Children’s Hospital of Wisconsin–Fox Valley

Medical-Dental Staff

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GENERAL OBLIGATIONS

Upon accepting an appointment to practice at Children’s Hospital of Wisconsin–Fox Valley (CHW-Fox Valley), members of the Medical-Dental Staff agree to abide by the Bylaws, Procedures, Rules and Regulations and hospital policies and procedures as well as any state and federal rules related to patient care and documentation.

MEDICAL-DENTAL STAFF CODE OF PROFESSIONALISM

This code describes the expectations that the Medical-Dental Staff Members (“Member”) have of each other. The expectations described below reflect current Medical-Dental Staff Bylaws, Procedures, Rules & Regulations, organizational policies and relevant regulatory requirements. This code is designed to bring together the most important issues found in those documents along with some key concepts that reflect our Medical-Dental Staff’s culture and vision.

Medical-Dental Staff leaders will work to improve individual and aggregate Medical-Dental staff performance through non-punitive approaches by providing appropriate feedback that allows each Member the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital and community.

Fundamental Principles:
- Dedication to patient and family welfare (altruism)
- Respect for patient and family autonomy
- Promotion of social justice/fair distribution of medical resources

Professional Responsibilities:
- Maintain professional competence/life-long learning
- Be honest with patients and families to establish trust
- Preserve patient and family confidentiality
- Maintain an appropriate physician-patient relationship
- Work for improvement in quality of care
- Work for improvement in access to care
- Work for improvement in safety of care
- Provide cost-effective health care
- Work for improvement in scientific knowledge
- Manage conflicts of interest appropriately
- Work collaboratively with colleagues and staff
- Maintain and enforce professional standards

Technical Quality of Care:
- Provide appropriate patient care that consistently meets or exceeds generally accepted medical staff standards as defined by comparative data, the medical literature and the results of peer review activities.
- Achieve surgical and medical patient outcomes that consistently meet or exceed generally accepted Medical-Dental Staff standards as defined by comparative data, the medical literature and the results of peer review activities.
- Participate in continuing education related to delineated clinical privileges and medical-dental license requirements.
• Provide for patient comfort including prompt and effective management of acute and chronic pain in coordination with other caregivers according to accepted guidelines in the medical literature.
• When appropriate, consider evidence-based guidelines, as approved by the Medical-Dental Staff, in selecting the most effective and appropriate approaches to diagnosis and treatment of patients.

Patient Safety:
• Participate in the hospital’s efforts and policies to assure patient safety and reduce medical errors.
• Order medications, blood and blood products consistent with current medical guidelines.
• Maintain medical records documentation consistent with the Medical-Dental Staff Bylaws, Procedures, Rules & Regulations and Hospital policies, and including, but not limited to, chart enter legibility and timely completion of History and Physical examination reports, Operative Reports, procedure notes, diagnostic interpretation reports and discharge summaries.
• When seeing or attending patients, wear appropriate identification and identify yourself to patients and families.
• Utilize “time out” review of patient identity prior to all appropriate procedures.

Quality of Service:
• Ensure timely and continuous care of patients, 24 hours per day, seven days per week, by clear identification of covering physicians and by appropriate and timely answering service and electronic communications availability.
  o For hospital-based inpatient and outpatient care, this means:
    - Immediate response to all calls deemed emergent by the requesting caregiver,
    - Maximum 6 hour communication response to all other “non-emergent” calls.
• Participate in emergency room coverage as determined by the departments and the Medical Executive Committee.
• When requesting inpatient consultation, make direct member-to-member contact providing a clear reason for consultation, with the exception of regularly scheduled routine consultations.
• Conduct non-emergent inpatient consults within 24 hours of notification or as agreed upon by requesting physician.
• Provide non-emergent hospital-based outpatient consultation in a timely manner.
• Respond in a timely and appropriate manner to information regarding patient dissatisfaction with Member performance.
• Support the Medical-Dental Staff’s efforts to improve patient satisfaction rates for members.
• Communicate effectively with patients and their families.
• Discuss end-of-life (including advance directives and patient and family support) when appropriate to a patient’s condition and honor patient and family desires.
• Support the Hospital’s efforts to improve patient satisfaction for every patient’s experience.

Resource Utilization:
• Strive to appropriately manage the use of valuable patient care resources according to current professional standards.
• Discharge or transfer patients to the medically appropriate level of care in a timely manner
• Provide accurate timely discharge instructions in collaboration with other caregivers, with a goal of contacting subsequent caregivers electronically, by fax, or phone within 24 hours of discharge.
Peer and Co-Worker Relationships:
- At all times act in a professional, respectful manner toward patients and their families, other Members, nurses, administrators, board members and other hospital personnel to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team.
- Refrain from inappropriate behavior toward fellow Members, students and trainees and the Hospital staff, patients and their families, including but not limited to the following:
  - Impulsive, disruptive, sexually harassing or disrespectful behavior,
  - Documentation in the medical record that does not relate to the clinical status of the patient and plan of care,
  - Documentation or commentary that is derogatory or inflammatory concerning the care provided to the patient.
- Recognize that disagreements are inevitable and can contribute to improving care. When disagreements occur, address these in a constructive, respectful and direct manner away from patients and their families or other non-involved caregivers.
- Respect patient privacy by not discussing patient care information and issues in public settings.

