

JACKSON HEALTH SYSTEM
MEDICAL STAFF
RULES AND REGULATIONS

Comprehensive Amendment
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Table of Contents

ARTICLE I	4
1 ADMISSION & DISCHARGE OF PATIENTS	4
1.1 ADMISSION OF PATIENTS.....	4
1.2 SUICIDAL PATIENTS	5
1.3 DISCHARGE OF PATIENTS	5
1.4 DECEASED PATIENTS.....	6
1.5 AUTOPSIES	6
1.6 DISCLOSURE.....	7
ARTICLE II	7
2 MEDICAL RECORDS	7
2.1 COMPLETION OF MEDICAL RECORDS	7
2.2 ADMISSION HISTORY & PHYSICAL	7
2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES	8
2.4 PROGRESS NOTES	8
2.5 OPERATIVE/PROCEDURAL REPORTS	9
2.6 INPATIENT CONSULTATIONS	9
2.7 OBSTETRICAL PATIENT HISTORIES.....	11
2.8 CLINICAL ENTRIES/AUTHENTICATION.....	11
2.9 ABBREVIATIONS/SYMBOLS.....	11
2.10 FINAL DIAGNOSIS	11
2.11 CONFIDENTIALITY AND ACCESS	11
2.12 USE OF MEDICAL RECORDS FOR STUDY AND RESEARCH.....	12
2.13 COMPLETE MEDICAL RECORDS.....	12
2.14 DISCHARGE DOCUMENTATION	12
2.15 DELINQUENT MEDICAL RECORDS	13
2.16 TREATMENT & CARE ORDERS.....	13
2.17 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES	13
2.18 TUMOR-NODE-METASTASES (TNM)STAGING	14
2.19 UNSIGNED PLANS OF CARE.....	14
ARTICLE III	15
3 GENERAL CONDUCT OF CARE	15
3.1 SAFE PRACTICES	15
3.2 ORDERS.....	15
3.3 PREVIOUS ORDERS	15
3.4 ADMINISTRATION OF DRUGS/MEDICATIONS.....	16
3.5 ORDERING/DISPENSING OF DRUGS.....	16
3.6 CONCERNS REGARDING CLINICAL CARE	16
3.7 PATIENT CARE ROUNDS.....	16
3.8 ATTENDING PHYSICIAN UNAVAILABILITY	17
3.9 PATIENT RESTRAINT ORDERS	17
3.10 PRACTITIONERS ORDERING TREATMENT	17
ARTICLE IV	17
4 GENERAL RULES REGARDING SURGICAL CARE	17
4.1 RECORDING OF DIAGNOSIS/TESTS.....	17

4.2	ADMISSION OF DENTAL CARE PATIENT	17
4.3	ADMISSION OF PODIATRIC PATIENTS	18
4.4	INFORMED CONSENT	19
4.5	PATIENT REQUESTS AND REFUSAL OF TREATMENT	19
4.6	EXAMINATION OF SPECIMENS	19
4.7	ELECTIVE SURGERY SCHEDULING.....	19
4.8	POST-OPERATIVE EXAMINATION.....	20
4.9	ANESTHESIA	20
4.10	ORGAN & TISSUE DONATIONS.....	21
ARTICLE V.....		21
5 GENERAL RULES REGARDING OBSTETRICAL CARE		21
5.1	HIGH-RISK NEONATAL CARE	21
5.2	LABOR AND DELIVERY	22
5.3	EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR.....	22
5.4	PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT	22
<u>ARTICLE VI.....</u>		<u>23</u>
6 EMERGENCY MEDICAL SCREENING TREATMENT, TRANSFER & ON-CALL.....		23
6.1	SCREENING, TREATMENT & TRANSFER	23
6.2	EMERGENCY DEPARTMENT CONSULTATIONS, REFERRALS & CALL	25
<u>ARTICLE VII.....</u>		<u>26</u>
7 PARTICIPATION IN RISK MANAGEMENT		26
<u>ARTICLE VIII.....</u>		<u>26</u>
8 TRAINING OF RESIDENTS/FELLOWS AND MEDICAL STUDENTS		26
8.1	RESIDENTS/FELLOWS	26
8.2	MEDICAL STUDENTS	28
<u>ARTICLE IX.....</u>		<u>28</u>
9.1	ADOPTION & AMENDMENT OF RULES & REGULATIONS.....	28

Jackson Health System Medical Staff Rules & Regulations

These Rules & Regulations are adopted in connection with the Jackson Health System (JHS) Medical Staff Bylaws ("bylaws") and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder.

