The foregoing Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital, Fresno, were adopted by Active Staff effective:

10/19/11
Date

Chief of Staff

The Rules and Regulations were approved by the Board of Directors effective:

Dec 2, 2011
Date

Assistant Secretary

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RULES AND REGULATIONS OF THE PROFESSIONAL STAFF OF

KAISER FOUNDATION HOSPITAL

FRESNO

INTRODUCTION

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

ARTICLE I - ADMISSION AND CARE OF PATIENTS

SECTION I-A. ADMISSION AND PROVISIONAL DIAGNOSIS.

A. 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. Admitting physician is responsible for determining the most appropriate status for the admission and documenting such on admission orders.

B. Practitioners may not admit or treat members of their immediate families. Immediate family includes spouse, children either natural, adopted or stepchildren, mother, father, mother-in-law, or father-in-law.

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 the 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 care 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 reasonably 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 the accepting physician and facility. The patient or the patient's legal representative, when she or he 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 such 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; (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 written 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 (or 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, registered nurses functioning under standardized procedures, and others who have been 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 circumstance 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 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 approved by the IRB.

SECTION I-K. QUESTIONING OF ORDERS

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

SECTION I-L UTILIZATION MANAGEMENT.

A. The attending practitioner is required to document the need for admission and continued hospitalization after specific periods of hospital stay as identified by the Utilization 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.

B. Upon the request of the Utilization 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 Utilization 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 fees, or offering, paying, or soliciting or receiving remuneration as an enticement for the referral of patients for care or services is prohibited.

ARTICLE II - MEDICAL RECORDS

SECTION II-A. GENERAL PROVISIONS.

A. 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 without the use of symbols or abbreviations.

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

1. Identification data
2. Medical complaint(s)
3. History of present illness
4. Past medical history
5. Allergy history, including allergies noted during hospital stay
6. Family history
7. Social history
8. Review of systems
9. Physical examination
10. Special reports covering all consultations, clinical laboratory examinations, x-ray examinations and similar information
11. Provisional diagnosis
12. Referrals to other providers and agencies
13. Evidence of informed consent
14. Medications, assessments and treatments ordered
15. Reports of operative and other invasive procedures
16. Anesthesia record, if applicable
17. Legal status of patients receiving Mental Health services
18. Emergency care provided to the patient prior to arrival, if any
19. Evidence of known advance directives
20. Consultation reports
21. Discharge instructions
22. Labor and delivery record, if applicable
23. Medical or surgical treatment recommended and carried out
24. Pathological findings
25. Daily progress notes

26. Condition on discharge.
27. Discharge summary
28. Post discharge plan
29. Autopsy report, when autopsy is performed
30. At the time of discharge, final diagnosis without abbreviation.

B. 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 on order of the Administrator. Records not completed within 14 days of the patient's discharge shall be considered delinquent. The Administrator shall make recommendations to the Executive Committee regarding handling of delinquent records and appropriate disciplinary action.

C. Signature and Authentication: As used in these rules and regulations, requirements for Practitioner signature may be met through handwritten signatures, signature stamps, or computer key. When a signature stamp or computer key is used, a statement shall be on file with the hospital to the effect that the person whose name is on the stamp or computer key is the only person who has access to and will use the stamp or computer key. A signature stamp may be used only in cases where the physician finds handwriting to be a hardship. 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. Countersignatures do not require a date and time except as otherwise required.

D. 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.

E. 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-C. 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 statute, subpoena, or court order. For purposes of this section, documents are to be considered under 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-D. PATIENT CARE ORDERS.

Ordinarily, orders for patient care are communicated in writing. All written orders shall be dated, timed and signed. Verbal orders may be given by a Practitioner with clinical privileges to a registered nurse, pharmacist, licensed vocational nurse, physical therapist, respiratory therapist, or registered dietitian (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 person receiving the verbal order shall also read back to the ordering practitioner what has been written and document that he or she did read the verbal order back to the ordering practitioner. The ordering practitioner or another practitioner responsible for the patient's care shall review and sign verbal orders within 48 hours and for restraints within 24 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-E SUPERVISION OF HOUSE STAFF.

House Staff shall be supervised in accordance with the Hospital's policies and procedures. The attending physician shall document his or her involvement with and supervision of House Staff by complying with supervision documentation requirements, including, but not limited to, countersigning operative reports, consultations, discharge summaries, and history and physical examination reports and by reviewing and correcting medical record entries made by House Staff.

