



Carolinus Medical Center  
NorthEast

## Medical Staff Rules & Regulations

*Approved by the Medical Executive Committee 08/13/2012*

*Approved by Board of Commissioners 09/11/2012*

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## Section A. Admission and Discharge of Patients

1. All members of the medical staff, with exception of the following departments and classifications, shall be entitled to admit patients to the medical center: Departments of Emergency Medicine and Pathology, and the classifications of telemedicine, non-residence and emeritus. A practitioner who has been granted Locum Tenens may also admit patients. Orders for medications and treatment may be written by members of the Medical Staff, as specified in the Bylaws.
2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, and for the completeness and accuracy of the medical record. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered into the medical record. The permission of the practitioner receiving the patient is required.
3. Except in an emergency, no patient shall be admitted to the hospital until 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.
4. Admission to Intensive and Cardiac Care Units: If any question as to the validity of admission or to discharge from any critical care unit should arise, that decision is to be made through consultation with medical director of the respective unit.
5. The Medical Staff will abide by the approved Utilization Management Plan as adopted by the Medical Staff.
6. Patients shall be discharged only on order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
7. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee. Policies with respect to release of dead bodies shall conform to state and local laws, and physicians are required to comply with medical examiner notification when applicable.
8. An autopsy may be performed only with a written consent, signed in accordance with state law. Indications for considering an autopsy are defined by the Medical Staff's Autopsy Policy.

## Section B. Medical Staff Availability

1. Each Individual Practitioner shall maintain availability consistent with the rules and regulations of the individual department to which he is assigned as well as other requirements delineated in the rules and regulations of the medical staff and the bylaws of the medical staff.
2. Each individual practitioner will provide, to the medical staff office and to the telephone operator office, a list each month of the person responsible for his/her patients for each day of that month. Both the medical staff office and the telephone operators must be notified of any changes in that list of the person responsible for the care of the practitioner's patients. This person will be the "on call" person. That person must be comparably qualified to render care to the patients of that practitioner.
3. Each individual practitioner will be responsible for providing to the medical staff office and to the telephone operator a method of contacting them when "on call". The "on call" person is expected to respond, at least initially by phone, within 20 minutes from the time the telephone operator is notified that the practitioner "on call" is needed.
4. A practitioner who is on call for himself or his group, or his designee, must promptly respond in a manner appropriate to the nature of the patient's emergency within the judgment of the requesting physicians as communicated between the requesting physicians and the consulting physician.
5. If the need revealed by that telephone contact does not involve an emergency or the question of an emergency, the response of the practitioner must meet the guidelines delineated in the rules

- and regulations of the individual department or the consultation policy.
6. As defined by the CMC-NorthEast Medical Staff Bylaws, all individual practitioners must arrange for continuous coverage of their patients by a comparably credentialed practitioner. This coverage arrangement, including back-up when the practitioner is unavailable, must be communicated to the Medical Staff Office at initial appointment and updated at reappointment. Should this arrangement change, it is the responsibility of the practitioner to immediately inform the Medical Staff Office.

### Section C. Medical Records Systems

1. **Content:** A complete and legible medical record shall be maintained on each patient treated at CMC-NE. Content of the record must be pertinent and current. A complete medical record contains the following documents as appropriate: History and physical, discharge summary, consultation report, operative or procedure reports, all orders dated, timed and signed, physician progress notes, notes of applicable disciplines, diagnostic studies and other documents as required per treatment of the patient. The legal record at CMC-NE resides in an electronic format in the current medical records database.
2. **Symbols and Abbreviations:** All medication-related documents will be free from use of prohibited abbreviations in compliance with the medical center's policy. The list of prohibited abbreviations include: U, IU, Q.D., Q.O.D., trailing zero (5.0 mg), lack of leading zero (.5 mg), MS, MS04, MgS04.
3. **History and Physical:** An adequate medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia or moderate sedation regardless of whether care is being provided as an inpatient or out patient.

