Presbyterian Espanola Hospital

Medical Staff Rules and Regulations

Revised: 8/20/2013
Approved Medical Executive Committee/Medical Staff: - 9/17/2013
Approved by the Board of Trustees – 9-24-2013
Medical Executive Committee/Medical Staff – 12/21/2015
Approved by the Board of Trustees – 1-29-2016
Addition: Physical therapy –Approved by MEC 1/15/2018
Approved by Board 1/23/2018

Table of Contents

Initial Medical, Dental & Podiatry Credentialing Process by Criteria Based Tracking

Application for medical staff membership and clinical privileges as well as request for additional clinical privileges, reappointment of privileges has been simplified using a criteria based process. Approved Policies regarding this "fast Track" method of credentialing are updated and approved by the Medical Executive
Committee and are delineated in the Medical Staff Bylaws, Credentials Manual, available in the Office of the Medical Staff Affairs.

Part One: Admission, Care and Discharge of Patients

1.1. Authority

The authority for admission of patients to Presbyterian Espanola Hospital inpatient facility (hereinafter "facility") has been vested in PHS Administrator by the Board of Trustees. Requests for admissions are made by the Staff member by final approval rests with the administrator.

1.2. Type of Patients

Presbyterian Espanola Hospital shall accept patients with all types of diseases, including emotional disturbances and addictive diseases, providing that all facilities are available for care of the patient and protection of personnel.

1.3 Generally

A patient may be admitted to, or discharged from the facility only by a member of the medical staff with admitting privileges.

1.4 Admission Information

Except in an emergency, no patient shall be admitted to the facility until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. In all case, staff members admitting patients shall be held responsible for giving such information as may be necessary to assure protection of the patient from self-harm and to assure the protection of others.

1.5 Timely Visitation after Patient Admitted

1.5.1 All hospitalized patients will be seen at least once daily by a privileged practitioner.

1.5.2 Timely admission orders for non-critical care units including diagnosis therapeutic orders, laboratory, diet and activity orders and other ancillary studies will be submitted.

1.6 Attendance of Patient

Opinions requiring medical judgment, evaluation of the significance of medical histories and physical examinations, authentication of medical records and the prescribing of treatment shall be made only by members of the Medical Staff with clinical privileges.

Part Two: General Responsibility for and Conduct of Care

2.1 Generally

The practitioner who admits a patient shall be responsible for the provision of medical care to the patient. Whenever a member transfers this responsibility it shall be entered in the medical record.

2.2 Transfer of Responsibility

Each member of the Medical Staff who is not available for the care of his/her patients shall name a member of the Medical staff with equivalent privileges who is available and who will accept responsibility for continuing care of the Staff member's patients in the hospital, including discharge or transfer to alternate facilities when medically indicated. In case of failure to name such an associate, the President of the Staff or Chief Medical Officer shall have the authority to call any member of the Active/Associate Staff to provide necessary medical care.

2.3 Consultations

2.3.1 Any member of the Medical or Ancillary Staff may consider obtaining consultative support when one or more of the following elements arise during the course of care:

- When a patient is seriously ill and the diagnosis is in doubt, improvement with therapy is not apparent (except in irreversible or terminal illness), or when specialized therapy or diagnostic procedures are to be used.
- When the patient has an illness or problem requiring an unusual degree of expertise or competency in a subspecialty area acquired through subspecialty training.

2.3.2 Members of the medical staff asked to provide consults for patients admitted to inpatient or observation status will personally assess the patient within 24 hours, unless explicitly specified otherwise. The consultant shall document that s/he personally has examined the patient and reviewed all pertinent medical records and lab findings.

Part Three: Emergency Services and Transfer of Patients

3.1 Participation on the On-Call Roster

A physician on-call schedule will be available at all times in the Emergency Department.

3.2 Transfer of Patient

When, in the opinion, of the attending physician, patient needs for care or safety could be better met in another facility, transfer shall be arranged in accordance with federal, state and health plan regulations and the transferring physician shall contact the physician to whom the patient is referred. Pertinent patient care portions of the medical record shall be copied to accompany the patient.

3.3 Referral of Patients to the Emergency Department by the Medical Staff

Members of the Medical Staff may refer and care for their patients in the Emergency Department for urgent or emergent conditions. This physician should notify the Emergency Department of the referral and give instructions for interim care. If the referring physician does not arrive before the patient, the Emergency Department physician will evaluate the patient and initiate care if the patient has an unstable condition. Any emergency care will be provided by the Emergency Department until the referring physician arrives.