Citizenship:
- Practice medicine as a Member in a manner that maintains and advances the culture of collegiality and cooperation that is the hallmark of our Medical-Dental Staff and Hospital.
- Utilize patient care satisfaction data provided by the Hospital to continuously improve care.
- When contacted regarding concerns about patient care, respond in the spirit of continuous improvement. Cooperate with the Hospital patient relations representatives to respond to patient and family complaints.
- When provided information on Medical-Dental Staff matters requesting your input, respond in a timely manner and accept decisions made by leadership.
- Make positive contributions to the Medical-Dental Staff and Hospital by participating actively in Medical-Dental Staff functions.
- In the spirit of early assistance, help to identify issues affecting the physical and mental health of fellow Members and cooperate with programs designed to provide assistance.

RULES AND REGULATIONS

I. COMMUNICATION AND SERVICE STANDARDS

Physician Roles
1. Any Medical-Dental Staff member with privileges to admit, evaluate, treat and discharge patients independently may act as an attending physician. The Attending Physician has the primary responsibility of patient care for this patient encounter or admission. When there are co-attending physicians, the responsibility is shared equally.
   2. A Consulting Physician provides input into the patient’s care.
3. The Primary Care Physician has the primary responsibility for the overall healthcare management of the patient, not just for a single visit, but also for all episodes of care.
4. The Referring Physician is the physician who refers the patient to CHW-Fox Valley for care.

Inpatients
1. The attending physician is responsible for communicating with the patient and/or family regarding the condition, prognosis and plan of care.
2. The attending physician is responsible for communicating with all relevant patient care providers regarding the plan of care.
3. Adequate communication is a combination of verbal communication and medical record documentation.
4. The attending physician is expected to communicate with the primary care physician. At a minimum, this needs to occur at admission and discharge. Interim progress reports to the primary care physician are also expected to occur weekly and more often as determined by clinical circumstances.
5. The attending physician is responsible for assuring that there is communication with the referring physician. A discharge summary should be dictated and sent to the primary care and referring physician within 48 hours of discharge.
6. The attending physician is expected to communicate with physicians in training, consulting physicians and other physicians who are involved in the care of patients.

**Outpatients**

1. The attending physician is expected to communicate with the primary care and referring physician in a timely manner.

II. INPATIENT MANAGEMENT: ADMISSION, TREATMENT AND DISCHARGE

**Section A. General Responsibilities**

1. The attending physician is responsible for admitting the patient, managing the care, and discharging the patient.
2. Documentation requirements are:
   a) A complete history and physical exam completed within 24 hours after admission, which includes:
      (1) Chief complaint, symptoms, duration
      (2) Family and social history
      (3) Inventory of systems with positive and negative findings
      (4) Physical examination
      (5) Preliminary diagnoses
   b) A thorough assessment and treatment plan.
   c) Progress notes pertinent to the patient’s condition.
   d) A discharge summary needs to be dictated. For patients with a length of stay under 48 hours, a brief discharge note is acceptable.
      (1) The brief discharge note must contain diagnosis information, the outcome of hospitalization, the case disposition, and any provisions for follow-up care.
      (2) The final progress notes may serve as the brief discharge note only if all required documentation is contained in the final progress notes.
   e) A discharge order.
   f) A discharge diagnosis.
3. A history and physical exam performed no more than 30 days before admission may be utilized provided that the copy is filed in the medical record. An updated medical record entry is required, documenting an examination for any changes in the patient’s current condition, and such entry is completed within 24 hours of admission. If the history and physical exam is older than 30 days, a new history and physical exam must be performed and documented in the medical record.
4. A physician may choose to delegate all or part of the history and physical exam to an appropriately privileged AHP or to a resident, but the physician must countersign the
history and physical exam and assume full responsibility for the history and physical exam.

5. A history and physical exam performed by a non-staff member may be used provided:
   a) A legible copy of the history and physical exam is filed in the medical record
   b) All required elements of a comprehensive history and physical exam as outlined above are present.
   c) An appropriately privileged staff member reviews the history and physical exam document and conducts a second assessment to confirm the information and findings
   d) The information and findings is updated as necessary, including a summary of the patient’s condition and course of care during the interim period and the current physical/psychosocial status
   e) The information is signed and dated as an attestation to it being current.

