WashingtonRegional
Medical Center
Fayetteville, Arkansas

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WASHINGTON REGIONAL MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

The Executive Committee shall adopt such Rules and Regulations as may be necessary. These shall relate to the proper conduct of Medical Staff organizational activities, as well as embody the level of practice that is required of each Member.

The Rules and Regulations may be amended in accordance with the procedures set forth in Article XI of the Medical Staff Bylaws.

The Rules and Regulations shall be reviewed annually.

Capitalized terms contained in the Rules and Regulations will have the meaning ascribed to such capitalized terms in the Bylaws.

A. ADMISSION OF PATIENTS

1. A patient shall be admitted to Washington Regional only by a Member with privileges. An admitting note briefly summarizing the patient's condition on admission, the reason for hospitalization, and the treatment proposed shall be entered into the electronic health record by the attending Member at the time of admission.

2. Patients shall be attended by a Member as selected by the patient or, in the event of an emergency, in accordance with the policies of Washington Regional.

3. Hospice patients shall be seen within forty-eight (48) hours.

4. A Member shall be responsible for the medical care of each patient in Washington Regional, and for the prompt completion and accuracy of the medical record, for necessary instructions, and for communicating reports of the condition of the patient to the referring Physician. Whenever these responsibilities are transferred to another Member, an appropriate notation shall be entered in the medical record on the order sheet (or through the electronic order entry system).

5. Except in an emergency, no patient shall be admitted to Washington Regional until a provisional diagnosis or valid reason for admission has been slated. An emergency is defined as a condition in which the life of the patient is in immediate risk and in which any delay of administering treatment would increase that danger. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

6. Dental Members may admit patients to Washington Regional under the supervision of the Department of Surgery or one of its services. Such Members shall designate, upon admission, in the medical record, a Physician Member, having primary medical responsibility for the patient. All patients admitted by a Dentist shall have the same basic medical assessment as other patients. A Physician Member shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

7. Oral surgeons who admit patients without known medical problems may perform an admission history and physical examination and assess the medical risks of the procedure on the patient, if privileged to do so. Patients with medical problems admitted to Washington Regional by qualified oral surgeons shall receive the same basic medical assessment as patients admitted to other services.

8. The admitting Member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of risk from any cause.

9. A Member who will be out of town shall, on the order sheet (or through the electronic order entry system) of the chart of each of his patients, indicate in writing the name of the Member who will be assuming responsibility for the care of the patient during his absence. This responsibility may only be assumed by a Member and may not be delegated to a non-physician practitioner. Any Member assuming responsibility for the care of the patient from another Member must have equivalent Clinical Privileges in the same medical specialty or subspecialty as the Member arranging for substitute coverage. *See* Section 4.11.1.B, *Bylaws of the Medical Staff*.

10. ICU/CCU Admissions - Each patient admitted to a Critical Care Unit (e.g., ICU/CCU) between 0700 and 1700 Monday through Friday shall be seen by their attending physician or his designee within 8 hours of arrival on the Unit. Alternatively, the attending physician or his designee may, within this period, telephone the Unit nursing staff to provide clinically appropriate information concerning the patient's condition and care needs. At all other times and on hospital recognized holidays, the attending physician or his designee shall see his patient within two (2) hours of the patient's admission to the Unit or, alternatively, have adequate telephone contact with the Unit nursing staff to supply clinically appropriate information concerning the patient's condition and care needs. Patients admitted overnight must be seen by the admitting physician or their designee no later than 1000 the following day.

The first instance of a failure by a physician to follow the requirements of this rule shall be reported to the Chief of Staff to be addressed in accordance with the Medical Staff Conduct Policy. Subsequent violations that occur in the same rolling calendar year as the initial violation shall be reported to the Chief of Staff to be addressed in accordance with the Medical Staff Conduct Policy and to the Medical Staff Peer Review Committee to be addressed in accordance with the Medical Staff Peer Review Policy.

11. Physician/Nurse Communication on Patients in Critical Care – When information is needed from a physician with a patient in the Critical Care Unit, the nurse shall page the appropriate physician on call through the operator. The physician should return the page to ICU/ CCU within 10 minutes. If the call is not returned within
10 minutes, the nurse should page the physician again through the operator. If the second call is not returned within 10 minutes, the nurse will request that the operator call the physician's home or personal phone. If the physician cannot be reached by home or personal phone, the nurse will immediately request that the operator page the physician's partner. If the nurse is unsuccessful in reaching the physician's partner in 10 minutes, the nurse should page the Chief Medical Officer, who will invoke the Medical Staff Rule on Emergency Care.

The first instance of a failure by a physician to follow the requirements of this rule shall be reported to the Critical Care Medical Director. The Medical Director will send the physician a letter reminding him of the rule. Subsequent violations that occur within the same rolling calendar year of the first violation shall be reported to the Chief of Staff to be addressed in accordance with the Medical Staff Conduct Policy and to the Medical Staff Peer Review Committee to be addressed in accordance with the Medical Staff Peer Review Policy.

B. MEDICAL ORDERS

1. All orders for treatment shall be in writing and must be legible, complete, dated, timed entered through the Washington Regional Electronic Medical Record and authenticated by the authorized practitioner. Authentication means to establish authorship by means of written signature, initials, computer key, or other code. Orders that are unclear or improperly constructed will not be authorized or followed until the defect is corrected.