3.4 Treatment of Mass Casualties

Under conditions involving mass casualties, all staff members may be assigned to posts in a facility, mobile casualty stations, or areas of refuge and it is their responsibility to report to their assigned stations. The implementation of the internal and external disaster plan will be under the direction of the Hospital Administrator's Office. The review of policy and procedure utilized by the facility will be under the direction of the approval of the Medical Executive Committee.

Part Four: Discharge of Patients

4.1 AMA

Should a patient leave a facility against advice, a notation of the incident shall be made in the record. The patient shall be requested to sign a release of responsibility form. Should the patient refuse to sign, the documentation will be made by the nurse on the form.

Part Five: Orders

5.1 General Requirements

Hospital based diagnostic and therapeutic services shall be provided under the direction of a physician or practitioner with admitting clinical privileges. All orders must be clear, complete and legible. All orders for treatment shall be in writing.

When orders are unclear, incomplete, or illegible, the authorized employee receiving the order shall obtain clarification from the practitioner. The order will not be carried out until clarified. The clarified order will be written as a verbal order and authenticated as with other orders.

5.2 Verbal Orders

Practitioners will minimize their use of verbal and telephone orders to emergent situations. The ordering practitioner or the practitioner covering is expected to promptly date, time and sign all verbal orders, when the patient is next seen, or within 72 hours.

Personnel authorized to accept and transcribe verbal orders are per Verbal Order Policy. All orders shall be considered to be in writing if dictated to the above mentioned personnel by the attending staff members.

Verbal orders are expressly prohibited for certain types of chemotherapy medications as outlined in "PC.CDS.110: Orders for Chemotherapy Medications"

5.3 Standing Orders

Standing orders must be approved by the Medical Executive Committee upon the recommendation of the appropriate service or committee. The standing orders are to be followed insofar as proper treatment of the patient will allow and shall be dated, timed and signed by the physician.

5.4. Restraint Orders

Restrained orders must be reviewed and renewed in accordance with Presbyterian-Wide Restraint Policy.

5.5 Automatic Cancellation of Orders

All orders for patient care shall be canceled at time of surgery or on transfer to the acute care unit. It shall be responsibility of the attending physician to write new orders promptly for continuation of the patient's care

5.6 Preoperative or Pre-transfer orders

All pre-operative or pre-transfer orders for patient care shall be reviewed and authenticated with signature, time and date by the attending physician at the time of surgery or on transfer to or from the Intensive Care Unit.

Part Six: Pharmacy and Medication Orders

6.1 Stop Orders

Stop Orders must comply with the Medical Staff approved Patient Care Policy on Medication Stop Orders.

6.2. **Formulary and Investigational Drugs**

Presbyterian Espanola Hospital facility formulary shall be maintained by the Pharmacy under the direction of the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee. The formulary permits a physician to order from drugs that are listed. When the brand of drug ordered is not listed in the formulary, the Pharmacy may dispense an equivalent drug of a different brand. However, it shall be within the discretion of the physician at the time of prescribing to disapprove substitution of drug of a different proprietary brand than that ordered. All medications are administered by or under the supervision of appropriately licensed personnel in accordance with applicable law and regulation.

6.**3 Policy on Patients' own Medications**

The use of patient's own medications shall be reserved for only those circumstances where it would be difficult or impractical to dispense the medication from the pharmacy. If a patient's personal supply will be used, a written order must be placed in the chart. The medication will be stored in the medication room along with the patient's medications. Patient's own medications may not be stored at the bedside. Orders for patients own medications or for self-administration shall include the name of the drug, dosage to be given and frequency of administration. The usage, storage and destruction of patient's own medication must comply with the Medical staff's approved Patient Care

6.4 Investigational Drugs

A staff member who desires to use a drug that has not been approved for any purpose by the Food Drug Administration shall follow procedures outlined by the Pharmacy and Therapeutics Committee and approved by in Medical Executive Committee. In all cases where such a drug is used, the patient shall complete an informed consent form approved by the IRB and the drug shall be dispense from the Pharmacy on order of the physician. The procedures to follow shall be available at the Pharmacy.

Part Seven: Informed Consent

Generally

A general consent form for diagnosis and treatment, signed by or on behalf of every patient admitted to a facility shall be obtained at the time of admission. Additional written, signed consents shall be obtained prior to diagnostic, therapeutic, or operative procedures which have inherent risk. In the case of emergencies involving a minor or a patient who is unconscious or otherwise incompetent or when the patient's life is in jeopardy and suitable consent cannot be obtained, the circumstances shall be fully recorded in the medical record. In such instances, when time permits, a consultant's opinion is desirable.