ARTICLE I

1 ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

- 1.1.(a) All patients admitted to the hospital shall have an admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.
- 1.1.(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff with admitting privileges.
- 1.1.(c) Physicians admitting patients shall be held responsible for providing information to other appropriate health care providers that may be necessary to ensure protection of other patients or to ensure protection of the patient from self harm.
- 1.1.(d) A list of medical staff positions requiring advanced certifications including but not limited to BLS, ACLS, ATLS, NALS, and PALS shall be maintained in the medical staff office. The practitioner shall be required to obtain and maintain all required certifications.
- 1.1.(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of the assigned attending physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for appropriate documentation justifying care provided, for transmitting reports of the conditions of the patient to any referring practitioner and to authorized representatives of the patient, where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the patient's medical record.
- 1.1.(f) The medical staff members are required to abide by the JHS Utilization Management and Case Management plans including adhering to and documenting appropriateness of admission, justification for continued stay, justification for utilization of resources, and plans for post-hospital care.
- 1.1.(g) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the designee is not readily available. Said designation shall be made in accordance with the requirements of the Medical Staff Office. In cases of inability to contact the Attending Physician, the following person(s) should be contacted, in order of priority listed below:

- (1) An alternate physician (preferable a partner, associate or designee of the Attending physician);
- (2) The Chief of Service, who may assume care for the patient or designate any appropriately trained member of the staff; or
- (3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CMO or designee to provide care for the patient.

1.1.(h) All clinical providers shall attempt to secure consent for autopsies in accordance with JHS policy and procedure. All autopsies shall be performed by a pathologist, or by a practitioner delegated this responsibility. As required by the College of American Pathology, provisional anatomic diagnosis shall be recorded in the medical record within 48 hours, and the final autopsy report should be made a part of the medical record within sixty days

1.2 SUICIDAL PATIENTS

For all patients who have attempted suicide or who have had a self-administered chemical overdose, a psychiatric consult and treatment must be ordered in accordance with JHS policies 400.44 Suicide Prevention and 400.44.1 Attempted/Completed Suicide.

1.3 DISCHARGE OF PATIENTS

The discharge policy is as follows:

- 1.3.(a) Patients shall be discharged only on order of the Attending Physician or designee. The discharge order, process, and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.
- 1.3.(b) Should a patient leave the hospital without proper discharge (AWOL), the Attending physician responsible for the patient must be notified. Documentation and notification of the incident shall be made in the patient's record in accordance with JHS policy.
- 1.3.(c) Should a patient express a desire to leave the hospital before the completion of his/her treatment (Against Medical Advice), the Attending Physician must be notified. The incident must be documented and the AMA form completed in accordance with JHS policy.
- 1.3.(d) At the time of discharge, the Attending Physician, or designee, providing care for the patient shall transition care back to the referring physician, or to a newly assigned physician. If upon discharge the patient has no identified provider, the attending physician or designee will provide documentation to the patient to facilitate on-going care.
- 1.3.(e) The Attending Physician is required to document the patient's condition and care in the JHS electronic medical record ("EMR") daily, including the need for continued hospitalization. This documentation must contain:
 - (1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

- (2) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the medical justification. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the JHS Medical Executive Committee ("MEC") for action.

1.3.(f) The Attending Physician shall keep the patient and authorized representatives informed concerning the patient's condition throughout the patient's hospitalization. The Attending Physician and hospital staff shall ensure that the patient or authorized representatives is provided with information that includes, but is not limited to, the following:

- (1) Conditions that may result in the patient's transfer to another facility or level of care;
- (2) Alternatives to transfer, if any;
- (3) The clinical basis for the discharge;
- (4) The anticipated need for continued care following discharge;
- (5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs; and
- (6) Printed discharge instructions in a form and manner that the patient or authorized representative can understand.
- (7) Disclosure of unexpected outcomes in accordance with JHS Policy.

1.4 DECEASED PATIENTS

In the event of a patient death, the deceased shall be pronounced dead by an Attending Physician, resident physician, or an Emergency Department Physician as appropriate. Such a pronouncement shall be documented in the patient's medical record. If the patient has a physician order for Do Not Resuscitate/Allow Natural Death and the patient expires, an RN, in lieu of an available physician, may pronounce the patient deceased. Documentation of the pronouncement is in accordance with JHS policy 400.057 Expired Patient Policy.

1.5 AUTOPSIES

Autopsies shall be secured by the Attending Physician, or his/her designee, in accordance with JHS policy 400.057 Expired Patient to ensure compliance with applicable state laws and regulations including those involving the Miami-Dade County Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian, or through documentation of a verbal consent from an appropriate family member or guardian, and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

1.6 DISCLOSURE

In the event of an unanticipated outcome or adverse event, the patient's attending physician, and/or if appropriate a consulting physician shall participate in discussion of the outcome or event with the patient, family, and/or legal representative to the extent appropriate in accordance with the JHS 400.012 Notification of Adverse Incidents to Patients and/or Family Members.

ARTICLE II

2 MEDICAL RECORDS

2.1 COMPLETION OF MEDICAL RECORDS

The Attending Physician shall be responsible for the preparation of a complete and legible physician component of the medical record for each patient. The content of the medical record shall be pertinent and current. The record shall include but is not limited to identification data, complaint, personal history, family history, history of present illness, physical examination, special reports (such as consultation), clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, transition of care needs and plans, and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall also contain a written plan of care, treatment and services appropriate to the patient's needs. The plan of care shall be discussed with the patient and shall be revised as necessary.

