# GLACIAL RIDGE HEALTH SYSTEM

# MEDICAL STAFF RULES AND REGULATIONS

**February 2017**

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The Medical Staff is responsible to the Glacial Ridge Health System (GRHS) Board of Directors for the professional medical care performed at GRHS 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.

1. PATIENT TYPES AND ADMISSION OF PATIENTS

1.1 Description

The Hospital is a general acute care hospital that responds to the medical needs of those patients who present themselves for care. The Hospital will accept for care patients suffering from all types of disease dependent only upon facility space and personnel. The Hospital has been designated a Critical Access Hospital (CAH).

1.2 Definitions

Patient encounters at GRHS fall into three general categories: inpatient, emergency and outpatient. These are based on the service provided as well as on specific regulatory requirements.

1.2.1 Inpatient: An inpatient is a person who has been admitted to the hospital for bed occupancy for purposes of receiving inpatient services. 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.

A. Swing Bed: A swing bed patient is a person who has previously received inpatient services at GRHS or at another Hospital. All applicable Swing Bed regulations will be followed. For the purposes of these Rules and Regulations, a Swing Bed patient is considered an Inpatient.

B. Transitional Care: A transitional care patient is a person that does not qualify for either Inpatient or Swing Bed services, but is admitted for custodial care. For the purposes of these Rules and Regulations, a Transitional Care patient is considered an Inpatient.

1.2.2 Emergency: Basic emergency medical services means the provision of emergency medical care in a specifically designated area of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting with urgent medical problems.

1.2.3 Outpatient: A hospital outpatient is a person who has not been admitted by the hospital as an inpatient, but is registered on the hospital records as an outpatient and receives services from the hospital.

A. Hospitalized Episodes

• Outpatient Surgery: Outpatient surgery procedures are invasive and require a period of recovery post procedure.

• Observation: Observation services are those services furnished on the hospital's premises, including the use of a

bed and periodic monitoring by nursing and other staff, which are reasonable and necessary to evaluate an outpatient's condition in order to determine the need for a possible admission to the hospital as an inpatient.

B. Other Outpatient Episodes/Services

- Clinic Visits: in the case of clinic visits, diagnosis and other information related to the encounter are provided by the physician or Allied Health Professional who performs the examination.
- Diagnostic and Therapeutic Services: Diagnostic services, such as laboratory and radiological studies, and therapeutic services, such as chemotherapy, mediation treatment, physical and occupational therapy; are performed based on the written order of a qualified practitioner, who is also responsible for providing the patient's diagnoses and other clinical justification for the test or therapy.
- Referred Specimens: These services are rendered when the patient does not present for service, but rather a specimen is sent by a physician office, hospital, or other institution for evaluation.

1.3 Admission of Patients

1.3.1 Patients may be admitted to the Hospital as an inpatient or accepted for observation services or outpatient surgery only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the Hospital in accordance with the Medical Staff Bylaws.

All patients will be under the direct care or supervision of a member of the Medical Staff or an Allied Health Professional under the supervision of a member of the Medical Staff.

1.3.2 A member of the Medical Staff will be responsible for the medical care and treatment of each patient; for the promptness, accuracy, and legibility in completion of the medical record; for orders for treatment; and for providing information to the patient and family.

1.3.3 Except in an emergency, no patient will be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement will be recorded as soon as possible, but no later than 24 hours after admission.

1.3.4 In the case of an admission through the Emergency Room, patients who do not have a private physician who is a member of the Medical Staff authorized to admit patients; may have a choice of selecting the physician on call or any physician on the Medical Staff who is authorized to admit patients, subject to that physician's acceptance of the patient.

1.3.5 The admitting physician will 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/her patient might be a source of danger from any cause whatsoever.

1.3.6 Each physician is required to respond within thirty (30) minutes of being notified of an emergency.

1.3.7 The physician will honor Advance Directives, Living Wills, and Durable Power of Attorney over Health Care; discuss with the patient, and incorporate into the plan of care.

1.3.8 Dental and Podiatry:
Dental or Podiatry admissions are a dual responsibility involving the dentist/podiatrist and a physician member of the Medical Staff. The Dental and Podiatry Staff must conform to the same rules and regulations as those governing the Medical Staff.