Part Eight: Ancillary Services

Routine laboratory procedures for patients admitted for one (1) day or less for diagnostic procedures or for surgical procedures may be developed as indicated by the appropriate clinical service. The surgery service with approval from the Medical Executive Committee may establish needed pre-operative laboratory and ancillary studies prior to operative procedures.

Part Nine: Infection Control

Isolation of patients for certain infections and contagious diseases shall be required as specified by the Infection Control Committee.
Individual infection control reports shall be maintained in the Infection Control Coordinator's office.

Part Ten: Mortality

In the event of a patient's death in a facility, the deceased shall be pronounced dead by the responsible physician or his/her designee. The body shall not be released until an entry has been made in the medical record by a member of the Medical Staff or his/her designee.

Part Eleven: Institutional Review Board

Any experimental or research procedure or study involving patients, hospital facilities, or clinical records in a facility shall first be approved by the Presbyterian Health Systems Institutional Review Board. Any reports resulting from such experimental or research procedures or study are reviewed by the Institutional Review Board.

Part Twelve: Medical Records

An adequate medical record shall be maintained for every individual who is evaluated or treated at Presbyterian Espanola Hospital as an inpatient, outpatient, clinic or emergency patient.

12.1 Ownership

All patient medical records, radiographic films and studies, fetal heart monitoring tracings, pathology specimens, microscopic slides, photographs, videotapes, photographic slides, and any other documents resulting from the care provided are the property of Presbyterian Espanola Hospital. Physicians and the individual departments are responsible for maintaining the integrity and confidentiality of the records. Under no circumstances may any of these originals be removed without express permission from the PEH HIM Department, or under court order. Copies may be obtained from the HIM Department in compliance with Federal and State Regulations.

12.2 Access

Each member of the Medical Staff with access to the hospital medical records agrees to comply with the information security policies of the hospital including those set forth in the PHS electronic Information Security policy, Information Technology Acceptable Use policy and Personal Computing Device Policy. Such policies include maintaining passwords and Personal Information Number (PIN), which allow access to computer systems and equipment, in strictest confidence and not disclosing passwords and/or PIN to anyone, at any time, for any reason.
Each member of the Medical Staff understands that patient records are confidential and that access to such records should be limited to those with a need-to-know I order to provide for the care of the patient.
Failure to comply with the information security policies of the Hospital may result in termination of access to computer systems, paper or other health information records, and in the initiation of corrective action as specified in the Bylaws. Loss of Medical Staff membership or limitation, reduction or loss of clinical privileges for any reason may be grounds to terminate access to the system immediately and without notice to the member.
Each member of the Medical Staff shall have access to previous hospital records of patients attended on an outpatient basis, when affiliation with the patient is evidenced by documentation of previous Hospital care. A requesting member must obtain written patient consent when affiliation is not evidenced in previous health care records. At the time of readmission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible at the time of and for the duration of the readmission.

12.3 Release

Unauthorized release of information from the hospital records is prohibited. Unauthorized release includes printing of documents and re-release of these documents to others whether or not they have appropriate access.
Access to all medical records of all patients shall be afforded to a member of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. Subject to the discretion of the Chief Medical Officer, former members of the Medical Staff shall be permitted access to information from the

medical records of their patients covering all periods which they attended such patients in the hospital.
Access to all medical records of all patients shall be accorded to duly constituted committees of the Medical Staff for the purpose of medical care evaluation and review of utilization.

12.4 Persons Authorized to Document in a Medical Record

Entries in the medical record may be made by members of the Medical and by other persons specifically authorized by Presbyterian Espanola Hospital Medical Staff. They may include: Registered nurses, licensed practical nurses, respiratory therapists, physical therapists, certified registered nurse anesthetists, registered dietitians, speech therapists, behavioral health therapists, polysomnography technicians, home health care coordinators, physician assistants, nurse practitioners, nurse specialists, certified nurse midwives, occupational therapists, pharmacists, radiology technicians and others as approved by the Medical Executive Committee.

