TABLE OF CONTENTS

RULES & REGULATIONS

EPHRATA COMMUNITY HOSPITAL
MEDICAL STAFF RULES & REGULATIONS

PREAMBLE

These Rules and Regulations are applicable equally to all members of the Staff without regard to sex, religion, race or ethnic status; neither age, relative position in the Hospital or community, frequency of usage of Hospital facilities or specialty certification shall warrant special consideration in determining applicability of the Rules & Regulations.

GENERAL INFORMATION

1. The Hospital and Medical Staff shall accept patients for care and treatment in compliance with the Pennsylvania Human Rights Act and title VI of the Federal Civil Rights Act of 1964 (as amended). If the service required is not part of the Hospital facility, the Medical Staff and Hospital Staff will do all possible to preserve life and limb until such time as the patient can be transferred to a suitable institution.

2. Except in emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

3. The discharging Staff member shall be held responsible for the preparation of a complete medical record for each patient and the record shall conform to the standards required by the Joint Commission on Accreditation of Healthcare Organizations. Each medical record entry shall be dated, timed and authenticated. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

4. Each member of the Staff shall designate a Staff member who may be called to attend his patients in an emergency. If the named Staff member is unavailable, the appropriate department chairman or his designee, is authorized to call upon any member of the Active Staff to provide necessary treatment. A list of alternate Staff members shall be posted at the telephone Switchboard, Registration Office and Emergency Room.

5. The Coroner's Office shall be notified immediately in all Dead-on-Arrival cases. The Borough or State Police must be notified immediately by telephone of all gunshot wounds, stabbings, assaults, traffic accidents, and attempted suicides, as well as any suspicion of foul play. Battered child syndrome cases are reportable to Lancaster County Children and Youth Social Service Agency.

6. Attendings are required by the Pennsylvania Department of Health to report all cases of communicable diseases. A list of the reportable diseases is maintained at each nursing station. The reporting forms are available through the Infection Surveillance Office.

7. No member of the Staff shall in any way act as an intermediary or place an infant in a free foster home or in any family for the purpose of adoption, except through an agent or agency licensed for adoption by the Commonwealth of Pennsylvania.

8. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her Supervisor, who in turn will discuss the matter with the involved practitioner. If warranted, the Supervisor may bring the matter to the attention of the Chairman of the Department wherein the practitioner has clinical privileges. When circumstances are such as to justify such action, the department chairman may himself request a consultation or take other action he deems necessary in the best interest of the patient.

SECTION ONE
ADOPTION AND AMENDMENT

1.1 Procedure

Upon the request of the President, the MEC, the Bylaws Committee, or upon timely written petition signed by at least 10 percent of the members who are entitled to vote, consideration shall be given to the amendment of these rules and regulations. Such action shall be taken by one of two methods, either:

a. by a vote taken at a regular or special meeting of the general Medical Staff, or

b. As approved by the MEC, by a mail ballot distributed to all active Staff members

1.1-1 In the case of 1.1a

a. notice of the proposed change was sent to all members at least 15 days prior to the date of the meeting; and,

b. the notice includes the exact wording of the existing rules and regulations language, if any, and the proposed change(s).

1.1-2 In the case of 1.1b

a.. The ballot contains the exact wording of the existing rules and regulations language and that the proposed change(s) are clearly indicated;

b.. that the proposed change(s) are grouped by the Bylaws Committee into logically connected changes which will be voted upon as a group; and

c.. that a date for mailing and a deadline for receipt of cast ballots will be set by the Bylaws Committee, and that the two dates will be separated by at least 14 days and by not more than 21 days.

1.2 Action on Rules and Regulations Change

A change in these rules and regulations by action of the medical Staff at a regular or special meeting of the general medical Staff (1.1a. above) requires the presence of a quorum as provided in section 10.3 of the Bylaws and shall require an affirmative vote of a majority of the members present and eligible to vote.

A change in these rules and regulations as a result of a mail ballot (1.1b. above) shall require an affirmative vote of a majority of the votes received by the set deadline. In this later case, the vote tally shall be confirmed by the medical Staff President, Vice-President and Treasurer/Secretary.