A. The dentist or podiatrist will have the following responsibilities:
- A detailed dental or podiatric history justifying hospital admission
- Dentist: A detailed description of the examination of the oral cavity and a preoperative diagnosis
- Podiatrist: A detailed description of the examination of the foot and a preoperative diagnosis
- A complete operative report, describing the findings and technique. In cases of extraction of teeth the dentist will clearly state the number of teeth and fragments removed.
- Progress notes pertinent to the oral condition or foot condition, as applicable
- Discharge summary (or summary statement)

B. The physician will be the admitting and attending physician and as such will have the following responsibilities:
- Pertinent medical history
- Physical examination to determine the patient's condition prior to anesthesia and surgery
- All appropriate orders relating to the patient's medical condition, including admission and discharge orders
- Supervision of the patient's general health status while hospitalized, discharge summary, and discharge diagnosis

C. A member of the Medical Staff will be present in the Hospital while general anesthesia is administered to the dental or podiatric patient.

2. CONSENT

2.1 General Consent for Treatment:
A general consent form signed by or on behalf of every Hospital patient will be obtained at the time of admission.

2.2 Legal Representatives:
Only the patient, or his/her legal representative if the patient is incompetent, can give consent for the patient's treatment. If the patient is a minor, or an adult deemed incompetent and incapable of making decisions, this should be clearly documented in the patient's medical record. In that circumstance, informed consent can be given by the legal representative, who may be a court appointed guardian, healthcare power of attorney, spouse, parent, or adult child, as applicable.

2.3 Informed Consent for Procedures:
Except in an emergency situation, the Practitioner must obtain informed consent from the patient to perform a procedure. Informed consent means that the patient (or his/her legal representative) consented knowingly and voluntarily, after receiving information about the specific procedure, the reasonably foreseeable risks and benefits of the procedure, and the reasonable alternatives for care and treatment. Written consents obtained more than thirty (30) days prior to the procedure will not be valid.

2.4 Emergency Situations:
Informed consent is implied by law in an emergency situation (e.g. surgery is needed to save the life or preserve the bodily integrity of the patient). If the patient needs emergency treatment, is physically or mentally unable to give informed consent, and the next of kin or a legal representative is not immediately available, these circumstances must be documented in the medical record. When possible, two (2) Physicians should concur and document that the situation is an emergency.

3. PATIENT ASSESSMENT

3.1 H&P Requirements:

3.1.1 All patients admitted to the Hospital or registered for outpatient surgery will have a Complete H&P (defined below) documented in the medical record. An H & P is not required for intravitreal injections. A Focused H&P (defined below) may be used for a patient registered for an outpatient surgery requiring conscious sedation. A Focused H&P also may be used for an Observation patient. Swing Bed patients may have an admission progress note in lieu of an H&P along with a copy of either the H&P or discharge summary from the inpatient qualifying stay. H&Ps or admission progress notes are not required for Transitional Care patients.

3.1.2 The H&P will be recorded by the admitting physician or designated Allied Health Professional within 24 hours after admission to the Hospital.

3.1.3 If a Complete H&P was performed no more than 24 hours prior to the patient's admission to the hospital, this may be used, provided it was recorded by, or cosigned by, a member of the Medical Staff.

3.1.4 If a Complete H&P has been recorded and performed within 1-30 days prior to the patient's admission, an Interval H&P (defined below) reflecting any additions to the history and any subsequent changes in the physical findings may be used.

3.1.5 In all circumstances, when an H&P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H&P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include, at a minimum, critical information about the patient's condition including pulmonary status, cardiovascular status, vital signs, etc.

3.1.6 Obstetrical records will include a legible copy of the prenatal record and an interval note documenting any significant changes in patient history and physical findings since the last recorded visit. This is acceptable as the history and physical for obstetrical patients with the exception of cesarean section patients which must have a Complete H&P following the requirements noted below.

3.1.7 An H&P performed and recorded by a physician who is not a member of the GRHS Medical Staff may be used provided it meets the following criteria:

A. It was completed within the requirements of 3.1.3 or 3.1.4
B. It meets the H&P requirements noted below.
C. A physician member of the GRHS Medical Staff, with admitting privileges, confirms the findings and authenticates the document.