6. Each physician is responsible for providing alternative coverage when said physician is not available.

7. Regardless of diagnosis, Medical-Dental Staff members have an obligation to both patients and the institution to provide their expertise in the care of patients, unless valid reasons exist not to do so.

Section B. Critically/Seriously Ill Patients or Patients with a Significant Deterioration
   1. Patients who are seriously ill or critically ill, or whose care needs are beyond the capabilities of the staff of CHW–Fox Valley will be transferred to an appropriate facility by an appropriate mode of transport.
   2. Critically ill patients, who are admitted to the NICU, or patients who are physiologically unstable on admission to the hospital or patients with significant deterioration in clinical status will be evaluated by the attending physician as soon as possible, but not later than 4 hours after notification of admission or notification of change in condition.

Section C. General Medical and Surgical Patients
   1. Newly admitted patients who are stable will be evaluated by the attending physician or designee within 24 hours of hospital admission.

Section D. Patients Transferred from Theda Clark Medical Center
   1. Patients who are transferred from Theda Clark Medical Center are those who have been discharged from Theda Clark Medical Center and admitted to CHW–Fox Valley.
   2. The transfer summary from Theda Clark Medical Center may serve as the history and physical exam if has been completed within 7 days by an appropriately privileged staff member, and if it contains sufficient information to meet the requirements of a history and physical as outlined above. An updated medical record entry is required, documenting an examination for any changes in the patient’s current condition, and such entry is completed within 24 hours of admission.

Ref: Patient Care Policies & Procedures: “Admission of a Patient to the Hospital”
III. CARE OF PATIENTS UNDERGOING SURGICAL/INVASIVE PROCEDURE, ANESTHESIA

Section A. Consent to Surgery/Invasive Procedure, Anesthesia
1. Physicians who perform procedures or provide sedation requiring informed consent are responsible for obtaining and documenting such consent, according to the current policy.

Ref: Patient Care Policies & Procedures: “Consent for Diagnosis and Treatment”

Section B. Pre-operative and Pre-procedural Histories and Physicals
1. Except in extreme emergencies, operative or other invasive procedures are performed only after completion of an appropriate history and physical examination.
2. The history and physical exam must have been performed no more than 30 days prior to the procedure date and a copy placed in the medical record. An update note must be recorded, dated, timed and signed prior to the procedure confirming the history and physical has been reviewed, the patient was examined, and no changes have occurred in the patient’s condition since the history and physical was completed, within the last 30 days. If the history and physical exam is older than 30 days, a new history and physical exam must be performed and documented in the medical record.
3. In the event of an extreme emergency, a progress note shall be made documenting a brief history, appropriate physical findings, the pre-operative or pre-procedure diagnosis and that the case is an extreme emergency. A complete history and physical exam is to be completed as soon as possible following operative/invasive procedure, but within 24 hours of admission.
4. A physician may choose to delegate all or part of a medical history and physical examination to an appropriately privileged AHP or to a resident. A medical-dental staff member must countersign the history and physical and as applicable update the note and assume full responsibility for the history and physical examination.

Ref: Patient Care Policies & Procedures: “Assessment/Reassessment of Patient”

Section C. The Physician Performing a Surgical/Invasive Procedure is Responsible for:
1. Providing a history and physical examination to include a summary of clinically pertinent negative and positive findings, justifying the admission/surgery/invasive procedure, prior to the procedure.
   a) For podiatric procedures, an appropriately privileged podiatrist is responsible for the part of the history and physical exam that relates to podiatry.
2. Recording progress notes pertinent to the patient’s condition and management of the patient.
3. Recording a preoperative/pre-procedure diagnosis.
4. Requesting consultations when appropriate.
5. Reviewing previous patient care records, applicable imaging studies and the current patient chart.
6. Marking the appropriate site, consistent with current Hospital policy
7. Conducting and/or participating in a time-out prior to the procedure, consistent with current Hospital policy, to confirm the correct patient, correct procedure and the correct site.
8. Performing the surgical/invasive procedure.
9. Prior to the patient being transferred to the next level of care or discharged from the recovery unit, the surgeon or their designee must complete a brief operative/procedure note that includes the name of the physician performing the procedure, any assistants, findings, procedure performed, a description of the procedure, estimated blood loss as indicated, specimens removed and postoperative/post-procedure diagnosis. This note must be dated, timed and signed by the surgeon and/or designee.

10. An operative/procedure report must be dictated within 24 hours of the procedure that describes the findings and technique. This document must be signed by the surgeon/physician who performed the procedure.


12. Dictating and signing the discharge summary.

Ref: Patient Care Policies & Procedures: “Verification of Correct Patient-Correct Procedure and Correct Operative-Procedure Site

Section D  Anesthesia Services.

1. The physician performing the procedure and the person assisting with the procedure must not be the person monitoring the patient.

