

Rules and Regulations

**COMMUNITY HOSPITALS AND WELLNESS CENTERS
MONTPELIER HOSPITAL**

A Medical Staff Document

I. Definitions

The definitions set forth in the Medical Staff Bylaws shall apply to these Medical Staff Rules & Regulations unless a different definition is otherwise specified herein.

II. Admission of Patients

A. Patients may be admitted to the Hospital by Practitioners or Advanced Practice Providers (APP) (subject to the conditions set forth below) with admitting Privileges.

1. Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), Certified Nurse Midwives (CNM), and Physician Assistants (PA) may admit patients to the Hospital if all of the following conditions are met:

a. The CNP, CNS, or CNM has a Standard Care Arrangement (SCA) entered into, in accordance with applicable Ohio law, with a collaborating Physician or Podiatrist who is a member of the Medical Staff with Clinical Privileges including the ability to admit patients.

b. The PA is listed on a Supervision Agreement entered into, in accordance with applicable Ohio law, for a Physician or Podiatrist who is a member of the Hospital's Medical Staff with Clinical Privileges including the ability to admit patients.

c. The patient is under the medical supervision of the collaborating or supervising Physician or Podiatrist.

d. The CNP, CNS, CNM, or PA has been granted the privilege of admitting patients to the Hospital.

e. Prior to admitting a patient to the Hospital, the CNP, CNS, CNM, or PA must notify his/her collaborating or supervising Physician or Podiatrist of the planned admission.

2. For purposes of these Rules & Regulations, in the event an APP has been granted admitting Privileges, then references to the admitting/attending/responsible Practitioner shall include the admitting APP to the extent permitted by applicable laws, rules, and regulations, the APP's Privileges and standard care arrangement or supervision agreement, and as applicable to the admitting APP's responsibilities toward his/her patient.

B. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been documented. In case of an emergency, the provisional diagnosis shall be documented as soon after admission as possible.

- C. Practitioners or APPs admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who the Practitioner or APP has reason to believe may be a source of danger or to assure protection of the patient from self-harm.
- D. Patients shall be attended by a hospitalist or the patient's private Practitioner/APP or covering Practitioner. Patients admitted through the Emergency Room who have no attending Practitioner/APP shall be assigned a Practitioner on duty with appropriate Privileges.
- E. All patients admitted to the Hospital must be under the care of an appropriate Practitioner/APP with Privileges consistent with applicable laws, rules, and regulations including, but not limited to, the applicable Medicare critical access hospital conditions of participation.

III. Medical History & Physical Examination ("H&P")

A. Elements of an H&P

1. Inpatients, Observation Patients, and Swing Bed (Skilled) Patients:

- a. H&Ps for inpatients, observation patients, and swing bed (skilled) patients must include, at a minimum, the following:
 - i. History of present illness
 - ii. Past medical history
 - iii. Allergies
 - iv. Current medications
 - v. Review of systems
 - vi. Physical exam
 - vii. Heart and lung assessment
 - viii. Neurological assessment
 - ix. Target organ assessment for reason for hospitalization
 - x. Diagnosis
 - xi. Plan of care

B. Requirements of H&P

1. Patients shall, as applicable, receive a medical history and physical examination no more than thirty (30) days prior to or within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to registration or admission, an update documenting any changes in the patient's condition shall be completed within twenty-four (24) hours after registration or admission, but prior to surgery or a procedure requiring anesthesia services. The update shall be based on an appropriate reassessment of the patient which should include a physical examination of the patient sufficient to update those components of the patient's current medical status that may have changed and to address any areas where more current data is needed since the H&P was completed.
2. The H&P shall be completed and documented by a Physician, an Oral & Maxillofacial Surgeon, or other qualified licensed individual who is granted the Privileges by the Hospital to do so in accordance with State law and Hospital policy.
3. Additional information regarding H&Ps is set forth in the Medical Staff Bylaws.

C. Countersignature

H&Ps completed and documented by APPs granted Privileges to do so must be countersigned by the APP's supervising or collaborating Physician who assumes full responsibility for the H&P.

IV. Orders

- A. Orders. All orders shall be in writing or electronically entered and authenticated, dated, and timed by the ordering Practitioner or APP. The Practitioner's or APP's orders must be clear, legible (if written), and complete.
 1. Practitioners shall have the authority to issue orders as permitted by their Privileges subject to applicable laws, rules, and regulations.
 2. The ability of an APP to issue orders, if any, shall be as defined in the applicable APP Privilege set. All APP orders must be (i) permitted by the APP's license and within the APP's scope of practice; (ii) within the APP's delineated Privileges; (iii) consistent with the APP's standard care arrangement or supervision agreement; and (iv) in accordance with all applicable laws, rules, regulations, and Hospital and Medical Staff policies.
- B. Verbal/Telephone Orders. Verbal and telephone orders are permitted but must be used infrequently and must not be a common practice. Verbal and telephone orders should be used only to meet the care needs of a patient when it is impossible or impractical for the ordering Practitioner or APP to write or electronically enter the

order without delaying treatment. Verbal and telephone orders shall be signed, dated, and timed by the person to whom dictated with the name of the ordering Practitioner or APP.

