TORRANCE MEMORIAL MEDICAL CENTER

MEDICAL STAFF

GENERAL STAFF RULES AND REGULATIONS

Bylaws Committee: 1/24/2020
Medical Executive Committee: 2/11/2020
Board of Trustees: 2/29/2020

A. GENERAL

1. General Conduct
   The general conduct of the Medical Staff shall be governed by the Bylaws and rules, regulations and such policies as may be formulated by the various Departments and Committees subject to the approval of the Medical Executive Committee.

2. Use of Personal Devices
   Members of the Medical Staff and Allied health Professionals using personal devices on the medical center campus, must have pass code locks on these devices.

3. Record Entries, Authentication, and Completion
   a. Patient records must be authenticated by the individual making the entry and the supervising physician as appropriate. Authentication is defined as an electronic signature that is timed and dated. Medical Records must be completed according to regulatory and Medical Staff requirements.
   b. Credentialing records shall be completed electronically.

4. Conditions of Admission
   a. Patients may be treated only by practitioners who have submitted the proper credentials and who have been approved for membership on the Medical Staff with delineated clinical privileges in accordance with the Medical Staff Bylaws.
   b. At the discretion of the Chief Executive Officer (CEO)/President, in concurrence with the advice of the Chief of Staff, the Hospital may refuse to admit patients with certain contagious diseases or any condition which would be likely to disturb the orderly care of other patients in the Hospital.
   c. Patients will not be admitted without admitting orders. Physicians who are admitting patients are required to enter an order for admission in the patient's Electronic Health Record prior to or at the time of the patient's admission.

5. Autopsies/Pathology Services
   The Medical Staff should attempt to secure autopsies as follows:
   a. All cases of unusual/unexplained deaths
   b. All deaths of a medico-legal nature
   c. All deaths of educational interest

   The process for obtaining permission to perform an autopsy and notification of the attending provider of the autopsy is outlined in the nursing policy/procedure: N.E.68b: Autopsy: Procedure and Consent.

   All anatomical parts, tissue, and foreign objects removed at operation shall be delivered to a pathologist designated by the Hospital and a report of the findings shall be in the patient's medical record.

6. Laboratory Services
   a. Laboratory services shall be provided to insure as complete a service possible. Services which cannot be performed in the Hospital shall be referred to an outside approved laboratory.
   b. The Medical Staff shall make improvements as indicated in the transfusion service based upon the result of performance improvement activities.

7. Radiology Services
   Request for radiology services must contain a concise statement of the reason for such services.

8. Anesthesia Services
   All general, spinal, epidural, pain management and sedation anesthesia shall be governed by the rules established by the Department of Anesthesia.

9. Patient Safety Initiatives
   All providers are required to follow all guidelines/policies related to the National Patient Safety Goals and other patient safety initiatives approved by the Medical Executive Committee.

10. Torrance Memorial Medical Staff/Medical Center Compact
    All providers agree to abide by the Torrance Memorial Medical Staff/Medical Center Compact.

B. MEDICAL STAFF RESPONSIBILITY DESIGNATION

1. Admitting Physician
   A physician with appropriate admitting privileges shall authorize the inpatient admission or observation status of a patient. Admitting orders are required at the time of or prior to the patient's admission.

2. Attending Physician or Designated Covering Physician
   The attending physician certifies and recertifies the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

   Each patient must have a designated attending physician. A proceduralist who admits a patient to the hospital will be considered the patient's attending physician until a hand-off is made to another physician that is documented in the medical record.

   The attending physician shall be responsible for:

   a. the management and coordination of the care, treatment, and services for the patient including direct daily visits, assessment, evaluation and for

documenting the daily visits in the medical record (including observation status patients),

b. the accuracy of the medical record,
c. the prompt completeness of the medical record,
d. necessary special instructions,
e. recording of appropriate informed consent (if appropriate),
f. transmitting reports of the condition of the patient to the referring physician,
g. completing the Discharged Summary: In the case where a physician is covering and discharging the patient, he/she can assume the responsibility of completing the discharge summary from the attending physician.

Whenever these responsibilities are transferred to another medical staff member, transfer of responsibility shall be documented in the medical record.

The attending physician shall provide assurance of immediate availability of adequate professional care for his/her patients in the Medical Center.

However, when an attending is not immediately available, an alternate covering physician who has clinical privileges at the Medical Center sufficient to care for the patient can cover the attending physician and provide care to patients.