1.3 Board Approval

Rules and Regulations changes adopted by the medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld.

1.4 Exclusivity

The two methods described herein shall be the sole methods for the initiation, adoption, amendment, or repeal of the medical Staff rules and regulations.

SECTION TWO
ORDERS

2.1 The following practitioners may give orders for medication or treatment: Physicians, Dentists, Podiatrists, Certified Nurse Midwives (CNMs), Certified Physician Assistants (PA-Cs), Certified Registered Nurse Anesthetists (CRNAs) [limited to emergency situations], and Certified Registered Nurse Practitioners (CRNPs), in accordance with their licensure and their clinical privileges.

Oral orders for medication or treatment shall be accepted only in urgent situations. The use of oral orders by on site practitioners should be limited to “life and limb” emergencies or when the ordering practitioner is engaged in a sterile field and the delay of direct entry of such order would be dangerous to the patient. In the event the ordering practitioner is off site, direct order entry into the electronic health record is preferred. Oral orders may be used in the event that no suitable electronic method is available for direct order entry.

Oral orders shall be administered only by personnel qualified by their professional license or certification including: a physician, dentist, podiatrist, registered nurse, licensed practical nurse designated by nursing service or other graduate nurse, a CRNP, CNM, CRNA or PA-C.

A pharmacist may administer oral orders pertaining to drugs. A physical therapist may administer oral orders pertaining to physical therapy regimens. A respiratory therapist may administer oral orders pertaining to respiratory therapy treatments. A registered cardiovascular invasive specialist may administer oral orders pertaining to the cardiovascular lab.

Oral orders are written or entered into the electronic health record and read by the receiver for confirmation. All orders shall be dated, timed, and signed by the transcriber and the name of the practitioner giving the order shall be noted. The order shall be countersigned by a practitioner within seven (7) days.

2.2 All Inpatient and Outpatient orders for medication and treatment shall be reduced to writing or entered into the electronic health record as outlined in Section 2.3 below, and must be written clearly, legibly and completely. The written order shall be dated, timed and signed by the ordering practitioner. Stamped signatures will not be permitted on orders.

2.3 With few exceptions, orders generally should be entered directly into the electronic health record (EHR) by the responsible practitioner. In some clinical locations or situations, or for some clinical practices defined as out of EHR scope, electronic orders may not be available. In these situations, orders should be written as outlined in Section 2.2 above. Practitioners who are not members of the medical staff, but who are licensed in the State of Pennsylvania, and act within the scope of practice under state law, may order outpatient rehab, sleep studies, imaging and laboratory services.

2.4 Prior orders for patients undergoing a surgical procedure requiring general, spinal or epidural anesthesia will be cancelled. New orders must be entered into the electronic health record post operatively. The use of blanket orders to “Renew,” “Repeat,“ “Resume,” and “Continue Orders” is not acceptable.

2.5 All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

2.6 Stop-order on Drugs: All orders for anti-infective agents (oral or parenteral), anti-coagulants (oral or parenteral), steroids, and Schedule II, III, IV and V drugs shall be automatically discontinued after 5 days, unless:

a. The order indicates an exact number of doses to be administered;
b. An exact period of time for the medication is specified, or;
c. The attending Staff member reorders the medication.

All medication orders shall be redone after a 30-day hospital stay.

2.7 Diets:

a. All diets, especially diets for diabetic patients, should be ordered as promptly as possible after the patient's admission.

b. Dietary consultation should be ordered at least one day before the contemplated discharge date of the patient when possible so that adequate consultation time can be arranged between the dietician and the patient.

c. 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.

2.8 Any patient out of the hospital at 12:00 midnight shall be considered discharged and a discharge order shall be completed by the discharging practitioner. Exception to this policy will be made when the insurance company or the patient agree to pay for the stay.

2.9 Patients should be discharged in accordance with hospital policy.

2.10 A private room required because of medical necessity will require an order by a practitioner.

SECTION THREE
PROGRESS NOTES

3.1 Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes should be in sequential order, signed, timed and dated.