3.2 Required Components of History and Physical Exams:

3.2.1 Complete H&P:

A complete H&P has the following components: History, physical examination, assessment, and treatment plan.

A. History includes:
- Chief complaint
- History of Present Illness
- Past Medical and Surgical History
- Family and Social History
- Current Medications
- Allergies
- Review of Systems

B. Physical Examination which should include an examination of body areas/organ systems as appropriate
C. Assessment
D. Treatment Plan

3.2.2 Interval H&P

The interval H&P must contain either the changes in medical history of physical exam, or a statement indicating that no changes have occurred. For surgical cases, the interval H&P will confirm the indications for the procedure are still present. In all cases the Interval H&P will be written in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status since the original Complete H&P.

3.2.3 Focused H&P

The Focused H&P should provide an account of the chief complaint, the present illness, including an assessment of contributing factors, relevant past medical history, an appropriate review of body systems, an impression and a proposed initial plan of evaluation and treatment. The Focused H&P should in all cases be written in sufficient detail to allow the formulation of a reasonable picture of the patient's clinical status.

A. Content:
- History of present illness (including chief complaint)
- Current medications
- Allergies
- Relevant past medical and surgical history
- Significant family history
- Review of systems
- Physical examination
- Assessment
- Treatment Plan

3.3 An H&P that is not completed following the above requirements will be treated as a delinquent record.

4. PLANNING CARE, TREATMENT AND SERVICES

4.1 Provider Orders:

4.1.1 All orders for treatment will be in writing and must be recorded clearly, legibly, and completely. Illegible or improperly written orders will not be carried out until clarified with the ordering provider. Orders will be dated, timed and authenticated by the ordering provider. Verbal orders may be accepted and transcribed by an RN or LPN. Personnel from ancillary departments may accept and transcribe verbal orders for their departments. Duly authorized persons (as defined by Organization policy) functioning within their sphere of competence may receive verbal orders from members of the Medical Staff for non-invasive outpatient diagnostic services.

4.1.2 The Medical Staff, in conjunction with the nursing staff and pharmacist, will formulate standing orders. Standing orders will be reviewed by the Medical Staff annually and revised as needed. The practitioner utilizing standing orders must, on a case-by-case basis, specifically order that such standing orders be applied.

4.1.3 Admission Orders for all patient types must include:

A. Working diagnosis
B. Provider following patient in the hospital
C. Level of care status; acute, observation, swing bed, respite

4.1.4 Discharge orders are required for all patients.

4.1.5 All verbal orders must be authenticated within 48 hours.

4.1.6 Changes in the attending physician during the course of hospitalization will be documented in the orders. Documentation will consist of the relinquishment of care (stating who is taking over the primary care) by the current attending physician along

with an indication of the designated amount of time or if the new attending physician will remain the primary provider.

4.1.7 All previous orders are cancelled when patients go to surgery.

4.2 Outpatient Services:

4.2.1 Outpatient therapeutic and diagnostic services may be ordered as noted below. All orders for outpatient services must provide adequate clinical information to verify the purpose and appropriateness of the requested service.

4.2.2 Appropriate reports or records for outpatient services will be incorporated into the patient's medical record. All outpatient radiology services will be interpreted by a radiologist, with results reported to the ordering provider. The results of all other diagnostic services will be reported to the ordering provider. The ordering provider retains the responsibility for communicating the results and any recommendations for follow-up examination or further treatment to the patient. The provision of outpatient services remains subject to reasonable limitations that may be imposed by the Medical Staff of the Glacial Ridge Health System.

4.2.3 An outpatient may receive therapeutic or diagnostic services upon the order of a physician member of the Medical Staff.

4.2.4. An outpatient may receive diagnostic services, rehabilitative services, Home Care or Hospice upon the authenticated written order of any physician or Certified Nurse Midwife licensed to practice in Minnesota. Licensure will be verified by Health Information Management staff.

4.2.5 Mid-level practitioners (physician assistants, nurse practitioners) that are licensed in the state of Minnesota may order outpatient diagnostic services and rehabilitative services. Supervising physician co-signature may be required on orders by any mid-levels not holding an APRN license.

