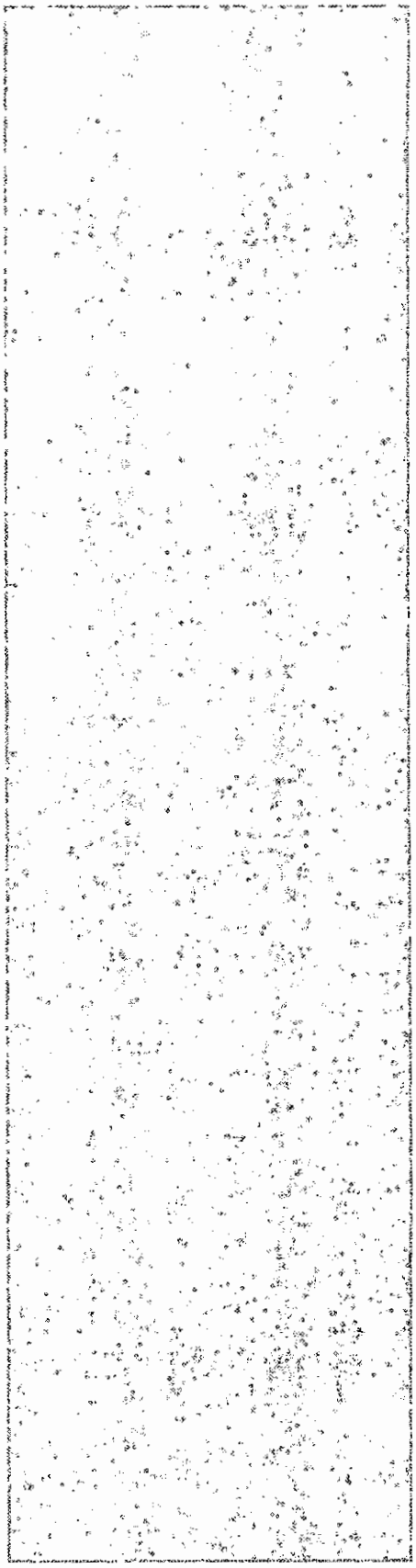
RULES & REGULATIONS OF THE MEDICAL AND DENTAL STAFF OF SOCORRO GENERAL HOSPITAL SOCORRO, NEW MEXICO

January 14, 2020



1. INTRODUCTION

1.1 DEFINITIONS

"ADVANCE DIRECTIVE" means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives include a "Declaration of a Desire for a Natural Death"
Do-Not-Resuscitate Orders and similar documents expressing the individual's preferences as specified in the Patient Self-determination Act.

DESIGNEE means any medical physician, osteopathic physician, dentist, podiatrist, clinical psychologist and advance practice clinicians holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

"CLINICAL PRIVILEGES" means the authorization granted to a practitioner to render patient care and includes unrestricted access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

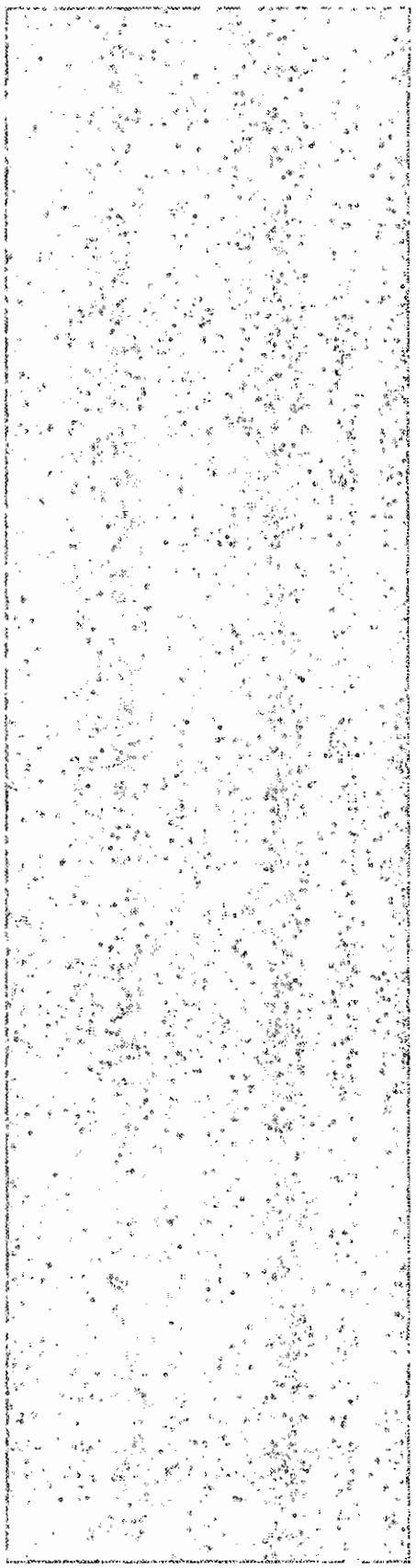
"FAMILY" means those persons who play a significant role in the individual's life. This may include persons who are not legally related to the individual.

"LIFE-SUSTAINING PROCEDURE" means a medical procedure or intervention which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

"HEALTH CARE AGENT" means an individual designated in a health care power of attorney to make health care decisions on behalf of a person who is incapacitated.

"INVASIVE PROCEDURE" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, incisions and drainage, surgeries, endoscopies, and implantations, and excluding venipuncture and intravenous therapy.

"PATIENT" means as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.



"PHYSICIAN" means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the New Mexico Board of Medical Examiners and who has a current valid licensed to practice medicine and surgery in New Mexico.

"PRACTITIONER" means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, and advance practice clinicians who has been granted clinical privileges.

"SURGEON" refers to any practitioner performing an operation or invasive procedure on a patient.

"UNABLE TO CONSENT" or "INCOMPETENT" mean unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does not include minors unless they are married or have been determined judicially to be emancipated [Adult Health Care Consent Act].

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

1.2 APPLICABILITY

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges.

1.3 CONFLICT WITH HOSPITAL POLICY

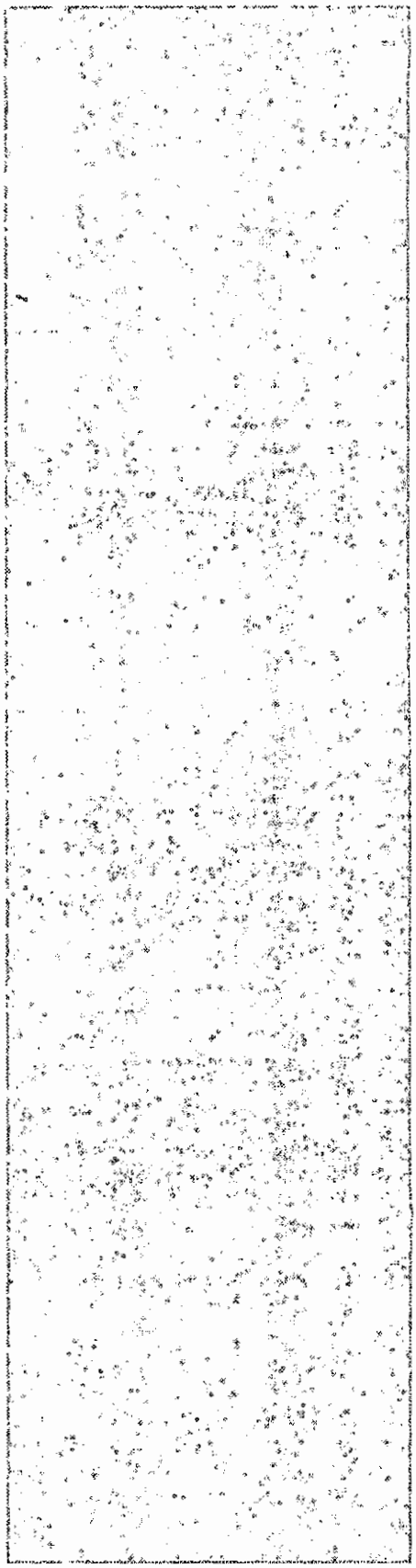
Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

1.4 AMENDMENT

These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.
This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

2. CREDENTIALING

2.1 Applications for Medical Staff membership and clinical privileges as well as requests for additional clinical privileges, reappointment, and reassignment of privileges have been simplified using a criteria based process. The Medical Staff Bylaws outline this process completely.



2.2 All Medical Staff members who graduated from an approved School of Osteopathy will automatically have privileges to perform osteopathic manipulation as part of their core privileges.

2.3 All podiatrists, certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists and physicians' assistants are considered members of the medical staff and are allowed to practice within the applicable state and federal rules and guidelines.

2.4 ACUPUNCTURE

Credentialing criteria for Acupuncture are as follows: The applicant must be a credentialed member of the Medical Staff. The applicant must have obtained 200 hundred hours of graduate training in Medical Acupuncture at AMA Category I Certified Programs or equivalent training approved by the hospital's Medical Acupuncture Committee if such a Committee is in operation, or by consultation with or endorsed by the American Academy of Acupuncture. The applicant must present three (3) letters of recommendation, specifically addressing and attesting to the applicant's qualifications and experience in practicing medical acupuncture. Providers practicing Medical Acupuncture in the hospital are expected to establish diagnosis within the traditional framework of western medical thought, through an appropriate work up of the patient's condition. They should also document the patient's treatment options and the rationale for using Medical Acupuncture in each case.

