



MEDICAL STAFF RULES AND REGULATIONS

PURPOSE:

Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privilege in the hospital, and shall act as an aid to evaluating performance under, and in compliance with, these standards. Rules and Regulations shall have the same force and effect as the Medical Staff Bylaws, the Medical Staff Credentialing Policy, Allied Health Professional Credentials Policy and the Medical Staff Organizational Manual.

The Rules and Regulations are established to:

- promote and maintain standards of medical care for patients treated by Medical Staff Members and Allied Health Professionals with clinical privileges and with the appropriate staff status per the Medical Staff Bylaws and Credentialing Policies; and
- initiate policies/directives for patient care, in keeping with Ethical and Religious Directives for Catholic Health Care Services

I. GENERAL:

1. The hospital shall accept all patients for care and treatment if appropriate service is available.
2. A patient may be admitted into the hospital only by a Medical Staff Member with clinical privileges and appropriate staff status per the Medical Staff Bylaws and Credentialing Policies. All practitioners will be governed by the admitting policies of the hospital.
3. A Dentist or Podiatrist with clinical privileges may initiate the procedure for admitting a patient with the concurrence of a physician member of the Medical Staff who shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Exception: If the Dentist or Podiatrist has privileges to complete the medical history and physical examination, (ASA1 and ASA 2 patients only) then a separate medical history and physical examination by a medical physician is not required.
*Reference to confirm privileges: HSHS EWD Intranet and Internet Physician and AHP Directory Privilege or Scope of Practice card for provider.
4. An Oral Surgeon who admits patients without underlying health problems (ASA1 and ASA 2 patients only) may perform an admission history and physical examination and assess the medical risks of the procedure on the patient if they have been credentialed to do so.

5. Except in an emergency, 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.
6. A Medical Staff Member or Allied Health Professional with clinical privileges and appropriate staff status per the Medical Staff Bylaws and Credentialing Policies, shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner.
7. Each Medical Staff Member must assure continuous timely, adequate professional care for his/her patients in the hospital by being available or, in his/her absence, having available through his/her office a Medical Staff Member who has clinical privileges in the hospital with whom prior arrangements have been made and who will assume responsibility for the care of his/her patients.
8. Be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient and conscientious manner. (“Appropriate coverage” means coverage by another member of the Medical Staff with appropriate privileges equivalent to the practitioner for whom he or she is providing coverage.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to: consistent with hospital and Medical Staff policies pertaining to response times:
 - a. respond within 15 minutes, via a phone or in person, to STAT pages for the Hospital and respond within 30 minutes, via phone or in person, to all other pages; and
 - b. appear in person to attend to a patient within 30 minutes of being requested to do so
 - c. Trauma Surgeon Response Time Policy (Reference SVG Trauma Services-Specific Department Policy)
9. All Medical Staff Member and Allied Health Professionals with clinical privileges will abide by the Medical Staff Bylaws and Medical Staff and Allied Health Professional_Credentialing Policy.

II. HOSPITAL MEDICAL ORDERS & MEDICAL RECORDS DOCUMENTATION:

1. Rules and Regulations Governing the Medical Record per the Health Information Management Policy Reference: Medical Records – Regulations MR-009 EWD

The medical record reflects standards of documentation, organization, format, and confidentiality to ensure that appropriate patient care is being provided by the medical staff and the hospital. The purposes of the medical record are to serve as a basis for planning patient care, to furnish documentary evidence of the course of the patient's hospital stay or visit, to serve as a communication tool for all health care personnel involved in the patient's care, to protect the legal interests of the patient, practitioners, and hospital, and to provide data for use in continuing education and Institutional Review Board approved research.

2. History and Physical Examination:

The monitoring for content and quality of the H&P's will be coordinated by the Health Information Management Department in conjunction with clinical staff and Medical Staff leadership and reported to the Utilization Review Committee with report to Medical Executive Committee.

III. TYPES OF ADMISSION:

Admission status definitions vary from payer to payer. The definitions below are provided as general guidelines. Please refer any specific questions to the hospital Case Management staff for clarification.

The following are types of admissions for the continuum of care.

