

Rules and Regulations

St. Johns Hospital Medical Staff

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MEDICAL STAFF RULES AND REGULATIONS

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A. Admission and Discharge of Patients

1. The Hospital will not discriminate against any patient on the basis of race, color, creed, national origin, gender, or sexual preference.
2. The Hospital shall accept patients for care and treatment, except when the Hospital has inadequate facilities or personnel, or for procedures not permissible by the Ethical and Religious Directives for Catholic Hospitals. All such patients shall be considered available for teaching purposes unless designated otherwise by the patient, the patient's family, or by the patient's admitting or attending Medical Staff member.
3. A patient may be admitted to the Hospital only by a member of the Medical Staff in good standing with admitting privileges. All patients admitted to the Hospital shall be under the care of a member of the Medical Staff and who is described as the "attending medical staff member." The "attending medical staff member" is ultimately the responsible practitioner who has the overall responsibility, both medically and legally, for the patient's care. Upon a patient's admission, the "admitting medical staff member" is the "attending medical staff member" unless the formal re-designation is documented in the patient's medical record.
4. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for prompt completeness and accuracy of the medical record, for necessary and special instructions and for transmitting reports of the condition of the patient to any referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff member (either on a permanent or temporary basis) an entry covering the transfer of responsibilities shall be made on the order sheet of the medical record at the time of the transfer. Members of the House Staff may participate in patient care as directed by the responsible Medical Staff member.
5. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or medically necessary reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible following the patient's admission.
6. Practitioners admitting emergency cases must be able to demonstrate to the MEC and the administration of the hospital that said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient's need for emergency admission and must be recorded on the patient's chart within 24 hours after admission. Evidence of willful misuse of the emergency category of admission will be brought to the attention of the Executive Committee for appropriate action.
7. A patient to be hospitalized as an inpatient or observation patient who does not have a local physician on Active or Active Associate Staff will be assigned to an Active or Active Associate Staff member on call for the department or service. The Chairman of each Medical Staff department shall be responsible for providing a call schedule for these assignments. A patient physician relationship, including obligation for follow up, exists until proper notification of termination (with appropriate offer to provide emergency care for up to 30 days) is given.

8. For the protection of patients, the Medical and Nursing Staff, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:
 - a. Unless the patient's medical condition dictates otherwise, any adult patient known or suspected to be suicidal shall be admitted to the Adult Psychiatry Unit. If there are no beds available in this area, the patient shall be referred to another institution where suitable facilities are available. Any patient who is not admitted to Psychiatry must be continuously observed. Arrangements for such supervision shall be made by the nursing care responsible for the patient in accordance with Hospital policy.
 - b. The Attending or Admitting Practitioner shall be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient may be a source of danger to himself or others from any known cause whatever.
 - c. Any patient, inpatient or outpatient, considered to be a suicidal risk by the Attending Medical Staff member at that particular time will be evaluated by a member of the psychiatric team and such evaluation must be recorded in the medical record and acted upon.
9. All admissions to the Intensive and Intermediate Care Units shall be in accordance with the admission criteria for those units. If any question as to the appropriateness of admission to or discharge from those units should arise, that decision will be made through consultation with the Medical Staff member responsible for the Intensive and/or Intermediate Care Unit and/or the Chairman of the particular department in which the patient's Attending Practitioner is a member, or his designee. To improve outcomes for patients admitted to ICU, all patients admitted to the ICU (with the exception of patients with a rapidly reversible condition whose anticipated length of stay is documented to be less than 24 hours) shall be accompanied by orders for consultation by an intensivist/Pulmonary Critical Care specialist.
10. The Attending Practitioner is required to document the necessity for admission and the need for continued hospitalization.
 - a. This documentation should contain
 - (1) An adequate written record of the reason for hospitalization;
 - (2) The estimated period of time that the patient will need to remain in the Hospital; and
 - (3) Plans for post-hospital care.
 - b. Upon request of the Case Manager, the Attending Practitioner must provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reason therefore. This report must be documented in the medical record within twenty-four (24) hours after receipt of such request. Failure to comply with this requirement will be brought to the attention of the Chief Medical Officer to determine appropriate action.
 - c. Each member of the Medical Staff must comply with all existing regulatory standards and guidelines concerning admission certification and length of stay review in addition to the criteria provided for in the Hospital's current Case Management Plan. All utilization management functions at the Hospital shall be performed in accordance with the most current Case Management Plan.
11. Patients shall be discharged only upon a written order of the Attending Practitioner or a licensed resident, when authorized by the Attending Practitioner.

12. If a patient leaves the Hospital against the advice of the Attending Practitioner, or without a proper discharge order, a notation of this fact shall be made in the patient's medical record and, if feasible, a release of responsibility statement completed and signed by the patient before leaving the hospital. The Attending Practitioner shall complete and sign the patient's medical record promptly.
13. Patients with suspected or proven cases of infectious, contagious or communicable disease shall be isolated from other patients in accordance with guidelines established by the Illinois Department of Public Health and also in accordance with Hospital policies and procedures as formulated from time to time by the Infection Control Committee and adopted by the MEC.
14. If questions arise regarding the appropriateness of a patient admission to, transfer to, or discharge from areas involving changes of levels of necessary care (i.e., Intensive, Intermediate, General Hospital or Skilled Nursing Care Facility) a definitive decision should be made by the Chairman of the appropriate Department, or his designee, utilizing recommendations of the Attending Physician(s), and the case management personnel, as appropriate.
15. Members of the Medical Staff are expected to conduct research in an ethical fashion. The right of patients to their privacy and to understand the nature of the research project they are participating in should be considered of paramount importance. Patients or their legal guardians are expected to give informed consent for participation in research projects.

