MEDICAL STAFF
RULES AND REGULATIONS

Ridgeview Medical Center
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RULES AND REGULATIONS

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ARTICLE 1

ATTENDING PHYSICIAN/PROVIDER

(A) The attending physician/provider shall be a member of the Medical Staff who is legally and primarily responsible for the care provided to and the treatment plan of a given patient during a specific episode of care. Such care may be delegated to other qualified health care professionals acting within the scope of their license and be a current member of the Advanced Practice Clinician Staff.

(B) The attending physician/provider has primary responsibility for the admitted patient. This patient care responsibility shall be delegated to an appropriately credentialed physician/provider ("on-call physician/provider") when the attending physician/provider is not available. If, during the course of a patient hospital stay, the primary responsibility for the care of the patient is transferred to a physician/provider other than the "on-call physician/provider," such a transfer must be documented in the doctor's orders. The second physician/provider then accepts and becomes the attending physician/provider.

(C) The admitting physician/provider is either the attending physician/provider admitting his/her own patient, or a physician/provider "on call" for the attending physician/provider at the time of the admission. The admitting physician/provider must: (a) be a member of the Medical Staff, (b) have appropriate privileges, and (c) accept responsibility for the inpatient care of the patient. It is the responsibility of the admitting physician/provider to name the attending physician.

(D) The attending physician/provider shall be responsible for the most effective use of acute care hospital services. The attending physician/provider shall be responsible for documenting the necessity of acute care hospital services and the need for continued hospitalization.

(E) The attending physician/provider shall be responsible for the preparation of a complete and legible medical record for each patient.

(F) When a consultant has been called in on a case, the attending physician/provider retains primary responsibility for the care of the patient and for the most effective use of acute care hospital services.

(G) As applicable, the exercise of clinical privileges within any service is subject to the rules and regulations, policies and procedures of that service and to the authority of the service chairperson.

ARTICLE 2

MEDICAL RECORDS

(A) GENERAL

(1) A medical record is maintained for every individual assessed or treated, including, as applicable, Inpatients, Outpatients, Ambulatory Surgery, Observation, Emergency Department, Hospice, and Home Care. The medical record incorporates information from subsequent contacts between the patient and the organization. The medical record shall be created and maintained in the electronic format ("Electronic Health Record" or "EHR") designated by the Hospital. Optimal utilization of the EHR and its functionality to meet organizational goals, reporting requirements, patient safety initiatives, public health requirements, transparency and interoperability needs shall be defined by the Hospital with input from the Medical Staff.

(2) Entries in the medical records are made only by individuals authorized to do so as specified in organization and Medical Staff policies.

(3) Every medical record entry is dated and timed, and electronically authenticated.

(4) Corrections in the medical record may only be completed by the author of an entry creating and authenticating an addendum in the EHR or by otherwise modifying or invalidating incorrect data or entries in the manner approved by the Hospital.

(5) The medical record must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. This record shall include identification data; chief complaint; an accurate, full and current problem list; medical history; history of present illness, including emergency care provided to the patient prior to arrival, if any; physical examination; prenatal records in all OB cases; as appropriate to the age of the patient, a summary of the patient's psychological needs, as appropriate; treatment plan; diagnostic and therapeutic orders electronically entered using Computer Physician Order Entry (CPOE) for Ridgeview Medical Center patients; electronic reconciliation of medications at the time of admission for Ridgeview Medical Center patients, transfer between settings of care, and discharge; findings of patient's assessment; special reports such as consultations, clinical laboratory, radiology reports, and others; provisional diagnosis; medical or surgical treatment; evidence of informed consent for surgical procedures and treatments for which informed consent is required by organization policy; operative report; pathological findings; progress notes that document response to care; nurses notes; medications dispensed or prescribed; discharge summary or discharge notes; condition on discharge; follow-up information; Physician's or Advanced Practice Clinician's instructions and plan for each current problem; discharge instructions and autopsy report when applicable and evidence of known advanced directives, other documentation necessary to support coding, reporting or other requirements of governmental, legal or payor entities.