3. ADMISSION, CARE & DISCHARGE OF PATIENTS

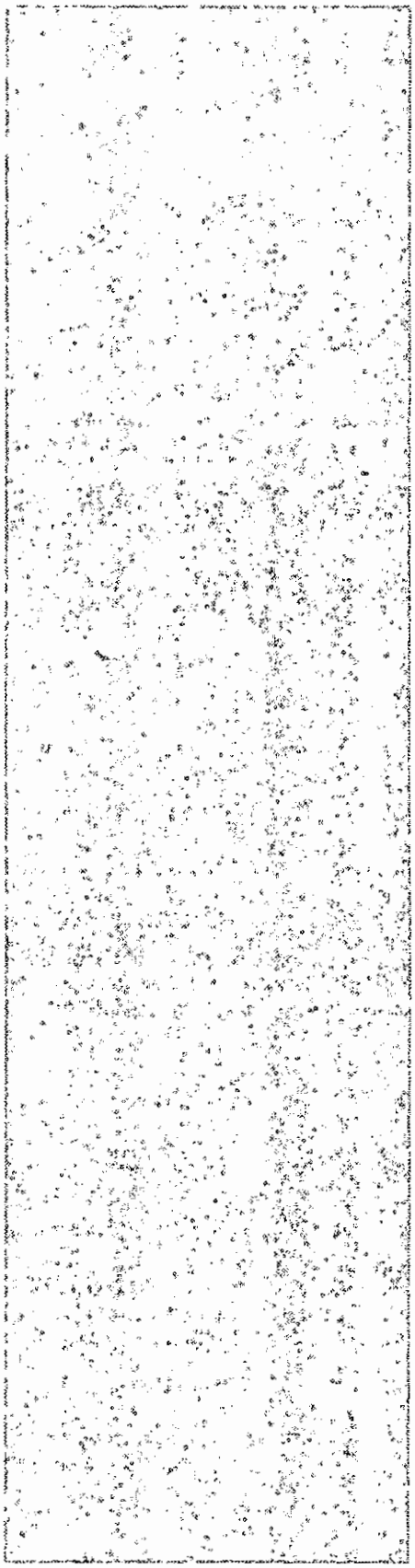
3.1 ADMISSION

3.1.1 Hospital Chief Executive may decline if SGH cannot accept admissions due to staffing or equipment.

3.1.2 Socorro General Hospital shall accept patients with all types of diseases providing that facilities are available for care of the patient and protection of personnel.

3.1.3 A patient may be admitted to, or discharged from a facility only by a member of the Medical Staff with admitting privileges or his/her designee. Should a patient leave a facility against advice, a notation of the incident shall be made in the record. Direct admits would be referred directly to the hospitalist.

3.1.4 Admitting Diagnosis: Except in an emergency, no patient shall be admitted to a 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 cases, Medical Staff members admitting patients shall be 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.



3.1.5 Admission Procedure ER to Hospitalist

- The ER Provider calls the Hospitalist about a patient who may need admission to the hospital
- The Hospitalist shall respond by phone within 30 minutes of the initial request except when dealing with a pressing patient matter. In such cases, the hospitalist will inform the ER Provider via messenger.
- After the initial phone contact, the Hospitalist will need to see the patient in the ER within 60 minutes for evaluation and disposition except when dealing with a pressing patient matter
- If the Hospitalist agrees to the admission without an in-person evaluation of the patient, they will arrange with the ER Provider for initial admission orders and then see the patient per standing timelines.

3.2 TRANSFERS

When, in the opinion of the attending provider, 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 provider shall contact the provider to whom the patient has referred. Pertinent patient care portions of the medical record shall be copied to accompany the patient.

3.3 PATIENT CARE

3.3.1 The provider who admits a patient shall be responsible for the provision of medical care to the patient record. Privision of medical care may be transferred to another provider with appropriate signout.

3.3.2 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 Medical Staff, Clinical Service Chair of the appropriate Clinical Service, Medical Director, or the Administrator on Call shall have authority to call any member of the Active/Associate Staff to provide necessary medical care.

3.3.3 All hospitalized patients will be seen at least once daily by a privileged provider, excluding patients in Hospice, Hospice Respite services, Swing beds or ICF beds.

3.3.4 Patient Assessment: Providers must see stable Hospital admissions within the following timelines:

- All patients including those admitted by the Nurse Practitioner are under the care of a physician during an admission and must be consulted by a physician every 24 hours.
- Patients from two to three days old (newborns discharged home and re-admitted) to 2 years of age must be seen within 8 hours of admission.
- Patients from 2 years of age and older must be seen within 12 hours of admission
- Newborns must be seen within 12 hours of birth

The Hospitalist is expected to see any appropriate patient as soon as possible if requested by the nursing staff or the ER provider.

4. STANDARDS OF PRACTICE

4.1 CONSENTS

4.1.1 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.

4.1.2 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.

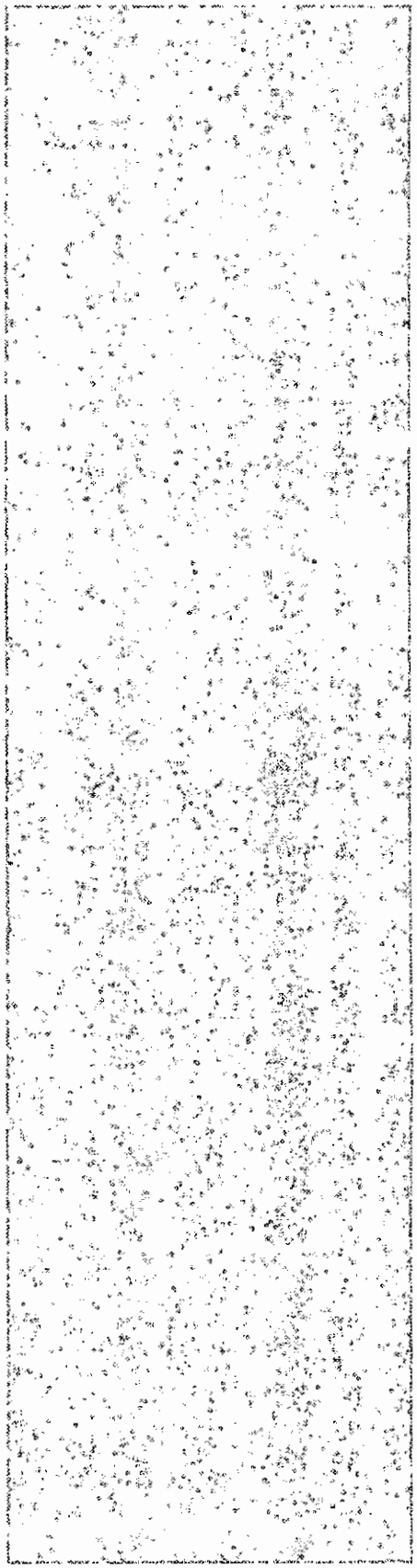
4.2 ORDERS

4.2.1 All dictated or written diagnostic and therapeutic orders must be authenticated by the responsible provider within seventy-two (72) hours.

4.2.2 Restraint orders must be reviewed and renewed every 4 hours for adults; every 2 hours for children (age 9-17); and every hour for children under the age of 9.

4.2.3 All pre-operative or pre-transfer orders for patient care shall be reviewed and authenticated with signature, time, and date by the attending provider at the time of surgery or on transfer to or from the designated care areas.

4.2.4 Timely admission orders including diagnosis, therapeutic orders, laboratory, diet and activity orders, and other ancillary studies will be submitted. When possible, emergency or urgent consultations will be personally requested by the attending provider.



4.2.5 Admission, pre-operative, post-operative, transfer and discharge orders will be entered electronically by the ordering provider. Providers will use electronic order entry consistently.

4.2.6 Verbal Orders: Practitioners will minimize their use of verbal and telephone orders. 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 the Verbal Order Policy. All orders shall be considered to be in writing if dictated to the above mentioned personnel by the attending staff members.

4.2.7 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.