1. **Inpatient** – a person formally admitted to a hospital by a physician order.
 - a. Emergency Admissions: includes a patient whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. The attending member shall perform History and Physical examination to document clearly, and justify the need for emergency admission, within twenty-four (24) hours after admission.
 - b. Urgent Admissions: includes a non-emergency patient whose admission is considered imperative by the attending member. Urgent admissions shall be given priority when beds become available over all other categories except emergency.
 - c. Pre-Operative Admissions: includes a patient already scheduled for surgery. Patients admitted prior to the day of surgery who are in need of acute medical care to determine stability of his/her medical condition prior to the procedure being performed. An explanation of the need to admit prior to the surgery date is identified in the Progress Note/History & Physical by the attending member admitting the patient.
 - d. Scheduled/Elective Admission: an admission to the hospital for specific pre-arranged services or procedures that require an inpatient level of care. The expectation is that the patient will remain in the hospital at least overnight. A written explanation will appear in the initial progress note/History & Physical for the need to be admitted to an acute care setting.
 - e. Direct Admission from Another Facility: The Medical Staff member who has agreed to accept an inpatient from a referring facility should notify the Nursing Supervisors of the patient's needs and to obtain a bed assignment. Level I & Level II Trauma patients being transferred out to a regional center must be seen in the St. Vincent Hospital Emergency Center for evaluation and potential activation of the trauma system. Registration-Observation Patient Policy EWD MR-004
 - f. Newborn Admission: Baby is born within this facility.

- g. Trauma Center Admission: visit to a trauma center/hospital licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving trauma activation.
2. **Outpatient** – a patient who receives diagnostic and minor therapeutic procedures at a hospital with the expectation they will be discharged or return home on the same day.
- a. Observation: a short term period of monitoring and assessment (expected to be less than 2 midnights) to determine whether further treatment and admission to inpatient status is necessary. Patients in observation status are not considered an inpatient even if they stay past the midnight census. A written order is required upon admission designating patient status as an observation stay. Reference: Registration-Observation Patient – MR-004 EWD
- b. The Clinical Decision Treatment Unit (CDTU) is an area where patients can be observed without admission. Patients who need further evaluation, treatment, and observation may be transferred from the Emergency Department (ED) to the CDTU. The CDTU is a designated area within and under the direction of the Emergency Department which is staffed with physicians from Emergency Medicine. Elements of the Unit include rapid treatment protocols, appropriate nurse and MD staffing, and continuous quality improvement. If determined that the patient meets inpatient care criteria, the attending physician shall write an order to “admit as inpatient”.
Reference: Clinical Decision Treatment Unit (CDTU) EC-016 (SMG/SVG)
- c. Pre-Operative Admissions: includes a patient already scheduled for surgery. Patients admitted prior to the day of surgery who are in need of acute medical care to determine stability of his/her medical condition prior to the procedure being performed. An explanation of the need to admit prior to the surgery date is identified in the Progress Note/History & Physical by the attending member admitting the patient.
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IV. PATIENT TRANSFERS

Rights to Treatment or Appropriate Transfer

Regardless of ability to pay, the sick or injured person receives, within the capabilities of the Hospitals' colleagues and facilities, the following:

- An appropriate medical Screening Examination (MSE);
- Necessary stabilizing treatment for any Emergency Medical Condition (EMC) (including treatment for unborn children, pregnant women, and psychiatric and substance abuse patients);
- If necessary, an appropriate and safe transfer to another facility.

Patient Transfers within the Hospital:

1. The attending Medical Staff Member(s) will be consulted on patient transfers.
2. Transfer priorities shall be as follows:
 - a. Intensive Care Patients
 - b. Intermediate Care Patients
 - c. General (Medical & Surgical) Unit Patients

The Nursing Supervisor is responsible for bed allocation based on patient need, Medical Staff Member request, staffing and bed availability.

Medical Screening Examination (MSE):

The process required to determine within reasonable clinical confidence where EMC does or does not exist and where a woman having contractions is in need of immediate medical attention. The MSE is an ongoing process and must be done within the facilities capabilities and the availability of qualified medical personnel. Reference: EMTALA HSHS Executive Policy and Medical Staff Bylaws Appendix C-Qualified Medical Personnel

Patient Transfers outside the Hospital:

1. Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient, or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or the attending Medical Staff Member, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.
2. The patient's attending physician must determine and document the need for transfer and write the order. The referring physician contacts the physician accepting the care at the receiving hospital. All patients must be evaluated medically and given stabilization treatment within the capabilities of the hospital, and prior to any transfer. The physician informs the patient or responsible party of the reason for, the risks, and likely benefits of the transfer. The appropriate consent is obtained and documented in the medical record. If a patient refuses to be transferred to another facility, a consent and documentation of such shall be contained in the medical record. The patient will be admitted to the hospital and the referral to/acceptance by the on-call specialty physician and/or another physician of the patient's choice will proceed.
3. For purposes of the Hospital's Policy on Screening, Treatment and Transfer (EMTALA), "Qualified Medical Personnel" means the personnel who are to conduct the medical screening exam (MSE), which includes Medical Staff Appointees, physician assistants, advanced practice registered nurses, nurse practitioners, sexual assault nurse examiners and registered nurses trained for labor and delivery, and Libertas Treatment Center who have completed the comprehensive orientation and skills inventory in accordance with professional Standards and Practice Guidelines. Guidelines for transfer's reference: Screening, Treatment and Transferring Patients "EMTALA" GN-009 EWD Emergency Medical Treatment and Active Labor Act (EMTALA) – HSHS Executive Manual