2. NPO status must be followed per American Academy of Pediatrics guidelines.

3. Anesthesia services may be provided by a Certified Registered Nurse Anesthetist (CRNA), under the supervision of an Anesthesiologist.

4. For patients receiving general, regional or monitored anesthesia, to include deep sedation, the Anesthesiologist/CRNA is Responsible for:
   a) Completing and documenting a pre-anesthesia evaluation prior to any inpatient or outpatient surgery, or procedure requiring anesthesia services. The elements of the pre-anesthesia evaluation of the patient that must be performed within the 48-hour timeframe* include:
      (1) Review of the medical history, including anesthesia, drug and allergy history;
      (2) Interview, if possible, given the patient’s condition and examination of the patient;
       (*The delivery of the first does of medication(s) for the purpose of inducing anesthesia marks the end of the 48-hour timeframe.)
   The elements of the pre-anesthesia evaluation of the patient that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days prior to the 48-hour time period, in preparation for the procedure include:
      (1) Notation of anesthesia risk according to established standards of practice. (e.g., ASA classification of risk);
      (2) 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)
      (3) Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);
      (4) Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and
b) Administering anesthesia and monitoring the physiological status during anesthesia. An intraoperative anesthesia record is maintained and must include:

   (1) Name and hospital identification number of the patient;
   (2) Name of practitioner who administered anesthesia;
   (3) Name, dosage, route and time of administration of drugs and anesthesia agents;
   (4) Techniques used and patient positions, including insertion/use of any intravascular or airway devices;
   (5) Name and amounts of IV fluids, including blood or blood products if applicable;
   (6) Time-based documentation of vital signs as well as oxygenation and ventilation parameters;
   (7) Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment.

   c) Completing and documenting a post-anesthesia evaluation no later than 48 hours after surgery or procedure requiring anesthesia services. The 48-hour timeframe begins at the point the patient is moved into the designated recovery area, but only once the patient has recovered sufficiently from the anesthesia to appropriately participate in the assessment. The evaluation should begin in the designated recovery location; however, it may be completed after the patient is moved to another inpatient location, or for same day surgery/procedure, after the patient is discharged so long as it is completed within 48 hours. For those patients who are unable to participate in the post-anesthesia evaluation, an evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate, to include reason for 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 documented within 48 hours; however, there should be 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. The post-anesthesia evaluation of the patient must include:

   (1) Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
   (2) Cardiovascular function, including pulse rate and blood pressure;
   (3) Mental status;
   (4) Temperature;
   (5) Pain;
   (6) Nausea and vomiting;
   (7) Postoperative hydration
   (8) Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

5. **For patients receiving moderate sedation, the privileged physician/dentist/CRNA directing the sedation is responsible for:**
a) A complete history and physical exam of the patient prior to administering sedation
b) A pre-sedation assessment must be performed within 48 hours prior to the procedure. (If the history and physical exam meets all the requirements of the pre-sedation assessment as outlined below, it may be used to meet the pre-sedation assessment requirements). The Pre-sedation assessment shall include the following:
   (1) *Health and risk assessment health history including allergies, current medications, current health problems, previous hospitalizations, previous sedation/anesthesia history, known pregnancy status, alcohol and illicit drug use
   (2) *Weight
   (3) *ASA physical status
   (4) *Mental status
   (5) *Assessment of airway opening and patency
   (6) *NPO status
   (7) *Prematurity status of infants less than 9 months old
   (8) Respiratory status
   (9) Cardiovascular status

   Items with an (*) may be delegated by the privileged physician/dentist to a clinician who has demonstrated competency in pre-sedation assessment when the pre-sedation assessment is not also serving as the history and physical exam. The appropriately privileged physician/dentist is responsible to review all of the delegated items before ordering sedation.

c) An immediate pre-sedation assessment shall be performed which at a minimum includes baseline vital signs immediately prior to administration of sedation.
d) A plan of care for sedation based on the assessment data, including documentation of patient risk, assignment of an ASA physical status, risk of procedure and risk of planned sedative technique.

Ref: Patient Care Policies & Procedures: “Procedural Sedation”
Ref: CMS Condition of Participation: Anesthesia Services CFR 482.52

IV. CARE OF DENTAL PATIENTS

Section A. A patient admitted for dental care may be admitted to the service of any member of the Dental Staff.

Section B. A co-attending physician member should be involved in the ongoing medical care.

Section C. Pre-operative Histories and Physicals
   1. Dentists are responsible for completing the part of their patient’s history and physical that relates to dentistry. The anesthesiologist involved with the case is responsible for conducting a pre-anesthesia assessment prior to anesthesia induction.
   2. A history and physical examination which is performed within 30 days of the dental procedure may be utilized provided that a copy is filed into the medical record and is updated to reflect the patient’s status at the time of admission/service. A statement confirming the patient’s status at the time of admission must be dated, timed and signed by the Dentist prior to the procedure. If a history and physical examination is older than 30 days, a new history and physical must be performed and documented in the medical record prior to the dental procedure.

