Children's Wisconsin-Fox Valley
Neenah, Wisconsin

MEDICAL STAFF

Rules and Regulations

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PREAMBLE

These Rules and Regulations are approved by the Children's Wisconsin (CW) Board of Directors to establish standards of practice for the Medical Staff and Professional Healthcare Providers (PHP) who have clinical privileges at the Hospital.

GENERAL OBLIGATIONS

As a condition of having clinical privileges at the Hospital, Medical Staff and PHPs agree to abide by the Medical Staff Bylaws, the Medical Staff Rules and Regulations, any and all Medical Staff and Hospital policies and procedures and any state and federal rules related to patient care and documentation.

I. DEFINITIONS

A. **Attending Physician –**a Medical Staff member who is a physician and who also qualifies as an Attending Provider (defined below). An Attending Physician has the ultimate responsibility of oversight of hospitalized patient care. When there are co-Attending Physicians, the responsibility of patient care oversight is shared by the co-Attending Physicians.

B. **Attending Provider –**a Medical Staff member who has been granted clinical privileges that permit such member to manage patients independently.

C. **Consultation** –a formalized deliberation between medical/surgical providers regarding a particular patient's care and/or the treatment of the patient.

D. **Consulting Provider** –a Medical Staff or PHP member who has been granted clinical privileges that allows such provider to provide input into the patient's care at the request of an Attending Provider.

E. **Referring Provider** –the provider who refers the patient to the Hospital for care.

F. **Primary Care Provider** –the provider who has the primary responsibility for the overall healthcare management of the patient outside of the Hospital and who may qualify as the Attending Provider if such provider has clinical privileges at the Hospital or as the Referring Provider.

To the extent that there are terms in these Medical Staff Rules and Regulations that are not defined in this Section 1.A. but appear in the Medical Staff Bylaws, such terms shall have the meaning set forth in Section 1.A. of the Children's Wisconsin-Fox Valley Medical Staff Bylaws: Governance and Organizational Manual.

II. PATIENT MANAGEMENT

A. HOSPITAL CARE

1. The Attending Physician is responsible for hospitalizing the patient, managing the patient's care, and discharging the patient.
2. The Attending Physician is responsible for communicating with the patient and/or family regarding the evaluation, condition, prognosis, plan of care, and plans for discharge or transfer, which must include reasons for discharge or transfer, and anticipated need for continued care, treatment and services.
3. The Attending Physician is expected to communicate with Consulting Providers, physicians in training and all other providers treating the patient regarding the plan of care. Adequate communication is a combination of oral communication and medical record documentation.
4. The Attending Physician is expected to communicate with the Referring Provider and the Primary Care Provider. At a minimum, this communication must occur at hospitalization and discharge. The Attending Physician shall also prepare interim progress reports as determined by the patient's clinical circumstances. Newly hospitalized patients who are stable will be evaluated by the Attending Physician or privileged designee within 24 hours of hospitalization or prior to discharge, whichever comes first.
5. Every critically ill, physiologically unstable infant who is admitted to the Neonatal Intensive Care Unit (NICU) should be evaluated by the Attending Physician or privileged designee as soon as possible but not later than 30 minutes of hospitalization.
6. Documentation should occur at the time of service and in accordance with the Documentation Standard Guidelines. Please refer to the "*CHW Medical Staff Guidelines: Provider documentation in the Electronic Health Record*". Required documentation for hospitalized patients includes:
   a. An order defining whether the hospital stay is inpatient or outpatient (procedural short stay or observation);
   b. A complete history and physical examination (H&P);
   c. Daily progress notes completed by the attending provider; and
   d. Discharge diagnosis, discharge order, and discharge summary.

B. ADDITIONAL REQUIREMENTS FOR CARE OF PATIENTS UNDERGOING INVASIVE OR DIAGNOSTIC PROCEDURES REQUIRING MODERATE OR DEEP SEDATION; OR REGIONAL OR GENERAL ANESTHESIA.