**Updates to H&P:** An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia or moderate sedation, when the history and physical examination is completed within 30 days before admission or registration. Procedural updates may be documented on the surgical progress note.

An H&P should be pertinent and relevant and include sufficient information necessary to provide the care and services required to address the patient's conditions and needs and may vary by setting or level of care, treatment, and services. The Medical Staff departments will decide at a departmental level which populations or settings of care are appropriate for a focused H&P rather than a comprehensive H&P. These decisions will be presented to MEC for final approval.

The history and physical documentation and update to the history and physical may be handwritten or dictated and transcribed and available on the patient's chart within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia or moderate sedation. In an emergency situation where there is inadequate time to perform a complete H & P examination, a hand-written note addressing the critical need(s) and/or pre-operative diagnosis and procedure will suffice. A procedure requiring sedation will not begin until a current, compliant H & P is documented in the record.

Exception: Non-viable fetus - The practitioner will document in the mother's chart why the infant is non-

viable, why the infant will not be resuscitated, and that this has been discussed with the mother.

5. **Non-Invasive Tests** not requiring anesthesia or moderate sedation (i.e. manometry, Ph studies, & videocapsule studies) do not require an H & P; however an order and the reason for the test must be documented prior to the test being performed.

6. **Consultation Reports:** When a consult is requested, the practitioner shall respond appropriately within twenty-four (24) hours of the request. The timeliness of consultations designated as urgent/emergent will be determined between the referring physician and the consultant. Consultations should include examination of the patient and patient's medical record.

7. **Progress Notes:** Pertinent progress notes shall be recorded at the time of all significant clinical events. These will be complete enough to permit continuity of care and transferability. Each of the patient's clinical problems should be clearly identified and correlated with orders and test results as well as clinical progress. Progress notes shall be required of the attending physician, a member of the attending physician's clinical services, or a consultant on a daily basis.

8. **Verbal Orders:** Verbal orders should be limited to situations where written communication is not feasible (emergent situations, communications via telephone). Verbal orders must be written down and repeated back by the approved healthcare provider to the ordering practitioners to verify accuracy. Verbal orders may be accepted and transcribed by authorized personnel within the scope of their job responsibilities. Authorized personnel include Physicians, RNs, CRNA, CNMW, NP, LPNs, PA, Pharmacists, Registered, Certified, or Licensed therapists, technicians or technologists, assistants, specialists, clinical dietitians (nutritional orders), social workers (discharge planning needs), and medical office assistants including CMA, MOAs, CNAs.

Verbal orders shall be authenticated, dated, and timed by the practitioner giving the order, or the practitioner covering for that practitioner, within forty-eight (48) hours of when the order was given. Physician Assistants and Nurse Practitioners may authenticate, date and time the attending physician's verbal order(s) within 48 hours.

9. **Surgical Records:** Records of patients admitted to the in-patient or out-patient surgical suite shall contain, at a minimum, a pre-surgical evaluation to include the reason for surgery, pertinent past medical history, current medications, allergies, and abnormal physical findings, if any, including a statement that the heart and lungs have been examined.

10. **Operative Reports:** An immediate hand-written post operative note is required for all operative and invasive procedures, or non-invasive procedures requiring anesthesia or moderate sedation. This note must be documented upon completion of the operation and before the patient is transferred to the next level of care. This note shall include: name of surgeon and assistants, preoperative diagnosis, post operative diagnosis, operative findings, procedure performed, estimated blood loss, type of anesthesia and specimens removed.

A complete operative report must be dictated or hand-written following the operative or invasive procedure (A brief post-op note does not suffice for an operative report).

11. **Anesthesia Consult:** The pre-anesthesia note should include the age and sex of the patient, the proposed procedure, the pertinent medical history, allergies, medications, previous anesthetic experience, pertinent diagnostic tests, and ASA classification. In addition, there should be a physical examination of the airway, lungs and/or heart if indicated by the patient's history. If the anesthetic management was

discussed with the patient or the patient's guardian, documentation of that discussion should be contained in the anesthetic pre-evaluation note. The patient is re-evaluated immediately prior to anesthesia induction.