3. Intensive Care Unit (ICU) Admissions
All patients in the Intensive Care Units (ICU), with the exception of the Burn Intensive Care Unit, will be assigned to a Board Certified or Board qualified Critical Care Intensivist who has been granted clinical privileges to provide such care. Intensivist managing patients in the Intensive Care Unit must be able to provide 24-hour on site coverage for patients. The intensivist will be the designated Attending physician for the duration of the ICU admission. The intensivist will direct patient care and will request consultations as he/she determines is appropriate for each patient. Intensivist must return calls/pages.texts within 5 minutes and must see and assess unstable patients emergently at the bedside.

4. Neurocritical Care Intensive Care Unit
Patients meeting criteria for admission with complex neurological disorders (see hospital policy for criteria) will be admitted directly or transferred to the designated Neurocritical Care Intensive Care Unit.

Patients will be admitted by those providers holding admission privileges (see Intensive Care privilege form) and shall be consulted by neurologists holding specific consultation privileges (see Neurology privilege forms).

5. Covering Physician
The physician who is temporarily providing coverage for the attending or consulting physician.

6. Consulting Physician Responsibilities
   The consulting physician has privileges to consult when formally requested by a physician to perform an evaluation of the patient. The consulting physician shall provide and record their consultation and recommendations in the medical record.
   a. A consultation must be requested via direct communication between physicians. Consultants shall make and authenticate a complete record of their evaluation, findings and recommendations in the medical record.
   b. A consultant may be any physician who sees a patient for a colleague when requested.
   c. Cases requiring consultation will be defined in the individual departmental rules and regulations.

7. PI/QA/Proctoring Physician
   The PI/QA/proctoring physician is defined as the physician who provides the initial care of the patient upon presentation to the Emergency Department or who responds to emergency codes in the hospital.

C. MEDICAL RECORDS

The "legal medical record" consists of all authenticated (signed) documentation, related to the care of an individual patient regardless of storage site or media. Medical records may not be removed from the Hospital premises without a specific court order, subpoena, or statue, except for storage purposes authorized by the Medical Center CEO/President.

All records are the property of Torrance Memorial Medical Center and shall not be removed except as pursuant to provision of law. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

1. The attending physician shall be held responsible for the preparation and completion of the medical record for the patient. Daily visits and progress notes must be provided by the attending physician or qualified member of the Medical Staff.

   Other physicians who round on the patient must document their findings in a note in the medical record.

   The medical record should be completed at the time of discharge and must be completed within fourteen (14) days of discharge.

2. A provisional diagnosis shall be stated at the time of admission.

3a. Complete History and Physical
   A complete History and Physical shall be performed, completed and provided no more than thirty (30) days prior to, or within 24 hours after, registration or inpatient

admission, but prior to surgery or a procedure requiring anesthesia services for all patients by a provided with such privileges.

A Transfer Summary containing all the elements of a History and Physical may be used as a History and Physical. An adequate History and Physical must contain the following elements:

1. Medical History
2. Chief Complaint
3. Details of Present Illness
4. Relevant Physical Examination/System Review
5. Statement of Conclusion or Impressions Drawn from Admission
6. Physical Examination
7. Statement of the Course of Action Planned for the Patient for the Current Episode of Care

For vaginal deliveries and cesarean sections, the prenatal records along with current physical examination may serve as a history and physical.

For inpatient surgical procedure, the previous full admission history and physical is permissible if it was performed no more than thirty (30) days prior to the admission and updated prior to the procedure.

For a medical history and physical examination that was completed within thirty (30) days prior to inpatient admission, following examination of the patient, an update documenting any changes in the patient’s condition must be completed within 24 hours after inpatient admission or prior to a procedure or surgery.

A consultation report may be considered the same as a history and physical examination report for purposes of meeting documentation requirements in the medical record if it contains all required elements.

The report of the Emergency Medicine physician is considered a consultation. The admitting physician will be responsible for providing a history and physical.

3b. Non-Inpatient (Out-Patient) Services – History and Physical Requirements
A history and physical, performed within 30 days prior, is required for all patients receiving general or regional anesthesia or other sedation.

A history and physical performed within 30 days and prior to the procedure, requires an update. This update must be performed and documented after admission, after the patient has been examined and prior to the beginning of the procedure.

A history and physical is required for those procedures that are known, prior to beginning the procedure, to require post procedure observation in a designated observation area.

The history and physical shall be conducted by the physician who will be performing the procedure unless one is provided by a provider who has been granted history and physical privileges or be the referring or primary physician who must be a member of the Medical Staff with such clinical privileges. The history and physical must have been performed and authenticated within the 30 day time period prior to the procedure. Reassessment of the patient must be performed and documented at the time of admissions or prior to the procedure by a provider with history and physical privileges.