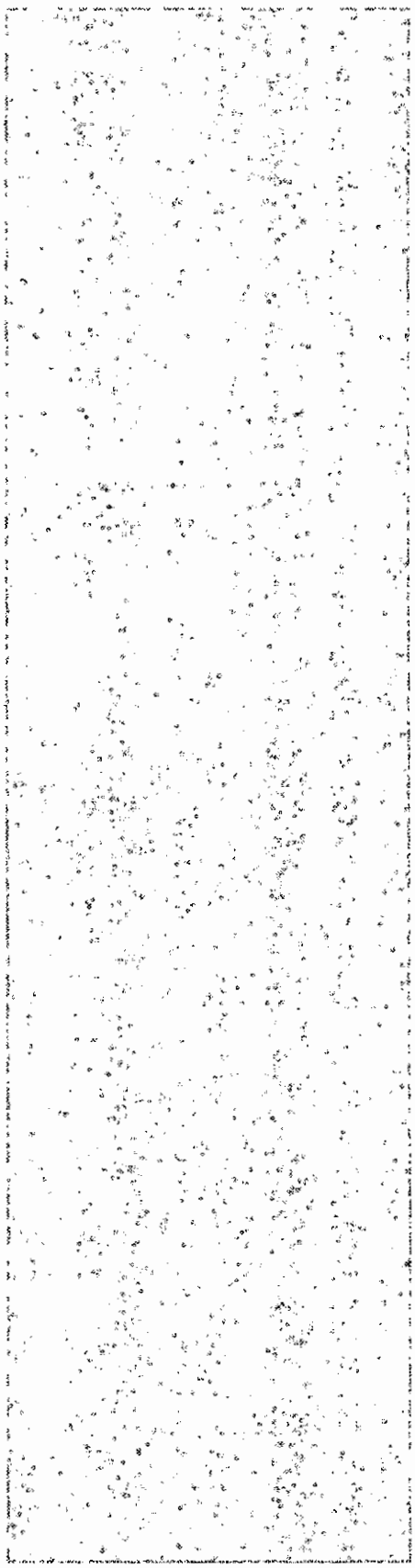
4.3. PHARMACY & MEDICATION ORDERS

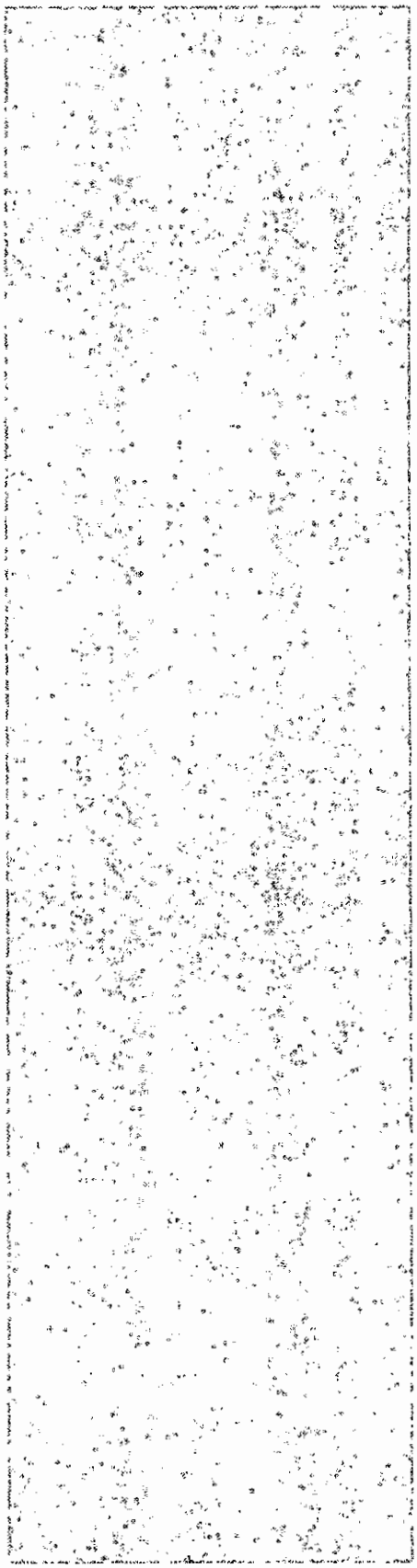
4.3.1. Stop Orders – Stop Orders must comply with the Medical Staff approved Patient Care Policy on Medication Stop Orders.

4.4 FORMULARY AND INVESTIGATIONAL DRUGS

Presbyterian Socorro 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 practitioner 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 practitioner 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.

4.41 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. Patients 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 approved policy.





4.5 DIAGNOSTIC TESTING

Routine laboratory procedures for patients admitted for one (1) day or less for diagnostic procedures or for surgical procedures may be ordered as indicated by the appropriate clinical service. Clinical Service Committees may establish needed pre-operative laboratory and ancillary studies prior to operative procedures.

4.6 INFECTION CONTROL

4.6.1 Isolation of patients for certain infections and contagious diseases shall be required as specified by the Infection Control Committee.

4.6.2 Individual infection control reports shall be maintained by the Infection Control Specialist.

4.7 DEATH

In the event of a patient's death in a facility, the deceased shall be pronounced dead by the responsible provider 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.

4.8 CONSULTS

4.81 Any member of the Medical Staff shall 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.

4.8.2 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.

5. CLINICAL EXPERIMENTS AND RESEARCH

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

6. TREATMENT OF MASS CASUALTIES

6.1 Under conditions involving mass casualties, all Medical 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.

6.2 SGH Emergency Operations Plan establishes a basic emergency program. The duties of the Medical Director are delineated under the roles and responsibilities, including assigning all Licensed Independent Practitioners (LIP) to medical response roles. All LIP will be part of the Disaster Call List. All LIP will respond to a Disaster Call, if not already on duty. Once contacted, all LIP will report to the Labor Pool and check in for assignment. All LIP will be assigned to medical response roles such as triage, treatment, decontamination, etc., depending on the staff available and the type and extent of the disaster.

6.3 SGH Medical Staff Response Policy for Fire/Disaster Incidents (Appendix B) establishes the duties and responsibilities of all SGH Medical Staff in the event of an Emergency Incident.

7. MEDICAL RECORDS

7.1 An adequate medical record shall be maintained for every individual who is evaluated or treated at Socorro General Hospital (SGH) as an inpatient, outpatient, or emergency patient.

7.2 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 the Hospital. Providers 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 SGH HIS Department, or under court order. Copies may be obtained from the HIS Department in compliance with Federal and State regulations.

7.3 ACCESS

7.3.1 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 Identification 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 in 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.

7.3.2 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.

7.3.3 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.

7.3.4 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 President of Medical Staff, former members of the Medical Staff 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.

7.3.5 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.

7.4 PERSONS AUTHORIZED TO DOCUMENT IN A MEDICAL RECORD

Entries in the medical record may be made by Members of the Medical Staff and by other persons specifically authorized by Socorro General Hospital Medical Staff.

They may include: registered nurses, licensed practical nurses, respiratory therapists, physical therapists, counselors, registered dietitians, speech therapists, behavioral health therapists, home health care coordinators, nursing technicians, nurse specialists, occupational therapists, pharmacists, radiology technicians and others as approved by the Medical Executive Committee

7.5 DOCUMENTATION REQUIREMENTS

7.5.1 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.

7.5.2 The medical record delinquency rate averaged from the last four quarterly measures is 50% or less of the average monthly discharge (AMD) rate. Each individual quarterly measure is no greater than 50% of the AMD rate.

7.5.3 Medical record entries must be permanently recorded electronically or in legible writing, dated, timed and authenticated with the name and title of the person making the entry. All orders shall be recorded and authenticated. The ordering provider, or his/her authorized designee, must authenticate all orders within 72 hours using an electronic signature; a handwritten signature maybe used under certain conditions. Appropriate symbols and abbreviations may be used unless expressly forbidden. Unacceptable abbreviations may not be used under any circumstances in the medical record.

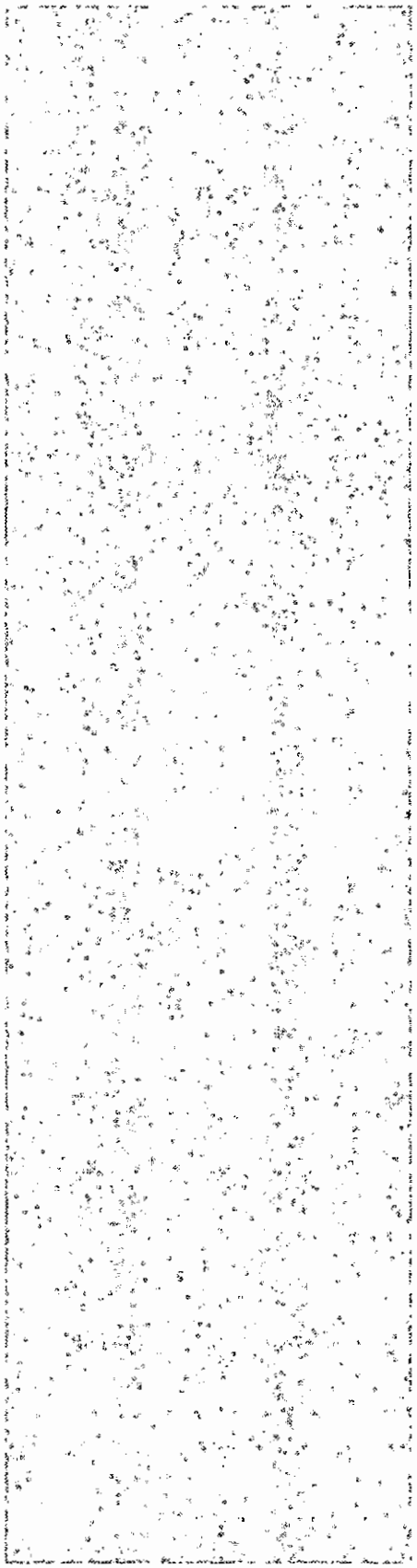
7.5.4 To facilitate consistency and continuity in patient care, the medical record must contain very specific information, ***including but not limited to the following:***

- Date and time of admission and discharge;
- Patient's name, address, date of birth, and the name of any legally authorized representative;
- Legal status of patients receiving behavioral health care services
- 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

7.6 HISTORY AND PHYSICAL: A 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 or process that if not planned and/or implemented correctly, has a significant potential for impacting the safety of the patient. An H&P may only be performed by a provider 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 H&Ps.

