RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

Approved by the Professional Executive Council on September 25, 2024

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DEFINITIONS

All definitions as set forth in the Bylaws of the Professional Staff of Children's Hospital and Clinics of Minnesota ("Bylaws") are hereby incorporated in this document by reference, unless the context clearly requires otherwise, with the following additional definitions:

1. **"Referring"** Provider/Physician/Practitioner is a health care Provider who refers a patient to the Hospital or to the care of a Practitioner.

2. **"Admitting"** Physician/Practitioner is a Member with admitting privileges who admits the patient to a Hospital Site for care. The Admitting Physician/Practitioner is also the Attending unless the Attending role is appropriately transferred.

3. **"Attending"** Physician/Practitioner is a Member with admitting privileges who is responsible for ordering, assessing, and managing the continuous comprehensive care of the patient, while the patient is registered at the Hospital for an episode of care. Each patient has only one Attending at any point in time.

4. **"Consulting"** Physician/Practitioner is a Member or Individual with Privileges requested by the Attending Practitioner to provide a consultative assessment and recommendations.

5. **"Primary Care"** Provider/Physician/Practitioner is the health care Provider the patient and family regard as the patient's primary Provider of healthcare supervision, generally within the patient's community of origin.

6. "**House Staff**" are **Interns**, **Residents**, **Fellows**, **Medical Students**, **Externs**, and **Physician Assistant Students** currently participating in an internal or affiliated training program and who are registered with the Hospital's Department of Medical Education.

7. **"Resident"** is a medical school graduate who is currently in training in an internal or affiliated residency program at the Hospital. The first year of residency is sometimes referred to as the internship year.

8. **"Fellow"** is a Physician who is generally fully trained in a specialty who is participating in a subspecialty fellowship program.

9. **"Medical Student"** is a student currently enrolled in an accredited medical school who is participating in a clerkship, elective, preceptorship, or observership, and who is registered with the Department of Medical Education. Medical Students include Externs.

10. **"Physician Assistant Student"** ("PA Student") shall be defined as a student enrolled in an accredited Physician Assistant program.

11. **"Physician Assistant Fellow"** ("PA Fellow") shall be defined as a fully trained and licensed Physician Assistant who is currently in training in an internal or affiliated Physician Assistant fellowship program at the Hospital.

12. **"Extern"** is a medical student currently enrolled in an accredited medical school (including foreign medical schools) that is outside the group of medical schools that regularly have medical students in the Hospital's training programs; or is a foreign medical graduate with a medical degree obtained outside of the United States who is not licensed to practice medicine in the United States.

Words used in these Rules and Regulations shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Rules and Regulations.

ARTICLE I: PURPOSE AND USE OF RULES AND REGULATIONS

PART A. PURPOSE

These Rules and Regulations establish guidelines for the conduct and processes relating to Members of the Professional Staff and Individuals with Privileges. These Rules and Regulations are intended to establish guidelines for the provision of a uniform standard of quality patient care, treatment and services in the Hospital.

ARTICLE I
PART B. ADDITIONAL RULES

These Rules and Regulations are intended to inform Members of the Professional Staff and Individuals with Privileges of the policies, procedures, rules, regulations, guidelines and requirements that apply to them. There are additional policies, procedures, rules, regulations, guidelines and requirements which apply, including the Bylaws of the Professional Staff, the Policy on Appointment, Reappointment and Clinical Privileges, the Policy on Professional Staff Committees adopted under Article XI of the Bylaws. It is each Member's or Individual with Privileges' sole responsibility to obtain, read, understand and abide by all bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and its Professional Staff.

ARTICLE I
PART C. INTERPRETATION

By submitting an application for appointment, reappointment or temporary privileges, every applicant, Member and Individual with Privileges agrees that these Rules and Regulations and all other bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital and/or its Professional Staff are subject to the interpretation of the Professional Executive Council, and/or the Hospital, and/or the Board of Directors, in their sole discretion.

In addition, these Rules and Regulations are intended to comply with all relevant laws, regulations and accreditation standards. If changes in laws, regulations or accreditation standards establish higher standards than stated in these Rules and Regulations, the relevant laws, regulations or accreditation standards shall apply.

In emergency situations, such as a work stoppage or disaster, the Chief of Staff with the concurrence of the Chief Medical Officer, may, in the interest of patient care, temporarily change elements of these rules & regulations, provided the temporary change remains within the requirements of law, regulation and accreditation standards, and the affected persons are duly notified of the implementation and termination of the temporary change. Such temporary changes shall extend beyond the emergency situation only as long as reasonably required for the orderly resumption of Hospital operations.

ARTICLE I
PART D. ENABLING PROCEDURES

These Rules and Regulations have been created pursuant to and under the authority of the Professional Staff Bylaws of the Hospital and are intended to establish guidelines for the provision of certain professional services at Hospital Sites. These Rules and Regulations have been designed to support the Professional Staff Bylaws.

ARTICLE I
PART E. ACCESS TO REFERENCED ORGANIZATIONAL POLICIES AND PROCEDURES

The Organizational Policies and Procedures referenced in these Rules & Regulations are accessible electronically on the Hospital Intranet or through the Professional Staff Portal.

ARTICLE I
PART F. AMENDMENTS TO RULES AND REGULATIONS

These Rules and Regulations may be amended only in accordance with procedures set forth in the Professional Staff Bylaws.

ARTICLE II: PROFESSIONAL STAFF EXPECTATIONS

PART A. GENERAL EXPECTATIONS

All Members of the Professional Staff and Individuals with Privileges are expected to deliver knowledge-based, family-centered, and systems-minded care through clinical care, service and citizenship excellence, and to adhere to high ethical standards in their respective disciplines:

1. **Clinical Care Excellence** through:

   (a) Effectiveness - by matching care to science and avoiding the underuse, overuse and misuse of resources;

   (b) Technical Skill – by striving for excellence in diagnostics, procedures, communication and teamwork;

   (c) Safety – through a commitment to safety, a non-blaming yet accountable environment, and prevention of harm to patients and staff; and

   (d) Cultural Competence – through the delivery of equitable care to all children and families, and to ensure that quality of care does not vary based on patient characteristics such as language, ethnicity or geographic location.

2. **Service Excellence** through:

   (a) Family-Centered Care – by demonstrating respect to individuality, values, culture, social endowments, information needs and preferences of each patient and family; Patients and families are partners in, and sources of control for, their care.

   (b) Timeliness – by providing timely access to care for all patients;

   (c) Communication – that it be open, honest, accurate, compassionate, and courteous in manner with patients, families and the health care team. Document and communicate information pertinent to the care of the patient in a confidential and timely manner. Consistent use of the designated, universal hospital communications application required of all professional staff in compliance with applicable instructions as may be updated from time to time.

3. **Citizenship Excellence** through:

   (a) Resource Utilization - through the efficient and wise management of resources for individual patients and all the children for whom we care, including medications, supplies, equipment, space, capital, ideas, and human spirit;

   (b) Peer and co-worker relationships - by recognizing and respecting peer and co-workers' role as partners in care, and adhering to and advocating Children's "Service Standards"; and

   (c) Contribution to Children's Hospital and Clinics of Minnesota and the Greater Pediatric Community - through contributions in education, research, leadership, performance improvement, advocacy, and/or the important committee work of Children's and the Professional Staff.

ARTICLE II
PART B. ETHICS

1. In keeping with the statements of mission and vision of the Hospital, Professional Staff shall adhere to high ethical standards in all of their dealings, which support the organization. This includes but is not limited to adherence to Hospital by-laws, policies, rules and regulations, Principles of Integrity and Compliance, and Children's Service Standards, Children's Confidentiality Agreement and Expectations for Professional Staff Performance.

2. When conflicts of interest exist in referral of patients (including self-referral) to facilities or organizations, equipment or pharmaceuticals in which the Member or Individual with Privileges has a financial or personal interest, that conflict of interest is disclosed to the patient or family and alternatives are also offered. Such referrals may be made only as permitted by applicable law. [See Organizational Policy 1048 Conflicts of Interest][1]

3. Identification and resolution of ethical issues in collaboration with families is the responsibility of each Member or Individual with Privileges. Consultation should be used as appropriate from professional colleagues, managers and medical directors, corporate compliance officer, the office of ethics and ethics committee, and/or the board of directors.[2]

4. Admitting Physicians/Practitioners are responsible for giving such information as may be reasonably necessary to assure the protection of other patients from those who are a source of danger.

5. Practitioners are expected to clearly document the need for continued hospitalization for all hospitalized patients, and provide reasons for decisions regarding admission, discharge, or transfer to the patient or guardian. [See Organizational Policy 620 Utilization Management Plan][3]

ARTICLE II
PART C. PRIVACY/CONFIDENTIALITY

1. Specific patient care information or the patient's or family's status should not be discussed in locations in which they can be overheard, e.g., elevators, hallways, cafeteria. Information about patients and families obtained during work at Children's, which is presented in writings, lectures, educational seminars or other public forums is presented after either obtaining prior consent or adequately redacting all identifying information. All Members and Individuals with Privileges are expected to adhere to the Organizational Policy 101.00 Confidentiality and Privacy.

2. Members or Individuals with Privileges who are users of the Hospital information technology systems are responsible for using those resources in an ethical, effective, efficient and legal manner. [See also Organizational Policies 1101.00 Workforce Member Information Security ; and 1106.00 Access to Medical Records]

ARTICLE II
PART D. ROLE OF THE ATTENDING

Every patient shall have one Member who is the Attending Practitioner responsible for the global care of the patient, appropriate to the setting in which the patient is receiving care. [See Definition: "Attending"]

[1] The Joint Commission – Hospital Accreditation Standards LD.04.02.01, EP 3
[2] The Joint Commission – Hospital Accreditation Standards LD.04.02.03, EP 1
3 CMS – Conditions of Participation §482.24(c). The Joint Commission – Hospital Accreditation Standards RC.01.01.01, EP 5-6

Duties include:

1. Responsible to supervise House Staff, students, trainees,

2. Direct requests for consultations,

3. Assure that all medically necessary care, treatment and services are offered to the patient and the patient's family is given appropriate information in a timely and medically appropriate manner, either by providing or ordering the services personally, or by requesting consultation and coordinating the consultant's recommendations.

The Attending is responsible for assessing the patient daily and for documenting a record of the assessment and plan of care.

The attending of record may provide for coverage of this Attending responsibility through other attending practitioners of the same or similar specialties to deliver the continuous 24-7 care of the hospitalized patient.

The Attending may delegate portions of the responsibility for ordering, assessing and managing a patient to one or more Consultants, Fellows, Residents, Advanced Practice Registered Nurses, or Physician Assistants, nevertheless, the Attending continues to retain global responsibility for the continuous comprehensive care of the patient during the episode of care.[4]

If the role of the Attending is transferred (other than regular changes in call coverage), it is the responsibility of the original Attending to document this transfer in the medical record, communicate directly with the receiving Attending, and notify the admitting office.

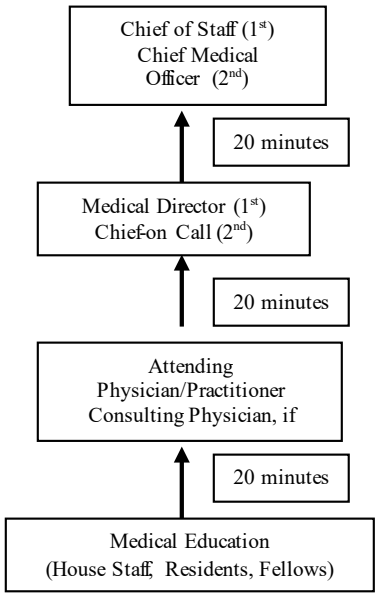
ARTICLE II
PART E. COLLABORATIVE COMMUNICATION

All Members and Individuals with Privileges are encouraged to communicate directly with patients, their families and their other health care Providers in a timely manner to advance the care and address their informational and medical needs. Such communication, including patient and family education, should be documented in the progress notes. Non-physicians, residents, fellows, and consultants are encouraged to document their daily communication with their collaborating Physician(s), including the Attending Physician/Practitioner.

ARTICLE II
PART F. CHAIN OF COMMAND

In order to assure the delivery of timely care, treatment and services, a chain of command has been established to address situations in which the Attending Physician/Practitioner or House Staff are not available, or are not able to be contacted. The algorithm for notification is as follows:

[4] CMS – Conditions of Participation §482.12(c)(1).

Stable Patient	Worrisome Patient	Unstable patient
e.g. patient/family concerns, questions, issues  	**RAPID RESPONSE TEAM** **Activation by any healthcare worker or family member** **CALL 4-3535 Internal 952-931-3535 Ext**	**e.g. physiologic deterioration, intensifying behavior (risk to self or staff)** **Emergency intervention** Call Dr. Blue St Paul 1-8899 MPLS 5-7777 **Note:** When emergency intervention is warranted, assistance by any means most expedient such as signaling a Dr. Blue must be sought.

[See Organizational Policies 201.00 Chain of Command, 216.00 The Stop the Line Rule, 360.00 Dr Blue Emergency and 361.00 Rapid Response Team for further details][5]

ARTICLE II
PART G. INTERPRETER SERVICES

Whenever there is a language or cultural barrier to effective communication, Practitioners must arrange for interpreter services. [See Organizational Policy 111.00 Interpreter Services][6]

ARTICLE II
PART H. PHOTOGRAPHIC IDENTIFICATION

All Members and Individuals with Privileges are expected to wear a visible appropriate identification badge with a recent photograph while physically present at any Hospital Site. The Member or Individual with Privileges should contact the Professional Staff Office to obtain a badge for identification. Badges originating from either the Member's or individual's employer or another hospital medical staff are acceptable identification; however, Hospital identification is preferred.[7]

ARTICLE II
PART I. MEETING ATTENDANCE

Attendance at general staff meetings, division meetings, educational conferences, and administrative

[5] The Joint Commission – Hospital Accreditation Standards, PC.02.01.19
[6] The Joint Commission – Hospital Accreditation Standards, PC.02.01.21, EP 2
[7] The Joint Commission – Hospital Accreditation Standards, EC.02.01.01, EP 7

meetings of the Professional Staff is encouraged, but not required, with the following exception: Professional Staff officers, division chiefs, associate division chiefs, associate division chiefs elect, and committee chairpersons are subject to specific meeting attendance requirements as specified in their position descriptions.

ARTICLE II
PART J. CONTINUING EDUCATION

All Practitioners must participate in continuing education in accordance with State Statutes and must include a significant proportion of continuing education related to the clinical privileges granted. Participation is considered in decisions about reappointment, renewal or revision of clinical privileges[8].

