

MEDICAL STAFF RULES AND REGULATIONS

A. ADMISSION AND DISCHARGE

1. Only physicians granted Staff appointment and clinical privileges may admit patients to this Hospital except as provided in the Staff Bylaws and Rules and Regulations. All physicians with authority to admit patients shall be governed by the official admitting policy of the Hospital.
2. Patients who are known to be suffering from drug abuse, alcoholism, and mental illness shall not be admitted unless proper safety precautions can be taken to safeguard the patient, other patients and employees.
3. A physician appointee of the Staff shall be responsible for the medical care of each patient in the Hospital. The admitting physician(s) shall be responsible for the treatment and the prompt completeness and accuracy of the medical record (Refer to Section C of these Rules and Regulations). Whenever these responsibilities are permanently transferred to another physician outside that physician's group, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the physician transferring his responsibility shall personally notify the other physician to ensure the acceptance of that responsibility is clearly understood. The progress note should also include documentation that the transfer is acceptable to the patient and/or family members. The patient shall be assigned to the service concerned in the treatment of the disease which necessitated admission. In the case of a patient requiring admission who has no physician, he shall be assigned to the physician on-call for the service to which the illness of the patient indicates assignment.

Patients admitted by a dentist with admitting privileges shall be under the care of a physician member of the Medical Staff with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner.

The admitting practitioner shall be responsible for securing the services of such physician member of the Medical Staff prior to admission of the patient and shall supply the name of the physician to the Hospital. All patients admitted by a dentist or podiatrist should have a history and physical examination by a qualified physician member of the Medical Staff as defined by these Rules and Regulations, unless the practitioner is an oral and maxillofacial surgeon who has been determined to be currently competent by the Medical Staff to perform a history and physical examination and has been granted that privilege.. The admitting practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide.

4. Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible. A legible copy of the emergency service record shall accompany the patient to the nursing unit.
5. Physicians shall be able to justify emergency admissions. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission but no

later than 24 hours. Frequent violators of this rule shall be referred to the Executive Committee for appropriate action.

6. A patient to be admitted on an emergency basis shall be given the opportunity to select a member of the Staff to be responsible for the patient while in the Hospital. If a dentist is selected by the patient, a physician shall also be selected to assume the medical responsibility for the patient. Where no such selection is made, the on-call physician shall assume responsibility for the patient.

The on-call physician must either accept the patient needing admission from the emergency department; arrange for another physician to see the patient (may be by telephone); or come in and see the patient and arrange for disposition from the emergency department. The patient will be referred to the on-call physician for follow-up care.

7. Each member of the staff shall be responsible for insuring that another member of the staff (alternate), with comparable privileges when possible, is assigned to provide appropriate care to the attending's patients when the attending is not available. Whenever these responsibilities are transferred, for more than 48 hours, except under extreme emergency or other unusual circumstances, to another physician outside that physician's group, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note documenting that the attending physician has personally notified the other physician should be written to ensure the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service concerned in the treatment of the disease, which necessitated admission.

In cases of a medical emergency, the alternate physician will be contacted. In case the alternate is not available, the chain of command shall be implemented with a call to the service chief and/or chief of staff as appropriate. Repeated failure of the appointee to meet these requirements shall result in disciplinary action.

8. Patients shall be discharged from the Hospital only on the order of an attending physician. If a patient leaves the Hospital against the advice of the attending physician, or without proper discharge, a notation shall be made in the patient's medical record that the patient left against medical advice.
9. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:
 - (a) Emergency
 - (b) Urgent
 - (c) Pre-operative
 - (d) Routine
10. Except in emergency situations, the patient shall not be transferred within the Hospital without the approval of attending physician.
11. Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the medical directors.
12. Physicians shall abide by the Hospital's utilization review plan to include:
 - (a) The appropriateness and medical necessity of admissions
 - (b) Continued stay
 - (c) Supportive services
 - (d) Discharge planning.

13. In the event of a Hospital patient death, the deceased shall be pronounced dead by the attending physician or his or her physician designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Staff. Policies with respect to release of dead bodies shall conform to Kentucky law. The coroner shall be notified of all deaths that meet set criteria as specified in KRS Chapter 72. The attending physician shall be notified of the coroners decision regarding autopsy. In non-coroner cases the attending physician shall be encouraged to order an autopsy for those deaths, which meet the approved medical staff criteria. When a request is received to perform an autopsy on a patient who expired within 24 hours of admission the pathologist will consult with the attending physician to determine if the cause of death was due to natural causes.
14. Physicians should write discharge orders that will allow patients to be discharged from the Hospital whenever possible on the day of discharge.
15. A patient admitted to an observation bed must be seen in the hospital by the attending physician during the observation period and a history and physical performed within 24 hours