4a. Orders
(See Policy/Procedure: Patient Care: Ordering and Transcribing for ordering details)

4b. Verbal Orders
(See Policy/Procedure: Patient Care: Ordering and Transcribing and the following for additional ordering details)

A verbal order is defined as an urgent or emergent order that has not been written and is relayed to the licensed practitioner verbally from the physician. The request for and use of verbal orders is limited to urgent or emergent situations. In all cases, these orders will not be considered complete until the individual receiving the order, reads back and verifies the content of the order. The exception for verbal orders will be extended to the Emergency Department, and Labor and Delivery for admission and holding orders.

Verbal orders for administration of medications may be received and recorded by licensed health professionals who are expressly authorized under their practice acts to receive medication orders and shall be recorded promptly in the medical records, noting the name of the person giving the order and the signature of the individual receiving the order.

Verbal medication orders must be authenticated, dated and timed within 48 hours by the ordering physician.

Texting of orders is prohibited.

5. Previous Record
In case of readmission of a patient, health information is made accessible when needed for treatment and services.

6. Operative and Other Procedure Documentation Requirements
   An operative or other high-risk procedure report shall be provided upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. This shall be authenticated.

   The exception to this requirement occurs when an operative or other high-risk procedure progress note is provided immediately after the procedure in which case the full report can be provided within 48 hours after the operation or procedure.

   If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be provided in the new unit or area of care.

   The operative or other high-risk procedure report includes the following information:

   a. The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
   b. The name of the procedure performed
   c. A description of the procedure
   d. Findings of the procedure
   e. Any estimated blood loss
   f. Any specimen(s) removed
   g. The postoperative diagnosis

   When a full operative or other high-risk procedure report cannot be entered immediately in to the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and post-operative diagnosis.

7. Discharge Summary
   The medical record shall follow the standardized Hospital regulations. A discharge summary is required on all patients hospitalized 48 hours or more. The clinical record will be utilized when completing the discharge summary. The following Discharge Summary Template shall be used:
   a. Date of Admission
   b. Date of Discharge
   c. Diagnosis (Avoid Abbreviations)
      1. Principle diagnosis (the diagnosis determined, after study to occasion the admission of the patient)
      2. Complications, co-morbid conditions addressed during this stay

d. Problem List/Past Medical History
   1. Ongoing
   2. Historical
e. Consultations
f. Medications
   1. Home medications to be continued
   2. No active home medications
   3. Home medications to be discontinued
   4. Home medications changed during this hospitalization
   5. New medications prescribed on discharge
g. Procedures/Diagnostic Testing
h. Procedures at TMMC (this visit only)
i. Reason for Admission (Admitting Diagnosis)
j. Hospital Course
k. Discharge Plan/Follow-up
l. Discharge Condition/Destination
m. Activity
n. Diet
o. Time Spent Coordinating Discharge
p. Additional Notes

8. <u>Suspension Rules</u>
   In regards to incomplete medical records, the following shall be the strict policy of the Medical Staff at Torrance Memorial Medical Center:

   a. On the first (1st) and fifteenth (15th) of each month, medical staff members with incomplete medical records will be notified.
   b. Physicians notified on the first (1st) of the month must complete all records available by the fourteenth (14th) of the month, or suspension will occur.
   c. Physicians notified on the fifteenth (15th) of the month must complete all records available by the end of the month, or suspension will occur.
      1. Physicians will be notified on a timely and periodic basis of their suspension status.
      2. After accruing 30 days of medical records suspension days in a 12 month calendar period, a fine of $50 per day, up to a maximum of $1,500, shall be levied on a physician for each day of suspension over 30 days.
      3. Physicians will be notified in writing that they are accruing a fine for any additional suspension days at the rate of $50.00 per day.
      4. Once a physician accrues suspension days in excess of 30 days but do not reach the $1,500 maximum fine (60 days of total suspension in a calendar year) the Health Information Management Department will notify him/her in writing of the immediate need to pay the medical record fine.

