WELLSPAN PHILHAVEN
RULES AND REGULATIONS FOR THE MEDICAL STAFF AND OTHER CLINICAL PERSONNEL

I. INTRODUCTION

These rules and regulations are for the guidance of the medical staff and other clinical personnel at WellSpan Philhaven in providing clinical care to patients. They are not meant to be exhaustive but are to be followed in conjunction with the governing body and medical staff bylaws, policies and procedures, and regulations promulgated by appropriate regulatory entities.

II. PATIENT CARE

A. Continuum of Care

Patient care is organized into a continuum of behavioral health services. Patients are assigned to a specific program, which offers the indicated appropriate care, utilizing an interdisciplinary treatment planning process. An attending psychiatrist shall be assigned to oversee the individualized treatment plan for each patient in programs where there are assigned or designated psychiatrists.

B. Senior Directors and Level of Care Directors

Responsibilities include, but are not limited to, the following:

1. Participate in the development of the organizational strategic plan;

2. Coordinate continuum of services and facilitate the integration of specialized services;

3. Provide leadership in the development and review of treatment protocols and services;

4. Facilitate development and implementation of new services;

5. Ensure that quality services are rendered in accordance with established standards, procedures and outcome requirements;

6. Develop standards for staff providing specialized services;

7. Provide consultation in the development of an operating budget for service line programs in accordance with the organization's strategic plan;

8. Work with Human Resources and program managers to ensure the availability of qualified staff.

C. Discipline Chiefs

Responsibilities include, but are not limited to, the following:

1. Participate in the recruitment of staff in coordination with the Medical Director's office, Level of Care Directors and Administration.

2. Participate in credentialing and privileging activities;

3. Actively involved in the orientation of new staff in their discipline;

4. Contribute to an active continuing education program;

5. Work in collaboration and cooperation with appropriate administrative personnel surrounding clinical & practicum experiences for trainees;

6. They or their designees may participate in the performance appraisal process for each clinician in their discipline through completion of a peer evaluation form;

7. Be responsible, as appropriate, for the performance improvement process and peer review within their discipline.

D. Consultation

Clinicians are encouraged to request consultation when indicated. The consultation request should identify the specific question or concern. Documentation of the consultation shall be entered in the patient's record.

E. Inpatient Care

The attending physician or a designee must see all inpatients daily. Additional contacts may be scheduled in accordance with the treatment plan or the patient's clinical condition.

F. Special Procedures

Special procedures such as hypnotherapy, etc. shall be conducted by individuals who meet the criteria in accordance with the most current policies and procedures.

G. Emergency Medical Care

In the event of a life-threatening medical emergency, unless a patient has given advance directives to the contrary, immediate attempts will be made to provide emergency medical care within the resources of WellSpan Philhaven, and emergency community resources shall be summoned for assistance and/or transport to an appropriate emergency care facility.

H. Advance Directives

The requests of patients with verified advance directives will be honored according to the most current policies and procedures. This will include organ donation advance directives and following Pennsylvania regulations, which require hospitals to request

that families of terminally ill patients consider donating organs and/or tissues suitable for transplantation.

I. Ethical Concerns

Ethical issues arising in the course of patient care will be referred to the Bioethics Committee of the medical staff.

J. Restraints or Seclusion

All clients have the right to be free from physical and mental abuse, and corporal punishment. All clients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the client, a staff member or others and must be discontinued at the earliest time possible. WellSpan Philhaven is committed to creating an organizational culture emphasizing prevention of and/or alternatives to the utilization of restraints or seclusion. When restraints or seclusion are clinically justified and when warranted by client behavior that threatens the physical safety of the client, staff, or others, their use will be in accordance with policies and procedures defined by the organization. All approaches to restraint and seclusion will protect the client's health and safety and preserve his/her dignity, rights and well-being. lt is the organization's policy not to use chemical restraints. The organization's plan for improving performance will include process monitoring activities focusing on restraint and seclusion reduction. See Policy 2500.030.

K. On-Call

Continuous psychiatric coverage will be arranged through the office of the Medical Director. In the event that some emergency precludes coverage by a scheduled clinician(s), the administrative on-call person should be consulted for the purpose of prompt provision of adequate coverage.

L. Elopement

In the event of an elopement from inpatient or residential treatment, an attempt shall be made to locate and convince the patient to return voluntarily. If that fails, staff may use reasonable and necessary means, under the circumstance, to return the patient to the facility.

In the event that physical harm to patient or staff would likely result from use of reasonable and necessary means, or in the event the patient cannot be located within a reasonable time, proceedings for involuntary commitment may be initiated and aid requested from appropriate authorities.