12.5 Documentation Requirements

Accurate, appropriate complete, legible, and timely documentation is the responsibility of all those that are authorized to make entries in the medical record. Medical Records must be completed within 30 days of a patient's discharge.
Medical records entries must be legible, permanently recorded (black, red or blue ink), dated, timed and authenticated with the name and the title of the person making the entry.
To facilitate consistency and continuity in patient care, the completed medical record must contain very specific information including but not limited to the following:

- Date and time of admission and discharge;
- Patient's name, address, date of birth, and the name of any legally authorized representative;
- Emergency care, treatment and services provided to the patient prior to arrival, if any;
- Documentation and findings of the patient's assessment;
- Conclusions or impressions drawn from the medical history and physical examination

12.5.1 Orders

All orders shall be recorded and authenticated. The ordering practitioner, or his/her authorized designee, must authenticate all orders in writing within 72 hours. An electronic signature may be used instead of a handwritten signature under certain conditions.

12.5.2 Symbols and Abbreviations

Appropriate symbols and abbreviations may be used unless expressly forbidden. (Refer to DNU Abbreviation Policy) Unacceptable abbreviations may not be used under any circumstances in the medical records.
The use of a signature stamp is not permitted at Presbyterian Espanola Hospital.

12.5.3 History and Physical

History and Physical: (refer to Part III: 6.11 of the Medical Staff Bylaws)
A medical history and physical examination be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by

a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
CA history and physical (H&P) is required for all operative or other high-risk procedures requiring anesthesia services. A high-risk procedure is a procedure that if not planned and/or implemented correctly has a significant potential for impacting the safety of the patient. A History & Physical may only be performed by a practitioner who is legally authorized to practice within the State of New Mexico, providing services within their authorized scope of practice and is privileged by the Medical Staff to perform History and Physicals.

Content for a Comprehensive History and Physical
The history and physical for inpatients must contain the following. When an element is not applicable it must be clearly noted on the H&P.

- Chief Complaint
- History of present illness
- Past Medical History
- Social and family histories
- Inventory of body system based on that which is clinically pertinent including both positive and/or negative findings
- Medications and allergies
- Psychosocial history, when applicable
- Conclusions or impressions drawn from the medical History & Physical examination.

Content for an expanded or problem focused History and Physical
The history and physical for outpatient procedures must contain the following:

- Chief complaint
- History of present illness
- Review of pertinent systems related to the procedure

Timeframe: For admissions and outpatient services for which a History & Physical is required, it must be performed and documented no more than 30 days prior to, or within 24 hours after inpatient admission.

Updates:
Within 30 days: For a History & Physical that was completed within 30 days prior to inpatient admission, an update documenting the patient's condition must be completed within 24 hours after inpatient admission or prior to surgery, whichever comes first. It must be signed, timed and dated by the practitioner who completes the update.

Outpatient procedures:

For those outpatient procedures for who a History & Physical is required, it may have been performed within 30 days prior to the date of the procedure, but must be updated immediately before the procedure. The update must be documented in the patient's medical record, and it must be signed, timed and dated by the practitioner who completed the update.

If, upon examination, the licensed practitioner finds no change in the patient's condition since the History & Physical was completed, s/he may indicate on the History & Physical or in a progress note in the patient's medical record that the History & Physical was reviewed, the patient was examined and that "no change" has occurred in the patient's condition since the History & Physical was completed. If the update is written in a progress note, it must be specified that the note is indeed an update to the History & Physical. Daily progress notes are not in and of themselves sufficient enough to meet the requirements for an update to the History & Physical. Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. Additionally, if the practitioner finds that the History & Physical done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the History & Physical, examining the patient, and completing the update may disregard the existing History & Physical, and conduct and document in the medical record a new History & Physical within 24 hours after admission or registration.

Inability to Obtain:

If the physician or his/her designee is unable to obtain a history from the patient or other source, the records should describe the patient's medical condition or other circumstance that precludes obtaining a history. This may include urgent/emergency condition(s), patient's inability to communicate, or that the patient is at high risk, where immediate action is necessary.

Delegation:

A physician (M.D., DO, DDS/DMD, DPM) may delegate all or part of the medical history and physical examination, discharge summaries, and operative reports or other documentation, physician orders, and verbal orders without a co-signature requirement. Other practitioners include certified nurse practitioners, physician assistants, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

12.5.4 Medical Record Content

12.5.4.1 Generally

A completed medical record includes the following:

- Diagnosis or diagnostic impression;
- Goals of treatment and the treatment plan;
- Evidence of known advance directives;
- Evidence of informed consent, when required by Hospital policy;
- Diagnostic and therapeutic orders, if any;
- All diagnostic and therapeutic procedures and test results;
- Test results relevant to the management of the patient's condition;
- All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- Progress notes made by the medical staff and other authorized individuals;

