THE RULES AND REGULATIONS OF THE PROFESSIONAL STAFF

KAISER FOUNDATION HOSPITALS – OAKLAND/RICHMOND

2021

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INTRODUCTION

Pursuant to Section 1-1-a, the Bylaws of the Professional Staff of Kaiser Foundation Hospital - Oakland/Richmond, the following Rules and Regulations are adopted to become effective upon approval of the Board of Directors of Kaiser Foundation Hospital.

ARTICLE I: ADMISSION AND CARE OF PATIENTS

SECTION I-A. ADMISSION AND PROVISIONAL DIAGNOSIS.

A patient shall be admitted to the Hospital only by a member of the Professional Staff with admitting privileges. A provisional diagnosis shall be stated for each patient upon admission to the Hospital.

SECTION I-B. RESPONSIBILITY FOR MEDICAL CARE

A member of the Professional Staff shall be responsible for the care and treatment of each patient in the hospital, for the timeliness, completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the patient and/or relatives of the patient.

The attending physician has the responsibility for the complete and continuing care of his or her patients. He or she is required to keep appropriate hospital personnel informed as to where he or she can be reached in case of emergency, and shall designate at least one physician to render emergency or other necessary patient care if he or she is not available. It shall be the responsibility of the Executive Committee to establish policies and procedures regarding minimum requirements for rounding by the attending Professional Staff.

SECTION I-C. PROTECTION OF PATIENTS.

All practitioners responsible for admitting patients to the Hospital shall obtain and furnish, to all Hospital personnel concerned, such information as is readily available and may be reasonable required for the protection of the patient from self-harm and for the protection of others from patients who are a source of danger.

SECTION I-D. PROVISION OF SERVICES.

Appropriate services, whether available in the hospital or requiring outside referral, shall be offered to patients based on their clinical need, including patients who are mentally ill, who become mentally ill while in the hospital, or who suffer from the effects of alcohol or other substances.

SECTION I-E. PROVISION OF PATIENT CARE.

Medically indigent patients who are admitted to the Hospital shall be attended by members of the Professional Staff.

SECTION I-F. TRANSFER OF PATIENTS.

A patient shall be transferred to another facility only when such transfer is authorized by the attending physician and has been agreed upon by an accepting physician and facility. The patient or the patient's legal representative, when he or she is reasonably available, shall consent to the transfer.

Before transferring a patient who has been diagnosed with an emergency medical condition or is in active labor, the physician shall provide emergency services and care to prevent, to the extent possible, a material deterioration of or jeopardy to the patient's medical condition or expected chances of recovery during transfer.

Clinically unstable patients shall not be transferred unless: a) the patient is being transferred to a higher level of care and the risks of transferring the patient are outweighed by the benefits of the transfer; or b) the patient insists on such transfer after being fully informed of the risks associated with the transfer.

SECTION I-G. DISCHARGE OF PATIENTS.

Patients shall be discharged only upon the order of the attending practitioner or designated member of the Professional Staff.

SECTION I-H. ATTENDANCE OF PATIENTS IN EMERGENCY SITUATIONS.

An appropriate medical screening examination within the capability of the hospital (including routinely available ancillary services) shall be provided to all individuals who come to the emergency department or labor and delivery and request (for on whose behalf a request is made) examination or treatment. Such medical screening shall be provided by qualified medical personnel. For purposes of this section, qualified medical personnel include physician members of the professional staff, [physician assistants, nurse practitioners, certified registered nurse midwives, residents interns and postgraduate fellows who are enrolled in an approved postgraduate training program] and others authorized to perform such examinations.

Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care shall be provided without regard to the patient's race, color, ethnicity, sexual orientation, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental disability, insurance status, economic status, or ability to pay for medical services, except to the extent such circumstances is medically significant to the provision of appropriate care to the patient.

The chief of each service shall establish policies and duty rosters of physicians, including physicians who serve on an "on call" basis, to provide coverage in emergency cases. In emergency situations, Professional Staff members are required to attend patients until appropriately relieved.

SECTION I-I. MEDICAL RESEARCH.

Medical research involving human subjects, including research utilizing confidential medical record information, shall be conducted only after review and approval of the [Kaiser Permanente Northern California Institutional Review Board] ("IRB"). Research shall be conducted in accordance with the applicable governmental regulations. In cases involving human subjects, appropriate written consent shall be obtained after full explanation of procedures, risks, and alternatives in a form acceptable to the IRB.

SECTION I-J. INVESTIGATIONAL ARTICLES.