B. EMERGENCY SERVICES

1. Appointees of the Active and Associate Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures. Any active staff member 60 years of age or older, or who has been a member of the staff for 30 years, may have the option of having his name removed from the ER call roster while retaining all other privileges of the Active Staff.
2. Clinical privileges shall be delineated for all practitioners rendering emergency care in accordance with Staff and Hospital procedures.
3. The Emergency Director has the authority and responsibility for implementing established policies and for providing overall direction in the continuing operation of the emergency service.
4. At least one physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven (7) days per week.
5. In cases of multiple trauma admitted to this facility, the Emergency Physician will contact a general surgeon to assume responsibility for care of the patient.
6. When appropriate, as determined by the emergency department physician on duty, or as requested by the patient, the patient's private practitioner shall be called in accordance with the emergency service policies and procedures.
7. All Emergency Department physicians shall provide and maintain current evidence of ACLS certification. .
8. Emergency service policies and procedures shall be developed by the Chief of Emergency Services or the Emergency Service. These policies shall then be submitted for approval to the Executive Committee, medical staff and Board of Trustees.

9. If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency practitioner, either for observation or for further treatment, the patient shall be admitted in the name of the patient's physician or the physician on-call. The physician or physician-on-call must be notified at the time of patient's admission.
10. Patients admitted through the Emergency Department who are deemed unstable shall be seen by their attending physician as soon as possible; those patients deemed stable shall be seen by their attending physician within twelve hours.
11. It is the responsibility of the Emergency Department Physician to make the evaluation of the patient's condition while in the Emergency Department and to insure that the condition is documented in the record and the attending physician is appropriately notified.
12. In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency physician, an x-ray follow-up form is initiated by the Radiology Department and forwarded to the emergency physician on duty. The emergency physician shall contact the patient's private physician who will determine the appropriate follow-up necessary, if any.
13. An appropriate emergency department medical record shall be kept for every patient receiving emergency service. The emergency service medical record shall include:
 - (a) Adequate patient information;
 - (b) Information concerning the time of the patient's arrival and by whom transported;
 - (c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital and history of allergies;
 - (d) Description of significant clinical, laboratory and x-ray findings;
 - (e) Diagnosis including condition of patient;
 - (f) Treatment given and plans for management;
 - (g) Condition of the patient on discharge or transfer; and
 - (h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.
14. Each patient's emergency medical record shall be signed by the physician in attendance who is responsible for its clinical accuracy.
15. The Emergency Department Director or the emergency committee shall coordinate the review of emergency records.
16. The Emergency Department Director shall be responsible for continual monitoring of the quality and appropriateness of various aspects of emergency patient care.
17. A copy of the emergency service medical record shall accompany patients being admitted as an inpatient.
18. Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility, when in the judgment of the attending practitioner or the Emergency Department physician, the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.

19. The Emergency Department Director or the emergency service committee shall make certain that emergency service procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.
20. On-call physician shall be available to the emergency care area within thirty-minutes of the time that he/she is contacted. Initial consultation may be made through two-way voice communication. When subsequent consultation is necessary with the physician, he/she is available to the emergency care area within approximately thirty minutes of the time that he/she is contacted.

C. MEDICAL RECORDS

1. The admitting practitioner shall be responsible for the preparation of an accurate, timely, complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; medical history; physical examination; diagnostic and therapeutic orders; appropriate informed consent(s); clinical observations including results of therapy, progress notes, consultations, and nursing notes; reports of procedures, tests and results including operative reports; conclusions at termination of hospitalization to include relevant diagnoses, clinical resume; and autopsy report when performed.

2. History and Physical

a. History and Physical Requirements

- i. The medical record must contain a history and physical examination (H&P). The H&P must be performed by an Licensed Independent Practitioner (LIP) no more than 30 days prior to hospital admission/outpatient surgery or 24 hours after hospital admission but prior to surgery/outpatient surgery.
- ii. When the H&P is performed within 30 days of the admission and /or outpatient surgery an appropriate reassessment must be completed at the time of admission and/or prior to surgery. A note updating any changes or indicating no change, based on the reassessment, is required. An update will not be required if the H&P is performed within 24 hours prior to the procedure/treatment unless there is a change in the patient's condition. The physician uses the patient's condition, and any co-morbidities, in relation to the reason the patient was admitted or to the surgery to be performed, when deciding what depth of assessment needs to be performed and what information needs to be included in the update note.
- iii. An H&P performed more than 30 days prior to hospital admission/outpatient surgery does not comply with the current requirements and a new H&P must be performed.
- iv. All or part of the H&P delegated to other practitioners in accordance with State law and hospital policy, but the LIP must sign the H&P and as applicable, the update note and assume full responsibility for the H&P within 24 hours of admission or prior to surgery or invasive procedures. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H&P, and/or the update assessment and note. (Update assessments and notes are considered part of the H&P)

b. History and Physical Content

The Medical Staff shall define those elements, based on current standards and regulatory requirements, that comprise a complete history and physical. The content shall vary by

setting or level of care. Quality of medical histories and physicals shall be monitored by the Medical Records Committee.