2. Verbal Orders

A. Verbal orders shall be accepted only by a licensed professional. The following personnel are qualified and authorized to accept and transcribe verbal orders: Licensed Independent Practitioners, Advanced Practice Professionals, registered nurses, respiratory therapists, dieticians, physical therapists, licensed practical nurses, occupational nurses, speech therapists, laboratory technologists, and radiology technologists. A verbal medication order may only be given to licensed nurses and pharmacists.

B. Upon receipt of a verbal order, the receiving professional shall transcribe the content of the order, the identity of the practitioner issuing the verbal order, and date, time and sign the order via Computer Provider Order Entry. The transcribing professional shall then read back the order to the ordering practitioner for verification and acceptance.

C. The authorized practitioner shall electronically sign the verbal order within forty-eight (48) hours of issuance. Members covering for an attending Member are authorized to authenticate any unsigned verbal order issued by the attending Member.

3. Do not resuscitate (DNR) orders (see Medical Staff DNR policy) shall be entered via Computer Provider Order Entry by a responsible Member. The order shall indicate the day and time when the order is given. A faxed, signed DNR order by a member is acceptable. Dictated, including telephone, DNR orders are acceptable, but must be witnessed by two (2) licensed nurses and signed by the Member within twenty-four (24) hours after being given.

4. Whenever the attending Member cannot be contacted, the Chief of Staff, Chief Medical Officer or their designee, the supervising nurse or any member of the nursing staff in the absence of the supervising nurse shall have the authority to call the appropriate Department Chairman for emergency orders.

5. The Organized Medical Staff of Washington Regional Medical Center utilizes Computer Provider Order Entry for all order submission.

6. The following may only be issued by a Member:

- History of present illness and initial physical exam (H&P Exam)

- Admission orders
- Consultation orders
- Medical Administration Record (MAR) Reconciliation Orders
- Autopsy orders
- Discharge orders
- Do-not-resuscitate (DNR) orders or orders withdrawing life-sustaining treatment

7. Standing Orders, Order Sets and Protocols. Standing orders, order sets and protocols may be developed and implemented for use in WRMC through the collaborative input of the organized Medical Staff and WRMC clinical administrative leadership for hospital-wide use or by an individual Member or group of Members.

A. All standing orders, order sets or protocols for patient orders must be developed and approved through the committees of the organized medical staff, which shall require approval from each of the relevant Services, Departments and Medical Executive Committee, and WRMC administrative leadership, which shall require approval from nursing and pharmacy leadership. Modifications or amendments to standing orders, order sets and protocols shall follow the same process.

B. All standing orders, order sets and protocols shall be established in accordance with nationally recognized and evidenced-based clinical guidelines.

C. All standing orders, order sets and protocols approved for use in WRMC shall be reviewed no less than annually by the leadership of the organized Medical Staff and WRMC administrative leadership to ensure the continued usefulness, safety and appropriateness of the orders, order sets and protocols in light of changes in nationally recognized and evidence-based clinical guidelines. Such review shall also determine whether there have been any preventable adverse patient events resulting from the use of the standing order, order set or protocol, and if so, whether modifications would reduce the likelihood of future similar adverse events.

D. All standing orders, order sets or protocols when utilized shall be dated, timed and authenticated in the electronic health record at the time of initiation, or as soon as practical thereafter, by the ordering practitioner or another practitioner responsible for the care of the patient.

E. Another practitioner who is responsible for the care of the patient may date, time and authenticate a standing order, order set or protocol in lieu of the ordering

practitioner so long as the other practitioner is authorized by Arkansas law to do so and such act is consistent with the practitioner's applicable licensure, scope-of-practice, hospital policies and the requirements of the Medical Staff Bylaws, Rules and Regulations.

F. When specific orders are not written by the attending Member, a standing order, order set and/or protocol shall constitute the orders for treatment. A standing order, order set or protocol may be suspended by the direct order of the attending Member when in his or her professional judgment the care of the patient would be best served.

G. Standing orders, order sets or protocols may not be developed or approved where they are specifically prohibited by law, e.g. standing orders for restraint or seclusion, or where governmental or third party payors refuse payment for services provided through standing orders, order sets or protocols.

8. Orders from non-WRMC Medical or Allied Health Staff Practitioners.

A. Orders from non-staff practitioners for outpatient diagnostic or therapeutic services will be recognized by Hospital and Medical Staff, subject to this Rule B.8. For purposes of this Section B.8., a "non-staff practitioner" shall be defined as a physician, podiatrist, chiropractor, advanced practice registered nurse or physician assistant with the scope of any license, certificate or other legal credential authorizing practice within the State of Arkansas and pursuant to which the practitioner is entitled to order outpatient diagnostic or therapeutic services of the type requested and permitted under this Rule B.8.

B. Diagnostic and therapeutic reports will be forwarded to the ordering practitioner to interpret the results of the tests, treatments, or procedures and for purposes of informing the patient, as appropriate.

C. Notwithstanding any provision of the Bylaws or these Rules and Regulations to the contrary, verbal telephone orders for outpatient radiology, laboratory or other services shall be performed only after receipt of the non-staff practitioner's written order.

