Southeast Health Center of Stoddard County

MEDICAL STAFF
RULES AND REGULATIONS

Approved: April 2008
Revised: April 2013

SOUTHEAST HEALTH CENTER OF STODDARD COUNTY

MEDICAL STAFF RULES AND REGULATIONS
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SOUTHEAST HEALTH CENTER OF STODDARD COUNTY

MEDICAL STAFF RULES AND REGULATIONS

These Rules and Regulations are adopted in connections with the Medical Staff Rules and made a part thereof. The definitions and terminology of the Bylaws also apply to these Rules and Regulations.

I. <u>ADMISSION AND DISCHARGE</u>

A. Admission of Patients

1. <u>Professionals Who May Admit and Care for Patients</u>

(a) Only Practitioners granted Medical Staff membership and clinical privileges may admit patients to this Hospital, as provided and delineated in the Medical Staff Bylaws and Rules and Regulations. Only Practitioners granted clinical privileges may treat patients at this Hospital, as provided and delineated in the Medical Staff Bylaws and these Rules and Regulations. All Practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital.

(b) Dentists, Podiatrists and other Independent Non-physician Practitioners (INPs) with authority to admit patients to the Hospital must obtain a physician member of the Medical Staff to perform an admitting history and physical for the patient being admitted, and all other requirements and limitations with respect to such Practitioners shall be carefully observed.

(c) Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the unit or service medical director or special care committee.

1. <u>Categories of Patients Who May Be Admitted</u>

The Hospital shall accept all categories of patients for care and treatment except as follows:

(a) Highly specialized care, equipment, or evaluation not available at this Hospital

(b) Major burns
(c) Neonates needing intensive care
(d) Organ Transplants
(e) Substance abuse, e.g. alcohol, drug abuse*
(f) Mental Disease*
(g) Pregnant Females in Active Labor

(See the Hospital's written plan for the care and/or appropriate referral of patients who are emotionally ill or who become emotionally ill while in the Hospital or who suffer the result of alcoholism or drug abuse)

*Patients who are known to be suffering from drug abuse, alcoholism, and mental illness shall not be admitted unless they have a medical condition requiring the care and facilities of this Hospital and that proper safety precautions can be taken to safeguard the patient, other patients, and employees. The Chief of Staff or his designee shall determine whether such admission is appropriate.

2. <u>Admission Policy</u>

(a) A qualified member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for prompt, complete and accurate medical records, and for the transmitting reports on the condition of the patient, if appropriate, to the referring Practitioner. Whenever these responsibilities are transferred to another Practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's conditions shall be made and the Practitioner, transferring his responsibility shall notify the other Practitioner, to ensure the acceptance of that responsibility is clearly understood.

(b) The patient shall be assigned to the service concerned in the treatment of the disease, which necessitated admission. In the case of the patient requiring admission who has no Practitioner, he shall be assigned to the physician on-call ("On-Call Physicians") for the service to which the illness of the patient indicated assignment.

(c) A patient to be admitted on an emergency basis shall be given the opportunity to select a member of the Medical Staff to be responsible for the patient while in the Hospital. The patient shall be advised of the non-physician status of certain Medical Staff members, whom he may select. Where no such selection in made or where the selected Practitioner cannot assume responsibility for the care for the patient, the On-Call Physician shall assume responsibility for the patient.

(d) Except in the case of emergency admission, no patient shall be admitted to the Hospital until a provisional or admission diagnosis or valid reason for admission has been stated. In the case of an emergency, such diagnosis shall be recorded as soon as possible. A copy of the emergency service record shall accompany the patient to the nursing unit.

(e) Practitioners shall be able to justify emergency admissions based on criteria developed by the Medical Staff. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admissions. Violators of this rule shall be referred to MEC for appropriate action.

(f) Whenever a patient will have to be admitted to the Hospital, the On-Call or admitting Practitioner shall when possible, first contact the admitting office or, if closed, the nursing supervisor, to ascertain if there is a bed available.

(g) Each member of the Medical Staff shall name another qualified physician member(s) of the Medical Staff as an alternate ("Alternate Physician") to be called to attend his patients in an emergency when the attending physician is not available or until the attending physician can be present. Each member of the Medical Staff shall advise the Chief of Staff and Hospital CEO in writing of the identity (ies) of his/her alternate(s). A master file shall be maintained in the Emergency Department. In case the Alternate Physician is not available, the Chief of Staff, Hospital CEO or his designee shall have the authority to call the On-Call Physician or any other qualified member of the Staff to attend the patient. Failure of a member of the Medical Staff to meet these requirements may result in disciplinary action.

3. Admitting Priority

Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds.

(a) Emergency
(b) Urgent
(c) Pre-operative (elective)
(d) Routine

The committee responsible for the UR functions shall review admissions that do not meet the established criteria for the above categories. Unjustified variations shall be reported to the MEC for appropriate action.

B. Discharge of Patients

1. A patient shall be discharged from the Hospital only on the order of the patient's attending Practitioner. If a patient leaves the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation immediately shall be made in the patient's medical record.

2. Practitioners shall use their best efforts to write discharge orders that will allow patients to be discharged from the hospital by 11:00 a.m. on the day of discharge.

C. Patient Transfers Within the Hospital

1. The patient shall not be transferred within the Hospital without the approval of the attending Practitioner. The order of priority for patient transfers shall be as follows:

   (a) From emergency service to intensive care unit.
   (b) From general care unit to intensive care unit in an emergency.
   (c) From emergency service to appropriate care unit.
   (d) From intensive care to general care unit.
   (e) From temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit for the patient being transferred.

2. If the ICU/SCU is full and a patient requires care, physicians attending patients in the ICU/SCU will be called to discuss the possibility of transferring a patient to the med/surg unit. If there is no agreement to transfer, the Chief of Staff shall make the decision. He/she may consult another physician in advance of making his/her decision.

D. Utilization Review

1. Practitioners shall abide by the Hospital's Utilization Review Plan to include:

   (a) The appropriateness and medical necessity of admissions.
   (b) The appropriateness and medical necessity of continued stay.
   (c) Alternatives to inpatient services such as home health and ambulatory care services.
   (d) Supportive services.
   (e) Discharge planning.

E. Deceased Patients

In the event of a Hospital death, the deceased shall be pronounced dead by the attending Practitioner or his designee, or the Emergency Department physician within a reasonable time. The body shall not be released until entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform to local law.

F. Autopsies

1. Southeast Health Center of Stoddard County has no in-house facilities for autopsies. All autopsies will be performed outside the Hospital in a facility with an adequately equipped autopsy morgue. Each attending Practitioner will be responsible for arranging autopsies, including transportation of the deceased to and from the Hospital.