Section D. The Dentist is Responsible for:
1. Providing a dental history and physical examination to include a summary of clinically pertinent positive and negative findings, justifying the admission/surgery prior to the procedure.
2. Providing a description of the examination of the oral cavity.
3. Recording the pre-procedure or preoperative diagnosis.
4. Recording progress notes pertinent to the oral condition.
5. Requesting consultations when appropriate.
6. Reviewing the dental record including the medical history, laboratory findings, appropriate charts and dental radiographs. Indicate the tooth number(s) or mark the teeth site or surgical site on the diagram or radiograph to be included as part of the patient record.
7. Ensuring that radiographs are properly oriented and visually confirming that the correct teeth or tissues have been charted.
8. Conducting a “time out” to verify patient, tooth, and procedure, consistent with current policy.
9. Performing the dental procedure.
10. Providing a signed procedure note or operative report, that describes the findings and technique. In case of extraction of teeth, the dentist should state the number of teeth and fragments removed.

Ref: Patient Care Policies & Procedures: “Verification of Correct Patient-Correct Procedure and Correct Operative-Procedure Site

V. MEDICAL/SURGICAL CONSULTATION AND TRANSFER OF SERVICE

Section A. A medical/surgical consultation is a formalized deliberation between Medical-Dental staff members regarding a particular patient’s care and/or the treatment of the patient.
1. A consultation must occur when
   a) There is a need for further evaluation or when patient care needs exceed the expertise or clinical privileges of the attending physician.
   b) A family or patient requests a consultation.

Section B. Expectations and Responsibilities of the Requesting Attending Physicians to the Consultant
1. The requesting attending physician or designee should:
   a) Discuss the purpose and need for the consult with the patient and family.
   b) Follow the current process for ordering consults.
   c) Communicate to the consultant:
      (1) The specific patient care issues that need to be addressed
      (2) The urgency (routine, urgent and emergent)
      (3) The level of involvement requested:
         (a) One time opinion only.
         (b) Evaluate for procedure.
         (c) Treatment of condition.
         (d) Co-management.
         (e) Transfer of care.
2. Whether diagnostic tests/treatments may be ordered or scheduled by the consultant service.
3. How and whom to contact to discuss findings and consultant recommendations.
Section C. Expectations and Responsibilities of the Consultant

1. The consultant or designee should:
   a) Acknowledge receipt of the consult request.
   b) Confirm the level of service requested and the urgency of the consult.
      (1) Emergent consults are for immediate threat to life or limb. A response either in person or by telephone is expected within 15 minutes of receiving the initial page.
      (2) Urgent consults are for those issues not seen as an immediate threat to life or limb. A response by telephone is expected within 30 minutes of receiving the initial page.
      (3) Routine consults are those issues that do not meet either an emergent or urgent status. A response by telephone is expected within 30 minutes of receiving the initial page.
   c) Communicate to the requesting attending physician any specific requirements or prerequisites (e.g. NPO status, diagnostic evaluations).
   d) Perform the consult within the established timeline.
      (1) Emergent consults should be done as expeditiously as possible given the specific patient care needs.
      (2) Urgent consults should be done within 4 hours of receiving the initial page request.
      (3) Routine consults should be done within 24 hours of receiving the initial page request, unless other arrangements are made between the requesting attending physician and the consultant.
   e) Verbally communicate with the requesting attending physician or his or her designee the initial findings or recommendations.
   f) Document in the patient’s medical record initial findings and recommendations.
   g) Provide a full written/dictated consult in the patient’s medical record within 24 hours of evaluation of the patient.
   h) Communicate the information to the patient or family only after discussing with the requesting attending physician or his or her designee.
   i) Specify which service will be responsible for follow-up on pending tests during the hospital stay and after discharge.
   j) Arrange for ongoing follow-up after discharge when indicated or formally document a sign off of the consultant’s involvement in the patient’s ongoing care.

VI. CARE OF OUTPATIENTS

Section A. The attending physician is responsible for providing care. Documentation must occur at the time of service. At a minimum, a short note summarizing the visit must be written in the record.

Section B. The complete clinical note containing pertinent elements of history, physical, and diagnostic studies and an evaluation and management plan must be written or dictated within 24 hours of service.

Section C. For those patients receiving ongoing ambulatory services (3 or more visits), there is a review and update of significant diagnoses, procedures, drug allergies, and medications at each encounter.
VII. CARE OF EMERGENCY DEPARTMENT PATIENTS

Section A. Patients who receive care in the Emergency Department are under the scope of Theda Clark Medical Center.