ARTICLE II
PART K. NEWS MEDIA

Marketing, Communications and Public Relations is the only department authorized to respond to news media requests, initiate news stories, act as a liaison between news media representatives and the Hospital, and designate spokespersons to address specific issues on behalf of the Hospital. Professional Staff Members and Individuals with Privileges must contact the marketing and communications department before any interaction with the media. No news media reporters or photographers are allowed in the Hospital without a media relations escort. No patients can be photographed or filmed unless the patient and/or parent/guardian agree to do so, and the parent or guardian has signed a consent form.[9] While inside Children's, staff members also have the right to refuse being filmed or photographed. [See Organizational Policies 813.00 News Media & 101.00 Confidentiality and Privacy]

ARTICLE II
PART L. HEALTH

A process is in place to identify and manage matters of individual health that is separate from the disciplinary function. The purpose of the process is assistance and rehabilitation, to aid a Member or Individual with Privileges in retaining or regaining optimal professional functioning consistent with protection of patients. [See Policy on Professional Staff Health].[10]

ARTICLE II
PART M. ALCOHOL AND DRUGS

Children's prohibits the use, possession, transfer, and sale of alcohol and/or illegal drugs while engaged in patient care, while on the premises owned or operated by Children's, and while operating any Children's vehicle, machinery or equipment. This prohibition also includes reporting to Children's to engage in patient care, being on call for a Children's service or patient, or working at any location on behalf of Children's while under the influence of alcohol and/or illegal drugs**.** Violation of this policy may result in discipline, up to and including suspension or revocation of appointment and/or clinical privileges in accordance with the professional staff bylaws and related documents. [See Organizational Policy 1508.00 Drug and Alcohol Zero Tolerance Policy for Professional Staff and Practitioners]

ARTICLE III: EMERGENCY SERVICES AND AMBULATORY CLINICS

PART A. EMERGENCY SERVICES
Section 1. Leadership

A qualified Physician Member of the Professional Staff must direct and supervise emergency medicine

[8] The Joint Commission – Hospital Accreditation Standards, MS.12.01.01 – EP5
[9] The Joint Commission – Hospital Accreditation Standards, RI.01.03.03
[10] The Joint Commission – Hospital Accreditation Standards, MS.11.01.01

services[11]. The Professional Staff herein establishes criteria for the qualifications for the director of the Hospital's emergency services in accordance with State law and acceptable standards of practice as including maintenance of unrestricted licensure to practice medicine in the State of Minnesota, appointment to and maintenance of appointment to the Professional Staff with unrestricted clinical privileges on the Active Staff in a specialty related to the delivery of emergency services, demonstrated leadership skills, and compliance with the requirements of the Hospital and its Professional Staff, and with the standards of professional ethics and practice established by the American Medical Association and the Minnesota Board of Medical Practice.

ARTICLE III – PART A
Section 2. Emergency Medical Screening

The Hospital will provide a medical screening examination (MSE) for anyone seeking emergency care at the Minneapolis and St. Paul hospital locations, regardless of the individual's age, condition, or ability to pay. If the medical screening examination reveals that the patient has an emergency medical condition, the Hospital will render the necessary stabilizing treatment, or, if the Hospital lacks the capacity or capability to provide the necessary stabilizing treatment, will affect an appropriate transfer to another facility. The Hospital will accept the transfer of patients experiencing unstabilized emergency medical conditions if the Hospital has specialized capabilities not available at the transferring facility and has the capacity to treat the patient.

Members with privileges who are Physicians, advanced practice registered nurses, or Physician Assistants are authorized to perform the medical screening examination. Physicians who are Resident or Fellows may also perform the medical screening examination in accordance with Physician-approved protocol(s) under the supervision of an Attending Physician.

See Hospital Policy 392.00 Emergency Medical Treatment and Active Labor Act (EMTALA).

ARTICLE III – PART A
Section 3. Emergency Consultation

See Article VI Part B for on call requirements for requested emergency consultations.

ARTICLE III – PART A
Section 4. Emergency Medical Record

See Organizational Policy 1103.00 Medical Record Documentation for the content requirements of the medical record.

ARTICLE III – PART A
Section 5. Appraisal of Patient and Non-Patient Emergencies at Off Campus Locations[12]

The Hospital will conduct appraisals of patients, families, and visitors with emergency medical conditions, make appropriate referrals, provide treatment and stabilization, and arrange for appropriate transportation at all of its off-campus locations that provide patient care, but do not have dedicated emergency departments. Interventions provided will be consistent with available resources and the education, licensure, and training of available staff at each off-campus location. See Organizational Policy 393.00 Appraisal of Patient and Non-Patient Emergencies at Off-Campus Locations for a description of the procedure to provide these appraisals.

[11] The Joint Commission –Hospital Accreditation Standards LD.04.01.05 – EP 6; CMS – Conditions of Participation §482.55(a).
[12] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 13; CMS Conditions of Participation, §482.12(f)(3)

ARTICLE III
PART B. AMBULATORY CLINICS

Section 1. Leadership

The quality of care, treatment, and services provided in each ambulatory clinic shall be under the oversight of a qualified Physician/Practitioner Member of the Professional Staff (such as a lead physician, medical director or division chief).

ARTICLE III – PART B
Section 2. Ambulatory Medical Record

Medical records are maintained for every ambulatory encounter including dating and documenting care assessed or provided for each separate visit in a series. A summary list will be initiated and maintained for every primary care visit by the third visit and is maintained thereafter.[13] The patient's summary list is updated whenever there is a change in diagnosis, medications, or allergies to medications, and whenever a procedure is performed. Specialists are encouraged to enter in the summary list diagnoses and procedures relevant to their specialties. The documentation requirements for ambulatory care encounters are defined in Organizational Policy 1103.00 Medical Record Documentation.

ARTICLE IV: ADMISSION

PART A. ADMISSION STATUS

For the purposes of this Article IV, the following definitions apply:

1. Admission: Placement of a registered patient who is physically present into inpatient status.
2. A patient can have inpatient, observation or outpatient in a bed status on any unit in the hospital.
3. Inpatient Status: The admission status of a patient meeting accepted national guideline criteria for inpatient admission regardless of the unit in which the services are provided. Status is independent of location.

Observation Status: the patient status of a patient meeting national guideline criteria for observation services or for a patient being observed to determine if their condition requires inpatient admission. Placement in observation status is reserved for patients that have a non-routine recovery from a procedure or for patients seen in the emergency department who are diagnosed with a condition that does not initially meet Inpatient admission criteria.

Outpatient in a bed status: includes pre and post outpatient sedation and anesthesia, outpatient procedures, some chemotherapy administration, infusion therapy and postoperative recovery that extends beyond the typical period of recovery from anesthesia or sedation. An example would be the post-procedure overnight stay to monitor an infant for apnea after undergoing tonsillectomy and adenoidectomy who had pre-existing obstructive apnea.

ARTICLE IV
PART B. AGE CRITERIA FOR ADMISSION

Only individuals who have not reached their 21st birthday shall be admitted to inpatient status or cared for as observation or outpatient in a bed status in the Hospital. Exceptions shall occur only when the required care is uniquely available at the Hospital Site and physical facilities, health care personnel and ancillary services are appropriately prepared to deliver the required care. Inpatient admission and Observation and Outpatient in a Bed care for patients 21 years of age and older must be approved by the Chief Medical Officer, except for the following approved services for patients twenty one (21) years of age and older:

[13] The Joint Commission – Hospital Accreditation Standards RC.02.01.07 – EP 1, 3-4

1. Adjustment of age criteria for admission while under an Emergency Operations Plan
2. Admission for problems arising from congenital cardiovascular disease;

3. Admission for oncology treatment under a pediatric treatment protocol for continuing oncology care, or for new oncology patients prior to the twenty fifth birthday;

4. Disease with onset in childhood, for which no adult providers or hospital facilities have been identified within the metropolitan Twin Cities area to safely deliver the required care;

5. Continuing care of an acute condition for which treatment at the Hospital was initiated prior to the 21st birthday that is expected to be resolved within six months after the 21st birthday;

6. Terminal care of a long-term patient of the Hospital in the last six months of expected life.

[See Organizational Policy 214.00 Inpatient: Admission / Transfer / Discharge]

ARTICLE IV
PART C. PROVISIONAL DIAGNOSIS

Except in an emergency, no patient shall be admitted until a provisional diagnosis has been stated. During times of critical bed shortage, the administrative representative (nursing supervisor) on duty has the authority to determine (in conjunction with appropriate medical leadership) the priority of and transfer of patients.

ARTICLE IV
PART D. TRANSMITTABLE DISEASE

If a patient has a potentially or known transmittable disease (e.g. Respiratory Syncytial Virus (RSV), Influenza, Methicillin Resistant Staphylococcus Aureus (MRSA), Tuberculosis, etc.), it is the responsibility of the Admitting Physician/Practitioner to notify admitting personnel in order to facilitate appropriate infection control precautions.

ARTICLE IV
PART E. UNCOMPENSATED CARE

Children's Hospitals and Clinics of Minnesota offers financial assistance programs for patients and families who meet guidelines set forth in Hospital policy, including Charity Care and an Uninsured Discount Program. [See Organizational Policies 1401.00 Charity Care and 1400.03 Uninsured Discount Program]

ARTICLE IV
PART F. TEACHING SERVICE ADMISSIONS

Teaching Service admissions include any admission in which individuals in graduate medical education programs are involved in direct care of the patient. The Attending may request the patient be admitted to the teaching service, if the teaching service is available. Parents may request that their child not be admitted to the teaching service. When admitted to the teaching service, the Attending Practitioner remains responsible for global care of the patient, and shall communicate directly with the senior admitting Resident at the time of admission. Admissions to the teaching service may be limited according to policy established by the Department of Medical Education.

ARTICLE IV
PART G. HISTORY AND PHYSICAL EXAMINATIONS (H&P)
Section 1. General Requirements

Except as otherwise stated in this article, for all inpatient admissions, observation and ambulatory surgical patients and most sedation and procedural services patients, a history and physical examination must be completed and documented in the medical record within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). An H&P must be completed prior to any procedure. For the purposes of Part G (this part), procedure shall mean any surgery, invasive procedure, induction of anesthesia, administration of moderate or deep sedation, or other procedure that places the patient at risk. An update to the H&P is required in some situations.[14] [See Sections 3 and 4 in this Part G]

ARTICLE IV – PART G
Section 2. Minimum Content Requirements for H&Ps

The minimum content requirements for a history and physical examination include history of the present illness, relevant social history, relevant family history, allergies, current medications, relevant past medical history, relevant review of body systems, physical examination, results of testing pertinent to the present illness (if any), a statement of the conclusions or impressions drawn, a plan of action, and, the signature of the Provider performing the H&P.[15]

[See Organizational Policy 1103.00, Medical Record Documentation]

ARTICLE IV – PART G
Section 3. Mandatory Requirement to Update H&Ps

In cases in which the H&P was performed prior to arrival at the Hospital, a signed, dated and timed update to the H&P is required indicating the presence or absence of changes in the patient's medical condition since the H&P was performed.[16] This update must be documented in the medical record by a Practitioner with history and physical examination privileges within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).H&Ps performed in the Hospital at the time of admission do not require an update. If the Procedure that places the patient at risk is performed greater than 24 hours after the admission, documentation of the patient's condition and changes to the patient's condition in the daily progress notes meets this update requirement.

The Practitioner performing a procedure is responsible to assure that the H&P update has been completed by a Practitioner with history and physical privileges before moderate or deep sedation, or before induction of anesthesia. In situations in which the patient is undergoing sedation or anesthesia for a procedure and the Practitioner performing the procedure does not hold history and physical examination privileges, the pre-sedation or pre-anesthesia assessment performed immediately before moderate or deep sedation, or before induction of anesthesia, shall meet the update requirement.[17,18] The Practitioner uses his/her clinical judgment, based upon his/her assessment of the patient's condition and comorbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record. The update note must document an examination[19] for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment. If, upon examination, the Practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P

[14] The Joint Commission – Hospital Accreditation Standards, PC.01.02.03 – EP 4; CMS – Conditions of Participation §482.51(b)(1)
[15] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 6
[16] The Joint Commission – Hospital Accreditation Standards, PC.01.02.03 – EP 5; MS.03.01.01 – EP 8; CMS – Conditions of Participation §482.22 (c) (5) (ii)
[17] The Joint Commission – Hospital Accreditation Standards, PC.03.01.03 – EP 1 & 8
[18] CMS – Conditions of Participation §482.22(c)(5)(ii)
[19] CMS – Conditions of Participation §482.22(c)(5)(i); 482.24(c)(2); 482.51(b)(1)

was completed. Additionally, if the Practitioner finds that the H&P performed prior to admission is incomplete, inaccurate, or otherwise unacceptable, the Practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document in the medical record a new H&P.[20]

ARTICLE IV – PART G
Section 4. H&P Requirements at Readmission

If a patient is readmitted to the Hospital and the H&P from the most recent admission was performed within thirty (30) days prior to the readmission, the H&P may be used, provided a copy is placed in the new admission medical record, and an update to the H&P is appropriately documented. An H&P originally performed more than thirty (30) days prior to the current admission may not be used.
A discharge summary for a discharge within thirty (30) days prior to readmission that also meets the minimum content requirements for an H&P shall meet the H&P requirements at readmission, provided a copy is placed in the new admission medical record, and an update to the H&P is appropriately documented.

ARTICLE IV – PART G
Section 5. Pre-Procedural H&Ps & Documentation Requirements

(a) General Pre-Procedural Documentation Requirements

The H&P must be present in the medical record in written or electronic form prior to the induction of anesthesia/sedation or starting the procedure (see exceptions for emergencies and dictation below).

Except in emergencies, all procedures shall be delayed until the H&P and any required update, and a provisional diagnosis[21] are obtained, documented, and available in the medical record.

(b) Use of Emergency Department Record to Satisfy Pre-Procedural H&P Requirement

An emergency department record may be deemed to satisfy the requirement for a pre-procedural H&P, provided the emergency department patient evaluation occurs within 30 days prior to the procedure and the record contains: a history of the present illness, allergies, current medications, relevant past medical history, relevant family history, relevant social history, relevant review of systems, physical examination, results of testing pertinent to the procedure, impression, plan of care, and the signature of a Practitioner with history and physical examination privileges. An emergency department record used as a pre-procedural H&P is subject to the same mandatory H&P update requirements described in Section 3 above.

(c) Documentation Requirements in Emergency Situations

In an emergency situation in which the patient's condition does not safely allow the documentation of an H&P prior to proceeding with an emergency procedure, the documentation of the H&P should be accomplished as soon as the patient's condition allows.[22]

ARTICLE IV – PART G
Section 6. Dental H&Ps

Dental patients are the dual responsibility of the dentist and a Physician/Practitioner Member. The same H&P requirements as defined in this Article IV Part G apply to dental patients prior to dental surgery,

[20] CMS – Conditions of Participation §482.22(c)(5)(ii)
[21] The Joint Commission – Hospital Accreditation Standards, RC.02.01.03 – EP 2
[22] CMS – Conditions of Participation §482.51(b)(1)

except that the dentist shall be responsible for only the dental history and dental physical examination and documentation of such in the medical record. A designated Physician with privileges on the Professional Staff shall be responsible for the medical care of the patient during the hospital stay whenever a pre-admission medical problem exists or when the dentist requests medical management for a newly discovered medical problem.

The dentist's responsibilities shall include a detailed description of the examination of the oral cavity, a preoperative dental diagnosis, a complete operative report (if surgery is done), a postoperative evaluation and a progress note at least once a day, pertinent to the oral condition. In cases of extraction of teeth, the dentist shall clearly document in the Hospital medical record the tooth numbers of the teeth and/or fragments removed. The patients, without other active medical conditions requiring inpatient care, may be discharged by written order of the dentist.