4.2.6 Mid-level practitioners (physician assistants, nurse practitioners) that are members of our Allied Health Professional staff may order specified outpatient therapeutic services if granted privileges to do so.

4.2.7 Chiropractors may order diagnostic radiology services for non-Medicare beneficiaries as follows:

A. MRI scans of the musculoskeletal system
B. CT scans of the musculoskeletal system
C. Plain films of the musculoskeletal system

*Note: Medicare Beneficiaries must be referred to a physician for the ordering of any radiology services.*

Such services will be provided for patients of chiropractors who agree to meet the conditions listed below:

A. The chiropractor must provide a copy of a current, unrestricted license to practice chiropractic in the State of Minnesota.

B. The service ordered must be consistent with the services identified above and must be necessary to make a determination of the presence or absence of a chiropractic condition.

C. Orders for tests must be in writing and must provide adequate clinical information to verify the purpose and appropriateness of the requested test.

5. MEDICATIONS

5.1 Drugs used will be among those listed in the Hospital Formulary as approved by the Medical Staff. Deviation from this rule will be well justified and will be reported to the Medical Staff Executive Committee as part of the Pharmacy and Therapeutics Function. Pharmacy may dispense the exact chemical equivalent (labeled in non proprietary terms) for those drugs ordered under a trade or proprietary name in the treatment of inpatients and outpatients. However, if any practitioner considers an exception to this policy is indicated for a particular patient, the practitioner will indicate this in the medication order.

5.2 An order for medication must comply with the Hospital's Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted in, medication orders.

6. PROVIDING CARE, TREATMENT AND SERVICES

6.1 Daily Care – Progress Notes:

6.1.1 The attending physician is required to document the need for continued hospitalization as specified in the Utilization Review Plan. Failure to do so will be brought to the attention of the Medical Staff for appropriate action.

6.1.2 Pertinent progress notes will be dictated at the time of observation sufficient to permit continuity of care and transferability. The attending physician or designated clinically privileged licensed health care provider will document a progress note at least daily or more frequently as required by the patient's condition or circumstances. When a surgeon has documented a progress note, a second note by the attending physician is not required if there are no changes.

6.1.3 All progress notes must be authenticated by the provider who wrote the note.

6.1.4 A final progress note, including the outcome of the hospitalization, case disposition, and instructions to the patient and/or family, must be recorded if a discharge summary is not required.

6.1.5 Progress notes for Swing Bed patients may be periodic, but not less than weekly.

6.2 Consultations:

6.2.1 Consultation is to be ordered by a physician when they are requesting that another physician see the patient. Consultation will be documented as an order and dated and authenticated by the attending physician.

6.2.2 A consult report will show evidence of a review of the patient's medical record by the consultant, pertinent findings upon examination of the patient, and the consultant's opinion and recommendations. This report will be made part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report.

6.2.3 When operative procedures are involved, the consultation note will be recorded prior to the operation.

6.2.4 The consultant assumes no responsibility for the ongoing care of the patient.

6.3 Anesthesia and Sedation:

6.3.1 Anesthesia must be administered only by a physician, dentist, podiatrist, or a Certified Registered Nurse Anesthetist (CRNA). CRNAs practicing in CAH facilities in Minnesota are exempt from the physician supervision requirement.

6.3.2 The surgeon or CRNA must complete the pre-anesthesia risk assessment on every surgical patient for which conscious sedation or anesthesia is used. The assessment must include:

A. Notation of anesthesia risk
B. Anesthesia, drug and allergy history
C. Any potential anesthesia problems identified
D. Patient's condition prior to induction of anesthesia

6.3.3 Prior to induction the CRNA will update vital signs and oxygen saturation. Physiologic monitoring is measured and assessed throughout anesthesia and documented on the anesthesia record.

6.3.4 The post anesthesia follow up report must be written within 48 hours after surgery. The report must include the following:

A. Cardiopulmonary status
B. Level of consciousness
C. Any follow-up care and/or observations; and
D. Any intra-operative anesthesia complications or any complications occurring during post-anesthesia recovery

6.3.5 The physician is permitted to delegate the post-anesthesia assessment and the writing of the post-anesthesia follow-up report to the CRNA who administered the anesthesia.