2.2 ADMISSION HISTORY & PHYSICAL

Every patient admitted for inpatient care shall have a complete admission history and physical examination as required by the Medical Staff Bylaws. The history and physical must minimally contain the following elements:

2.2.(a) History identifying data:

- (1) Chief complaint
- (2) History of present illness
- (3) Medications, including over the counter medications or herbal;
- (4) Allergies, social history (tobacco, alcohol, other); and
- (5) Past medical/surgical history (as applicable to the procedure)
- (6) Family history

2.2.(b) Physical

- (1) Vital Signs
- (2) Physical examination

2.2.(c) Pertinent diagnostic results; and

2.2.(d) Assessment and Plan of Care

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded within 30 days prior to any surgical procedures or invasive diagnostic procedures, whether inpatient or outpatient. For a medical history and physical examination older than 30 days or completed outside of the institution, an H & P update documenting any changes in the patient's condition must be completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

When a history and physical examination, pertinent laboratory, x-ray or EKG reports is not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such a delay presents an imminent threat to the patient's health.

2.4 PROGRESS NOTES

Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Progress notes by the medical staff shall:

- Be entered at the time that services are rendered;
- Give a pertinent chronological report of the patient's course in the hospital;
- Be legible, recorded, dated and timed at the time of observation;
- Contain sufficient content to ensure continuity of care if the patient is transferred;
- Have each of the patient's clinical problems clearly identified and correlated with specific orders as well as results of tests and treatment;
- Reflect any change in condition;
- Contain the results of treatment; and
- Include plans for future care.

Progress notes shall be written at least daily by the attending practitioner on critically ill patients, those where there is difficulty in diagnosis and management of the problem, and those with a significant deterioration in their clinical status. For those patients awaiting extended care facility placement, progress notes shall be as frequent as medically indicated. Progress notes shall be written at least daily by the attending practitioner or designee for all other patients. The Medical Staff Member must document his or her involvement with the patient in the medical record, reflecting his or her level of participation in the care of the patient and supervision of learners also caring for the patient. The Medical Staff Member may attest to progress notes written by learners such as residents and fellows, or designees, such as physician assistants and advance practice nurses. Pertinent progress notes shall also be made by other such individuals who have been granted these clinical privileges and specified professional personnel.

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports for operating room and bedside procedures include one or both of the following:

- 2.5.(a) Pre-operative/pre-procedural report – prior to the initiation of any procedure, a pre-procedural note must be documented on the medical record. The components of the pre-procedural note include the following:
- (1) The indications for surgery and the surgical plan of care
 - (2) The History and Physical which may be combined with the pre-operative note
 - (3) Consent indicating risks, benefits, and alternatives

The pre-operative/pre-procedural note must be signed by the surgical attending

- 2.5.(b) Immediate post-operative/procedural note: Unless the detailed post-operative note (see 2.5.(c). below) is entered in the patient's record immediately after surgery and prior to transfer to the next level of care, an immediate post-operative/post-procedural note will be entered into the patient's record following surgery or procedure prior to the patient's transfer to the next level of care. The immediate post-operative/procedural note shall include:
- (1) Name(s) of primary surgeon/physician and assistants;
 - (2) Pre-operative diagnosis;
 - (3) Post-operative diagnosis;
 - (4) Name of the Procedure performed;
 - (5) Findings of the Procedure;
 - (6) Specimens removed;
 - (7) Estimated Blood Loss; and
 - (8) Date and Time Recorded.

- 2.5.(c) The operative report must be completed and in the patient's current medical record within 24 hours of the completion of the surgery and authenticated within 48 hours. This note shall include a detailed description of the procedure that includes the elements listed in 2.5 (b).

Any practitioner failing to complete operative/procedural notes as required herein will be brought to the attention of the Chief Medical Officer for appropriate action.

2.6 INPATIENT CONSULTATIONS

The purpose of a consultation is to provide prompt and expert specialty evaluation and clinical management advice that benefits the patient and meets the expectation of both the patient and requesting physician. Quality consultations result from well-established ongoing, working relationships between services.

Consultations shall be addressed as medically indicated. The Medical Staff Member is ultimately responsible for the quality and content of the consultation.

- 2.6.(a) Indications for consultation may include:
- (1) All patients with severe psychiatric symptoms including suicidal tendencies or attempts, severe depression, or agitation, unless the attending physician is a psychiatrist;

- (2) When, in the opinion of the Physician Member, the advice of a specialist or another physician would enhance the quality of care;
- (3) When the diagnosis is obscure or when there is doubt as to the best therapeutic measure to be utilized and there are significant differences of opinion as to the best choice of therapy;
- (4) When a patient requires care which is outside the scope of privileges granted the attending physician; or
- (5) When requested by the patient.

2.6.(b) Consultation Request:

- (1) Consultations are initiated with an explicit electronic order.
- (2) The consultation request must include:
 - i. a specific question or request; and
 - ii. the name of the Medical Staff Member requesting the consultation.

2.6.(c) Documenting Consultations:

- (1) The consultation documentation shall include the name of the responsible Medical Staff Member.
- (2) The consultation should address the specific request, but does not need to be limited in its scope. A consulting service may determine other issues germane to the specialty which can and should be addressed by the consulting service.

2.6.(d) On-going services provided by a consulting team:

- (1) A consulting service should document assessment, evaluation, and recommendations for the patient's condition related to the condition that prompted the consultation.
- (2) The consulting service may enter orders for a patient at the request of the primary service.
- (3) A consulting service shall communicate with an appropriate member of the primary service before performing any diagnostic or therapeutic procedure that requires a patient's consent.
- (4) When a consulting service has finished its work with a patient, it shall complete a note in the patient's record, explicitly signing-off. The primary service may ask the consulting service to see the patient again if it feels consulting services are still needed.