Inpatient

- 1) Chief Complaint: Major reason for hospitalization. Chief complaint may be addressed in the History of Present Illness.
- 2) History of Present Illness: Chronology of present illness to justify hospitalization and treatment
- 3) Past Medical History: past illnesses, surgeries, medications, allergies
- 4) Social History
- 5) Family History when indicated
- 6) Pertinent Review of Systems
- 7) Vital signs
- 8) Physical Examination: current physical assessment that documents findings of a thorough examination of the body system(s) involved in the chief complaint and in the history of present illness. Additional body systems must be documented for complex, serious illnesses and/or multiple health problems.
 - *General
 - *HEENT
 - *Neck
 - *Lungs/Chest
 - *Cardiovascular: heart/Vascular
 - *Abdomen
 - *Extremities/Musculoskeletal
 - *Neurological
 - *Lymphatics: as indicated by HPI or co-morbid
 - *Genitourinary: as indicated by HPI or co-morbid
 - *Rectal: as indicated by HPI or co-morbid
 - *Vaginal: as indicated by HPI or co-morbid
 - *Breast: as indicated by HPI or co-morbid
- 9) Conclusion/Impression: Statement of findings/symptoms-possible differential diagnosis
- 10) Plan: Treatment to be given, to include studies

Outpatient surgery, Obstetrical and Pediatric

To be used on inpatient admissions with an expected length of stay <48 hours and/or outpatient procedures where general, spinal, epidural or conscious sedation/analgesia is used.

- 1) Chief Complaint/Indications for Procedure: may be addressed in history of present illness
- 2) History of Present Illness: Address 1-3 of following elements:
 - a. Location
 - b. Quality
 - c. Severity
 - d. Duration
 - e. Timing
 - f. Context

- g. Modifying factors and associated signs/symptoms
- 3) Past Medical History: past illnesses, surgeries, medications and allergies
- 4) Pertinent Review of Systems:
- 5) Immunizations for pediatric patients
- 6) Family History: as indicated
- 7) Social History: as indicated
- 8) Physical Examination
 - a. Mental Status of patient
 - b. Examination specific to proposed procedure
 - c. Examination specific to any co-morbid conditions
 - d. Auscultation of heart and lungs
 - e. Assessment regarding patient's general health

Invasive Radiological Procedures/Injections

Used for all interventional procedures, CT guided biopsy, ultrasound guided biopsy, stereotactic breast biopsy, myelogram and TEE transesophageal echocardiogram.

- a. History of Present Illness: Documentation of the indications for procedure
 - b. List of current medications
 - c. Physical Examination
 - d. Assessment of Patient's General Health
3. When the history and physical examination (H&P) are not recorded before an operation or any potentially hazardous invasive diagnostic or therapeutic procedure, the procedure shall be delayed until the H&P is complete. In emergency cases where there is threat to life or limb, a note by the physician regarding the condition of the patient's heart and lungs should be documented prior to the procedure being done.
 4. Progress notes should be written with appropriate frequency, but at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem. Pertinent progress notes at least every day, shall be recorded, dated and encouraged to be timed at the time of observation sufficient to permit continuity of care and transferability.
 5. Operative reports shall include a detailed account of the findings at surgery as well as the details of the a) primary surgeons and assistants, b) complications, c) surgical procedures used, d) estimated blood loss, e) specimens removed, f) postoperative diagnosis. Operative reports shall be written () immediately following surgery and dictated within 24 hours.
 6. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated by the responsible physician.
 7. A consult will be requested when the condition of the patient exceeds the privileges granted to the practitioner. Consultations should be requested by the attending physician contacting the Consultant personally or an order should be written indicating the reason for the consultation and the time frame the consultation is necessary.
 8. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. Attending and consulting physicians shall document each visit. The note shall be sufficient to

permit continuity of care and transferability. If patients' condition remains unchanged, no more than one visit per 24 hours needs to be documented. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