(B) ORDERS

(1) **Order Entry**

1. All medical orders shall be entered by CPOE, or by other electronic means as applicable, by the physician or APP responsible for the care of the patient except during downtime procedures.
2. A request for visit or procedural scheduling alone need not be considered a medical order.
3. Verbal and telephone orders are to be used infrequently but are acceptable in urgent situations where the ordering practitioner is not able to promptly enter orders by CPOE. Verbal and telephone orders are considered valid if they are:
    a. Given to designated authorized personnel. These designated personnel include:
        1. Registered Nurses;
        2. Pharmacists for orders relevant to Pharmacy;
        3. Physical Therapists, Occupational Therapy, Speech Therapy for orders relevant to their respective disciplines;
        4. LPN's in home care with appropriate RN acknowledgement for orders relevant to home care;
        5. Respiratory Care Practitioners for orders relevant to Respiratory Therapy;
        6. Laboratory technicians, phlebotomist, EKG technicians for orders relevant to Laboratory;
        7. Paramedics for orders relevant to pre-hospital treatment
        8. Imaging Tech and Imaging Schedulers for orders relevant to Imaging; and
        9. MNTs for orders relative to dietary or nutritional needs or products.

    Only Registered Nurses and pharmacists are authorized to accept verbal and telephone orders for medication.

    b. Confirmed by repeat-back by the accepting personnel to the ordering physician or APP
    c. Entered electronically in the EHR by the accepting personnel
    d. Authenticated (by electronic means) by the originating physician or APP as soon as possible and within 10 days of patient discharge or death.

Order Sets

1. Defined as a grouping of individually selectable interventions that the ordering practitioner may choose to standardize and expedite the CPOE processes.
2. Order sets may be transcribed by a provider's delegate. The individual transcribed orders must be read back to the provider and must be authenticated by the ordering provider prior to any order action, unless in case of emergency. Provider login and authentication credentials may not be shared.
3. Order sets are developed and maintained by appropriate Ridgeview Service Line, Pharmacy, Nursing, and Information Technology groups.
4. Order set content and utilization may be reviewed for appropriateness by divisions of Administration and Medical Executive Committee.

Protocol Orders

1. Defined as an action or series of actions for diagnostic and/or therapeutic interventions that may be initiated based on the presence of specific clinical criteria.
2. The protocol criteria must be present and documented in the patient's medical record.
3. Once clinical criteria are met, an order by a provider or licensed independent practitioner is required to initiate the protocol.
4. Protocol orders must be consistent with nationally-recognized and evidence-based guidelines and references.
5. Protocol orders require at least an annual review and sign-off for approval by the appropriate physician, Ridgeview Service Lines, Nursing leadership and Pharmacy and Therapeutics Committee.
6. A **registered nurse** may implement a protocol that does not reference a specific patient and results in a prescription of a legend drug that has been predetermined and delegated by a licensed practitioner as defined under section 151.01, subd. 23
7. Protocol order content and utilization may be reviewed for appropriateness by divisions of Administration and Medical Executive Committee.

Standing Orders

1. Defined as diagnostic or therapeutic interventions initiated by clinical care team members without an order by a provider for patients meeting specific clinical criteria. Also known as 'contingency orders'.
2. Standing orders are defined by departmental policies/procedures and must be consistent with nationally-recognized and evidence-based guidelines and references.
3. Standing orders require at least annual review and sign-off for approval by the appropriate physician, Ridgeview Service Lines, Nursing leadership and Pharmacy and Therapeutics Committee.
4. Standing order content and utilization may be reviewed for appropriateness by divisions of Administration and Medical Executive Committee.

Documentation Assistants

1. Also known as 'scribes', Documentation Assistants enter information into the electronic health record (EHR) on behalf of providers performing a billable service.
2. A Documentation Assistant must not attend to a patient in any clinical capacity but may concurrently document through direct entry the physician or APP's narration and activities when present for the performed services.

   Examples of additional services Documentation Assistants may provide include:
   a. Assisting others in navigating the Electronic Health Record (EHR)
   b. Locating and relaying information to the provider, such as test and lab results
   c. Supporting workflow and documentation for medical record coding
   d. At the direction of a physician or APP, perform Order Preparation. The use of repeat-back of the order by the Documentation Assistant is encouraged.