3.2 Each 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.

3.3 The initial progress note for an admission must be written within 24 hours of the admission and for each calendar day thereafter there shall be a progress note recorded on the chart. Newborns must be seen within 24 hours of admission or prior to discharge, whichever is sooner. The initial progress note for an Acute Care Rehab admission must be written within 24 hours, thereafter, a note is written based on the medical necessity and/or need of the resident with a minimum of 3 times a week.

3.4 The progress notes should include an admission note unless the history and physical examination is present on the chart at the time of admission.

3.5 The admission note shall include the reason for admission including the provisional diagnosis and pertinent information about the age and general physical condition of the patient.

3.6 If the discharge summary is dictated on the day of discharge, it may be considered as the progress note for that day.

3.7 Transfusions shall be documented in the progress notes.

3.8 In the event of a hospital death, the deceased shall be pronounced dead by the attending or his designee within a reasonable time.

3.9 The responsible practitioner must place in the patient's medical record the timely, pertinent evaluation of the results of respiratory therapy.

SECTION FOUR
CONSULTATIONS

4.0 "Hand-Off" Communication to the covering physician should contain sufficient information to communicate the clinical status of the patient. Information regarding the needed care of the patient will be communicated by direct contact with the covering physician or by detailed progress notes.

4.1 A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

4.2 The patient's group is responsible for requesting consultation when indicated. Department chairmen and the Medical Executive Committee, through appropriate monitoring mechanisms, shall ascertain that practitioners are utilizing consultations where indicated and proper.

4.3 The family physician with appropriate clinical privileges may write non-contradictory orders on the chart of his patient who is attended by a specialist.

4.4 Practitioners shall request consultations according to the following categories:

a. Consultation only: Recommendations are made.

b. Consultation and follow with me: Both the attending group and the consultant will follow the patient for each particular problem.

4.5 Consultations must be completed by the consultant within 24 hours of the order unless otherwise specified in the order. When a practitioner wants a consultation in less than 24 hours, he must stipulate the time frame in the order and he is responsible for relating the degree of urgency to the consultant.

4.6 Consults within the following specialties will require a peer to peer communication: Ophthalmology, Dermatology

SECTION FIVE
SURGERY/PROCEDURES

5.1 Surgeons must be in the Operating Room and ready to commence operation 10 minutes prior to the scheduled surgical time.

5.2 Both the Surgeon and the person administering anesthesia are to record in the patient's medical record that the patient has been positively identified by checking the wrist band and by talking with the patient. This shall be done after the patient has been placed on the procedure table and prior to commencement of the procedure.

5.3 There shall be documentation in the medical record that the patient has been examined by the practitioner performing the procedure prior to the procedure.

5.4 If a practitioner performs or attempts to perform a surgical or invasive procedure for which he does not have privileges, this shall be reported to the appropriate Department Chairman, Vice Chairman, the President, Vice President or Secretary/Treasurer of the Medical Staff, the Vice President for Medical Affairs, or another representative of the Hospital Administration (in order of availability). The informed party should take immediate action to remedy the situation if possible. He shall make a report of the incident including any actions taken, providing copies of this report to the Department Chairman, the President and the Vice President for Medical Affairs. The Department shall review the matter and make recommendations to the MEC which in turn, will review the matter and make recommendations to the Board, if deemed necessary. Nothing contained herein shall be deemed to prevent the President of the Staff or the Chief Executive Officer from taking corrective action.

5.5 A post procedure note must be written immediately after a procedure (before the patient goes to the next level of care). The note must contain the following: the name(s) of the licensed independent practitioner(s) who performed the procedure and the assistant(s); the name of the procedure performed; a description of the procedure; findings of the procedure; any estimated blood loss; any specimen(s) removed and the postoperative diagnosis.

5.6 A complete operative report must be completed within 24 hours of the procedure.

5.7 There shall be a complete anesthesia or conscience sedation record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

5.8 Except in the case of emergency, no surgery will be performed unless a properly executed, signed, consent form is on the patient's chart.