1. The provider performing the procedure is responsible for:
   a. Obtaining and documenting consent to any procedure requiring informed consent beyond the Consent for Treatment.
   b. Providing a history and physical exam (H&P) completed or countersigned by a physician that contains all of the legally required or policy required elements and

the indications for the procedure, which are clearly stated.

i. A H&P or clinic note performed within 30 days of the procedure may be utilized.

ii. H&Ps from non-staff physicians are acceptable if they are countersigned by a privileged member of the Medical Staff.

iii. An electronic or durable, legible copy of the H&P must be filed in the patient's medical record, and the provider performing the procedure must review and sign or co-sign the H&P. By signing or co-signing the H&P, the Attending Provider attests to the accuracy of the H&P.

iv. An additional statement confirming the patient's status at the time of the procedure must be entered into the patient's medical record and signed by the Attending Provider if the H&P is completed prior to the day of the procedure.

v. In an emergency, when there is no time to complete a H&P, a note containing the pre-operative diagnosis and the reason for the emergency must be recorded by the Attending Physician or privileged designee prior to the procedure.

c. Completing a complete operative report within 24 hours of procedure which must include:

i. Name(s) of the provider performing the procedure and any assistant(s);

ii. Findings;

iii. Procedure(s) performed;

iv. Estimated blood loss as indicated;

v. Whether or not any specimens were removed and their description;

vi. Complications; and

vii. Post-procedure diagnosis.

2. If the operative report is not completed immediately, a post-procedure note which includes the elements set forth in Section B.1(c) must be completed.

3. Operative documentation must be signed by the provider who performed the procedure.

4. The anesthesia service or the provider administering the sedation is responsible for all aspects of sedation/anesthesia care, including:

a. Conducting a pre-sedation/pre-anesthesia assessment prior to the start of the sedation/anesthesia.

b. Discussing and documenting relevant sedation/anesthesia options and risks with the patient and/or family.

c. Developing and documenting the sedation/anesthesia plan.

d. Administering sedation/anesthesia and monitoring the physiological status according to hospital standards.

e. Continuing post-procedure assessment and monitoring as appropriate for the patient's sedation and physiological status with appropriate handoff.

f. Completing all required documentation in the patient’s medical record as defined by Medical Staff and Hospital policy.

NOTE: Elements of this sedation/anesthesia must either be personally performed by a privileged physician or delegated to a qualified individual pursuant to hospital policy, but the physician must either be physically present or immediately available to assist the qualified delegate continuously until the patient has met criteria for post-anesthesia discharge according to hospital policy.

5. Dental and podiatry providers are responsible for:

   a. Ensuring that a H&P is completed or countersigned by a physician.

   b. Providing a day of surgery specialty-specific H&P update to include the pre-procedure diagnosis, a summary of clinically pertinent positive and negative findings which justify the need for the procedure and a detailed description of the examination of the focused area.

   c. Performing the procedure.

   d. Completing the immediate post-procedure note or operative note which completely describes the findings and technique. In the case of extraction of teeth, the dentist should indicate the number and type of teeth and fragments removed.

   e. Arranging for an Attending Physician to manage the hospitalization of the patient, if necessary.

   f. Recording pertinent daily progress notes.

   g. Documenting the discharge diagnosis.

C. CONSULTATION

Collaborative conversations between providers about patients help us provide better and safer care. These conversations do not involve an actual exam of a patient, may or may not involve review of patient information, and do not constitute a formal consultation. These discussions may involve conversations between providers outside of, or as a part of, an existing provider-patient relationship. The Medical Staff assumes that these discussions do not constitute a binding physician-patient or PHP-patient relationship, as applicable.

The individual or service conversed with may always request that a formal consultation be ordered before offering an opinion or advice.

1. A consultation may occur when:

   a. There is a need for further evaluation or when patient care needs exceed the expertise or clinical privileges of the Attending Provider; or

   b. A family or patient requests a consultation.

2. An order should be entered and the intent of the consultation, the type of consultation and the level of involvement expected should be clarified.

3. All consultations should be documented in the patient's medical record.
4. Types of consultations may include:
    a. Formal review of pathology results
    b. Opinion only regarding diagnosis or management
    c. Assistance with diagnosis or management
    d. Evaluation for a procedure
    e. Treatment of a stated condition
    f. Co-management
    g. The requesting Attending Provider or designee must communicate to the Consulting Provider:
        h. The specific patient care issues that need to be addressed.
        i. The urgency of the consultation:
            1. **Emergent** consultations for immediate threat to life or limb.
            2. **Urgent** consultations for those issues not seen as an immediate threat to life or limb.
            3. **Routine** consultations for those issues that do not meet either an emergent or urgent status.
    j. Pertinent past history and findings relevant to the consultation.
    k. Whether diagnostic tests/treatments/procedures may be ordered, scheduled or performed by the Consulting Provider.
    l. How and whom to contact to discuss findings and recommendations.
    m. Thoughtfully consider the recommendations and findings from each Consulting Provider, and clearly communicate to other members of the health care team and the family any changes in the plan of care.
5. The Consulting Provider or designee should:
    a. Acknowledge receipt of the consultation request. Resolve any questions about whether a consultation is appropriate through collegial conversations with the requesting Attending Provider.
    b. Confirm with the requesting Attending Provider the level of service requested and the urgency of the consultation:
        i. Emergent: A response either in person or by telephone is expected within 15 minutes of receiving the initial consultation request. Emergent consultations should be performed as expeditiously as possible given the specific patient care needs, but should be within one hour of receiving the initial consultation request
        ii. Urgent: A response in person or by telephone is expected within 30 minutes of receiving the initial consultation request. Urgent consultations should be