1. Authentication of Verbal/Telephone Orders. Verbal and telephone orders must be authenticated, dated, and timed promptly by the ordering Practitioner/APP or another Practitioner who is covering for the ordering Practitioner/APP and responsible for the care of the patient.
2. Receipt and Documentation. Only designated licensed Hospital personnel, as specified in applicable Hospital policy (as such policy may be amended from time to time), are authorized to receive and document verbal and telephone orders within their scope of practice.
3. Read-Back. All verbal and telephone orders require read-back verification of the complete order with the ordering Practitioner/APP.

C. Outpatient Orders. To the extent permitted by, and consistent with, applicable laws, rules, and regulations, Hospital outpatient services may be ordered (and patients may be referred for Hospital outpatient services) by a Practitioner or Ohio APP who is (i) responsible for the care of the patient (ii) licensed in, or holds a license recognized in, the jurisdiction where he/she sees the patient; (iii) acting within his/her scope of practice under State law; and (iv) authorized by the Medical Staff to order the applicable outpatient services under these Rules & Regulations and/or applicable Medical Staff/Hospital policy as approved by the Board.

V. Medical Records

A. Authentication of Medical Record Entries

1. “Authentication” means to establish authorship by written signature, identifiable initials, electronic signature/computer key, or other code.
2. For authentication, in written or electronic form, a method must be established to identify the author.
3. Authorized users of electronic authorizations shall sign a statement assuring that they alone will use the electronic signature/computer key or code.

B. Content of Medical Record

1. The medical record contains the following demographic information as applicable:
 - a. The patient’s name, address, and date of birth, and the name of any legally authorized representative
 - b. The patient’s sex, race, and ethnicity.

- c. The legal status of any patient receiving behavioral health care services
 - d. The patient's communication needs, including preferred language, for discussing health care
2. The medical record contains the following clinical information as applicable:
- a. The reason(s) for admission or for care, treatment, and/or services
 - b. The patient's initial diagnosis, diagnostic impression(s), and condition(s)
 - c. Any findings of assessments and reassessments
 - d. Any allergies to food
 - e. Any allergies to medications
 - f. Any conclusions or impressions drawn from the patient's medical history and physical examination
 - g. Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections)
 - h. Any consultation reports
 - i. Any observations relevant to care, treatment, and/or services
 - j. The patient's response to care, treatment, and/or services
 - k. Any emergency care, treatment, and/or services provided to the patient before his or her arrival
 - l. Any progress notes
 - m. All orders
 - n. Any medications ordered or prescribed
 - o. Any medications administered including the strength, dose, and route
 - p. Any access site for medication, administration devices used, and rate of administration

- q. Any adverse medication reactions
 - r. Treatment goals, plan of care, and revisions to the plan of care
 - s. Results of diagnostic and therapeutic tests and procedures
 - t. Any medications dispensed or prescribed on discharge
 - u. Discharge diagnosis
 - v. Discharge plan and discharge planning evaluation
3. As needed to provide care, treatment, and/or services, the medical record contains the following additional information:
 - a. Any advance directives
 - b. Any informed consent, when required by Hospital policy
 - c. Any records of communication with the patient, such as telephone calls or emails
 - d. Any patient-generated information
 4. The medical record of a patient who receives urgent or immediate care, treatment, and/or services contains all of the following:
 - a. The time and means of arrival
 - b. Indication that the patient left against medical advice, when applicable
 - c. Conclusions reached at the termination of care, treatment, and/or services including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and/or services
 - d. A copy of any information made available to the Practitioner or medical organization providing follow-up care, treatment, and/or services
 5. Other information as required by applicable laws, rules, regulations, and/or accreditation standards.
- C. Discharge Summary. The medical record shall contain a discharge summary or final progress note in accordance with the requirements set forth in Section X of these Medical Staff Rules & Regulations.
- D. Progress Notes. Progress notes shall be recorded at the time of examination to facilitate continuity of care. Each of the patient's clinical problems should be

clearly defined in the progress notes and correlated with specific orders as well as the results of tests and treatments. Progress notes shall be entered into the medical record at least daily.