7.6.1 Content for a Comprehensive H&P: The history and physical (H&P) 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 by body system based on that which is clinically pertinent including both positive and/or negative findings



- Medications and allergies
- Psychosocial history, when applicable
- Clinically pertinent examination
- Conclusions or impressions drawn from the medical history and physical examination

7.6.2 Content for an expanded, problem-focused H&P: The history and physical (H&P) for outpatient procedures must contain the following:

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

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

7.6.4 Updates:

- For an H&P 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 provider who completes the update.

- For outpatient procedures for which an H&P is required, it may have been performed within 30 days prior to the date of 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 provider who completed the update.

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

7.6.5 Inability to Obtain:

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

7.6.6 Delegation:

A provider (M.D., D.O., or DDS/DMD) may delegate all or part of the medical history and physical examination, discharge summaries, and operative reports to other providers. A provider may also delegate to other providers progress note documentation, provider orders, and verbal orders without a co-signature requirement. Other providers include certified nurse practitioners, physician assistants, certified registered nurse anesthetists, certified nurse midwives, and House Staff.

7.7 MEDICAL RECORD CONTENT

7.7.1 A complete 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;
- Consultation reports, if applicable;
- Every medication dispensed or prescribed to an ambulatory patient or an inpatient on discharge;
- Every dose of medication 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;
- For comprehensive inpatient programs the following information shall be present as well: rehabilitation evaluation including medical, psycho-social history and physical exam; rehabilitation plans including goals for treatment; documentation of patient care conferences held minimally every two weeks, or as indicated, by appropriate disciplines involved in the care and treatment of the patient, in which the patient's treatment and response to rehabilitation services shall be evaluated and modified as indicated.

7.7.2 Surgical patients: Medical records of all patients undergoing surgery or invasive procedures 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 postoperative note, completed immediately after the surgery or the invasive procedure should include 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

7.7.3 Emergency Room patients: A medical record shall be initiated and maintained for each individual assessed or treated in the Emergency Department and shall be incorporated into the patient's permanent record. The attending provider is responsible for a timely, legible and complete medical record for each patient seen in the Emergency Department. This record should be completed within four hours of discharge and not to exceed 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.

7.7.4 Newborn patients: The records of newborn 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' names, 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 into each eye at delivery;
- Date and time of New Mexico State Metabolic Screening tests;
- Report of initial physical examination, including any abnormalities, signed by the attending provider; 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

7.7.5 Obstetrical Patients: The current obstetrical record should include a complete prenatal record whenever possible when the patient has had an established patient-provider relationship for the course of the pregnancy. The prenatal record must be a durable, legible copy of the attending provider's office or clinic record transferred to the Obstetrical Department before admission. An internal admission note must be completed 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 and 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.

7.7.6 Other Types of Medical Record Entries

7.7.6.1 Progress Notes (except for Swing bed patients): A daily visit and note by the attending provider is required for all patients*. 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 provider. 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. House Staff may write the daily visit note if permitted by the policies of the teaching program and authenticated by an attending level provider.

7.7.6.2 Operative, Special Procedures, and Tissue Reports: Operative and special procedure reports must contain, as applicable, the indications, the name of the procedure performed, and specimens removed if any, a detailed account of the findings, a complete description of the procedure used, the pre- and postoperative diagnosis, the estimated blood loss, and the name of the practitioner performing the procedure and any assistants. If the report is dictated and not immediately transcribed, the practitioner must enter a brief operative progress note in the medical record immediately after the procedure, providing sufficient and pertinent information for use by any practitioner who is required to attend the patient. The complete report must be entered or dictated immediately following the procedure and filed in the medical record as soon after the procedure as possible.

7.7.6.3 Tissue Examination and Reports: The provider 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 provider and if certain specimens are not sent, it shall be noted in the medical record. The pathologist shall document receipt of the specimen and make any examination as is necessary to arrive at a pathological diagnosis. The Medical Staff of the hospital may exempt specified tissues or other specimens from pathological examination. It is the duty of the provider performing the procedure to be aware of the status of the pathological diagnosis as incorporated in the medical record and to resolve any discrepancies between the final diagnosis and pathological diagnosis.

7.7.6.4 Postoperative Entries: The following items must be entered as appropriate: Vital signs, patient status during recovery period and any problems encountered, documentation of reason for transfer to another level of care or setting, discharge order by the provider, 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.

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

7.7.6.6 Anesthesia and Sedation/Analgesia Record: A pre-anesthesia or pre-sedation/analgesia evaluation of the patient by an anesthesiologist or other licensed independent provider shall be recorded in the patients' medical record within 48 hours prior to the surgery or procedure and before preoperative medication has been administered. The pre-anesthesia or pre-sedation/analgesia evaluation shall include past and present medical and drug history and previous anesthesia or pre-sedation/analgesia experience(s), a physical status assessment or anesthesia risk (i.e., ASA classification), any potential anesthesia or sedation/analgesia problems, the results of relevant diagnostic studies, if any, the planned choice of anesthesia or sedation/analgesia, and the patient's appropriateness for anesthesia or sedation/analgesia.

The patient should be reassessed immediately before sedation/analgesia administration or induction of anesthesia to include the patient's physiological status and appropriateness for anesthesia or sedation/analgesia. In the case of a patient without medical problems admitted for dental procedures, the pre-anesthesia or pre-sedation/analgesia evaluation may be conducted by a qualified oral surgeon. A reference in the medical record to the use of spinal, regional, topical, local anesthesia, general, or sedation/analgesia should be made by the responsible provider.

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 patient may be discharged by either the licensed independent provider who performed the procedure or designee, or an RN

using discharge criteria approved by the Medical Staff and according to Clinical Service protocol.

7.8 ENTRIES AT CONCLUSION OF HOSPITALIZATION

7.8.1 Discharge Diagnosis_- The discharge diagnosis (es) must be entered or dictated in full at the time of the patient's discharge.

7.8.2 Discharge Summary - A discharge summary must be recorded for all patients. The summary shall include reason for hospitalization, 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. The accepted PHS Discharge Summary should be used in EPIC.

7.8.3 Final Progress Note: 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 (2 days)
- Normal newborn infants; and
- Patients with uncomplicated vaginal deliveries
- Extended Day Surgeries

The progress note must contain a final diagnosis, outcome of hospitalization, the case of disposition, and any provisions of follow-up care.

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

7.9 PROBLEM LIST

7.9.1 Statement of Purpose: The Problem List (PL) contains the most specific diagnoses that outline the patient's current overall health status and is updated and reviewed at every visit and throughout the hospital stay by treating providers.

7.9.2 Problem List Structure

- All active and clinically significant medical problems are listed in the PL
- PL contains the most specific diagnosis for a particular problem

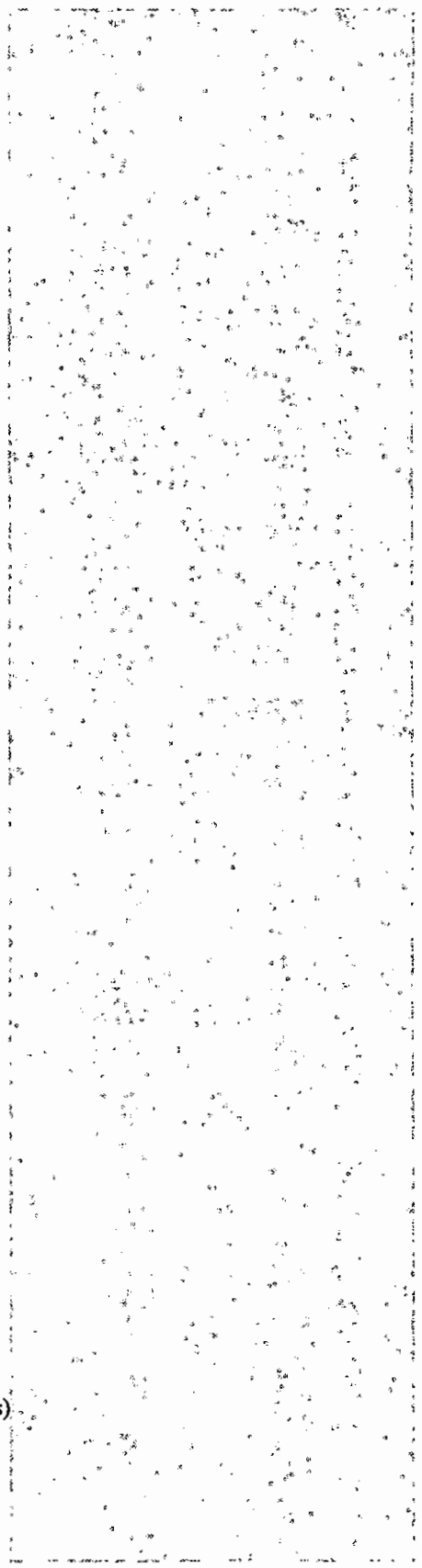
- PL contains medical problems, including behavioral health, that require continued treatment, screening, laboratory, or other monitoring
- All prescribed chronic medications are associated with a medical problem or diagnosis in the PL
- A problem should be marked chronic if it is expected to be active for longer than one year

7.9.3 Problem List, Past Medical History (PMH), and Family History

- The Problem List is used to build an accurate PMH
- When treatment of a problem is complete:
  - o the Ambulatory Clinician files the Problem to PMH as appropriate, and then clicks "Resolve" in the Problem List
  - o The Inpatient Clinician clicks "Resolve" in the Problem List for transient hospital problems that do not impact ongoing care
- Resolved Medical Problems, Past Surgical History, and Family History are added to the Problem List only when they impact ongoing health status. Some sample inclusions
  - o Resolved Medical Problems (example exception: Breast Cancer)
  - o Surgical History (example exception: s/p Aortic Valve Replacement)
  - o Family History (example exception: PH early coronary disease)
- Problem List and PHM should have minimal duplication