2. Family Request

(a) The appropriate individual must sign permission for the autopsy.

(1) If there in an Advance Directive citing an individual as Health Care Power of Attorney designated by the patient, this is the individual who will be required to grant permission for the autopsy.
(2) In the absence of Health Care Power of Attorney, the following priority list will be used to determine who may sign for permission:
    (i) Legally appointed guardian.
    (ii) Surviving spouse (or in the case of a child, both parents or parent with legal custody.
    (iii) Adult child of deceased (over 18 years of age)
    (iv) Adult sibling of deceased.
(3) In the event the telephone permission in obtained, this phone verification should be made by two staff members and noted on the permission for autopsy.
(4) If any limitations to autopsy are stipulated, these shall be noted on the permission.

(b) The Attending Practitioner shall be notified of the autopsy request.

(c) The Laboratory is responsible for notification of the Pathologist, or other designated Physician with autopsy privileges.

2. <u>Physician Request</u>

(a) It is recommended that the medical staff attempt to seek permission for autopsy in the following cases:

(1) Unanticipated death.
(2) Death occurring while the patient is being treated under any new therapeutic trial regimen.
(3) Intraoperative or intraprocedural death.
(4) Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
(5) Death incident to pregnancy or within 7 days of delivery.
(6) Death where the cause is sufficiently obscure to delay completion of the death certificate.
(7) Death in infants/children with congenital malformations.

(b) Attending Physician is responsible for obtaining permission if autopsy is desired. Explanation of the procedure is the responsibility of the physician, with consultation of the Pathologist if desired. Authorization for granting autopsy permission shall follow the guidelines noted above.

(1) Facility staff may assist in completing paperwork for permission, and witness such permission.

(2) Facility staff will notify the Laboratory of autopsy request.
(3) Laboratory will be responsible for notification for the Pathologist.

4. <u>Medical Examiner Cases</u>

(a) Permission should not be sought for cases identified by the following criteria, or cases previously identified as falling under the jurisdiction of the county Coroner or Medical Examiner. Medical Examiner or Coroner is directly responsible for disposition of the following groups of death:

(1) Dead on arrival at the hospital.
(2) Death occurring within 24 hours of admission if not conscious during admission, and not regaining consciousness prior to death.
(3) Death involving an accident, suicide attempt or successful suicide, or suspicious circumstances of any type (regardless of length of hospitalization).
(4) Unattended death, regardless of cause. (Definition: Death where a person dies of apparently natural causes but has no physician who can certify the death as being due to natural causes).
(5) Workers compensation cases (regardless of length of hospitalization).
(6) Death in which the physician is unwilling to sign the death certificate (regardless of length of hospitalization).
(7) Death of a child after birth but before the age 7, if death is unexpected or unexplained.
(8) When the patient is an inmate of any penal institution or in the custody of law enforcement agents.

(b) Physicians are ultimately responsible for determining if Medical Examiner criteria are met.

(c) In the event Medical Examiner criteria are met, the physician should either request facility staff, notify the coroner or indicate the physician will notify the coroner.

(1) Facility staff will notify the Coroner upon request of the physician and follow instructions given by the Coroner.
(2) Notation of this process shall be made in the medical report.
(3) Notification of the Coroner should occur as soon after demise as possible.

(d) If facility staff does not receive an order to notify the Coroner and has reason to suspect that Medical Examiner criteria is met, the CEO or Administrative person on-call should be notified.

(1) If after review of the case, the CEO or designee determines criteria is met, the Physician should be queried regarding notification or query the Coroner for clarification and provide the information to the physician.
(2) The CEO or designee shall document this process in the medical record.

(E) Preparations of Remains in Medical Examiner Cases

(1) No invasive apparatus (IV lines, Foley catheter, ET tubes, chest tubes, etc.) should be removed until the Coroner so authorizes removal.
(2) IV fluids, ventilators, etc. may be turned off, clamed, plugged, etc., but no removal should occur until the Coroner authorization or release is provided.

4. Medical Record Inclusion of Data

(a) Results of autopsy, with gross and microscopic findings shall be recorded in the medical record within 30 days of the autopsy.
(b) In cases not under the jurisdiction of the Medical Examiner, all microscopic interpretations will be made by the Pathologist.

II. EMERGENCY SERVICE

A. General Conditions

1. Members of the Medical Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.

2. Clinical privileges shall be delineated for all Practitioners rendering emergency care in accordance with Medical Staff and Hospital procedures.

3. The Emergency Services Medical Director or the Emergency Service Committee shall have the overall responsibility for emergency medical care.

4. At least one emergency physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven (7) days per week. The emergency physician shall respond to any patient emergency "Code Blue" when the attending Practitioner is not immediately available, provided such response does not endanger emergency department patient, in which case, the emergency department physician must decide which case(s) take priority.

5. When appropriate, as determined by the emergency service physician on duty, the patient's private physician shall be called in accordance with the emergency service policies and procedures.

6. Emergency service policies and procedures shall be approved by the Emergency Services Medical Director, the Critical Care Committee, the Medical Staff and the CEO.

7. Except in cases where transfer to surgery is not indicated in the judgment of the emergency physician, all surgery shall be performed in surgery.

8. In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency physician, the radiologist shall notify the emergency physician currently on duty and/or the patient's private physician as soon as possible and copies of the radiologist's report shall be made available to the emergency physician and the patient's private physician.

9. The Emergency Services Medical Director shall coordinate the review of emergency department records with the appropriate Medical Staff committee.

10. The Emergency Services Medical Director or the Emergency Service Committee shall be responsible for periodic patient care evaluation studies concerning the quality and appropriateness of patient care.

B. <u>Emergency Room Records.</u>

1. An appropriate emergency department record or log shall be kept listing every person who presents himself or is brought to the emergency department for treatment or care and a notation concerning treatment or transfer.

2. An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's Hospital record. The emergency service record shall include:

   (a) Adequate patient identification.

   (b) Information concerning the time of the patient's arrival and by whom transported.

   (c) Pertinent history of the injury or illness, including details of first aid or emergency care given to the patient prior to his arrival at the Hospital and history of allergies.

   (d) Description of significant clinical, laboratory and X-ray findings.

   (e) Diagnosis, including condition of patient.

   (f) Treatment given and plans for management.

   (g) Condition of patient on discharge or transfer; and,

   (h) Final disposition, including instructions given to the patient and/or family, and necessary follow-up care.

3. Each patient's emergency medical record shall be signed by the Practitioner in attendance, who is responsible for it's clinical accuracy.

4. The original emergency service medical record shall accompany a patient being admitted as an inpatient and is included as part of the inpatient record.