9. Any qualified physician with clinical privileges in this Hospital can be called for consultation.
10. Final, or tentative, diagnoses shall be recorded or dictated in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.
11. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized except for normal newborn infants and for patients whose stay is less than forty-eight hours and the patient had no major surgery. In the latter case, a final progress note including disposition of patient, discharge medications, instructions and follow-up visit may be substituted for the discharge summary. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.
12. Written consent of the patient or his legal representative is required for release of medical information to persons not otherwise authorized to receive this information.
13. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.
14. Symbols and abbreviations that are included on the JCAHO "Do Not Use Abbreviations List," shall not be used in any documentation.
15. A summary shall be written on all patients who die within the hospital regardless of the length of time they are at the hospital. This shall include Emergency Department patients and DOA's.
16. Original records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the CEO. The consequences of the first violation of this rule shall be a written warning and suspension of privileges until all records are returned. A second violation will result in an automatic fifteen (15) day suspension of clinical privileges. A third violation may result in a permanent revocation of hospital privileges.
17. Free access to all medical records of all patients shall be afforded to members of the 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 Executive Committee before records can be studied. Subject to the discretion of the CEO, former members of the Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
18. Physicians shall be responsible for insuring that an informed consent is obtained from the patient. The informed consent shall contain at least the following:

- Name of patient and when appropriate patients legal guardian
- Name of hospital
- Name of specific procedure(s)
- Name of all practitioners involved in performance of the procedure(s)
- Risks
- Alternative procedures, treatments or therapies
- Signature of patient or legal guardian
- Date and time consent obtained
- Statement that procedure was explained to patient or guardian
- Signature of professional person witnessing the consent
- Name/signature of person who explained the procedure to the patient or guardian

If consent is not obtainable, due to an emergent situation, the practitioner shall insure that the documentation in the medical record clearly reflects the reason for lack of consent.

19. The attending physician should complete the medical record at the time of the patient's discharge, to include progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at time of discharge, the medical record will be available in the Medical Record Department. (If the discharge summary cannot be dictated at the time of discharge, a final progress note should be written in the medical record including a final, or tentative, diagnosis.)
20. Unless an exception is requested, in writing, to the Director of the Health Information Management Department, the physician responsible for completion of the patient record will be the admitting physician unless the patient is formally transferred to another physician's service.
21. Medical record charts will become delinquent thirty days from the date of discharge. Health Information Management will track these charts. If the medical record is incomplete 21 days after discharge, a written notice shall be sent to the physician by the Health Information Management Department notifying him that he has 9 days from the date of the notice to complete the chart(s). If the physician does not complete the charts within thirty (30) days of the discharge date, he will be placed on delinquent status and all hospital clinical privileges shall be withdrawn. It shall be the physician's responsibility to see that in-house patients are assigned to another physician with hospital membership with like clinical privileges (Section A#7). If records become incomplete while the physician is ill or on vacation, the physician shall have one week to complete the records after resuming his active practice. In order for this to be activated within the Medical Record system, a formal notification of physician unavailability must be received by the PBX Operator. Retroactive notifications cannot be accepted.
22. Delinquency status shall be rescinded upon the completion of records. The Director of the Health Information Management Department shall inform Registration and other appropriate department/areas of the completion of records. Completion of records shall be defined as completion of dictation and all possible signatures on all available documents.
23. The Health Information Management Department shall be responsible for analyzing medical records for the purpose of administering this rule.

24. When a physician has been suspended three times within a calendar year, he/she will lose clinical privileges for a three-month period.
25. Medical records of Frankfort Regional Medical Center patients shall be retained in their "original form" or microfilm for a minimum of twenty-one years.
26. A query form is utilized as a communication tool between the physician and coder to clarify any documentation issues in the patient's medical record. A query form is not to be utilized as a substitute for medical record documentation. The query form requires that the physician agree or disagree with the query by checking "Yes" or "No" on the form.

A "No" response to the query shall require the physician to authenticate and date the query form.

A "Yes" response to the query shall require the physician to authenticate and date the query form, and add a handwritten or dictated addendum to the patient's medical record. The addendum shall be authenticated and dated with date it was added, by the physician.

An unsigned query form shall be included in the delinquent chart count for that physician.

D. CONFIDENTIALITY AND INFORMATION SECURITY

1. Individuals with clinical privileges at Frankfort Regional Medical Center shall treat all medical records or patient information, to include computerized patient information, confidentially.
2. In order to assure compliance, all individuals having access to software systems as part of their performance or duties at Frankfort Regional Medical Center must read, sign and abide by an Information Security Agreement.
3. Misuse or breach of confidential information or breach of the Information Security Agreement may result in revocation of electronic privileges/computer access and possible corrective action as outlined in Article VII of the Medical Staff Bylaws.
4. Information Security Agreements shall be obtained at initial appointment and reappointment.
5. HIPPA Privacy and Appropriate Access
 - a. System access by all physicians will be routinely reviewed through the use of conformance and monitoring audit reports. Physicians who are self assigning to patients where there is no evidence of direct care responsibilities will be challenged to explain why he or she self assigned to the patient.
 - b. If the physician fails to provide evidence of direct care responsibilities this inappropriate access will be submitted as a potential reportable event to the OIG.
 - c. The CEO and the FISO will communicate violations of Appropriate Access policies by a physician or allied health professional to the individual.
 - d. Disciplinary action will be based on guidelines in the Medical Staff Bylaws and may include action from oral and written warnings to the revocation of privileges.
 - e. Documentation of any disciplinary action will be maintained in accordance with the Medical Staff Bylaws.

