RULES & REGULATIONS OF THE MEDICAL STAFF

PETERSBURG MEDICAL CENTER

2023

1. No patient shall be admitted to the hospital without a provisional diagnosis. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. The attending physician (or his or her designated mid-level coverage) shall be responsible for all hospital orders. Orders shall be entered into the electronic medical record. A verbal order, either in person or over the telephone, can be given to the appropriately licensed personnel. Such orders shall be entered by the licensed personnel into the electronic medical record. All such verbal orders shall be co-signed by the staff physician within 72 hours. Appropriate licensed personnel include registered nurses, pharmacists, physical therapists, radiological technicians, and medical technologists.

3. Should a need for written hospital orders arise, they must be written so as to be legible. Staff is responsible for notifying and clarifying such orders with the ordering ~~physician~~ provider as soon as possible.

4. The attending ~~physician~~ provider shall be held responsible for the completion of the ~~physician~~'s provider's portion of the electronic medical record for each patient under his or her care. This portion includes the initial history and physical exam, progress notes completed at least daily, procedure notes, discharge summary and properly electronically signed and completed physician orders. The content of these notes will be in keeping with current medical record standards.

5. A complete history and physical exam shall be available in the electronic medical record within 72 hours.

6. All paper & electronic records and images are the property of the hospital and shall not be taken from the building without the following:
   a. Paper charts: Paper medical records may not be taken from the hospital except by a subpoena or court order. In case of readmission of a patient, all previous records shall be available for use of the attending physician. This shall apply whether the patient is attended by the same ~~physician~~ provider or by another.
   b. Computer charts: Full disk encryption is required on any computers containing medical records that leave the facility. All charting outside of the facility is accepted with an approved computer utilizing a virtual private network and a minimum of AES-128 full disk encryption (BitLocker). Refer to the Acceptable Use Policy.

Surgery

7. All patients admitted to the operating suite for surgery shall have a recorded history and physical examination in the chart. When such requirements are not met, surgery shall be cancelled unless the attending physician (surgeon) states in writing that such delay would be detrimental to the patient.

8. A surgical procedure shall be performed only with the informed consent of the patient or his/her legal representative, except in emergencies.

9. All tissues removed during an operation and that are deemed necessary shall be sent to the contracted pathologist, who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis and shall sign the report.

10. Anesthesia practice shall be in keeping with current standards of anesthesia care and existing hospital policies where applicable. A proper anesthesia record shall be kept in all cases where an anesthetic is administered.

Consultations

11. Staff physicians and/or allied health professionals shall be encouraged to obtain appropriate physician consultations with either another member of the staff or outside physicians as deemed appropriate in a given clinical situation. In situations where a nurse feels that further consultation is necessary but not forthcoming, despite having raised their concern with the attending physician, they are to notify the Chief Nursing Officer of the circumstance. If the Chief Nursing Officer agrees that concern over the need for additional consultation is warranted, they are to notify the acting Chief of Staff or Medical Director who will review the clinical circumstances and discuss the matter with the attending physician. If the matter is resolved between the attending physician and the ~~acting~~ Chief of Staff or Medical Director, no further action will be required. If the Chief of Staff or Medical Director feels that the patient is at risk as a result of the care plan, he or she will have the option of assuming patient care. In this circumstance, outside peer review will be required of all pertinent medical records.

Medications

12. Every effort will be made to respect the wishes and beliefs of hospitalized patients in regard to what are often termed alternative therapies. Alternative therapies are here defined broadly as any treatment outside the realm of generally accepted medical practice or science. An example would include the cedar bark teas favored by local Native Alaskans for a variety of maladies.

13. All medications administered in the hospital setting shall be under the direction of the attending physician and nursing staff. Patient's own medications may be administered by hospital staff only if stated by physician order and the medicine is available in a clearly marked container listing the name of the medication, the dose strength and the expiration date. The nursing staff shall be given discretion to decline administering patient's own medicine (substituting hospital formulary medicine) if concerns exist about the safety and/or reliability of available patient medication. The attending physician and patient shall be notified of such concerns. Any such therapy (oral, topical or inhaled medicine, nutritional or dietary supplement, physical modalities (e.g. heat, acupuncture, electricity, magnetism) etc.) deemed by the medical or nursing staff to be potentially harmful to the patient, staff, other hospitalized patients or long-term care residents will not be allowed in the hospital setting. All proposed alternative therapies will be reviewed by the attending physician and orders entered in the chart regarding their use and the appropriate documentation of their use. If a nurse has concerns about the safety of an alternative therapy despite written orders, existing rules regarding conflict resolution shall be followed.

14. A plan for the care of mass casualties adopted by the hospital requires that all ~~physicians~~ providers shall report to their assigned posts and follow the disaster plan.

15. All ~~physicians~~ providers of Petersburg Medical Center shall at all times remain in compliance with Alaska State Law concerning abortion as detailed in Sec. 18.16.010

16. An adequate electronic medical record must be kept on every patient treated in the emergency room or as an outpatient.

Emergency Room Coverage

17. A. All active and locum tenens staff physicians will cooperatively schedule, share and provide emergency room coverage for the hospital. Being "On Call" requires the physician to be immediately available by telephone, radio, and available on site within 30 minutes 42 C.F.R. 485.618 & 42C.F.R.489.20.

    B. The "On Call" physician will have the responsibility of securing a replacement "On Call" physician should he/she desire to be "Off Call". In the event of a medical evacuation which is attended by the "On Call" physician, every effort will be made to secure a physician to accept the "On Call" in the absence.

    C. Call rotation will be determined by the medical staff and shall remain as such until mutually changed by the medical staff.