Use of investigational drugs, devices, and biologics ("Articles") shall be approved by the Chief of Staff and the Kaiser Permanente Northern California Institutional Review Board ("IRB"). Such drugs shall be administered as part of an approved medical research study, or otherwise approved by the IRB, and only under the direct supervision of the approved Professional Staff member(s). Unexpected or significant adverse reactions shall be reported by the attending physician to the IRB, the study sponsor, and to the U.S. Food and Drug Administration, as required. Prior to administration of an investigational Article, the physician under whose direction the Article is administered shall ensure that patient written informed consent is obtained in a form approval by the IRB.

SECTION I-K. QUESTIONING OF ORDERS.

Physician orders may be questioned by nurse and other personnel in accordance with professional practice standards and established hospital and Professional Staff policies.

SECTION I-L. RESOURCE MANAGEMENT

The attending practitioner is required to document the need for admission and continued hospitalization after specific periods of hospital stay as identified by the Resource Management Committee and approved by the Executive Committee. This documentation must contain:

1. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
2. The estimated period of time the patient will need to remain in the hospital.
3. Plans for post hospital care.

Upon the request of the Resource Management Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reasons therefor. This report shall be submitted promptly upon receipt of such request. Failure of compliance with this policy will be referred to the Resource Management Committee for appropriate action.

SECTION I-M. REQUEST FOR EMERGENCY ASSISTANCE.

In the event that a member of the nursing staff requests a member of the Professional Staff to respond to a patient or an emergency, the Professional Staff member shall render appropriate emergency care and/or advice and shall assist in contacting the patient's attending physician.

SECTION I-N. PROHIBITION OF SPLITTING OF FEES

The practice of dividing or splitting of fees, or offering, paying, soliciting or receiving remuneration as an enticement for the referral of patients for care services is prohibited.

ARTICLE II: MEDICAL RECORDS

SECTION II-A. GENERAL PROVISIONS.

1. Complete Medical Record: The attending practitioner(s) shall be responsible to assure that a complete, legible, dated and authenticated medical record is prepared for each patient accepted for care by the Hospital. This record shall be in such form and shall contain such information as the Executive Committee and Hospital Administrator shall jointly prescribe. Entries in the medical record may be electronic or hard copy. A medical record is complete when:
    a. its contents reflect the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge
    b. its contents, including any required clinical resume or final progress notes, are assembled and authenticated; and
    c. all final diagnoses and complications are recorded.

    The following minimum information shall be included, to the extent applicable:

        i. Identification data

ii. Medical complaint(s)

iii. History of present illness

iv. Past medical history

v. Allergy history, including allergies noted during hospital stay

vi. Family history

vii. Social history

viii. Review of systems

ix. Physical examination

x. Special reports covering all consultations, clinical laboratory examinations, x-ray examinations and similar information

xi. Provisional diagnosis

xii. Referrals to other providers and agencies

xiii. Evidence of informed consent

xiv. Medications, assessments and treatments ordered

xv. Reports of operative and other invasive procedures

xvi. Anesthesia record, if applicable

xvii. Legal status of patients receiving Mental Health services

xviii. Emergency care provided to the patient prior to arrival, if any

xix. Evidence of known advance directives

xx. Consultation reports

xxi. Discharge instructions

xxii. Labor and delivery record, if applicable

xxiii. Medical or surgical treatment recommended and carried out

xxiv. Pathological findings

xxv. Daily progress notes

xxvi. Condition on discharge

xxvii. Discharge summary

xxviii. Post discharge plan

xxix. Autopsy report, when an autopsy is performed

xxx. At the time of discharge, final diagnosis without abbreviation.

2. Timely Completion: After discharge of the patient from the Hospital, records shall be promptly completed. No medical record shall be filed until it is complete, except at the direction of the Health Information Management Committee Medical Records. Records not completed within 14 days of the patient's discharge shall be considered delinquent. The Health Information Management Committee shall make

recommendations to the Executive Committee regarding handling of delinquent records and appropriate disciplinary action.

3. Signature and Authentication: As used in these rules and regulations, requirements for Practitioner signature may be met through handwritten signatures, signature stamps, or electronic signature. When a signature stamp or electronic signature is used, a statement shall be on file with the hospital to the effect that the person whose name is on the stamp or electronic signature is the only person who has access to and will use the stamp or electronic signature.

   Each entry in the medical record shall be signed by the person making the entry, dated, and the time shall be noted. The date and time shall be the date and time the entry is made regardless of whether the contents of the note relate to a previous date and time.

4. Symbols and Abbreviations: A list of symbols and abbreviations which may not be used in the medical record shall be approved by the Executive Committee

5. Progress Notes: Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity and transfer of care. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be recorded by the responsible practitioner(s) not less frequently than daily or more often when warranted by the patient's condition.