- All reassessments and any revisions of the treatment plan;
- Relevant observations;
- Patient's response to care, treatment and services;
- Consultant reports, if applicable;
- Every medication dispensed or prescribed to an ambulatory patient or an inpatient on discharge;
- Every dose of mediation administered and any adverse drug reaction;
- Known medication allergy and drug reaction history
- All relevant diagnoses established during the course of care;
- Any referral and communications made to external or internal care providers and to community agencies, conclusions at termination of hospitalization;
- Discharge instructions to the patient and family;
- Discharge summaries or a final progress note or transfer summary.
- A post-operative documentation record of the patient's discharge from the post anesthesia care area
- Tissue reports, including a report of microscopic findings if hospital policies require that microscopic examination be done. If only microscopic examination is warranted, a statement that the tissue has been received and a microscopic description of the findings shall be provided by the laboratory and filed in the medical record;
- Autopsy findings when applicable;

12.5.4.2 Surgical patients

Medical records of all patients undergoing surgery shall include, in addition to the above referenced requirements, the following:

- A comprehensive history, physical, special examinations, and diagnosis recorded prior to operation
- Anesthesia record, including post-anesthetic condition signed by the anesthesiologist, certified registered nurse anesthetist or surgeon
- A written postoperative note shall contain the following elements, as applicable: Date, time and signature, post-procedure diagnosis, procedures performed, findings, name of the surgeon and any assistant(s), estimated blood loss, and specimen(s) removed;
- Dictated full operative report
- Pathologist's report on all tissues removed at the operation

12.4.4.3 Emergency Department Patients

A medical record shall be initiated and maintained for each individual assessed or treated in the Emergency Department and shall be incorporated in the patient's Universal record. The attending practitioner is responsible for a timely, legible and complete medical record for each patient seen in the emergency department. This record must be completed within 24 hours of discharge.

In addition to the brief summary required for patients admitted to inpatient units, the record for each Emergency Department visit must include at a minimum:

- Identification data, including patient name and date. When not available, state the reason;
- Time, means of arrival, and by whom transported;

- Problem-focused history and physical;
- Documentation of emergency care given the patient prior to his arrival at the hospital, where such information is available;
- Evidence of appropriate informed consent, or if not obtainable, the reason documented in accordance with the hospital's policies on informed consent;
- Diagnostic and therapeutic orders, if any;
- Treatment given;
- Clinical observations, including results of treatment and tests;
- Diagnosis or diagnostic impression;
- Documentation of the patient's leaving against medical advice, if appropriate, in accordance with the hospital's policies;
- Disposition, patient's condition on discharge or transfer, and any instructions given to the patient and/or authorized representative for follow up care; and,
- Any referrals and communications made to care providers or community agencies.

12.4.4.4 Newborn Patients

The records of newborns infants shall be maintained as separate records and shall include the following:

- Type of identification on infant in delivery room
- Date and time of birth, birth weight and length, period of gestation, sex;
- Parents name and addresses
- Description of complications of pregnancy or delivery including premature rupture of membranes
- Conditions at birth including color, quality of cry, method and duration of resuscitation;
- Record of appropriate antibiotic solution in each eye at delivery
- Results of PKU tests;
- Reports of initial physical examination including any abnormalities, signed by the attending physician; and,
- Progress notes including temperature, weight, and feeding charts, number, consistency and color of stools; conditions of eyes and umbilical cord; condition and color of skin and motor behavior

12.4.4.5 Obstetrical patients

The current obstetrical record should include a complete prenatal record whenever possible when the patient has had an established patient-practitioner relationship for the course of the pregnancy. The prenatal record must be a durable legible copy of the attending practitioner's office or clinic record transferred to the OB department before admission. An internal admission note must also be written within 24 hours that includes pertinent additions to the history and any subsequent changes in the physical findings.

All obstetrical patients undergoing major surgery must have a history and physical examination recorded as required by these Rules and Regulations. In addition, the record should include the following:

- Comprehensive History & Physical;
- Complete description of progress of labor and delivery, including reasons for induction and operative procedures;

- Records of anesthesia, analgesia, and medications given in the course of labor and delivery;
- Records of fetal heart rate and vital signs;
- Signed reports of consultants when such services have been obtained;
- Names of assistants present during delivery; and,
- Progress notes including descriptions of involution of uterus, type of lochia, condition of breast and nipples, and report of condition of infant following delivery.

12.5.5 Other Types of medical Record Entries

12.5.5.1 Progress Notes

A daily visit and note by the attending practitioner or designee is required for all patients. Designee refers to practitioners who are appropriately credentialed members. Pertinent progress notes should be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever 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. Progress notes shall be authenticated by the author at the time they are created.