2.6.(e) Consultation Priority

(1) Stat Consultation

A "STAT" consultation must be completed within one hour and requires direct physician to physician communication.

(2) Urgent Consultation

An "Urgent" consultation must be completed within 4 hours.

(3) Routine Consultation

A "Routine" consultation must be completed within 24 hours.

2.6.(f) Consultations not Completed in Time Frame

Consultations that are not completed within the required time frame will be reported by the requesting service to the Chief of Service of the consultant. The Chief of Service will be responsible for resolving tardy consultations. Repeated offenses by an individual physician or practitioner will be referred to the Chief of Service or appropriate medical staff committee for resolution. Consultations from non-physician consultative services shall be referred to their administrative director.

2.7 OBSTETRICAL PATIENT HISTORIES

The history for obstetrical patients, when adequately updated with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical throughout the hospital for surgery and other procedures related to obstetrical patients.

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including verbal orders, shall be accurately dated, timed, authenticated, and legible. Authentication shall be defined as the establishment of authorship by signature and for written documents shall include the JHS identification number. The use of a rubber stamp signature is not acceptable.

2.9 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEG and filed with the Health Information Management Department. Use of "do not use" abbreviations as specified by the Joint Commission is forbidden.

2.10 FINAL DIAGNOSIS

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. The final diagnosis shall be part of the discharge summary documentation and shall be dated and signed by the Attending Physician at the time of discharge of all patients.

2.11 CONFIDENTIALITY AND ACCESS

Original records or official copies of the legal medical record may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for disciplinary action to be determined by the MEG.

Copies of medical records should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.12 USE OF MEDICAL RECORDS FOR STUDY AND RESEARCH

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Clinical Research Review Committee (CRRC) before records can be studied. Per the Medical Staff Office, 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.

Certain types of information, including but not limited to psychiatric medical records, alcohol and drug abuse records and HIV records, are protected by statute, and require a signed release from the patient or a court order before being released to any person.

2.13 COMPLETE MEDICAL RECORDS

A medical record shall be considered complete when the responsible attending physician(s) has authenticated all required components of the patient's medical record per JHS Policy 400.0218 Medical Record Policy. If the attending physician expires or is unavailable, the medical record shall be closed incomplete as ordered by the Chief Medical Officer or designee.

2.14 DISCHARGE DOCUMENTATION

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The electronic or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be entered or dictated that this information is pending. The components of the discharge summary shall include but is not limited to the following:

- (1) Reason for hospitalization
- (2) Significant findings
- (3) Procedures performed
- (4) Care, treatment, and services provided
- (5) Patient's condition at discharge
- (6) Discharge information provided to the patient and family such as
 - a) Medications
 - b) Diet
 - c) Physical activity
 - d) Follow-up Care

2.15 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every seven (7) days. At the fifteenth (15th) day for any incomplete medical records, the notification will include a warning that the record(s) will be delinquent at thirty (30) days and the physician's privileges will be suspended if any records become delinquent.

- 2.15.(a) Automatic Relinquishment of Clinical Privileges. A chart which is not completed within thirty (30) days of discharge will trigger automatic relinquishment of the responsible physician's privileges. When a staff member is notified of automatic relinquishment of clinical privileges, the staff member may not provide any hands-on patient care, whether inpatient or outpatient. Emergency surgeries for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The affected physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the President of the Medical Staff and the CMO or designee.
- 2.15.(b) The affected staff member is obligated to provide to the CMO and the President of the Medical Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that physician provides.
- 2.15.(c) All hospital departments shall be notified of an automatic relinquishment of clinical privileges to enable the enforcement of the suspension.
- 2.15.(d) Any physician who is repeatedly forced to relinquish clinical privileges per JHS Policy 400.021.1 Medical Record Suspension shall be referred to Peer Review.
- 2.15.(e) At the time of automatic relinquishment, the affected physician shall be notified that failure to complete the record(s) within 14 days will result in automatic resignation from the Medical Staff.

2.16 TREATMENT & CARE ORDERS

Orders for treatment and care of patients may be documented by an Allied Health Professional under the supervision of an attending physician and cosigned by the Attending Physician.

Preoperative orders must be cosigned prior to being followed unless the orders are telephone orders given by the physician as described in Article III, Section 3.2 of these Rules & Regulations.

2.17 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Any corrections to the medical record must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated. Any alteration in

the medical record made after the record has been completed or document finalized is considered an addendum and should be dated, signed and identified as such.

To amend an entry in the paper record, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

In the EMR, corrections can be made by using the "modify" function. If the document is a PowerForm, the prior documentation will remain, but with a single line through the original documentation. The new documentation will reflect the date/time/author of the original documentation and the date/time/author of the updated documentation. All other forms of documentation in the EMR, including free-text documentation, PowerNotes, and transcribed dictations can only be amended after they have been finalized. The original documentation will not be crossed out with a single line, but the indicator "this document contains an addendum" will be added to the topic of the document and any corrections or additional documentation will be added at the bottom of the document; date/time/author will be captured at the time of electronic signature when any modifications occur. Free-text documentation, PowerNotes, and transcribed dictations can be "saved" in the EMR as preliminary documents that are viewable to others. If changes are made to these preliminary documents prior to the document being finalized, these changes are not captured as an addendum and they are not represented with a line through the original documentation. The preliminary version is saved in the EMR and available to all users if there is a question of inconsistency, however, documents do not indicate whether there is a preliminary version available for review.