SECTION SIX
DISCHARGE SUMMARY

6.1 A discharge summary shall be written or dictated on all medical records. With rare exception, a discharge summary is expected to be recorded for all inpatient and observation visits within 24 hours of patient discharge, excluding normal newborn and uncomplicated maternity cases.

6.2 The discharge summary shall briefly state:

a. all relevant diagnoses established by the time of discharge as well as all operative procedures performed;

b. why the patient entered the hospital (a brief clinical statement of the "chief complaint" and the history of the present illness);

c. what the pertinent laboratory, x-ray, and physical findings were (pertinent negative as well as positive findings);

d. what medical and/or surgical treatment was given (course, complications, consultations, operations, etc.);

e. the patient's physical condition and disposition at discharge (ambulation, self-care, able to work, etc.);

f. instructions given to the patient and/or family about further care (medications, activities, follow-up care, and diet). This must be on the discharge summary if not documented on a discharge instruction sheet.

6.3 A final progress note may satisfy the requirement for a discharge summary in the case of normal newborn infants and uncomplicated obstetrical deliveries.

6.4 A Discharge Summary “For Length Of Stay Under 48 Hours” form may be used for a stay less than 48 hours, in lieu of a dictated discharge summary.

SECTION SEVEN
EMERGENCY PATIENTS

7.1 Patients presenting to the Emergency Department will be treated, admitted, referred or discharged. Emergency Department personnel will discourage follow-up or continuing care by the Emergency Department. In conjunction with their primary practitioner's input, the patient's preferences in regard to admitting or consulting practitioners should always be complied with if possible.

7.2 All patients presenting themselves for emergency treatment will be examined regardless of the patient's race, creed, color, religious belief or ability to pay. A medical screening examination will be provided by qualified personnel as per the departmental policy where the patient presents

7.3 In any acute life-threatening emergency, the necessary treatment shall be started at once by the Emergency physician.

7.4 A medical record shall be kept for every patient receiving emergency service, and it shall become an official hospital record. Such medical record shall include:

a. patient identification data;
b. time of arrival;
c. by whom transported;
d. pertinent history of injury or illness;
e. clinical, laboratory, and roentgenologic findings;
f. diagnosis;
g. treatment given;
h. procedure note, if applicable;
i. all necessary consent forms, properly executed;
j. condition at time of discharge; and,
k. final disposition, including instructions given for necessary follow-up.

7.4-1 Every record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

7.4-2 A review of Emergency Department medical records shall be conducted regularly to evaluate the quality of emergency medical care as part of the hospital's continuous quality improvement plans.

7.5 Treatment in the Emergency Department will be governed by the Emergency Department Policies and Procedures.

7.6 The Emergency Department personnel will be available to assist during an emergency within the hospital or until the attending can arrive to treat the patient.

7.7 It is both a privilege and a responsibility of Active Staff members to provide on-call coverage to the Emergency Department and to the Maternity Service. All members who provide on-call coverage agree to comply by all regulations, specifically "The Emergency Medical Treatment and Labor Act" (EMTALA), and standards concerning on-call coverage. In compliance with EMTALA, all members who provide on-call coverage must provide care regardless of ability to pay, insurance company affiliation, race, religion, or other prohibited criterion.

7.7-1 Participation in the on-call schedule is generally contingent upon the member having an office in the Ephrata Community Hospital service area. However, the Medical Staff, through the Medical Executive Committee, reserves the right to call upon Active Staff members not having offices in the Ephrata Community Hospital service area and Courtesy Staff members to help support the on-call schedule when a shortage of specialists in any field is felt to compromise the health of the community.

7.7-2 It is the prerogative of each Division to determine how it will share the on-call schedule among its members. However, if the members are unable to reach mutual agreement, an on-call schedule will be created by the Department Chairman awarding on-call time in proportion to the number of Active Staff members in a group (excluding provisional members).

7.7-3 Members may relinquish their right to on-call time if this is acceptable to the other members of the Division.