7.9.4 Adding to, Deleting from, and Updating the Problem List

- Treating providers can add to the Problem List by
  - o Adding to the Problem List from Encounter Diagnosis
  - o Adding to the Problem List from Medical History or Surgical History
  - o Searching for a diagnosis in the Problem List
  - o Noting when consult letters or test results indicate a new problem (e.g. hypercalcemia) or diagnosis (e.g. primary hyperparathyroidism)
- Treating providers can delete from the Problem List by using
  - o File to History as appropriate then "Resolve" in the PL (Ambulatory providers)

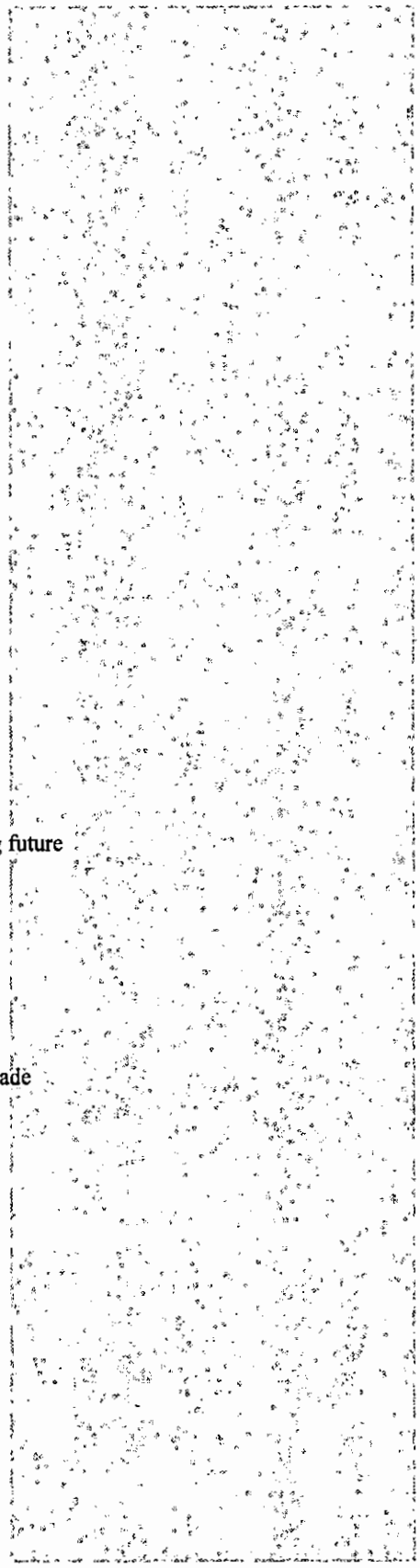


- "Resolve" in the PL and File to History as appropriate (Inpatient providers)
- "Delete" under Problem List Details

- Treating providers should feel comfortable adding, deleting, and resolving problems on the Problem List
- During transitions of care the providers shall review and update the Problem List
- Licensed clinicians who are not providers should document in the PMH, Social History, Family History, and Past Surgical History sections as part of required inpatient documentation as approved through the Clinical Governance Committee
- Outpatient clinicians who are not providers may document in the PMH, SH, FH, and PSH sections of the chart

7.9.5 Problem List Overview Note

- The overview note is a long-term note that includes information relevant to the problem from the onset to the present. This note allows all clinicians to quickly familiarize themselves with the problems without reviewing each assessment and note.
- The Overview Note ***should*** include
  - Problem List details with the most specific ICD - code(s) to save time during future visits
  - Name of treating specialist
  - Major milestones during the history of the problem, surgeries performed to treat the problem, past treatments and their outcomes, and any other relevant details.
  - Key data supporting diagnosis such as initial findings when the diagnosis is made
  - Key data supporting management if it is not easily accessible in EMR
  - Clinicians can review a report showing past instances of the Overview Note by clicking Past Versions in the note text box
- The Overview Note should ***not*** include
  - Any information relevant to a single visit
  - Multiple sets of lab data that can be viewed in other sections of the EMR, we should not list sequential lab results



- Current doses of medication
- Major milestones during the history of the problem, surgeries performed to treat the problem, past treatments and their outcomes, and any other relevant details.

7.10 INCOMPLETE/DELINQUENT MEDICAL RECORDS

Federal & State laws require that records be completed, including all necessary signatures, in a timely fashion. Signature and content requirements for each component of the medical record are found in Sections 7.1 through 7.9 of these Rules & Regulations.

7.10.1 Incomplete - Medical records are incomplete: if any component of the record or any required signature/authorization of the record is missing.

7.10.2 Delinquent - Medical records are delinquent if a record remains incomplete after the specified time frames noted in the Table of Completion Requirements for inpatient and ambulatory records listed below.

- Consultation reports completed and signed by the responsible consulting provider;
- Responsible provider's signature is present on all verbal/telephone orders

TABLE OF COMPLETION REQUIREMENTS - INPATIENT

Medical Record Component	Content and Signature must be Completed by
H&P (Admitted Patients)	• Completed within 30 days prior to inpatient admission or • Within 24 hours of admission
Update to H&P (Surgical/Procedure Patients)	Whichever event occurs first: • Prior to surgery/procedure • No later than 24 hours after admission
Immediate Operative/Invasive Procedure Note	Immediately after procedure
All other portions of the Medical Record	No later than 21 days after the patient's discharge date

TABLE OF COMPLETION REQUIREMENTS-OUTPATIENT / AMBULATORY

Medical Record Component	Must be Completed by
Visit Note	No later than 21 days after Visit Date

7.10.3 Notices and Suspensions: The Health Information Management Department (HIM) of the hospital is delegated the task of monitoring all medical records for completeness and timeliness as well as issuing communications to providers who have not (i) not completed any required portion of a medical record and/or (ii) have not provided required signature/authorization for any required portion of the medical record. Providers will be given Electronic Health Record (HER) notifications as identified in the following Table of Provider Delinquency Notices & Suspensions (found at 7.10.4) so that the Provider has an

opportunity to complete the record prior to further notice or any medical record suspension being issued by the Medical Executive Committee.

- If a Provider is issued a medical record suspension from the Medical Staff, **the scope** of such suspension is as follows until all delinquent medical records assigned to the Provider are completed: Suspended from admitting privileges
- Suspended from booking Operating Rooms
- Suspended from all surgical procedures
- Suspended from attending inpatients
- Suspended from outpatient visits

Suspended providers will still have access to the HER so that they may complete delinquent records as soon as possible and have the medical record suspension lifted.

Failure to complete all delinquent medical records within ninety (90) days after a Suspension Notice is issued will be subject to an automatic voluntary resignation from Medical Staff membership and/or privileges. If, after an automatic voluntary resignation occurs pursuant to this process, any provider seeking to reinstate membership and/or privileges must meet all the requirements for reappointment and complete the reappointment process.

7.10.4 Disputes Regarding Delinquency Notices and Medical Record Suspensions:
If a Provider disputes a delinquency notice or suspension and/or needs assistance in determining how to complete a delinquent record, they must first contact the HIM department who have personnel available 24/7 365 days a year to assist all Providers with delinquency and medical record suspension issues. If, after seeking assistance from HM personnel the Provider still disputes the delinquency or medical record suspension or otherwise has an emergency related to delinquent or suspended records, the Provider may escalate the matter to the Administrator, the Chief Medical Officer (CMO) or their designee on call. The CMO or their designee, in consultation with HIM personnel, will determine the resolution of the delinquency or medical record suspension dispute and what steps, if any need, to be taken with respect to immediate patient care issues.

Repeated suspensions for medical record delinquencies will be tracked as part of every provider's ongoing professional performance evaluation (OPPE) data. The Credentials Committee or Medical Executive Committee may make recommendations or take action as them deem necessary to address a Provider's repeated suspensions. However, HER delinquency notices and medical record suspensions are **not** matters subject to report by the Hospital to the New Mexico Medical Board (NMMB) or National Practitioner Databank (NPDB) and are not disclosed as part of inquiries between Medical Staffs for new or renewing appointment of privileges unless a delinquency and/or medial record suspension was related to an adverse action that is otherwise reportable to the NMMB or NPDB.

7.10.5

TABLE OF PROVIDER DELINQUECY NOTICES AND MEDIAL RECORD SUSPENSIONS

Record Component	First Notice	Second Notice	Suspension Notice	Automatic Voluntary Resignation from the Medical Staff
H&P	X *Notice will be sent at time order is placed for patient to be admitted or placed in observation		Suspension occurs at 24 hours after patient admitted or place in observation	After 90 days from suspension notice
Updated H&P	X *Notice will be completed/ scanned into system		OR procedure staff will notify Provider of failure to complete prior to surgery / procedure. Provider's failure to respond to staff' request will be escalated to the Administrator, CMO or designee on call	After 90 days from suspension notice
Immediate Operative/Invasive Procedure	X *Notice will be sent at time order is placed to be admitted or placed in observation		Suspension occurs at time patient is transferred or discharged from recovery phase of care	After 90 days from suspension notice
All other components of record	* *7 days after patient discharge or ambulatory visit	X * 14 days after patient discharge or ambulatory visit	X * 21 days after patient discharge or ambulatory visit	After 90 days from suspension notice

7.11 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 provider to complete the record, the

President of the Medical Staff or designee shall complete the medical record if possible or consider the circumstances and may enter such reasons in the record and order it to be filed.