ARTICLE IV – PART G
Section 7. Sedation and Procedural Services/Short Stay Unit H&P Requirements.

(a) General Requirements

H&Ps are required for all Sedation and Procedural Services/Short Stay Unit patients, except as described below. A complete Emergency Department record is sufficient documentation to meet this H&P requirement for observation and Sedation and Procedural Services patients. Additional information is in Organizational Policy 1103.00 Medical Record Documentation.

(b) Exceptions

H&Ps are not required for brief outpatient visits for the purpose of drawing blood, laboratory testing, simple surgical procedures requiring only local anesthesia, intramuscular injections, uncomplicated intravenous infusions, physician only visits, nurse only visits and noninvasive radiology procedures not requiring moderate or deep sedation.[23] However, a recent H&P may be retained in the medical record for reference on patients with stable medical conditions or therapies that may require repeated outpatient visits. If a recent H&P is not available and is deemed to be important for the appropriate care and safety of the patient, the staff may request that a new H&P be completed. "Recent" is generally considered to be within twelve (12) months. Questions concerning the necessity of an H&P shall be directed to and addressed by the Medical Director of the Sedation and Procedural Services Unit. The decision of the medical director shall be final as to whether an H&P is required for an individual patient meeting the above exception criteria.

ARTICLE IV – PART G
Section 8. Attending Physician/Practitioner Responsibility and Delegation

The H&P is the responsibility of the Member who is the Attending Physician/Practitioner. The Attending Physician/Practitioner may delegate without countersignature all or part of a patient's H&P to another Practitioner with privileges to perform histories & physical examinations, including, but not limited to, a physician, an advanced practice registered nurse, or a physician assistant acting within the scope of his/her licensure and physician - physician assistant delegation agreement. An Attending Physician/Practitioner may delegate an H&P to a Fellow or Resident Physician, or Physician Assistant Fellow, acting under his/her supervision, provided the supervising Physician countersigns the H&P. In situations in which a Fellow or Resident Physician has also been granted clinical privileges by the Board to perform H&Ps, no Attending Physician/Practitioner countersignature is required.[24]

[23] The Joint Commission – Frequently Asked Questions (FAQ) – Medical Staff, "History And Physical For Hospital Outpatient Procedures", revised November 24, 2008;
[24] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01, EP 8-10

ARTICLE IV – PART G
Section 9. H&Ps by Providers without Privileges[25]

For the purpose of obtaining accurate medical histories and physical examinations performed by healthcare Providers with the greatest knowledge of the patient, H&Ps may be accepted from Physicians, advanced practice registered nurses, and physician assistants without privileges at the Hospital, provided that the individuals are licensed to practice within the State in which the H&P is performed and are providing services within their scope of practice. A Physician without privileges may delegate a H&P to a Fellow or Resident acting under his/her supervision provided the supervising Physician reviews and countersigns the H&P.

ARTICLE IV – PART G
Section 10. H&Ps by Students

Medical students (including osteopathic students and externs), advanced practice registered nurse students, and Physician Assistant students may document a history and physical examination in the medical record as part of their educational experience. The name, educational title, and signature of the author of such an educational H&P must be identifiable in the record. An educational H&P may not be considered as the definitive H&P in a medical record unless one of the following conditions applies: a) a Physician/Practitioner was present during the entire history and physical examination, and the Physician/Practitioner documents in a duly authenticated note attesting that the he/she was present during the entire H&P and that the H&P is an accurate representation of the history, physical examination, assessment and plan of care for the patient; or b) a Physician/Practitioner obtains a history and performs a physical examination separate from the medical student and attests in the medical record that the history, assessment and plan recorded by the medical student is accurate and the Physician/Practitioner separately documents the key findings of their physical examination. In all other cases, a separate H&P must be recorded in the medical record by the Attending Physician/practitioner or his/her authorized designee as outlined earlier in this Article. [26]

ARTICLE IV – PART G
Section 11. Registered Nurses Involvement in H&Ps

Registered nurses (including registered nurses [RN], certified registered nurses [RN,C], and registered nurses who carry the job title of "nurse clinician[27]," but not including advanced practice registered nurses) who are employed by or are under contract to an Attending Physician, may act as a scribe in documenting history and physical examinations in the medical record under the direct supervision (physical presence) of the Attending Physician. The name, credentials (e.g. RN; RN,C), role ("scribe" or "transcribed for"), and signature of the author of such a transcribed H&P must be identifiable in the record. Such a transcribed H&P may not be considered as the definitive H&P in a medical record unless the Physician was present during the entire history and physical examination, and the Physician documents in a duly authenticated note attesting that the he/she was present during the entire H&P and that the H&P documented is an accurate representation of the history, physical examination, assessment and plan of care for the patient. Attending Physician countersignature alone is not considered to be sufficient documentation of the Attending Physician's involvement in a transcribed H&P.

The Joint Commission – Frequently Asked Questions – Provision of Care, Treatment and Services, "Delegation of the History and Physical Examination" (Updated November 24, 2008)

[25] The Joint Commission – Frequently Asked Questions – H&Ps from Non-Credentialed Practitioners, April 22, 2015.

[26] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 8-10
The Joint Commission – Frequently Asked Questions – Provision of Care, Treatment and Services, "Delegation of the History and Physical Examination" (Updated November 24, 2008)

[27] The use of the title "nurse clinician" does not imply any special authorization or expanded scope of practice beyond that of a "registered nurse."

Attending Physicians/practitioners may not request these services of registered nurses employed by or under contract to the Hospital.

In all other cases, an H&P must be recorded in the medical record by the Attending Physician/Practitioner, or his/her authorized designee, as outlined earlier in this Article.

ARTICLE IV
PART H. DIRECT ADMISSION

The purpose of direct admission is to ensure patient safety and to close gaps in care that may occur at transitions and transfers of care. A direct admission is a non-elective (unscheduled) admission to an inpatient unit of a patient whose diagnosis, assessed medical/surgical condition, and established patient/Provider relationship permits the patient to be directly and safely admitted to the Hospital without requiring that he/she undergo further assessment or stabilization in the emergency department.

See Organizational Policy 214.00 Inpatient: Admission / Transfer / Discharge for the detailed requirements for direct admission.

ARTICLE IV
PART I. ADMISSION OR TRANSFER TO INTENSIVE CARE UNITS

1. All patients admitted to intensive care (critical care) units shall be under the care and direction of an Attending neonatologist or intensivist, and be according to the criteria for admission.

   All patients admitted to a neonatal intensive care unit (NICU), a pediatric intensive care unit (PICU), or other critical care unit shall be seen by the Attending neonatologist or intensivist (or designee) within two (2) hours of admission. The neonatologist/intensivist (or designee) shall dictate or document a dated and timed assessment in the medical record as soon as it is feasible and within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). . The assessment shall include relevant clinical information, diagnostic impressions, and a management plan.

2. Admissions or Transfers to NICU

   The Attending neonatologist or intensivist of the unit shall assure that the Attending/referring practitioner is notified of the admission.

   New admissions to the NICU are generally limited to infants 30 days of age or less who meet admission guidelines. Infants who are more than 30 days of age and have been recently discharged from the NICU may be readmitted to NICU if, in the judgment of the neonatologist, in consultation with nursing, it is decided that this is the optimal location for the care of the patient. Infants from 10-30 days of age may be admitted to either the NICU or the PICU based upon the needs of the patient in the judgment of the neonatologist, pediatric intensivist, primary Attending Physician or consultant. [See Organizational Policy 214.00 Inpatient: Admission/Transfer/Discharge]

ARTICLE IV
PART J. SEDATION AND PROCEDURAL SERVICES/SHORT STAY UNIT ENCOUNTERS

Medical records are maintained for every Sedation and Procedural Services/Short Stay Unit encounter. The requirements of the record are defined in Hospital Policy 1103.00 Medical Record Documentation.

ARTICLE IV
PART K. SURGICAL ADMISSIONS

Section 1. Pre-Scheduling of Surgical Procedures

Surgical procedures, except for emergencies, shall be pre-scheduled at all Hospital Sites. Pre-scheduled procedures may include last minute requests from a physician's office if the schedule can accommodate the addition to the schedule without compromising patient safety or the quality of patient care, treatment, and services provided.

ARTICLE IV – PART K
Section 2. Ambulatory Surgical Facility Admissions

At Children's Minnetonka and at United/Children's Day Surgery Center, only approved ambulatory surgical procedures specific to each Hospital Site shall be scheduled. General scheduling criteria require that patients be healthy, meet American Society of Anesthesiologists (ASA) status classification I or II, and meet the age criteria for short stay status admission[28]. Patients being electronically monitored for apnea are excluded from admission to these facilities. Some ASA classification III patients may be treated with approval from an anesthesiologist.

ARTICLE IV
PART L. ADVANCE DIRECTIVES

All adult patients, those 18 years of age and older, who are hospitalized at the Hospital Sites or receive home hospice care, will be informed of their rights to accept or refuse medical or surgical treatment and the right to execute an advance directive, called a health care directive in accordance with Minnesota Law and the Patient Self Determination Act. Health care directives executed properly under Minnesota law express the treatment preferences of the adult patient and are considered binding on the health care provider unless rescinded by the patient or formally invalidated by legal action. The health care directive becomes effective whenever the patient is unable to make or communicate health care decisions in the judgment of the Attending Physician/Practitioner. Practitioners are encouraged to discuss advance directives with patients before admission to the Hospital or hospice service. [See Organizational Policy 115.00 Health Care Directives][29]

ARTICLE V: ASSESSMENT AND CARE OF PATIENTS

PART A. GENERAL REQUIREMENTS
Section 1. General

Practice within Scope of Privileges: Practitioners shall provide treatment and perform operative and other procedures only within areas of competency as specified in their clinical privileges. Additional privileges must be requested to treat or perform procedures not included under current privileges. See the Policy on Appointment, Reappointment and Clinical Privileges.[30]

Responsibility for Continuous Care[31]: Each Practitioner, shall be responsible for the continuous care of his/her patients at or for the Hospital, planning for continuing care, prompt and timely response to pages and calls regarding his/her patients, completeness and accuracy of the medical record, necessary special instructions, relaying reports of the condition of the patient to the Referring Provider and to parents and/or legal guardians of the patient, and providing for and coordinating medically appropriate transitions of care to other Practitioners, Providers, or health care facilities. A designee of the Practitioner may perform those functions as assigned. Members and Individuals with Privileges are

[28] See Rules & Regulations, Article IV, Part B: Age Criteria for Admission
[29] CMS – Conditions of Participation §482.13(b)(3)
The Joint Commission – Hospital Accreditation Standards, RI.01.05.01; CMS – Conditions of Participation §482.13(b)(3)
[30] CMS - Conditions of Participation §482.22(c)(6)
The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 2
[31] The Joint Commission – Hospital Accreditation Standards, PC.04.01.01

encouraged to communicate directly and in a timely manner with patients and families to address their informational and medical needs.

ARTICLE V – PART A :
Section 2. Management and Coordination of Care of Patients with Psychiatric Problems

A patient's general medical condition is managed and coordinated by an Attending Physician/Practitioner.. For hospitals that use Joint Commission accreditation for deemed status purposes: A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist[32].

ARTICLE V – PART A:
Section 3. Transfer and Delegation of Care

Please refer to Article II – Part D. Role of the Attending, for requirements regarding transfer and delegation of care.

ARTICLE V – PART A:
Section 4. Point of Care Testing

Test procedures and instrumentation used in point of care testing must have the approval of the Laboratory Medical Director.[33] [See Organizational Policy 204.00 Point of Care Testing]

ARTICLE V
PART B. CONSENTS AND AUTHORIZATIONS
Section 1. General Consent

Patient consent, (or in the case of minors, consent by a legal guardian), is required before care, treatment, and services are rendered, or, in the case of an emergency, as soon as practicable as described in Section 3 below. Additional consents required are described in Sections 2, 4, 5 and 6 below.

ARTICLE V – PART B
Section 2. Informed Consent

Children's recognizes the right of patients to give knowing, voluntary consent before receiving medical treatment. The purpose of the informed consent form is to verify that the process of informed consent has occurred between the patient/parent/legal guardian and the person performing the procedure. The informed consent form serves as a mechanism to confirm that the patient/parent/legal guardian understands the procedure, and it provides an opportunity for them to ask additional questions about the proposed treatment or procedure, sedation or anesthesia.

Informed consent must be obtained prior to any operative or invasive procedure, and any non-invasive procedure that places the patient at significant risk of harm (for greater detail on when informed consent is required, see Organizational Policy 121.00 Informed Consent). It is the responsibility of the person performing the procedure to obtain and document informed consent. Obtaining informed consent is this Practitioner's responsibility and cannot be delegated to anyone else unless expressly allowed in Hospital policy. Informed consent is a discussion between the person performing the procedure and the patient or patient representative (in a language or means of communication he/she understands) that describes the procedure, the benefits, the risks (including potential complications), alternative treatments, and consequences of not doing the procedure.

[32] The Joint Commission – Hospital Accreditation Standards, MS.03.01.03 – EP 3; CMS – Conditions of Participation §482.12(c)(1)
[33] The Joint Commission – Hospital Accreditation Standards, WT.01.01.01; WT.02.01.01 – EP 2-6

The Hospital informed consent form must be completed, signed, dated and timed by the person performing the procedure, patient/parent/legal guardian, and the anesthesiologist (if applicable) before the procedure begins and before the induction of anesthesia. This form should be completed no earlier than forty-eight (48) hours before the procedure or treatment is scheduled to begin, except as noted in Organizational Policy 121.00 Informed Consent.[34]

ARTICLE V – PART B
Section 3. Consent for Common Critical Care Procedures

Critical care units and teams transporting patients to critical care units may, from time to time, develop forms to obtain advance informed consent for procedures that might be reasonably anticipated to be needed on an urgent or emergent basis in the course of care, treatment and services within a critical care unit, and are generally performed within the critical care unit by a critical care specialist Practitioner. Such consents, when signed, shall apply for the duration of the Hospital stay, regardless the unit to which the patient may be transferred.

ARTICLE V – PART B
Section 4. Emergency Consent

A patient may be treated without consent if immediate treatment is necessary to prevent serious impairment of the patient's health. In this situation, consent is implied. The person performing the procedure should document the attempt to contact the legally authorized person with a thorough note that explains the emergency situation and the need to proceed with treatment and/or surgery. It is recommended that a second person concur with this decision and document agreement in the medical record. The patient or their legal representative should be informed of the procedure as soon as feasible and provided an opportunity to discuss the procedure with an appropriate staff person. [See Organizational Policy 121.00 Informed Consent – Emergency Treatment without Consent]

A minor (child) can request an examination or treatment for an emergency medical condition. The Hospital must conduct the examination if requested by an individual or on the individual's behalf to determine whether an emergency medical condition exists. Hospital personnel should not delay the Mental Status Evaluation by waiting for parental consent. If, after screening the minor, it is determined than no emergency medical condition is present, the staff can wait for parental consent before proceeding with further examination and treatment[35].