To ensure the patient's rights and satisfy Federal regulations, the Medical Staff must have all research protocols reviewed by an Institutional Review Board that satisfies Federal regulations and that is acceptable to Hospital Administration and the MEC unless such local Board deems an additional review unnecessary. Research projects may not be undertaken in the hospital without prior Institutional Review Board approval and, when necessary, MEC oversight and approval deemed.

B. Medical Records and Medical Staff Responsibilities

1. The official Medical Staff policy regarding medical record completion, delinquency, and suspension is updated as needed and approved by the MEC. Policies and procedures are available on the hospital's intranet (FRANCIS) in the Medical Staff section under Administration.
2. The Admitting Practitioner shall be responsible for preparation of the complete medical record for each patient, unless specifically designated otherwise in the medical record. All practitioners who make entries into a medical record shall be responsible for appropriate and legible documentation. The record's contents shall be pertinent and current. This record shall include patient complaints, personal history, family history, history of present and past illnesses, approved department specific physical examination, provisional diagnosis, medical or surgical treatment, operative report, and discharge summary or death summary. When multiple physicians treat a patient during an inpatient or outpatient hospitalization, the attending practitioner shall ensure the completion of the history and physical. A discharge clinical summary shall be written or dictated by the responsible physician on all medical records of patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries and normal newborn infants, optimally on the day of the discharge or within fifteen (15) days after discharge. Any patient death regardless of length of stay would require a death summary. This summary should include the reason for admission, significant findings, procedures performed and treatment rendered, medications, condition of the patient on discharge, a list of medications to be taken that is identical to the instructions given to the patient, the name of the next provider of care and any specific instructions given to the patient and/or family at the time of discharge.

3. In situations where a patient dies within the first twenty-four (24) hours of a hospital stay or leaves the Hospital against medical advice within twenty-four (24) hours after admission and the Admitting Practitioner has had no previous knowledge of or care of the patient, a concise summary progress note must be made part of the permanent record.
4. The medical record is ordinarily considered complete when the required contents, including any required discharge summary or final progress notes, are assembled and authenticated (as feasible) and when final diagnosis and any complications are recorded without the use of symbols or abbreviations. The records of discharged patients must be completed within a period that in no event exceeds twenty-one (21) days following discharge. Whenever a Medical Staff member(s) responsible for the record completion is permanently unavailable, the Chief Medical Officer or his M.D. designee will so document in the medical record and, with appropriate Department Chairman assistance, if necessary, provide the most logical and apparent final diagnosis and treatment for coding purposes and not to attest to the prior medical care provided.
5. The report of the physical examination shall reflect a comprehensive physical assessment appropriate for the department of the admitting practitioner and the patient's admitting diagnosis. A history and physical shall in all cases be recorded within twenty-four (24) hours after inpatient admission, and must be authenticated by the attending Medical Staff member in charge of the patient. An H&P is acceptable if performed within thirty (30) days prior to admission and updated at the time of admission or prior to an invasive procedure. This report should include all pertinent findings resulting from an assessment of appropriate systems of the body and should include a proposed course of action(s) plan for the patient while in the hospital. History and Physical examinations for inpatients, outpatients, observation patients and Long Term Care facility patients (LTC) must be provided as required by guidelines of the Illinois State Hospital Licensing Act, Centers for Medicare and Medicaid Services (CMS), and TJC standards.
6. When the history and physical examination is not in the medical record before either an elective inpatient or outpatient operative or invasive procedure, the procedure shall be postponed or cancelled, until the H & P is provided or unless the Attending Practitioner states in writing that such delay would be detrimental to the patient and the appropriate department chairperson or designee agrees to permit the procedure to proceed. A history and physical examination shall be documented on all patients in accordance with hospital policy, regardless of the type of anesthetic used, or if no anesthesia is used. In emergency cases, sufficient information shall be written on the progress sheet to justify the procedure contemplated and to provide available information to the anesthetist or anesthesiologist.
7. Any individual involved in patient care may make factual and/or objective entries into the medical record at his functional level if he is a:
 - a. Healthcare professional employed by the Hospital or who has been granted privileges to attend or visit patients within the hospital;
 - b. Member of the Medical Staff;
 - c. Member of the House Staff; or
 - d. Student participating under the sponsorship of any Hospital department or Hospital program, or the SIU School of Medicine.