SECTION II-B. PROTECTION OF MEDICAL RECORDS.

All medical records and other records, whether in hard copy or electronic form relating to the admission, care and discharge of a patient are the property of the Hospital. The original documents shall not be removed from control by the Hospital except as required by statue, subpoena, or court order. For purposes of this section, documents are to be considered under the control of the Hospital if in the possession of The Permanente Medical Group or at the corporate offices of Kaiser Foundation Hospitals, Kaiser Foundation Health Plan, Inc. or their respective attorneys. Medical record information may be released when authorized by the patient, his or her guardian, conservator, the administrator of the patient's estate, or when required by law. Bona fide medical researchers may have access to medical records, providing they assure preservation of confidentiality of patient identity.

SECTION II-C. PATIENT CARE ORDERS.

Ordinarily, orders for patient care are communicated in writing. All written orders shall be dated, timed and signed. A written order may be hardcopy or in electronic form. Verbal orders may be given by a Practitioner with clinical privileges to a registered nurse, pharmacist, licensed vocational nurse, physical therapist or a respiratory therapist (within the lawful scope of their activities) and others as determined by the law and as authorized by the Hospital Administrator. The person receiving the verbal order shall document the order and the name of the ordering practitioner in the medical record and date, time and sign the entry with his or her own name and title. The ordering practitioner, or another practitioner responsible for the patient's care, shall review and sign verbal orders within 48 hours, unless earlier review and signature is otherwise required by law or hospital policy and procedure.

Whenever there is a significant change in the level of a patient's care, after appropriate evaluation, patient care orders shall be reviewed and revised.

SECTION II-D. SUPERVISION OF HOUSE STAFF.

House Staff shall be supervised in accordance with the hospital's graduate medical education policies and procedures, as stipulated in the program requirements by the Accreditation Council of Graduate Medical Education. Supervision can be provided by attending physicians and qualified allied health professionals. The attending physician shall document his or her involvement with the supervision of House staff by complying with supervision documentation requirements, including, but not limited to, countersigning/attesting to progress notes, operative reports, consultation, procedure notes, discharge summaries, death notes, history and physical examination reports, and by reviewing and correcting medical record entries made by House Staff. Allied Health Professionals shall document their involvement with supervision of House Staff by complying with supervision documentation requirements which includes addending/attesting progress notes, consultation notes, delivery notes, discharge summaries, history and physical examination reports, and procedure notes. Allied Health Professionals will participate in patient care under the direction of members of the Professional Staff as per our Bylaws. A member of the Professional Staff shall be responsible for the care and treatment of each patient per Section I-B.SECTION II-E. CONSENT.

The competent patient is entitled to be informed about the nature of the proposed diagnostic and therapeutic procedures, possible benefits, risks, reasonable alternatives to the proposed care or treatment, side effects related to the alternatives, risks of not receiving the proposed care, and potential complications. It is the Professional Staff member's responsibility to convey the necessary information appropriate to the patient and the circumstances, in language which the patient is likely to understand, and to document this discussion in a separate entry in the medical record.

Except in emergencies, no patient shall be subjected to any surgical, diagnostic, or therapeutic procedure that involves a significant risk of bodily harm unless informed consent is obtained from the patient or his or her legally recognized representative and all other persons, if any, from whom consent is required by law. The medical record should indicate the emergent reason for not obtaining consent.

In exceptional cases where the patient asks not to be informed, and/or where discussion of the risks or complications might, in the opinion of the Professional staff member, cause greater harm to the patient than is warranted, the Professional Staff member shall discuss the risks, complications, benefits and alternative treatments, if any, with individuals who would be an appropriate decision maker if the patient lacked capacity to make health care decision. Such a situation should be noted in the patient's medical record.

In cases where a patient is unconscious, or is an unaccompanied, unemancipated minor and requires emergency care, such condition will be documented in the medical record.

Special consents may be required, such as for patient photographs, or for observation of a surgical procedure or delivery, or for educational purposes, and will be identified by the Executive Committee consistent with legal requirements. All such consents shall become part of the medical record.

SECTION II-F. DISCHARGE SUMMARIES/DISCHARGE NOTES.

A concise discharge summary shall be included in the medical records at discharge which contains: the reason for the hospitalization; significant findings; procedures performed and treatment rendered; the patient's condition at discharge; and instruction to the patients hospitalized for less than 48 hours with minor problems, a progress note that includes the above elements may substitute for the discharge summary. For the purpose of this section, a minor problem or intervention is a problem or intervention which does not pose a significant hazard to the patient.