In all cases of elopement, the president of WellSpan Philhaven’s office (or the administrator on call, if after hours) shall be notified immediately.

III. DOCUMENTATION OF PATIENT CARE

A documented clinical record is to be maintained for each patient receiving treatment through a WellSpan Philhaven program. The clinical record is used to provide a means of communication among all staff members who contribute to the patient's treatment. The clinical record is the property of WellSpan Health and may be released or copied only pursuant to the regulations promulgated by the Pennsylvania Department of Human Service and applicable Federal privacy laws.

A. Admission

1. Inpatient

An initial assessment of the patient's medical condition shall be made by the admitting physician. A diagnostic impression, treatment plan and initial orders will be entered in the clinical record at the time of admission.

Upon admission, Access Intake shall be completed. All commitment forms shall be completed, reviewed, and signed with the patient, as appropriate. The attending physician is responsible for completing the psychiatric assessment which shall explain the reason for hospitalization. The completed psychiatric assessment shall be entered into the patient's record within 24-hours of the time of the order of admission. The admission time is defined by the time that the admission order is placed into the electronic health record by the admitting physician.

2. Day Hospital / Partial Hospitalization

A psychiatric assessment will be completed and entered into the clinical record within five (5) treatment days of the initial interview.

A Consent for Treatment must be completed, signed, and dated by the patient and staff person conducting the interview prior to treatment.

3. Outpatient

An initial evaluation will be completed and entered into the clinical record according to the most current applicable policies and procedures.

4. Residential

a. DiversIon – Adult

An initial assessment describing the status and chief complaint of the patient should be prepared and entered into the medical record within seventy-two (72) hours of admission to the program.

B. General Medical Conditions

1. Inpatient

A physician, certified nurse practitioner, or physicians' assistant under the supervision of a physician shall complete a history and physical examination within twenty-four (24) hours of admission. When a history and physical examination is completed by a physicians' assistant, it will be validated and cosigned by a physician within forty-eight (48) hours of completion of the exam.

The following data elements comprise a comprehensive history and physical examination. Cranial Nerves and sensory exam do not need to be examined unless a gross deficit is observed during the neurological screen.:

Client Name and age
Vital signs
Chief complaint
General appearance
Skin
Head, Ears, Eyes, Nose, Throat & Neck
Chest
    Breast, Heart
Abdomen
Extremities, Pulse
Back
Neurological screen
    Gait, Sensory, Cranial Nerves, Reflexes

Generative organs
Rectal
Allergies
Operations/injuries
Major illnesses
Review of Systems
    HEENT, Respiratory, Cardiac, GI/GU, Neuro, Muscle/skeletal
Pain – current
History
    Family History (Medical)
Habits
Recent Medications
Diet
Assessment/Impression
Medical Diagnosis
Course of Action

2. Day Hospital / Partial Hospitalization

The physician involved with the patient's admission will review the available medical records and will record the general medical conditions, which need to

be addressed while the patient is in the program. If appropriate, the WellSpan Philhaven physician will recommend further assessment and/or follow-up by the patient's primary care physician.

3. Outpatient

At the time of admission, a medical history is obtained during the interview process and is entered into the record as part of the providers note.

4. Residential

a. Diversion - Adult

A history and physical examination will be completed within one (1) week of the time of admission to the program, using the same data elements as in section III.B.1. When a history and physical examination is completed by a physicians' assistant, it will be validated and co-signed by a physician within seventy-two (72) hours of completion of the exam.

C. Treatment Plan

An individualized plan of treatment shall be prepared for each patient. The plan is to be based upon a careful assessment of the patient's status, which includes examination of medical, psychological, social, cultural, behavioral, familial, educational, vocational, and developmental aspects. This plan shall set forth the treatment goals and prescribe an integrated program of therapies, activities, experiences and education designed to meet these goals. The treatment plan is to be based on the collaborative recommendations of the patient's interdisciplinary team. To the extent feasible, the plan should be formulated in consultation with the patient.

The plan should be reviewed with and signed by the patient, parent and/or designee (in programs serving patients under age 14) and entered in the clinical record and updated according to WellSpan Philhaven policies and procedures. This applies to all Inpatient, Outpatient, Day Hospital, and Residential programs.

D. Social History

1. Inpatient

A social history shall
be in the patient's clinical record.

2. Outpatient

A social history shall in the patient's clinical record.

3. Day Hospital / Partial Hospitalization

A social history be in the patient's clinical record.