SECTION II-F. CONSENT.

A. The competent patient is entitled to be informed about the nature of the proposed diagnostic and therapeutic procedures, possible benefits, risks, potential complications and alternative approaches available. 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.

B. Except in emergencies, no patients 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.

C. 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 decisions. Such a situation should be noted in the patient's medical record.

D. 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.

E. 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-G. DISCHARGE SUMMARIES/DISCHARGE NOTES

A concise discharge summary shall be included in the medical records at discharge which contains: the reason for hospitalization; significant findings, procedures performed and treatment rendered; the patient's condition at discharge; and instruction to the patients and family if any. For normal newborns with uncomplicated deliveries, or for 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 - SURGERY

SECTION III-A. REQUIREMENTS PRIOR TO SURGERY.

Except in cases of grave emergency, all of the following shall be completed and recorded before surgery is begun:

A. History and physical examination as required by Section II-B.
B. Pre-operative diagnosis.
C. All necessary diagnostic work.
D. Pre-anesthetic assessment.
E. Assessment of likely need to administer blood or blood components.
F. Consultation, if, and to the extent that, consultation is required by Article IV.
G. Informed consent for the surgery and any associated 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.

A preoperative diagnosis shall be recorded prior to surgery by a Professional Staff member with appropriate hospital privileges. Immediately following surgery, the surgeon must enter a brief postoperative note in the medical record, which shall include those elements required by Hospital policy. All surgery performed shall be fully described by the operating surgeon. This description shall become a part of the medical record. Such description shall include the name of the primary surgeon and his or her assistants, a detailed account of the techniques used, identification of tissues and foreign material removed, if any, estimated blood loss, a description of the findings, and the post operative diagnosis. Such description shall be written or dictated directly after surgery.

SECTION III-C PATHOLOGICAL EXAMINATIONS.

Unless exempted by hospital policy, all tissue and foreign material, if any, removed in surgery shall be submitted as appropriate, 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 inclusion in the patient's medical record.

SECTION III-D. ANESTHESIA RECORD.

In addition to the operating surgeon's report, the record of every operation involving the use of an anesthetic other than local anesthesia shall include a proper anesthetic record and post-anesthetic follow-up report.

ARTICLE IV - CONSULTATION

SECTION IV-A. CRITERIA FOR CONSULTATION

Except where 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:

A. when the diagnosis is obscure after ordinary diagnostic procedures have been completed;
B. when there is doubt as to the choice of therapeutic measures to be used;
C. high risk patients undergoing major operative procedures;
D. in situations where specific skills of other physicians may be needed;
E. 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 of death is not known with certainty on clinical grounds; and
3. Cases of unusual academic interest.

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

A provisional anatomic diagnosis shall be entered into the medical record within three (3) days of the autopsy and a complete protocol shall be entered within sixty (60) days of such autopsy. The appropriate members of the Professional Staff and the attending practitioner of the decedent patient will be notified if/when such a request is made.

SECTION V-C EMERGENCY PREPAREDNESS.

In preparation for possible catastrophes and disasters, the Hospital Administrator and Chief of Staff shall be jointly responsible for the establishment of a Disaster 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. Members of the Professional Staff will be assigned to appropriate tasks during the emergency situation and will be required to participate.

The Disaster 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, prepared for and reviewed by the Executive Committee.

SECTION V-D EMERGENCY SERVICES.

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

B. 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 inpatient record. Emergency Department records shall include to the extent applicable:

1. Patient identification.
2. Information concerning time of arrival, means of arrival and how transported.
3. History of the emergency, injury or illness and care received prior to arrival at the Hospital.
4. Description of significant physical, laboratory and radiologic findings.
5. Diagnostic impression.
6. Treatment given.
7. Condition of patient on discharge.
8. Final disposition, including instructions given to the patient and family regarding necessary follow-up care.
9. Signature of the attending practitioner who is responsible for the clinical accuracy of the record.

C. There shall be periodic review of the Emergency Department medical records in accordance with the Quality Assessment and Improvement Program Description of the Hospital.

D. 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, the Principles of Responsibility, and support and participate in the Regulatory Compliance Program.

SECTION V-F 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 prevention activities.

The foregoing Rules and Regulations of the Professional Staff of Kaiser Foundation Hospital, Fresno, were adopted by Active Staff effective:

Date

Chief of Staff

The Rules and Regulations were approved by the Board of Directors effective:

Date

Assistant Secretary