7.7-4 A participant in the on-call schedule may have another practitioner cover his call time on a limited basis to allow for temporary illness, vacations, etc. The substitute must have clinical privileges at Ephrata Community Hospital in the same Division/specialty and must be available to respond to the Emergency Department in a timely manner. The name of the substitute will be provided to the Emergency Department by the primary on-call practitioner.

7.7-5 A list of Active Staff members will be maintained by the Medical Staff Office.

7.7-6 Printing, distributing, and posting the Emergency Department and Maternity Service on-call schedules will be accomplished by the Emergency Department in a timely manner.

7.7-7 Necessary changes to the established on-call schedule, other than temporary substitutions as noted in 7.7-5, will be provided to the Emergency Department by the Division Chief.

7.7-8 If there is a shortage of on-call participants within a specialty, and upon agreement of all Division members, the Division may request the Medical Executive Committee to permit Courtesy Staff members and Active Staff members without offices in the Ephrata Community Hospital service area to be included in the on-call schedule.

7.7-9 Collection of fees for professional services provided by participating practitioners is the sole responsibility of those practitioners.

7.7-10 Participants in the on-call schedule are required to be readily available. If a practitioner is unable to be present within this thirty-minute timeframe, another practitioner within the required specialty could be contacted or appropriate arrangements will be made for the patient.

7.8 Unless specifically requested otherwise by the patient, Emergency Department staff will report any contact to the noted primary care provider.

7.9 Policies will be maintained in the Emergency and Maternity Services Departments regarding the specific types of providers who are permitted to perform medical screening examinations.

SECTION EIGHT
CONSENTS/RELEASES

8.1 Hospital supplied and Staff and Board approved authorization forms will be used appropriately. If alternative consent or authorizations are felt by the treating practitioner to be more appropriate, these may be custom made, but must be approved prior to being used in the hospital. The object will be that the patient understands the risks and complications associated with the procedure and the possible alternative methods of treatment prior to giving consent. A notation with the signature of the patient should be made in cases in which the patient adds provisions for incomplete or altered consents or authorizations in addition to the original consent. Denial of consent (such as refusing blood) need not rule out treatment but should be considered in the plans for treatment and care should be taken to document the will of the patient.

8.2 It is the practitioner's obligation to obtain an informed consent. Informed consent shall be obtained at a time the patient is mentally competent to understand the information provided. It is not the responsibility of a nurse or other hospital personnel to explain a procedure to a patient or to obtain consent.

8.3 Procedures requiring a consent form: Procedures which are invasive or require cutting performed in the OR, ER, or at the bed side; procedures requiring anesthesia but not considered invasive or requiring cutting; certain invasive diagnostic tests such as, but not limited to, arteriograms, myelograms, lumbar punctures and bone marrow aspirations; transfusion of any of the following blood products: whole blood, packed red blood cells, fresh frozen plasma, platelets, or cryoprecipitate. Permits are not necessary for well-established procedures with little risk such as venipuncture, blood gases, routine x-rays, nuclear scans and sonography.

8.4 There are special consent forms approved for use in the hospital. A list of the approved consent forms is maintained in the Health Information Services Department.

8.5 Consent shall be obtained in writing on forms provided for the purpose by the hospital whenever possible. The signature of the patient and the practitioner providing the information must appear on the consent form as well as the date and time of signatures.

8.6 A consent form shall remain valid for a maximum of 60 days if the patient's condition or the available treatments do not change significantly. Patients will be required to re-sign the consent form after 30 days. Consent forms for recurrent therapies shall remain valid for a maximum of 90 days, if the patient's condition or the available treatments do not change significantly. Chemotherapy treatment consent forms will be valid for a maximum of 365 days, unless the chemotherapy regimen is changed. If the chemotherapy regimen is changed, a new consent must be signed. Consent forms for pregnancy-related treatment will be valid for the length of the pregnancy.

8.7 Any patient leaving the hospital against the advice of the attending Staff member shall be requested to sign a statement releasing the hospital and the Staff member from any responsibility. In the case of a minor, such a statement should be executed by his legal representative. In cases where this request is denied, the Staff member shall so state in the record.