ARTICLE III: OPERATIVE AND HIGH RISK PROCEDURES THAT REQUIRE MODERATE OR DEEP SEDATION OR ANESTHESIA.

SECTION III-A. REQUIREMENTS PRIOR TO SURGERY OR A HIGH RISK PROCEDURE.

Except in cases of grave emergency, all of the following shall be completed and recorded before any surgery or a high risk procedure, which is defined in this section as those procedures requiring moderate or deep sedation or anesthesia:

1. Verification of the patient's identity, and the site or spinal region to be operated upon; At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or patient safety.
2. A history and physical examination no more than 30 days prior to or 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services or procedural sedation. If the history and physical was completed within 30 days prior to registration or admission, an interval medical history and physical examination update must be performed and recorded within the previous 24 hours prior to surgery or a high risk procedure;
3. Pre-operative or pre-procedure diagnosis or indication;
4. All necessary diagnostic work, including appropriate screening tests based upon the needs of the patient accomplished and recorded within 72 hours prior to surgery or high risk procedure;
5. Pre-anesthetic, moderate or deep sedation assessment. A pre-sedation assessment is completed prior to administration of moderate sedation. The pre-anesthesia or deep sedation evaluation is completed within 48 hours prior to surgery or a procedure requiring deep sedation or anesthesia services.
6. Documentation of discussion of informed consent to surgery or the procedure, including the possible administration of blood or blood components.
7. Consultation if, and to the extent that consultation is required; and
8. Documentation of informed consent for any associated anesthesia or moderate or deep sedation.
9. Before administering sedation or anesthesia, the plan or concurrence with the plan for sedation or anesthesia.
10. Reevaluation of the patient immediately before administering moderate or deep sedation or anesthesia.

If, in any surgical case, these requirements are not met before the time scheduled for surgery, the operation shall be canceled and rescheduled unless the attending practitioner states in writing that such delay would be detrimental to the patient. The medical record should then indicate the nature of the patient's condition before the start of surgery.

SECTION III-B. RECORD OF OPERATIONS AND HIGH RISK PROCEDURES.

A preoperative/pre-procedure diagnosis shall be recorded prior to the performance of surgery or high risk procedures by a practitioner with appropriate privileges who is responsible for the care of the patient.

Monitoring of the patient during operative or other high risk procedures and/or during the administration of moderate or deep sedation or anesthesia is documented.

Immediately following surgery or the procedure and before the patient is transferred to the next level of care, the surgeon or practitioner must enter a brief postoperative or post-procedure note in the medical record, which shall include those elements required by Hospital policy.

All surgery or high risk procedures performed shall be fully described by the practitioner performing the procedure. This description shall become a part of the medical record. Such descriptions shall include the name of the primary surgeon and his or her assistants or practitioner(s), the name of the procedure performed, a detailed account of the techniques used, identification of tissues, specimens and foreign material removed, if any, estimated blood loss, if any, a description of findings, and the postoperative or post-procedure diagnosis. Such description shall be written or dictated directly after surgery or a high risk procedure and placed in the medical record. A post procedure note may be written immediately and does not need to include a detailed account of the techniques. A detailed report must be documented in the medical record within 24 hours of the performance of the surgery or procedure.

The medical record contains post-procedure information: patient vital signs and level of consciousness, any medications administered, including IV fluids and administration of blood, blood products and blood components, and any unanticipated events or complications related to the surgery or procedure.

SECTION III-C. PATHOLOGICAL EXAMINATIONS.

Unless exempted by hospital policy, all tissue and foreign material, if any, removed in surgery shall be submitted, together with adequate clinical information, to the hospital pathologist. The pathologist shall make such examination as he or she may deem necessary to arrive at a pathological diagnosis, and shall submit his or her report including recommendations, if any, in writing for the inclusion in the patient's medical record.

SECTION III-D. ANESTHESIA AND DEEP SEDATION RECORD.

In addition to the practitioner's report, the record of every operation or procedure involving use of an anesthetic or deep sedation medication shall include a proper anesthetic or medication record with (i) a pre-anesthesia or pre-procedure evaluation of the patient and pertinent information relative to the planned choice of anesthesia or sedation and the surgical , obstetrical or other procedure anticipated; (ii) the administration of deep sedation or anesthesia, and (iii) a post-anesthesia or deep sedation follow-up report to be written within 48-hours of surgery or a procedure requiring anesthesia or deep sedation indicating the presence or absence of complications related to anesthesia or deep sedation.