Countersignature

All progress notes written by AHPs and medical students must be countersigned by the attending physician within 24 hours indicating that the attending practitioner's observation coincide with those of the AHP or student.

12.5.5.2 Late Entries

Late entries are made by entering the current date and time, identified as a "late entry", followed by the desired information.

12.5.5.3 Tissue Examination and Reports

The practitioner performing a procedure is responsible for seeing that all tissues, foreign bodies, artifacts and prostheses removed during a procedure are properly labeled and sent to the pathologist, provided, however, the determination as to whether to send specimens to the pathologist shall be made by the practitioner and if certain specimen are not sent, it shall be noted in the medical record. The pathologist shall document receipt of the specimen and make any exam nation as is necessary to arrive at a pathological diagnosis. The Medical Staff of the hospital may exempt specified tissues or other specimens from pathological diagnosis as incorporated in the medical record and to resolve any discrepancies between the final diagnosis and the pathological diagnosis.

12.5.5.4 Postoperative Entries

The following items must be entered as appropriate: Vital signs, patient status during recovery period and any problems encountered, documentations of reason for transfer to another level of care or setting, discharge order by the physician, discharge note or discharge protocol assessment, diagnoses, name of operation/procedure, patient disposition and discharge instructions to include diet, medications, activity and return to office.

12.5.5.5 Consultation Reports

Each consultation report must be written or dictated and include the opinions and conclusions reached and, where appropriate, documentation of an actual examination of the patient and patient's medical record.

12.5.6 Anesthesia & Sedation/Analgesia Record

12.5.6.1 Pre-Anesthesia Evaluation

A pre-anesthesia or pre-sedation/analgesia evaluation of the patient by a provider qualified to administer anesthesia shall be recorded in the patient's medical record within 48 hours prior to surgery or procedure and before preoperative medication has been administered. The pre-anesthesia or pre-sedation/analgesia evaluation shall include;

- Past and present medical history,
- Previous anesthesia or pre-sedation/analgesia experiences(s)
- A physical status assessment or anesthesia risk (ASA classification)
- Any potential anesthesia or sedation/analgesia problems
- The results of relevant diagnostic studies, if any,
- The planned choices of anesthesia or sedation/analgesia, and,
- The patient's appropriateness for anesthesia or sedation/analgesia

The pre-anesthesia or pre-sedation/analgesia evaluation may be documented by an appropriately credentialed Allied Health Professional or Hospital employee provided an anesthesiologist or licensed independent practitioner reviews the evaluation and co-signs the note.

12.5.6.2 Intra-operative Anesthesia Record

The anesthesia provider shall maintain a complete record of anesthesia events to include monitoring of the patient, the dosage of all drugs and agents used, the type and amount of all fluids administered, including blood and blood products, the technique(s) used, unusual events during the anesthesia period, and the status of the patient at the conclusion of anesthesia.

12.5.6.3 Post-Operative Anesthesia Record

The patient's postoperative or post-procedure status is assessed on admission to the post-anesthesia or sedation/analgesia area and before discharge from the post-anesthesia or sedation/analgesia area. The post anesthesia evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia no later than 48 hours post-procedure or a procedure requiring anesthesia services.

The patient may be discharged by either the licensed independent practitioner who performed the procedure or designee, or an RN using discharge criteria approved by the medical staff and according to departmental protocol.

12.5.7 Entries at Conclusion of Hospitalization

12.5.7.1 Discharge Diagnosis

The discharge diagnosis, (principal diagnosis) reason for hospitalization and significant findings and treatments must be written or dictated in full at the time of patient's discharge.

12.5.7.2 Discharge Summary

A discharge summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization (principal diagnosis), significant findings, medical necessity, the procedures performed and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission and any specific discharge instructions given to the patient. Additional documentation may be required by departmental policies.

A final progress note may be substituted (as an exception) for the discharge summary in the case of the following categories of patients:

- For an outpatient status (short stay, extended recovery or observation status) less than 48 hours.
- Normal newborn infants; and,
- Patients with uncomplicated vaginal deliveries.
- The progress note must contain a final diagnosis, (principal diagnosis) outcome of hospitalization, the case of disposition, and any provisions of follow up care.

12.5.7.3 Instructions to Patients

Any specific instructions regarding physical activity, medication, diet and follow up care given to a patient by the attending practitioner shall be documented in the medical record.