E. Timely Completion of Medical Records.

1. All medical records must be completed within 30 days following the patient's discharge or outpatient care.
2. Practitioners and APPs shall be notified of any medical records that are incomplete within ten (10) days after the date of completion of service, and the Practitioner or APP shall have until thirty (30) days after the completion of service to complete such medical records. A follow up phone call will be made to the Practitioner or APP no later than twenty-five (25) days after completion of service to set up a time for the Practitioner or APP to complete medical records that remain incomplete. Medical records that remain incomplete beyond thirty (30) days of service are delinquent. The Practitioner's or APP's Privileges will be automatically suspended as of the 31st day. The automatic suspension will be communicated to the Practitioner or APP in writing and will take effect immediately.
3. A Practitioner or APP whose Privileges are automatically suspended may not, as applicable, exercise any Privileges at the Hospital, participate in Emergency Room Call, or otherwise provide professional services within the Hospital for patients with the exception that such Practitioners or APPs may:
 - a. Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.
 - b. Attend to the management of any patient under his or her care whose admission was scheduled prior to the effective date of the automatic suspension.
 - c. Attend to the management of any patient requiring emergency care and intervention.
4. An automatic suspension will continue until such time as all of the Practitioner's or APP's delinquent medical records are completed. If a Practitioner's or APP's Privileges are automatically suspended three (3) or more times in one (1) Medical Staff Year for delinquent medical records, the Practitioner or APP will be referred to the Credentials Committee for review and appropriate follow up action.

F. Property/Release of Medical Records. Information regarding medical records and release of information contained within medical records is set forth in the Hospital's

Health Information Management policies and procedures as such policies and procedures may be amended from time to time.

G. Access to Medical Records

1. Access to medical records of all patients shall be afforded to Practitioners and APPs, to the extent applicable, for bona fide study and research subject to preservation of the confidentiality of personal information concerning the individual patients, MEC approval of the research, and compliance with all applicable federal and state laws, rules, and regulations (*e.g.*, governing the confidentiality of medical records, *etc.*).
2. Subject to the discretion of the Chief of Staff and CEO and all applicable federal and state laws, rules, and regulations governing the confidentiality of medical records, former Practitioners and APPs shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
3. In the case of readmission of a patient, the patient's previous medical records shall be available via the electronic health record for reference by the treating providers.

VI. Medications

- A. All medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia-National Formulary with the exception of medications for *bona fide* clinical investigations or other justified exceptions as determined on a case-by-case basis by the Pharmacy and Therapeutics Committee and MEC.
- B. A Practitioner or, if applicable, an APP requesting use of an investigational medication for treatment of a specific inpatient must:
 1. Use such investigational medications in accordance with applicable FDA regulations.
 2. Consult with and obtain approval from the Pharmacy and Therapeutics Committee chair and the Institutional Review Board of the Hospital.
 3. Obtain informed consent from the patient or the patient's legal guardian(s) or authorized representative(s).
- C. To ensure that the medication therapy of an individual patient is reviewed on a regular basis by the prescribing Practitioner/APP, compliance with Hospital policies MED00025 (Hard Stop Date Orders) and PHARM166 (Hard Stop Order Report Run Procedure), as such policies may be amended from time to time, is expected.

- VII. Consent. A general consent form must be signed by or on behalf of every patient treated at the Hospital. Except in cases of emergency, an appropriate informed consent must be obtained from the patient or his/her legal guardian(s) or authorized representative(s) by the treating Practitioner prior to performance of designated treatments or procedures. Additional requirements with respect to informed consent are set forth in applicable Hospital policy as such policy may be amended from time to time
- VIII. Coverage. Practitioners must be available to provide continuous care to their patients or make arrangements for appropriate coverage in the Practitioner's absence in accordance with the requirement set forth in the Medical Staff Bylaws. In the event that both the Practitioner and covering Practitioner are not available, the CEO or designee shall have the authority to call any Appointee with appropriate Privileges to provide care, treatment, and/or services. APPs must be available to provide continuous care to their patients or make arrangements for appropriate coverage in the APP's absence with his/her collaborating or supervising Practitioner or another APP with appropriate Privileges.
- IX. Call Coverage. It is the policy of the Hospital to assure the emergency department is adequately covered by on-call Physicians and, as applicable, other Practitioners with Medical Staff appointment and Privileges at the Hospital, consistent with the services provided at the Hospital and the resources the Hospital has available, according to a schedule for such coverage.
- A. On-call Practitioners should respond by telephone within ten (10) minutes after being contacted by the Hospital. On-call Practitioners should arrive at the Hospital within a reasonable period of time after being contacted as is medically appropriate as dictated by the patient's condition.
- B. Practitioners who treat patients while on-call shall be responsible for treating the patient through the acute emergency phase of their treatment and for any necessary office follow-up care related to the emergency visit. Such treatment shall not be based on or limited by the patient's ability to pay.
- C. Qualified personnel for purposes of conducting a medical screening examination of a patient who presents to the Emergency Department shall be defined to mean a:
1. Physician (or other Practitioner within such Practitioner's scope of practice).
 2. PA or CNP, as applicable, within such other PA's or CNP's scope of practice.
- X. Discharge and Discharge Summary
- A. Patients shall be discharged only on order of the responsible Practitioner or APP (granted Privileges to admit patients to the Hospital).
- B. A discharge summary shall be entered into the medical record within fifteen (15) days after discharge. A discharge summary shall address the:

1. Reason for hospitalization.
 2. Procedures performed.
 3. Care, treatment, and services provided.
 4. Outcome of hospitalization; or, for outpatient records, the outcome of treatment, procedures, *etc.*
 5. Patient's condition and disposition at discharge.
 6. Information provided to the patient and/or his/her legal guardian or authorized representative.
 7. Provisions for follow up care.
- C. A discharge summary is not required when a patient is seen for minor problems or interventions as defined by the Medical Staff. In this instance a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

XI. Patient Death

A. Pronouncement of Death

1. Only a Physician may declare a patient dead at the Hospital.
2. Pronouncement of death shall be in accordance with the requirements set forth in applicable Hospital policy as such policy may be amended from time to time.

B. Autopsies

1. The Medical Staff should contact the coroner in all cases of unusual deaths and of medical-legal and/or educational interest.
2. If the coroner defers the case, the attending Practitioner is then notified that an autopsy is being recommended or is desired by the family. The Medical Staff is expected to order autopsies when the immediate cause of death is questionable and does not meet coroner criteria.
3. The mechanism for documenting permission to perform a Practitioner ordered autopsy shall be as set forth in applicable Hospital policy, as such policy may be amended from time to time.
4. Autopsies shall be performed by a pathologist or at a contracted health care facility and transportation will be arranged.

5. The provisional and final diagnosis will be made part of the medical record.
- XII. Disaster Assignments. At the time of any disaster, Practitioners and APPs will be governed by the applicable provisions of the Medical Staff Bylaws or APP Policy, as applicable, and the Hospital Disaster Plan as written and integrated with the Civil Defense of Williams County.
- XIII. Compliance. It is the policy of the Medical Staff to comply with all federal and state laws, rules, and regulations pertaining to the delivery of health care in a hospital setting. Each Practitioner and APP is expected to maintain compliance with applicable state and federal laws, rules, and regulations including, but not limited to, the Medicare critical access hospital conditions of participation and applicable accreditation standards governing the Hospital and the delivery of health care in the Hospital.
- XIV. Consultations
- A. Any Practitioner with Privileges can be called for consultation within the Practitioner's area of expertise.
 - B. Consultations are recommended when, in the judgment of the attending Practitioner:
 - 1. There is doubt as to the best therapeutic measures to be utilized.
 - 2. When requested by the patient or patient's legal guardian(s) or authorized representative(s).
 - 3. To manage a medical condition outside the scope of the attending Practitioner's expertise.
 - C. A satisfactory consultation includes examination of the patient, review of the patient's medical record, and documentation of the opinion of the consultant in the patient's medical record.
 - D. A consultation for an inpatient or observation patient is to be completed within twenty-four (24) hours after notification of the order.
 - E. The consultation note should be recorded prior to an invasive procedure, except in an emergency.
 - F. The patient's Practitioner is responsible for requesting consultation and communicating the reasons for a consultation. Practitioner to Practitioner communication to request a consultation is preferred.
 - G. Consultations for swing (skilled) patients may be completed in a time period mutually agreed upon by the ordering Practitioner and the consulting Practitioner. These consultations may take place in the Hospital or the patient may be sent to the

consultant's office to the extent permitted by applicable laws, rules, and regulations.

- H. A PA or CNP with Privileges at the Hospital may request a third party consultation in cooperation with his/her supervising or collaborating Practitioner. A PA or CNP who is granted Privileges to do so may provide a consultation within his/her scope of practice if requested to do so in accordance with the requirements, as applicable, set forth in this section.

- XV. Restraints. Restraints shall be used (1) only when all other interventions have been exhausted and (2) consistent with the Hospital's Restraint Policy as set forth in its Nursing Procedure Manual, as such policy may be amended from time to time.

- XVI. Advanced Directives. The Hospital will, to the best of its ability, recognize legal documents pertaining to Living Wills, Durable Power of Attorney for Health Care, Do Not Resuscitate Comfort Care, Do Not Resuscitate Comfort Care-Arrest, and Declarations for Mental Health Treatment that are appropriately and properly executed as recognized under Ohio law. Additional information with respect to Advanced Directives and Do Not Resuscitate orders is set forth in applicable Hospital policy, as such policy may be amended from time to time.