8. If any portion of the medical record has been dictated, the practitioner who dictated the report shall note this fact on the patient's chart (with date, time, and dictation job #) and sign the entry. A notation on the patient's chart with respect to the dictation of such information shall be deemed to be in compliance by the practitioner with his obligation to complete medical records, even in the event that such dictation is lost or delayed in transcription. However, in such event, it shall be the practitioner's responsibility to redictate the unavailable portions of the medical record within twenty-one (21) days.
9. In the acute care hospital setting, pertinent progress notes should be recorded by the physician most involved in directing the patient care at the time of observation and be sufficient in frequency and content to permit continuity of care and transferability. Consulting physicians shall make appropriate progress notes in accordance with the degree of the consultants involvement in patient care.
10. Operative reports shall include a detailed account of the findings at surgery, the details of the surgical technique, primary surgeon and assistants, pre-op diagnosis, procedure performed, post-op diagnosis, estimated amount of blood loss specimens removed and indications. An operative report for all invasive procedures shall be dictated immediately after surgery for both inpatients and outpatients, and signed promptly by the Practitioner performing the surgery. An operative progress note shall be written immediately after surgery for both inpatients and outpatients including the name of the licensed independent practitioner and assistants; procedure(s) performed and description of the procedure findings; estimated blood loss; specimens remove; and postoperative diagnosis. The reports shall be made part of the patient's current medical record.
11. The current obstetrical record shall include a complete prenatal record, if prenatal care was obtained. The prenatal record may be a legible copy of the Attending Practitioner's office record transferred to the Hospital prior to the patient's anticipated delivery date, around 32-36 weeks. However, an interval history and physical must be documented by the Admitting Physician or his MD designee, or other credentialed designees, e.g. resident physician, advanced practice nurse or physician assistant. The interval H&P must be documented at the time of admission, must include pertinent additions to the prenatal record and/or any subsequent changes in patient condition at the time of admission, and if documented by a designee that is not a member of the medical staff, must be countersigned by the attending physician.
12. All clinical entries in the patient's medical record must be accurately dated, timed and authenticated, either by written or electronic signature in compliance with Joint Commission and CMS standards, Medical Staff and Hospital Bylaws, and Federal and State Laws.
13. Symbols and abbreviations utilized the in medical record may be used only when approved by the Medical Staff Executive Committee. An official record of all approved abbreviations is kept current and available on the hospital's intranet (FRANCIS). A list of Do Not Use abbreviations is also maintained.
14. Medical records are the property of the Hospital and may be removed from the Hospital only in accordance with a court order, subpoena, or statutory requirement. Other than court order, subpoena, or statutory requirement, medical records shall not be removed from the Hospital without specific permission of the Chief Executive Officer. In the case of readmission of a patient, all previous records shall be available for use of the Attending Practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of medical records from the hospital is grounds for disciplinary action in accordance with these Rules, Regulations, and Bylaws.

15. All study and research projects must be approved by the Institutional Review Committee (IRC). Members of the Medical Staff have access to records of former St. John's Hospital patients, but should only access patient records of other physicians if they are conducting Institutional Review Board (IRB) approved research projects. Subject to the discretion of the Chief Executive Office, former members of the Medical Staff shall be permitted free access to information from medical records of their patients covering all periods during which they attended such patients in the hospital.

Subject to the recommendation of the Medical Staff Executive Committee, with agreement of the Chief Executive Officer, certain other qualified individuals may be afforded access to medical records of all patients for approved study and research.

16. Any member of the Medical Staff or AHP who wishes to terminate his staff membership for any reason (including relocation to another area or retirement) must submit a written notification in accordance with the Bylaws.
17. Pertinent lab, x-ray, or other ancillary service reports regarding tests or procedures performed by approved clinical facilities outside St. John's Hospital may be placed in patient records by the attending physician(s). An original, photocopy or FAX copy of an original is accepted for said placement.
18. In instances of need to provide appropriate patient care under emergency circumstances, prior patient medical records at St. John's may be FAXED to St. John's Medical Staff members and to medical practitioners who are not St. John's Medical Staff members who are located outside St. John's Hospital on verbal request of a physician, dentist, or podiatrist and the patient or patient representative; this request is to be followed by a written authenticated request for release of medical records to St. John's as soon as feasible.

In non-emergency patient care situations, this process for release of FAXED medical records is the same as in the preceding paragraph with exception that a written authenticated request for release from the patient or patient representative is needed at St. John's prior to providing FAXED copies.

Behavioral health and substance abuse medical records may be FAXED only if the patient or patient representative has properly authenticated the release in accordance with current statutes and rules. They may also be faxed for continuity of care to behavioral institutions accepting the patient's transfer.

C. Procedure for House Staff and Medical Student Entries on Hospital Charts

1. House Staff

- a. House Staff may perform and write or dictate the history and physical examination, add progress notes to the chart, write or dictate discharge summaries, write or dictate consults and may sign all these documents. The Attending Practitioner must cosign the history and physical, preoperative and operative notes and consults.
- b. House Staff may write orders, both diagnostic and therapeutic, in keeping with the laws of this State.
- c. House Staff may write or dictate operative/procedural notes when the proper level of competency is developed, as determined by the operating surgeon.
- d. The Emergency Room record is considered part of the inpatient medical record when the patient is admitted. If a patient is seen by a resident only, then the Attending Practitioner shall co-sign the Emergency Room record. If the resident who examined the patient is acting as a resident of the Emergency Medicine physician, then that Emergency Medicine physician shall co-sign the Emergency Room report.
- e. In many situations, patient care orders may be written by designated members of the House Staff, however, this policy may not be extended to prohibit orders being written by the patient's private Attending Medical Staff member. Furthermore, the Medical Staff member's declination to participate in teaching activities shall not, in itself, be a basis for sanctions relating to Staff membership or the holding of clinical privileges or to the loss of any other Staff prerogatives.

2. Medical Students

- a. Medical students may perform and write histories and physicals. All histories and physicals performed by medical students must be reviewed and countersigned by the Attending Practitioner if the student history and physical is to be used as the sole history and physical for the medical record.
- b. Medical students may enter progress notes on the usual progress record. They may enter also, as progress notes, information concerning operative or other procedures performed.
- c. The privilege of writing orders may be granted to a medical student by the Attending Practitioner. Before writing an order, the student must first consult with the Attending Practitioner or the appropriate licensed House Staff member assigned to the care of the patient in question. One of these practitioners must countersign any order written by a medical student prior to its implementation.
- d. The method of signature which will be used by medical students is "medical student's name—MS III or MS IV—."