D. Scope of Outpatient Diagnostic Tests and Therapeutic Services Non-staff Practitioners May Order

i. Physicians who have a valid medical license in the state in which they reside will be allowed to order outpatient diagnostic radiology, laboratory, electrodiagnostic, pulmonary function, physical rehabilitative services, and other diagnostic studies. A physician,

or his/her physician designee, must be available to receive abnormal diagnostic test results 24 hours a day. If the physician violates this requirement two times, their permission to order outpatient tests at WRMC may be revoked.

ii. Licensed chiropractors and podiatrists will be allowed to order outpatient diagnostic radiological imaging tests.

iii. Advanced Practice Registered Nurses and Physician Assistants: Nurse Practitioners (APRNs)/Physician Assistants (PAs) may order non-invasive outpatient tests, outpatient rehabilitation and patient education independent of a collaborative physician signature when the following criteria are met:

a. The APRN has a valid Arkansas advanced practice registered nursing license and an established protocol on file with the Arkansas State Board of Nursing, and is practicing within that protocol and within the scope set forth by the American Academy of Nurse Practitioners.

b. The PA has a valid Arkansas Medical License and an established protocol on file with the Arkansas State Medical Board and is practicing within said protocol.

c. The outpatient tests are limited to outpatient diagnostic lab work, outpatient electrodiagnostic studies, outpatient diagnostic radiology, and outpatient rehabilitation.

d. The Advanced Registered Nurse Practitioner or Physician Assistant must be available to receive critical diagnostic test results 24 hours a day. If the APRN or PA violates this requirement two times, their permission to order outpatient tests at WRMC may be revoked.

E. It shall be the responsibility of the outpatient/ancillary department to ensure that a process is in place to: verify the non-staff practitioner's state licensure, obtain appropriate authentication of all orders issued by the non-staff practitioner before carrying those orders out, and to confirm the non-staff practitioner is not listed on the U.S. Department of Health and Human Services, Office of Inspector General sanctions website. The ordering non-staff practitioner must provide contact information where he or she can be reached when the service is provided.

C. GENERAL CONDUCT OF CARE

1. Any conflict between a patient and his Member regarding care should be resolved by the two parties. If an agreement cannot be reached, and either one or both parties wish to terminate the Member-patient relationship, two options are available.

A. If the Member feels that he cannot ethically or professionally abide by the patient's wishes regarding the desired treatment/care plan, the Member shall remove himself from the case, but only after securing the services of another Member acceptable to the patient and one who has the medical expertise which proper care of the patient requires.

B. If the patient feels that his interest would be better served with a different member, the patient should so inform the attending Member. In such case, it is the responsibility of the patient to select another Physician. Although not obligated to do so, the Member should assist the patient to select another Member. The attending Member must retain responsibility for the patient until another Member assumes responsibility for the care of the patient.

2. No surgical or invasive procedure and no treatment that may present risk to the patient shall be performed without both of the following documented in the medical record:

A. The "informed consent" of a patient or legally authorized representative. It shall be the responsibility of the Member performing the procedure or his or her medical associates or other licensed and appropriate health care professionals under his or her direction to (1) inform the patient of the proposed surgery/procedure so that patient may make an informed decision, and (2) obtain written consent from the patient or their legally authorized representative evidencing their consent to the proposed surgery/procedure. A properly executed informed consent shall include at least the following:

i. Identify WRMC as the hospital where the surgical or invasive procedure is to take place.

ii. The name of the specific surgical or invasive procedure, or other type of medical treatment for which consent is being given.

iii. The name of the practitioner who is performing the surgery or procedure, or administering the medical treatment.

iv. A statement that the procedure or treatment, including the anticipated benefits, material risks and alternative therapies, was explained to the patient or their legal representative.

v. An explanation of the possible consequences of refusing the proposed treatment or procedure.

vi. The date and time the informed consent is signed by the patient or the patient's legal representative and at least one witness.

B. The patient's or their legally authorized representative's written consent to treatment on an approved WRMC consent form to be completed at the time of admission.

3. Informed consent should be in writing, signed by the patient or his authorized representative, and at least one witness. The consent shall be placed in the patient's medical record before surgery, except in emergencies. If a patient is to receive preoperative medication, the patient must sign the consent form prior to administration of the preoperative medication. The responsibility for obtaining the patient's signature on the consent form may be delegated by the Member to a member of the Allied Health Staff provided there is documentation in the medical record that the Member has obtained informed consent.

4. Informed consent will be obtained for the following anesthetics, surgeries, and invasive procedures:

A. Any procedure requiring the administration of general, spinal, regional, or local anesthesia or IV sedation, regardless of whether an entry to the body is involved.

B. Any major or minor surgery which involves an entry into the body either through an incision or one of the natural body openings;

C. Any diagnostic or therapeutic procedures which is invasive, risky, controversial and/or experimental. These procedures include but are not limited to:

- Amniocentesis
- Thoracentesis
- Paracentesis
- Circumcision
- Cystoscopy
- Arteriogram
- Myelogram
- Endoscopy
- Upper GI Endoscopy
- Colonoscopy
- Lumbar Puncture

- Biopsy (all types)
- Flexible Sigmoidoscopy
- Thoracotomy
- Bone marrow aspiration
- Moderate sedation
- Transfusion of Blood Products

5. Procedures performed in the Emergency Department in the course of urgent or emergent care are covered by the WRMC consent for treatment form and do not require a separate consent for surgery to be completed.

6. No experimental procedures or treatments shall be performed on WRMC patients without a research protocol and associated written informed consent forms having first been approved by the WRMC Institutional Review Board ("IRB") in accordance with IRB Standards of Operation.

