuals operate under appropriate standardized procedures.
 - 2) Physician Assistants provided such licensed individuals operate under appropriate practice agreements.
- C. A medical record must be kept for every patient and becomes part of the SHC legal medical record.
- D. A Medical Staff member, or a member of the housestaff under the direct supervision of an SHC Medical Staff member, may determine the need to transfer a patient to another medical facility. This must be done in accordance with EMTALA guidelines and the practitioner making the determination must complete and sign all forms related to the transfer including a transfer statement
- E. On call physicians will respond in person to emergency consultation requests within 30 minutes if on call in-hospital and within 60 minutes if on call outside the hospital. Longer response times are acceptable if agreeable to the requesting physician. In specialties (e.g., radiology, pathology) where direct examination of the patient is often not clinically indicated, the physician must view the relevant images, specimens, or other clinical materials within the specified time limits

14. CONFLICT OF CARE RESOLUTION

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about a patient’s care. The chain of command involves administrative and clinical lines of authority which are established to ensure effective conflict resolution in patient care situations. In all cases, the final authority in the chain of command on patient care decisions rests with the Chief of Staff or the Chief of Staff designee.

15. SUPERVISION OF HOUSESTAFF

All members of the Housestaff are under the supervision of the Medical Staff. Members of the Medical Staff exercise that supervision under the guidelines established by the Graduate Medical Education Program. Medical Staff members who serve as housestaff supervisors must be licensed independent practitioners and must hold clinical privileges that reflect the patient care, treatment, and service responsibilities given to the housestaff. Housestaff, who are approved to provide patient care, treatment, and services, may write orders unless otherwise specified in the Bylaws, Medical Staff Rules and Regulations, or Service requirements. However, supervising members of the Medical Staff are responsible for the patient care, treatment, services, safety and quality, and documentation activities of the residents they supervise. The Graduate Medical Education Committee must provide regular reports of the activities of the Graduate Medical Education Program to the Medical Executive Committee, which will communicate this report to the SHC Board of Directors.

16. CONFIDENTIALITY

- A. All members of the Medical Staff, Advanced Practice Providers associated with the Medical Staff, and their respective employees and agents, must maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by SHC or by business associates of SHC, in accordance with any and all privacy and security policies and procedures adopted by SHC to comply with current federal, state and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with SHC's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff member to any health care provider within the facility who has responsibility for that patient's care. This applies to general patients, psychiatric patients, and substance abuse patients as defined by the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act of 1996.
- B. The use of electronic signature or rubber stamp signature is acceptable only if the practitioner whose signature the electronic signature or rubber stamp represents is the only person who has possession of the electronic user ID and password combination or rubber stamp and is the only one who uses it.
- C. All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other SHC medical records. Passwords used by a member of the Medical Staff to access SHC computers may be used only by such member, who may not disclose the password to any other individual (except to authorized security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member may not permit any practitioner, resident, or other person to use his/her passwords to access SHC computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Medical Staff and/or the SHC Board of Directors regarding security measures, be a violation of state and federal law and may result in denial of payment under Medicare and MediCal.

Approvals:

Medical Executive Committee	3/7/0on, 4/7/10, 8/3/11, 7/2015. 12/2016, 12/2017, 6/2019
Board of Directors	3/14/07, 5/12/10, 11/14/12, 5/14/14. 7/2015, 12/2016, 12/2017, 6/2019, 3/21, 4/23