RULES AND REGULATIONS OF THE MEDICAL STAFF OF LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

I. ADMISSION AND DISCHARGE OF RESIDENTS

A. The Hospital, depending on availability of beds, shall accept Residents for admission in accordance with Service 115.1 of the Health Code of the City and County of San Francisco.

B. A Resident may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admission policy of the Hospital.

C. A member of the Active Medical Staff shall be the Primary Physician, responsible for the medical care and treatment of each Resident on his or her assignment in the Hospital. On Resident relocation, the responsibility is transferred to the newly assigned Primary Physician.

D. In the absence of the Primary Physician, other Active Medical Staff physicians or as-needed night and weekend physicians are assigned by the Service Chief or Chief Medical Officer shall have the responsibility for the care of the Resident.

E. Exception can be made to the hospital admission policy in case of disaster.

F. Residents shall be admitted, transferred or discharged only on the written order of a physician.

L. In the event of a Resident's death, he/she shall be pronounced dead by a physician member of the Medical Staff within a reasonable period of time. Notification of the family shall be done by a physician except in unusual circumstances. The body shall not be released until an entry has been made in the medical record by a physician member of the Medical Staff certifying time of death. The release of bodies shall conform to hospital policy.

N. Death certificates shall be completed by the Primary Physician or the covering physician as soon as possible but no later than one business day following expiration.

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Residents admitted to the Hospital shall be under the care of an Active staff physician.¶
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Residents shall be transferred only on a written order by the responsible physician.¶
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Residents with a significant psychiatric history will be screened by the Behavioral Assessment Team prior to admission.¶
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II. MEDICAL RECORDS

A. All Medical Staff members shall be responsible for complete, accurate and legible documentation in the medical record.

B. For residents admitted to skilled nursing units, the responsible physician shall complete an admission history and physical examination within 48 hours of admission or within 72 hours if the weekend intervenes. For residents admitted to the acute units, the responsible physician shall complete an admission history and physical examination within 24 hours of admission.

C. Each of the Resident's clinical problems shall be clearly identified and addressed in the medical records. All patients in acute medical or rehabilitation require daily evaluation and progress notes. For all other Residents a monthly evaluation and progress note is required, at a minimum, unless prior arrangement is made between the Primary Physician and Chief Medical Officer or designee regarding medically stable residents who meet the criteria established by the Chief Medical Officer, for which an evaluation and progress note is required every 60 days, at a minimum. Residents who are critically ill or have complex medical problems, more frequent progress notes that reflect ongoing management are required.

D. The transferring physician shall complete relocation notes upon relocation between care units. These shall include a summary of Resident problems, treatment suggestions for continued management, indication of need for follow-up on pending data, need for tests, and any other pertinent information.

E. Residents discharged from the acute medical or acute rehabilitation unit shall have a dictated discharge summary completed by the primary physician or covering physician within 48 hours.

I. The non medication orders shall be reviewed, updated and signed at least monthly for skilled level of care Residents and as needed for acute level of care Residents. For skilled nursing units, the problem list and medication list will be verified electronically at the time of the visit. For acute units, the orders will be reviewed and updated daily.

J. Consultations shall be part of the Resident's medical record.

L. All entries in the Resident's medical record shall be dated, timed, and signed. All Provider names must be printed or stamped under the signature.

M. Entries in the medical record shall not be erased, crossed out, or removed with eradicator or other similar techniques. Errors noted at the time they are made shall be lined through and the correction made immediately following and initialed.

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H. . A surgical note shall be documented in the Resident's medical record at the time of a surgical procedure. Surgical reports shall include a detailed account of findings as well as the details of the surgical technique used.¶

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K. Written entries in the medical record shall be only in black ink.¶

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N. Errors in the content of the medical record, discovered after the time that they are made, may not be changed. A currently dated statement by the physician in the progress notes should be made, stating the correction and the reason for the correction. A notation in the margin of the page where the error was made should indicate that an error was made and refer to note with correction.

O. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and shall be signed by the Attending Physician.

P. 1. A dictated or typed discharge summary shall be completed on all Residents hospitalized for more than 24 hours and shall be signed by the physician member of the Medical Staff who completed the summary. Such summaries must be completed upon transfer of Residents between acute level of care and skilled nursing level of care units at the Hospital and when a Resident is transferred out of the facility. The Laguna Honda physician will communicate required information about the resident to the receiving physician at the time of transfer. For Residents hospitalized for less than 24 hours, the discharge summary and the admission history and physical examination may be combined in one report.

Q. When the Primary Physician is absent, the physician assigned to cover shall be responsible for completing admission histories and physical examinations, for signing the monthly orders, and for maintaining the medical record as if he or she were the Primary Physician.