7. Emergency Consent. In the event that a patient, due to his or her medical or mental condition, is unable to give consent for a necessary treatment or a surgical procedure, and there is no legal representative or surrogate decision maker immediately available to give consent, treatment may be undertaken when, in competent medical judgment, it is immediately or imminently necessary and any delay occasioned by an attempt to obtain consent would reasonably be expected to jeopardize the life, health, or safety of the patient or would reasonably be expected to result in disfigurement or impaired faculties. These circumstances should be fully documented in the patient's medical record.

8. Any procedure under investigation through a root cause analysis process is subject to a moratorium pending completion of the investigation. Violation by a Member of a moratorium authorized by a root cause analysis is grounds for immediate suspension from the Medical Staff.

9. A moratorium on any procedure, whether under investigation or not, may be placed by the Administrator upon consultation with the Chief of Staff.

10. Delegation of Practitioner Responsibilities. In order to ensure quality health care for all patients, certain responsibilities must be performed by a physician and are not to be delegated to non-physicians. These responsibilities are as follows:

a. Admission of patients to the Hospital.
b. A physician must obtain and review the history of the present illness and perform the initial physical examination or review and countersign if performed by an Advanced Registered Nurse Practitioner or Physician Assistant.
c. Completion of operative reports.

d. Completion of discharge summary.
e. Discharge of patients from the Hospital.

D. CONSULTATIONS

1. Members may only obtain a consultation from another Member who possesses the requisite Clinical Privileges to admit, treat, or manage a patient whose needs exceed the responsible Member's Clinical Privileges.

2. Consultations must be ordered in writing by the attending Member. An appropriate consultative request must include the name of the Member consulted and the reason for the consultation. The ordering Member is responsible for initiating contact for consultation. All requests for consults should be communicated physician to physician. Acceptable methods of communication include, but are not limited to, texting, email within the electronic health record inbox system, and use of the electronic health record "reason for consult' option. Where direct physician to physician communication is not possible, an intermediary may be used to request a consultation, provided adequate information is given to the consultant by the intermediary. All requests for consultations must include a sufficient clinical detail to support a request for consultation.

3. A consultant must be qualified to give an opinion in the field in which his or her opinion is sought. The qualifications of a consultant are determined by the Medical Staff on the basis of training, experience, competence, and Clinical Privileges.

4. A satisfactory consultation includes examination of the patient and the medical record. A dictated or electronically generated opinion, signed by the consulting Member, must be included in the medical record. When operative procedures are involved, the consultation note shall be recorded prior to the operation. Allied Health Providers may only assist a Member in the performance of a requested consultation by gathering data and ordering and performing diagnostic tests, consistent with their licensure, scope of practice and Practice Authorization. Allied Health Professionals may not perform a consultation independent of their sponsoring Member.

E. DISCHARGE OF PATIENTS

1. Patients shall be discharged only on a written order of the attending Member.

2. Any patient leaving Washington Regional without the consent of the attending Member shall be requested to sign a statement that he is voluntarily leaving Washington Regional against the advice of the Member and that in so doing, he absolves the Member and Washington Regional from any and all responsibilities resulting from his being discharged against medical advice.

3. It shall be the responsibility of the attending Member to discharge patients as early on the day of discharge as possible.

4. At the time of discharge, the attending Member shall see that the patient's medical record is satisfactorily completed and record: the principal diagnosis, all secondary diagnoses, and any procedure performed, the prognosis, any significant findings or events, the advisable subsequent care, and the name of the Member, if any, to whom the patient is directed for further care.

5. The principal (final) diagnosis is defined as the condition, which after study, occasioned admission to Washington Regional.

6. In the event of the death of a patient at Washington Regional, the decedent shall be pronounced dead by a Member or an authorized practitioner. This should be done within a reasonable time. The body shall not be released from Washington Regional until an entry, including date, time, and cause of death, has been made and signed by a Member or an authorized practitioner in the medical record of the decedent.

F. CRITERIA FOR PERFORMANCE OF AUTOPSIES

1. Every Member shall attempt to secure an autopsy in all deaths that meet the criteria adopted by the Medical Staff. The attending Member shall be notified when an autopsy is being performed. Members shall follow criteria listed below when considering autopsies:

A. Deaths in which autopsy may held to explain unknown and unanticipated death;
B. Intraoperative or intraprocedural death;
C. Death occurring within 48 hours after surgery or an invasive diagnostic procedure;
D. Death incident to pregnancy or within seven (7) days following delivery;
E. Death where the cause is sufficiently obscure; and
F. Deaths of medical-legal and educational interest.

2. No autopsy shall be performed without written consent obtained from a legally authorized representative of the decedent or unless required by law.

A. A patient may consent to an autopsy prior to their death if they do so through a writing that is signed and acknowledged prior to death;

B. Consent for performance of an autopsy may be provided by whichever of the following individuals assumes custody of the body for purposes of burial:

- Father
- Mother
- Husband
- Wife
- Child
- Guardian
- Next of kin
- In absence of any of the above, a friend or person charged by law with the responsibility for burial

C. The signed consent shall be documented in the decedent's medical record before the autopsy is performed.

3. When an autopsy is performed a provisional anatomic diagnosis shall be recorded in the medical record within seventy-two (72) hours after completion of the procedure, and the complete protocol must be made part of the record within sixty (60) days after completion of the procedure.

G. MEDICAL RECORDS

1. History and Physical Examinations

A. A complete history and physical examination appropriate to the patient's condition shall be completed, authenticated and recorded by the attending Member no more than thirty (30) days before and within twenty-four (24) hours after a patient's admission for inpatient, outpatient or observation care or ***prior*** to surgery or a procedure requiring moderate sedation or anesthesia services.