D. House Staff and Medical Student Activities and Conduct

1. Members of the House Staff (including Interns, Residents, and Fellows) and Medical Students may utilize Hospital facilities and review patient records for clinical, educational, and research purposes in accordance with all pertinent portions of these Bylaws, Rules, Regulations, and Departmental Rules and Regulations as they pertain to all Medical Staff members. The Trainees may participate in patient care only under the supervision of Medical Staff members possessing necessary designated privileges to care for the patient's needs and in accordance with any pertinent stipulations of regulatory or accrediting agencies.
2. Selection of House Staff members shall be for a specified time frame, and subject to the joint approval of the Chief Executive Officer or designee, the Chief Medical Officer, the appropriate Hospital Department Chairman, and designees of the MEC, upon recommendation of appropriate SIU School of Medicine faculty members.
3. Methods of handling complaints/grievances:
 - a. Any complaint/grievance filed by or against a Medical Student shall be immediately referred to the Chief Executive Officer, Chief Medical Officer, or Medical Staff President for review. If the complaint appears valid, it shall be immediately referred to the Dean of the SIU School of Medicine for further action under appropriate Medical School Student Policy.
 - b. If a complaint has been filed against or by a House Staff member, it shall be handled in accordance with the most current SIU House Staff grievance procedure, the most current Hospital personnel policy, and or the most current Bylaws, Rules and Regulations, and Departmental Rules and Regulations of the Hospital, whichever is most appropriate. The Chief Executive Office, Chief Medical Officer, or Medical Staff President will be responsible for assuring the appropriate receipt and referral of such complaints.

E. General Conduct Concerning Patient Care

1. Consents
 - a. 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 office shall notify the Admitting Practitioner whenever such consent has not been obtained. When so notified, it shall, except in an emergency situation, be the Admitting Practitioner's obligation to see that proper consent is obtained before the patient is treated in the Hospital.
 - b. A specific consent must be obtained and documented in the patient's medical record prior to any surgical procedure, or prior to the performance of special treatment or diagnostic procedures as determined by the various Medical Staff and Hospital Departments. The consent must be witnessed by an adult. Although a practitioner may request responsible Hospital personnel (i.e., registered nurse, registered technologist) to obtain the patient's signature on the consent form, the practitioner who will perform the procedure remains personally responsible for providing for or conducting a conference necessary to inform the patient of the nature and extent of the proposed surgical or medical treatment, the anticipated results, possible risks and consequences of the procedure and any available alternative treatments. The obligation of obtaining "appropriate informed consent" rests primarily with the responsible physician.

2. Advance Directives

- a. Advance Directive is a term applied to four specific documents that are made available upon request for adult patients who are admitted to the hospital:
 - (1) Durable Power of Attorney for Health Care (DPAHC): Names a decision maker or agent (not to be confused with a surrogate as defined by the Health Care Surrogate Act) in the event the patient loses or designates to another person decisional capacity regarding health care decisions.
 - (2) Living Will: Communicates the patient's wish that their moment of death is not to be artificially postponed.
 - (3) Declaration for Mental Health Treatment: An adult of sound mind may make a declaration of preference re: mental health that may include consent to or refusal of mental health treatment.
 - (4) IDPH Uniform Do-Not-Resuscitate (DNR) Advance Directive: Used to create a physician order that reflects an individual's wishes about receiving cardiopulmonary resuscitation.
- b. Physicians are encouraged to discuss Advance Directives with their patients and encourage those who have not completed such documents to do so. Physicians should counsel patients and their agents in an effort to make appropriate choices for their individual circumstances. This is especially encouraged in patients with conditions that are considered terminal or in which the burden of treatment will likely exceed the anticipated benefit. These discussions should be documented by the physician or designated persons authorized to do so in the medical record.
- c. Physicians are to seek informed consent from the patient for all medical care decisions. When (and only when) a patient lacks or designates to another person decisional capacity, those designated as agents in the Durable Power of Attorney for Health Care should be consulted for medical care decisions on behalf of the patient.
- d. If no Advance Directives are available to guide medical decision making for patients lacking decisional capacity, the Health Care Surrogate Act should be followed to choose a surrogate to provide consent for medical care and to make informed choices on behalf of the patient.
- e. Orders placing limits on specific care are to be written after the above process has been followed and documented. The order should specify the treatments, including but not limited to CPR and ACLS (Do not resuscitate) that are to be restricted. In the absence of such orders, all reasonable efforts to prolong life will be provided.
- f. Orders limiting individual treatment processes that would be a critical component of resuscitation while allowing or demanding resuscitation should be rarely, if ever written.

3. Orders

- a. All orders for treatment, medications, or diagnostic tests shall be in legible writing, timed, dated and authenticated by signature or initials. Verbal orders should be limited to emergency situations when a practitioner cannot interrupt patient care to write an order. A verbal order shall be considered to be in writing if dictated to a Hospital authorized person functioning within her/his sphere of competence and signed before the Medical Staff or House Staff member leaves the area. Verbal or telephone orders from a member of the Medical or House Staff may be accepted by Hospital personnel, provided that the person accepting the order is assured of the identity of the person giving the order and further providing that the person taking the order is willing and has the ability to have the order executed. Telephone orders shall be used only when necessary and signed by the appropriate authorized person who wrote the dictated order with the name of the practitioner at the time the phone order was received, and verified by the Medical or House Staff member consistent with current Illinois State Law and Medicare rules and regulations.,
- b. The medical directors of the laboratory, radiology, or diagnostic services may, by general department policy, authorize the performance of diagnostic tests and procedures at the request of practitioners who are not members of the Medical Staff in accordance with policies approved by the Medical Staff and Board. All orders for recurring testing must be renewed annually by the ordering physician.
- c. The medical directors of the physical therapy or rehabilitation department or the Chief Medical Officer may authorize the provision of physical therapy or rehabilitation services or treatments at the request of other than members of the Medical Staff in accordance with policies approved by the Medical Staff and Board.
- d. All 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 Hospital personnel.
- e. Radiology Requests: All requests for diagnostic or therapeutic radiological examination or procedures shall include a concise statement for the indication for the request.
- f. DNR Documentation: Any “Do Not Resuscitate” order must be recorded, timed and justified and renewed in the medical record in accordance with the current established policy and directives of the Hospital and Medical Staff.
- g. Allied Health Professionals: Allied Health personnel that are licensed as an advanced practice nurse or physician assistant may be allowed to order medications or laboratory or x-ray procedures without physician co-signature if:
 - (1) Such authority has been delegated in the collaborative/supervising agreement; and
 - (2) Credentials have been approved by the MEC and the Board.
 - (3) An advanced practice nurse or physician assistant’s order is to be recorded as:
Dr. _____ by _____ APN or PA-C/Specialty Certification.”
 - (4) An order written by a Health Care Assistant, Medical Student, or other Allied Health Professional whose credentials have not been approved by MEC and the Board shall not be carried out until it has been co-signed or confirmed verbally by the Attending Practitioner or a member of the House Staff.