ARTICLE V – PART B
Section 5. Research Consent

Human subject research cannot be conducted at the Hospital without prior approval of the Institutional Review Board (IRB) and without the consent of the patient or person legally authorized to give consent on a consent form duly approved by the IRB for this research purpose[36]. Such IRB approval and informed consent is not required for research conducted by the Hospital for quality assurance purposes only.

Patients who are potential subjects in research, investigation, and/or clinical trials shall be provided

[34] CMS – Conditions of Participation §482.51(b)(2); The Joint Commission – Hospital Accreditation Standards, RI.01.03.01 – EP 1-3
[35] CMS Conditions of Participation – State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Rev. 46, 05-29-09, page 38; and Organizational Policy 121.00 Informed Consent.
[36] The "Informed Consent for Surgery/Invasive Procedure and/or Anesthesia/Sedation" form is not to be use to obtain consent for a patient's inclusion in a research study. See Organizational Policy 110.00 Research Proposals-Institutional Review.

adequate information to participate or to refuse participation. Adequate information includes an explanation of the purpose of research, and expected duration of participation, expected benefits, potential discomforts, risks, alternative services and a full explanation of procedures to be followed. All information given to patients and all consent forms shall be maintained in the medical record or in an accessible research file. Documentation indicating that the patient is enrolled in a study protocol shall be made in the medical record. [See Organizational Policy 110.00 Human Subjects Research – Institutional Review][37]

ARTICLE V – PART B
Section 6. Authorization for Release of Medical Records

The Hospital ensures valid access to and security of medical records to protect the confidentiality of the patient's personal history and health care treatment. Confidentiality is protected according to legal, regulatory and ethical guidelines.

The patient/legal guardian must authorize the release of medical record information in accordance with Organizational Policy 1700.00 HIPAA: Uses and Disclosures of Protected Health Information. All authorization for release of information must be coordinated with Health Information Management, in order that such releases may be tracked in accordance with federal and state statutes. [See Organizational Policy 1106.00 Access to Medical Records][38]

ARTICLE V – PART B
Section 7. Other Specialized Consents

Patient/parent/legal guardian consent must be obtained for other purposes including but not limited to Allowing Natural Death: Do Not Resuscitate [Organizational Policy 116.00]; Death of a Patient : Reporting and Autopsy [Organizational Policy 1501.00]; Organ, Eye and Tissue Donation after Death by Neurologic Criteria (Brain Death) or after Circulatory Death [Organizational Policy 120.00]); and Photography, Video and Audio Recordings [Organizational Policy 1131.00.]. Specialized consent forms are available for these issues.

ARTICLE V
PART C. INFECTION PREVENTION AND CONTROL

Members and Individuals with Privileges are expected to comply with Hospital infection control precautions for all Patient Contacts.

Members or Individuals with Privileges with chronic transmissible infectious diseases identified as reportable by law to the Minnesota Department of Health must practice within guidelines developed by the Minnesota Department of Health, and in conjunction with infection control policies and related administrative policies of the Hospital.

ARTICLE V
PART D. SAFETY
Section 1. General

(a) Medical Devices: Members or Individuals with Privileges who become aware of any information suggesting that a medical device has or may have caused or contributed to the death, serious injury or illness of a patient, and/or medical personnel will remove the equipment from service immediately, notify risk management promptly and complete a safety report. [See Organizational Policy 900.00 Problems with Medical Devices and Products: Reporting, Alerts and Recalls]

[37] The Joint Commission – Hospital Accreditation Standards, RI.01.03.05
[38] CMS – Conditions of Participation §482.24(b)(3)

(b) Smoke Free: The Hospital Sites are smoke free facilities and are committed to provide a smoke free environment. Smoking is not permitted in the Hospital or Hospital site parking areas. [See Organizational Policy 902.00 Smoke-Free Workplace]

(c) **Code Red** is used for fire, flame, or visible smoke: In case of a fire the main hospital buildings of Hospital Sites are non-evacuation buildings; that is, they are divided into zones separated by fire doors and fire walls. In the event of a fire, Professional Staff should assist hospital employees to alert authorities, and follow the Rescue, Alert, Confine, Extinguish (RACE) responses. [See Organizational Policies 908.00 Fire Safety Plan, and 909.00 Shelter in Place, Relocation and Evacuation]

(d) **Code Pink** is used upon suspicion of a missing infant or child or upon suspicion of an infant or child abduction. An overhead page of Code Pink is announced. Listen for the description of the infant/child, be alert to all infants/children leaving the building, and immediately report infants/children that meet the description or any suspicious individuals to Security. [See Organizational Policy 911.00 Abduction/Missing Patient or Person (Code Pink)]

(e) **Code Orange** is an external or internal emergency involving mass casualties, influx of a large number of patients, or other disaster requiring the implementation of the Emergency Management Plan. Children's utilizes the Hospital Incident Command System (HICS) to respond to all disaster situations within the hospitals. The HICS system is designed to provide a clear reporting and authority structure so as to manage an emergency efficiently and effectively. Code Orange may require triage and treatment of victims to ensure continuity of existing patient care, cooperative participation in the event of a countywide disaster plan, and the necessary expansion of hospital activities. Code Orange may be activated at one of three Levels, depending upon the resources required. All Members and Individuals with Privileges on the premises available to provide services should report to the Emergency Department to assist with patient care when a Partial or Full Code Orange is announced. [See Organizational Policy 948.01 Code Orange]

(f) **Code Yellow** refers to security incidents, including bomb threats. Do not touch or move any suspicious objects. Report location and description to Children's Security. If a telephone call is received, DO NOT HANG UP, and keep the caller on the line as long as possible, try to obtain specific information about the bomb, such as the location, type of bomb, detonation time, etc. Listen carefully to any background noise that is heard. Write down the information you obtain and notify Children's security. Await further instructions from Children's security or administration. [See Organizational Policy 948.03 Security Emergency (Code Yellow)]

(g) **Code Green/Restraint Personnel Requested (RPR)** is used to provide immediate assistance for emergency situations in which immediate physical restraint is required (other than medical or fire). [See Organizational Policy 948.04 Code Green/RPR (Restraint Personnel Requested)]

ARTICLE V – PART D
Section 2. Medical Accidents, and Disclosure, Including Sentinel Events

A medical accident, sentinel event, or near miss event with the potential to cause harm to a patient in health care is a call for action and an opportunity for organizational learning. The Hospital attempts to identify and analyze all events related to patient safety and partners with parents and patients to improve patient safety. The Hospital also endorses a policy of full disclosure of medical accidents and sentinel events.

Members of the Professional Staff and/or Individuals with Privileges are required to attend the review of near miss medical accidents, or accidents (including Sentinel Events). The Chief Medical Officer or

designee must be notified in advance if attendance at the review is not possible. Failure to attend a review or repeated requests to be excused from reviews may result in a referral to the Credentials Committee.

For additional information and definitions, see Organizational Policy 703.00 Medical Accidents and Disclosure-Including Sentinel Events.

ARTICLE V – PART D
Section 3. Safety Reports and other Required Reporting

(a) Safety Reports: A Safety Learning Report should be completed and submitted to the office of patient safety by any Staff Member or Individual with Privileges who observes, discovers, or is directly involved in a medical accident, near miss medical accident, or identifies an accident waiting to happen. Reports should be made using the on-line safety reporting system. The safety report information is for quality improvement purposes, and is protected under Minnesota Statute 145.61 et seq. [See Organizational Policy 703.00 Patient safety and Adverse Health Events]

(b) Other Required Reporting: Any Member or Individual with Privileges who observes, discovers or is directly involved in any event listed below shall report the event through established channels, or may report the event to their division chief, Chief Medical Officer, or designee:

(1) Illegal, unacceptable or inappropriate conduct from employees, Physicians, patients or visitors. [See Hospital Service Standards, Expectations for Professional Staff Performance, and Organizational Policy 1054.00 Positive Environment / Appropriate Work Behavior / Harassment Prevention);
(2) Reasonable doubt that a patient is receiving quality care;
(3) Any response to a drug that is noxious, unexpected and unintended and that occurs at doses used in humans for prophylaxis, diagnosis or therapy should be reported immediately utilizing an adverse reaction form. [See Organizational Policy 300.00 Adverse Drug Reaction];
(4) Failure to act in accordance with established policy or procedure;
(5) Lack of response to emergency call; and,
(6) Lost, stolen, damaged or destroyed property (report to Security).

ARTICLE V
PART E. ORDERS
Section 1. General

Orders must be documented for all aspects of care provided to patients to document ongoing patient care, meet legal, accreditation, and regulatory requirements, adhere to professional standards, and support reimbursement.[39] Prescribers are authorized to issue patient care orders at the Hospital. Prescriber, for the purposes of patient care orders, includes resident Physicians, Fellows, and duly privileged Practitioners acting within the scope of their licensure, DEA registration, job description, and privileges. In the case of orders for outpatient care (retail prescriptions, ambulatory testing, etc.), prescriber also includes non-privileged Providers acting within their licensure.

All orders for treatment (including orders generated in accordance with approved protocols) should be documented legibly, dated, timed and authenticated on paper or in electronic format before being accepted.[40] Registered nurses may receive all patient care orders. Registered pharmacists may receive medication, intravenous solution, total parenteral nutrition, and lipid orders in addition to orders for nutritional supplements and other products dispensed by pharmacy. Registered pharmacists may also document orders on paper or in electronic format within the confines of Pharmacy & Therapeutics Committee approved protocols and can document orders on paper or in electronic format based on verbal

[39] Joint Commission – Hospital Accreditation Standards, PC.02.01.03
[40] CMS – Conditions of Participation §482.24(c)(1)(i)

order. Registered rehabilitation professionals can accept orders for rehabilitation. Respiratory care practitioners and pulmonary function technologists can document orders for respiratory therapy and any medication delivered via the respiratory route. Registered dieticians can receive nutrition orders. Psychologists and social workers can accept consultation and therapy orders. All orders following an approved protocol shall be authenticated by the Attending Practitioner as soon as possible and before permanent filing of the medical record. Orders written by medical students, externs, nurse practitioner students, or physician assistant students shall be immediately countersigned by a Physician, nurse practitioner or physician assistant with clinical privileges prior to being submitted for action. [See Organizational Policy 1104.00 Patient Care Orders]

ARTICLE V – PART E
Section 2. Orders: Verbal

In the interest of patient safety, verbal orders shall be limited to situations in which written or electronically submitted orders are not feasible, such as when scrubbed for a procedure, when giving telephone orders from an off-unit location, or during the acute management of a life-threatening emergency when the benefits outweigh the risks of a verbally communicated order. Orders from off-unit locations should be documented and faxed if possible, as an alternative to giving a verbal order. Verbal orders cannot be accepted for Do Not Resuscitate (DNR) order or orders to initiate chemotherapy, (however, a verbal order may be obtained to clarify an existing chemotherapy order.) All verbal orders are to be reduced immediately to writing in the patient record by the recipient, who shall read the order back to the ordering practitioner and receive verbal confirmation of accuracy. Verbal orders must be authenticated in a timely manner by a dated and timed signature.

ARTICLE V – PART E
Section 3. Orders: Admission

A Practitioner or oral and maxillofacial surgeon with admitting privileges must document an order for admission, or delegate the documentation of the order to a resident, Fellow, advanced practice registered nurse, or physician assistant. When delegated, the order must state the name of the Attending Practitioner or group to which the patient is being admitted. The status of admission, inpatient or short stay, should be specified.

ARTICLE V – PART E
Section 4. Orders: Blood

An approved blood product order form must be used when ordering all blood products. Documentation of informed consent for elective administration of blood products is required and is the responsibility of the Member or Individual with Privileges. Emergency blood transfusions may be administered without informed consent. [See Policy 366.00 Blood Product Administration]

ARTICLE V – PART E
Section 5. Orders: Lab and Radiology

(a) All laboratory and medical imaging procedures require a documented order and relevant supporting clinical information recorded in the patient's medical record. All radiology requests and requests for pathologic specimen interpretation shall contain the clinical indications for the examination.

(b) Orders for toxicology screen on a newborn must be documented if the Member or Individual with Privileges has reason to believe, based upon assessment of the mother or the infant, that the mother has used a controlled substance for a non-medical purpose. [See Organizational Policy 369.00 Newborn Toxicology Screening]

(c) As part of infection control measures and assessment of risk for health care-associated infection, Infection Control Practitioners may document protocol-based orders without the need for a

cosignature by a Member or Individual with Privileges for the following:

(1) Mantoux skin tests;
(2) Cultures of patients, family members, and healthcare workers for methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococcus (VRE), and other organisms as necessary.

(d) Nuclear medicine studies may be ordered by Practitioners and duly licensed Providers in accordance with Federal and State law[41].

ARTICLE V – PART E
Section 6. Orders to Forgo Life-Sustaining Treatment or Resuscitation/Allow Natural Death

Orders to forgo life-sustaining treatment, forgo resuscitation (Do Not Resuscitate or DNR) and/or allow natural death (AND) must be completed by the Attending Physician/Practitioner or nurse practitioner managing the patient's care with the consent of the patient or their legal guardians, in keeping with applicable state and federal laws. [See Organizational Policy 116.00 Allowing Natural Death: Do Not Resuscitate]

ARTICLE V – PART E
Section 7. Orders: Restraints

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time[42]. The Hospital is committed to reducing the use of violent, self-destructive restraints and promoting nonphysical interventions as preferred interventions. Care planning and treatment focuses on preventing and decreasing frequency of situations that have the potential to lead to the use of restraint. When restraints are the only option, the least restrictive form of restraint to protect the physical safety of the patient, staff or others is used in compliance with federal and state law. Restraints are not used as a means of coercion, discipline, convenience, staff retaliation, or in a manner that causes undue physical discomfort, harm, or pain to the patient. Discontinuation of restraint occurs as soon as clinically indicated, regardless of the scheduled expiration of the order[43].

The attending practitioner must be notified and consulted as soon as possible after application of a violent, self-destructive restraint, if he or she did not order the restraint. When an Attending Practitioner is not available, Organizational Policy 201.00 Chain of Command applies. Practitioner orders for medically necessary non-violent, non-self-destructive restraints shall expire after 24 hours or upon discontinuation of the restraint, whichever is earlier. Orders for medical necessary restraints shall be renewed in accordance with Organizational Policy 1104.00 Patient Care Orders. *PRN orders for restraints are never acceptable.* For current definition of the procedure for violent and non-violent medical/surgical restraints see Organizational Policy 359.00 Restraints. Additional information is available in Organizational Policy 350.00 Management of Patients with Acute Behavioral Health Problems and/or at Risk of Suicide. [44]

ARTICLE V - PART E
Section 8. Orders: Medications

(a) Medications shall include solid, liquid, or gaseous single or multiple ingredient agents intended

[41] CMS – Conditions of Participation §482.53(d)(4)
[42] CMS – Conditions of Participation §482.13(e)
[43] Organizational Policy 359.00 Restraints
[44] The Joint Commission – Hospital Accreditation Standards, PC.03.05.01-PC.03.05.19

for the treatment of patients, and include albumin, intravenous immunoglobulin (IVIG), and factor concentrates, but not other blood products.