VIII. MEDICAL ORDERS

Section A. General Rules
1. When possible, medical orders should be in writing.
2. All orders, including verbal orders, must be dated, timed, and authenticated according to Hospital policy.
3. There are no standing orders that apply universally to all patients admitted to the hospital.
4. A facsimile transmitted order with signature is acceptable as a written order.

Section B. Inpatient Orders
1. All inpatient orders will be documented according to Hospital policy.
2. Medical orders must be reviewed and modified, as necessary, when a patient is transferred from one unit or service to another.

Section C. Outpatient Orders
1. Medical orders for outpatient diagnostic studies may only be ordered by a licensed physician, dentist, podiatrist or their appropriately qualified advanced practice nurse or physician assistant and must include clinical indications for the studies.
2. Authorized scheduling or registration personnel may accept telephone orders for outpatient diagnostic studies. This telephone order must be followed with a written or facsimile order.

Section D. Peri-operative Orders
1. The following applies to all situations where a patient receives anesthesia:
   a) The surgeon or appropriately qualified advanced practice nurse or physician assistant is responsible for reviewing and modifying all pre-operative orders prior to entering post-operative orders.
   b) Post-operative orders must be entered immediately following the procedure.

Section E. Restraint Orders
1. Guidelines for patient restraint are outlined in Patient Care Policies & Procedures: “Restraints.”

Section F. Medication Orders
1. All medication orders must be written in accordance with Patient Care Policies & Procedures: “Medical Orders – Prescribing Medical Care.”
2. Medications, which are ordered for inpatient use, must be from the Hospital formulary. In unusual situations, a non-formulary medication may be requested by contacting the Pharmacy.
3. Certain medications are restricted. These must be ordered by the knowledgeable specialist.
4. To reorder previous medication orders, the prescribing provider must reorder all previous medications. An order to reinstate all previous medications will not be acceptable.

Section G. Investigational Drugs
1. Drugs for investigational or experimental purposes may be used only with permission of the Research and Publications Committee/Institutional Review Board.

Section H. Verbal Orders
1. Verbal orders are acceptable in emergency situations or when the ordering physician is performing a procedure, except in situations where verbal orders are restricted by Hospital policy.
2. Verbal orders may be accepted by a registered nurse, an advanced practice nurse or a physician’s assistant.
3. The following health care workers may accept and implement verbal orders for care or services within the scope of their practice: pharmacist, respiratory care practitioner, physical/occupational therapist, registered dietitian, social worker, speech pathologist, laboratory technologists and radiology technicians.

Section I. Telephone Orders
1. Telephone orders are acceptable in a patient emergency or when a physician does not have immediate fax access (except in situations where verbal orders are restricted by Hospital policy (e.g. Digitalis orders).
2. Telephone orders may be accepted by a registered nurse, an advanced practice nurse or a physician’s assistant.
3. The following health care workers may accept and implement telephone orders for care or services within the scope of their practice: pharmacist, respiratory care practitioner, physical/occupational therapist, registered dietitian, social worker, speech pathologist, laboratory technologists and radiology technicians.

Section J. Recording and Authenticating Verbal or Telephone Orders
1. After giving a verbal or telephone order to the individual authorized to accept such order, the prescribing provider must provide time for the person accepting the order to write the order and read it back to verify accuracy.
2. Verbal or telephone orders can be authenticated by either the prescribing provider or another provider who is responsible for the care of the patient as long as such provider has knowledge of the patient’s hospital course, medical plan of care, condition and current status. A provider who does not possess this knowledge about a patient should not be authenticating verbal or telephone orders for this patient. Authentication includes date, time and signature.
3. All verbal and telephone orders shall be authenticated within 48 hours of receipt. Authentication includes the date, time and signature. 42 CFR 482.23(c)(2)(ii) and HFS 124.12(5)(b)(11).

Section K. Stat Orders
1. The prescribing provider must notify the appropriate Hospital personnel immediately when a stat order is written.

Section L. Order Sets
1. Order sets may be created by individual providers or groups of providers. Such providers will have responsibility for developing and maintaining the order sets in collaboration with Hospital staff according to hospital policy.

Section M. Delegated Medical Orders
1. Delegated medical orders are medical interventions (orders) that are:
   a) Ordered and/or carried out by an advanced practice nurse, a physician assistant or a registered nurse, or in some situations, another health care professional;
b) Outlined in protocols, order sets or clinical guidelines that are approved by the supervising physician.

**Section N. Physician Signature for Delegated Medical Orders**

1. If a medical order is entered by a physician assistant or advanced practice nurse and is under protocol, order set or clinical guideline that is agreed upon with the supervising/collaborating physician, it does not require co-signature by the supervising/collaborating physician.

2. If a medical order is entered by a physician assistant or advanced practice nurse and is not outlined in a protocol, order set or clinical guideline, the supervising/collaborating physician is responsible for signing the order.