ARTICLE IV: CONSULTATION

SECTION IV-A. CRITERIA FOR CONSULTATION

Except when consultation is precluded by emergency circumstances or is otherwise not indicated, the attending Practitioner shall consult with another qualified Professional Staff member in the following cases:

1. when the diagnosis is obscure after ordinary diagnostic procedures have been completed;
2. when there is doubt as to the choice of therapeutic measures to be used;
3. high risk patients undergoing major operative procedures;
4. in situations where specific skills of other physicians may be needed;
5. when otherwise required by the Professional Staff or Hospital rules.

ARTICLE V: MISCELLANEOUS PROVISIONS

SECTION V-A. DUPLICATION OF LABORATORY PROCEDURES.

Laboratory testing done prior to Hospital admission need not be repeated following admission if the tests have been carried out recently enough to be pertinent to the condition of the patient. A copy of the results of such

reports shall be made a part of the hospital medical record. For surgical patients, appropriate laboratory work must be performed, not more than 72 hours, before the commencement of the surgical procedure or the administration of a general anesthetic.

SECTION V-B. CRITERIA FOR AUTOPSIES.

It shall be the duty of all Professional Staff members to attempt to secure meaningful autopsies in all deaths which meet the following criteria, as identified by the College of American Pathologists, as follows:

1. deaths in which an autopsy would explain unknown or unanticipated medical complications;
2. deaths in which the cause is not known with certainty on clinical grounds;
3. deaths in which an autopsy would allay concerns of or reassure the public or family regarding the death; and
4. cases of unusual academic interest.

Autopsies will be performed only upon the written consent of a legally authorized person in the form consistent with the applicable statutes. In cases within the jurisdiction of the Coroner, his or her authorization shall be obtained first.

A preliminary report of the gross pathologic diagnoses shall be entered into the medical record within two (2) working days of the autopsy. For cases with complicated dissections or rush histology, the report may be entered into the medical record within up to four (4) working days of the autopsy The final autopsy report shall be entered into the medical record within sixty (60) working days of such autopsy. The appropriate members of the Professional Staff and the attending practitioner of the decedent patient will be notified when an autopsy is performed.

SECTION V-C. EMERGENCY PREPAREDNESS.

In preparation for possible catastrophes and disasters, the Hospital Administrator and Chief of Staff shall jointly be responsible for the establishment of an Emergency Operations Plan. The scope of this plan will relate to situations arising within the Hospital and the community surrounding it. The operational aspects of the plan will be designed to coordinate to the greatest degree possible with area-wide disaster planning.

When the Emergency Operations Plan is activated, members of the Professional Staff are to report to the Hospital and will be required to participate consistent with the Emergency Operations Plan. Practitioners may provide services consistent with the scope of their respective hospital privileges and will be assigned to appropriate tasks during the emergency situation. The Emergency Operations Plan should be rehearsed at least twice a year, preferably as a part of a coordinated drill in which other community emergency service agencies participate. There shall be a written report and evaluation of all drills, which is prepared for and reviewed by Hospital Administration and the Executive Committee.

SECTION V-D. EMERGENCY SERVICES.

Only physicians who are members of the Professional Staff shall serve in the Emergency Department.

An appropriate medical record shall be maintained for each patient cared for in the Emergency Department. If the patient is admitted, such records shall be incorporated into the hospital record.

Emergency Department medical records shall include to the extent applicable:

- Patient identification.
- Information concerning time of arrival, means of arrival and how transported.

- History of the emergency, injury or illness and care received prior to arrival at the Hospital.
- Description of significant physical, laboratory and radiologic findings.
- Diagnostic impression.
- Treatment and medications given.
- Condition of patient on discharge, including an indication that the patient left against medical advice, when applicable.
- Final disposition, including instructions given to the patient and family regarding necessary follow-up care.
- Signature of the attending practitioner who is responsible for the clinical accuracy of the record.
- Copy of any information made available to the practitioner or medical organization providing follow up care, treatment, or services.

There shall be periodic review of the Emergency Department medical records in accordance with the Quality Improvement Plan of the Hospital.

All departments shall provide for regularly available consultative services to the Emergency Department.

SECTION V-E. REGULATORY COMPLIANCE PROGRAM

All Professional Staff members and practitioners who exercise clinical privileges shall comply with local, state and federal laws and regulations, accreditation standards and the Principles of Responsibility, and shall support and participate in the Regulatory Compliance Program.

SECTION V-F. PATIENT SAFETY & SIGNIFICANT EVENTS

All Professional Staff members and practitioners who exercise clinical privileges shall support and participate in the identification, reporting and investigation of suspected Significant Events and other patient safety improvement and risk reduction activities.