(b) The ordering of medications by Members and other Individuals with Privileges must comply with organizational policies on medications [Policies 300 – 349] and 1104.00 Patient Care Orders, including the following requirements:

(1) All orders for medication must be dated, timed, and authenticated (signed).[45]

(2) To be accepted, all medication orders should include medication name, total dose (dose per kilogram or both total dose and dose per kilogram for certain drugs is recommended), route, frequency and specific information such as start date, time, number of doses or discontinued date and time.[46]

(3) All medications ordered for a patient must have a documented rationale for use in the medical record (i.e. indication, diagnosis, or patient condition). All PRN medications must include a documented rationale included in the drug order.[47]

(4) Medications prescribed must be Food and Drug Administration (FDA) approved for prescriptive use, allowed by the FDA for general public use (e.g., over the counter medications), or be used under an IRB-approved investigational use protocol or policy. Dietary supplements and herbal medicines may also be prescribed. The use of these products is addressed in the Pharmacy Department policy entitled, "Use of Complementary and Alternative Supplements."

(5) Existing medications are discontinued when a patient undergoes general anesthesia for major surgery in the operating room. Procedures that are excluded from this requirement are defined in Organizational Policy 1104.00 Patient Care Orders. Unless the procedure is excluded as stated above, new orders for all medications must be documented post-operatively and when a patient is transferred to or from the PICU or NICU. Blanket reinstatements of previous medications are not acceptable, such as "continue home meds" or "continue previous meds". [See Organizational Policies 1104.00 Patient Care Orders]

(6) Orders should not be documented as "dose per age" or "pharmacy to dose."

(7) Unsafe abbreviations identified by Children's as Do Not Use Abbreviations shall not be used.[48]

(8) Discharge medication orders and home care pharmacy orders must be documented using an approved outpatient prescriptive method, in addition to being documented in the inpatient medical record.

(9) Professional Staff Members with clinical privileges and Individuals with Privileges who are registered with the Drug Enforcement Administration in the State of Minnesota for any drug schedule must seek and maintain authorization for all of the following drug schedules: 2, 2N, 3, 3N, 4, and 5, except as limited by a Joint Prescribing Agreement (advanced practice registered nurses), or a Physician and Physician Assistant Delegation Agreement (physician assistants). With these exceptions, only those authorized in the State

[45] CMS – Conditions of Participation §482.23(c)(2)
[46] The Joint Commission –Hospital Accreditation Standards, MM.04.01.01; CMS – Conditions of Participation §482.23(c)
[47] The Joint Commission –Hospital Accreditation Standards, MM.04.01.01, EP 9; CMS – Conditions of Participation §482.23(c)

[48] The Joint Commission –Hospital Accreditation Standards, IM.02.02.01 – EP 3

of Minnesota by the DEA for all of these latter drug schedules may prescribe any scheduled drug to a Hospital patient.

ARTICLE V
PART F. MEDICATIONS
Section 1. Medication Reconciliation

Medication Reconciliation[49] is the process of comparing what medication the patient is taking at the time of admission, entry to a new setting or level of care, or discharge with what the patient was previously taking to avoid errors such as conflicts or unintentional omissions. [See Organizational Policy 336.00 Medication Reconciliation for process specifics]

ARTICLE V – PART F
Section 2. Sample Medications

The use of sample medications at Hospital Sites is discouraged. Any sample medications brought into the Hospital Site must be documented and their dispensing tracked. Samples are accepted and signed for by a Physician or Individual with Privileges and logged by the staff on the sample medications log. When dispensed, samples must be logged out by the staff and documented in the patient's medical record. [See Organizational Policy 303.00 Medication Samples]

ARTICLE V – PART F
Section 3. Home Medications

The use of home medications will be allowed only if the prescriber determines it is of significant importance in the care of the patient to receive the therapy, the drug product is not obtainable by the pharmacy department, and no alternative therapy can be prescribed. The prescriber shall document, "patient may take home medications" with the order and a pharmacist must verify that the contents of the container of medications are correct.
Specific exceptions when home medications are allowed are noted in Organizational Policy 308.00 Use of Home Medications. All home medications must be properly re-labeled and verified by a pharmacist for inpatient use. The patient cannot use medications from home that are not properly labeled or that the pharmacy cannot verify. [See Organizational Policy 308.00 Use of Home Medications][50]

For patients who come into the Hospital Sites on chronic therapy with an investigational drug the Member or Individual with Privileges may document an order to "use patient's own supply." In this case the Institutional Review Board does not need to review the protocol; however, an investigator's brochure, protocol, or other appropriate drug information materials must be made available for the pharmacy and health care professionals providing care for the patient. [See Organizational Policy 311.00 Investigational Drugs]

ARTICLE V – PART F
Section 4. Investigational/Experimental Drugs

All investigational and experimental drugs for patient use at Hospital Sites shall be registered with the Institutional Review Board (IRB), except in the case of patients who come into the Hospital Sites on chronic therapy with an investigational drug. Orders or prescriptions must be documented for the drug to be administered and must include directions for the total dose (dose per kilogram recommended), frequency, route, and specific information such as start date, time, number of doses or discontinued date and time.

[49] The Joint Commission – Hospital Accreditation Standards, NPSG.03.06.01
[50] The Joint Commission – Hospital Accreditation Standards, MM.03.01.05

Emergency single-patient use drugs are investigational or experimental drugs that are provided by a manufacturer for individual patients when there is no therapeutic alternative. Physicians or Individuals with Privileges should contact the IRB administrator before administering these types of medications. The Physician or Individual with Privileges seeking to use the investigational or experimental drug must call the drug manufacturer and provide the manufacturer with necessary patient-specific information required confirming the patient's protocol eligibility. [See Organizational Policy 311.00 Investigational Drugs]

If a Member or an Individual with Privileges is suspected to have engaged in scientific misconduct relative to the use of an investigational drug, Organizational Policy 1803.00 Responding to Allegations of Scientific Misconduct shall apply. Contact the department of Research and Sponsored Programs for information regarding this policy.

ARTICLE V – PART F
Section 5. Medication Management at the End of Life

When a patient is dying, and it is determined, in collaboration with the patient and/or family, that the most important goal of treatment is relief of pain and suffering, this must be noted in the medical record. In such situations, medication doses should be appropriate to relieve pain and suffering even if ordered in excess of medication doses typically used to treat acute pain or if a secondary effect of hastening death may occur. Use of medication with the primary intent of hastening death is not acceptable. Euthanasia is not acceptable. Medication use with the primary intent of relieving pain and suffering but with the potential secondary effect of hastening death may be acceptable when understood and agreed to by the patient and/or family. The ordering of these medications must comply with Organizational Policy 118.00 Pain and Suffering Management for the Dying Child.

ARTICLE V
PART G. LABORATORY AND PATHOLOGY SERVICES

A staff pathologist shall be available or on call at all times. All clinical laboratory procedures shall be monitored and reviewed, and upon request, interpreted by a staff pathologist. When a staff pathologist is consulted to interpret an outside diagnostic laboratory specimen, he/she shall do so if the outside diagnostic laboratory specimen is felt to be of sufficient diagnostic quality. When a patient has received an initial diagnosis based on laboratory or pathology material obtained at an institution other than Children's, such specimens shall be made available for review and be reviewed by a Children's staff pathologist before final diagnostic reports are issued for patient material subsequently obtained at Children's, except in urgent situations or when the outside specimen is not available in a timely manner.

All tissues and certain non-tissue devices and materials removed from patients shall be identified, reviewed, recorded and submitted to Pathology, except those exempted by the Pathology Department and approved from time to time by the chief pathologist in consultation with the Surgery Division Chief. The exceptions are available on the Professional Staff Portal under the title "Specimen Submission for Gross and Microscopic Examination to the Pathology Department."

ARTICLE V
PART H. RADIOLOGY & NUCLEAR MEDICINE SERVICES
A radiologist[51] who is a Physician Member of the Professional Staff qualified by education and experience in radiology must supervise ionizing radiology services[52].

The Professional Executive Committee periodically reviews and approves the qualifications of radiology staff who use equipment and administer procedures[53].

[51] CMS – Conditions of Participation §482.26(c)(1)
[52] Joint Commission –Hospital Accreditation Standards MS.06.01.03 – EP 9
[53] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 EP16.

A staff radiologist shall be available or on call at all times. All medical imaging procedures, including radiography, fluoroscopy, ultrasound, MRI, CT, interventional and others, shall be monitored or performed by a staff radiologist. Interpretation of all radiographic studies shall occur within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion),. Upon request by the referring physician, the radiologist will expedite a report for critical decision making in the care of a patient.[54]

Radiologists will review outside medical imaging examinations on Hospital patients when requested by the patient's healthcare Provider. The radiologist will provide a verbal or written interpretation or request that the examination be repeated depending upon the clinical question that needs to be answered and the quality of the images submitted.

In a situation in which radiographic examinations are interpreted in a preliminary manner by a radiologist or other Member, and the preliminary interpretation is intended to be used as a basis for clinical care before the final interpretation is available, the preliminary interpretation shall be documented in the medical record by the person making the interpretation. When a preliminary interpretation is made by a radiologist, this preliminary interpretation shall be documented in the Medical Record or included as part of the final interpretation documentation.

A Physician Member of the Professional Staff qualified by education and experience in nuclear medicine must direct nuclear medicine services.[55]

ARTICLE V
PART I. RESPIRATORY CARE SERVICES

A Physician Member of the Professional Staff qualified by education and experience in respiratory care must direct respiratory care services.[56]

ARTICLE V
PART J. PROGRESS NOTES: REQUIREMENTS

All patients must have a dated and timed progress note entered into the medical record by the Attending Practitioner or a Member representing the Attending Practitioner and completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). Residents and/or medical students involved in the case are also encouraged to document a progress note, but such notes may not substitute for that of the Attending Practitioner.

ARTICLE V
PART K. DISCHARGE
Section 1. Discharge Planning[57]

> Multidisciplinary discharge planning is provided for all inpatients and their families. Discharge planning begins upon admission with an assessment of discharge needs made by the registered nurse (RN). Discharge planning documentation may be performed by all disciplines. The team will include the child and family, Attending Practitioner, primary RN, care management and other members as needed. [See Organizational Policy 603.00 Discharge Planning]

ARTICLE V – PART K
Section 2. Final Diagnoses

[54] Joint Commission –Hospital Accreditation Standards, PC.01.02.15 – EP 2
[55] The Joint Commission –Hospital Accreditation Standards, LD.04.01.05 – EP 7; CMS – Conditions of Participation §482.53(a)(1)
[56] The Joint Commission –Hospital Accreditation Standards, LD.04.01.05 – EP 7; CMS – Conditions of Participation §482.57(a)(1)
[57] The Joint Commission – Hospital Accreditation Standards, PC.04.01.03

Final diagnoses shall be recorded in full for all patients without the use of symbols and abbreviations, and be dated and authenticated by the responsible Practitioner.[58]

ARTICLE V – PART K
Section 3. Discharge Order

Patients shall be discharged by written order of the Attending Practitioner or his/her designee.

ARTICLE V – PART K
Section 4. Information for Patient and Family at Discharge

For the purposes of guarding patient safety and minimizing the occurrence of preventable readmission to the hospital, it is considered a best practice at the time of discharge for the collaborating clinical team to prepare, provide to the patient and family, and verbally explain a written summary that contains the following:

(a) A list of the patient's current medical problems,
(b) A list of the current medications that includes for each medication the drug name, strength or concentration, dose, time and/or frequency of administration, route, and, for new prescriptions the name, address and phone number of the pharmacy to which the prescription was routed;
(c) A list of appointments with practitioner, date, and time. It is considered best practice that the patient or responsible family member personally schedule the appointment(s) with staff guidance as needed;
(d) A list of the anticipated problems of clinical importance that the patient and family member(s) may reasonably encounter, accompanied by a description of the steps that should be taken when each problem is identified, including the name and contact information of clinicians to be contacted;
(e) Contact information for the discharging Practitioner;
(f) Contact information for the primary care practitioner and key specialist consultants.

While the above is currently understood to be an aspirational best practice, by inclusion in this Section it shall not be construed to be the current community standard of care.

ARTICLE V – PART K
Section 5. Discharge Summary

A discharge summary shall be documented on all medical records of inpatient, observation, short stay, day surgery, emergency department, and other outpatient care, excluding those patients seen for nurse only care. [59]

Preparation of the discharge summary may be delegated by the Attending Practitioner to a Fellow, resident, extern, medical student, or physician assistant. Attending Practitioners may not delegate the preparation of discharge summaries to registered nurses (RN, including those given the title of "nurse clinician[60]") or certified registered nurses (RN,C). All summaries are the responsibility of Members of the Professional Staff. Whether delegated or non-delegated, the person who documents the discharge summary should authenticate, date, and time their entry and additionally for delegated discharge summaries, the Practitioner responsible for the patient during his/her hospital stay shall co-authenticate and date the discharge summary to verify its content[61]. The discharge summary must be finalized within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

[58] CMS – Conditions of Participation §482.24(c)(4)(viii); The Joint Commission – Hospital Accreditation Standards, RC.02.01.01
[59] CMS – Conditions of Participation §482.24(c)(4)(vii); The Joint Commission – Hospital Accreditation Standards, RC.02.04.01
[60] The use of the title "nurse clinician" does not imply any special authorization or expanded scope of practice beyond that of a "registered nurse."
[61] CMS – Conditions of Participation §482.24(c)(4)(vii)

Once authentication by the Attending Practitioner has been completed, no further authentication is required.

A concise discharge summary provides information to other caregivers and facilitates continuity of care. The discharge summary for inpatient care shall include the following:

(a) Reason for hospitalization[62];
(b) Procedures performed[63];
(c) Care, treatment and services provided[64];
(d) Outcome of the treatment, procedures, or surgery[65];
(e) Patient's condition and disposition at discharge[66];
(f) Principal and secondary final diagnoses[67];
(g) Provisions for follow-up care[68]
(h) Instructions provided to the patient and family[69], as appropriate;

All discharge summaries for non-inpatient care must include, at a minimum, the following[70]:
(a) The outcome of the treatment, procedures, or surgery;
(b) The disposition of the case; and
(c) The provisions for follow-up care.

A final progress note may serve as the discharge summary for non-inpatient care provided the minimum requirements stated above are included in the final progress note[71].
A discharge summary for a discharge within thirty (30) days prior to a readmission may be used as the H&P for that readmission provided that the discharge summary contains additional content that meets the minimum content requirements for an H&P[72], a copy is placed in the new admission medical record as the H&P, and an update to the H&P is appropriately documented.

ARTICLE VI: CONSULTATION AND REFERRAL

PART A. CONSULTATIONS

Section 1. Consultation Types

Practitioners may seek clinical information from a variety of sources in the course of patient care, treatment and services. The following definitions are intended to guide appropriate consultative interaction and guide documentation of such consultative interactions.

(a) **General Consultative Advice** is sought and delivered without disclosing patient identifiers. General Consultative Advice may be used in patient care as clinically appropriate. Names or other identifiers of the individuals giving General Consultative Advice should not be included in patient medical record documentation. While the provision of General Consultative Advice is not generally considered to establish a physician patient relationship, it is advisable for the consultant to document such conversations in a retrievable record, including a brief description of the clinical problem and the recommendations given.