**Section O. Medication Reconciliation**

1. The physician or appropriately qualified advanced practice nurse or physician assistant is responsible for
   a) Obtaining a complete and accurate list of each patient's home medications (including name, dosage, frequency and route).
   b) Comparing the list to any medications the organization provides.
   c) Updating the patient's current list as orders change during an episode of care.
   d) Communicating the updated list to the next provider at transfer/discharge.

Ref: Patient Care Policies & Procedures: “Medical Orders – Prescribing Medical Care”
Ref: Patient Care Policies & Procedures: “Collaborative Practice Protocols”
Ref: Patient Care Policies & Procedures: “Medication Management”
Ref: WI Administrative Code Med 8.08 – Physician Assistants - Prescribing Limitations
Ref: WI Statutes Chapter 441 – Board of Nursing; 441.16(2) – Prescription Privileges of Nurses

**IX. PROCESS FOR DELINQUENT MEDICAL RECORDS**

**Section A. Suspension Process for Delinquent Records**

1. An incomplete medical record is considered delinquent thirty (30) days post discharge.

2. Staff members who fail to complete a medical record within two weeks of notice of delinquency will be placed on suspension at which time the physician is not able to admit, consult or perform procedures at CHW–Fox Valley. Physicians may continue to care for their patients already at CHW–Fox Valley. Exceptions will be made for physicians who notify the Health Information Department of a leave of absence or vacation.

3. Suspension is rescinded immediately after verification of complete medical records.

4. If medical records remain incomplete by ninety (90) days post discharge, a certified letter will be sent to the suspended staff member notifying them of automatic resignation if medical records are not completed within seventy-two (72) hours of receipt, pending Medical Executive Committee review.

5. Physicians who experience three suspensions for delinquent medical records in a rolling calendar year will be further reviewed by the Medical Executive Committee to determine appropriate action. If termination occurs due to delinquent medical records, such action is not subject to a fair hearing and appeal process.

6. Physicians who automatically resign or are terminated due to delinquent medical records may be allowed to reapply to the Medical-Dental Staff. Such physicians will be required to interview with the Medical Executive Committee to explain how they plan to maintain compliance with medical record completion requirements, if reinstated.
Section B.  The Chiefs of the Departments of Medicine and Surgery shall ensure compliance with this policy.

Ref:  Administrative Policies & Procedures: “Suspension Process for Delinquent Medical Records”

X.  PATIENT DEATH, TISSUE AND ORGAN DONATION, AND AUTOPSY

Section A.  Reporting of Deaths

1.  All deaths, which occur at CHW–Fox Valley, must be reported to the Medical Examiner, as required by local regulations.
2.  The attending physician/physician designee will contact the referring physician and/or primary care physician.

Section B.  Documenting a Death

1.  The physician pronouncing death will document the events leading up to and including the patient's death in the medical record within two hours of the event and complete the “report of death” form.

Section C.  Organ/Tissue Donations

1.  The attending physician is responsible for informing the family of their right to give an anatomical gift.
2.  No organ or tissue donation shall be obtained without the written consent of the parent or the legal guardian.
3.  All deaths must be reported to the Organ Procurement Organization.

Section D.  Autopsies

1.  It is the responsibility of the attending physician or designee to request an autopsy and notify the pathologist if an autopsy is to be done.
2.  No autopsy shall be performed without the written consent of the parent or the legal guardian.
3.  For cases not under the jurisdiction of the Medical Examiner, the attending physician must request consent for an autopsy in deaths meeting the following criteria:
   a.  Any death that occurs within 24 hours of admission.
   b.  Any death that occurs within 24 hours of anesthesia and/or surgery.
   c.  Any death in which the clinical diagnosis is unclear.
   d.  Any death associated with trauma.
   e.  Any unanticipated death, which occurs in a patient who is under a research protocol.
   f.  Any newborn death associated with significant congenital malformation.
   g.  Unanticipated death.
4.  The pathologist will notify the attending physician of the date and time of the autopsy.


XI.  MEDICAL EDUCATION

Section A.  All patients/families will be available for teaching purposes unless otherwise requested by the attending physician.

Section B.  Medical-Dental Staff Members are Responsible for:
   a)  Teaching colleagues, residents and other health care professionals
   b)  Assuring that the patient and family's well-being will be taken into consideration.
c) Being available to residents and fellows in person or by telephone and able to be present within a reasonable period of time, appropriate to the patient care need.

**Section C. Resident Physician (Fellow, Resident and Intern) Responsibilities**

1. While assigned to CHW–Fox Valley, all residents and fellows are under the supervision of an attending physician with clinical privileges at CHW-Fox Valley.
2. While participating in patient care activities, residents and fellows are responsible to the patient's attending physician or appropriate consulting physician and are subject to the Rules and Regulations of the Medical-Dental Staff and policies and procedures of the Hospital.
3. Residents and fellows are permitted to assume increasing levels of responsibility for patient care activities commensurate with their individual progress in experience, skill, knowledge and judgment as determined by the supervising physician.