7.12 AMENDING MEDICAL RECORDS

Providers may make changes to a medical record subsequent to a patient encounter so long as the provider

- Clearly and permanently identifies that any amendment, correction, or delayed entry is a subsequent change
- Indicates the date and author of the amendment, correction, or delayed entry
- Does not delete but instead identifies original content in the medical record.

8. GENERAL RULES FOR SURGICAL CARE

8.1 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 a part of the record.

8.2 Surgeons shall be in the Operating Room and ready to commence operation at the time scheduled.

8.3 The primary operating surgeon shall have a member of the Medical Staff assist at operative procedures as determined by the Obstetrics/Surgery Clinical Services.

8.4 Patients scheduled for minor procedures shall be admitted at least two (2) hours before the procedure is scheduled. More time shall be allowed when laboratory studies are required.

8.5 All patients admitted to the Operating Suite for surgery who do not yet have a recorded history and 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 be canceled unless the attending surgeon states in the record that such delay would constitute a hazard to the patient.

8.6 Where a choice of side/site for a surgical procedure exists, no patient shall leave the holding area for the operating room without having the side and site of surgery clearly marked. Surgery will be delayed, just as with the requirement for a history and physical in 8.5 above, until the surgeon completes the appropriate marking of the surgical side/site.

8.7 A postoperative note of all operations shall be entered 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 entered within 24 hours following the procedure.

8.8 In the cases of 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.

8.9 Surgeons shall round on post-operative patients remaining in the hospital and enter a daily progress note in the Medical Record. The post-op rounding on OB patients may be delegated to the OB provider with mutual consent.

8.10 In every case where an anesthetic is administered, a record shall be made of pre- and post-anesthetic examinations; and an anesthetic record shall be completed.

8.11 All specimens and tissues removed during a surgical procedure, except those exempted by the Obstetrics/Surgery Clinical Service, the Division of Pathology of Presbyterian Healthcare Services, and approved by the Medical Executive Committee shall be properly labeled and sent to the pathologist, who shall determine the extent of examination necessary for diagnosis.

9. GENERAL RULES FOR EMERGENCY CARE

9.1 It shall be the Emergency Room (ER) provider's responsibility to initiate emergency care when necessary, to medically screen all patients that come to the SGH ER, to see that appropriate care or referral is provided, and to provide care for patients as requested by the patient or the patient's provider. All patients requiring extensive or involved treatment or admission to the Hospital shall be referred to the Hospitalist or other appropriate specialists or service.

9.1.2 If patient needs to be admitted to hospital, ED provider shall contract the hospitalist to admit to appropriate specialty service.

9.2 All qualified members of the Active Staff of the Hospital shall serve on the Emergency Room (ER) Back-up Panel in the area in which they have sufficient privileges. The panel provider shall be available to the ER on the days that he/she is scheduled. If he/she will not be available it will be his/her responsibility to obtain a substitute who has sufficient privileges in the field to be covered and who has agreed to accept the responsibility of coverage, and he/she shall notify the ER of the substitution.

9.3 The Emergency Room may refer patients who do not have a provider to a local provider for a follow-up visit. The patient shall be requested by the Emergency Room to call the referred provider's office within two working days for an appointment or consultation. If after the initial visit, the panel provider does not wish to continue caring for the patient, the provider will make a reasonable effort to arrange for necessary continuing care for the patient with another provider.

9.4 The provider providing service to a patient in the Emergency Room shall be responsible for a medical record on each patient that contains a brief history, the essential findings, the treatment, disposition of the patient, and instructions given the patient when the patient is not admitted.

9.5 If consultation is necessary, the patient will be asked if he has a preference of provider and the preference will be followed.

9.6 If a private provider requests that a patient be sent to his office that transfer will not occur until the patient has been assessed by the Emergency Room provider to assure no harm will result from the transfer.

9.7 The Emergency Room provider will provide diagnostic work-up and/or short-term definitive treatment and refer the patient for follow-up to an appropriate provider of the patient's.

9.8 All patients requiring extensive or involved outpatient treatment will be referred to either a provider of the patient's choice.

9.9 The Emergency Room provider will not involve themselves in any treatment, not of a lifesaving nature, which requires prolonged time and may result in other Emergency patients having to wait an unreasonable length of time.

9.10 Each provider called to the Emergency Room, must be personally available within 40 minutes or the provider must discuss with the Emergency Room provider within 20 minutes plans for interim care. The provider must respond in person when requested to do so by the Emergency Room provider.

9.11 Emergency Room personnel should attempt to contact providers by all available routes and not rely solely on the call service.

9.12 If a Staff provider wishes another staff provider to see a patient, it shall be the Staff provider's obligation to obtain such a consultation.

9.13 MEDICAL SCREENING EXAMS

- All patients presenting to the Emergency Room will have a medical screening exam by a practitioner.
- All patients will be triaged by appropriate personnel.

9.13.1 Obstetrical Patients presenting to the Emergency Room with pregnancy related complaints:

- Patients less than 20 weeks gestation will be evaluated in the Emergency Room
- Patients at 20 weeks gestation or greater will be evaluated in OB
- All evaluations of obstetrical patients presenting with pregnancy related complaints will follow the OB EMTALA Screening

9.13.2 Obstetrical Patients presenting with non-pregnancy related complaints

- Patients of any gestational age who present with trauma and/or emergency medical conditions and/or non-pregnancy related complaints will be evaluated in the Emergency Room.
- The location of further treatment and assessment are at the discretion of the ER practitioner.

9.15 RULES GOVERNING EMERGENCY ROOM ~~PROVIDER~~ PRACTITIONER

9.15.1 The Emergency Room provider will refer all patients to the provider of the patient's choice.

9.15.2 Emergency Room providers will be assigned shifts in advance and the schedule posted in each Emergency Room. It is the scheduled provider's responsibility to see that the assigned shift is covered.

9.15.3 The Emergency Room provider must remain on duty until relieved by the next shift provider.

9.15.4 The Emergency Room provider is not expected to have expertise in all medical specialties, but must be able to recognize life threatening conditions and initiate emergency treatment for all patient types, and follow through with referral to appropriate specialists.

9.15.5 The Emergency Room shall respond to Code Blue calls within the hospital and coordinate ACLS/PALS/NRP until relieved by an attending provider qualified to continue care.

9.15.6 Rapid Response Team: The Emergency Room Provider shall endeavor to respond to Rapid Response Team calls within five minutes. If unable to provide timely bedside assessment due to conflicting duties, he or she will ask nurse to notify the Hospitalist and be available as soon as possible.

- Bedside assessment may include reviewing patient history, diagnosis, and medications.
- Examine patient as indicated
- Ordering appropriate tests and interventions.
- Emergency Room Provider may request Hospitalist to attend patient if ongoing bedside care is felt necessary.

- It shall be the responsibility of the Hospitalist to arrange patient transfers should this becomes necessary.

10. GENERAL RULES FOR HOSPITALIST CARE

10.1 Daily Rounds on the Medical/Surgical/Pediatric Unit and Newborns

10.1.1 Daily Completion of Progress Notes & charges on all patients

10.2 Consults to the Emergency Room, Obstetrics for medical questions, and to the Operating Room for medical concerns and/or Podiatry H&P if needed.

10.3 Admissions

10.3.1 All children over the age of two years, normal newborns, and adults must be seen by the Hospitalists within 12 hours of admission, no matter what the time of admission.

10.3.2 All children up to the age of two years must be seen by the Hospitalist within eight hours of admission.

10.3.3 The above only applies to stable patients, the Hospitalist is required to be at the bedside at the request of any nursing staff and/or any provider who is present in the hospital and feels that the Hospitalist is needed to provide ongoing care.

10.4 Surgical Patients

10.4.1 The Hospitalist is an automatic Consultant on all surgical patients admitted to the floor. A consult must be completed and then daily rounds are necessary to manage medical problems. If there are no medical problems the Hospitalist may elect to sign off the case.

10.4.2 Podiatry patients with complicated medical conditions are CO-ADMITTED by the Hospitalist and the Podiatrist.

10.4.2.1 The History and Physical is done by the Hospitalist.

10.4.2.2 The Discharge is done by the Hospitalist with the approval of the Podiatrist or the Podiatrist with the approval of the Hospitalist

10.4.2.3 All medical problems are managed by the Hospitalist.

10.5 Outpatient Rehabilitation Referral

Physical therapists and occupational therapist in New Mexico are able to see patient under self-referral, or direct access, without a referral from medical provider. Part of

the DPT training is a medical screening, and determining if a patient is appropriate for PT/OT or needs a referral to their practitioner.

10.5.1 Direct Care Requirements: A physical therapist shall refer a patient to the patient's licensed health care provider if:

10.5.1.1 After thirty (30) days of initiating physical therapy intervention, the patient has not made measurable or functional improvement with respect to the primary complaints of the patient; provided that the thirty (30) day limit shall not apply to:

- Treatment provided for a condition related to a chronic, neuromuscular or developmental condition for a patient previously diagnosed by a licensed health care provider as having a chronic, neuromuscular or developmental condition;
- Services provided for health promotion, wellness, fitness or maintenance purposes; or
- Services provided to a patient who is participating in a program pursuant to an individual education plan or individual family service plan under federal law; or

10.5.1.2 At any time, the physical therapist has reason to believe the patient has symptoms or conditions requiring treatment that is beyond the scope of practice of the physical therapist.