4. Residential

a. Diversion – Adult

The social history shall be entered in the patient's clinical record within twenty-four (24) hours of admission.

E. Psychological Consultation and Assessment Summary

1. Inpatient

When psychological testing is ordered, a note shall be entered into the medical record following completion of each psychological assessment. This note should include a brief summary of findings and any treatment recommendations. For all administered assessments, a comprehensive psychological summary shall be completed and entered in the medical record within fifteen (15) days of the date of discharge.

2. Outpatient

When psychological testing is ordered, a note shall be entered into the medical record following completion of each psychological assessment. This note should include a brief summary of findings and any treatment recommendations. For all administered assessments, a comprehensive psychological summary shall be completed and entered in the medical record within thirty (30) days of completion of the testing.

3. Day Hospital / Partial Hospitalization

When psychological testing is ordered, a note shall be entered into the medical record following completion of each psychological assessment. This note should include a brief summary of findings and any treatment recommendations. For all administered assessments, a comprehensive psychological summary shall be completed and entered in the medical record within fifteen (15) days of completion of the testing.

4. Residential

a. Diversion – Adult

When psychological testing is ordered, a note shall be entered into the medical record following completion of each psychological assessment. This note should include a brief summary of findings and any treatment recommendations. For all administered assessments, a comprehensive psychological summary shall be completed and entered in the medical record within thirty (30) days of completion of the testing.

F. Progress Notes*

1. Inpatient

A progress note shall be entered in the inpatient record to reflect each Inpatient contact. The documentation should occur at or near the time of events being recorded, when possible, and should not exceed 24-hours of the meeting. When a progress note is entered by a physicians' assistant, it is to be validated and co-signed by a physician within twenty-four (24) hours.

2. Outpatient

A progress note shall be entered in the outpatient record to reflect each outpatient contact. The documentation should occur at or near the time of events being recorded, when possible, and should not exceed 24-hours of the meeting. When a progress note is entered by a physicians' assistant, it is to be validated and co-signed by a physician within seven (7) working days.

3. Day Hospital / Partial Hospitalization

A progress note shall be entered in the patient's record to reflect each therapy session and physician contact. The documentation should occur at or near the time of events being recorded, when possible, and should not exceed 24-hours of the meeting. When a progress note is entered by a physicians' assistant, it is to be validated and co-signed by a physician within seven (7) working days.

4. Residential

a. Diversion – Adult

A progress note shall be entered in the patient's record to reflect each therapy session and physician contact within twenty-four (24) hours. When a progress note is entered by a physicians' assistant, it is to be validated and co-signed by a physician within 72 hours (3 working days).

* True for all levels of care - "More frequent notes will be indicated in any situation that needs further documentation such as a change in physical or mental condition or potential risk management issue. Progress notes pertaining to these issues shall be entered in the record at the time of or immediately after the occurrence. Progress notes are intended to provide a chronological picture of the patient's clinical course in treatment and to document treatment rendered to the patient. Progress notes should document the implementation of the treatment plan. If at all possible, progress notes should describe the response of the patient's social system to the therapeutic process and include descriptions of behavioral observations. All progress notes shall be dated and signed by the individual making the entry."

G. Orders*

*True for all orders: with few exceptions medical record generally should be entered directly into the electronic health record (EHR) by the responsible practitioner. Some emergency situations create the necessity of oral and telephone orders, together referred to herein as verbal orders.

1. Inpatient

Licensed physicians, nurse practitioners and physician assistants may give and record orders. Telephone/Verbal orders may be given by licensed physicians, nurse practitioners and physician assistants. Telephone/ verbal orders may be accepted and recorded by registered nurses and licensed pharmacists. All telephone/verbal orders must be signed or co-signed and dated and timed by a physician, nurse practitioner or physician assistant within twenty-four (24) hours. All orders shall be dated and timed upon entry. A physician may delegate the responsibility of managing an individual patient's diet to a registered dietitian consistent with the Medical Nutrition Therapy Order-Writing Protocol and Scope Protocol. The physician remains responsible to supervise and direct the registered dietitian's management of the patient's diet.

3. Diversion

Licensed physicians, nurse practitioners and physician assistants, may give and record orders. Telephone/Verbal orders may be given by licensed physicians, nurse practitioners and physician assistants. Telephone/verbal orders may be accepted and recorded by registered nurses, licensed practical nurses and licensed pharmacists. All telephone/ verbal orders must be signed or co-signed and dated and timed by a physician, nurse practitioner or physician assistant within 7 days. All orders shall be dated and timed upon entry.