C. Emergency Department Consultations, Referrals, Transfers and Admissions

1. When the Emergency Department physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department physician is needed, the patient shall be permitted to request the services of a specific physician. This request will be documented in the patient's medical record as well as the physician or their designee ("Requested Practitioner") contact attempts.

2. An appropriate attempt to contact the Requested Practitioner will be considered to have been made when the Emergency Department physician or Emergency Department designee has followed the individual notification process for a specific physician as outlined below:

   (a) Attempted to reach the physician in the hospital;
   (b) Called the physician at home;
   (c) Called the physician and his/her office; and
   (d) Made at least 3 attempts to contact the physician by pager.

   Thirty (30) minutes will be considered a reasonable time to carry out this procedure.

3. An Emergency Department Physician, when they reasonably believe it is necessary, shall have the authority to require that a patient **be evaluated** by the Requested Practitioner (or On-Call Physician, if necessary). The On-Call Physician/Requested Practitioner is required to respond by telephone within fifteen (15) minutes after the notification process is initiated pursuant to Section II.C.2 above. If requested to come in, they are to respond within one (1) hour of the ER attempt to contact the On-Call Physician. Until the imposed requirement is met, the Emergency Department Physician shall continue to be responsible for the patient's medical management. Upon examination of the patient, the Requested Practitioner (or On-Call Physician, if necessary) assumes responsibility for the care of the patient.

4. The patient's Requested Practitioner (or On-Call Physician, if necessary) shall be notified of planned admission by the Emergency Department Physician. Until the actual physician-to-physician notification takes place, the Emergency Department physician remains principally responsible for the patient. After

notification of the admission, the Requested Practitioner (or On-Call Physician, if necessary) assumes the responsibility for the patient.

5. If the Requested Practitioner (or On-Call Physician, if necessary) feels that consultation with another physician is indicated, it will be that physician's responsibility to make the second referral once (s)he has accepted care of the patient. If the first physician has not accepted care of the patient from the Emergency Physician, the Emergency Physician is responsible for making the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

6. Patients with conditions whose definitive care is not within the scope of services provided by the Hospital shall be referred to the appropriate facility when in the judgment of the attending physician, the patent's condition permits such a transfer. EMTALA regulations will be followed on any emergency services patient transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.

D. Physician On-Call Process

1. The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. The on-call calendar ("calendar") will be prepared at least ten (10) days in advance of each calendar month. The Calendar will list the days each physician is responsible for "official" emergency call, i.e. serve as the On-Call Physician. The Calendar will at a minimum include primary care services. Additional specialties and subspecialties will be included if a particular specialty service e.g., general surgery, orthopedics, cardiology, gastroenterology, is provided on a full time basis at the Hospital.

   Unless otherwise modified by the Medical Staff, the primary care and any specialty care on-call lists will be rotated alphabetically per calendar day.

   In the event a specialty has only one or two physicians, those physicians must notify the Hospital in advance of the Calendar publication date any future days they will be unavailable. A specialty physician is not required to be on-call more then one day out of three. Therefore, there will be some days with no On-Call Physician in that specialty. A specialty physician failing to notify the hospital in advance of the Calendar publication date of any days they will not be available will automatically be put on the Calendar on a rotating one day every three-day basis.

   When a physician is on the Calendar that is considered an "official" day and they must provide care for any and all patients in their specialty. On days the

physician is in town but not on the Calendar, they are not obligated under federal rules to provide care.

Physician trading-off "official" day call coverage with another physician must notify the Emergency Department in advance so that the Calendar can be modified.

2. In the event that the patient does not have a private physician or the Requested Practitioner states there is no ongoing patient-physician relationship and refuses the patient's request for services or the Requested Practitioner cannot be contacted within fifteen (15) minutes of the initial attempt, the On-Call Physician shall provide the necessary consultation and/or treatment for the patient. The On-Call Physician may not refuse to respond. Any such refusal shall be reported to the Chief of Staff and Hospital CEO for further action and may constitute grounds for disciplinary action.

3. The On-Call Physician shall be responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit transfer or discharge of the patient by the On-Call Physician. The physician remains responsible for the care of the patient if the patient returns to the hospital within fourteen (14) days of discharge with the same medical problem.

4. All members of the Active Staff (and Provisional Staff seeking Active Staff membership) shall participate in the on-call calendar process.

5. The On-Call Physician/Requested Practitioner is required to respond by telephone within fifteen (15) minutes after the notification process is initiated pursuant to Section II.C.2 above. If requested to come in, they are to strive to respond within one (1) hour after notification by telephone. The request to come in may be made by a physician or the Nursing Supervisor only.

E. Screening, Treatment & Transfer Under EMTALA Regulations

(a) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination within the capability of the Hospital's emergency medical department to determine whether that individual is experiencing an emergency medical condition. An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of **immediate** medical attention could reasonably be expected to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy;
(2) Serious impairment to any bodily function;
(3) Serious dysfunction of any bodily organ or part; or
(4) With respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery or that the transfer may pose a threat to the health or safety of the woman or the unborn child.

(b) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.

(c) All patients shall be examined by qualified medical personnel, which shall be defined as a physician or registered nurse trained in emergency medicine pursuant to hospital policy, Medicare and other applicable state and federal regulations.

(d) Services available to Emergency Department patients shall include those ancillary services routinely available to the Emergency Department, even if not directly located in the Department.

(e) If an emergency physician treats a patient who has been evaluated at another facility for the same condition, it shall be reported to the Emergency Services Medical Director and CEO, who shall then be responsible for evaluating and reporting any EMTALA violations.

2. Stabilization

(a) Any individual experiencing an emergency medical condition must be stabilized within the staff and facility capabilities at the Hospital prior to transfer or discharge, excepting conditions set forth below.

(b) "Stabilization" is achieved when no material deterioration is likely to result from the transfer or discharge of the individual, or, in the case of a pregnant woman having contractions, when the woman has delivered (including the placenta).

(c) Any individual does not have to be have to be stabilized when:

(1) The individual, or responsible party, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or

(2) Based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the increased risk to the individual,

and a physician signs a certification, which includes a summary of risk and benefits to this effect.

(d) If any individual refuses to accept the proposed stabilizing treatment, the Emergency Department physician, after informing the individual of the risks and benefits of the proposed treatment and the risks of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department physician shall document the patient's refusal in the patient's chart.

3. Transfer

(a) The Emergency Department physician/transferring physician shall be responsible for contacting the accepting physician or their representative.

(b) The Emergency Department physician/transferring physician or designated hospital employee shall obtain the consent of the receiving hospital facility before the transfer of an individual and shall also make arrangements for the patient transfer with the receiving hospital.