[62] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[63] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[64] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[65] CMS – Conditions of Participation §482.24(c)(4)(vii)
[66] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[67] CMS – Conditions of Participation §482.24(c)(4)(viii)
[68] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[69] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3
[70] CMS – Conditions of Participation §482.24(c)(4)(vii)
[71] The Joint Commission – Hospital Accreditation Standards, RC.02.04.01 – EP3, Note 1
[72] See Rules & Regulations, Article IV, Part G.

(b) An **Indirect Consultation** is a consultation between two health care professionals via telephone, telemedicine, other device, or in-person about a specific patient. Such consultation may involve a discussion of medical history, physical findings and/or the results of testing for the purpose of determining or providing advice relevant to the diagnosis, treatment, or the next clinical course of action, but does not involve the consultant obtaining a medical history directly from the patient or family or performing a physical examination, either in-person or through a telemedicine link.

(1) All Indirect Consultations should include disclosure of at least two patient identifiers to the consultant,

(2) The consultant engaged in an Indirect Consultation is advised to document the interaction specific to the patient in a medical record, including patient identifiers (e.g. name, date of birth, medical record number, etc.), date and time the indirect consultation took place, the names of the parties involved in the conversation, a brief description of the clinical problem, and the recommendations given.

(3) If the health care professional receiving the Indirect Consultation intends to use any information derived from the discussion in the care of the patient, he/she should document his/her understanding of the recommendations made by the consultant in the patient's medical record including the name and specialty of the consultant. A copy of the portion of the medical record relevant to the Indirect Consultation, including record entries of the name of the consultant and the documentation of the consultant's recommendations should be transmitted to the consultant in a manner that will allow the consultant to review the record and either make clarifying entries into the record, or to request that the health care professional make such entries and transmit a copy of the new entry to the consultant.

(4) It is the reciprocal accountability of both the requestor and the consultant to determine if a Direct Consultation is medically indicated and to communicate this determination to the other party. If either the requestor or consultant makes such a determination, a Direct Consultation should be requested and accomplished in a clinically timely manner.

(c) **Direct Consultation** is consultation provided to another health care professional after the consultant has personally obtained a history from the patient or patient surrogate, performed a physical examination of the patient in-person or through telemedicine link, and reviewed pertinent results of testing prior to making recommendations for further patient care, treatment and services. All Direct Consultations should be documented in the medical record by the Practitioner performing the Direct Consultation. In situations in which continuing clinical involvement by a consultant in the care of a patient is anticipated, a Direct Consultation should be requested.

ARTICLE VI – PART A
Section 2. Requirements

A Member or Individual with Privileges shall obtain consultation from an appropriate specialist for medically indicated services that are not within the scope of the license and granted clinical privileges of the Member or Individual with Privileges, when additional evaluation by a consultant is warranted by the prevailing standard of care, or when additional evaluation by a consultant is deemed to be medically necessary to deliver appropriate care, treatment and/or services to the patient. Consultation may also be obtained for the purpose of confirming the appropriate approach to a patient care problem. The Attending Member is primarily responsible for requesting consultation when indicated and for communicating the reason(s) for the consultation to a qualified Consulting Member. All requests for Direct Consultation must be documented in the medical record. [73]

[73] The Joint Commission – Hospital Accreditation Standards, MS.03.01.03 – EP 4

The Consulting Member, the Member designee on call, or Individual with Privileges shall accomplish a Direct Consultation, including documentation in the medical record, as soon as clinically indicated and completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).. A consultant requested to perform a Direct Consultation may request that the patient and family be advised to wait for the consultant to arrive to perform a Direct Consultation, provided the consultant communicates a reasonable estimated time of arrival. When operative procedures are involved, the consultation notes shall, except in emergency situations, be recorded prior to the operation.

ARTICLE VI – PART A
Section 3. Records of Direct Consultation

Documented reports of a Direct Consultation shall include:

(a) Name of the person requesting the consultation;
(b) Reason for the consultation;
(c) Pertinent history;
(d) Pertinent physical findings;
(e) Pertinent finding for the diagnostic tests;
(f) Consultants opinion;
(g) Recommendations.

All Direct Consultation reports shall be authenticated by the Member or Individual with Privileges performing the Direct Consultation.[74] Consultants are encouraged to communicate their recommendations directly to the Attending Practitioner as soon as possible after an initial consultation, or at any time that major new recommendations are made. Through discussion with the Attending Practitioner, consultants are also encouraged to clarify the level of involvement the consultant will have in the continuing care of the patient, including what types of orders will be documented by the consultant.

Consultation progress notes subsequent to a Direct Consultation shall be recorded at the time of observation, documenting the course and results of care within the scope of the consultation sufficient to permit continuity of care and informed transfer of care, and shall be completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

ARTICLE VI
PART B. EMERGENCY CONSULTATION: ON-CALL RESPONSIBILITIES

Except as otherwise provided by contract between the Hospital and the Practitioner (or by a Hospital contract applicable to the Practitioner), all Practitioners, or an appropriately privileged Practitioner designee, shall provide both inpatient and outpatient emergency consultation when requested. All such relevant contract provisions shall have been duly reviewed by and approved by the affirmative vote of the Professional Executive Council. Notwithstanding the foregoing, all Practitioners have an obligation to provide for the continuous care of a patient[75].

If deemed necessary by the Medical Director(s) of Emergency Services, Members who have at least ten (10) Patient Contacts per year within the Hospital Sites shall be subject to a mandatory emergency department call schedule at each Hospital Site in which that Member has at least one (1) patient contact per year, except as otherwise provided by Hospital contract (see paragraph above). However, for those Members practicing at more than one site, mandatory call for Direct Consultation will be required at only one Hospital Site. When on call for Direct Consultation for any Children's Hospital Site, the Member shall verbally respond as soon as possible, but at least within twenty (20) minutes to a request, and use best efforts to remain close enough to arrive at the Hospital for an emergency Direct Consultation within thirty (30) minutes and for other urgent Direct Consultations within ninety (90) minutes after the verbal response. Response to call may be monitored and considered in the credentialing process.

[74] CMS – Conditions of Participation §482.24(b)
[75] See Rules & Regulations, Article V, Part A, Section 1 Responsibility for Continuous Care

The Medical Directors of Emergency Services are authorized to develop subspecialty emergency call rotations as needed to meet the need for timely and appropriate care of patients with emergency medical conditions. The Medical Directors of Emergency Services, in consultation with the Credentials Office, and Health Information Management will determine which Members fulfill criteria to be included in the subspecialty emergency call rotations. The Medical Directors of Emergency Services, in consultation with the subspecialists, will be responsible for developing and distributing the Subspecialty Emergency Call Schedule to the Members affected by the call schedule. [76]

ARTICLE VI
PART C. MENTAL HEALTH
Section 1. Mental Health Referrals for Risk of Suicide Management and other Behavior Problems

Following the medical screening examination to rule out an emergency medical condition, patients hospitalized at Hospital Sites for a primary medical diagnosis who attempt, threaten, or appear to be at risk for suicide should have a prompt mental health assessment. [See Organizational Policy 350.00 Management of Patients with Acute Behavioral Health Problems and/or at Risk of Suicide][77]

ARTICLE VI – PART C
Section 2. Suspected Child Abuse and/or Neglect

It is the responsibility of the Hospital, all Members, and all Individuals with Privileges to report child abuse and/or neglect as mandated by law. In cases where there is reason to believe there is child abuse, Midwest Children's Resource Center (MCRC) conducts evaluations and provides case management. For suspected child neglect, Social Work conducts evaluations and provides case management. [See Organizational Policy 355.00 Management of Suspected Child Abuse/Neglect (SCAN)][78]

ARTICLE VI – PART C
Section 3. Suspected Domestic Abuse

The Hospital and Professional Staff will attempt to identify patients/families in which domestic abuse is a problem and offer support, counseling, and referral. If a Member, Individual with Privileges, or other Hospital staff member suspects that a patient or family member is either a victim of domestic abuse or may be affected by domestic abuse in their home, a referral shall be made to social work. [See Organizational Policy 368.00 Domestic Abuse]

ARTICLE VII: SURGERY AND OTHER INVASIVE PROCEDURES

PART A. GENERAL

Pre-Procedural History and Physical examination requirements are contained in Article IV Part G.

The surgeon or proceduralist is responsible to ensure that the provisional diagnosis is recorded in the medical record before the operative or other high-risk procedure. [79]

If a patient on the surgery service has an unusual course or a complicated/ prolonged hospital stay, the surgeon is responsible for keeping the Primary Care Provider informed of the patient's status, and/or directly involved in the patient's care.

If a surgical patient has a medical/non-surgical problem, and the patient's Primary Care Provider is not a

[76] The Joint Commission – Hospital Accreditation Standards, MS.03.01.03 – EP 12
[77] The Joint Commission – Hospital Accreditation Standards, PC.01.02.13 – EP 1-2
[78] The Joint Commission – Hospital Accreditation Standards, PC.01.02.09
[79] The Joint Commission – Hospital Accreditation Standards, RC.02.01.03 – EP 2

Member of the Professional Staff, then the Admitting surgeon will request appropriate consultation from a Primary Care/Hospitalist Physician who is a Member.

ARTICLE VII
PART B: PRE-OPERATIVE TESTING

There are no routine requirements for preoperative laboratory or radiographic testing for inpatients or outpatients, except as indicated by the condition of the patient, the procedure to be performed, or as established in specific Hospital or departmental policy (e.g. pregnancy testing). Pregnancy testing requirements are stated below.

Regardless of location or registration status, pregnancy testing is required for all patients with a uterus who are ten (10) years old or older, are younger than 10 years old but have begun menstruation OR state they are sexually active or may be pregnant prior to the onset of general anesthesia, procedural sedation, MRI contrast, teratogenic drugs, and chemotherapy. [See Organizational Policy 385.00 Pregnancy Testing: Pre-Operative-Procedural][80]

ARTICLE VII
PART C. UNIVERSAL PROTOCOL: PRE-PROCEDURE VERIFICATION, SITE MARKING AND TIME OUT

The Universal Protocol applies to all operative and other invasive procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room. The Organizational Policy 387.00 Universal Protocol outlines the requirements for pre-procedure verification process, site marking, and time outs. If The Joint Commission or other regulatory updates are received reflecting changes in the Universal Protocol, the most stringent will apply.

(a) Pre-procedure verification process:
This is done to ensure that surgery and other invasive procedures are performed on the correct patient and on the correct site and side, if applicable, by instituting a consistent standardized verification process outlined in the Universal Protocol and its implementation guidelines. [See Organization Policy 387.00 Universal Protocol][81]

(b) Site Marking:
Site marking is used to verify the correct side and site. The site shall be marked before the procedure and, if possible, with the patient, parent, and/or guardian involved. [See Organization Policy 387.00 Universal Protocol for the detailed site marking protocols and exemptions][82]

(c) Time out:
(1) All invasive procedures will have a "time out" before the procedure begins, and in the location where the invasive procedure will be performed. All team members must agree at a minimum on the following:[83]

a. Correct patient identity [See Organization Policy 376.00 Patient Identification Bands, Allergy and Latex Alerts];
b. Correct site;
c. Site marking completed and visible, if applicable;
d. Procedure to be done.

(2) This confirmation is mandatory and shall involve active verbal communication among the immediate members of the procedure team including the proceduralist(s), anesthesia

[80] The Joint Commission – Hospital Accreditation Standards, MM.01.01.01 – EP 1
[81] The Joint Commission – Hospital Accreditation Standards, UP.01.01.01
[82] The Joint Commission – Hospital Accreditation Standards, UP.01.02.01
[83] The Joint Commission – Hospital Accreditation Standards, UP.01.03.01 – EP 4

providers(s), circulating nurse, scrub technician, and other active participants as appropriate to the procedure. Note: Invasive procedures performed outside of the OR may have unique procedure team members. [See Organization Policy 387.00 Universal Protocol][84]

(3) The surgeon or the Practitioner performing the procedure or sedation begins the time out by:

a. Calling for the time out,
b. Stating that patient's name,
c. Stating the procedure and the side/site location, and
d. Verifying the visible site marking, if applicable.

(4) A designated staff member, other than the Practitioner performing the procedure, reads out loud from the consent form (or other form in the medical record) the following:
a. The patient's name,
b. Date of birth,
c. Procedure and the side/site location, then verifies the site marking.

(5) The Practitioner performing the procedure and ALL PERSONS in the room verify the patient identity, procedure, and side/site.

(6) The procedure is not started until all questions or concerns are resolved.

ARTICLE VII
PART D. OPERATIVE AND OTHER HIGH-RISK PROCEDURE REPORTS AND PROGRESS NOTES
Section 1. Operative or Other High Risk Procedure Report

(a) A full operative or high risk procedure report shall be dictated or documented electronically upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.[85] The report shall be completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

(b) If the Practitioner performing the operation or other high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report may be dictated or documented electronically in the new unit or area of care.[86] The report shall be completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

(c) In the case that an operative or high-risk procedure progress note is documented immediately after the procedure, the full operative or high-risk procedure report may be documented or dictated and completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). The operative or high-risk procedure progress note itself shall be completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

(d) The full operative or other high-risk procedure report must be signed by the Attending surgeon. The signature must be dated and timed. If the report is dictated or otherwise prepared by another "responsible surgeon," the Attending surgeon must co-sign the report. The Hospital and its Professional Staff interprets "responsible surgeon" to include the Attending surgeon, assistant surgeon, Practitioner performing or assisting with a procedure, Fellow, or Resident present

[84] The Joint Commission – Hospital Accreditation Standards, UP.01.03.01 – EP 2
[85] The Joint Commission –Hospital Accreditation Standards, RC.02.01.03 – EP 5; CMS – Conditions of Participation §482.51(b)(6).
[86] The Joint Commission –Hospital Accreditation Standards, RC.02.01.03 – EP 5, Note 2

during the entire procedure.[87]

(e) The full operative or high-risk procedure report shall include[88]:

(1) Date of the procedure;
(2) Patient's name and medical record number;
(3) The name of the Practitioner(s) who performed the procedure and his or her assistant(s), and other persons performing surgical tasks (even when performing those tasks under supervision);
(4) Surgeons or Practitioners name(s) and a description of the specific significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
(5) Pre-operative and post-operative diagnosis;
(6) The name of the specific procedure(s) performed;
(7) Type of anesthesia administered;
(8) Description of the techniques and findings for each procedure;
(9) Any estimated blood loss;
(10) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any;
(11) Description of tissues or specimens removed or altered, if any;
(12) Complications, if any;
(13) Signature of the responsible surgeon with the date and time the operative report is completed; and
(14) Countersignature of the Attending surgeon, if applicable.

[See also Organization Policy 1103.00 Medical Record Documentation]

ARTICLE VII – PART D
Section 2. Operative or Other High-Risk Procedure Progress Note

(a) When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note (IPON) must be entered in the medical record by the responsible surgeon[89] and completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). The Hospital and its Professional Staff interprets "responsible surgeon" to include the Attending surgeon, assistant surgeon, Practitioner performing or assisting with a procedure, Fellow, or Resident present during the entire procedure. Operative or other high-risk procedure progress note (IPON) is required even when the operative report is **dictated** immediately after the procedure, as dictated reports do not appear immediately in the medical record.