E. GENERAL CONDUCT OF CARE

1. Attending physicians must see each patient daily and write daily progress notes.

2. All orders for treatment shall be in writing. A resident of an approved professional education program may write patient care orders under the direction of a sponsoring physician. All patient care orders written by a resident will be counter signed by a sponsoring physician. A verbal order shall be considered to be in writing if given to a registered nurse, Laboratory Personnel, Registered Pharmacist, Respiratory Therapy, Physical Therapy, Diagnostic Imaging, Social Worker and Dietitian functioning within his/her scope of licensure. The order receiver must receive these orders directly from the prescriber, except in the case of a patient care emergency. Verbal orders must not be taken by any other personnel. All verbal orders shall be signed by the appropriate authorized person, who received the order, with the name of the practitioner per his or her own name. The verbal order shall be read back by the authorized person and the physician shall verify that the order read back is correct. The read back and verification shall be documented. The responsible physician shall authenticate the verbal order at the next visit or within 48 hours, whichever is earlier.
3. A "no code" order should be written by the attending physician; however, verbal orders will be accepted when these are witnessed by two nurses. This verbal order must be authenticated no later than twenty-four (24) hours from the time the order is given. The progress notes should reflect the basis of this decision and that the patient and/or significant other was counseled and consideration for advance directives was given.
4. The withdrawal or withholding of life support will be done by the physician in accordance with the Kentucky Living Will Act and other applicable laws, regulations and court decisions.
5. A consent for treatment form, signed by or on behalf of, every patient admitted to the Hospital, shall be obtained at the time of admission.
6. The physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out by the nurse until clarified. Orders which are illegible or improperly written will be clarified by the nurse as soon as possible.
7. All previous orders are cancelled when patients go to surgery or, whenever there is a change in the level of care.
8. Any Medical Staff member who knowingly allows a suspended physician to admit a patient in his name and then allows the suspended physician to render care to that patient shall also have his privileges suspended for a period of five days.
9. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.
10. All Schedule 2 narcotics will carry an automatic 60 day stop order unless a specific length of treatment is prescribed. If no length of treatment is specified and the practitioner desires to continue these medications he must reorder them at the end of the 60th day. The attending practitioner or his designee shall be notified by the responsible nurse when drugs are due an automatic stop order.

11. Drug orders continued for 60 days will be subject to Automatic Stop Orders. Drug orders will be cancelled when a patient undergoes surgery or changes level of care. The prescriber shall write new orders for medications.
12. The attending physician or practitioner is primarily responsible for requesting consultation when indicated or when the condition of the patient exceeds the clinical privileges of the practitioner, and for calling a qualified consultant; this will be done with the knowledge and approval of the patient and/or significant other.
13. All medications brought into the Hospital by a patient must be sent to the Pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the practitioner has prescribed.
 - i. Medications brought into the Hospital by a patient or his family will not be given to the patient during his hospital stay without the express authorization of the attending physician.
 - ii. All medications received by the Pharmacy will have a receipt, the original of which will be attached to the patient's chart.
 - iii. Medications shall be returned to the patient at time of discharge upon presentation of receipt attached to patient's chart.
 - iv. Medications not called for by this method will be kept in the Pharmacy for up to 14 days after discharge at which time the pharmacy shall contact the patient before the medication is destroyed.
14. Blood, which has been cross-matched and is being held for a patient will be held for 48 hours at which time the order for the blood will be cancelled unless reordered for another 48 hours after notification of physician. Blood will not be released without notifying the appropriate physician.
15. Consultation request forms for radiology, diagnostic imaging and pathology shall be filled out adequately. The attending physician is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes by a nurse.
16. 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 or he shall call this to the attention of her or his superior who in turn may refer the matter to the CEO or the CNO. If warranted, the CEO or CNO may bring the matter to the attention of the attending practitioner, Chief of Service, or the Chief of Staff as appropriate. Where circumstances are such as to justify such action, the Chief of Staff may request a consultation.
17. Standing orders and/or instruction sheets shall be instituted only after approval of the Executive Committee of the Staff. Such standing orders and/or instruction sheets shall be reviewed at least annually and revised as necessary. All standing orders and/or instruction sheets should be signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.

F. SWING BED

1. A physician must write an order to transfer a patient to a swing bed and for diet, medication and therapeutic services. The physician must record a medical evaluation (within 24 hours) of admission with current medical findings, medical history, physical examination and diagnosis. The discharge summary from acute

care may be used if within five days of admission to swing bed status and meets above requirements.