(c) The condition of each transferred individual shall be documented in the Medical Records by the Physician responsible for providing the medical screening, examination, and stabilizing treatment.

(d) Upon transfer, the Emergency Department shall provide appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who had refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(e) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer. The consent or refusal must be documented in the medical record.

III. MEDICAL RECORD RELATED MATTERS

A. General

1. Comprehensive and accurate records are critical to the delivery and documentation of quality care as well as to various legal and regulatory requirements. The following rules must be read, understood and carefully

adhered to. Record keeping requirements referred to in other sections of these Rules and Regulations and the Medical Staff Bylaws also apply.

2. All entries into the record should include the date, time and signature.

3. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

4. In case of readmission of a patient, all previous records shall be available for use by the attending Practitioner.

B. Responsible Part and General Content

The attending Practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; complaints; general personal history; allergic history; family history; history of present illness; physical examination; diagnostic and therapeutic orders; appropriate informed consents; special reports such as consultations, results of therapy, clinical laboratory, radiology services; provisional diagnosis, medical or surgical treatments; operative report; pathological findings; progress notes; final diagnosis; condition on discharge and instructions given for further care, such as medications, diet or limitations of activity; discharge summary or note; clinical resume; and autopsy report, when performed.

C. Admission History

(a) A complete admission history and physical examination shall be recorded by a physician member of the Medical Staff within twenty-four (24) hours of admission. The report should include all pertinent finding resulting from an assessment of all systems of the body, an age-specific assessment of the patient, and all pertinent findings documenting the need for the admission including a concise summary of the patent's chief complaint, condition, provisional diagnosis, and a place for evaluation or therapy. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information.

(b) If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstance surrounding the need for additional acute care.

(c) Failure to record the patient's history and physical within twenty-four (24) hours after admission shall result in the Physician being notified that the history and physical is delinquent. The Chief of Staff or his/her designee or the CEO (or his/her designee) may take appropriate steps to enforce compliance.

4. If a complete history has been recorded and a physical examination performed within seven (7) days prior to the patient's admission to the Hospital, a reasonable durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings always must be recorded.

5. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending Practitioner states in writhing that such delay would be detrimental to the patient.

D. Progress Notes

Progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, reflect changes in condition as well as results of tests and treatments. Progress notes shall be written or dictated at least daily on all patients, expect on the day of admission.

E. Co-Signature of Allied Heath Staff (AHS)

The attending physician, dentist or podiatrist shall countersign all orders for treatment and care of patients, the history and physical examination, and pre-operative notes when they have been recorded by an AHS, including a physician assistant.

F. Permanently Filed Medical Records

A medical record shall not be permanently filed until it is completed and signed by the responsible Practitioner or is ordered filed by the Medical Executive Committee or other appropriate medical staff committee with an explanation of why it was not completed by the responsible Practitioner.

G. Operative/Procedural Reports

Operative/Procedural reports shall include a detailed account of the finding at surgery, the technical procedures used, specimens removed, postoperative diagnosis, estimated blood loss, and the name of the primary surgeon and any assistant.

Operative/procedural reports shall be written (or dictated) immediately following surgery when possible, but always within twenty-four (24) hours after surgery. The report shall be promptly signed by the surgeon and made a part of the patient's current medical record. When the report is not immediately available a progress note should be written in

the medical record immediately after surgery to provide pertinent information for use by any other health care professional who are required to care for the patient.

H. Clinical Entries/Abbreviations/Symbols

1. All clinical entries in the patient's medical record shall be accurately dated and authenticated. Authentication shall be defined as the establishment of authorship by written signature of identifiable initials. The Health Information department and Pharmacy shall maintain a current record of physician signatures and/or initials.
2. Symbols and abbreviations may be used only when they have been approved by the Medical Staff.

3. The following persons may make entries in medical records of Hospital patients: Practitioners, Allied Health Professionals, and Hospital nursing personnel, case managers, dietitians, physical therapists, Respiratory Therapists, Occupational Therapists, Speech Therapists, social workers, and pharmacists. The MEC may authorize other persons or classes of persons to make such entries.

I. Consultations

1. Any qualified physician with clinical privileges in the Hospital can be called for consultation within his area of expertise. Consultations shall be obtained only through order of the Attending Practitioner, appropriately documented in physician orders.

2. The Consultant's report shall show evidence of review of patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's records. A limited statement, such as "I concur" does not constitute and acceptable report of consultation. When operative procedures are involved, the consultation notes, except in emergency situations so verified on the record, shall be recorded prior to the operation.

3. Consultations shall be held, except in extreme emergencies, under the following conditions:

(a) When the patient is not a good risk for operation or treatment.

(b) Where the diagnosis is unclear after ordinary diagnostic procedures have been completed.

(c) Where there is doubt as to the choice of therapeutic measures to be utilized.

(d) In unusually complicated situations where specific skills of other Practitioners may be needed.

(e) In any instances in which the patient exhibits sever psychiatric symptoms.

(f) All curettages or other procedures by which a known or suspected normal pregnancy may be interrupted.

(g) When requested by the patient or their family.

(h) When required by the policy of a special care unit.

4. Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose. Recommendations of such services must be documented in the patient's medical records.

K. Completion of Medical Records and Delinquency

1. All Practitioners shall make their best efforts to complete their documentation in the Medial Record at the time of the patient's discharge, to include progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at time of discharge, the medical record will be available in the Medical Record Department. If the discharge summary cannot be done at the time of discharge, a final diagnosis shall be recorded on the face sheet.

2. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized except for patients discharged to home that were hospitalized for less than 48 hours. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible Practitioner and, in the case of non-physician Practitioners, by a qualified physician member of the Medical Staff.