performed within 4 hours of receiving the initial consultation request.

iii. Routine: A response in person or by telephone is expected within 30 minutes of receiving the initial consultation request. Routine consultations should be performed within 24 hours of receiving the initial consultation request unless other arrangements are made between the requesting Attending Provider or designee and the Consulting Provider.

c. Review the medical record, examine the patient when indicated, and verbally communicate with the requesting Attending Provider or such provider's designee the initial findings or recommendations.

d. Perform the consultation within the established timeframe.

e. Document in the patient's medical record when the consultation was initiated, the initial findings and recommendations.

f. Communicate to the requesting Attending Provider or designee any specific requirements or prerequisites (e.g. NPO status or diagnostic evaluations).

g. Document the full consultation note in the patient's medical record within 24 hours of evaluation of the patient unless other arrangements are made between the requesting Attending Provider or designee and the Consulting Provider.

h. Communicate preliminary information to the patient or family.

i. Final recommendations should be communicated to the patient/family only after a discussion with the requesting Attending Provider or designee has occurred.

j. Specify which service will be responsible for follow-up on pending tests during the hospital stay and after discharge.

k. Arrange for ongoing follow-up after discharge when indicated or formally document a sign off of the Consulting Provider's involvement in the patient's ongoing care.

D. TRANSFER OF SERVICE

1. A transfer of service occurs only after there is agreement by the accepting physician to assume care.
2. An order to transfer care to a different service should be entered.
3. If the patient care is being transferred to a service which does not have prior knowledge of the patient, transfer documentation should be completed by the transferring service. This documentation should include a summary of the hospital course, significant diagnostic testing results and current relevant treatments and should be sufficient for the new service to assume care of the patient. The documentation should be available prior to a planned transfer and completed promptly after an emergent/unplanned transfer.

E. ALTERNATIVE PLAN OF CARE:

Code status is presumed to be a full code unless there are alternate code orders entered.

Conversations with patients and families about alternate care plans should be documented in the patient's medical record.

F. CARE IN THE SPECIALTY CLINIC (NON PRIMARY CARE CLINICS)

1. All care must be performed under the direction of a privileged Medical Staff provider or PHP.
2. Documentation should occur at the time of service and should comply with the documentation standards set forth by the Medical Staff.
3. Providers are expected to call the Referring Provider after an assessment, if requested.

Please refer to the "*CHW Medical Staff Guidelines: Provider documentation in the Electronic Health Record*".

G. CARE OF PATIENTS RECEIVING TELEHEALTH SERVICES

1. Any telehealth services provided at the Hospital must be provided through an established program and an executed agreement that includes written standards of care that have been reviewed and recommended by the MEC and approved by the Board.
2. Medical Staff providers and PHPs providing telehealth services must comply with the Medical Staff Bylaws and applicable laws and regulations, including appropriate licensure to practice medicine in Wisconsin and as required by the law or policy of the state in which the patient is located.
3. Documentation must occur at the time of service. At a minimum, a short note summarizing the care provided must be written in the patient's medical record.
4. The clinical note containing pertinent elements of the history, physical examination, and diagnostic studies and an evaluation and management plan must be completed within 24-hours of service.
5. The quality of telehealth services will be reviewed as part of the regular privileging and credentialing process for any Medical Staff provider or PHP who provides telehealth services.

Please refer to the Administrative Policy & Procedure: *"Telemedicine Services between CHHS Entities"*.

H: TELEPHONIC CONVERSATIONS OR ELECTRONIC COMMUNICATION

Telephonic conversations or electronic communications regarding care that occur among providers and patients and/or families should be documented in the patient's medical record.