B. The history and physical examination shall be comprehensive and include:

1. identification data;
2. chief complaint/reason for admission;
3. details of present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status;
4. relevant past medical and surgical, social, and family histories appropriate to the age of the patient;
5. inventory of body systems;
6. current physical examination;
7. allergies/medications/dosage/reactions;
8. when clinically relevant to the care of children and adolescents, an evaluation of the patient's developmental age, consideration of educational needs, and daily activities, as appropriate; immunization status; and the family or guardian's expectation for, and involvement in, the care of the child; and
9. provisional diagnoses and plan of care.

C. A comprehensive and legible original or copy of a medical history and physical obtained in a physician's office completed within thirty (30) days prior to date of admission is acceptable if the patient's clinical status information is updated by the attending Member within twenty-four (24) hours after admission or ***prior*** to a surgery or procedure requiring moderate sedation or anesthesia if occurring within twenty-four (24) hours. The update must include any changes in condition, the acute reasons for admission and details of the acute condition. If upon examination, the attending Member finds no change in the patient's condition since the history and physical was completed, he may indicate in the patient's medical record that the history and physical was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition in the period since the history and physical was performed.

D. In an emergency situation, the attending Member must conduct at least an abbreviated physical examination regarding the condition of the patient prior to the start of the procedure and include a brief description of why the surgery is necessary. A complete history and physical examination is then to be recorded

immediately following the emergency procedure.

E. A history and physical that is more than thirty (30) days old will not be accepted. Except in extreme emergencies, no patient will undergo surgery without a complete and authenticated history and physical documented within the medical record.

2. Medication Administration Report Reconciliation. Medication administration report reconciliation may only be performed by a Member utilizing the electronic medication reconciliation process of the electronic health record. Medication administration reconciliation shall be performed at the time of admission, discharge, and all transfers of level of care during the hospital stay. Reconciliation utilizing a written process will be allowed only when the electronic process is unavailable.

3. Progress Notes. Pertinent progress notes shall be recorded into the electronic health record at the time of observation, sufficient to permit continuity and transferability of care. Progress notes should be dated and timed. If possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. The authorized practitioner shall record progress notes at intervals appropriate to the case, so as to accurately reflect the patient's course of treatment at Washington Regional, but at a minimum, shall be recorded daily on all patients. Written progress notes shall be acceptable only when the electronic method is unavailable.

4. Operative Notes. A detailed and complete operative report shall be completed immediately following surgery by the attending Member. The report shall include at a minimum: Patient name and hospital identification number, date and time the procedure commenced and ended, the primary surgeon and any assistants or other practitioners who performed surgical tasks, estimated blood loss, name of the surgical procedure performed, findings of the procedure, details of the surgical procedure/technique, any specimens removed, the pre and post-operative diagnosis, type of anesthesia administered, complications, if any, and any prosthetics, grafts, tissue, devices or transplants implanted or explanted. The report shall be fully entered or dictated immediately following the surgical procedure. When the report is dictated, an electronic progress note shall be immediately entered into the electronic health record, before the patient is transferred to the next level of care, describing the operation, significant findings, and condition of the patient post-surgery for continuity of care pending receipt of the formal, transcribed report. The complete operative report shall be entered on the medical record and authenticated by the surgeon within seventy-two (72) hours.

5. Anesthesia Report. A report of pre-anesthetic assessment, reassessment, intraoperative anesthetic management, and post-anesthesia care shall be entered into the electronic medical record by an authorized provider. The anesthesia report shall include written documentation of anesthesia services provided including the following:

A. a pre-anesthesia evaluation shall be completed and documented within 48 hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services and shall include a review of patient symptoms, social history, previous anesthesia experience and medication history, allergies, physical assessment, any potential anesthesia problems or risks relating to anesthesia (e.g., ASA classification of risk), the modality of anesthesia planned, and evidence that informed consent for the anesthetic plan has been acknowledged by the patient;

B. a review of the patient's condition immediately prior to induction of anesthesia, and documentation of the actual operating room time (day of surgery and exact arrival and departure times);

C. a record of all events taking place during induction of, maintenance of and emergence from anesthesia, the name of the authorized practitioner who administered the anesthesia, including as applicable the supervising anesthesiologist, the name, dosage, route and time of administration of medications and anesthetic agents, techniques utilized and patient position(s), including the insertion/use of any intravascular or airway devices, the name and amounts of IV fluids, including blood or blood products, if applicable, time-based documentation of patient vital signs, and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered and patient responses to treatment;

D. an immediate post-anesthesia assessment of the patient's condition, continuum of care, and condition prior to discharge, including;

E. a summary of post-anesthetic condition, including the presence or absence of anesthesia related complications, if any, documentation of actual recovery time and notation as to whether or not the patient was able to participate in the post-anesthesia evaluation, shall be documented in the electronic medical record prior to the patient's discharge, but in no event more than forty-eight (48) hours after surgery.

F. Moderate sedation does not qualify as "anesthesia" for purposes of this Rule G.5, and therefore, the requirements of this Rule G.5 do not apply to the evaluation and management of patients undergoing moderate sedation.

6. Clinical Entries

A. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated by written signature or identifiable initials, except that the initial admission order must bear the signature of the Member. Medical and house staff, as well as nurses, dieticians, and professional personnel from areas of respiratory therapy, physical therapy, social services, occupational therapy, infection control, radiology, pharmacy, and hemodialysis are authorized to make appropriate medical record entries.