2. The physician must visit the patient at least every 7 days. Visits and significant changes in patient's condition must be documented in progress notes.
 - a. The physician must write an order to discharge and any follow-up orders.
 - b. The physician must dictate a discharge summary within 30 days of discharge.
 - c. All verbal orders must be signed at the next visit.

G. SURGICAL CARE

1. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall document in the patient's chart the preoperative diagnosis, the condition of the patient's heart and lungs prior to performing the procedure. Anesthesia shall not be administered, except in an emergency, without the above being documented.

2. Surgeons shall be in the operating room ready to commence surgery at the time of the scheduled case.

If a surgeon is repeatedly or flagrantly late, the issue will be referred to the OR Steering Committee.

3. Surgeons shall remain in the Surgical Services area until the patient is in stable condition as determined by the Anesthesia Staff.
4. Observers in surgery who are not members of the Medical Staff or are not OR personnel or nursing staff shall comply with OR policies and informed consent requirements.
5. Anesthesia staff shall maintain an appropriate anesthesia record to include evidence of current pre-anesthetic evaluation, pre-induction evaluation, course of anesthesia and post-anesthetic follow-up of the patient's condition.
The post anesthesia assessment for inpatients shall be completed and documented by any individual credentialed to administer anesthesia within 48 hours after surgery. The post anesthesia assessment for outpatients shall be performed by a credentialed anesthesia provider, or according to rigorously applied criteria approved by the medical staff.
The post anesthesia assessment shall include:
 - Cardiopulmonary Status
 - Level of Consciousness
 - Any complications during post anesthesia recovery
 - Any follow up care needed
6. There shall be a qualified first assistant approved by the Medical Staff for every major operation, at the discretion of the operating surgeon.
7. A patient admitted for dental care is a dual responsibility of the dentist and physician appointee of the Staff.

- a. Dentist's responsibilities:
 - i. A detailed dental history and physical pertaining to dentistry justifying hospital admission.
 - ii. A detailed description of the examination of the oral cavity and pre-operative diagnosis.
 - iii. A complete operative report, describing the findings and techniques. All tissue (excluding teeth, if the number extracted is documented in the operative report) must be submitted to the pathologist for examination.
 - iv. The dentist is totally responsible for the oral or dental care.
 - v. Progress notes as are pertinent to the oral condition.
 - vi. Discharge summary.

- b. Physician's responsibilities:
 - i. Medical history pertinent to the patient's general health.
 - ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - iii. Supervision of the patient's general health status while hospitalized.
 - iv. Physician is not responsible for any dental care or consequences thereof.

- 8. A written, signed, informed, surgical consent (see section C of these regulations) shall be obtained and dated prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record.

- 9. All tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record. Any exceptions to this must be approved by the Medical Staff.

- 10. When the operating/anesthesia team consists entirely of non physicians (i.e. dentist with nurse anesthetist) there shall be a previously designated physician immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia.

- 11. Surgical procedures performed by dentists will be under the overall supervision of the Chief of Surgery.

H. OBSTETRICAL CARE

- 1. The current obstetrical records shall include an appropriate prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital and should be up to date.

- 2. Sterilization for the sole purpose of sterilization may be done at the discretion of the attending practitioner and the fully informed consent of the patient being sterilized. When the patient is a minor the attending practitioner should document carefully the pertinent historical information of the case.

- 3. In cases of patients being funded by government or other agencies where payment is contingent upon regulations and enforced by said agencies, it is the responsibility of the

patient's physician to see that necessary guidelines are followed in order to protect all parties concerned.

4. All obstetrical medical records shall have appropriate prenatal history, physical examination and discharge summary (a discharge progress note or brief summary).
5. Consent for the delivery shall be obtained on the patient's arrival to labor area, if possible.

I. NEWBORN CARE

1. A physical examination shall be recorded in the medical record of all newborns within fifteen (15) hours of delivery.
2. Oxygen will be prescribed by physician order with the exception of emergency situations. In an emergency situation the oxygen will be administered at the lowest level possible to relieve symptoms. It will be discontinued by physician order.
3. Newborn screening shall be done on all newborns prior to discharge as required by current state regulations.