III. ACCEPTED ABBREVIATIONS

Use of abbreviations should be kept to a minimum. The only abbreviations to be used in the medical record are those that are published in "*Stedman's Medical Abbreviations, Acronyms &*

Symbols" or abbreviations that are not on The Joint Commission's Official "Do Not Use" List of Abbreviations.

Please refer to the Patient Care Policy & Procedure: *"Abbreviations"* for a list of unapproved abbreviations.

IV. MEDICAL ORDERS

A. General Rules

1. There are no standing orders that apply universally to all hospitalized patients.
2. When possible, medical orders should be entered into the patient's medical record by the ordering provider as per hospital policy.
3. A facsimile transmitted order with signature is acceptable as a written order.
4. All medical orders must be reviewed, modified as needed, and authenticated by the ordering provider or designee with the exception of those orders which are done under a delegated medical protocol.

B. Verbal Orders

Verbal orders must comply with hospital policy. Please refer to the Patient Care Policy & Procedure: "*Patient Care Orders*."

C. Refusal to Sign/Authenticate an Order

In the circumstances that a listed provider or designee(s) refuses to authenticate an order, the provider or designee shall reject the order and select the reason for the rejection. Health Information Management personnel will then review the rejected order and determine the reassignment of that order. In cases where there is a dispute regarding who the ordering provider should be, it will be assigned to the Attending Physician of record for the day the order was written.

V. PATIENT DEATH, TISSUE AND ORGAN DONATION, AND AUTOPSY

Managing the death of a patient, tissue donation and consent for an autopsy shall be done in accordance with Hospital policy. Please refer to the following Patient Care Policies & Procedures: *"Care of a Dying Patient and Disposition of a Body"; "Consent for Treatment"; and "Organ and Tissue Donation"*, as applicable.

VI. RESTRICTIONS ON TREATMENT OF SELF, FAMILY MEMBERS AND CO-WORKERS

All providers must comply with hospital policy. Please refer to the Administrative Policy & Procedure: *"Self or Co-worker Diagnosis and Treatment of Work-Related Injuries or Other Health Related Problems"* as it relates to treating self, family members and co-workers.

VII. DELINQUENT MEDICAL RECORDS

An incomplete inpatient medical record is considered delinquent seven (7) days post-discharge. An ambulatory service encounter is considered delinquent fifteen (15) days postdate of service as defined by Hospital policy.

Please refer to the Administrative Policies & Procedures: "Suspension Process for Delinquent Medical Records" for inpatient medical records and "*Medical Records – Completion of the Medical Record*" for ambulatory services medical records for detailed process on suspension of scheduling privileges for delinquent operative/procedure reports and suspension of privileges for delinquent medical records.

VIII. MEDICAL EDUCATION

A. All patients are eligible to be observed by or to receive care from medical trainees (fellows, residents and students) unless the Attending Physician or the family objects to trainee participation.

B. Fellows and Residents.

1. All fellows and residents are considered to be under the supervision of the teaching director of their respective programs while assigned to the Hospital.
2. While participating in patient care activities, fellows and residents are responsible to the patient's Attending Physician or appropriate Consulting Provider and are subject to these Rules and Regulations of the Medical Staff, and policies and procedures of the Hospital.
3. Fellows and residents are permitted to assume increasing levels of responsibility for patient care activities commensurate with their individual progress in experience, skill, knowledge, and judgment, as determined by their program directors.

C. Medical Students.

Medical students are responsible to the training director or assigned Attending Physician.

D. Medical Staff provider and PHP's responsibilities

Medical Staff providers and PHPs are expected to collaborate and communicate with trainees in order to jointly provide safe and quality care to patients. Concerns about a trainee's conduct or patient care should immediately be reported to the trainee's teaching director or Department Chair or designee.

Please refer to the Administrative Policy & Procedure: "*Supervision of Resident Physicians and Medical Students*".

IX. CLINICAL RESEARCH AND PUBLICATION

In order to perform research on human subjects at the Hospital, all investigators must obtain the approval of an Institutional Review Board in accordance with hospital policy. Please refer to the Administrative Policy & Procedure: "*Research: The Process of Conducting Research on Human Subjects at Children's Hospital of Wisconsin and Affiliates*."

X. AMENDMENTS TO RULES AND REGULATIONS

These Rules and Regulations may be amended by the MEC and shall become effective once approved by the Board.

Adopted by the Medical Staff: 12/10/2021

Approved by the Board: 2/16/2022