12. **Consents:** The medical record must contain a document confirming the patient's informed consent for any procedures and treatments that require informed consent.

#### Informed Consent Confirmation Forms

A properly executed consent should reflect the patient informed consent process. Except as specified for emergency situations in the hospital's informed consent policies, all inpatient and outpatient medical records must contain a properly executed consent confirmation form prior to conducting any procedure or other type of treatment that requires informed consent.

A properly executed consent confirmation form contains the following minimum elements:

- Name of the specific procedure, or other type of medical treatment for which consent is being given;
- Name of the responsible practitioner who is performing the procedure or administering the medical treatment;
- Statement that the procedure or treatment, including the anticipated benefits, significant risks, and alternative therapies, was explained to the patient or the patient's legal representative;
- Signature of the patient or the patient's legal representative; and
- Date and time the consent form is signed by the patient or the patient's legal representative.
- Name of the practitioner who conducted the informed consent discussion with the patient or the patient's representative. Date and time the consent confirmation form is signed by the practitioner.
- Date, time, and signature of the person witnessing the patient or the patient's legal representative signing the consent form.
- Statement that physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, accordance with the hospital's policies and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner.
- Statement, if applicable, that qualified medical practitioners who are not physicians who may perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital.

13. **Pathology Reports:** All tissue removed during the procedure shall be sent to the hospital pathologist who shall make such examinations as required to arrive at a pathological diagnosis. (Exceptions: Those specimens approved by the Medical Executive Committee)

14. **Obstetrical and Newborn Records:** In the case of normal newborn infants and uncomplicated obstetrical deliveries, a progress note may be submitted for the discharge summary if the period of hospitalization has been less than forty-eight (48) hours. The final progress note should include any instructions given to the patient and/or family.

15. **Communication of Critical Tests & Critical Test Results** is done in a manner that allows for active communication to verify and clarify the information that is given and received. Critical tests and

values may be accepted and transcribed by authorized personnel within the scope of their job responsibilities. Personnel include MD/DO/Licensed Independent Practitioner (LIP), RN/LPN, Dependent Practitioners, Respiratory Therapist, Pharmacist, MOA (outpatient setting).

16. **Discharge Summaries:** The discharge summary should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed, the treatment rendered, the condition of the patient on discharge, and instructions given to the patient and/or family as pertinent. A final progress note may be substituted for the discharge summary in the case of patients admitted to an observation status, as well as newborns and uncomplicated obstetrical deliveries of less than forty-eight (48) hours. The final progress note should include any medications, diet, discharge instructions, and follow up given to the patient and/or family. Discharge medications will be noted in the medication reconciliation document(s).

In all cases, the content in the medical record shall be sufficient to identify the patient, support the diagnosis, justify the treatment, and document the course of treatment. All summaries shall be authenticated by the responsible practitioner.

17. **Non-Independent Practitioner Entries:** Physician Assistants and Nurse Practitioners may document in the medical records in accordance with their detailed scope of practice signed by the supervising physician and on file at CMC-NE. Entries in the medical record shall be legible, accurate, dated, timed and authenticated promptly. Verbal orders must be signed, dated and timed in 48 hours. All other entries must be signed within 30 days of discharge.

18. **Authentication/Completion:** All medical record entries must be legibly authenticated, dated, and timed by the responsible practitioner. Authentication may be written signature, or electronic signature. Rubber stamp signatures are not acceptable in the medical record. Electronic signature identification requires a log-on security authorization and a signed statement that computer key authentication is affixed by the authorized individual only. Use of an electronic signature and/or authorization codes assigned to another individual is prohibited.