12.6 Incomplete/Delinquent Medical Records

12.6.1 Incomplete Records

Medical records are considered incomplete under the following conditions:

- Omission of provisional diagnosis or principal problem necessitating admission, additional diagnoses, history and physical examination, complications, operative or special procedure reports, final diagnoses, condition on discharge, discharge instructions and discharge summary; or,
- Omission of required signature or authentication of discharge summary, discharge orders, operative or other special procedure reports, history and physical examination or consultation reports.

12.6.2 Delinquent Records

All patient medical records shall be considered delinquent if available records are not completed within 30 days of patient discharge. A medical record is considered complete when the following criteria are met:

- History & Physical examination completed within 24 hours of admission and signed by the attending physician.

- Discharge summary dictated and signed by the attending physician;
- Operative and invasive procedure reports completed within 24 hours of the procedure and signed by the responsible physician;
- Consultation reports completed and signed by the responsible consulting physician;
- Responsible practitioner's signature is present on all verbal/telephone orders. Medical records that do not contain these elements when applicable will be deemed to be delinquent. Failure to complete these reports as is required within 24 hours will also be deemed to be a delinquency.

12.6.3 Failure to Comply

For failure to comply with section 12.6.2 of these Medical Records Rules and Regulations the Medical Staff member's privileges to admit or participate in the care of new patients or to schedule new surgeries/procedures, with the exception of requirement for emergency department backup coverage call obligations, shall be automatically temporarily suspended pursuant to Bylaws Part II. 3.1.3. The member will be sent a written notice of warning of suspension when a medical record is identified as incomplete 21 days after discharge. Suspension will occur on the date the medical record(s) become delinquent and shall remain in effect until all available delinquent medical records are completed. Medical record suspensions will be tracked during each term of membership and will not be cumulative from one appointment cycle to the next.

Failure to complete all delinquent medical records by 60 days after an initial notice of suspension shall be deemed a voluntary resignation of Medical Staff membership. If after a voluntary resignation occurs pursuant to this process, the member requests reappointment to the Medical Staff, s/he must meet the requirements for reappointment of practitioners who have voluntarily resigned from the staff due to medical record noncompliance.

12.7 Filing of Incomplete Medical Records

No medical record shall be filed until it is complete and properly authenticated. In the event that a medical record remains incomplete by reason of the death, resignation, or other inability or unavailability of the responsible practitioner to complete the record, the President of the Medical Staff or designee shall consider the circumstances and may enter such reasons in the record and order it to be filed.

Part Thirteen: General Rules for Surgical Care

A surgical procedure shall be performed only with the informed consent of the patient or his/her legal representative. In an emergency, where a consent form cannot be completed in the usual manner, a statement by another staff member attesting to the existence of an emergency shall be obtained. The statement shall be made part of the medical record. Surgeons shall be in the Operating Room and ready to commence operation at the time scheduled. The primary operating surgeon shall be a member of the Medial staff, or have surgical privileges.

Patients schedule for minor procedures shall be admitted timely before the time of the procedure.

All patients admitted to the Operating Suite for surgery who do not yet have a recorded history & physical examination on the chart shall have an admission note stating the reasons for admission, the essential findings, other pertinent information, and a provisional diagnosis before surgery is undertaken. When such requirements are not met, surgery shall not proceed unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

An immediate postoperative note of all operations shall be written immediately after surgery. The postoperative note shall contain, as applicable the following elements: date, time and signature, post-procedure diagnosis, procedures performed, findings, the name of the surgeon and any assistant(s), estimated blood loss and specimen(s) removed. An operative report must be dictated within 24 hours following the procedure.
In the cases surgical procedures requiring hospital stay of only a few hours, the medical record shall contain enough information to explain the reason for admission, the findings, the procedure, and the results.

In every case where an anesthetic is administered by an anesthetist, a record shall be made of pre- and post-anesthetic examinations, and an anesthetic record shall be completed.
All specimens and tissues removed during a surgical procedure, with the exception of: appliances, teeth, hardware, scar tissues, newborn foreskin (adult foreskin at the discretion of the surgeon), cataracts, normal placenta, vas deferens and bone (if no carcinoma is suspected) shall be sent to the pathologist, who shall determine the extent of examination necessary for diagnosis.

Part Fourteen: General Rules for Emergency Care

The emergency department shall have a physician in attendance at all times. It shall be the Emergency Medicine physicians' responsibility to initiate emergency care when necessary to screen all patients that come to the Emergency Department, to see that appropriate care or referral is provided and to provide care for patients as requested by the patient or the patient's physician.
The practitioner providing service to a patient in the Emergency Department shall be responsible for a medical record that contains a brief history, the essential findings, the treatment, disposition of the patient, condition on discharge, and instructions given the patient when the patient is not admitted.
If a private physician requests that a patient be sent to his office, that transfer will not occur until the patient has been assessed by the Emergency Room physician to assure no harm will result in that transfer.