8.8 A surgical operation shall be performed only on consent of the patient or his legal representative. In emergencies, if the patient is unconscious or incapable of making a decision and there is not sufficient time to locate a relative who can authorize the procedure, the requirement for informed consent can be waived, if adequate explanation is documented.

8.9 The operative permit should contain all procedures to be performed, such as dilatation and curettage, biopsy, and cauterization, rather than just dilatation and curettage. The description of the procedure to be performed should be written in layman terminology and without abbreviations if at all possible so that it is easily understood by the patient.

8.10 Permission to perform an autopsy should be sought by the appropriate member of the Staff when the autopsy may provide a useful, educational, scientific, legal or other purpose. No autopsy shall be performed without consent of the legally responsible person. A properly witnessed written or telephone consent is acceptable. All autopsies shall be performed by the hospital pathologist, the county coroner, or by a physician to whom they may delegate the duty.

SECTION NINE
LIFE-SAVING ABORTION

9.1 Life-saving abortion may be performed in accordance with the laws of the Commonwealth of Pennsylvania. No physician should be required to perform, nor should any patient be forced to accept an abortion.

9.2 Definition: Life-saving abortion involves expulsion of a nonviable fetus (one which cannot survive outside the womb) from the uterus. The term life-saving abortion applies only to those abortions performed within the letter of the present law, regardless of the purpose intended, the means utilized or the persons performing the act. Life-saving abortion occurs "when pregnancy is terminated artificially at an early stage of gestation (up to and including 16 weeks) in order to preserve the life of the mother."

SECTION TEN
DISASTER

10.1 All members of the Active Staff of this Hospital may be assigned to various posts according to the Hospital Disaster Plan. It will be the responsibility of the members of the Active Staff to report to their assigned places at the Hospital and carry out their disaster assignments promptly.

10.2 The Director of the Emergency Department or his designee will coordinate the activities of the hospital. The director, with the cooperation and approval of the President of the Staff, will direct the evacuation and transfer of patients, assisted by various departments involved.

10.3 All policies concerning patient care will be the joint responsibility of the Director of the Emergency Department, the chairmen of the clinical departments and the President of the Staff. In their absence, their designated assistants will assume responsibility.

10.4 All Staff members of the Hospital specifically agree to relinquish direction of the professional care of their patients to the director of the Emergency Department during the period the hospital disaster plan is in effect. (This power would be necessary only in the event of a major disaster requiring relocation of hospitalized patients; whenever possible consultation with the attending would be secured.)

10.5 In the event of an internal disaster, the Staff authorizes the Hospital to take steps necessary to protect the welfare of the patients and the property of the Hospital.

SECTION ELEVEN
MEDICAL RECORDS

11.1 Each inpatient shall have a medical record that will contain the following:

a. Identification
b. Date
c. History and Physical examination and/or Admission Note
d. Diagnostic and therapeutic orders (including consultation requests and response when indicated)
e. Reports of laboratory, x-ray, and other studies, procedures and tests
f. Clinical observations, including results of therapy
g. Conclusions at termination of studies, hospitalization, evaluation or treatment
h. Instructions on discharge that include diet, activities, medications, plans for further treatment or follow-up care
i. Diagnosis--admitting and final with complications and outcome
j. Operative and procedure notes as required in section 5.5
k. Nurses' and Dietician's records involving care and progress
l. Final progress note or discharge summary outlining initial and final diagnosis, dates of admission and discharge, data about studies leading to diagnosis, treatment and discharge instructions
m. Evidence of informed consent when appropriate
n. Pertinent prenatal information which should be made part of the patient's medical record prior to delivery

11.2 Contents of emergency, short stay, and observation records are described in sections 7, 12, and 13, respectively, of these rules and regulations.

11.3 All records are the property of the Hospital and shall not be removed from the Hospital except in response to a properly executed subpoena, court order, statute, or for some special reason if approved by the Chief Executive Officer of the Hospital, or his designee. In case of readmission of a patient, all previous records shall be available for the use of the treating personnel. This rule shall apply to all patients, whether attended by the same Staff member or by another Staff member.