3. Patient medical records are to be completed within thirty (30) days of discharge. The Hospital's Health information department will provide each physician with his/her incomplete medical records at least every fourteen (14) days.

   a. A chart that has any item of actual (e.g. H&P, operative report) or potential (e.g. discharge note or summary, missing signatures)

deficiency after twenty-eight (28) days past discharge will trigger a delinquency “warning” notification.

b. A delinquency “notice” will be sent after twenty-eight (28) days post-discharge. The delinquency “notice” shall inform the Practitioner that failure to complete medical records in a timely fashion shall be cause for the Chief of Staff and the CEO to be notified of delinquency. They may take appropriate steps to enforce compliance up to and including suspension for elective admissions and procedures (“Suspension Level I”). When a Practitioner is on Suspension Level I, the Practitioner may not provide hands-on patient care, whether inpatient or outpatient, except for **emergencies**. Patients who have already been scheduled for admission or an outpatient test or procedure in advance of the suspension are exempt. The Practitioner remains on the emergency room On-Call Calendar, and may provide emergency consultations on patients in the hospital. New elective admissions, or the scheduling of elective inpatient and outpatient procedures are not permitted. Removal from Suspension Level I will occur when the Practitioner completes all delinquent charts. HIM Department will notify the Practitioner and all appropriate departments of suspension removal.

c. When a Practitioner has not removed himself/herself from Suspension Level I by completion of all delinquent charts within fourteen (14) days of the Suspension Level I date, he/she will be notified that a recommendation will be made to MEC that all hands-on hospital activity will cease, including consultations and emergency care (“Suspension Level II”). The MEC shall determine if suspension Level II shall be put into effect or if other action will effect the timely completion of the delinquent chart. The Practitioner at the time of suspension is obligated to provide the Hospital CEO and Chief of Staff with the name of another Practitioner who will take his/her consultations, provide emergency room coverage, and any other services that the Practitioner provides. Removal from Suspension Level II occurs when the Health Information Department verifies that all delinquencies have been addressed.

d. If a Practitioner has not removed himself/herself from either Suspension Level I or II within three (3) months of the Suspension Level I date, he/she shall be notified that at the next regularly scheduled meeting of the Medical Executive Committee, a recommendation will be made that his/her Medical Staff privileges be terminated. If the MEC votes to begin the termination process, the termination process may be stopped by the Health Information department providing the Chief of Staff and CEO with verification

that all delinquencies have been addressed, including a typed, signed hard copy of any dictation.

L. Removal of Medical Records

Records may be removed for the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records including imaging films, are the property of the Hospital and shall not otherwise be taken away without permission of the Administrator. In any case of readmission of a patient, all previous records shall be available for the use of the attending Practitioner. This shall apply whether the patient is admitted by the same Practitioner or by another. Unauthorized removal of records from the Hospital is grounds for suspension or discharge of the Practitioner for a period of time to be determined by the MEC.

M. Access to Medical Records

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted access to information from the medical records of their patient's covering all periods during which they attended such patients in the Hospital.

N. Informed Consent

The Practitioner who is to perform the procedure on the patient shall be responsible for obtaining the patient's informed consent prior to treatment. The patient shall be informed of the nature and risks of the procedure and of the possible alternatives. Immediately thereafter, both patient and Practitioner shall sign the consent form affirming that the Practitioner has personally informed the patient prior to the consent. Space shall be provided on the form for the Practitioner to document what was explained to the patient and that the patient understood and agreed to the proposed treatment.

O. Alterations/Correction of Medical Records Entries

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "White-Out".

To correct or amend and entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with a legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been permanently filed is considered to be an addendum and should be dated and signed and identified as such.

IV. GENERAL CONDUCT OF CARE

A. Treatment Orders

1. All orders for treatment shall be in writing; timed, dated and signed. A verbal or telephone order shall be considered to be in writing if dictated to an authorized recipient functioning within his/her background, training, sphere of competence and signed by the responsible Practitioner. All orders dictated over the telephone shall be dictated by the Practitioner and shall be signed with the signature dated and timed by the appropriately authorized person to whom dictated with the name of the Practitioner per his or her own name. The responsible Practitioner shall authenticate such orders at the next visit, within twenty-four (24) hours, and failure to do so shall be brought to the attention of the MEC for appropriate action. The following Hospital personnel are authorized to accept verbal and telephone orders: RNs, LPNs, Registered Physical Therapists, Licensed Physical Therapy Assistants. Lab Technologists, Radiology Technologists, Clinical Dietitian, Registered Respiratory Therapists, Respiratory Therapy technicians, Registered Pharmacists, CRNAs and Nurse Practitioners.

2. The Practitioner's orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or clarified by the nurse.

3. All previous Hospital orders are cancelled when patients go to major surgery or are transferred to OR from the cardiac/intensive care unit.

4. Verbal orders will not be accepted for investigation drug, device or procedure protocols, Do Not Resuscitate orders, or orders for withdrawal or withholding of life support unless verified by two authorized recipients. (see Section IV.A.1 from above) and authenticated by the Practitioner within twenty-four (24) hours.

B. General Consent Form

A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending Practitioner whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

C. Drugs and Medications

1. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service: AMA Drug Evaluations. Drugs of bona fide clinical investigations may be utilized only after approval by the P&T Committee and the Medical Staff. These shall be used in full accordance with the statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

2. The Practitioner must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from the Hospital Pharmacy.

3. All medications brought into the Hospital by a patient must be sent to the pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the physician has prescribed.

   (a) Medications brought into the Hospital by a patient or his family will not be given to the patient during his hospital stay without the express authorization of the attending physician.

   (b) All medications received by the Pharmacy will have a receipt, the original of which will be attached to the patient's charts, and the duplicate retained in the Pharmacy.

   (c) Medications shall be returned to the patient at the time of discharge upon presentation of receipt attached to the patient's chart.

   (d) Medications not called for by this method will be kept in the Pharmacy for up to 14 days after discharge and then destroyed in an appropriate manner.

4. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order

5. In all cases wherein a Practitioner orders a drug by trade name, the pharmacist may automatically dispense the drug by it's generic name unless the Practitioner designates next to the name of the drug "Dispense as Written".

6. All antibiotics and narcotic medications, hypnotics and sedatives, hyper alimentation, anticoagulants, and oxytoxics will carry an automatic stop orders as set by the P&T Committee. If the Practitioner desires to continue these medications, he must reorder them at the end of this period. The attending Practitioner or his designee shall be notified by the responsible nurse when drugs are due for an automatic stop order.

7. All medication orders will be discontinued when a patient goes to surgery or when a patient is transferred into or out of the ICU/CCU.

8. Certain medications may be administered only by a physician or under his direct supervision when given by the I.V. push method. These medications include:

(a) Those medications for which no "FDA Approved" indication for direct I.V. administration, i.e.: I.V. push, is stated in the official package insert unless such medication has been specifically exempted from this restriction by the P&T Committee and Medical Staff.

(b) Those medications having "FDA Approved" indicated for direct I.V. push administration but which have been restricted from such administration by the P&T Committee and Medical Staff. A list of the latter drugs shall be maintained in the policy manuals of nursing services and the department of pharmacy.

Only licensed nurses may administer non-restricted drugs by the IV push method.

D. Blood

Blood, which has been cross-matched and is being held for a patient, will be held for 48 hours at which time the order for the blood will be canceled unless reordered for another 48 hours. Blood will not be released without notifying the appropriate physician.