B. Medical record entries by House Staff and authorized APRNs and PAs that require co-signature of the appropriate Member include: the admission note and/or history and physical, any consultation performed, operative reports, and the discharge summary. Members shall be in compliance with ***CMS Documentation Guidelines for Teaching Physicians*** including but not limited to elements of an E/M service documented by a medical student that can be referenced, appropriate use of macros, and teaching physician attestation statements included with resident notes.

C. AHPs who are not otherwise authorized to issue orders in accordance with these Rules, their licensure, or practice authorization, may make entries into the patient record as allowed by their category, practice authorization, and licensure. All entries into the medical record shall be authenticated within 48 hours by the sponsoring Member, or authorized practitioner (which shall mean an APRN or PA, consistent with their respective licensure, scope of practice and Practice Authorization).

7. Authentication; Abbreviations

A. All entries in the medical record shall be legible and in black or blue ink. Pencil entries are not permitted. Entries are to be accurately timed, dated and authenticated. The acceptable methods of authentication include:

i. The practitioner's written signature or identifiable initials.

ii. Electronic authentication, provided the practitioner uses a unique password; the practitioner whose signature the electronic password represents is the only individual who has possession of or knows the password; and the practitioner has provided the Health Information Services Department of WRMC with a signed statement to the effect that he or she is the only one who has possession of, knows of, and will use this password. Under no circumstance is it permissible for a practitioner to share his or her EMR password or allow another individual to log in or document care using the practitioner's own ID and password; doing so shall constitute grounds for disciplinary action.

iii. The use of a signature stamp is prohibited.

B . Symbols and abbreviations may be used on the medical record only when they have been approved by the Medical Executive Committee. An official record of approved abbreviations and a DO NOT USE list of abbreviations is kept on file in the Health Information Services Department and the Medical Staff Office.

C. Members of a medical practice group, i.e., partnership, professional association, limited liability company, or similar organization, are authorized to sign all necessary signatures of the medical chart in the absence of another Member of the group.

8. Diagnostic Reports

A. All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the CPOE System. Reports of diagnostic imaging, electrophysiological examinations, and procedural examinations shall be dictated within twenty-four (24) hours after completion of the procedure.

B. In situations in which there may be a delay between the time of the performance of any examination and the availability of results of the examination to any clinician, the interpreting physician shall make an entry of the results into the progress notes of the patient's medical record or notify the physician of record, so as to maintain continuity of patient care.

C. A report for all outpatient examinations (radiologic, cardiologic, neurologic, sleep laboratory, and others) shall be completed within twenty-four (24) hours of completion of the examination and the record shall be signed within seventy-two (72) hours.

D. The departments of radiology and cardiology shall monitor the completion of those requirements on a daily basis and report the status of outpatient medical records to all Members performing such examinations.

9. Discharge Summary. All patient medical records must contain a discharge summary, whether the patient is an inpatient, outpatient or observation status patient. The discharge summary shall recapitulate the significant findings and events of the patient's hospitalization, the final diagnosis, disposition of the patient, and provisions for follow-up care. The discharge summary shall be authenticated, dated and timed as to entry within the electronic health record by the responsible Member no later than thirty days from the date on which the patient is discharged.

10. All medical records shall be complete and contain all required signed documentation (including physician reports) no later than thirty (30) days from the date on which the patient is discharged. A medical record shall not be permanently filed until it is completed

by the responsible Member or is ordered filed incomplete.

11. Confidentiality

A. The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is permissible when access is sought for patient care, payment, risk management, peer review, approved research, or other authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored. In addition, WRMC safeguards patients' records against unauthorized disclosure and/or use, loss, defacement or tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records shall be grounds for disciplinary action. Sharing or misuse of passwords to the electronic health record or CPOE system is prohibited. Free access to all medical records shall be afforded Members in good standing for study and research, consistent with preservation of the confidentiality of personal information concerning individual patients.

B. All medical records are the property of Washington Regional, and no medical records shall be removed from the premises, except as required by law. Unauthorized removal of any medical records from Washington Regional is grounds for disciplinary action, as determined by the Medical Executive Committee.

C. Except as otherwise required or permitted under applicable law, written consent of the patient is required for release of a patient's protected health information.

D. Subject to applicable law and the discretion of the Administrator and the Chief of Staff, former Members shall be permitted free access to information from medical records of their patients, covering all periods during which they attended such patients.

12. Resignations from the Medical Staff will not be accepted as being in good standing if the Member has incomplete medical records. Incomplete medical records will be referred to the Medical Executive Committee.

H. DELINQUENT MEDICAL RECORDS

1. **DEFINITIONS**

Complete Medical Record
Federal and Arkansas law require that medical records be complete and contain all required signed documentation (including physician reports) no later than thirty (30) days from the date on which the patient is discharged.

Delinquent Medical Record
A delinquent Medical Record is defined as any medical record that does not meet the definition of a Complete Medical Record.

"Delinquent Record Notice"
The HIS Department sends a "Delinquent Record Notice" each Wednesday to those Members who have Delinquent Medical Records. The Delinquent Record Notice informs the Member as to which medical records are incomplete and that the Member's admitting and/or consulting privileges will be suspended if the record is not completed within ten (10) days of the date of the notice or unless the Member demonstrates good cause to the Chairman of the Medical Record Committee as to why the record cannot be completed within that time.