R. The Primary Physician shall complete the Resident's chart within 14 days after discharge from acute level of care units and 30 days from skilled nursing level of care units. If records are not completed within 2 working days of a notice of delinquency, the name of the physician shall be referred to the Chief of Staff who may bring the matter to the Medical Executive Committee for appropriate action.

S. For a Medical Staff member resigning or retiring, every effort must be made to complete medical records before leaving. If an incomplete record is found after a member is no longer on the staff, the record will remain incomplete and closed as such with the approval of the Health Information System Committee.

T. Written consent of the Resident or his/her authorized legal representative is required for the release of medical information, unless required by law.

U. All medical records are legal documents and the property of LHH and may not be removed from the Hospital's jurisdiction and safekeeping without a court order or subpoena. In the case of readmission of a Resident, all previous records shall be available for the use of the Attending Physician. Unauthorized access or removal of medical records will result in appropriate legal act or disciplinary action. The Health Information Services Department is the custodian of all medical records.

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V. Medical records may be made available for study and research on projects approved by the Medical Executive Committee and the Hospital Executive Committee. Confidentiality of personal information shall be maintained.

III. ORDERS

All orders for treatment shall be:

1. Complete and clearly and legibly written or electronically entered;

2. Signed legibly by a practitioner;

3. Immediately reduced to writing, when dictated or telephoned to a registered nurse. The nurse taking such orders must sign them and give the name of the prescriber. The nurse taking the telephone order must repeat the order back to the physician who will then confirm accuracy. Such orders must be countersigned by a physician. The expectation is all verbal orders are signed by the end of the shift. Per rules and regulations, all verbal orders on acute units must be signed with 48 hours, and on SNF units within 5 days. A name stamp alone without a signature shall not be used. Failure of a practitioner to properly sign his/her orders for treatment will be reported to the Chief Medical Officer for appropriate action.

4. Licensed Rehabilitation Therapists may take verbal orders for rehabilitation therapies. All orders for rehabilitation therapies shall be immediately reduced to writing. The therapist taking the order must sign them and give the name of the prescriber. Such orders must be countersigned by a physician.

5. Respiratory Therapists, Dietitians and Pharmacists may take verbal orders within the scope of their practice.

IV CONSULTATIONS

D. Any qualified practitioner with clinical privileges in the Hospital may be called into consultation within his/her area of expertise. In acting as a consultant, the practitioner may make recommendations regarding diagnosis, treatment, and follow-up, and/or provide ongoing management. The primary responsibility for the general medical care of the Resident shall remain with the primary physician.

E. The Attending Physician is primarily responsible for requesting consultation. Most consultations are done by electronic referral. A report shall be created on all consultations.

F. All consultations must be documented and signed electronically or in writing by the consultant.

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G. Where circumstances justify such action, the Chief Medical Officer, Chief of Staff or Chief of Servcie may request a consultation.

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V. GENERAL RULES REGARDING SURGICAL CARE

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A. Surgical services at the Hospital are limited to procedures that can be safely performed under local anesthesia with the personnel and equipment available at the Hospital.

B. The surgeon is responsible for the proper identification of the Resident who is to have a procedure performed.

C. All Residents scheduled for surgical procedures shall have in their medical record a medical history and physical examination and appropriate laboratory tests. If these are not recorded, the operation shall be canceled. In an emergency, the foregoing is not required, but a comprehensive note should be made in the record explaining the circumstances and the condition of the Resident prior to the start of the procedure.

D. Consent shall be obtained prior to any surgical procedure or any invasive diagnostic procedure unless the delay involved in obtaining consent would be imminently detrimental to the health or well-being of the Resident.

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E. A surgical note shall be documented in the Resident's medical record at the time of a surgical procedure. Surgical reports shall include a detailed account of findings as well as the details of the surgical technique used.

F. A register of all surgical procedures needing a consent shall be kept in the Surgical Clinic.

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G. All specimens removed surgically shall be properly labeled and sent to the Hospital's contractual pathology laboratory for identification and, when indicated, tissue diagnosis shall be performed by a qualified pathologist. The pathologist's authenticated report shall be made a part of the Resident's medical record.

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H. Contaminated cases shall be assigned to, and performed in, an operating room designated for this purpose.

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VI. EMERGENCY SERVICES

A. In the event of an emergency, any member of the Medical Staff or affiliated professionals, as well as any other licensed health care professional, shall be permitted to do everything reasonable to save the life of a resident or to save a resident from serious harm. The member, affiliated professional, or other licensed health care professional

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shall promptly yield care to a more qualified member of the Medical Staff when one becomes available.

B. The Chief Medical Officer or his/her designated substitute shall work with the Administration in defining the role of the Medical Staff in Emergency Preparedness.

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VII. RESIDENT CARE POLICIES

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The Policies and Procedures adopted by the Medical Staff shall supplement these Rules and Regulations.