- h. Patient Care Order Sets - Medical Staff members may utilize various patient care order sets as defined and specified as follows:
 - (1) Departmental order sets - defined as order sets approved by medical staff for utilization by any medical staff member on their individual patients as a “routine” (i.e. routine newborn nursery or adult cardiac orders). They are:
 - i. Developed or revised by an appropriate medical staff department(s) or committee(s);
 - ii. Approved by the MEC and referred to IS for Hospital computer system entry;
 - iii. Activated by any medical staff member upon his acceptable order on his individual patient.
 - (2) Protocol order sets - defined in approved hospital policies, procedures, or treatment plans as orders which do not require medical staff member authentication for implementation (e.g. patient prep for radiology procedures or diagnostic testing). They are:
 - i. Developed or revised by appropriate Hospital services
 - ii. Approved by the MEC and referred to IS for Hospital computer system entry
- i. File copies of all patient care order sets will be maintained in the Hospital computer system and other designated area(s). Periodic review and/or revision will be conducted through the Medical Staff Office in accordance with current Medical Staff and hospital order set policy.
- j. When preprinted instructions are given to the patient or patient’s family by Medical Staff members or Hospital staff, the medical record should include a copy of these instructions.
- k. Signature authentication by specifically assigned computer key is acceptable for all designated portions of the medical record.

4. Medications

- a. St. Johns Hospital Pharmacy oversees the procurement of medications, chemicals, and biological agents administered to St. John’s patients.
- b. Non-formulary items requested for use are reviewed by the Director of Pharmacy or designee for patient safety and effectiveness prior to procurement.

- c. All medications brought into the hospital must meet the following standards:
 - (1) United States Pharmacopoeia or National Formulary standards.
 - (2) Biopharmaceutical equivalence standards when such medications are documented in medical or pharmaceutical literature to exhibit bioavailability variation.
 - (3) Be produced in compliance with good manufacturing practice.
 - (4) Be clearly and accurately labeled by the manufacturer with the following information:
 - i. Generic name
 - ii. Trade name (if any)
 - iii. Manufacturer's lot number
 - iv. Expiration date of the product
 - v. Provide package insert information with each unbroken package of medication or biological
 - vi. Special storage instructions, if any
 - vii. Name of the manufacturer distributing the product
 - (5) Be approved for use by the P&T committee.
- d. Samples are not used for St. John's Hospital patients because of the inability to assure they meet procurement standards.
- e. Non formulary requests
 - (1) Physician is contacted to request a formulary compatible switch.
 - (2) If the physician cannot be contacted to resolve a non-formulary request, items approved by the FDA and listed in Facts & Comparisons will be dispensed as written.
 - (3) If the item is not FDA approved and listed in Facts & Comparisons, the pharmacist may consult with the Director of Pharmacy or designee, the P&T Chairman, Chief Medical Officer, or Department Chairman.

- f. Patients who bring medication from home:
 - (1) Medications will be given back with instructions to have them returned to the patient's home immediately or at the time of discharge
 - (2) After careful consideration by the pharmacist and physician, accurate identity, integrity verification and documentation; equivalent medications will be dispensed from the hospital pharmacy for administration to the patient with the following exceptions:
 - i. Medication is unavailable.
 - ii. Pediatric care is potentially compromised by palatability of hospital dispensed medication.
 - iii. Short-term high cost medication.
 - iv. Ovulation suppressing medications.
 - v. Skilled nursing patients who have the legal right to obtain their medications from outside sources (Social Security Administration Guideline 405.1124(g)7.
 - vi. Home Hospice patients admitted to the Hospice Skilled Nursing Facility for observation or respite care.
- g. Automatic Stop Order Notification
 - (1) A computerized list of medications due for renewal will be generated daily by pharmacy. The unit clerk will stamp the patient's chart with the "Notice of Automatic Stop Order" to notify the physician that it is time to re-evaluate the patient's drug therapy. If the stop order has not been answered by the date of expiration, the medication will not be automatically discontinued. The nurse should notify the physician as soon as possible and restamp the order sheet.

5. Consultations:

- a. Except in emergencies, consultation shall be required in all cases in which:
 - (1) Undiagnosed critical illness in patients who are becoming progressively worse or critical illness in the patient with favorable prognosis who is not responding to accepted therapy.
 - (2) Unexpected critical complication(s) which appear to have arisen during diagnostic or therapeutic procedures, and which may require management expertise either not possessed or not being provided by the managing practitioner.
 - (3) Departmental rules and regulations, approved by the MEC, require consultation.
- b. Consultant is defined as "a Member of the Medical Staff who is available at the particular time and who is by training, experienced, and demonstrated competence qualified to be a consultant for the particular situation." The recommendations of consultants will not justify violations of the Ethical and Religious Directives for Catholic Hospitals.
- c. The expected behavior when requesting a consultation is to write an order for "consultation" and to initiate a direct conversation from referring to consulting physician, particularly between the hours of 1700 h and 0700 h the following day.