The patient's attending physician shall be responsible for completion of the medical record unless the patient has been officially transferred to another physician who has agreed to accept the care of that patient. In the event a patient's care is transferred, a transfer note must be written by the transferring physician in the medical record. Individual practitioners involved in the patient's care will also be responsible of the completion of their portion of the record.

19. **Corrections to Medical Records:** Corrections to dictated reports may be made by the dictating physician prior to the report being signed. The physician has the ability to correct the report manually in the electronic medical record (prior to signing), or a corrected report may be dictated and uploaded into the EMR for signature. If the original report has already been signed, a corrected report, or addendum, may be dictated, stating that the original report is being corrected. Both the original report and the corrected report must remain in the medical record.

If a correction is required in the paper medical record, draw one line through the inaccurate information, document the correct entry; date, time, and sign the correction.

20. **Medical Information from Other Hospitals or Health Care Facilities:** Documentation from other hospitals or health care facilities may be entered into the records to enhance patient care.

21. **Delinquent Medical Records:** All medical records must be completed within 30 days post

discharge.

Practitioners with incomplete medical records more than 23 days post discharge will be notified by a letter faxed to their office. Practitioners with records incomplete 7 days following the notification will automatically be suspended until records are dictated and signed. Physicians will be unable to admit patients to the hospital or schedule any procedures until all records are completed. The North Carolina Medical Board will be notified after the third suspension for failure to complete medical records.

Temporary waiver of the rules regarding delinquent medical records may be granted by the President of the Hospital or his designee in the case of rare emergencies. Privileges shall automatically be reinstated upon completion of medical records.

**22. Possession, Access, and Release of Medical Records:** All records are the property of the hospital. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of records from the hospital is grounds for suspension as determined by the Medical Executive Committee.

In the case of readmission of a patient, all previous records shall be available for use by the attending Physician and others caring for the patient.

Free access to medical records of all patients shall be afforded to practitioners in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients and consistent with IRB policies and rules and regulations governing research.

#### Section D. General Conduct of Care

1. Pre-printed orders, protocols, and/or standing orders may be developed and approved by the applicable department/committee and approved by the Medical Executive Committee. Each page of the pre-printed orders, protocols, and/or standing orders shall be reproduced on the record or photocopies made and placed on the record and signed, dated and timed by the responsible physician.
2. The attending practitioner is primarily responsible for initiating consultation when indicated. He will provide written authorization to permit another attending physician to attend or examine his patient. In an emergency, this authorization may be verbal. The consulting physician will record those portions of the history and physical pertinent to the problem for which he/she is consulted. Pertinent diagnostic tests will be referenced. Recommendations for further diagnosis and/or treatment will be documented.
3. Communicable diseases are to be documented by the attending physician at the time diagnosis is made. Required reports shall be made to the County Health Department by the physician or Department of Infectious Diseases following consultation with the attending physician.
4. All patients with infections which constitute a hazard as determined by the Infection Control Committee will be isolated. If a physician fails to order isolation, a member of Infectious Disease Department contacts the physician to obtain the order to place the patient in isolation. The Chairman of Infection Control may initiate the order if needed. Prior to the institution of isolation, the attending physician shall be consulted by the Nursing Staff or Infectious Diseases.
5. Clinical decisions are based on identified patient need, not on financial incentives.
6. No practitioner shall refuse to see a patient because of financial reasons.
7. Moderate sedation will be administered only by those physicians who have demonstrated competency through appropriate education and/or proctoring.
8. All practitioners will abide by the restraint policy, which promotes the active reduction of the use of restraints.

## Section E. Ongoing Professional Practice and Focused Professional Practice Evaluation

Members of the medical staff are involved in activities measuring, assessing and designed to improve performance on an organization-wide basis. Professional Practice Evaluation activities are used to establish an objective evaluation of medical practice, providing information for both focused and ongoing assessment of physician competency, used to identify system-wide performance improvement opportunities and to be used as part of the medical staff reappointment process.