6.4 Surgery:

6.4.1 Informed consent is completed as noted in Section 2.3.

6.4.2 A preoperative diagnosis, history and physical and pre-anesthetic evaluation must be recorded in the patient's medical record prior to any surgical procedure except in severe emergencies. If not recorded, the operation will be cancelled. In an emergency the practitioner will make a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

6.4.3 Post-operative Note and Operative Reports:

A. An immediate post-op note will be handwritten in the progress notes whenever a surgery is performed. It will briefly state the procedure performed, diagnosis, any complications, blood loss, etc.
B. Operative reports will be written or dictated immediately following surgery for outpatients as well as inpatients. The operative report will be promptly authenticated by the surgeon. Operative reports should contain:
   - Pre-op Diagnosis
   - Post-op Diagnosis
   - Operations performed
   - Principal Surgeon, assistant surgeons
   - Type of anesthesia administered
   - Intra-operative findings
   - Description of the procedures performed
   - Intra-operative complications, if any
   - Specimens removed

6.4.4 An operative report not written or dictated immediately following surgery will be treated as a delinquent record.

6.5 Obstetrical Care:

6.5.1 Obstetrical patients will be admitted to the birthing suite. The attending physician will have routine orders for pre-delivery care on record at the Hospital.

6.5.2 After delivery, the responsible physician or Allied Health Professional will perform a physical exam of the baby and document the findings in the medical record. A discharge exam of the baby will also be documented in the newborn's medical record.

6.5.3 Except in emergency cases, consultation with another qualified physician is required in first cesarean section cases.

6.5.4 Obstetrical records will include an H&P as noted in 3.1.6.

6.5.5 A labor and delivery note will be completed for every delivery.

6.5.6 An operative note and discharge summary are required for all cesarean section deliveries.

7. COORDINATING CARE AND TREATMENT

7.1 Discharge:

7.1.1 Patients will be discharged only upon a written or verbal order of the responsible physician. It is the responsibility of the attending physician to plan discharge in a timely and coordinated fashion.

7.1.2 Should a patient leave the hospital against the advice of the attending physician or without proper discharge, the attending or on-call physician will be notified and a notation of the incident will be made in the patient's medical record. The patient should be requested to sign the appropriate release form.

7.1.3 No patient will be transferred to another facility without such transfer being approved by the responsible physician. Emergency Medical Treatment and Active Labor Act (EMTALA) rules will be followed for each transfer.

7.1.4 Discharge Summary

A. A discharge summary is required for all patients who were hospitalized over forty-eight (48) hours except normal deliveries and normal newborns. For patients with a stay less than 48 hours a discharge note is required. All inpatient deaths will have a discharge summary regardless of length of stay.

B. Contents:

- Final diagnosis
- Significant findings, treatment provided and patient outcome

- Procedures performed and complications, if any
- Condition of patient upon discharge and to where the patient is discharged
- Discharge medication, follow-up plan, and specific instructions given to the patient and/or family

C. The discharge summary will be dictated or written within twenty-five (25) days of discharge.

D. The discharge summary will be completed by the physician or Allied Health Professional (AHP) responsible at the time of discharge unless a previous physician or AHP provided care for more time than the discharging physician or AHP.

7.2 Death

7.2.1 In the event of death, the patient will be pronounced dead by the attending or on-call physician within a reasonable time and according to policies and procedures approved by the Medical Staff.

A. Exceptions will be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death.

B. Policies with respect to release of dead bodies will conform to State and local laws.

C. Attempt will be made to notify the attending physician.

7.2.2 The physician pronouncing death will be responsible for determining if the death is reportable to the County Coroner's Office and will make such reports in accordance with applicable Minnesota Statutes.

## 8. RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

8.1 Autopsy:

8.1.1 It will be the duty of all Medical Staff members to secure meaningful autopsies whenever indicated to improve the quality of hospital care. At a minimum the Medical Staff will attempt to secure an autopsy in all cases of unusual deaths and those of medicolegal and educational interest.

8.1.2 Unless otherwise required by the Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law.

8.1.3 All autopsies will be performed by the Hospital or consulting pathologist.

8.1.4 The Hospital will be responsible for paying the cost of the autopsy performed for the improvement of care at the Hospital. Autopsies

requested by the family are the financial responsibility of the family.