2.18 TUMOR-NODE-METASTASES (TNM) STAGING

The Tumor-Node-Metastasis (TNM) Clinical Stage (CS) of tumor will be assigned before medical record is completed. If the Pathological Stage (PS) of the tumor is available before discharge, it should also be included.

2.19 UNSIGNED PLANS OF CARE

2.19(a) The referring/ordering provider's signature must be obtained to signify approval of the recommended plan of care for outpatient rehabilitative services as required by Federal, State, or Insurer's guidelines.

2.19(b) Plans of Care that require signatures as outlined in 2.19(a) that are not signed by the referring/ordering provider within 30 days of the initial evaluation/reevaluation will be subject to the following:

- (1) Patients will be placed in a hold status until the plan of care is signed or discharged from therapy treatment if all reasonable attempts to obtain signature are unsuccessful.
- (2) Physical Medicine and Rehabilitation Therapist will document the unsuccessful attempts to obtain provider signature within the patient's medical record
- (3) Physical Medicine will Update EMR Notes for Health Information Management/Billing.

ARTICLE III

3 GENERAL CONDUCT OF CARE

3.1 SAFE PRACTICES

Medical staff members are expected to participate in providing a safe care environment for all patients at all times and to adhere to all hospital policies and procedures, including but not limited to safe practices such as:

- 3.1.(a) Hand hygiene before and after every patient and environmental encounter
- 3.1.(b) Hospital isolation practices
- 3.1.(c) Universal protocol in the operating room and for bedside procedures
- 3.1.(d) Adherence to the Central Line Insertion procedure

3.2 ORDERS

Orders shall be dated, timed, authenticated and legible. Orders which are illegible, are improperly written, or illegibly signed will not be carried out until rewritten.

Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

- 3.2.(a) Verbal orders are discouraged except in emergency situations. Physicians are expected to authenticate verbal orders prior to leaving the area.

A verbal/telephone order shall be accepted and acted upon when:

- (1) the complete transcribed order has been read back to the prescriber to assure accuracy. A medication in the sound alike list shall be spelled back to the prescriber;
- (2) the prescriber has verbally confirmed that the order is correct;
- (3) the transcriber has confirmed in writing "read back" or "RiB"; and
- (4) the transcriber has initialed next to transcribed order.

- 3.2.(b) Telephone orders must be authenticated by the ordering physician within 48 hours. Unsigned orders are considered delinquent medical records. Registered nurse, licensed practical nurse, respiratory therapist, or physical/occupational therapist, registered pharmacist, and CRNA's may accept verbal orders relating to their area of practice.

Verbal/telephone orders will not be accepted for investigational drug, device or procedure protocols, or for orders to withhold or withdraw life support (including Do Not Resuscitate and POLST orders). Verbal/telephone orders will not be accepted for chemotherapy drug orders. Withdrawing of life support will only be implemented with an order authenticated by the prescribing practitioner, **AND** in accordance with JHS Policy 400.015 regarding advanced directives.

3.3 PREVIOUS ORDERS

All previous orders are canceled when patients go to surgery, change *level* of care, or change clinical service. The use of "renew", "repeat" "resume" and "continue previous orders" are not acceptable in the written record. In the EMR, a renew function can be used.

For all patients with previous DNR orders, the patient's DNR status must be discussed with the patient and/or health care surrogate before commencing any procedure requiring general anesthesia.

3.4 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the JHS Formulary. Drugs for bona fide clinical investigations may be utilized only after approval by the Clinical Research Review Committee.

The appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques are outlined in JHS Policies 400.025 Medication Administration, 400.031. Patient Controlled Analgesia- Adult Protocol, 400.036 Administration of Analgesic Agents for Pain Management via Epidural, Interpleural, and/or Regional Nerve Block Catheter.

3.5 ORDERING/DISPENSING OF DRUGS

The practitioner must order drugs in accordance with JHS Policy 400.023. Orders for drugs must include the following elements: drug name, rate, dose, route of administration, frequency, and urgency of first dose. In addition, documentation must include diagnosis, condition, and indication for use for each medication ordered. Drugs shall be dispensed from and reviewed by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria.

When the patient brings medication to the hospital from home, those medications which are clearly identified shall be administered and handled by the nursing staff only in compliance with JHS Policy 400.027 Medications Brought to the Hospital.

Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order.

3.6 CONCERNS REGARDING CLINICAL CARE

Concerns regarding the appropriateness of care may be communicated to the Chief Nursing Officer or Chief Medical Officer as appropriate

3.7 PATIENT CARE ROUNDS

Hospitalized patients shall be seen at least daily, and more frequently if their status warrants, by the Attending Physician or his/her designated attending alternate. Patients in the Skilled Nursing Facility shall be seen at least weekly, and more frequently if their status warrants, by the Attending Physician or his/her designated attending alternate. Patients admitted to Critical Care should be seen by the Attending Physician and/or his/her designated attending alternate within 12 hours after admission to the unit.