E. Respiratory Therapy

Oxygen and respiratory therapy will be administered according to the attending physician's orders. In those cases where duration of treatment is indefinite or

unspecified, the attending physician will be notified on the third (3rd) day of treatment for new orders by the fourth (4th) day.

The Practitioner will write new orders as soon after notification on the third (3rd) day as possible, not to exceed the fourth (4th) day. If new orders are not given, the nurse will contact the Practitioner for orders regarding continuing or discontinuing the reparatory therapy.

F. Radiology and Pathology

1. Consultation request forms for radiology and pathology shall be filled out completely. The attending physician is responsible for providing necessary clinical data. The necessary data may be taken form the order sheet or progress notes by a nurse.

2. All requests for radiology and nuclear medicine services must include information from the requesting Practitioner justifying the need for the examination(s) requested.

3. Radiology procedures will not be performed on women of child bearing age if there is any suspicion of pregnancy or past due pregnancy test. In case of an emergency, the radiologist must provide proper protection and permission from the patient must be obtained.

G. Questioning of Care

If a nurse or other licensed professional in the employment of the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of his/her superior who, in turn, may refer the matter to the Director of Nursing Services. If warranted, the Director of Nursing may bring the matter to the attention of the attending physician, the Chief Executive Officer, or the Chief of Staff as appropriate. These circumstances are such as to justify action, the Chief of Staff may himself request a consultation.

H. Standing Orders

Standing orders and/or instruction sheet shall be instituted only after approval of MEC. Such standing orders and/or instruction sheets shall be reviewed at least annually and revised as necessary. All standing orders and/or instruction sheets must be signed and dated by the responsible Practitioner who utilize, as required for all orders for treatment.

I. Patient Care Rounds

1. Hospitalized patients shall be visited and physically examined at least daily (every 24 hours) and as frequently as their status warrants. Daily rounds should be performed by 2 p.m. unless they are extenuating circumstances.

2. Patients admitted to Critical Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event, within twelve (12) hours.

J. Attending Physician Unavailability

1. Should the Attending Physician be unavailable, another qualified physician will assume responsibility for patient care pursuant to Section I.A.3 (g).

K. Patient Restraint Orders

It shall be the duty of the Attending Physician, after conducting a clinical assessment of the patient, to write or verbally give an order for restraint of the patient for the safety of the patient, staff or other person.

1. The order must include:

(a) The purpose of the restraint. Uses of restraints are prohibited for purposes of punishments or staff convenience. The clinical justification for using the restraint should be documented in the patient's medical records and the inadequacy of less restrictive intervention techniques addressed;

(b) A specific time limit that restraints may be used, not to exceed twenty-four (24) hours.

(b) Frequency of observation of the patient if more frequent than the hospital standard. Under no circumstances shall this period be longer than the periods established by the hospital standard; and

(c) Type of restraint to be utilized and the reason therefore.

2. A new order will be required each time that the restraints are used after the expiration of the original order. Each order shall contain the elements noted in Section VI.K.1.

3. In an emergency, (where the patient constitutes an immediate serious threat the himself/herself or other and a physician is not available), restraint may be initiated and observed according to hospital standards, by an individual permitted under state law for a period not to exceed one (1) hour, at which time a Physician order is required if restraint is to be continued.

4. PRN orders may not be used to authorize the use of restraint.

5. All use of restraints shall be reported daily to the Chief Nursing Office. Restraint use may also be reported to a designee who reviews all uses of seclusion or restraints and investigates unusual or possibly unwarranted use patterns.

K. Organ & Tissue Donations

The Hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement organization (OPO) in order to determine donor suitability.

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

V. SURGICAL (and Endoscopy) CARE

A. Required Pre-Surgery Information

1. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of an emergency where any or all of the above entries have not been made, the operating surgeon shall state in writing that a delay would be detrimental to the patient, and shall make a comprehensive note in the medical record indicating the patient's condition. In all other cases, the responsible nurse shall notify the operating surgeon, preferably not later than the night before surgery is scheduled, and preparation for surgery, including pre-medication, shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

2. Written, signed, informed surgical consent shall be obtained and placed on the patient's chart prior to the operative procedure, except in those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient only after the risks and benefits of the procedure, alternative treatment methods and other information necessary to make a fully informed consent has been explained to the patient by the surgeon. After informed consent has been obtained by the surgeon, the surgeon shall obtain the patient's signature on the consent form. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from parents, guardian or next of

kin, these circumstances should be fully explained on the patient's medical record. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken. If it is known in advance that two (2) or more procedures are to be carried out at the same time, said procedures may be described and consented to on the same consent form.

3. Except in an emergency, consultations with another member of the Medical Staff should be required on all major surgical cases in which the patient is at considerable risk, on all critically ill patients and on patients for which the diagnosis is unclear, or the preferred method of treatment is an issue. A satisfactory consultation includes examination of the patient and the medical record. Consultations shall be recorded or dictate prior to the operation.

C. Elective Surgery Scheduling and Priorities

1. Surgeons shall be in operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he may have his privilege to schedule 8:00 a.m. surgery suspended or may be referred to the MEC for other action.

2. The rules for the scheduling elective or non-emergency surgery will be as follows:

   (a) The schedule is available for posting of cases at all times. Cases should be scheduled by 3:00 p.m. the previous day.

   (b) The following patient information is required in order to post a case:

      (i) The patient's full name
      (ii) Age
      (iii) Sex
      (iv) Surgery procedure
      (v) Type of anesthesia
      (vi) Operating surgeon
      (vii) Time and name of person posting the case
      (viii) Assistant surgeon

   (c) After the 8:00 a.m. time slots are filled, the order of cases will be based on time of the cases posted, availability of assistant physician, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.

(d) If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule. These cases will be scheduled in accordance with rule (c) and will be done as near to that time as a room is available in the order the case is posted. The time may be changed if it does not interrupt the normal schedule as determined by the Surgical Services Committee Chairman.

3. The start time for a surgery shall be deemed to be the time of incision or invasion.

C. <u>Physician Surgical Assistant</u>

1. If, in the opinion of the operating surgeon and/or Surgical Services Committee Chairman, there is in any surgical procedure an unusual hazard to life, there shall be present, as first assistants, a qualified licensed physician or certified physician's assistant.

2. On all major surgical cases a qualified licensed physician on the hospital staff shall be first assistant.

D. <u>Dental/Podiatry Dual Responsibility</u>

1. A patient admitted for dental or podiatry care is a dual responsibility of the dentist/podiatrist and physician member of the Medical Staff to the extent set forth in these Rules and Regulations and the Medical Staff Bylaws.