8.1.5 Provisional anatomic diagnoses will be recorded on the medical record within seventy-two (72) hours and the complete post-mortem will be made a part of the record within sixty (60) days unless special studies are requested.

8.2 Suicidal Patient:

Any patient known or suspected to be suicidal in intent will be referred to other facilities where suitable care is available. If, in the judgment of the physician, serious medical problems exist of a higher priority than the underlying psychiatric problem, the patient should be admitted to the appropriate nursing unit and put on one-to-one nursing care until an appropriate transfer can be arranged.

8.3 Restraints and Seclusion:

8.3.1 A restraint or use of seclusion can only be used if needed to improve the patient's well-being or to protect the safety of other patients or others and less restrictive interventions have been determined to be ineffective.

8.3.2 The order for restraint or seclusion must comply with the Medical Staff approved policy on restraints and seclusion. Seclusion may only be used in the Emergency Department.

8.3.3 Hospital policy will specify the time within which an updated 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.

8.4 Organ and Tissue Donation:

Postmortem tissue and organ donation will be conducted in accordance with the Uniform Anatomical Gift Act. When a tissue or organ of the donor is to be removed for transplantation pursuant to the Uniform Anatomical Gift Act, and the death of the donor is established by a determination that the person has suffered a total and irreversible cessation of brain function, the pronouncement of death is made by the patient's attending physician, or his/her substitute attending physician. The physicians making the determination of death will not participate in the procedures for removing a tissue or organ.

8.5 Tissue Specimens:

All tissues removed at surgery or during any procedure, except those tissues specified in advance by the Medical Staff, will be sent for examination by a surgical pathologist.

9. TRANSFER/REFERRAL OF PATIENT

9.1 Each member of the Medical Staff will provide assurance of immediacy of adequate professional care for his/her patients in the hospital by being available, or having available, an eligible alternate physician with whom prior arrangements have been made. The alternate physician must be a qualified member of the Medical Staff who has been granted the privilege to admit patients to the Hospital in accordance with the Medical Staff Bylaws. In the case of failure to name such a physician, the Chief of the Medical Staff or the Administrator will have the authority to call any member of the Active Staff to assume care of the patient. Failure of the attending physician to meet the above requirements may result in loss of Medical Staff privileges and membership.

9.2 Medical Staff members who will be out of town for over twenty-four (24) hours should indicate, by documenting in the medical record as an order, the name of the physician who will be assuming the responsibility for the care of those patients during his/her absence.

9.3 Referral of a patient to another Medical Staff member will indicate the complete transfer of all patient care responsibilities to that Medical Staff member. Referral will be documented in the medical record as an order.

9.4 Specialty referral will indicate the transfer of a portion of a patient's care to another Medical Staff member who will become responsible for that portion of the patient's care. The remainder of the patient's care will remain the responsibility of the attending physician. A specialty referral will be documented in the medical record as an order and must clearly state the specialty area of referral.

10. GENERAL RULES REGARDING EMERGENCY

10.1 Emergency care will be provided in the Emergency Room on a 24-hour basis by the Medical Staff, or qualified PA or NP under the supervision of Medical Staff.

10.2 The Executive Committee of the Medical Staff will be responsible for maintaining an on-call rotation schedule. Active Medical Staff members and Allied Health Professionals identified on the on-call rotation schedule are responsible to respond, examine and treat patients with emergency medical conditions.

10.3 The Medical Staff must comply with Emergency Medical Treatment and Active Labor Act (EMTALA) policies and procedures. All persons who present themselves to the Hospital and who request examination and treatment for an emergency medical condition or active labor, will be evaluated for the existence of an emergency medical condition, or where applicable, active labor. This medical screening examination (MSE) must be performed by a qualified medical person.