2. Where a Member fails to record a Complete Medical Record within the electronic health record, and the Member has been sent a Delinquent Record Notice from the HIS Department, the Member's admitting and/or consulting privileges shall be administratively suspended until such time as the Member takes the necessary action to complete each Delinquent Medical Record identified in the Delinquent Record Notice. Notice of the administrative suspension shall be delivered to the Member by certified mail or personal delivery and shall state that the Member's admitting and/or consulting privileges are suspended until such time as the Member takes the necessary action to complete each Delinquent Medical Record identified in the Delinquent Record Notice.

3. The Member may continue to treat patients who were admitted to the hospital before the effective date of the administrative suspension of the Member's admitting and/or consulting privileges. Upon subsequent completion of all Delinquent Medical Records identified in the Delinquent Record Notice, the Member's admitting and/or consulting privileges shall be automatically reinstated.

4. A Member who has received a Delinquent Record Notice on three (3) successive Wednesdays or who has received a Delinquent Record Notice on more than five (5) but less than eight (8) Wednesdays in any rolling thirteen calendar week period, shall receive a letter from the Chairman of the Medical Records

Committee, which letter shall be personally delivered or sent by certified mail, notifying the Member of their failure to comply with this Rule and that the practitioner is expected, without delay, to take actions to rectify the noncompliance.

5. A Member who has received a Delinquent Record Notice on more than eight (8) but less than twelve (12) Wednesdays in any rolling twelve (12) calendar month period shall receive a letter from the Chairman of the Medical Records Committee directing that they appear at the next scheduled meeting of the Medical Records Committee to present a corrective action plan that defines how he/she will meet the requirements of this Rule.

6. A Member who has received a Delinquent Record Notice on more than twelve (12) Wednesdays in any rolling twelve (12) calendar month period shall receive a letter from the Chairman of the Medical Records Committee notifying the Member of the immediate administrative suspension of their admitting and/or consulting privileges, which will remain in effect until the practitioner completes all Delinquent Medical Records, appears before the next regularly called meeting of the Medical Records Committee, and receives a corrective action plan developed by the Medical Records Committee to assure future compliance with this Rule. Notice of the administrative suspension shall be delivered to the Member by certified mail or personal delivery and shall state that the Member's admitting and/or consulting privileges are suspended until such time as the Member takes the necessary action to complete each Delinquent Medical Record identified in the Delinquent Record Notice, meets with the Medical Records Committee, and receives a corrective action plan developed by the Medical Records Committee. The Member may continue to treat patients who were admitted to the hospital before the effective date of the administrative suspension of the Member's admitting and/or consulting privileges.

7. Members should notify the Chairman of the Medical Records Committee, or designee, to relay any justifiable reason for failure to timely complete medical records in accordance with the time frames established in this Rule. Justifiable reasons include, without limitation, the illness of the Member or unavailability of the Member prior to the administrative suspension date.

8. Outpatient medical record delinquencies shall be summarized weekly, as part of the routine Medical Staff medical records completion requirements and reported as delinquencies in accordance with this Rule H.

I. EMERGENCY CARE

1. The responsibility for providing emergency care within Washington Regional rests with the Medical Staff. Because this responsibility cannot be delegated, every active and provisional active Member shall serve according to the published call schedule and be available for emergency room and for inpatient emergencies. This obligation shall not be lessened when Member coverage in the emergency room is provided by staff emergency room Physicians. Any changes necessitated in the published call rosters, initiated by a Member during normal working hours (8:30A.M – 4:30 P.M., Monday through Friday), shall be reported to the medical staff secretary, who will notify the director of clinical services, the PBX operator on duty, and the emergency room charge nurse. Any changes initiated after normal working hours or on holidays shall be reported by the Member to the PBX operator on duty and the emergency room charge nurse. Any Member making such a change in the call roster is responsible for ensuring the availability of a substitute Member.

2. Any individual who comes to the Emergency Department and requests treatment or examination for a medical condition, or has such a request made on their behalf, shall receive an appropriate medical screening examination performed by a "Qualified Medical Person". The term "Qualified Medical Person" shall be defined as physicians, advanced registered nurse practitioners, physician assistants, Sexual Abuse Nurse Examiners, and obstetric registered nurses.

A. Where an individual presents to the Emergency Department and requests examination or treatment for an alleged sexual assault, or has such a request made on their behalf, a certified Sexual Abuse Nurse Examiner or physician shall perform the medical screening examination.

B. Where a pregnant woman presents to the Emergency Department and requests examination or treatment of symptoms related to labor, or has such a request made on their behalf, an Obstetric Registered Nurse or physician shall perform the medical screening examination.

C. Where an individual presents to the Emergency Department and requests examination or treatment for a medical condition, or has such a request made on their behalf, and where the individual has been assigned to level 4 or level 5 of the Emergency Severity Index after triage, an advanced practice registered nurse, physician assistant or physician shall perform the medical screening examination.

Notwithstanding the foregoing, practitioners identified in the above-listed categories are not authorized to provide a medical screening examination on a patient if such a screening would require the practitioner to perform a procedure, assessment, diagnostic test or other task that is not within the scope of their licensure, certification or scope of practice as established under Arkansas law, or Practice Authorization or Clinical Privileges.

D. In all other cases where an individual presents to the Emergency Department requesting examination or treatment for a medical condition, or has such a request made on their behalf, only a physician shall perform the medical screening examination.

E. If the Qualified Medical Person performing a medical screening examination determines that a physician's presence is necessary, the physician will evaluate the patient in the Emergency Department or obtain the presence of an appropriately credentialed physician to evaluate the patient.