V. KNOWN OR SUSPECTED SUICIDAL PATIENTS

Patients who verbally threaten or through actions demonstrate self-destructive or suicidal behavior will have suicidal precautions implemented as medically appropriate. Specific guidelines are followed for the detention of medically unstable psychiatric or drug/alcohol toxic patients.

Reference: Suicide Precautions/Emergency Detention EWD GN- 096

VI. ADMISSION TO INTENSIVE CARE, INTERMEDIATE CARE AND CARDIAC CARE UNITS

Patients are admitted and discharged from Intensive Care Unit/Critical Care Services/Cardiovascular Intensive Care Units bases on established criteria.

Reference: Critical Care Services/Cardiovascular ICU Regulations, GN-018 (SVG) Reference: Admission/Discharge – ICU-CCS-CVICU GN-076 (SMG/SVG/SNS)

VII. CONTINUED CARE:

1. The appropriate attending Medical Staff Member is required to provide ongoing documentation to support the appropriateness and necessity of inpatient hospitalization in accordance with the hospital's medical record regulations. Reference: Medical Records – Regulations, MR-009 EWD
2. Patients admitted to the hospital must be seen at least daily (every 24 hours) by the attending Medical Staff Member or his/her alternate or by a credentialed & privileged Midlevel Provider (PA-C, APRN, CRNA) working with the physician or physician group and working within their scope of practice. An appropriate progress notes is made in the record at least daily. At a minimum, the Medical Staff Member must assess the patient and document in the EMR the condition of the patients once every 48 hours. The Medical Staff Member must see their patient within 24 hours prior to discharge. *Exception:* In Inpatient Rehab, at least three days/week the physiatrist is required to make and document face-to-face visits throughout the patient's stay for the purpose of assessing the patient both medically and functionally as well as modify the course of treatment. On days when a patient is not seen by the attending physiatrist, the physiatrist should be personally present on the unit to discuss care with the nursing staff.
3. A transfer of care order should be documented and signed in the patient's medical record when the attending Medical Staff Member transfers care to another attending Medical Staff Member.

VIII. DISCHARGE:

1. Patients shall be discharged only by a written or verbal order from the attending Medical Staff Member or his designee. Should a patient leave the hospital without proper discharge or against the medical advice of the attending practitioner, complete documentation of the incident shall be made in the patient's medical record in accordance with the hospital's medical record policies. Note: Psychologists do not discharge patients.

2. It shall be the duty of the Medical Staff Members to secure autopsies whenever they may contribute to understanding the patient's disease process. An autopsy may be performed only with written consent, signed in accordance with Wisconsin law. All autopsies shall be performed by a pathologist delegated this authority. Provisional anatomic diagnosis shall be recorded in the medical record within 2 working days; the complete protocol and signed autopsy report shall be made a part of the record within 60 working days of completion of the anatomic autopsy. Reference: Autopsy MS-023 EWD and EWD MR-009

IX. PATIENT RIGHTS:

Medical Staff members and the hospital will ensure and honor patient and family rights. Inpatients and outpatients are informed of their rights and responsibilities in writing upon admission. Reference: Patient/Family Rights Policy GN-008 EWD

X. OTHER:

1. On-Call Rotation Responsibilities:

The chairperson of each department, on behalf of the hospital, shall be responsible for developing an on-call rotation schedule that includes name and pager number of each member in the department who is required to fulfill on call duties per the Medical Staff Bylaws and Credentials Policy. On-call rotation schedules shall be maintained through the EWD Medical Staff Services Department and HSHS EWD Intranet Central Logic Unassigned Call List. Reference: EWD Physician On-Call Policy and Rosters, MS-006 (SMG/SVG/SNS/SCO)