10.4 An appropriate medical record will be kept for every patient receiving emergency service and such record will be incorporated into the patient's hospital record. The record will be authenticated by the physician and/or Allied Health Professional in attendance who is responsible for its clinical accuracy. The record will include:

10.4.1 Adequate patient identification

10.4.2 Information concerning the time and means of the patient's arrival and by whom transported

10.4.3 Pertinent history of the injury/illness, including details relative to first aid or emergency care given the patient prior to arrival at the Hospital

10.4.4 Description of significant clinical, lab, x-ray, and other diagnostic findings

10.4.5 Diagnosis

10.4.6 Treatment given

10.4.7 Nurses Notes

10.4.8 Condition of patient on discharge or transfer

10.4.9 Final disposition, including instructions given to the patient and/or family pertaining to necessary follow-up care

10.4.10 It is expected that ER dictation will be completed immediately upon patient discharge from the ER; however, it is acceptable to complete the dictation within 12 hours of patient discharge in extenuating circumstances.

10.4.11 In case of transfer, a transfer note will accompany the patient and all applicable Federal regulations will be followed.

10.4.12 If the patient is admitted from the Emergency Room to the Hospital, the History and Physical may be used in lieu of an ER Record.

## 11. MEDICAL RECORDS

11.1 Description:

The medical record consists of information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is included in the Legal Medical Record Definition for GRHS. All medical records are regulated by the Centers for Medicare and Medicaid Services (CMS) and the Minnesota Department of Health.

11.2 Access:

Access to confidential materials by members of the Medical Staff 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, or some other appropriate 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.

11.3 General Documentation Rules:

11.3.1 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 will be as stated in the Hospital's Policies and Procedures governing medical records.

11.3.2 All entries must be legible and complete, and must be dated and authenticated promptly by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

11.3.3 When non-physicians have been approved for such duties as taking medical histories or documenting aspects of physical examination, such information will be co-signed by the responsible physician. If the history and physical exam are recorded by a medical student, resident, or Allied Health Professional, the attending physician will review it, make any necessary changes, and countersign to indicate approval of its contents.

11.3.4 The attending physician will be responsible for the preparation of a complete, pertinent, and legible medical record for each patient. All inpatient records will include:

A. Identification data including consent to medical treatment.
B. Medical history including chief complaint, history of present illness, past medical and surgical history, relevant family and social history
C. Physical examination, impression or assessment, and plan of care
D. Special reports (consultation reports, clinical laboratory, radiology and other imaging and diagnostic services)
E. Diagnostic and therapeutic orders
F. Report of medical or surgical treatment
G. Progress notes
H. Operative reports when indicated
I. Pathological findings
J. Final diagnoses
K. Condition on discharge
L. Plan for follow-up care and discharge instructions to patient
M. Discharge summary including instructions given to patients
N. Autopsy report, when performed

11.3.5 The medical record will include all other department documentation; such as, nursing history, graphic records, medication record.

11.4 A final diagnosis should be documented on every inpatient and Observation patient, in the discharge summary or discharge progress note if applicable. Symbols or abbreviations may not be used in the final diagnosis, but may be used within the medical record when approved by the Medical Staff.

11.5 A list of permitted and *not* permitted symbols and abbreviations has been approved by the Medical Staff. Use of *not* approved 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 *not* permitted list until the physician has been contacted for order clarification.

12. MEDICAL RECORD - COMPLETION

12.1 A patient's medical record will be completed within thirty (30) days of discharge. A record will be considered complete when the required contents are assembled and authenticated, and all final diagnoses are recorded. Time limitations for completion of the medical records as prescribed by Hospital and Medical Staff policy will be strictly followed.

12.2 If a physician, dentist or podiatrist has incomplete records that are delinquent; this practitioner will be placed on suspension.

Note: Suspension status indicates that, in addition to automatic relinquishment of admitting privileges, the physician may not order any diagnostic or therapeutic interventions for patients; will not be allowed to cover call or to make rounds on hospitalized patients; and coverage for hospitalized patients will need to be arranged for by the Medical Staff member. The clinic will be notified that the individual has been placed on suspension status and that a replacement must be found to cover the physician's call and to round on any patients the physician may have in the hospital until suspension status has been removed.

12.3 Reinstatement of privileges is automatic upon completion of records.

12.4 Copies of the Warning Notice of Intent to Suspend and the Notice of Suspension will be sent to the Chief of Staff and the CEO. One copy will also be placed in the quality file of the practitioner for consideration when suitability for future staff reappointment is reviewed.