Documentation Assistants who are not authorized to perform Order Issue should leave the order as pending for licensed personnel to issue the order.

2. A scribed note by a Documentation Assistant for a physician or APP must accurately reflect the clinical services provided on a specific date of service. The physician or APP is ultimately responsible for the content of scribed documentation and affirms the document's accuracy through authentication of the document.
3. A medical record note composed by a Documentation Assistant should state his or her role in composing the documentation (e.g., "Nancy Jones acted as documentation assistant for this encounter."). This statement can be documented by the Documentation Assistant, the physician or APP, or by a function of the EHR system.
4. Documentation Assistants are required to notify the physician or APP of any alerts provided through the EHR. The alerts must be addressed by the physician or APP.
5. Documentation Assistants must access the EHR under their own login identification and authentication. Provider login and authentication credentials may not be shared.
6. In certain circumstances, members of the care team may act in the capacity of a documentation assistant in addition to their clinical duties outlined by departmental policies, procedures, and job description.
7. Perform Order Preparation under the direct supervision of the physician or APP. The use of repeat-back of the order at time of entry is required.
    a. Only physicians and APPs may complete and authenticate orders, except in the case of Standing Orders.
    b. Only staff authorized by Ridgeview Medical Staff Rules and Regulations may accept verbal and telephone orders.
    c. Care team members acting as documentation assistants who are not authorized complete and authenticate orders should leave the order as pending for certified or licensed personnel to authenticate and issue the order.

All previous orders are canceled when patients go to surgery.

All orders for outpatient services shall include adequate patient identifier, the service/testing requested, the diagnosis, sign or symptom necessitating the service, and the physician's authentication.

(C) PROGRESS NOTES

(1) Provider progress notes for acute hospital and observation admissions, excluding Behavioral Health Unit patients and newborns, shall be recorded daily. Progress notes for Skilled Swing-Bed admissions shall be recorded a minimum of every seven days. All progress notes shall be authenticated, dated and timed at the time of observations. The progress note should contain sufficient information to permit continuity of care and transferability; in addition, allow coordination of care, treatment, and services

among the practitioners involved in a patient's care, treatment, and services. Progress notes should give pertinent chronological report of the patient's course in the Hospital and should reflect any change in condition and the result of treatment. The progress notes should reflect treatment plan changes based on a patient's current needs and clinical status. Progress notes shall continually reflect the need for acute hospital care.

(2) Provider progress notes for newborns shall be recorded within 24 hours of birth and include an admission exam. A discharge examination shall be performed on a subsequent day prior to discharge.

(3) Provider progress notes for Behavioral Health Unit patients shall be recorded at least three times per week. Progress notes should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the result of treatment. The progress notes should reflect treatment plan changes based on a patient's current needs and clinical status. Progress notes shall continually reflect the need for Behavioral Health Unit hospital care.

(4) Entries in the progress notes created by medical, PA, or CNP students must be on dual signature or other appropriate templates and require electronic attestation by the attending physician or, if such means are not available, require countersigning by the attending physician.

(D) CONSULTATIONS

(1) Any qualified practitioner with clinical privileges at the Hospital may be called for consultation within his/her area of expertise.

(2) The attending practitioner shall be responsible for requesting consultation when indicated and calling in a qualified consultant. When requesting an inpatient consultation, other than routine, the attending practitioner should make reasonable attempts to contact the consultant directly to provide the purpose and urgency of the consultation. Completion of the consultation shall occur appropriate to the seriousness and urgency of the problem being addressed, with best practice for completion being within 24-48 hours.

(3) If the physician caring for a seriously or critically ill patient in the CICU does not have privileges for hemodynamic monitoring, ventilator therapy, and other special therapeutic and diagnostic modalities, or the capacity to monitor and interpret them, he/she should obtain appropriate consultation in the patient's hospital course.

(4) The consultation must be electronically created and authenticated by the consultant.

(E) FINAL DIAGNOSIS/DISCHARGE SUMMARY

(1) A discharge summary shall be created in the EHR, dictated, or otherwise entered by the attending practitioner on all inpatient medical records.