(a) Dentist's/Podiatrist responsibilities include:

(1) A detailed history justifying hospital admission.
(2) A detailed description of the oral cavity examination/podiatric findings and the pre-operative diagnosis.
(3) A complete operative report, describing findings and techniques.
(4) The dentist/podiatrist is totally responsible for dental/podiatric care and the consequences thereof.
(5) Progress notes as are pertinent to the condition.
(6) Discharge summary.

(b) Physician's responsibilities include:

(1) Medical history pertinent to the patient's general heath.
(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
(3) Supervision of the patient's general health status while hospitalized.

(4) The physician is not responsible for any dental care or podiatry care or consequences thereof.

(c) The discharge of the patient shall be on written order of the dentist/podiatrist of the Medical Staff approved by the attending physician.

2. When the operating/anesthesia team consists entirely of non-physicians (e.g., dentists or podiatrist with nurse anesthetist), there shall be a previously designated physician immediately available in case of emergency such as cardiac standstill or cardiac arrhythmia.

E. Anesthesia and Conscious Sedation

1. Anesthesia includes general, regional, and conscious sedation given in the OR, emergency department, or any other location within the Hospital where such services are administered, and during special imaging procedures and Endoscopy.

2. The Practitioner administering the anesthetic agent shall obtain and document informed consent for anesthesia and shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation to determine whether the patient is an appropriate candidate for the planned anesthesia and post-anesthetic review of the patient's condition upon admission to and discharge from the post-anesthesia recovery area.

3. The Practitioner administering the anesthetic agent is responsible for assuring that an ACLS certified individual is immediately available, for evaluating the patient and for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This note shall include the patient's significant drug history and prior anesthetic experiences, any perceived potential for anesthetic problems, the ASA rating, and shall indicate a choice of anesthesia and the surgical, endoscopic, invasive or obstetrical procedure anticipated.

4. The Practitioner administering the anesthetic agent is responsible for writing a post-anesthetic note (to include date, time and status of condition) within 24 hours of patient's discharge from recovery area to include at least a description of the presence or absence of anesthesia-related complications.

E. Examination of Specimens

1. All tissue, with the exception of the following, removed at the time of the operation shall be sent to the Hospital Pathologist, who shall make such examinations as he/she may consider necessary to arrive at a tissue diagnosis.

His/her authenticated report shall be made part of the patient's medical record. Each specimen shall be accompanied by pertinent clinical information.

Exceptions:

(a) Specimens that by their nature or condition do not permit fruitful examination, such as cataract, toenails, orthopedic appliance, debrided edges of lacerations, or portions of rib removed only to enhance operative exposure.
(b) Traumatically injured appendages that have been amputated and for which examination for legal or medical reasons is not deemed necessary.
(c) Foreign bodies (for example bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
(d) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant.
(e) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.
(f) Teeth, provided the number, including fragments, are recorded in the medical record.
(g) Sebaceous cysts.
(h) Lipomas.
(i) Tattoos.
(j) Non-lesional skin from primary cosmetic surgery, i.e., blepharoplasty, face lifts, nasal reconstruction/rhinoplasty, abdominal panniculectomy and others.
(k) Any other material or tissues removed in a similar nature as those exempted about which the surgeon specifies that pathological examination is not indicated. Exceptions are made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used, and when there is an authenticated operative or other report that documents the removal.

Despite the foregoing exceptions, the surgeon may have the option of sending any material or tissue he wishes for pathological examination, as indicated in the particular case.

2. <u>Surgical Procedures for Which Normal Tissue is Expected:</u>

(a) Amputation, traumatic.
(b) Blepharoplasties.
(c) Entropion/Ectropion repairs.
(d) Foreskin from circumcision.
(e) Nasal septum from rhinoplasty.
(f) Negative biopsy-endoscopy.
(g) Pyeloplasty.
(h) Teeth.

(i) Testes for prostatic cancer.

VII. DISASTER PLAN

A. Master Plan (Blue Safety Manual available in the Physicians Library)

1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.

2. The disaster plan should make provision within the Hospital for:

(a) Availability of adequate basic utilities and supplies, including water, food and essential medical and supportive materials;

(b) An efficient system of notifying and assigning personnel;

(c) Unified medical staff command under the direction of the Chief of Staff or his designated substitute;

(d) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care;

(e) Prompt transfer, when necessary, and after preliminary medical or surgical services has been rendered, to the facility most appropriate for administering definitive care;

(f) A special disaster medical record, such as an appropriately designated tag, that accompanies the casualty as he/she is moved;

(g) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;

(h) Maintaining security in order to keep relatives and curious persons out of the area; and

(i) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual.

B. Physician Response/Patient Care Decisions

1. All physicians may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of Staff and the CEO (or their designees) will work as a team to coordinate activities and directions.

2. In cases of evacuation of patients from one section of the Hospital to another or evacuation from the Hospital premises, the Chief of Staff or CEO during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief of Staff and CEO of the Hospital. In their absence, the Vice Chief of Staff and alternate in administration are next in line of authority, respectively.

C. Documentation

Disaster procedures, when actually undertaken, shall be documented as promptly as possible after the incident.

D. Periodic Drills

The disaster plan shall be rehearsed at least semi-annually provided there was not initiation of an actual disaster that stressed the capabilities of the Hospital. A drill may be held as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

VIII. MISCELLANEOUS

A. Appointment of Medical Directors

In order to provide Medical Staff guidance and direction to certain hospital services, the Chief of Staff will appoint specially trained Medical Directors. Said Medical Directors will have acquired experience and demonstrated competence related to the care provided by that service. These services shall include, but not be limited to the following:

1.Intensive Care Unit
2.Respiratory Therapy;
3.Surgical Services;
4.Emergency Services.

Said Medical Directors shall participate in the Medical Staff's Performance Improvement functions. Their responsibilities will include duties such as interpretation of policies and procedures, consultations and performance improvement activities.

B. Ethics Committee

1. Purpose

The purpose of the Ethics Committee is to consider, discuss and attempt to resolve conflicts or ethical issues associated with medical or nursing care provided to patient. The Committee shall serve as a forum for discussing and attempting to resolve such issues or conflicts. The Committee will serve in an advisory capacity only, and shall not have any authority to enforce its recommendations. The purpose of the Committee is to assist, augment or enhance, but not replace, the decision of physicians, nurses, family members or patients when determining appropriate care and treatment. All decisions recommended by the Ethics Committee shall be in accordance with applicable state and federal law.

2. Compositions

Membership appointments to the Ethics Committee shall be selected by the Chief of Staff and shall consist of:

(a) A representative of the Hospital Administration;
(b) At least two (2) Medical Staff representatives;
(c) Two (2) Nursing Staff representatives;
(d) Hospital Attorney or designee;
(e) One Clergy and
(f) Up to two (2) Laypersons.