5. Physicians who accrue suspension days in excess of 30 days but do not reach the $1,500 maximum fine (30 additional suspension days) will receive a bill from the Health Information Management Department at the end of the calendar year for the number of suspension days over 30 days at the rate of $50.00 per day.
6. A physician who accrues suspension days in an excess of 60 days within a 12-month calendar period will be referred to the Medical Executive Committee.
7. For those instances of suspension for H&Ps, Operative Reports, the physician will accumulate delinquent days of suspension in the same manner as other days are accumulated.
8. All funds collected as a result of the fining process will be deposited into the Medical Staff account.

d. In accordance with Article VIII, Section 8.3-3 of the Medical Staff Bylaws, a member who has refused to pay a medical records fine within thirty (30) days of the imposition of the fine, shall be immediately and automatically terminated from the medical staff.

e. Physicians on suspension due to delinquent medical records may not admit, treat, schedule, or perform procedures at Torrance Memorial Medical Center, except in emergency situations and illness/vacations (see below). Further procedures scheduled prior to the physician going on suspension may not be performed if the physician is still on suspension at the time of the scheduled procedure.

f. Bona fide vacations or illness may constitute an excuse for delinquent completion of medical records, subject to approval by the Medical Executive Committee. Members whose membership and privileges have been suspended for delinquent completion of medical records may continue to care for patients who were admitted to the Hospital prior to the suspension period and take Emergency Department Call but, unless otherwise approved by the Chief of Staff at his/her sole discretion, may readmit such patients or admit new patients only in life-threatening situations. The suspension shall continue until terminated by the Chief of Staff or acting Chief of Staff. If the suspended practitioner fails to complete such medical records within one hundred twenty (120) days after the date that the suspension went into effect, the matter shall be referred to the Professional Relations Committee.

9. Medical Record Entry
All medical record entries must be authenticated. In death cases, the diagnosis of the probable cause of death shall be entered into the chart as soon as possible.

10. Symbols and Abbreviations
Symbols and abbreviations may be used providing such symbols and abbreviations are not ion the approved “Do Not Use” abbreviations list.

D. DEPARTMENT RULES AND REGULATIONS
Each department should set rules and regulations to resolve its own issues. These Rules and Regulations shall be approved by the Medical Executive Committee.

E. PHARMACEUTICAL POLICIES
1. Medication errors and drug reactions shall be reported immediately to the responsible practitioner and to the pharmacist.
2. If patients bring their own drugs into the Hospital, such drugs shall not be administered unless they can be identified, are provided in a properly labeled container, and written orders to administer them are given by the responsible practitioner.
3. Self-administration of medications by patients may be permitted only when specifically ordered by authorized practitioners and the patient meets the criteria to self-administer (see Handling of Patient's Own Medications PC.E.160).
4. Investigational drugs properly labeled shall be used only under the supervision of the principal investigator and the appropriate Medical Staff committee.
5. See Policy/Procedure: Patient Care: Ordering and Transcribing for a table of drug classes and automatic stop limits.

F. NURSING SERVICES
Nursing performance in inpatient, outpatient, emergency and special care areas shall be conducted by mechanisms as may be established by the Medical Staff. The findings from the evaluation of nursing care shall be documented and reported to the Vice President, Nursing for action.

G. EMERGENCY CALL PANEL
By action of the Medical Executive Committee on September 12, 1995, all Active, Associate, Courtesy and Provisional (where proctoring has been successfully completed) staff members will be required to provide emergency call coverage. This includes in-house and Emergency Department coverage when, requested, by the physician on the Emergency Call Panel the day of the request, not the day the patient was admitted to the hospital. Excluded from emergency call coverage are Affiliate staff members, Retired staff members and Provisional staff members (who have not completed their proctoring). Required emergency call will be assigned according to the physician's primary specialty unless otherwise specified.

Any physician assigned for emergency call coverage will also be required to provide coverage for patients admitted to the hospital as requested by the attending physician.

Members on emergency call, shall respond to calls within twenty (20) minutes at which time, if no response is received, a second (2nd) call shall be placed. If the member does not respond within 40 minutes of the first call (following two (2) calls), the subspecialty chair or department chief (of the concerned department) will be called upon to resolve the situation. If the department chief is not available, the Chief of Staff shall be called to resolve the matter.

If requested, exemption from emergency call coverage can be granted by the Medical Executive Committee for physicians over the age of 60 or for health reasons. Physicians must have been members of the Medical Staff for a minimum of five (5) years prior to requesting removal from the Emergency Call at the age of 60. Physicians may arrange for other physicians to take their emergency call coverage.

Failure to respond while on emergency call will incur the following penalties (at the discretion of the department chief):

1. The first time a physician fails to respond to the emergency call, he/she will be required to take emergency call two (2) times for the alternate physician who covered his/her call.
2. For the second and subsequent failures to respond to emergency call that member will be required to take emergency call two (2) times for the alternate physician who covered his/her call; and pay a fine to the Medical Staff.
3. Once a physician is required to pay a fine, the Medical Staff Services Department will notify him/her in writing of the immediate need to pay the emergency call penalty fine. Failure to pay the fine will result in referral to the Medical Executive Committee for appropriate action.