Review of individual cases or clinical data may be performed by practitioners, or a panel of appropriate practitioners and other personnel as identified by the MEC and/or hospital administration. Information used for professional practice evaluation may include chart review, monitoring clinical practice patterns, outcome data, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel). Comparisons with individual historical, departmental and external benchmarks may be made and where appropriate, referenced for corrective action.

Members responsible for reviewing practitioner data shall be selected based upon their professional knowledge, availability and willingness to participate. Members may be appointed by the Chief of the Medical Staff, Department Chair, VP Nursing Services (for reviewing dependent practitioner data) or other physicians given responsibility by the MEC for conducting of the review.

All Medical Staff members and dependent practitioners are expected to participate in and respond to requests for evaluations. Unless otherwise specified, a response is expected within two weeks of the completed review and report. When a department, Quality Improvement Committee or Medical Staff Committee with quality-related functions is unable to enlist the timely cooperation of a member in an appropriate review, the Committee shall refer the matter to the Chief of the Medical Staff. Failure to participate in these evaluations upon request may result in a suspension of privileges.

## Section F. Investigational Review Board (IRB)

Any member of the Medical Staff desiring to use investigational drugs, protocols or devices not approved by the Food and Drug Administration shall make a request to the hospital's Investigational Review Board in accordance with that Board's guidelines.

## Section G. Rules Regarding Surgical Care

1. Except in severe emergencies, the pre-operative diagnosis and required diagnostic tests must be recorded on the patient's medical record prior to any surgical procedure. In any severe emergency, the practitioner shall make at least a pertinent note regarding the preoperative diagnosis prior to induction of anesthesia and the start of surgery.
2. A patient admitted for dental and/or oral surgical care is a dual responsibility involving the dentist/oral surgeon and a physician member of the Medical Staff.
  - Dentist/Oral Surgeon responsibilities:



- (a) A detailed dental history justifying hospital admission.
  - (b) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
  - (c) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue shall be sent to the hospital Pathologist for examination. Exempted from the requirement to be examined by a pathologist include teeth, provided the anatomic name or anatomic number of each tooth, or fragment of a tooth, is recorded in the medical record.
  - (d) Progress notes as are pertinent to the oral condition.
  - (e) Clinical resume (or summary statement).
  - (f) Medical history and physical by oral surgeon if approved for that privilege.
- Physician's responsibilities:
    - (a) Medical history pertinent to the patient's general health. (Unless the oral surgeon has been approved by the Surgery Department to obtain the history.)
    - (b) A physical examination to determine the patient's condition prior to anesthesia and surgery. (Unless the oral surgeon has been approved by the Surgery Department to perform the physical examination).
    - (c) Supervision of the patient's general health status while hospitalized.
  - The discharge of the patient shall be on written order of the dentist and medical member of the Medical Staff.
3. A written, signed, and informed surgical consent shall be obtained 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. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.
  4. A complete anesthetic record shall be maintained and include evidence of pre-anesthesia evaluation, re-evaluation immediately prior to induction of anesthesia, and post-anesthetic follow-up of the patient's condition.
  5. All patients discharged from post-anesthesia care units must be discharged on the order of a physician.
  6. The Pathologist's authenticated report shall be made a part of the patient's medical record. Exceptions to this rule will be as recorded in each Medical Staff Department's Rules and Regulations, effective as of the date of approval of those Rules and Regulations and exceptions by the MEC and the Board of Directors.

## Section H. General Rules Related to EMTALA

### **EMTALA COMPLIANCE, INCLUDING PATIENT TRANSFERS (EMERGENCY MEDICAL TREATMENT AND LABOR ACT)**

#### **SUMMARY STATEMENT**

Emergency services and care are provided to all patients who present to the hospital who request examination or treatment of a medical condition to determine if an emergency medical condition exists, according to federal laws.

## **PROCEDURE**

A. A medical screening examination will be performed on any person presenting to the hospital who either personally, or for whom any person, requests emergency service or care to determine whether or not an emergency medical condition exists.