- d. When direct verbal conversation is not possible, the referring physician will provide at a minimum, by written order, the:
 - (1) Request for “consultation”;
 - (2) Diagnosis/reason for the consultation;
 - (3) Expectation of the time in which the consultation is to occur (stat, next time on rounds); and
 - (4) One or more methods to contact the physician or covering associate immediately for clarification (numbers for cell phone, pager, answering service, office, home).
- e. Consultant call schedules should be respected by depending on the consultant on call to complete the consultation, avoiding demands for specific consultants in a group with a rotating call schedule.
- f. For the purposes of this policy:
 - (1) “Written orders” is understood to mean those orders personally written or transmitted by telephone order to a nurse caring for the patient;
 - (2) Emergency room physicians may call the consultant on behalf of the referring physician when patients are unstable and in urgent need of subspecialty care;
 - (3) For patients who are stable or for chronic problems, the expectation is that the primary physician will see the patient before requesting consultations.
 - (4) Consultants should be contacted by the nurse caring for the patient if direct physician to physician conversation does not occur.
 - (5) Electronic tools available (Sophia, alpha numeric text pagers, text message by cell phone, voice mail and other methods of asynchronous communication) are acceptable if the receipt of messages is confirmed to the sender and privacy regulations are observed.
- g. Consultation shall include, but not be limited to:
 - (1) Examination of the patient and their medical record;
 - (2) Written opinion documented in the medical record concerning the patient’s diagnosis; and
 - (3) Suggested treatment.

6. Patient Death and Autopsies

- a. In the event of patient death within the hospital, the death may be recognized and documented by registered nurses. Only licensed physicians and the Coroner may pronounce death. Documentation shall contain notification of all involved medical staff members and residents as well as appropriate organ/tissue donation agencies. Body donations and autopsy requests will be appropriately addressed and all policies regarding release of deceased bodies will be in accordance with local and State laws.
- b. It shall be the duty of all Medical Staff members to secure autopsies whenever appropriate and possible. An autopsy may be performed only with a written consent, signed in accordance with state law and Hospital policy.

- c. All autopsies shall be performed by a Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours after the patient's demise and a complete autopsy protocol will be made a part of the medical record within sixty (60) days after the autopsy unless exceptions for special studies are established by the Medical Staff.
 - d. Autopsies should be especially encouraged when diagnosis is in doubt, complications of therapeutic procedures are suspected or when legally required.
7. Use of Restraints and Seclusion Facilities
- a. The use of restraints and seclusion facilities within the Hospital shall at all times comply with legal requirements and Joint Commission Standards and will be delineated in detail in hospital directives.

F. General Rules Regarding Surgical Care

1. A surgical operation shall be performed only with written consent of the patient or his legal representative, except in emergencies, at which time the surgeon shall so document in the medical record.
2. All operations performed in the operating room shall have an operative report dictated by the operating surgeon or his designee immediately following the surgery. A brief operative note recording the name of the licensed independent practitioner and assistants; procedure(s) performed and description of the procedure; findings; estimated blood loss; specimens removed; and postoperative diagnosis shall be entered in the patient's record by the operating surgeon or designee immediately following the procedure.
3. All tissues (including teeth) removed at operation, all tissues and other pertinent materials spontaneously passed and all foreign bodies (including orthopedic hardware and prostheses) shall be sent to the hospital pathologists for examination consistent with State and Federal law, Joint Commission regulations, and CMS requirements. The responsible pathologist or other designated physician will verify receipt of these specimens, perform such examination as may be necessary or requested to arrive at appropriate pathologic diagnosis, and provide a signed interpretation in the medical record. Any exceptions to this procedure shall be only by approval of the Chairman of the Hospital Department of Pathology. All specimens submitted shall be accompanied by the preoperative diagnosis written prior to the operative procedure, as well as any other pertinent medical information or request for special examination. Provision of this information shall be the responsibility of the patient's surgeon.
4. Surgeons must be in the operating room and ready to commence the operation at the time scheduled. The operating room will not be held longer than fifteen (15) minutes after the time scheduled without prior notice and evidence of reasonable extenuating circumstances. The official Medical Staff policy regarding use of the operating room(s) will be the most current operating room rules as approved by the Medical Staff Executive Committee and Hospital Administration with appropriate authority provided to implement individual requirements as designated in these rules. In order to implement this rule, it is advised that anesthesia and supporting services should be available at least thirty (30) minutes before the scheduled surgical start time.
5. The operating surgeon shall have a qualified assistant, as delineated by the Medical Staff Bylaws and Hospital directives, and approved by Administration, present at all major surgical procedures and/or as required by any rules and regulations of the appropriate surgical department.