    D. All conflicts relating to which physician is on call shall be referred to the acting Chief of Staff. If unable, the Hospital Administrator will be notified and assume responsibility of clarifying who is on call.

18. A. Medical Orders for outpatient laboratory, x-ray, ultrasound, mammography, physical therapy, or other diagnostic tests, may be placed by medical or osteopathic licensed physicians; or, by other allied health professionals according to their State license restrictions; and, as long as the orders are in compliance with hospital protocols.

    B. All patients presenting to the Emergency Department will receive a medical screening exam to make an initial determination within the resources of the hospital, whether that individual has an emergency medical condition, in accordance with EMTALA regulations. All patients will be seen by the on-call provider in the Emergency Department or will be appropriately transferred same-day to the clinic.

    C. The initial medical screening exam will be performed by the practitioner on staff or nursing staff. When delegation of the medical screening exam to non-physician staff occurs, specific protocols established by the medical staff and outlined in the Emergency Room policies and procedures will be followed. No patient shall be discharged from the Emergency Department or transferred to the Clinic without first contacting the On-Call physician with results of the screening exam.

D. RN's who have completed ER orientation, which includes training in conducting the medical screening exam, are designated as qualified non-physician staff authorized to perform the initial screening exam by the medical staff and by the hospital board of directors.

Transfers

19. When, in the opinion of the attending practitioner, patient needs for care or safety could be met better in another facility, transfer shall be arranged, and the transferring practitioner shall contact the practitioner to whom referred. A copy of the necessary patient records shall accompany the patient. All applicable hospital policies regarding transfer will be followed.

20. Patients shall be discharged only by order of the attending practitioner. 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.

Disruptive Behavior Policy

This policy is applicable to all individuals granted medical staff or allied health professional privileges

Purpose:

- To assure optimum patient care by promoting a safe, cooperative, and professional health care environment.
- To prevent or eliminate conduct which
  - Disrupts the operations of the hospital, or
  - Affects the ability of staff to do their jobs, or
  - Creates a hostile work environment, or
  - Interferes with an individual's ability to practice competently.

Reports of disruptive behavior may come from any member of the Medical Staff, any hospital employee, any patient or visitor.

Unacceptable conduct examples:

- Attacks (verbal or physical) which are personal, irrelevant or go beyond the bounds of professional conduct, leveled at any practitioner, hospital personnel, patients or visitors
- Comments (or illustrations) that are impertinent or inappropriately made in a patient's medical chart or other official documents
- Criticisms that are non-constructive, addressed to the recipient in such a way as to intimidate, undermine confidence or imply stupidity or incompetence.

Reporting and Documentation of Disruptive Behavior

Reports are made to the Chief of Staff, Medical Director or the Hospital Administrator.

Written reports are required and should be done as quickly as possible following the event. Enough relevant information should be included such as names, dates, witnesses, circumstances and outcomes to allow a thorough investigation, if warranted.

If the complaint involves questionable behavior on the part of the acting Chief of Staff or if the acting Chief of Staff is unavailable within a reasonable time frame, the Hospital Administrator will designate an appropriate alternate physician for the purposes of investigation and review.

Investigation

The process of investigation will start within 10 working days of the receipt of a written complaint.

The Chief of Staff or administrator shall notify the accused practitioner of an investigation as soon as possible. Reprisals against individuals involved will not be tolerated and will result in formal disciplinary actions as directed by the Chief of Staff in consultation with the Hospital Administrator and President of the Hospital Board.

The accused practitioner will be requested to provide a written explanation of the event.

In situations where the behavior in question may have impacted the quality of patient care, the Chief of Staff or Hospital Administrator may request formal outside peer review.

Steps following the initial investigation

Unfounded accusations may be dismissed by the Chief of Staff. This shall be documented and reported to the practitioner. If the unfounded accusation came from a hospital employee, this may be reported to the individual's supervisor for corrective action if warranted.

A meeting of the parties in conflict may be appropriate to discuss the events and to discuss how to alleviate future issues. This meeting will be chaired by the Chief of Staff and may involve the Hospital Administrator, the Director of Nursing and/or a representative from the Hospital Board as deemed appropriate by the Chief of Staff. If, in the opinion of the Chief of Staff, this meeting appears to settle the matter to the satisfaction of the parties involved no additional action or reporting will be taken. In the event the accused practitioner refuses to participate in a meeting, the issue will be reviewed by the Chief of Staff, Hospital Administrator and President of the Hospital Board (JCC) for corrective action.

Unclear or complex situations, or with extenuating circumstances may result in an informal meeting with the practitioner to discuss the situation and how it could have been handled better.

Action after evaluation

A full report will be made to the Hospital Administrator and/or the President of Hospital Board. If deemed appropriate, the report may be placed in the practitioner's credentialing file. The practitioner is entitled to make a written rebuttal to the report, which will be kept with the report. Reported events shall be taken into consideration during the renewal of privileges evaluation by the Medical Staff and Hospital Board.

A single confirmed incident might be limited to a collegial discussion with the offending practitioner. The Chief of Staff or designee shall initiate such a discussion. If the practitioner's behavior was a complaint about an employee's performance, the practitioner shall be directed on how to report through the chain of command, rather than reacting in a disruptive manner

A pattern of disruptive behavior or in consideration of the magnitude of the occurrence, more formal actions shall be taken as follows:

1. Counseling session in person with the practitioner and the Chief of Staff.
2. A letter of reprimand may be issued.
3. Disruptive behavior may be grounds for temporary or permanent loss of privileges and appointment.

The practitioner working toward improving performance, problems with behavior, etc., may have the warning(s) purged from their file after one full year of demonstrated, acceptable performance and/or conduct.