2. Peer Review:

- a. Ongoing Professional Practice Evaluation (OPPE) is a process whereby St. Vincent Hospital continually evaluates the current competence of practitioners (Medical Staff Member or Allied Health Professional) at St. Vincent Hospital who have been granted privileges. The OPPE process is utilized in order to assure all existing privileged practitioners are providing safe, high quality patient care and current competence. Focused Professional Practice Evaluation (FPPE) is a process whereby St. Vincent Hospital consistently evaluates the privilege-specific competence of a practitioner (Medical Staff Member or Allied Health Professional) who does not have documented evidence of competently performing requested privilege(s) at St. Vincent Hospital. The FPPE process can also be utilized when a question arises about an existing privileged practitioner's ability to provide safe, high quality, patient care. FPPE is a time-limited period in which St. Vincent Hospital evaluates and determines the practitioner's professional performance. The OPPE and FPPE process is utilized consistently with every credentialed practitioner who is granted privileges.
- b. Peer review will be conducted as an ongoing process throughout the year and recommendations will be made as the need arises. It is expected that members of the department will avail themselves of the information concerning present standards in hospital practice as determined by the Medical Staff. In the event there is failure to meet these standards, recommendations will be forthcoming from the Medical Staff Departments.

- c. Peer review is performed in accordance per the Medical Staff Bylaws and Credentialing Policy. Reference: St. Vincent Hospital Medical Staff Bylaws, Medical Staff Credentials Policy and AHP Credentials Policy, and Medical Staff Peer Review Policy MS-011 (SMG/SVG/SCO)

3. Emergency Management:

- a. Emergency management is the coordination of activities and personnel during a disaster or an emergency situation. It may require the mobilization and direction of the medical staff to ensure health and safety and to appropriately remedy problems. The hospital has emergency preparedness plans to ensure an effective response to disasters and emergencies.
Reference: Emergency Operations Plan and Emergency Preparedness Manual–Emergency Preparedness Manual RM-056 and Emergency Disaster Credentialing MS-015 EWD

4. Research Activities:

- a. Participation in research projects by Medical Staff Members is encouraged. To ensure adequate compliance with any applicable laws, regulations, ERD’s or guidelines, Medical Staff Appointees shall consult with and obtain the approval of the Institutional Review Board regarding any research projects in which they propose to participate prior to conducting any of the proposed activities.
- b. It shall be the responsibility of the principal investigator to obtain approval from the hospital's Institutional Review Board before any research study may be undertaken at this hospital.
- c. Policy considerations pertaining to medical and/or scientific research projects of the medical staff shall be reviewed by the Institutional Review Board.
- d. The results of all research projects (clinical, statistical or otherwise) and all publications written or provided by Medical Staff Members using the name of this hospital, must be submitted to the Institutional Review Board or Chief Executive Officer or his/her designee for approval prior to any publication.
- e. Specific protocols shall be followed in the case of any pharmaceuticals to be used. Such protocols shall be submitted to the hospital's Institutional Review Board for review and approval.

5. Definitions:

The definitions contained in Article I of the Medical Staff Bylaws and Article I of the Medical Staff Credentials Policy are hereby incorporated by reference and shall apply to these rules and regulations as well.

XI. AMENDMENTS:

Rules and Regulations may also be adopted, amended, repealed, or added as outlined in the Medical Staff Bylaws, Article 9.

XII. ADOPTION:

These rules and regulations are adopted and made effective upon approval of the Governing Body, superseding and replacing any and all previous medical staff rules and regulations, and henceforth all activities and actions of the medical staff and of each individual exercising clinical privileges in the hospital shall be taken under and pursuant to the requirements of these rules and regulations

Reference Documentation Location:

- Policies: HSHS EWD MCN Policy Management System, HSHS Policy Manager. hshs.ellucid.com
- Medical Staff Bylaws, Medical Staff Credentials Policy, Allied Health Professionals Credentials Policy, Medical Staff Organizational Manual: HSHS St. Vincent Hospital – Intranet – Departments – Medical Staff Services – (Select Document)
- Privilege or Provider Scope of Practice Confirmation: HSHS EWD St. Vincent Hospital/St. Mary's Hospital/St. Clare Memorial Hospital/St. Nicholas Hospital Intranet, Medical Staff Services Department – Physician and AHP Directory – Privilege or Scope of Practice Card

Medical Staff Executive Committee: Approval: 9/27/2011;
Revised/Approved: 3/27/2012; Revised/Approved 8/28/2012;
Revised/Approved: 6/25/2013; Revised/Approved: 3/24/2015;
Revised/Approved: 7/25/2017; Revised/Approved: 11/28/2017;
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Board of Directors: Approval: 11/16/2011; Approved: 5/16/2012;
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Review Responsibility: Medical Staff Services Department