(2) The discharge summary shall concisely recapitulate the reason for hospitalization, significant findings, procedures performed, treatment rendered, outcome of hospitalization, statement of condition at time of discharge, disposition of the patient, final diagnoses, a statement of instructions and plan of care for current problems, and provisions for follow-up care. Follow-up care provisions include any post-hospital appointments, how post-hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.

(3) The patient will be given a discharge instruction sheet which must be authenticated by the attending practitioner. For patients at Ridgeview Medical Center, the Hospital, and thus the practitioner, will provide patients or their representatives instruction and other data about their care via electronic means or secure electronic access within 36 hours of dismissal from the Hospital.

(4) The final diagnosis shall be included in the discharge.

(F) INFORMED CONSENT

Informed consent shall be obtained by the appropriate provider for procedures and treatments identified in the Informed Consent Hospital policy.

(G) SURGICAL PROCEDURES

(1) Operative reports shall be dictated in the medical record or created in the EHR immediately after surgery and contain at least the following:

(A) Name and hospital identification number of the patient;

(B) Date and times of the surgery;

(C) Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) 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);

(D) Pre-operative and post-operative diagnosis;

(E) Name of the specific surgical procedure(s) performed;

(F) Type of anesthesia administered;

(G) Complications (if any encountered);

(H) A description of techniques, findings, and tissues removed or altered;

(I) Estimated blood loss (specify N/A if no blood loss); and

(J) Prosthetic devices, grafts, tissues, or devices implanted (if any).

(2) All surgeries or invasive procedures that require anesthesia services (excluding minimal or moderate sedation or topical analgesics, which are not considered to be "anesthesia") require an operative report or a post-operative/post-procedure note if the operative report is not immediately available.

(3) The operative report shall be dictated or documented and authenticated in its entirety before the patient is transferred to the next level of care (i.e., before the patient leaves the post anesthesia care area).

(4) When a full operative or other high-risk procedure report cannot be entered immediately into the patient medical record after the operation or procedure, a brief post-operative progress note must be entered in the medical record by the responsible surgeon before the patient is transferred to the next level of care. The "responsible surgeon" includes the attending surgeon, assistant surgeon, or practitioner performing or assisting with a procedure present during the entire procedure. The brief post-operative note shall include identification or description of:

(A) The surgeon and assistants;

(B) Pre-operative and post-operative diagnosis;

(C) Procedures performed;

(D) Specimens removed;

(E) Estimated blood loss (specify N/A if no blood loss);

(F) Complications (if any encountered);

(G) Type of anesthesia administered; and

(H) Grafts or implants (if any).

(5) Delivery reports shall be created in the EHR immediately following the delivery. The report should contain pertinent information relating to the pre-natal and labor course and delivery. The report must be authenticated by the delivering physician.

(H) AUTOPSY

(1) The Medical Staff shall attempt to secure autopsies in all deaths that meet the criteria adopted by the Medical Staff, which may include unusual deaths or those of medical/legal or education interest. An autopsy may be performed only with a written consent by an appropriate individual, signed in accordance with state law. All

autopsies shall be performed by the relevant County Medical Examiners. Provisional anatomic diagnosis shall be recorded in the medical record within three days and the complete protocol should be made a part of the record within 60 days.

(2) The complete autopsy protocol must be authenticated by the hospital pathologist or by a practitioner delegated this responsibility.

(3) The physician ordering the autopsy, if not the primary, should notify the primary physician of autopsy request.

(I) COMPLETION OF MEDICAL RECORDS

(1) It is required that all practitioners complete training in use of the EHR appropriate to their specialty (and role). The training methodology, frequency, and requirements shall be determined by the Hospital. Medical records shall be created and completed electronically at all times with the exception of system downtime or those exemptions approved by the Hospital.

(2) The attending physician/provider is responsible for the completion of medical records for each patient. This includes all entries into the medical record. All entries must be legible, dated, and authenticated. A provider may have clinical privileges automatically relinquished for delinquent medical records. Clinical privileges include orders, scheduling, consulting, surgery, procedures, and admitting of all inpatients and outpatients. Automatic relinquishment of clinical privileges does not affect patients in-house prior to the relinquishment and does not apply to emergency admissions.