3.8 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her attending designee will assume responsibility for patient care.

3.9 PATIENT RESTRAINT ORDERS

Orders for use of restraint or seclusion shall include length of time. Restraints or seclusion may be used per restraint orders or protocols. All orders for restraint will be given with strict adherence to the JHS Administrative Policy 400.08.Restraints.

3.10 PRACTITIONERS ORDERING TREATMENT

Licensure and National Practitioner Identifier (NPI) numbers will be verified for all practitioners upon credentialing. NPI numbers are required when ordering treatment modalities including but not limited to home health, cardiac rehabilitation, physical therapy, chemotherapy, and durable medical equipment.

ARTICLE IV

4 GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

Prior to any surgical procedure, a history, physical and other appropriate information including the preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record. If not recorded, the operation shall be delayed until completed, or canceled. In all emergencies, the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

4.2 ADMISSION OF DENTAL CARE PATIENT

A patient admitted for dental care is a dual responsibility involving the dentist who is a member of the medical staff and a physician member of the Medical Staff.

4.2.(a) Dentist's Responsibilities

The responsibilities of the dentist are:

- (1) To provide a detailed dental history justifying hospital admission;
- (2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis;

- (3) To complete an operative report describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the hospital pathologist for examination;
- (4) To provide progress notes as are pertinent to the oral condition; and
- (5) To provide a clinical summary.

4.2.(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery;
- (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
- (3) To supervise the patient's general health status while hospitalized.

4.2.(c) The discharge of the patient shall be the dual responsibility of the attending dentist and the physician.

4.3 **ADMISSION OF PODIATRIC PATIENTS**

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a member of the Medical Staff and a physician member of the Medical Staff designated by the podiatrist.

4.3.(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

- (1) To provide a detailed podiatric history justifying hospital admission;
- (2) To provide a detailed description of the podiatric findings and a preoperative diagnosis;
- (3) To complete an operative report describing the findings and technique. All tissue shall be sent to the hospital pathologist for examination;
- (4) To provide progress notes as are pertinent to the podiatric condition; and
- (5) To provide a clinical summary.

4.3.(b) Physician's Responsibilities

The responsibilities of the physician are:

- (1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;
 - (2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
 - (3) To supervise the patient's general health status while hospitalized.
- 4.3.(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

4.4 INFORMED CONSENT

All consents shall be obtained in accordance with JHS Administrative Policy 150a Informed Consent Process.

Each consent form shall include the name of the hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; and the signature of the patient or the patient's legal representative. The form must also comply with the requirements of applicable state law.

4.5 PATIENT REQUESTS AND REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient's behalf, must be documented in the patient's medical record.

A patient has the right to request treatment. A patient's request for treatment is not necessarily binding on the clinician or the institution. Such requests may be declined if determined to be medically inappropriate or non-beneficial by the treating physician or his/her designee. All communication and documentation shall be done in accordance with Policy 400.015 Withholding, Withdrawing and Forgoing of Life Sustaining Treatment.

4.6 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects, removed during a surgical procedure shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in the patient's electronic medical record.

4.7 ELECTIVE SURGERY SCHEDULING

In order to reduce patient wait times and maximize utilizations of resources, guidelines are used for scheduling elective and emergency surgeries. Emergency procedures shall take priority above all other cases. Scheduling at Jackson Memorial Hospital is per JHS Perioperative Policy 150.

Jackson North Medical Center scheduling is per Perioperative Policy 150a and Jackson South Community Hospital is per Perioperative Policy 150b.

4.8 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the surgeon prior to discharge home.

4.9 ANESTHESIA

Only qualified individuals as defined in JHS policies and procedures may provide procedural sedation or deep sedation or anesthesia. The Department of Anesthesiology shall approve credentialing guidelines consistent with Joint Commission standards for individuals providing procedural sedation, deep sedation or anesthesia.

Pre-anesthesia evaluation.

The relevant anesthesia provider shall maintain a complete sedation or anesthesia record including a complete pre-sedation or pre-anesthesia evaluation. The pre-anesthesia evaluation of the patient includes but is not limited to the following:

- Review of the current and past medical history, including anesthesia, drug and allergy history;
- Interview and examination of the patient;
- Notation of anesthesia risk according to established standards of practice (e.g. ASA classification of risk);
- Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
- Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

The anesthesia provider will be responsible to obtain and document informed consent for anesthesia in the medical record per JHS Administration Policy 150a Informed Consent Process. In order to ascertain the patient's wishes as they relate to the continuance of advance directives, said advance directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the Attending Physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

Pre-procedural Sedation, Pre-deep Sedation, and Pre-anesthesia.

Included in the anesthesia record shall be an immediate pre-sedation or pre-anesthesia evaluation. The patient is reevaluated immediately before procedural sedation, deep sedation, or anesthesia use. The assessment includes but is not limited to vital signs, status of the airway and response to any pre-procedure medications per JHS Administrative Policy 400.016 Adult Procedural Sedation

Post-anesthesia.