11.4 All entries in the medical record must be legible, complete, dated, timed, and signed. Stamped signatures will not be permitted on medical records. Only authorized individuals may document information on the Medical Record. Authorization will be granted by the Medical Records Committee. Illegibly written charts including the use of unapproved abbreviations will be returned for completion.

11.5 Symbols and abbreviations may be used only when they have been approved by the Medical Staff and may have only one meaning per abbreviation. Only hospital approved abbreviations can be used on the face sheet of the record.

11.6 Surgical procedures performed in the Emergency Room before the patient is admitted should be noted on the face sheet of the inpatient record.

11.7 Patients shall be discharged only on order of a member of the attending group. The discharging physician shall see that the record is complete, state his final diagnosis, and sign the record. A physician is required to complete a satisfactory record within 30 days after discharge. The HIS staff will assign the attending physician status to the physician who provided the admission orders.

11.8 In accordance with regulatory standards and in accordance with Health Information Management (HIM) policy, all medical records shall be completed within 30 days after the discharge or treatment of the patient, including all review editing, and authentication. No medical record shall be considered complete until all assigned deficiencies are resolved. Notices of records available for completion, delinquent records, and suspensions will be sent to the practitioner according to HIM policy and procedure. Failure to comply with the designated timeframes set forth in the policy will result in automatic and immediate temporary suspension of clinical privileges until the record is deemed to be complete.

A. During the temporary suspension of privileges:
    1. Patients already hospitalized may be cared for, but no new patients should be admitted to the practitioner’s service.
    2. Consults already ordered can be completed, but no new consultations shall be followed.
    3. Procedures already scheduled may be completed by the practitioner, but no new procedures may be scheduled.
    4. Except On-Call or Emergencies: To be determined by the Vice President for Medical Affairs
B. Any variances shall be reported directly to the Vice President of Medical Affairs

11.9 The discharging practitioner will be considered to be responsible for completion of the medical record; however, the record will be made available to the group for completion in his/her absence.

11.10 More than ten violations, or subsequent groupings of ten violations, of the requirements for completion of a history and physical examination within 24 hours of admission, or the completion of a full operative report within 24 hours of surgery during any Medical Staff year will initiate additional actions listed in Section 11.12.

11.11 If routine monitoring of medical records reveals a pattern of non-compliance with any other medical record requirements, additional actions will be taken as listed in Section 11.12.

11.12 The actions to be taken by the Medical Executive Committee in response to non-compliance with medical record requirements as specified in this Section are at the discretion of the Medical Executive Committee, and include the following:

a. Mandatory interview with the Medical Executive Committee where the practitioner will be asked for his corrective action plan that includes what steps he will take to prevent future medical records deficiencies;

b. A letter from the Chairman of the Hospital Board of Directors;

c. One week suspension of privileges, or longer period if determined to be a chronic issue by the Medical Executive Committee; or

d. Revocation of staff membership and clinical privileges.

11.13 Records of patients admitted to the Behavioral Health Unit will be separated from the records of those same patients for admission to other than the Behavioral Health Unit. These Behavioral Health Unit Records will not be placed at nursing stations other than the Behavioral Health Unit. They may be placed for record keeping in the same folder with, but separated from, the other records of the patient. When a confidential chart is requested by a nursing station other than the Behavioral Health Unit, a note will be placed in the folder stating that the confidential record may be seen in the Health Information Services Department, but may not be removed from there.

11.14 Records for patients admitted to the Acute Rehabilitation Unit must be separately identified from those of the hospital and must be readily available.

SECTION TWELVE
SHORT STAY RECORDS

12.1 Each short stay patient shall have a medical record that will contain the following:

a. Identification
b. Date of service
c. History and Physical examination or a Short Form History and Physical
d. Diagnostic and therapeutic orders (including consultation requests and response when indicated)
e. Reports of laboratory, x-ray, and other studies, procedures and tests
f. Clinical observations, including results of therapy
g. Reason for visit
h. Instructions on discharge that include diet, activities, medications, and plans for further treatment or follow-up care
i. Diagnosis--final with complications and outcome
j. Operative and procedure notes as required in section 5.5
k. Nurses' records involving care and progress
l. Post operative/progress notes regarding conclusions at termination of studies, treatment or surgery
m. Evidence of informed consent when appropriate

12.2 Sections 11.3 through 11.12 of these Rules and Regulations shall also apply to short stay records.

SECTION THIRTEEN
OBSERVATION SERVICE PROGRAM

13.1 The attending is responsible for the patient placement in observation service. The patient's disposition should be addressed within 24 hours.