1. This will be done without discrimination, except to the extent that a circumstance such as age, sex, pre-existing medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the person.

2. Medical screening examination and stabilizing treatment will not be delayed in order to inquire about method of payment, insurance status or to obtain authorization for payment from the patient's insurance carrier.

3. The medical screening examination will be performed by qualified medical personnel as designated by the hospital's Board of Commissioners, and when medically appropriate, shall include consultation with the on-call specialist physician.

a. Physicians who serve on an on-call basis to the Emergency department (specialist physicians) may not refuse to respond to a request for assistance from the emergency physician on the basis of the above criteria. When determined to be medically necessary by the emergency physician, the specialist physician shall review the patient's medical record, and come to the Emergency Department to examine and treat the patient in person.

b. The medical screening examination shall be conducted within the capability of the Emergency Department and/or Labor and Delivery Unit, and the ancillary services which are routinely available to the Emergency Department.

B. Definitions:

1. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

b. Serious impairment to bodily functions.

c. Serious dysfunction of any bodily organ or part.

2. "Emergency medical condition" includes, with respect to a pregnant woman having contractions, that:

a. There is inadequate time to effect safe transfer to another hospital before delivery.

b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

c. This policy is applicable to every infant who is born alive, at any stage of development as stated in the Born Alive Infants Protection Act of 2002.

C. The hospital shall maintain a log and record the following minimum information identifying each person presenting to the hospital who requests treatment of an emergency medical condition: date, time, means of arrival, name, age, sex, nature of complaint (dead on arrival, if applicable) record number, disposition, and time of departure.

D. If it has been determined by qualified medical personnel that an emergency medical condition does not exist:

1. Follow-up care – If the individual requires follow-up care, he or she may be admitted as per standard admissions procedure, transferred to another facility or referred to another facility or provider.
2. No Follow-up care – If the individual does not require follow-up care, he or she may be released with self-care instructions.

E. If it has been determined by qualified medical personnel that an emergency medical condition exists:

1. Emergency Services and Stabilizing Care – Treatment will be provided by the hospital, the emergency physician, and when medically necessary, by the on-call specialist physician, to relieve, eliminate or stabilize the emergency medical condition within the capabilities of the staff, ancillary services, and facilities available to the hospital.
2. Refusal of Emergency Services and Care – If the individual or legally responsible person refuses to consent to treatment, hospital personnel shall complete the following:
  - a. Inform patient/family of obligations to screen or treat.
  - b. Explain risks and benefits.
  - c. Determine patient/family competence to make an informed refusal.
  - d. Make reasonable effort to secure the individual's written informed consent to refuse.
  - e. Document in the medical record, the risks and benefits explained and the treatment offered but refused by the patient.
    - i. The patient shall be asked to sign the Refusal to Submit to Treatment Form. If the individual refuses to sign the form, hospital personnel should document such refusal on the form.
    - ii. Refusal of emergency care must be documented in the medical record by the physician when the individual is transferred or discharged against medical advice in accordance with hospital policy.

F. Medical records: Medical records shall be maintained for all persons receiving emergency services and care.

G. Transfer requirements:

1. Transfer of Unstabilized Patient for Medically Indicated Reasons- Prior to any transfer of an individual who presented to the hospital with an emergency medical condition and whose condition remains unstable, the emergency physician, or when applicable, the on-call specialist physician, must examine and evaluate the person and certify in writing (see below), that, based upon reasonable risks and benefits to the patient and information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual's medical condition that may result from effecting the transfer.
  - a. The emergency physician's and/or on-call specialist physician's determination must be documented in the patient's medical record.

- b. The emergency physician and/or on-call specialist physician must complete the CHS Transfer Form.
- c. The emergency physician and/or on-call specialist physician must arrange an “appropriate transfer”, as defined below, for the individual.
- d. Patient Consent and Refusal to Consent to Medically Indicated Transfer. The individual or legally responsible person will be advised orally, or in writing, of the reasons for the transfer including its risks and benefits.