10.6 Hospitalist are responsible for writing orders and overseeing the care of infusion of OP services

10.6.1 Definition

- Blood Transfusions not requiring another type of admission
- IV infusions with supporting documentation
- IV fluids only
- IVIG
- IV Antibiotics
- IV Venofer
- Other IV Drugs with and/or without IV Fluids
- Other possible procedures, not otherwise specified

10.7 Responsibility of Responding to a Code

10.7.1 Generally ER practitioners are responsible to respond to all codes in the hospital and campus. However if ER practitioner is unavailable the hospitalist is responsible to respond to the code.

10.8 Other Responsibilities

10.8.1 Accept and manage Critical Lab values that are reported after hours or on the weekend

10.8.2 Answering Outpatient Pharmacy Questions about community patients

10.8.3 Assist the Home Health Care (HHC) nurse managing HHC & Hospice patients when the Medical Director is unavailable

10.8.4 Being available for Good Samaritan Nursing Home Patients when requested by the attending provider who cares for all the patients there

10.8.5 Being on call for Hospice patients if requested by the Hospice Medical Director.

10.8.6 Complete diagnostic or other results for the other Hospitalists

10.8.7 Any labs, especially cultures that become available after the patient has been discharged

- Check in the medical record to see that appropriate action was taken, if not then make sure that patient gets appropriate medical care
- Document in the medical record

10.8.8 Other requests as they arise

11 GENERAL RULES FOR OBSTETRICAL CARE

11.1 Medical Screening Examinations

11.1.1 Obstetrical Patients presenting with pregnancy related complaints

11.1.1.1 Patients less than 20 weeks gestation will be evaluated in the Emergency Room

11.1.1.2 Patients at 20 weeks gestation or greater will be evaluated in OB or the ER by both the ER practitioner and OB/GYN practitioner if necessary.

11.1.1.3 All evaluations of obstetrical patients presenting with pregnancy related complaints will receive medical screening examine and stabilizing care.

11.1.2 Provider will review and sign medical record within 24 hours after patient discharged from Triage

11.2 OB Guidelines for Obstetrical Call

11.2.1 If a provider plans to manager/deliver their own patient, a courtesy call to the On-Call OB Provider is expected, so the on-call provider is well informed.

11.3 INDUCTIONS

11.3.7 Elective inductions will be scheduled per staffing availability. NO Patient will be denied an induction if medically indicated. Elective inductions are not considered a priority.

12 ORIENTATION AND SUPERVISION

12.1 Orientation

12.1.1 All new medical staff members who are to provide services at SGH including PRN, locum tenens, and contract providers (CRNA) have a mandatory orientation to

12.1.1.1 PHS — done by Human Resources and/or their designee

12.1.1.2 SGH — done by the Medical Director and/or their designee

12.1.2 This orientation includes but is not limited to

- Introduction to SGH; Critical Access Hospitals; Community Providers
- Administrative Information
  - Bed Status/ Admission Procedures
  - Phone Numbers
  - Dictation Procedures
    - Do not use abbreviations
  - Verbal Orders
  - Coding
- Clinical Performance
  - FPPE/OPPE Process

- Specific Job Expectations with Work Hours/Call Expectations
- Order Sets
- Clinical Guidelines/Protocols
- Mandatory Trainings - Certifications

- Behavioral Performance
  - Medical Staff Code of Conduct
  - Zero Tolerance of Disruptive Behavior
  - Dress Code
- PMG Handbook – available electronically/or can get a written copy
- Emergency Procedures
- Quality Initiatives
- Patient Satisfaction Initiatives
- Medication Management including Pharmacy Information

12.2 Supervision

12.2.1 All new medical staff members have an initial FPPE wherein the assigned preceptor observes their medical practice

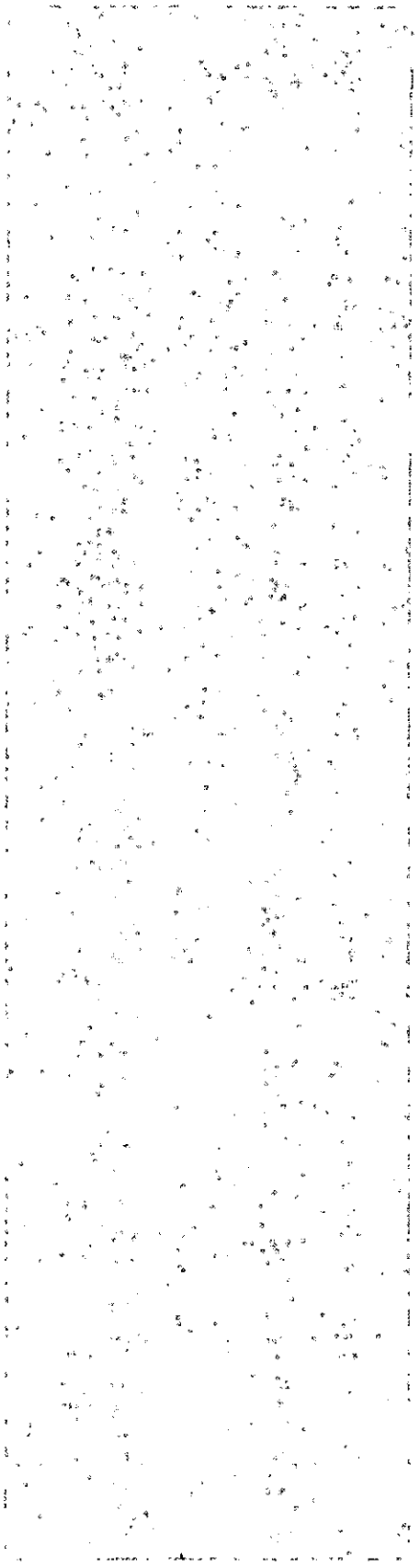
12.2.2 The FPPE is specifically designed for each new provider

13 OUTPATIENT ORDERS AND PROCEDURES

13.1 Ordering Providers:

13.1.1 Outpatient services may be ordered (and patients may be referred for hospital outpatient services) by a practitioner who is

- Responsible for the care of the patient
- Licensed in, or holds a license recognized in the jurisdiction where he or she sees the patient
- Acting within the scope of his or her practice under state law
- Authorized by the medical staff to order the applicable outpatient services under a written hospital policy that is approved by the Hospital



Board. This includes both practitioners who hold Medical Staff privileges that include ordering the services, as well as other practitioners who are not on the Medical Staff, but who satisfy the hospital's polices for ordering the applicable outpatient services and for referring patients for hospital outpatient services.

13.2 Procedure:

13.2.1 Patient Registration verifies that the ordering practitioner is either a member of the Medical Staff or if not a member, does hold a current license to practice in the jurisdiction where the provider sees the referred patient as outlined in the Orders for Outpatient Tests and Procedures Policy.

13.2.2 If the practitioner's licensure cannot be verified, the order is denied.

13.2.3 If the practitioner is listed on the OIG (http://exclusions.oig.hhs.gov/) and/or SAM.gov (http://www.sam/gov/portal/public/SAM) websites as an excluded provider, the order cannot be carried out and the practitioner is notified.

13.2.4 If the order is urgent, the patient may be referred to the Emergency Room for evaluation.

13.3 Process of Sending Patients from Outpatient Offices to SGH ER

13.3.1 Provider to Provider phone call with brief summary of reason for sending patient to ER. (Nurse to nurse phone call for patient care hand-off is also needed.)

13.3.2 The Emergency Medical System (EMS) may be utilized to transport patients from clinic to the SGH ER if appropriate to patient condition/ symptoms.

13.3.2 A Tech or RN may escort patients to ER from clinic via wheelchair if appropriate to patient condition/symptoms.

14 ADVANCED PRACTICE CLINICIANS

14.1 DEFINITION: Certified nurse midwife (CNM); certified nurse practitioner Certified Registered Nurse Anesthetist (CRNA), Independent licensed Social Worker and Audiologist.

14.2 SCOPE OF PRACTICE

14.2.1 APC's are members of the Medical Staff at SGH and as such are bound by all SGH Medical Staff Bylaws; Rules and Regulations and Policies and Procedures.

14.2.2 May make independent decisions regarding health needs of individual, family or community and carry out health regimens, including the prescription and distribution of dangerous drugs, including controlled substances from schedules II through V of the Controlled Substances Act

14.2.3 May prescribe in accordance with rules, regulations, guidelines, and formularies for by the New Mexico Board of Nursing. The APRN may practice independently, serving as primary health care provider, in their assigned field and as necessary collaborate with licensed Medical Doctors, Osteopathic Physicians, Podiatrist, Chiropractors and Dentists.

14.2.4 The APC must conform to the rules and regulations concerning dispensing as defined by the New Mexico Pharmacy Act.

14.2.5 The APC is required to maintain all necessary certifications as outlined in their privileges.

14.3 HOSPITALIST CERTIFIED NURSE PRACTITIONER (NP)

NP's will care for adult or pediatric patients.