A post-sedation or post-anesthesia evaluation must be documented in the patient's medical record within forty-eight (48) hours of the end of sedation or anesthesia. The patient must be sufficiently recovered so as to be able to actively participate in the post-anesthesia evaluation. The following elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care:

- Cardiovascular function. including pulse rate and blood pressure;
- Mental status;
- Temperature;
- **Pain**;
- Nausea and vomiting; and
- Post-operative hydration.

The post-sedation or anesthesia follow-up shall include documentation of the patient's response to care.

4.10 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal. The Uniform Anatomical Gift Act that has been adopted in nearly all States provides that the attending physician cannot participate in organ transplant.

The organ procurement organization shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

ARTICLE V

5 GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK NEONATAL CARE

Only those physicians who have training in high risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1.(a) All cesarean sections;

5.1.(b) Premature infants less than thirty-five (35) weeks gestation, with or without complications;

- 5.1.(c) Premature infants less than four (4) pounds eight (8) ounces, with or without complications;
- 5.1.(d) All premature infants with complications; and
- 5.1.(e) Full term infants with complications requiring invasive intervention.

5.2 LABOR AND DELIVERY

Physicians providing obstetrical care are required to arrive at the Emergency Department or Labor and Delivery Unit, as applicable, within thirty (30) minutes of initial contact regarding a cesarean delivery or other emergency condition.

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

The purpose of the medical screening examination is to determine if an emergency medical condition exists (as defined in 6.1). The medical screening examination must be provided when an individual comes, herself, or with another person, to the hospital and a request is made by the individual or on the individual's behalf, or a prudent layperson observer would conclude from the individual's appearance or behavior a need for examination or treatment of a medical condition, regardless of their ability to pay. The medical screening exam shall be provided by the examining physician(s) or other qualified medical personnel of the hospital, which may include attending physicians, advanced registered nurse practitioners, certified nurse midwives, and registered nurses.

When a pregnant individual presents to the hospital, the triage provider shall determine whether the presenting complaint is onset of labor or a problem unrelated to labor. Individuals reporting the onset of labor without complications and a gestational age greater than 20 weeks will be transported to the Labor and Delivery unit with qualified medical personnel, where they shall receive a complete medical screening examination. All other pregnant individuals presenting to the hospital will receive a medical screening exam as provided in Article VI of these Rules and Regulations.

For individuals who present directly to the Obstetric Triage unit, the medical screening exam shall be initiated by a qualified medical provider trained in obstetrics, specifically, either a registered nurse, a certified nurse midwife, advanced registered nurse practitioner, or a physician. If the medical screening exam determines an individual is not in active labor, her disposition shall be determined by the obstetric provider that is providing her prenatal care. In the case of an unassigned individual, who has had either no prenatal care or care by a physician who is not a member of the Medical Staff, a consult with the obstetric physician on call shall be generated and the on-call physician shall determine the patient's disposition.

If the medical screening exam determines an individual to be in active labor, or in the event the relevant qualified medical personnel believes the obstetrician's physical presence is necessary to complete the medical screening examination, the provisions of Section 6.2 regarding consultations, referrals and emergency call shall apply.

5.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.3, above. The nurse shall contact the admitting physician upon any change in the patient's condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital (if not on premises) within thirty minutes of said contact. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants, but in any event no later than twelve (12) hours after admission.

ARTICLE VI

6 EMERGENCY MEDICAL SCREENING TREATMENT, TRANSFER & ON-CALL

6.1 SCREENING, STABILIZATION & TRANSFER

6.1.(a) Screening

- (1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination by a qualified medical provider to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.
- (2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.
- (3) All patients shall be examined by qualified medical personnel, which shall be defined as one of the following:
 - A doctor of medicine or osteopathy who is a member of the medical staff or who holds clinical privileges approved by the Medical Executive Committee and Governing Board; OR
 - A doctor of medicine or osteopathy who is a medical resident or fellow acting under appropriately documented medical staff member supervision; OR
 - A physician's assistant, registered nurse, advanced registered nurse practitioner or midwife functioning within the scope of his or her license and whose clinical privileges have been approved by the Medical Executive Committee and Governing Board, and in the case of a registered nurse, the appropriate competencies.
- (4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

6.1.(b) Stabilization

- (1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.
- (2) A patient is Stable for Discharge, when within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or, the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.

- (3) A patient is considered Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.
- (4) A patient does not have to be stabilized when:
 - i. the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or
 - ii. based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.
- (5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1.(c) Transfer

- (1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.
- (2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.
- (3) Upon transfer, the Emergency Department shall provide a copy of appropriate medical records to the receiving facility regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.
- (4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

6.2 EMERGENCY DEPARTMENT CONSULTATIONS, REFERRALS & CALL

6.2.(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific physician who is a member of the medical staff. This request will be ordered in the patient's electronic medical record.

6.2.(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.

6.2.(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

- (1) Attempted to reach the physician in the hospital;
- (2) Called once on the physician's pager;
- (3) Called the physician at his/her office; and
- (4) Called the physician at home.

Twenty minutes will be considered a reasonable time to carry out this procedure.

6.2.(d) The on-call lists, containing the names and phone numbers of the on-call physicians shall be maintained by the hospital and made available. In the event that the patient does not have a specific requested physician, the requested physician refuses the patient's request to come to the Emergency Department, or the requested physician cannot be contacted within twenty (20) minutes of the initial request, the on-call list shall be used to select an attending physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the on-call list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CMO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

6.2.(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the hospital or physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts responsibility for the patient.