Consent must be obtained as follows:

- i. Consent must be documented in the medical record
  - ii. Written consent to the transfer must be obtained using the CHS Transfer Form.
  - iii. In the event an individual or legally responsible person refuses to consent to a medically indicated transfer in accordance with this policy, the emergency physician and on-call specialist physician shall:
    - a) Inform the patient/family of the hospital’s obligation to screen or treat;
    - b) Explain risks and benefits;
    - c) Determine patient/family competence to make an informed refusal;
    - d) Make reasonable efforts to secure the individual’s written informed consent to refuse the transfer;
    - e) Document in the medical record, the risks and benefits explained and the treatment offered but refused by the patient as follows:
      - The individual or legally responsible person shall sign a Refusal to Submit to Treatment Form, or Transfer Form;
- and
- The refusal shall be documented in the medical record.

2. Transfer Based on Patient Demand- An individual who presents to the hospital with an emergency medical condition and whose condition remains unstable may not be transferred or discharged other than for medical reasons as stated in the above paragraph unless the patient or legally responsible person demands the transfer or discharge and refuses treatment.

- a. If the patient or legally responsible person demands transfer to another facility or discharge, the emergency physician shall document such demand, and the reason for such demand, in the patient’s medical record.
- b. The patient or legally responsible person shall be informed of the risks and benefits associated with the transfer or discharge and shall sign a Refusal to Submit to Treatment Form, or Transfer Form before the transfer or discharge. The patient or legally responsible person also shall be informed, orally and/or by giving the patient or legally responsible person the CHS Transfer Form, of the hospital’s obligations under federal and state law to treat individuals with an emergency medical condition. A copy of the form, signed by the patient or legally responsible person shall be made and retained in the patient’s medical record.
- c. The emergency physician shall complete the CHS Transfer Form and obtain the patient’s written informed consent to the transfer.
- d. The emergency physician and/or on-call specialist physician must arrange an “appropriate transfer”, as defined below for the individual.

3. Transfer of Stabilized Patient- No Medical Hazard- EMTALA does not apply to the transfer of stable patients; however, prior to any transfer of an individual who presented to the hospital with an emergency medical condition and whose condition has now been stabilized, or any individual who did not have an emergency medical condition, the emergency physician, or when applicable the on-call specialist physician, must examine and evaluate the individual and determine that, within reasonable medical probability, the transfer or the delay caused by the transfer will not create a medical hazard for the patient.
  - a. “Medical hazard” means a material deterioration in, or jeopardy to, a patient’s medical condition or expected chances for recovery, including with regard to pregnant women having contractions, delivery;
  - b. It is recommended that the emergency physician’s and/or on-call specialist physician’s determination be documented in the medical record.
  - c. It is recommended that the emergency physician and/or on-call specialist physician complete the CHS Transfer Form and arrange for an “appropriate transfer,” as defined below, for the patient.
  - d. Additional issues that may be considered regarding transfer to another facility of an individual who presented with an emergency medical condition and whose condition has not been stabilized, may include:
    - i. The patient’s wishes;
    - ii. Regulations that prohibit the hospital from admitting certain categories of patients, (i.e., acutely mentally disturbed patients or those in custody of law enforcement agencies, etc.);and
    - iii. Regulations regarding treatment of military personnel.
4. Arranging an “Appropriate Transfer”- All EMTALA required transfers will be arranged as an “Appropriate Transfer”. It is also recommended that those patients who are stable at the time of transfer be arranged as an “Appropriate Transfer”.