(b) The operative or other high-risk procedure **progress note** (IPON) shall include the following elements[90]:

(1) Patient's name and medical record number;
(2) Date and time progress note is written;
(3) Name of the primary surgeon and assistant(s);
(4) Preoperative/procedural and postoperative/procedural diagnoses;
(5) Name of the specific procedure(s) performed;
(6) A description of each procedural finding and complications, if any;
(7) Estimated blood loss;

[87] CMS – Conditions of Participation §482.51(b)(6) and its Interpretive Guidelines
[88] The Joint Commission –Hospital Accreditation Standards RC.02.01.03 – EP 6; CMS – Conditions of Participation §482.51(b)(6) and its Interpretive Guidelines
[89] CMS – Conditions of Participation §482.51(b)(6) and its Interpretive Guidelines.
[90] The Joint Commission –Hospital Accreditation Standards RC.02.01.03 – EP 7

(8) Specimens/Tissue removed; and
(9) Signature of the responsible surgeon.

ARTICLE VIII: ANESTHESIA AND SEDATION

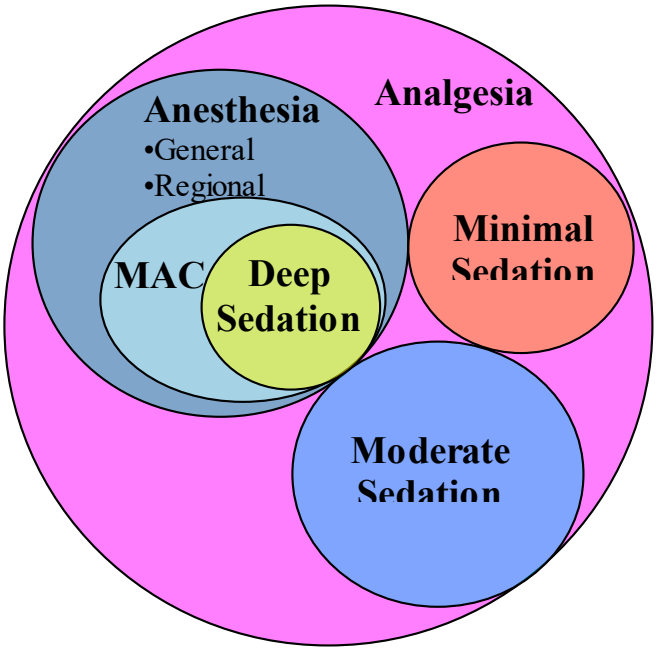
PART A. OVERSIGHT OF ANESTHESIA SERVICES (including Sedation & Analgesia)

All services along the continuum of anesthesia services provided throughout the Hospital (including all departments in all campuses and off-site locations when anesthesia services are provided) shall be organized under a single anesthesia service, which is directed by a qualified Physician and consistently implemented in every Hospital department and setting that provides any type of anesthesia services[91]. The oversight of all services along the continuum of anesthesia services at the Hospital is under the direction of a Physician Member of the Professional Staff qualified by education and experience in anesthesiology[92].Anesthesia services is accountable to the Surgery Division with recommendations forwarded to the Professional Executive Council and other committees and decision making bodies as needed.A Physician Member of the Professional Staff qualified by education and experience in moderate and deep sedation may be responsible for the operations of the sedation services, but shall be accountable to the Surgery Division with recommendations forwarded to the Professional Executive Council and other committees and decision making bodied as needed.

A Physician Member of the Professional Staff qualified by education and experience in the management of pain may be responsible for the operations of the pain (analgesia) services, reporting to the Professional Executive Council and other committees and decision making bodies as needed.

ARTICLE VIII
PART B. ANESTHESIA SERVICES - SCOPE

Anesthesia services, which include anesthesia, sedation, and analgesia, are provided along a continuum, ranging from the application of local anesthetics for minor procedures to general anesthesia for patients who require loss of consciousness as well as control of vital body functions in order to tolerate invasive operative procedures[93]. This continuum includes anesthesia core services (including general anesthesia, regional anesthesia, monitored anesthesia care (MAC) which includes deep sedation[94] by anesthesia practitioners, and the analgesia provided by anesthesia), sedation services (including minimal sedation, nitrous oxide sedation, moderate sedation, deep sedation by non-anesthesia Practitioners, and the analgesia provided by sedation), and pain services (including all other non-anesthesia, non-sedation analgesia).



[91] CMS – Revised Hospital Anesthesia Services Interpretive Guidelines – State Operations Manual (SOM) Appendix A (5-21-2010).
[92] The Joint Commission –Hospital Accreditation Standards, LD.04.01.05 – EP 7, 9
[93] CMS – Revised Hospital Anesthesia Services Interpretive Guidelines – State Operations Manual (SOM) Appendix A (5-21-2010).
[94] CMS – Revised Hospital Anesthesia Services Interpretive Guidelines – State Operations Manual (SOM) Appendix A (5-21-2010): A-1000, §482.52 Anesthesia Services, Monitored anesthesia care (MAC).

ARTICLE VIII
PART C. ORDERING AND ADMINISTRATION OF ANESTHESIA (including Sedation and Analgesia)

1. The ordering and administration of minimal sedation, moderate sedation, and deep sedation shall be accomplished in accordance with Organizational Policy 351.00 Sedation during Diagnostic and Therapeutic Procedures.

2. Any Practitioner may order or administer topical anesthetics, local anesthetics, and minimal sedation.

3. Any Practitioner may order nitrous oxide sedation. Nitrous oxide sedation may be administered only by authorized, appropriately trained staff within the scope of applicable licensure under the general oversight of a Practitioner with privileges in nitrous oxide sedation.

4. Moderate sedation may be administered only by a Practitioner with privileges in moderate sedation, or by authorized, appropriately trained staff within the scope of applicable licensure when a Practitioner with moderate sedation privileges is physically present while the sedation is administered.

5. General Anesthesia, regional anesthesia and monitored anesthesia care (MAC – including deep sedation) may only be administered by[95]:

   (a) A qualified anesthesiologist granted such privileges by the Board

   (b) A Physician (other than an anesthesiologist), if granted such privileges by the Board;

   (c) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law, if granted such privileges by the Board;

   (d) A certified registered nurse anesthetist (CRNA) who has been granted such privileges by the Board[96];

   (e) A supervised trainee in an approved educational program;

   (f) Deep sedation may be administered by authorized, appropriately trained staff within the scope of applicable licensure when a Practitioner with deep sedation privileges is immediately available in the same area where the sedation is administered.

ARTICLE VIII
PART D. PRE-PROCEDURE RESPONSIBILITIES

1. The following must occur before operative or other high-risk procedures are initiated, or before general anesthesia, regional anesthesia, monitored anesthesia care (MAC – including deep sedation), or moderate sedation is administered[97]:

   (a) A pre-sedation or pre-anesthesia patient assessment shall be conducted;

   (b) The anticipated needs of the patient are assessed in order to plan for the post-procedure care;

[95] The Joint Commission – Hospital Accreditation Standards, PC.03.01.01, EP 10
[96] Minnesota is an "opt-out" State and, as such, supervision of a CRNA by the operating practitioner or by an anesthesiologist who is immediately available is not required by MN State law, but may be required by granted privileges.
[97] The Joint Commission – Hospital Accreditation Standards, PC.03.01.03

(c) The pre-procedural treatment, services, and education are provided according to the plan for care;

(d) Before administering moderate or deep sedation or anesthesia, a Practitioner with appropriate clinical privileges plans or concurs with the plan for sedation or anesthesia;

(e) The patient is reevaluated immediately before the administration of moderate or deep sedation or anesthesia;

2. For general anesthesia, regional anesthesia, monitored anesthesia care (MAC – including deep sedation), a pre-anesthesia evaluation shall be completed and documented by a Practitioner qualified and granted current privileges to administer anesthesia/deep sedation and completed within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). The pre-anesthesia evaluation shall contain, at a minimum, the following elements:[98]

(a) Review of the medical history, including anesthesia, drug and allergy history;

(b) Interview and examination of the patient;

(c) Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk);

(d) Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access;

(e) Additional pre-anesthesia evaluation, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation); and,

(f) Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia.

ARTICLE VIII
PART E. INTRA-PROCEDURE RESPONSIBILITIES

1. During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient's oxygenation, ventilation, and circulation are monitored continuously[99].

2. An intraoperative anesthesia/sedation record must be documented for each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care (MAC – including deep sedation), which, at a minimum, shall include[100]:

(a) Patient's name and medical record number;

(b) Name of Practitioner who administered anesthesia/deep sedation, and as applicable, the name and profession of the supervising anesthesiologist, sedating Practitioner or operating Practitioner;

[98] CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010): §482.52(b) (1) Interpretive Guidelines
[99] The Joint Commission – Hospital Accreditation Manual, PC.03.01.05
[100] CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010): §482.52(b) (2) Interpretive Guidelines

(c) Name, dosage, route and time of administration of drugs and anesthesia agents;

(d) Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

(e) Name and amounts of intravenous fluids, including blood or blood products if applicable;

(f) Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and,

(g) Any complications, adverse reactions, or problems occurring during anesthesia/deep sedation, including time and description of symptoms, vital signs, treatments rendered, and the patient's response to treatment.

ARTICLE VIII
PART F. POST-PROCEDURE RESPONSIBILITIES[101]

1. The patient is assessed immediately after the operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia;

2. The patient's physiological status, mental status, and pain level are monitored at a frequency and intensity consistent with the potential effect of the operative or other high-risk procedure and/or sedation or anesthesia administered.

3. A qualified Practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified Practitioner, patients are discharged according to criteria approved by clinical leaders, with documentation of the name of the Practitioner responsible for discharge[102]; For general anesthesia, regional anesthesia, monitored anesthesia care (MAC – including deep sedation), a post-anesthesia evaluation shall be completed and completely documented by a Practitioner qualified and granted current privileges to administer anesthesia/deep sedation within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion).

4. For those patients who are unable to participate in the postanesthesia evaluation (e.g. post-operative sedation, mechanical ventilation, etc.), a postanesthesia evaluation should be completed and completely documented within the stated timeframe for completion, as outlined in Article XI Part D (Medical Record Completion). For outpatients, the post-anesthesia evaluation must be completed within the stated timeframe for completion as outlined in Article XI Part D. Medical Record Completion.
5.

6. The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including: [103]

   (a) Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
   (b) Cardiovascular function, including pulse rate and blood pressure;
   (c) Mental status;
   (d) Temperature;
   (e) Pain;
   (f) Nausea and vomiting;
   (g) Post-operative hydration; and

[101] The Joint Commission – Hospital Accreditation Manual, PC.03.01.07 & RC.02.01.03
[102] The Joint Commission – Hospital Accreditation Manual, RC.02.01.03, EP 11
[103] CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010): §482.52(b) (3) Interpretive Guidelines

(h) Additional types of monitoring and assessment appropriate to the specific procedure performed, as necessary.

ARTICLE IX: INTENSIVE CARE UNITS

PART A. DIRECTORS

The neonatal intensive care unit (NICU),pediatric intensive care unit (PICU) and cardiovascular intensive care unit (CVICU) shall have Physician directors who are responsible for coordinating the efforts of the health care team and are responsible to the Professional Staff and Hospital Executive Leadership. The medical director of the NICU shall be Board Certified in neonatology. The medical director of the PICU shall be Board Certified in pediatric critical care medicine. The medical director of the CVICU shall be Board Certified in pediatric critical care medicine or Board Certified in pediatric cardiology and having completed a fellowship in pediatric cardiac intensive care.

ARTICLE IX.
PART B. ATTENDING COVERAGE

An Attending neonatologist (or third-year neonatology Fellow under the general supervision of an Attending neonatologist) or intensivist (or third-year critical care Fellow under the general supervision of an Attending intensivist) accountable for each critical care unit shall be available in-house at all times. For the purpose of this requirement, "in-house" shall include an adjacent adult hospital.

ARTICLE IX
PART C. TRANSFERS OF PATIENTS FROM INTENSIVE CARE UNITS (NICU AND PICU)

When NICU and PICU patients are transferred to the medical/surgical units, the staff neonatologist or intensivist shall identify and communicate appropriate clinical information to the newly designated Attending Physician and shall continue to be responsible for the patient's care until the newly designated Attending Physician accepts the responsibility verbally or documents it in the record.

When a patient is transferred from the NICU, PICU or ICC generally all orders are discontinued. [See Organizational Policy 1104.00 Patient Care Orders]

ARTICLE X: DEATH OF PATIENTS

PART A. ALLOWING NATURAL DEATH: DO NOT RESUSCITATE & FORGOING LIFE-SUSTAINING TREATMENT

The Hospital recognizes choices of patients or their parents/legal guardians to determine their overall course of treatment including the right to forego life-sustaining treatment in situations in which the burdens of continued treatment outweigh the benefits. Ethics consultation is available to patients, families, employees and Physicians. [See Organizational Policy 116.00 Allowing Natural Death: Do Not Resuscitate; see Orders in Article V Part E Section 6 of this document]

ARTICLE X
PART B. DEATH AND NOTIFICATION OF MEDICAL EXAMINER

In the event of a death at a Hospital Site, the deceased shall be pronounced dead by the Attending Physician or his/her physician designee and an entry stating the circumstances leading up to the death, including cause of death, should be made, dated, timed and authenticated in the medical record. Policies with respect to release of the body and notification of the medical examiner shall conform to current applicable law. [See Organizational Policy 398.00 End of Life/Death of a Patient: Care and Support]

ARTICLE X
PART C. AUTOPSY

A postmortem examination must be offered to families of all perinatal and pediatric deaths, regardless of age or underlying disease.

It is the responsibility of the Attending Practitioner (or designee) to offer a postmortem examination to all families and obtain and document their permission or denial [See Organizational Policy 1501.00 Death of a Patient: Reporting and Autopsy]. The responsible Practitioner or designee will identify and report deaths that fall under the jurisdiction of the state medical examiner, who may legally mandate an autopsy without family permission. [See Organizational Policy 398.00 Death of a Patient: Reporting, Care and Support]

An autopsy may only be performed with a proper consent. The request for an autopsy or the refusal of an autopsy must be documented in the medical record.

Available records shall be reviewed and/or clinical information discussed with the Attending Practitioner before conducting the autopsy.

The Attending Practitioner or on call designee, shall be notified of the date and time an autopsy is scheduled to be performed.[104]

Staff pathologists qualified in anatomic pathology shall perform or review and give final approval of the final published reports, including the final anatomic diagnosis, on all autopsies, except in cases falling under state regulations.

A documented preliminary report of the gross pathologic diagnosis(es) and the final autopsy report shall be completed in accordance with Hospital policy or The College of American Pathologists (CAP) guidelines, whichever is most strict. [See Organization Policy 1501.00 Death of a Patient: Reporting and Autopsy and the latest published CAP Anatomic Pathology Checklist available on-line at the CAP website, www.CAP.org].