J. MEDICAL STAFF PEER REVIEW

The Patient Care practices of Frankfort Regional Medical Center practitioners are evaluated routinely and continuously through regular quality/peer reviews. In addition, there will be practitioner peer review of those cases in which the performance of an individual medical staff member is brought to question for clinical issues. The peer review process provides evaluation by associates with in the same clinical department. Through this process caregivers gain feedback related to their effectiveness of professional, technical and interpersonal skills in providing patient care. Routine and ongoing reviews of practitioner performance are accomplished through the various departmental and procedural reviews. As a result of these routine reviews and via multiple other sources, the Risk and Medical Staff Services Department may then identify cases, which require the peer review process. Once a case has been identified, the peer review process will proceed as follows:

- 1) Risk and Medical Staff Services (RM/MSS) will refer the case for peer review via the Peer Review Referral Form, which will be attached to the corresponding medical record.
- 2) RM/MSS will identify a member of the Peer Review committee to review the case.
- 3) The reviewer will receive the medical record prior to the scheduled Peer Review meeting in order to perform the review, and to determine if the care was appropriate or requires discussion at the meeting. If action or discussion is not required the reviewer shall score the case a "1" predictable event within the standard of care or "2" unpredictable event within the standard of care. If discussion is required, the case will be scored at the meeting after all necessary information is obtained.
- 4) Additional information may be requested from the involved practitioner anytime the committee determines that the information provided is not sufficient to perform a complete and thorough review.

- 5) Any case where the committee determines there to be a deviation from the standard of care shall be referred to the Medical Executive Committee for review and final outcome.
- 6) Peer Review Referral Forms are placed in the appropriate file and minutes are sent to the Medical Executive Committee.
- 7) Actions voted upon by the committee are executed in a timely manner.
- 8) Focused review is conducted in accordance with Frankfort Regional Medical Center Staff Bylaws.
- 9)

The components, functions and operating structure of the Peer Review Process are as follows:

- 1) Methods for routine quality review and identification of cases for Peer Review:
 - a) Associate Staff review
 - A minimum of two charts per month will be reviewed by the Service Chief for each associate staff member in the active or courtesy staff category.
 - The charts will be reviewed as a part of the required medical record review, blood utilization review, utilization of services review, drug utilization review, mortality review and surgical appropriateness review.
 - Quality of care issues will be referred to the Risk and Medical Staff Office via the Meditech Quality Module.
 - Quality of care issues and any trends will be forwarded to the Peer Review Committee.
 - Quarterly the Medical Staff Office will complete the Physician Competency Profile with the data received.
 - The appropriate Chief of Service will review the profile quarterly and report findings and any recommendations to the MEC.
 - b) Hospital-wide risk/quality indicators.
 - c) Medical staff department specific risk/quality indicators.
 - d) Medical Staff approved generic screening indicators.
 - e) Medical Record Review
 - f) Blood Utilization Review
 - g) Operative & other Invasive procedure Review
 - h) Medication Use Review
 - i) Mortality Review
 - j) Patient Complaints
 - k) Occurrence Reports
 - l) CHOIS Data
 - m) Evidence-Based Medicine, including but not limited to Core Measures
 - n) New procedure review
 - o) Adverse or unexpected patient outcomes.
 - p) Other sources as needed
- 2) Committee Structure – Each medical staff service will be represented on the committee. Service chiefs who have completed their term as chief will be requested to serve as a committee member. An additional three (3) members of the active staff will be appointed to serve on the committee.
 - a) The Chief of Staff appoints members of the Peer Review Committee.

- b) The past Chief of Services, Medicine, Surgical/GYN, OB/Peds, and ER will serve as members. An additional four (4) members will be appointed by the Chief of Staff.
 - c) Members shall serve for a one (1) year term.
 - d) The Director of Risk/Medical Staff Services will serve as non-voting members of the committee.
 - e) A in-service will be offered for all members.
 - f) In the event a case is referred to the peer review committee and if appropriate clinical expertise is not available to provide meaningful peer evaluation, a member of the medical staff may be designated by the Peer Review Committee Chair to participate in the peer review process for that case.
- 3) Function of the Committee
- a) Review of Patient Safety/Performance Improvement data
 - b) Indicator development
 - c) Review of cases failing indicator review or as identified from the sources described in Section one (1).
 - d) Special case review
 - e) Individual practitioner trending for use in the reappointment process

4) Time frame to committee after identification by RM/MSS:

After the RM/MSS Department has identified a case, as needing peer review, an initial review by a member of the Peer Review Committee will be conducted as soon as possible to ensure the case is presented at the next scheduled peer review meeting. Peer review meetings will occur at least quarterly or more often as necessary.

5) Time frame to complete review by the committee:

- a) After a case has been forwarded to the Peer Review Committee for internal or external review, the committee will complete review within 3 (three) months if all data is available within the medical record. This time frame does not apply if a case is referred for external review.
- b) If case review is unable to be completed within 3 (three) months due to the volume of cases for review, consideration will be given to scheduling additional peer review meetings as needed.