3. Day Hospital

Licensed physicians, nurse practitioners, and physician assistants may give and record orders. Telephone/verbal orders may be accepted and recorded by registered nurses and licensed practical nurses**.** All telephone/ verbal orders recorded must be signed or co-signed and dated and timed by a physician within seven (7) days. All orders shall be dated and timed upon entry.

*True for all levels of care – "When an order is written by a physicians' assistant, it is to be validated and co-signed by a physician within forty-eight (48) hours."

H. Discharge

1. Inpatient

Each patient shall receive written discharge instructions at the time of

discharge. A copy of these instructions will become a part of the patient record.

A discharge summary shall be entered into the record within twenty-four hours of the patient's discharge, by the attending physician or their designee, while recognizing that rare exceptions may delay the documentation. In no case should the discharge summary be delayed more than one hundred sixty-eight (168) hours, after the patient's discharge. The following data elements comprise a comprehensive inpatient discharge summary:

- Name of Patient
- Date of Birth
- Admission Date
- Discharge Date
- Age
- Nicotine Use Status/Treatment
- Most Recent Metabolic Monitoring (If Applicable)
- Rationale for Multiple Antipsychotics (If Applicable)
- Type of Admission
- Discharge Diagnosis
- Psychosocial Stressors
- Reason for Treatment
- <u>Course of Treatment</u>

  Clinical Course

  Medical Course
- <u>Discharge Condition</u>

  Mental Status

  Psychological Health Status

  Physical Health Status

  Functional Status
- <u>Patient/Family Instructions</u>

  Discharge Medications

  Allergies

  Special Instructions
- <u>Aftercare</u>

  Therapy (Recommendations to provider)

  Medication Management (Recommendations to provider)

  Primary Care (Recommendations to provider)

  Specialty Services (Recommendations to provider)

2. Outpatient

   A discharge note shall include all diagnoses, reason for discharge, condition at discharge, type of treatment and aftercare plans, if any. This note should be promptly shared as appropriate in order to facilitate continuing care.

3. Day Hospital /Partial Hospitalization

A discharge summary shall be prepared and placed in the medical record within fifteen (15) days of the date of discharge. This document shall include a review of the diagnosis, course of treatment, condition on discharge, aftercare plan and discharge medication. This summary should be promptly shared as appropriate in order to facilitate continuing care.

4. Residential

a. Diversion – Adult

A discharge summary shall be entered in the medical record within fifteen (15) days of the date of discharge. This document shall include a review of the diagnosis, course of treatment, condition on discharge, aftercare plan and discharge medication. This summary should be promptly shared as appropriate in order to facilitate continuing care.

I. Medical Record Completion

1. Time Limit

All documentation shall be complete and entered into the medical record within thirty (30) days of the date of discharge.

2. Legibility

All documentation in the medical record shall be legible.

3. Suspension

An automatic suspension of a medical staff members privileges to admit patients, treat and consult (except with respect to his or her patients already admitted to the hospital, day hospital or residential services) shall after 7 days warning of delinquency, be imposed for failure to complete medical records within the guidelines established by the Rules and Regulations. Such suspension shall be considered to be a voluntary relinquishment of the practitioner's admitting, consulting and treating privileges and shall be effective until all delinquent records are completed, at which time the practitioner's privileges shall be automatically reinstated. This relinquishment of privileges shall not apply to emergency admissions needs or on-call responsibilities and will not release the practitioner who is responsible to carry out his or her assignments on service should he or she be on service at the time the suspension of privileges occurs.

For the purpose of enforcing this section the following, without limitation, may be considered justified reasons for delay in completing medical records.

a. The practitioner or any other individual contributing to the record is ill, or otherwise unavailable, for a period of time due to circumstances beyond his or her control.
b. A practitioner is waiting for the results of a late report and the record is complete otherwise except for the discharge summary and final diagnosis.
c. A delay in transcription process

IV. MEDICAL STAFF HEALTH

Recognizing that the medical staff has an obligation to protect patients from harm, the medical staff has designed a process that provides education about medical staff members' health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnoses, treatment and rehabilitation of medical staff members who suffer from a potentially impairing condition. The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a medical staff member in returning or regaining optimal professional functioning, consistent with protection of patients. If at any time during the diagnosis, treatment or rehabilitation phase of the process it is determined that a medical staff member is unable to safely perform the privileges he/she has been granted, the matter is forwarded to medical staff leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements. This process is outlined in the most current applicable policy and procedure.

ADOPTED by the Medical Staff on March 5th, 2024

APPROVED by the Board on March 18th, 2024