6. Except for emergencies, the patient's history, physical, preoperative diagnosis and required laboratory and/or x-ray testing (all within the past 30 days) must be present in the patient's record prior to any surgical procedure, including any updates of the patient's condition since the original assessment . If such is not present or recorded, the operation may be postponed. In an emergency, the Attending Practitioner shall document at least a concise statement regarding the patient's condition prior to the commencement of anesthesia.
7. The anesthesiologist will maintain a complete anesthesia record which includes evidence of pre-anesthesia exam by Medical Staff member, as well as post-anesthesia follow-up of the patient's condition, both on leaving the recovery room and within forty-eight (48) hours postoperatively, or as appropriate thereafter for all patients remaining in the hospital over forty-eight (48) hours. The anesthesiologist may relinquish responsibility for patients in the recovery area after they have documented appropriate recovery from the effects of the anesthetic agents utilized; this will particularly pertain to those instances in which the recovery area is being utilized as a holding area prior to the patient's transfer to an intensive or other care area. In certain instances direct transfer of the patient from the OR to an appropriate care area is permissible.
8. Cultures will be taken in all operative cases where apparent infections are encountered. Cultures shall be ordered by the Attending Practitioner or the Practitioner who performed the operation for post-operative infections. If such cultures are not ordered, they may be obtained in accordance with the standing orders of the Infection Control Committee and as delineated in the most current copy of the Infection Control Manual, with or without the consent of the attending Practitioner or surgeon.
9. House Staff Involved in Surgical Training Programs
 - a. Case Scheduling
 - (1) During routine or non-routine scheduling hours, an elective surgical procedure may be placed on the schedule in any operating area (delivery room, operating room, emergency area) by any level resident if the resident indicates on the patient's record that he has consulted with the Attending Physician and/or Program Director to whom he is assigned and has been instructed to so schedule the case. Hospital personnel in charge of the area and/or the anesthesiologist responsible are at liberty to contact the attending Medical Staff member and/or Program Director for clarification and confirmation of the request.
 - (2) Emergency procedures may be "scheduled" or the operating room personnel notified by any level resident, in accordance with an emergency situation. Hospital personnel in charge and/or anesthesiologist may contact the Attending Practitioner for clarification and confirmation if they deem necessary

b. Procedure Performance

- (1) At some point during the established training program for residents in surgery specialties, and obstetrics and gynecology, residents of any level may be permitted to perform those surgical procedures in which the resident has sufficient familiarity and training. In those areas where the Attending Medical Staff member deems the resident proficient, the Attending Medical Staff member may authorize the resident to proceed directly without the Attending Medical Staff member being present; in the majority of cases, this pertains only to advanced standing (third year and above) level residents. In these circumstances, the patient must be advised and proper written consent obtained confirming the resident will be performing the procedure without the presence of the Attending Medical Staff member.
 - (2) In emergencies, residents of any level may be requested by Attending Medical Staff member to initiate a case while the Attending Practitioner is physically not on the Hospital premises, but is on the way to the Hospital. Hospital personnel and/or anesthesiologists are at liberty to discuss this matter with the resident and Attending Practitioner for further clarification and in particular to determine if the Attending Practitioner requests the resident notify the patient or patient's family in regard to the resident's participation. In all cases in which the Attending Medical Staff member is physically present within the operating area, informed consent should be completed by the Attending Medical Staff member.
 - (3) In some Residency programs more definitive guidelines will be developed and, after proper review by Hospital Medical Staff departments involved, should be followed as long as they conform to prior established guidelines.
10. All preoperative patient orders, including orders limiting extraordinary care, are discontinued when patients go to surgery unless specifically directed otherwise by the patient's Attending Practitioner. After surgery the physician must renew each discontinued order that is to be resumed.
 11. Guidelines regarding "outreach surgery" at St. John's Hospital will be those as recommended by the appropriate department and approved by the Medical Staff Executive Committee and Administration.

G. Emergency Services

1. The Medical Staff shall adopt a plan for providing Medical coverage in the Emergency areas. Such plan shall be consistent with the Hospital's basic plan for delivery of emergency services including delineation of clinical privileges for all Medical Staff members and Allied Health Professionals who render emergency care and identification of medical persons deemed qualified to conduct an initial medical screening exam to determine whether or not an emergency medical condition exists.

2. All patients who present themselves to the Emergency Department and those patients presenting to the Birth Center requesting a medical screening examination will initially be interviewed, examined and evaluated by one of the following Qualified Medical Personnel (QMP)
 - a. Emergency Medicine Physician
 - b. The patient's attending Physician
 - c. Trauma Surgeon
 - d. Physician Assistant (PA) or Advanced Practice Nurse (APN) granted privileges through the Department of
 - e. Emergency Medicine
 - f. RN assigned to triage the Birth Center
 - g. Members of the House Staff under supervision
3. The Emergency Medicine physicians or PAs and APNs credentialed through the Department of Emergency Medicine must establish a procedure to interview, examine, and evaluate all patients who present themselves to the Emergency Department. If during the interview it is determined that the patient has come to the Emergency Department at the request of his private Medical Staff member or a House Staff member for the purpose of being examined there by the Medical Staff member or House Staff member, the Emergency Medicine physician is not required to proceed with an examination and evaluation of the patient. However, if it is not clear why the patient is there, if the patient was sent there by his private Medical Staff member or House Staff member for examination by the Emergency Medicine physician, or if there appears to be an unreasonable length of time to wait for either House Staff or Medical Staff member to respond and/or at the patient's specific request, the Emergency Medicine physician will then proceed with the medical screening examination and treatment of the patient.
4. If a QMP other than a physician determines that a woman is in false labor, a physician must certify the diagnosis.