(3) A medical record shall be considered delinquent when:

(A) A history and physical examination (excluding psychiatric evaluation on behavioral health units) is not documented within 24 hours of patient admission.

(B) An operative/procedural report is not documented immediately after the procedure.

(C) Any portion of the medical record remains incomplete 30 days after the discharge or death of a patient.

(D) An emergency room visit is not documented within 24 hours of the visit.

(4) Before a physician/provider has clinical privileges automatically relinquished for delinquent medical records or any portion thereof, he or she shall receive a:

(A) Courtesy notification regarding incomplete medical records or portions thereof;

(B) Notice of pending automatic relinquishment due to delinquent medical records or portions thereof at least 48 hours prior to the suspension; and

(C) Reminder telephone call to his or her office the day prior to the automatic relinquishment.

When the above reminders have been issued and medical records or any portion thereof remain delinquent, the physician/provider may have privileges automatically relinquished. A notification letter that automatic relinquishment of clinical privileges has occurred, including the number of automatic relinquishments in the current fiscal year, will be sent to the physician/provider the week of the automatic relinquishment.

(5) If a physician/provider has automatically relinquished his or her clinical privileges:

(A) seven or more times in a calendar year for delinquent charts, or

(B) seven or more times in the calendar year for delinquent reports to include histories and physicals, Operative Reports, Emergency Department Reports, Urgent Care Reports or

(C) twelve or more times in the calendar year for a combination of delinquent charts and reports, or

(D) automatically relinquished clinical privileges four weeks in a row, the physician/provider will have relinquished staff appointment. Reapplication will be necessary to regain appointment. This process can only be initiated upon completion of delinquent medical records or any portion thereof.

(6) Refer to Medical Staff Policy for the procedure related to incomplete medical records.

(J) AVAILABILITY AND CONFIDENTIALITY OF RECORDS

(1) All records are the property of the Hospital and may be removed or otherwise made available from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. In the case of readmission or outpatient visit, previous records shall be available for use by the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Documented consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

(2) Access to medical records of patients shall be afforded to members of the Medical Staff 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 Medical Executive Committee. Service chairpersons and medical directors, or their designees, may review the EHR for the purpose of complaint resolution, quality assurance, or quality improvement.

(3) Subject to the discretion of the President and Chief Executive Officer or Vice President/Administrator, former members of the Medical Staff shall be permitted

access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

ARTICLE 3

ADMISSION AND DISCHARGE

(A) A patient shall be admitted to the Hospital only by a member of the Medical Staff.

(B) The admitting practitioner shall be responsible for providing the reason for acute care hospitalization and any required preadmission certification.

(C) In the case of an emergency admission, patients who do not have a private practitioner may select any practitioner in the applicable specialty. Where no such selection is made, a member of the active staff in the applicable specialty will be assigned to the patient, on a rotation basis. Each specialty shall have a schedule for such assignments developed in conjunction with the Emergency Department. For emergency admissions at Ridgeview Le Sueur Medical Center and Ridgeview Sibley Medical Center, patients will be admitted by the doctor on call and care will be assigned to a staff member via the provider schedule.

(D) Each member of the Medical Staff shall name another member of the Medical Staff to attend his/her patients in an emergency or when he/she is not available. In case of failure to name such a physician/provider, the Chief of Staff or the President and Chief Executive Officer of the Hospital shall have the authority to require any member of the Medical Staff to attend to the patient.

(E) The Medical Staff shall adhere to the Hospital's policies and procedures concerning the care of patients who are emotionally ill, suffer the results of alcoholism or drug abuse, are potentially suicidal, or become difficult to manage. The Medical Staff shall make use of community resources as identified by the Hospital which provide services needed by these patients, that are not provided directly by the Hospital.

(F) The Medical Staff shall adhere to the regulations under EMTALA in the event of a patient being transferred in an emergent condition.

(G) Discharge planning shall be initiated as early as a determination of need for such activity is identified.