- Hospitalists/NP's will care for Newborns on the Maternal –Infant Care Unit.
- Patients who are admitted may have the admission order and History & Physical written by a Nurse Practitioner. The admission order and History & Physical will be reviewed electronically the assigned supporting physician.
- Nurse Practitioners will consult a supporting physician every 24 hours,
- Patients will need the discharge order electronically reviewed by the assigned supporting physician, along with the medical record review and a physical statement in the discharge summary.
- The supporting practitioner will be involved in the care of all admitted patients cared for by the APC

14.4 CERTIFIED NURSE MIDWIFE

14.4.1 PRACTICE GUIDELINES

The CNM assumes the responsibility of the primary management of medically uncomplicated patients throughout the labor and delivery process. When circumstances differ from this, a decision must be made collaboratively by the

CNM and the physician about the appropriateness of CNM or CNM/MD/DO care.

Regardless of the level of care decided upon – primary or collaborative, the CNM will keep the physician abreast of the patient's progress as warranted.

The CNM may utilize accepted nursing and nurse-midwifery procedures for patients requiring immediate emergency assistance. The guidelines herein will be used and medical assistance and consultation will be obtained while emergency procedures are being instituted.

Patients selected for CNM management includes, but are not limited to the following:

- Patients presenting to labor: These may be patients who have been followed by a Medical Group for prenatal care; or they may have been followed elsewhere, or may not have received prenatal care. Those patients in the last two categories may have a history and physical completed by the CNM who will then consult with the physician as warranted.
- Patients presenting to the ER or OB triage with pregnancy related concerns: History and physical examination will be completed by CNM who will consult with the physician if as warranted.
- Labor patients with medical, surgical, or past obstetrical history which suggests an increased risk will be evaluated by the CNM and or physician, on a case by case basis, for appropriateness of care by CNM. Factors to be evaluated may include the nature of the patient's condition, the current status of the condition, patient compliance, need for special diagnostic work up or continuing medical management, and the presence of multiple risk factors.

14.4.2 INTRAPARTUM GUIDELINES FOR CONSULTATION FOR COLLABORATIVE CNM/MD MANAGEMENT OR TRANSFER TO MD/DO MANAGEMENT

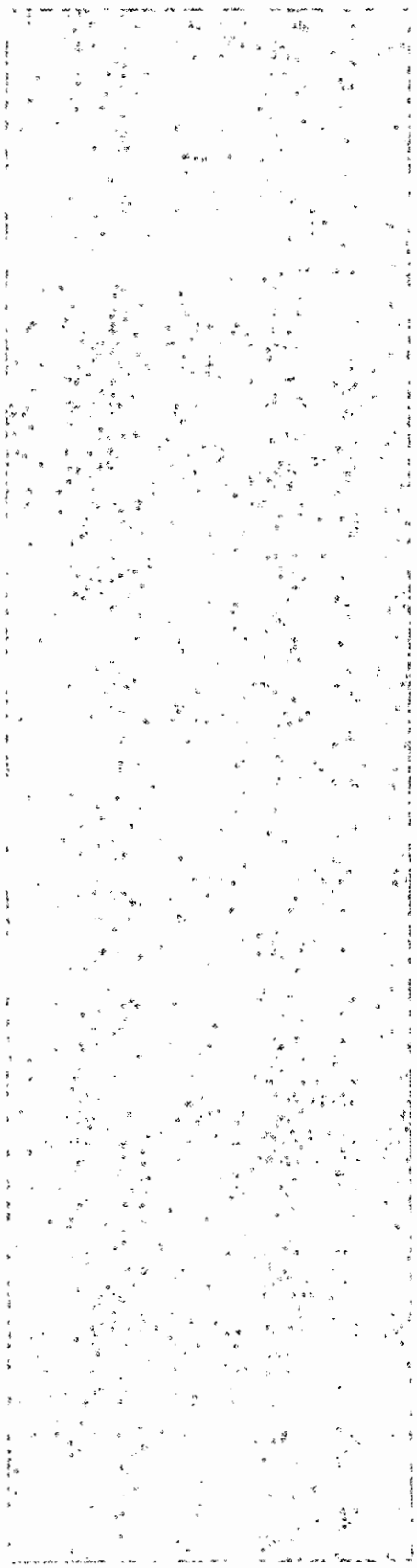
It is recommended that the CNM seek consultation with the collaborating Physician regarding the disposition of women who present with the following conditions. These lists are adjunct to good clinical judgment and are not inclusive of all possible complications:

- Active or significant liver disease (e.g., active Hepatitis B; cirrhosis; etc.)
- Any other serious medical condition
- Chronic hypertension
- Chronic renal disease

- Collagen vascular disease
- Diabetes Mellitus
- Hemoglobinopathies or other blood dyscrasia
- HIV positive status
- Neurologic disorders
- Severe asthma, active tuberculosis or other significant lung disease
- Autoimmune disorders
- Thrombo-embolic disease/cardiac disease

Obstetrical complications, including:

- Active chemical drug dependency, involving opiates, cocaine, sedative-hypnotics or other drugs the withdrawal from which can be life-threatening
- Active herpes-simplex-virus lesions in the presence of ruptured membranes or labor
- Cervical cerclage present
- Evidence of small for gestational age (SGA)
- Evidence for large for gestational age (LGA)
- Evidence of oligohydramnios
- Insulin-requiring Gestational Diabetes
- Intrauterine fetal demise
- Isoimmunization
- Known significant fetal anomalies
- Malpresentation
- Multiple gestation
- No prenatal care
- Pitocin induction/augmentation
- Placenta Previa (if in late second or third trimester)
- Pre-eclampsia or eclampsia
- Pregnancies at or beyond 42 weeks
- Pregnancy-induced hypertension without evidence of pre-eclampsia
- Preterm labor <36 weeks gestation
- Previous cesarean delivery with classical scar or unknown scar



- Suspected placental abruption, or chronic abruption
- Use of prostaglandins/misoprostol for cervical ripening
- Uterine infection
- Vaginal bleeding

14.4.3 SUPERVISION

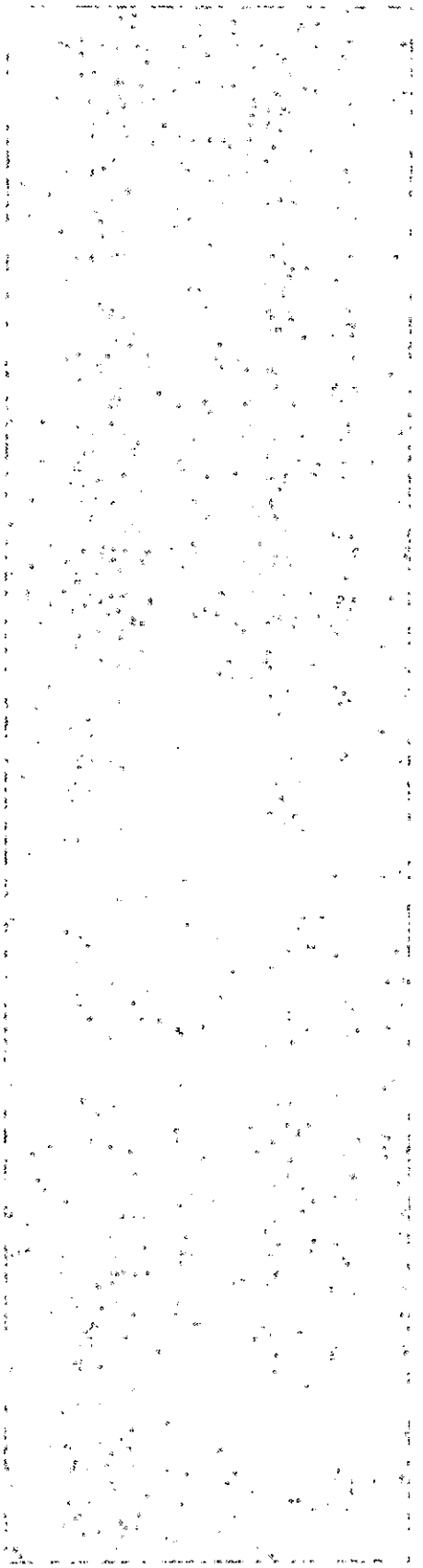
- Participate as requested in the evaluation of competency (i.e., at the time of reappointment and, as applicable, at intervals between reappointment, as necessary);
- Be physically present, on hospital premises or readily available by electronic communication or provide an alternate to provide consultation when requested and to intervene when necessary;
- Assume total responsibility for the care of any patient when requested or required by the polices referenced above or in the interest of patient care;
- Sign the privilege request of the practitioner he/she works with; and

OB EMTALA

1. PURPOSE

To provide a consistent system for the evaluation of presenting women with pregnancy-related issues in compliance with federal EMTALA requirements.

In the event that the patient is discharged prior to delivery, the medical record shall contain the time of discharge, the vital signs of the patient and fetus at discharge, and the labor status of the patient at discharge, and the electronic or verbal orders of the provider shall be documented in the record.



ADOPTION

These Rules and Regulations shall be adopted by a majority vote of the total membership of the Active Staff eligible to vote. They shall replace any previous Rules and Regulations and shall become effective when approved by the SGH Medical Staff.

Adopted by the Medical Staff of Socorro General Hospital.

January 21, 2020
Date

President of the Medical Staff

January 21, 2020
Date

Communication Officer of the Medical Staff

Approved by the Board of Socorro General Hospital

January 21, 2020
Date

SGH Board of Trustee Chair