ARTICLE X
PART D. ORGAN AND/OR TISSUE DONATION

All patients experiencing death or eminent death by either cardiopulmonary or brain death criteria are considered potential organ, eye and/or tissue donors and must be referred to an organ procurement organization for assessment [113]. The organ procurement agency will evaluate all potential donors for eligibility for donation of organs and tissue procurement. If donor criteria are met, the patient/family will be approached by the organ procurement organization staff to provide information about the option to donate or not to donate organs or tissue. The choice to donate organs or tissue is entirely voluntary and solely the choice of the patient or their guardian. The discussion of the request for organ donation must be documented in the medical record. [See Organizational Policy 120.00 Organ. Eye and Tissue Donation after Death by Neurologic Criteria (Brain Death) or Circulatory Death]

ARTICLE XI: MEDICAL RECORDS

A medical record is initiated and maintained for every individual assessed or treated at the Hospital Sites. The medical record for any individual consists of both the paper record and any documentation in the individual's electronic medical record. Every assessment, evaluation, treatment, plan of care, and interaction must be documented in the medical record. Every patient encounter will be documented in an objective, comprehensive, and factual manner in the medical record to provide information for evaluating the adequacy and appropriateness of care, communication among patient care team members, clinical data for research and

[104] The Joint Commission – Hospital Accreditation Manual, MS.05.01.01 – EP 9; CMS – Conditions of Participation §482.22(d)

education, adequate data to substantiate reimbursement, and a legal business record for the organization.

ARTICLE XI
PART A. CONTENT OF THE MEDICAL RECORD

Requirements for Medical Record Documents are defined in Organizational Policy 1103.00 Medical Record Documentation. Additional documentation requirements for a given topic may be found in other sources such as another organization policy, departmental policy or clinical standard.

ARTICLE XI
PART B. AUTHENTICATION[105]

All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. Each author must take a specific action to verify that the entry being authenticated is his/her entry or that he/she is responsible for the entry, and that the entry is accurate. Authentication may include signatures, written initials or computer entry that positively identifies the author of the authentication. Authentication of a medical record entry may only be performed by the person identified. When authenticating an entry with an electronic signature, the individual must be the sole user of his/her computer code / password / signature. It is recommended that identification of the author be accomplished by including last name, first name, middle initial, degree, and telephone or pager number.

The Hospital discourages the use of rubber stamps for authentication in the medical record. All use of rubber stamps must be approved in advance by the Health Information Management Committee. When a rubber stamp is approved for authentication, the stamp may be used only by the individual whose signature it represents. There shall be no delegation of stamps to another individual.

Co-signatures (co-authentications) are required in the following situations:

(a) All student orders and notes must be cosigned by the appropriate supervisor(s) before the order or document is used to direct clinical care. Resident and Fellow Physicians may perform this function for medical students, unless the type of entry requires co-signature by a Physician Member.

(b) Patients admitted to inpatient units may only be admitted to the service of a Member of the Professional Staff with admitting privileges. If the admission order is entered by an individual without admitting privileges, no co-signature of the order for admission is required, but a Member of the Professional Staff with admitting privileges must have knowledge of and assume responsibility for the admission.

(c) Admission H&Ps, or the H&P Update if the H&P was done prior to admission, must be authenticated by a Practitioner with privileges to perform H&Ps.

(d) Orders and medical record documents created by Fellows do not require co-signature, except for operative reports, unless the Fellow is also a Member of the Professional Staff with privileges to perform the function.

(e) All verbal orders must be authenticated by a resident, Fellow, Member or Individual with Privileges, preferably, but not necessarily, by the individual who issued the verbal order[106].

[105] CMS – Conditions of Participation §482.24(c)
[106] The Joint Commission – Hospital Accreditation Manual, RC.02.03.07, EP 4, Note 2, and the related CMS CoP state that the temporary period will expire on January 26, 2012 in which it is acceptable for another Practitioner who is responsible for the patient's care to authenticate the verbal order of the ordering Practitioner. Thus, unless this temporary period is extended, as of January 26, 2012 all verbal orders must be authenticated by the ordering Practitioner.

(f) According to Hospital policy, other orders for high-risk patient care, treatment or services may also require more than one signature.

[See Organizational Policy 1104.00 Patient Care Orders]

ARTICLE XI
PART C. SYMBOLS AND ABBREVIATIONS

The use of abbreviations should be avoided in clinical documentation. In an effort to improve patient care and promote safety, Children's Hospitals and Clinics of Minnesota has adopted an unacceptable / Do Not Use list of abbreviations and numerical representations that are not allowed in any medical record documentation. Orders containing any unacceptable abbreviations and numerical representations will be considered invalid until the order is re-written. All other use of abbreviations should be limited and used in the appropriate context of the body system being referenced in the documentation. Procedure descriptions shall be recorded in full without use of symbols and abbreviations. [See Organizational Policy 1103.00 Medical Record Documentation]

ARTICLE XI
PART D. MEDICAL RECORD COMPLETION

Reasonable effort should be made to complete each patient's medical record on the date of service. When this is not possible, such as when final laboratory or other essential reports have not been received, the patient's medical record shall be available electronically or on paper for purposes of completing the record.

Completion of medical records is supported by Health Information Management, under the oversight of the Professional Staff. Health Information Management will periodically notify the Practitioner of medical record deficiencies. If a medical record remains incomplete more than thirty (30) days beyond the documentation standard, suspension of clinical privileges and deemed voluntary resignation from the professional staff for failure to complete medical records may apply (see Bylaws Article VIII Part D (t)); Policy on Appointment, Reappointment and Clinical Privileges V Part C).

Children's Hospitals and Clinics of Minnesota sets the following timeframes for document completion in the medical record. These Rules and Regulations are intended to comply with all relevant laws, regulations and accreditation standards. If changes in laws, regulations or accreditation standards establish higher standards than stated in these Rules and Regulations, the relevant laws, regulations or accreditation standards shall apply.

(a) History & Physical (H&P): No more than thirty (30) days prior to and within twenty-four (24) hours after the time of admission.
   (1) Sometimes, updates are required to H&Ps: In cases in which the H&P was performed prior to the patient's arrival at the Hospital, a signed, dated and timed update to the H&P is required indicating the presence or absence of changes in the patient's medical condition since the H&P was performed.[107] This update must be documented in the medical record by a Practitioner with history and physical examination privileges within twenty-four (24) hours after the time of admission, but prior to any Procedure that places the patient at risk.[108] For more information about mandated updates, see ARTICLE IV – PART G Section 3 (Mandatory Requirement to Update H&Ps).

(b) Teaching-Service Patient H&P: No more than thirty (30) days prior to and within twenty-four (24) hours after the time of admission.

[107] The Joint Commission – Hospital Accreditation Standards, PC.01.02.03 – EP 5; MS.03.01.01 – EP 8; CMS – Conditions of Participation §482.22 (c) (5) (ii)
[108] The Joint Commission – Hospital Accreditation Standards, MS.03.01.01 – EP 10

(c) Daily Progress Note: All patients must have a dated and timed daily progress note entered into the medical record by the Attending Practitioner or a Member representing the Attending Practitioner. Progress notes should be recorded at the date and time of service, documenting the course and results of care sufficient to permit continuity of care and informed transfer of care [109] and completed within 24 hours of the date and time of service.

(d) Operative Report: Within twenty-four (24) hours after the time the Practitioner completes his or her portion of the procedure. [110]

(e) Operative or Other High-Risk Procedure Progress Note: Must be entered into the medical record before the patient is transferred to the next level of care and completed within twenty-four (24) hours after the time the Practitioner completes his or her portion of the procedure. As stated in ARTICLE VII – PART D Section 2, when a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note (IPON) must be entered in the medical record.

(f) Consultations: Within twenty-four (24) hours after the consultation.

(g) Consultation Progress Note: Consultation progress notes subsequent to a Direct Consultation should be recorded at the date and time of service, documenting the course and results of care within the scope of the consultation sufficient to permit continuity of care and informed transfer of care and completed within 24 hours of the date and time of service.

(h) Radiology Reports: Within twenty-four (24) hours after the radiographic examination, except when the examination requires additional time to complete computerized post-processing or to obtain the opinion of an additional radiologist or to complete a review of the pertinent literature or review of the patient's previous examinations. The reasons for such delays must be documented within the report.

(i) ICU Admission: Within two (2) hours after the patient is admitted to the ICU.

(j) Pre-Anesthesia Evaluation: A pre-anesthesia evaluation shall be completed and completely documented by a Practitioner qualified and granted current privileges to administer anesthesia/deep sedation within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia/deep sedation. [111] The delivery of the first dose of medication for the purpose of inducing anesthesia/deep sedation marks the end of the 48-hour timeframe. [112]

(k) Post-Anesthesia Evaluation: Within forty-eight (48) hours after surgery or a procedure requiring anesthesia/deep sedation. [113]

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[109] CMS – Conditions of Participation §482.24(c)(1)

[110] The Joint Commission – Hospital Accreditation Standards, RC.02.01.03 – EP 5, Note 1

[111] The Joint Commission – Hospital Accreditation Standards, PC.03.01.03 EP 18: CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010): §482.52(b) (1)

[112] CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010):: A-1003, 482.52 (b) (1) Interpretive Guidelines

[113] The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. The evaluation generally should not be performed immediately at the point of movement from the operative area to the designated recovery area. Accepted standards of anesthesia care indicate that the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g. answer questions appropriately, perform simple tasks, etc. While the evaluation should begin in the PACU/ICU or other designated recovery location, it may be completed after the patient is moved to another inpatient location. CMS Conditions of Participation – Revised Hospital Anesthesia Services Interpretive Guidelines §482.52(b) (3) – State Operations Manual (SOM) Appendix A (January 14, 2011)

(1) For those patients who are unable to participate in the post-anesthesia evaluation (e.g. post-operative sedation, mechanical ventilation, etc.), a post-anesthesia evaluation should be completed and completely documented within forty-eight (48) hours with notation that the patient was unable to participate. This documentation should include the reason for the patient's inability to participate as well as expectations for recovery time, if applicable. For those patients who require long-acting regional anesthesia to ensure optimum medical care of the patient, whose acute effects will last beyond the 48-hour timeframe, a post-anesthesia evaluation must still be completed and completely documented within forty-eight (48) hours. However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.
(2) For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge, however documentation may be completed after discharge but within forty-eight (48) hours.[114]

(l) All other documents: Within fifteen (15) days following the date of service unless an extended deadline is approved by the Health Information Management Committee for specific documents or document types.

A medical record shall not be permanently filed until it is complete or is ordered to be filed by the Chief of Staff or his/her designee.

ARTICLE XI
PART E. RELEASE OF MEDICAL INFORMATION

See Rules & Regulations Article V Part B Section 5 Authorization for Release of Medical Records.

ARTICLE XI
PART F. REMOVAL OF MEDICAL RECORDS FROM HOSPITAL SITES

Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a proper court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Director of Health Information Management. Unauthorized removal of charts from the Hospital Site may result in corrective action in accordance with the Bylaws Article VII, Part A. Corrective Action.

ARTICLE XI
PART G. READMISSION AVAILABILITY OF PREVIOUS RECORDS

In case of readmission of a patient, all previous records shall be available for use by the Attending Practitioner. This shall apply regardless of whether the patient is attended by the same Practitioner or by another.

ARTICLE XI
PART H. ACCESS TO MEDICAL RECORDS FOR RESEARCH

Access to medical records of all patients (in a manner consistent with applicable laws) shall be afforded to Members for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Institutional Review Board (IRB) before records can be studied.

ARTICLE XII: QUALITY, PERFORMANCE IMPROVEMENT, PEER REVIEW, AND ISSUES, COMPLAINTS AND GRIEVANCES

[114] CMS – Clarification of Interpretive Guidelines for Anesthesia Services Conditions of Participation (May 21, 2010): §482.52(b) (3) Interpretive Guidelines

PART A. QUALITY OF CARE AND PERFORMANCE IMPROVEMENT

The Professional Staff is involved in measuring, assessing and improving the quality of care delivered on the following levels:

(a) Interactions between individual Members or Individuals with Privileges and patients;

(b) Within clinical divisions and departments/units; and,

(c) Within organizational committees, projects and oversight bodies.

The Professional Staff maintains a leadership role in quality review and performance improvement activities related to those processes that are dependent primarily upon the activities of one or more individuals with clinical privileges. These processes include, but are not limited to: medical assessment and treatment; use of medications, blood and blood components; operative and other procedures; effectiveness of clinical practice patterns; use of clinical pathways; and significant departures from established patterns of clinical practice. Additionally the Professional Staff participates with other disciplines and Hospital staff in the measurement, assessment and improvement of other patient care processes such as: service quality; access; coordination of care with other practitioners; and accurate, timely, legible completion of medical records.

Division chiefs are responsible for the ongoing, effective operation of their divisions and for assessing quality and improving its performance. Each division develops a measurement plan, which includes relevant organizational measures to monitor the individual and aggregate quality of care/service, including criteria for peer review.

Division chiefs, Professional Staff Officers, and the members of the Professional Executive Council are responsible for identifying which quality measurements, rules, rates, and/or outcomes of performance improvement initiatives shall be used to review a Member's or Individual's with Privileges competencies at time of reappointment and/or reprivileging in accordance with the Bylaws and the Policy on Appointment, Reappointment and Clinical Privileges.

Intensive assessment of a process to learn in greater detail about how it operates may be triggered by important single events; levels of performance, patterns, or trends that vary significantly and undesirably from those expected; a sentinel event; or a medical accident with potential for serious harm. Comparative data, both internal and external, will be used whenever possible, to assist in identifying opportunities to improve.

When the findings from assessment activities are relevant to an individual's performance, the Professional Staff is responsible for determining their use in peer review and in the ongoing evaluation of continuing competence, in accordance with the Bylaws and Policy on Appointment, Reappointment and Clinical Privileges.

ARTICLE XII
PART B. PEER REVIEW

Peer review is the process by which the care, treatment, and services delivered to patients are reviewed and evaluated by peers. The Professional Staff has established a multi-specialty peer review structure in order to minimize individual and group bias in the peer review process. In situations that involve clinical issues that are deemed to be highly specialty specific, appropriate specialty review is requested by a peer who is without a disqualifying conflict of interest[115].

Indications for peer review and the peer review process are described in the Professional Staff Policy on Peer Review.

[115] Policy on Peer Review, Article I, Part H. Disqualifying Conflicts of Interest

ARTICLE XII
PART C. ISSUES, COMPLAINTS AND GRIEVANCES

An issue is any concern about an experience, which does not meet patient/family expectations and is brought to the attention of a Children's staff member.

Complaint and grievance are equivalent terms indicating a formal or informal written or verbal complaint that is made to the hospital by a patient or family that cannot be promptly resolved at the point of care by staff or a supervisor/manager who is quickly available. Complaints from patients or families, nursing staff, Professional Staff or other Hospital staff members will be appropriately channeled through the Division Chief, Chief of Staff, Immediate Past Chief of Staff, or Chief Medical Officer and in accordance with Organizational Policy 109.00 Patient/Family Complaints and Grievances.

ARTICLE XIII: AMENDMENTS

The procedure for making amendments to these Rules and Regulations is described in Article XI of the Bylaws of the Professional Staff.

Rules and Regulations
Children's Hospitals and Clinics of Minnesota