(H) Patients shall be discharged only on an order of the attending practitioner or a member of his/her group. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. The patient or guardian shall be requested to sign or authenticate the appropriate release form.

(I) In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee.

(J) All patients, excluding Behavioral Health Unit patients, shall be seen within 24 hours of admission, by a practitioner. Follow-up visits are conducted daily by a practitioner, with the exception of Behavioral Health Unit and newborn patients. A phone consult will be required

for Behavioral Health Unit patients by the attending psychiatrist immediately (within two hours) upon admission to the unit, and the attending psychiatrist shall see the patient within 48 hours of admission and three times per week thereafter. Normal, healthy newborns shall be seen within 24 hours of birth and a discharge examination shall be performed on a subsequent day prior to discharge. For admissions of patients by an Advanced Practice Clinician at Ridgeview Le Sueur Medical Center and Ridgeview Sibley Medical Center, the Advanced Practice Clinician will notify a physician member of the Medical Staff of the patient admission and the physician member of the Medical Staff will monitor the patient if the patient's medical or psychiatric condition is outside the scope of practice of the Advanced Practice Clinician.

(K) All patients admitted to the CICU are to be seen within 12 hours of admission. If patient has a diagnosis of respiratory failure, acute MI, septic shock or upon a nurse or MD request the patient must be seen within one hour.

(L) Any physician on the Medical Staff of the Hospital may initially admit patients to CICU. However, the physician providing ongoing care in the unit must follow the policy regarding the care of patients in the CICU.

(M) The Medical Staff shall adhere to the rules/regulations, policies/procedures regarding care of patients in CICU.

ARTICLE 4

APPROPRIATENESS OF CARE

(A) Hospital staff who have concerns about appropriateness of care should notify their Manager/Director, who would then notify, if appropriate, the service chairperson, Chief of Staff or Chief Medical Officer.

(B) If, in the judgment of a service chairperson, Chief of Staff, or Chief Medical Officer a patient's condition requires consultation or transfer, the service chairperson, Chief of Staff, or Chief Medical Officer shall have the authority to require the patient's attending physician/provider to obtain a consultation or transfer.

(C) All patients with the same health problem, regardless of age, shall receive the same level of care wherever provided in the hospital.

ARTICLE 5

SURGICAL CARE

(A) The Medical Staff shall adhere to the rules/regulations, policies/procedures regarding care of patients receiving Surgical Care.

(B) The care of patients who receive surgical (including diagnostic or therapeutic invasive procedures) and anesthesia services shall be the responsibility of licensed, independent practitioners with clinical privileges granted by the Board of Directors.

(C) The practitioner's list of surgical privileges shall be kept by the Medical Staff Office. This list is also available on Ridgenet.

(D) Except in extreme emergencies, surgery shall be performed only after an appropriate history, physical exam, and any indicated lab and x-ray examinations have been completed and preoperative diagnosis has been recorded (and authenticated) in the medical record.

(E) Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. An operative report shall be written and dictated immediately after surgery by the operating surgeon for all procedures performed in the operating room.

(F) The anesthesiologist or anesthetist shall maintain a complete and authenticated anesthesia record for all patients receiving general, spinal, or major regional anesthesia. The record shall include evidence of pre-anesthetic evaluation and post-anesthesia follow-up of a patient's condition.

(G) All appropriate tissues and specimens removed during the operation shall be sent to the hospital or consulting pathologist who shall make such examinations as may be necessary to arrive at a histologic diagnosis. A report shall be completed and authenticated promptly by the pathologist and filed in the medical record.

ARTICLE 6

EMERGENCY CARE

(A) The Medical Staff shall adhere to the rules/regulations, policies/procedures regarding care of patients receiving emergency care.

(B) The Emergency Department shall be directed by a physician member of the Medical Staff.

(C) The care of patients who receive emergency services shall be the responsibility of licensed independent practitioners with clinical privileges.

(D) All members of the Medical Staff shall have the privilege of examining and treating patients in the Emergency Department within the limitations of the privileges granted by the Board of Directors.