6.2.(f) The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon

the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department.

Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes.

- 6.2.(g) The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written policy.

ARTICLE VII

7 PARTICIPATION IN RISK MANAGEMENT

The Medical Staff shall actively participate in the following risk management activities related to the clinical aspects of patient care and safety:

- 7.1.(a) The identification and reporting of general areas of potential risk;
- 7.1.(b) The development of criteria for identifying and reporting specific cases with potential risk;
- 7.1.(c) The attendance of Root Cause Analysis where applicable
- 7.1.(d) The correction of problems identified by risk management activities;
- 7.1.(e) To design programs to reduce risk in the clinical aspects of patient care and safety;
and
- 7.1.(f) Provide mechanisms to identify and correct areas of potential risk in clinical aspects of patient care and safety.

ARTICLE VIII

8 TRAINING OF RESIDENTS/FELLOWS AND MEDICAL STUDENTS

Residents/fellows are Physicians or Dentists in post graduate training who are pursuing clinical training in the Jackson Health System.

8.1 Residents/Fellows

- 8.1.(a) Residents/fellows will be appointed by the Public Health Trust upon recommendation of the appropriate Chief of Service and/or Program Director.
- 8.1.(b) Supervision

Resident/Fellow supervision will be guided by the following:

- The Resident Supervision Policy JHS Administration Policy 282;
- The ACGME Requirements;
- Clinical practice and patient safety standards that ensure safe and high quality care; and
- Utilization requirements that ensure cost-effective health care.

8.1.(c) Performance and Professionalism

Concerns about Residents/Fellow clinical performance and professionalism shall be conveyed to the Chief Medical Officer, who will notify the appropriate Chief of Hospital Service and Program Director.

Chiefs of Services and Program Directors are ultimately responsible for administration and supervision of each resident/fellow in the discharge of inpatient and outpatient care activities. This involves a combination of supervision, progressively more complex and independent activities, and the competence of the resident/fellow physicians, the latter of which shall be evaluated on a regular basis. The Program Directors shall maintain confidential records on evaluations.

8.1.(d) Documentation

Resident/fellow physicians are authorized to document appropriate patient care documentation and orders including provision of care commensurate with the physician's level of advancement and competence, under the general supervision of appropriately privileged medical teaching staff. The Jackson Health System will provide an environment where all resident/fellow physicians:

- i. participate in safe, effective and compassionate patient care under supervision. Develop an understanding of ethical and medical/legal issues that affect graduate medical education and learn how to apply cost containment measures in the provision of patient care;
- ii. participate in the education activities of the training program and, as appropriate, the assumption of responsibilities for teaching and supervising other residents and students, and participate in institutional orientation and education programs and other activities involving the clinical staff;
- iii. participate in institutional committees and councils to which the resident/fellow physician is appointed or invited;
- iv. perform these duties in accordance with established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the residents/fellows are assigned; including, among others, state licensure requirements and timely completion of all responsibilities with respect to medical records; and
- v. All entries in the medical record related to histories and physicals, operative reports, consultations, discharge summaries, and outpatient notes must be authenticated by the licensed independent practitioner directly supervising the resident.

8.1.(e) Resident/Fellows with Attending Responsibilities

Designated residents or fellows may be credentialed and privileged to admit and supervise the care of patients in a service other than the one in which they are training. To qualify under this rule, the resident or fellow must have been so approved for this type of responsibility by his Program Director under which he/she is currently receiving training, so designated for this type of responsibility by the Chief of Service where the resident/fellow will serve, be fully credentialed pursuant to the Public Health Trust Medical Staff Bylaws, and follow all PHT Medical Staff Bylaws, Rules and Regulations and JHS Policies and Procedures.

8.2 **Medical Students**

8.2.(a) Documentation

Third and fourth year medical students will be allowed to make entries in medical records under the supervision of supervising House Staff or supervising Physician Member of the Medical Staff. Medical students shall clearly identify his/her entries with the initials MS3/CC3 or MS4/CC4. Medical student documentation and orders must be countersigned by a supervising resident, fellow or Attending Physician. Medical student orders will not be carried out until countersigned.

8.2.(b) Supervision

Medical Student Supervision will be guided by:

- Medical Student Supervision JHS Policy#
- LCME requirements;
- Clinical practice and patient safety standards that ensure safe and high quality patient care; and
- Utilization requirements that ensure cost-effective health care

8.2.(c) Performance and Professionalism

Concerns about medical student clinical performance and professionalism shall be conveyed to the Chief Medical Officer, who will notify the appropriate Dean of Undergraduate Medical Education

ARTICLE IX

9.1 ADOPTION & AMENDMENT OF RULES & REGULATIONS

Adoption and amendment of these rules and regulations shall be in accordance with the PHT Medical Staff Bylaws.

MEDICAL STAFF RULES & REGULATIONS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: _____
Presi

8/1/12
Date

PUBLIC HEALTH TRUST:

By: 
Chairperson

8/16/12
Date

JACKSON HEALTH SYSTEM:

By: 
Chief Executive Officer

8/14/12
Date

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

By: **c Vl**
Legal Counsel

Aug 13, 2012
Date