12.5 The HIM Director will notify the Hospital Director of Nurses, Surgery Department and ER Department of any physicians on suspension. The HIM Director will notify these same areas if/when privileges are reinstated.

12.6 The Chief of Staff will notify physicians when they have reached four appearances on suspension status, and the physician will then be required to review this policy.

12.7 Six appearances on suspension status in the previous twelve (12) months may result in automatic voluntary resignation from the Medical Staff.

12.8 If a Medical Staff member has notified the medical records department that he/she is on vacation, he/she will not be placed on suspension status while on vacation; however, the Medical Staff member must complete his/her medical records within seventy-two (72) hours of return from vacation. It is the Medical Staff member's responsibility to notify the medical records department of vacation plans.

12.9 If a Medical Staff or Allied Health Staff member has an unplanned extended absence (greater than 30 days) or has passed away; all incomplete charts will be reviewed by the Medical Staff Committee as part of the Medical Record Review function. The Chief of Staff may assign this review to various committee members prior to the meeting.
12.9.1 The Chief of Staff will sign an Approval Document indicating why the Staff member is unable to sign him/herself and that the Medical Staff Committee has approved the documents.
12.9.2 The Chief of Staff will e-sign any documents or verbal orders.
12.9.3 The Approval Document will be retained with each patient's medical record.

13. MEDICAL RECORD - RELEASE

13.1 All medical records are the property of GRHS and will not be removed from GRHS's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute.

13.2 Written consent of the patient, or his/her legal representative if applicable, is required prior to release of medical information to persons not otherwise legally authorized to receive such information.

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 the patient's condition that they believe are not being adequately addressed or they have concerns about decisions being made in the care of the patient.

The chain of command involves administrative and clinical lines of authority. The lines of authority are established to ensure effective conflict resolution in patient care situations. The concerned member of the team should express their concerns to their immediate supervisor. If they still feel the issue is not adequately resolved they should ask to speak to the supervisor's manager up the chain of command.

In all cases, the final authority in the chain of command on patient care decisions will rest with the Chief of Staff or the Chief of Staff designee.

15. CONFIDENTIALITY

15.1 All members of the Medical Staff, Allied Health Practitioners associated with the staff, and their respective employees and agents, will maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by GRHS or by business associates of GRHS, in accordance with any and all privacy and security policies and procedures adopted by GRHS to comply with current federal, State and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information will not be requested, accessed, used, shared, removed, released or disclosed except in accordance with GRHS'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. It can also be furnished to any health care provider outside the Facility who will be participating in that patient's care.

15.2 The use of electronic signature (computer key) is acceptable only under the following conditions:

15.2.1 The practitioner whose signature the electronic signature represents is the only one who has possession of the electronic User ID and password combination, and is the only one who uses it; and

15.2.2 The HIM Director retains a signed statement to the effect that the practitioner is the only one who has the computer key password and is the only one who will use it.

15.3 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 GRHS medical records. Passwords used by a member of the Medical Staff to access GRHS computers will be used only by such member, who will not disclose the password to any other individual (except to authorized security staff of the computer system). The use of member's passwords is equivalent to the electronic signature of the member. The member will not permit any practitioner or other person to use his/her passwords to access GRHS computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Glacial Ridge Health System Board of Directors regarding security measures, be a violation of State and federal law and may result in denial of payment under Medicare.

16. AMENDMENTS

These Rules and Regulations may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that

Committee where a quorum exists, provided that written recommendations concerning the proposed amendments were received and reviewed by the members of the Committee prior to the meeting. No such amendment will be effective unless and until it is adopted by the Board of Directors.

17. ORGANIZED HEALTH CARE ARRANGEMENT

As permitted by 45 C.F.R.164.501, 164,502 and 164,520, the following covered entities are designated as an Organized Health Care Arrangement under the Standards for Privacy of Individually Identifiable Health Information: Glacial Ridge Health System and Glacial Ridge Health System's non-employed Medical Staff members and others physicians granted Clinical Privileges at Glacial Ridge Health System.

This designation is made solely in accordance with the Standards for Privacy of Individually Identifiable Health Information. This designation is not intended and shall not be construed to have any other legal effect or to create between the parties a partnership, joint venture, employment relationship, or any other relationship.