(E) Ridgeview Medical Center's policy on notification is included in the Policy on Notification of Patient's Private Physician. For Ridgeview Le Sueur Medical Center and Ridgeview Sibley Medical Center, the emergency on-call provider must be within 30 minutes of the appropriate hospital.

(F) Patients who present for emergency care who do not have a private physician/provider shall be examined by the emergency physician/provider and/or the emergency physician assistant and/or a sexual assault nurse examiner (SANE nurse), if appropriate, and treatment rendered.

(G) A patient who requires admission and does not have a private physician may select any physician in the applicable specialty. Where no selection is made, a member of the active staff in the applicable specialty shall be assigned to the patient on a rotation basis. For Ridgeview Medical Center, each specialty shall have a schedule for such assignments posted in the Emergency Department.

(H) Specialty consultation shall be available within approximately 30 minutes by request of the attending practitioner. For Ridgeview Le Sueur Medical Center and Ridgeview Sibley Medical Center, specialty consultation will be scheduled if requested by the attending provider. There shall be a mechanism established in the Emergency Department for notification of the patient or the patient's primary physician of any subsequent findings which may affect continued care.

(I) All prior pertinent inpatient and ambulatory care patient medical record documentation, including previous visits to the Emergency Department, shall be made available, whenever possible, when requested by the attending physician/provider.

(J) An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's hospital record, if such exists. The record shall include the time and means of arrival, pertinent history, pertinent physical findings, diagnostic impression, final disposition, condition at discharge, and instructions for follow-up care. Refusal of medical treatment will be documented according to Hospital policy.

(K) Each medical record must be authenticated by the practitioner in attendance who is also responsible for its clinical accuracy.

(L) The Ridgeview Medical Center multi-casualty plan is known as Casualty Response. During a mass casualty, physicians shall be notified and assigned to specific patient treatment areas as specified in the Casualty Response Plan.

The multi-casualty plan for Ridgeview Le Sueur Medical Center and Ridgeview Sibley Medical Center is known as the Disaster Plan. During a mass casualty, providers will be notified and assigned to specific treatment areas as specified in the Disaster Plan. Disaster Plan drill must include Medical Staff participation.

ARTICLE 7

MATERNAL CHILD HEALTH (LABOR, DELIVERY, NURSERY, PEDIATRICS)

The Medical Staff shall adhere to the Maternal Child Health Department's rules/regulations, policies/procedures regarding admission and care of patients.

ARTICLE 8

PATIENTS RECEIVING CONTINUING AMBULATORY CARE SERVICES

The medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. The list is initiated for each patient by the third visit and maintained thereafter.

ARTICLE 9

DENTISTS AND PODIATRISTS

(A) The care of a patient admitted for a dental or podiatric condition shall be a dual responsibility involving the dentist or podiatrist and a physician/provider member of the Medical Staff.

(B) The dentist/podiatrist shall adhere to the rules/regulations, policies/procedures where care is rendered.

(C) Dentist/podiatrist responsibilities:

(1) Completion and authentication of the patient's history and physical examination that relates to dentistry or podiatry.

(2) Completion and authentication of an operative report (when performed).

(3) Progress notes as are pertinent to the dental or podiatric condition.

(4) Discharge of the patient.

(D) Medical Staff responsibilities for dental or podiatric patients:

(1) Medical history and physical exam.

(2) Supervision of the patient's general health status while hospitalized.

ARTICLE 10

MEDICATIONS AND INTRAVENOUS SOLUTIONS

(A) The Medical Staff shall adhere to the policies/procedures and drug formulary as recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee.

(B) All practitioners prescribing drugs subject to the Controlled Substance Act must have their DEA (BNDD) number on file with the Pharmacy or write the number on the order sheet of the chart every time a controlled substance is prescribed.

(C) There shall be an automatic cancellation of standing drug orders when a patient undergoes surgery. Other advisory stop orders for drugs are as follows:

- Control drugs – 5 days
- Antibiotics – 5 days
- All other drugs – 10 days

ARTICLE 11

MEDICAL STAFF ACCESS TO CREDENTIALS AND QUALITY FILES

Practitioners are notified of their rights to review, correct, or receive a status update on their file at the time of the initial or re-credentialing application process via the application portal/web.