13.2 The patient being placed into observation services must have an order indicating such and must be seen by the attending within eight hours of the order for observation.

13.3 Each patient placed in observation services shall have a medical record that will contain the following:

a. Identification
b. Date of service
c. History and Physical or a Short form History and Physical (with justification for observation services)
d. Diagnostic and therapeutic orders (including consultation requests and response when indicated)
e. Reports of laboratory, x-ray, and other studies, procedures and tests
f. Clinical observations, including results of therapy
g. Reason for visit
h. Instructions on discharge that include diet, activities, medications, and plans for further treatment or follow-up care
i. Diagnosis--final with complications and outcome
j. Nurses' records including assessment, care and progress
k. Progress notes regarding conclusions at termination of studies or treatment
l. Evidence of informed consent when appropriate

13.4 Sections 11.3 through 11.12 of these Rules and Regulations shall also apply to observation ~~status~~ services records.

SECTION FOURTEEN
OUTPATIENT RECORDS

14.1 Documentation requirements for outpatient records (examples: chemotherapy, dobutamine therapy, transfusions, neopogen injections, electroconvulsive therapy [ECT], angiography) shall be as delineated in this section.

14.2 Each patient shall have a medical record that will contain the following:

a. Patient identification
b. Date of service
c. Problem list
d. Medication record
e. Assessment dated within the last 30 days. An acceptable assessment would be one of the following: consult, history and physical, short form history and physical, or a sufficient office note that would include diagnoses, past history, review of systems, and treatment plan.
f. Nursing assessment
g. Diagnostic/therapeutic orders
h. Reports of any labwork, imaging or other studies; procedures; or tests
i. Nursing notes
j. Evidence of informed consent when appropriate
k. Final diagnosis

14.3 Sections 11.3 through 11.12 of these Rules and Regulations shall also apply to these outpatient records.

SECTION FIVETEEN
ASSISTED SUICIDE

15.1 The Ephrata Community Hospital Medical Staff does not support or condone assisted suicide at this institution.

15.2 Nothing in this section shall preclude the alleviation of pain and suffering or our commitment to compassionate care.

SECTION SIXTEEN
REHABILITATION PROGRAM

16.1 The Rehabilitation Program shall be organized under the direction and supervision of a Medical Director who is a member of the medical staff and who, on the basis of training and experience, is knowledgeable in physical medicine and rehabilitation.

16.2 Each patient admitted to the Rehabilitation Program shall receive a prescreening evaluation to determine the patient is appropriate for the program and will benefit from the services to be provided.

16.3 Each patient admitted to the Rehabilitation Program shall have a medical record that will contain the following:

a. Identification
b. Date of service
c. Prescreening evaluation to determine appropriateness for rehabilitation services.
d. History and Physical examination
e. Diagnostic and therapeutic orders (including consultative requests and response when indicated)
f. Reports of laboratory, x-ray, and other studies, procedures and tests
g. Clinical observations, including results of therapy
h. Evidence of an interdisciplinary team conference, at least every other week during the stay on the rehabilitation unit
i. A current written plan of care, based on the direction of the attending physician and on the rehabilitation potential of the patient. The plan of care shall state the needs and limitations of the patient as well as the goals of the treatment program for that patient.
j. Instructions on discharge that include diet, activities, medications, and plans for further treatment or follow-up care.
k. Diagnosis – final with complications and outcome.
l. Nursing and therapy records including assessment, functional status, care and progress.
m. Progress notes regarding conclusions at termination of studies or treatment.
n. Evidence of informed consent when appropriate.

16.4 Sections 11.3 through 11.12 of these Rules and Regulations shall also apply to Rehabilitation Program records.