6) Time frame for MD response if requested by the committee:

- a) If the committee requests a response from the medical staff member regarding a case under review, the medical staff member will be notified in writing by the Committee Chair.
- b) The medical staff member must respond in writing within 30 (thirty) days to the committee or notify the committee chair that they will respond in person at the next scheduled meeting. If the medical staff member is unable to meet this time frame, he/she must inform the Peer Review Committee in writing of the reason and make alternative arrangements as soon as possible as set by the committee.

7) Peer Review Scoring System and Required Actions.

- a) The performance scoring system developed by the Peer Review Committee consists of the following categories of performance grades by which each case is rated following review.

Performance Score	Findings	Outcome Category on Profile	Required Action
1	<ul style="list-style-type: none"> • No quality problem identified. Practice meets standard of care. 	Predictable Event within standard of care	None
2	<ul style="list-style-type: none"> •Potential for adverse effect, but no actual detrimental effect occurred; and/or •Practice differs from usual approach, but special mitigating circumstances present 	Unpredictable event within standard of care	None
3	<ul style="list-style-type: none"> •Adverse patient outcome and/or detrimental effect that requires additional treatment and/or •A significantly unusual approach 	Marginal deviation from standard of care	Letter to practitioner from the Peer notifying him/her of the review and findings. Will include a specific statement outlining concern(s), expectations, and a statement that information will be included in Quality Profile. <ul style="list-style-type: none"> •A request for response or corrective action.
4	<ul style="list-style-type: none"> •Adverse patient outcome resulting in death, permanent loss or disability; and/or •Inappropriate and contraindicated approach. 	Significant deviation from standard of care	Letter to practitioner from the Peer Review Committee notifying him/her of the review, findings and concerns with request for response prior to the next meeting. <ul style="list-style-type: none"> •The Peer Review Committee will make a recommendation to the Medical Executive Committee.

- b) Each review will be documented on a review summary form with the assigned grade and recommended action documented in the committee minutes.

8. Criteria for external review.

- a) In specialties where the number of medical staff members available for peer review is small, it may be necessary to obtain external peer review.

- b) External review will also be considered when:
 - 1) A second opinion is needed
 - 2) There is an appeal by the medical staff member being reviewed.
 - 3) There is no one on staff who is qualified to review a particular specialty.
 - 4) When the Peer Review Committee determines a conflict of interest exist.
 - c) The Peer Review Committee must approve requests for external peer review.
 - d) Reports received from the external reviewer will be shared with the medical staff member undergoing the review.
9. Reporting of Peer Committee findings/actions.
- a) Findings of peer review cases will be reported to the medical staff member involved.
 - b) Peer review activities including area of review, findings and actions will be reported to the Medical Executive Committee and the Board of Trustees.
 - c) Trend analysis is reported biannually to the Peer Review Committee meeting for review and recommendations.
10. Confidentiality.
- a) Activities conducted in good faith for the purpose of peer review are protected by Kentucky Law.
 - b) Medical Staff peer case review findings are recorded on the Practitioner Referral Form. This form may not be copied. If a medical staff member requests to review the form, it must be reviewed in the Medical Staff office with a member of the Medical Staff Services present.
 - c) Upon final review by the peer review committee, the data is entered in the QM Module of Meditech. The QM module never purges data and access is restricted to the RM/MSS Department only.
 - d) Patients are identified by medical record number only during the peer review case presentation and discussion.
 - e) Minutes are recorded at all peer review meetings.
11. Practitioner Profiles
 Medical Staff profiles are prepared and placed in the member's quality file for credentials review at the time of reappointment. Profiles will not be released to other persons.

K. MISCELLANEOUS

- 1. The Hospital Safety Officer has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors, or personnel exists.
- 2. The Performance Improvement Plans of this Hospital as approved by the MEC of the Staff and the Trustees, shall be adhered to by all attending practitioners.

3. Policies and Procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate services of the Staff and approved by its MEC and the Trustees, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of all current directives.
4. Policies and Procedures referred to above, and elsewhere in these Rules and Regulations, are to be found on the Hospital Intranet.
5. In cases where an individual has died or death is imminent, the patient's attending physician shall determine whether the patient is a potential organ/tissue donor and shall complete all necessary documentation required to comply with KRS 311.175, as set forth in The Organ Procurement for Transplant Protocol. With a current Kentucky Medical License, proper identification, and signed release/consent forms, any physician working with the Surgical Recovery Team for KODA (Kentucky Organ Doners Association) shall be granted Temporary Emergency privileges and hospital Bylaws and Rules and Regulations shall apply to their conduct while in the hospital, for the purpose of harvesting donated organs.
6. Upon making initial application or reappointment application to the Medical Staff or Allied Health Professional Staff, all applicants must provide documentary evidence of current TB test. (Please refer to Application for Initial Appointment and Article III of the Bylaws Reappointment Process.)