(A) Applicants have the right to be informed of the status of their credentialing and recredentialing applications upon request. Requests for information on the status of an application will be made in writing to the Medical Staff Office. The Medical Staff Office, after will provide a written response to a request for application status within 14 days and specify the status of the application.

(B) Practitioners will be given an opportunity to review and to respond in writing to any written communication concerning the individual's practice and included in the individual's credentials and/or quality file.

(C) Each practitioner will be notified of the right, and offered a reasonable opportunity, to inspect his/her file and to make notes regarding it, in the presence of the Medical Staff manager, Medical Staff Leader, or President and Chief Executive Officer. In no case shall a practitioner remove the file or portions thereof from the Medical Staff Office or make copies of it, without the express permission of the President and Chief Executive Officer or other authorized designee.

Practitioners have the right to correct erroneous information in their file. Ridgeview will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner.

The notification sent to the practitioner will detail the information in question and will include instruction to the practitioner indicating:

- The requirement to submit a written response within 14 calendar days of receiving notification from Ridgeview.
- In the response, the practitioner must explain the discrepancy, may correct any erroneous information and may provide proof that is available.
- The practitioner's response must be sent to the Ridgeview Medical Staff Office.

Upon receipt of notification from the practitioner, Ridgeview will document the receipt of the information in the practitioners credentials file.

(D) The Medical Staff manager, Medical Staff specialist, Medical Staff Leader, or President and Chief Executive Officer will correct or delete materials contained in a practitioner's file only after the individual has submitted a written request demonstrating good cause for the correction or deletion and the request has been approved by the Medical Executive Committee and the President and Chief Executive Officer.

The credentialing system will automatically track and date any changes in the practitioners electronic file. The reason for the change will be documented in the practitioner file.

If a new primary source verification is obtained, it will be added to the practitioners file. It will not replace the previous verification. However, corrected data will override any previously entered information.

CONFIDENTIALITY:
Ridgeview will ensure all information obtained in the credentialing process is confidential, except as otherwise provided by law. This process includes but is not limited to: secure software system which requires password access and role based security, locked computer when unattended, badge access to office suite, user activity logs reviewed on a quarterly basis and the following process noted below:

(E) A practitioner will routinely be permitted access to the following information, provided appropriate notice is given to the Medical Staff Office:

(1) Applications for appointment, reappointment, and requested changes in staff status or clinical privileges, with all attachments.

(2) All information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in staff status or clinical privileges (except for confidential reference information obtained from third parties).

(3) Results of queries to the National Practitioner Data Bank.

(4) Any performance improvement trend sheets, and reports concerning the individual's practice at the Hospital, including quality profiles.

(5) Any routine correspondence between the Hospital and the practitioner.

(6) Information concerning the practitioner's meeting attendance record and compliance with other requirements.

(F) A practitioner may review the documents listed below while in the presence of an appropriate Medical Staff Leader or President and Chief Executive Officer. At this meeting, the practitioner will be shown the document or an appropriate summary of it (but will not be told the identity of any individuals who provided the information). The practitioner shall be given the right to submit a written explanation for inclusion in the file.

(1) Any and all incident reports concerning the practitioner which are placed into the file, along with any written explanations submitted by the individual.

(2) Any confidential correspondence and/or memos to the file, prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual.

(3) Any periodic review and appraisal forms completed by the appropriate service chairperson, including those completed at the time of appointment or reappointment.

(4) Any routine peer review evaluation forms completed.

(5) Any evaluation or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual.

(6) Confidential reports and/or minutes of peer review committees pertaining to the practitioner.

(7) Any correspondence setting forth formal Medical Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits.

(G) Because of the expectations of confidentiality on the part of individuals who submit documents, a practitioner may not have access to these documents, unless the individual providing such information consents to the disclosure, or the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Credentials Policy. These documents are as follows:

(1) Any and all confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the practitioner's training, clinical practice, professional competence, or conduct at any other health care facility or medical school.

(2) Notations of telephone conversations concerning the practitioner's qualifications with references and other third parties, including date of conversation, identification of parties, and information received and/or discussed.