F. A Qualified Medical Person may not discharge a patient from Washington Regional until he or she has:

1. performed a medical screening examination;
2. documented the medical screening examination, interventions, orders, disposition of the patient, and discharge instructions/care plan; and
3. documented and provided the patient with discharge instructions, including any applicable follow-up plan of care.

3. If, in the course of performing a medical screening examination, the emergency physician determines that the appropriate uniform screening information requires a specialist's review and opinion, the emergency physician shall notify the appropriate specialist on call, who shall be physically present in the emergency department within thirty (30) minutes of notification. If the patient/family has a preference to consult a different Member, an attempt shall be made to determine whether the physician is available. Unless a Member is on call, responding to the request is voluntary.

A. Members on-call shall adhere to the thirty (30) minutes time requirement, under normal transportation conditions.

B. If the scheduled on-call Member cannot be reached within ten (10) minutes of a first attempt to contact him, a second attempt shall be made. If the on-call Member cannot be reached after the second attempt (and within twenty (20) minutes of the first attempt), is unavailable, or declines to provide on-site care or consultation, the emergency physician shall: a) attempt to enlist another Member specialist to provide care; and b) contact the Department Chairman. The Department Chairman shall assume care for the patient (if same has not been arranged) or assign another Member in the Department to do so. If such other physician is unavailable, then the emergency physician shall assure that the patient is appropriately transferred to another facility for treatment. There shall be documentation in the medical record concerning the reason an on-call Member does not appear (e.g., refusal, unavailability.)

C. If there is no Member on call who has the requisite privileges to treat and stabilize the individual who has an emergency medical condition, and no other qualified physician is willing to treat and stabilize the individual, the emergency physician shall make the arrangements for transfer to the appropriate specialists, pursuant to the hospital's policy "Stabilization and Transfer of Patients with an Emergency Medical Condition." The individual and family shall be involved as much as possible in choosing the location of the referral.

D. Once the patient is determined not to have an emergency medical condition, if the individual requires outpatient follow-up care, the emergency physician, advanced practice registered nurse, or physician assistant assist the patient in attempting to identify and make arrangements with an appropriate physician or other provider for follow-up care. The individual/family shall be involved in the choice of physician, to the extent possible.

E. Washington Regional recognizes that it is often necessary for specialists to provide patient care at more than one area hospital. Members who serve on more than one published call schedule shall be available within the aforementioned time requirements for the emergency room and for inpatient emergencies at Washington Regional.

i. In the event a Member on call is unavailable within the defined time because of a co-existing emergency at Washington Regional or because he is detained by an emergency at another facility where he is also on call, the attending emergency physician shall determine:

    a. the time of any potential delay; and
    b. whether the delay endangers the safety of the patient.

ii. Based on assessment of the above, the emergency physician shall determine:

    a. whether the patient can be stabilized during such delay;
    b. whether the patient can be managed by another specialty;
    c. whether the patient should be transferred to the hospital where the on-call member is on site or to another hospital with appropriate specialty coverage, because the benefits of such transfer exceed the risks. Such benefits and risks shall be noted with particularity in the medical record by the emergency physician. The transfer shall be accomplished incompliance with EMTALA requirements; or
    d. in order to expedite transfer in such situations, the director of the emergency department shall enter into transfer agreements with other hospitals with appropriate specialty coverage for use when necessary and medically indicated in the judgment of the emergency physician. Transfer agreements must be approved by the Administrator of Washington Regional.

4. The emergency physician may recommend hospital admission for patients evaluated in the Emergency Department. If the attending Member or designee agrees, the emergency physician may write initial admission orders and an admission note, specifying the reason for admission, along with pertinent history and physical findings. The emergency physician's responsibility ends with admission note and orders.

5. An active Member who is sixty (60) years of age or older, and who has taken emergency room call for twenty (20) years or more at Washington Regional, or who has reached the age of sixty-five (65), regardless of years of service, may request of his Department that he be relieved of the duty of emergency call. The department's recommendation will be forwarded to the Executive Committee, whose decision will be final.

6. POLICY # WRMS-1.09 EMTALA (Emergency Medical and Active Labor Act) is incorporated within and made a part of this Rule I ("Emergency Care") and should be consulted for additional details concerning emergency care responsibilities at WRMC.

J. POLICIES

1. Regulatory and Accreditation bodies (CMS, The Joint Commission, Arkansas State Board of Health) require the hospital to develop and implement policies to ensure compliance with those regulations and accreditation standards.

    a. Examples include, but are not limited to, policies relating to: sentinel events, use of restraints, and pain management. The Medical Staff's role in such regulations and policies is to:

        i. Acknowledge the necessity for and participate in the development and implementation of necessary policies;
        ii. Approve necessary policies through the organized Medical Staff structure;
        iii. Educate the Medical Staff with regard to such regulations and policies;
        iv. Ensure compliance with such regulations and policies; and
        v. Periodically review existing policies and develop amendments thereto as appropriate.

2. Medical Staff Policies
    a. Medical Staff Conduct Policy
    b. Medical Staff Impaired Member Policy
    c. Medical Staff Sexual Harassment Policy
    d. Medical Staff Peer Review Policy
    e. Medical Staff Committee on Physician Health
    f. Telemedicine Policy
    g. Emergency Privileges Credentialing
    h. TB Skin Testing
    i. Focused Professional Practice Evaluation
    j. Influenza Vaccination Policy
    k. Redirection of Care Policy