Ref: Patient Care Policies & Procedures: “Supervision of Resident Physicians”

**XII. CLINICAL RESEARCH AND PUBLICATION**

**Section A. Research on Human Subjects**

1. All human research conducted by the Hospital staff and members of the Medical-Dental Staff that involve children, parents or staff must be reviewed, approved by and performed under the direction of the Children’s Hospital of Wisconsin Research and Publications Committee/Human Rights Review Board.

**Section B. Investigational Devices or Drugs**

1. Devices or drugs for investigational or experimental purposes may be used only by approval of the Children’s Hospital of Wisconsin Research and Publications Committee/Human Rights Review Board

Ref: CHW Main Campus Administrative Policies & Procedures: “Research: The Process of Conducting Research on Human Subjects at Children’s Hospital of Wisconsin”

**XIII. PHYSICIANS' MEMBERSHIP REQUIREMENTS**

**Section A. Vigilance in maintaining an environment that minimizes infections, including the use of hand cleansing techniques**

**Section B. Continuing Medical Education relevant to the member’s practice**

**Section C. Timely return of reappointment information**

**Section D. Compliance with Hospital policies regarding TB skin testing and follow-up**

**Section E. Payment of dues and fines**

**Section F. Compliance with required immunizations:**

1. All applicants/members must provide acceptable evidence of immunity to the following:
   a) Rubella - Documented (1) MMR vaccination or titer shows positive immunity to Rubella
   b) Rubeola (measles) - If born in or after 1957, documented (2) MMR vaccinations or titer shows positive immunity to Rubeola (measles). If born before 1957, provider’s attestation of history of disease (If history is unknown, titer to be drawn.)
   c) Mumps - Documented (2) MMR vaccinations or (1) MMR vaccination for unvaccinated born before 1957 who do not have history of physician-diagnosed
mumps or titer shows positive immunity to Mumps or provider’s attestation of history of disease
d) Varicella (chicken pox) - Documented (2) Varicella vaccinations or titer shows positive immunity to Varicella or provider’s attestation of history of disease
e) Hepatitis B - Documented (3) Hepatitis B vaccinations or titer shows Hepatitis B antibody.

2. If titer shows questionable or non-immunity, applicant/member will be required to be vaccinated.
3. Members who do not fulfill the criteria for immunity for a disease may be excluded from entering the Hospital during an epidemic of the disease.

XIV. ACCEPTED ABBREVIATIONS

Section A. Use of abbreviations should be kept to a minimum. Only those abbreviations recognized by all practitioners involved in the care of the patient should be used.

Section B. Only approved abbreviations shall be used in the patient medical record.

Ref:  Patient Care Policies & Procedures: “Documentation – Patient Care”
Patient Care Policies & Procedures: “Abbreviations”

XV. AMENDMENTS TO RULES AND REGULATIONS

Section A. Departments, Sections or Committees of the Medical-Dental Staff may propose recommendations for amendments to the Rules and Regulations. The Medical Executive Committee shall review and approve amendments prior to adoption. Such Rules and Regulations shall become effective when approved by the Board of Directors.

XVI. APPROVAL OF RULES AND REGULATIONS

Section A. These Rules and Regulations shall become effective when adopted by the Medical Executive Committee of the Medical-Dental Staff and approved by the Board of Directors.

Approved by MEC 3/7/01, Adopted by Medical-Dental Staff MEC 6/6/01, Approved by BOD 6/13/01
Revised MEC 10/3/01 and 11/7/01, Approved by BOD 11/14/01
Revised MEC 12/4/02, Approved by BOD 12/11/02
Biennial Review by CMO 3/5/03
Revised MEC 1/7/04, Approved by BOD 1/30/04
Revised MEC 6/2/04, Approved by BOD 11/18/04
Revised MEC 8/3/05, Approved by BOD 8/17/05
Revised MEC 2/7/07, 3/7/07, Approved by BOD 3/29/07
Revised MEC 5/2/07, Approved by BOD 6/4/07
Revised MEC 8/5/08, Approved by BOD 8/21/08
Revised MEC 6/3/09 & 8/5/09, Approved by PAC 8/17/09, BOD 9/10/09
Revised MEC 1/6/10, Approved by QC 1/14/10, Approved by BOD 2/17/10
Revised MEC 2/3/10, Approved by QC 3/11/10, Approved by BOD 4/21/10
Revised MEC 8/4/10; Approved by QC 9/9/10; Approved by BOD 10/20/10
Revised MEC 4/6/11; Approved by QC 6/2/11; Approved by BOD 6/22/11