14.1 Rules Governing Emergency Department Physicians

- The Emergency Department will be assigned shifts in advance and the schedule posted in the Emergency Department.
- The Emergency Department physician must remain on duty until relieved by the next shift physician.

- The Emergency Department physician shall respond to “Code Blue” calls within the hospital and coordinate ACLS until relieved by an attending practitioner qualified to continue care.
- The Emergency Department medical director or designee shall be involved in maintaining, testing and continuously evaluating policy and procedures for the management of internal and external disaster situations.

Part Fifteen: General Rules for all Practitioners with Privileges at Hospital

- Practitioners with privileges are responsible for the quality of all medicine practiced in the hospital.
- Privileges will be granted as per the qualifications noted in the Medical Staff Bylaws Credentials Manual and Privilege forms approved by the Medical Executive Committee and Board of Trustees.
- The initial assignment of privileges, or extension of privileges, is provisional and shall be under conditions of supervision as defined for a minimum of six (6) months. In accordance with the Medical Staff Bylaws, Part III, section 4. All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The Credentials Committee, with the approval of the MEC, will define the circumstances, which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The credentials committee will also establish the duration and/or number of cases for such FPPE and triggers that indicate the need for performance monitoring.
- The provisional member planning a procedure requiring direct supervision shall notify the appropriate supervisor who will supervise and complete a supervision report and submit the report to the Office of the Medical Staff Affairs.
- At the end of six (6) months, the PEC will assess the findings of the review and submit findings to the Credentials Committee will determine and recommend to the Medical Executive Committee that privileges be assigned without supervision, continued supervision or revocation of privileges. Privileges may be limited or terminated at any time if substandard or incompetent performance is observed.

Part Sixteen: Podiatry/Dentistry

16.1 Podiatry

Qualifications for practicing podiatry at Presbyterian Espanola Hospital are delineated in the Medical Staff Bylaws, Credentials Manual: Section 2.
Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients (in or outpatients) will receive a (history and physical) by a member of the medical staff with privileges to perform such an evaluation that will be recorded in the medical record.

16.2 Dentistry

Qualifications for practicing dentistry at Presbyterian Espanola Hospital are delineated in the Medical Staff Bylaws, Credentials Manual: Section 2.
Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oromaxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oromaxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oromaxillofacial surgery and demonstrated current competence.

16.3 Limitations for Dentists and Podiatrists

Dentists and podiatrist members of the Medical Staff may attend patients in the hospital. A physician member of the Medical Staff must perform a basic medical appraisal (including History and Physical examination) for each dental and podiatric patient, manage the medical aspects of care, and must perform an evaluation of the overall medical risk and effect of any planned procedure or operation on the patient's health, as outlined in the current history and physical. It is the obligation of the dentist or podiatrist to make advance arrangements for medical consultations.

Part Seventeen: General Rules for Allied Health Personnel

Allied Health Personnel employed by the hospital may provide services to patients within the limit of their skills and the scope of lawful practice upon recommendations of the Medical Staff and approval of the Boards. The assigned permit is not a contractual or property right and can be terminated at any time for substandard performed or conduct. Medical Staff Bylaws, Credentials Manual, Part 6.5
Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Allied health practitioners (AHPs) in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of these AHPs shall terminate immediately, without right to due process, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the medical staff organization is terminated for any reason.

For the purpose of this section, AHPs shall include the following categories:

- Qualified nurse practitioners who have completed additional education requirements are license as registered nurses and are certified to practice as nurse practitioners in the State of New Mexico.

- Physician assistants who have completed a prescribed course of study and are certified as a Physician Assistant by the New Mexico Board of Medical Examiners.
- Physical Therapists and Occupational Therapists who are licensed in the State of New Mexico (added 1/23/2018)

The performance of all AHPs is subject to continued review by the medical staff. The Medical Staff shall have the duty to initiate corrective measures, including termination of permits where appropriate. In the event that there is unsatisfactory performance, the sponsoring physician will be notified in writing and corrective action will be taken.

Physical Therapists and Occupational Therapists:

- In order to allow Physical Therapists and Occupational Therapists to accept self-referral/direct care patients, they shall be authorized to order applicable Physical Therapy/Occupational Therapy outpatient service. The therapist will act within their scope of practice and shall refer a patient to the patient's licensed health care provider according to the state of NM practice act requirements.