3. Membership Terms

Members will hold 2 year terms provided, however, that ½ of the initial appointments shall be for only 1 year terms to assure over-lapping terms and continuity of membership on the Committee.

4. Chairmanship

The Chairperson of the Ethics Committee shall be a Medical Staff Member, designated by the Chief of Staff.

5. Meetings

The Ethics Committee shall meet on an as-needed basis, document its findings and recommendations as described below, and may report to the Medical Staff Committee, MEC or CEO as appropriate.

6. Quorum

A quorum of the Ethics Committee shall consist of at least three (3) members, a majority of who shall be healthcare members. Provided further that if the Committee is considering a decision regarding a withdrawal of any life support system, the Hospital Attorney must also have to be present at the meeting or consulted, either personally or via a telephone conference call.

7. Duties

The duties of the BEC Committee shall include the following:

(a) Biomedical ethical issues should be carefully presented and thoroughly discussed in an effort to achieve clarification and consensus, if possible. It is the chairperson's duty to ensure all participating committee members' and interested parties' points of view are considered, discussed and mediated.

(b) The rights of patients, family members and health care personnel should be clarified and respected when recommending decisions or giving advice.

(c) Biomedical ethical issues should also be considered in the larger context of society as a whole, and not only in the narrow context of one specific case.

(d) Biomedical ethical issues should also be considered in the context of associated costs and reimbursement constraints.

(e) Members must respect and maintain to the extent possible, the confidentiality concerns of all parties involved in any biomedical ethical dilemma.

(f) Members should educate themselves about current and previous biomedical ethical issues and concerns, and encourage other health care providers to do the same. This may include, for example, attending seminars and lectures in bio-ethics in order to remain current on ethical issues.

(g) All recommendations by the Committee shall be in accordance with applicable state and federal law.

7. Documentation

(a) Any notes, minutes or documents of any kind relating to the Committee's meetings, deliberations or recommendations are intended

to and shall be considered Medical Peer Review materials, which are privileged and subject to all applicable State and Federal laws protecting the confidentiality of those materials. All such documents shall be turned over to the Chairperson of the Committee at the conclusion of each Committee meeting.

(b) The Committee may make a notation on the patient's chart noting only that it was called to meet to discuss a particular issue. No other notations or additions to any patient records shall be made regarding any meeting, deliberations or recommendations by the Committee.

C. Infection Control

The Infection Control Committee, through its Chairman or Practitioner members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors and personnel exists.

D. Adherence to Policies and Procedures

1. Polices and Procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Medical Staff and approved by the MEC or Medical Staff, shall be adhered to by all attending Practitioners and said Practitioners are responsible for remaining abreast of all current directives.

2. Policies and Procedures referred to above, and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedures dual of the Hospital.

E. Physician Proctoring

Proctoring is a process by which physicians and medical support staff may complete components of the credentialing process, expand their spectrum of clinical certification, or maintain adequate levels of competence in existing areas of certification.

The MEC or one of its established committees may recommend proctoring for a new appointee or credentialed individual as part of the continuing credentials process or periodically as needed to ensure continued proficiency in established areas of clinical procedures and interventions.

In these situations, one or more proctors will be designated by the Chief of Staff at the recommendation of the MEC or one of its established committees and appropriate goals and allotted time period for proctoring clearly established and reviewed with the proctors and individual involved in the proctorship. Performance reports will be completed in a timely fashion by proctors and reviewed in a constructive and educational and professional manner with the individual(s) undergoing the process. These reviews and reports will be initialed by the proctored individual(s) and filed with the Chief of Staff or their designee for review by the appropriate committee at the close of the proctoring period.

At the completion of the initial proctoring period, the committee originally recommending the proctorship will complete a review of the performance of the proctored individual(s). The review will include the reports of the proctors and any supporting materials, statements, and interviews as deemed necessary to provide an adequate and objective and professional evaluation of clinical performance during the proctoring period. The committee may then recommend approval or denial of certification in the area or procedure being proctored or may, if appropriate, recommend extension of the proctoring period to permit attainment of an adequate level of clinical performance in the area of study.

When proctoring involves an invasive or surgical procedure, it is recognized that situations and complications may arise which could extend beyond the realm of experience of the proctored individual. Every attempt should be made to guide the proctored individual through such situations to achieve maximal educational benefit provided patient safety and good outcome can be reasonably assured. In such extreme situations, the proctor may find it necessary to assume direct management of the case to protect the life and health of the patient and allow the proctored individual additional educational training in the particular situation at hand.

In the rare instance that a proctor deems it medically necessary to assume direct management of a procedure or operation, the proctor must clearly, politely, and professionally announce to the proctored individual that the proctor must assume management of the case. At that time the proctored individual must relinquish case management to the proctor without dispute.

If the individual feels that the proctor has acted in error or inappropriately, they must still relinquish case management to the proctor without dispute and then may file a professional grievance with the Chief of Staff and request a review of the case and the decision of the proctor.

In all cases of physician proctorship, the proctored individual will retain the right of billing as primary physician and/or surgeon regardless of who

completes the procedure or operation. The proctor agrees to bill as consultant and/or first assistance regardless of which physician manages the case at the completion of the procedure or operation.

F. Smoking Not Permitted in Facility

Smoking is not permitted within the Hospital. The Hospital Safety Committee shall designate locations outside the facility for smoking.

IX. ADOPTION & AMENDMENT OF RULES & REGULATIONS

A. Development

The Medical Staff shall have the initial responsibility to bring before the Board of Directors ("Board") formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

B. Adoption, Amendment & Reviews

1. The Medical Staff Rules & Regulations may be adopted, amended or replaced by a majority vote of the Medical Staff members at any meeting where a majority of those eligible to vote are present. At least five (5) business days written notice, accompanied by the propose Rules & Regulations, in "redline" format, must be given of the intention to take such action.

2. Actions taken by the Medical Staff to adopt, amend, or replace the Rules and Regulations require the approval of the Board.

3. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

C. Documentation & Distribution of Amendments

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

(1) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board of Trustees; or

(2) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules and Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Trustees.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner. A "redline" version of any restated Rules and Regulations will be available in the Medical Staff Services Office.

SOUTHEAST HEALTH CENTER OF STODDARD COUNTY

MEDICAL STAFF RULES & REGULATIONS APPROVED & ADOPTED:

MEDICAL STAFF:

By:_________________________________ _________________________

Chief of Staff **Date**

BOARD OF DIRECTORS:

By:_________________________________ _________________________

Chairman **Date**

HOSPITAL:

By:___________________________________ ____________________________

Chief Executive Officer Date