5. An appropriate medical record shall be kept whenever a patient receives emergency services. This record shall be incorporated into the patient's hospital record, if such exists, and shall include:
 - a. Identifying information;
 - b. Information concerning time of patient's arrival;
 - c. The means of arrival, any pre-hospital care;
 - d. Pertinent history of the injury or illness, including information from a prior hospital or in a pre-hospital setting;
 - e. A description of significant clinical laboratory and imaging findings;
 - f. The apparent diagnosis;
 - g. A description of the treatment given in the Emergency Department;
 - h. The condition of the patient upon discharge from the Emergency Department, transfer to another facility, or admission; and
 - i. Final disposition including a description of the instructions given to the patient and/or his family regarding follow-up care.
6. The Medical Staff may approve protocols that permit a non-physician QMP, who has conducted a medical screening examination, to provide treatment within the scope of practice of the QMP.
7. Each patient's Emergency Department or Birth Center record shall be signed by the Practitioner in attendance. Such Practitioner is responsible for the clinical accuracy of the record.
8. There shall be ongoing review of Emergency medical records by the Department of Emergency Medicine for purposes of evaluating the quality of emergency medical care.
9. The transfer or discharge of patients from the Emergency Department shall be in accordance with the policies developed by the Department of Emergency Medicine and in accord with any current legislation.
10. Medical Staff members assigned to the emergency call schedule by their Department Chairman must be available, or must provide a designee of a similar specialty to:
 - a. Provide advice when requested by Emergency Medicine physicians for those patients presenting to the Emergency Department who are not currently under the care of a member of the Medical Staff.
 - b. Provide inpatient care within their privilege assignment for patients as delineated in (a) when an emergency inpatient admission appears necessary.
 - c. Provide for outpatient follow-up care as medically indicated for patients delineated in (a), at least for the current acute illness or injury.
 - d. Provide any additional on-call activity that may be delineated in the appropriate approved specific departmental rules.
 - e. Emergency Department records must list the referral physician's name if copies of the medical record are to be sent to that physician for continuing care of the patient.

H. Emergency Management Plan

1. The approved plan for management of a community or Hospital emergency, which may involve mass casualties, circumstances associated with disasters or potential disasters shall be the pertinent sections of the most current Hospital Emergency Management Manual. All directives contained in the manual will be implemented as official Medical Staff Policy whenever the plan is activated.
2. Medical Staff assignment will be as designated in the Emergency Management Manual, with such assignments to be coordinated with other Hospital and Emergency Agencies within the community. Generally, Medical Staff members will not perform duties other than those assigned in the Manual.
3. The awarding of emergency privileges in the event of a declared disaster (defined as any officially declared emergency, whether it is local, state or national) will be guided by current medical staff policy approved by the hospital administration, MEC and Board and as time to time is amended.
4. Medical Staff members assigned to the Emergency Management Committee will be appointed annually by the Medical Staff President.
5. If the necessity arises to evacuate patients from one section of the Hospital to another, to transfer patients to another hospital, or to discharge patients, all Medical Staff members specifically authorize these activities as delineated in the Emergency Management Manual.
6. Emergency Management Plan rehearsal, as required by accrediting and licensing bodies, must be conducted as frequently as required and must have documented evaluation and corrective activities.

I. General Rules Regarding Obstetrics and Gynecology

1. Consultations on diagnostic D&Cs and incomplete spontaneous abortions are not necessary.
2. Consultations should be obtained in any case where the Attending Physician feels there is doubt concerning the possibility of interrupting a viable pregnancy.
3. An approved laboratory test for pregnancy is required in all female patients ten (10) to 55 years of age prior to any surgical procedure in which the patient is to receive a general or regional anesthetic or a sedative medication.
 - a. Exceptions:
 - (1) Those patients who have had a hysterectomy or are known to be pregnant at the time of the procedure,
 - (2) When the attending physician waives the requirement for other appropriate reasons.
 - (3) An available blood or urine pregnancy test, by an approved laboratory, within three days prior to the procedure.
 - (4) The test is also required as it may seem necessary in such cases in which presence of pregnancy would render a surgical procedure illicit (see Ethical and Religious Directives for Catholic Health Facilities).

J. General Conduct Regarding Medical Staff

1. Continuing Medical Education (CME):
 - a. Staff members shall document participating in CME activities at least every other year or as otherwise directed by the MEC. The minimum annual hours of documented appropriate Continuing Medical Education activities acceptable to maintain Medical Staff status will be consistent with State Licensure Requirements. Exceptions may be made to this policy upon reasonable request to the MEC.
2. Infection Control:
 - a. The official Medical Staff Policy regarding infection control for all patients and licensed independent practitioners in hospital facilities' will be the most recent edition of the MEC approved infection control manual, as amended, with the currently designated Infection Control Officer provided the authority to implement all specifications contained within the Infection Control Manual if and when the need arises.
3. Quality Improvement:
 - a. The official Medical Staff Policy regarding quality improvement activities will be the most current Performance Improvement Program/Plan approved by the MEC, Administration, and Board, with appropriate authority provided to implement all the individual specifications designated in the Plan.
4. Medical Staff Year:
 - a. The official medical Staff year will be the calendar year, January 1st through December 31st, unless designated otherwise by the MEC.
5. Alternate Medical Staff Members for Call Coverage
 - a. In order to provide for continuous care of patients, every preapplicant, applicant and Medical Staff member must designate at least two Active Medical Staff members who agree in writing to attend and oversee treatment of his patients when he is temporarily unavailable.
 - b. These alternate Medical Staff members should be in the same specialty or subspecialty with appropriate clinical privileges. Any exceptions to this requirement will be only on recommendation of the appropriate Department chair and approval by the MEC and Board.
 - c. If the designated alternate Medical Staff members are also unavailable when needed, the appropriate Medical Staff member who is providing group coverage or the unassigned medical staff member on emergency call will be contacted for necessary emergency assistance. The appropriate Department chair, Medical Staff President and Chief medical officer should be promptly notified of this situation.
 - d. Medical Staff members' alternates will not be required to provide written letters of agreement when these Bylaws become effective.
 - e. Each Medical Staff member is responsible to keep his alternate listing up-to-date at all times.

- f. In order to assure continuity of care, it is the responsibility of each member of the Medical Staff to notify his respective alternates or other designated “covering” Medical Staff member whenever his absence is anticipated.

6. Transition Authorization

- a. Upon approval of these Rules and Bylaws by the Medical Staff and the Board, the MEC is authorized to develop appropriate policies to ensure a smooth transition.