The elements of an “Appropriate Transfer” include:

- a. CHS Transfer Form- A form completed by the physician and hospital staff concerning the nature of the transfer and consideration of transfer arrangements.
- b. Receiving Facility Consent- Telephone contact must be established between the attending emergency physician or on-call specialist physician and the receiving hospital. A report on the patient’s condition shall be made and the need for transfer shall be discussed. No patient shall be transferred without positive acceptance by the receiving hospital. The name of the accepting hospital and the name of the person who accepted the patient on behalf of the accepting hospital shall be documented in the patient’s medical record using the CHS Transfer Form.
- c. Receiving Facility Consent- It must be confirmed by the person responsible for transfer at the receiving facility that the receiving facility has available space, qualified

personnel, and equipment and that the individual will be provided appropriate medical treatment. A confirmation shall be documented in the medical record.

d. Transportation- The transferring physician(s) shall determine the appropriate mode of transportation for transferring the patient. The transfer shall be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

e. Medical Records- The receiving hospital will be provided with:

i. A copy of all medical records pertaining to the examination and treatment provided to the individual due to the existence of an emergency medical condition, that are available at the time of transfer;

ii. A copy of all lab tests and x-rays performed;

iii. A copy of appropriate nurses notes;

iv. The name and address of any on-call specialist physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

and

v. Any other documentation pertaining to the patient's treatment or condition.

5. Other Requirements- The transfer shall meet such other requirements that are subsequently determined by federal, state or local regulations to be in the interest of the health and safety of patients transferred.

6. Reporting- Any transfer of an unstable patient received into the hospital, which is deemed inappropriate by the receiving physician, shall be reported to the CHS Legal Services Department. Quality Assurance: A review of Emergency Department and in-house transfers of patients to another facility shall be conducted periodically for compliance by designated employees in the ED and inpatient units. The results shall be reported through the Corporate Compliance Committee.

H. Transfers to CHS Facilities: Hospital Responsibilities: A participating hospital that has specialized capabilities or facilities (including but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

## Section I. Graduate Medical Education

The mechanism for the supervision of the family medicine residents who train at CMC-NorthEast is outlined in Policy 04-09 entitled, "Supervising and Precepting Residents." A copy is on file in the Medical Staff Office and available in Meditech. The residents do not have privileges but have a job description, and a copy is available on the medical center's intranet site, as well as in the Medical Staff Office describing their level of care according to the PGY level. The mechanism for communication between the committees responsible for graduate medical education and the medical staff and the governing body are outlined in Policy 04-10. A copy is

available in the Medical Staff Office and Meditech. This policy is to ensure graduate medical education is adequately monitored for the performance of the residents, for patient safety issues and for quality of care.

2. While performing their daily activities, all residents are expected to perform with due diligence and attention to detail expected of all medical professionals. The well being of the patient is always of paramount importance and the resident is expected to act accordingly.

Entries made in the medical record (including written or verbal orders) by residents do not require countersignature by the attending physician.

Exceptions to this include the following:

- History/physical examinations performed by the resident as part of the admission process require countersignature by the attending physician.
- Discharge summaries completed by the resident require countersignature by the attending.
- Procedure notes completed by the resident require countersignature by the attending.

#### Section J. Organized Health Care Arrangement (OHCA)

The Medical Staff at NorthEast Medical Center (“NorthEast”) agree that, as part of their duties as a credentialed provider with privileges while practicing at NorthEast, its subsidiaries and affiliates, they shall be treated as a member of NorthEast Organized Health Care Arrangement (“OHCA”) as defined by the Health Insurance Portability and Accountability Act (“HIPAA”) and will follow and abide by all Privacy Policies, Rules and Regulations set forth by NorthEast. The Medical Staff understands that, while working at NorthEast, its affiliates and subsidiaries, they are subject to the Joint Notice of Privacy Practices issued by NorthEast and agree to abide by the terms and conditions of that Notice.

The Medical Staff understands and agrees that their participation in the NorthEast OHCA is effective only while practicing on-site at NorthEast, its subsidiaries and affiliates. Therefore, upon returning to their off-site practices and professional activities, the Medical Staff understands that they will no longer be covered by the Joint Notice of Privacy practices and must independently comply with HIPAA.