SACRED HEART HOSPITAL
EAU CLAIRE, WISCONSIN

MEDICAL STAFF
RULES AND REGULATIONS

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ARTICLE I

DEFINITIONS

Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as Medical Staff and hospital bylaws documents.

The following definitions shall apply to terms used in these rules and regulations:

(1) "Administrator" means the hospital Chief Executive or that individual's designee.

(2) "Allied health professional" means an individual, other than a licensed physician, dentist or podiatrist, whose patient care activities require that his or her authority to perform specific patient care services or to exercise a specific scope of practice be processed through Medical Staff channels or with involvement of Medical Staff representatives.

(3) "Appointee" means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

(4) "Authorized representatives" means any persons who have responsibility for obtaining or evaluating credentials, acting upon applications, or conducting professional review activity, including Board members, Medical Staff appointees or committee members, hospital employees, consultants and legal counsel.

(5) "Automatic relinquishment" of clinical privileges or scope of practice means a lapse in clinical privileges or scope of practice deemed to automatically occur as a result of stated conditions.

(6) "Board" means the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis.

(7) "Clinical privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff appointee or other independent practitioner to render specific patient care services in the hospital within defined limits.

(8) "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").

(9) "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."

(10) "Federal health program" means Medicare, Medicaid or any other federal or state program providing health care benefits which is funded directly or indirectly by the United States government.

(11) "Hospital" means Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis.

(12) "Medical Staff" means all physicians, dentists and podiatrists who are granted appointment and privileges to treat patients at the hospital.

(13) "Order Set" means a group of orders which contains selectable orders specific to an individual patient's needs and dependent upon an ordering provider's clinical decision.

(14) "Performance improvement" means the continuous evaluation and adaption of functions and processes of the hospital and its facilities to increase the probability of achieving desired outcomes and to better meet the needs of patients, other users of services and the community.

(15) "Physicians" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(16) "Podiatrist" shall be interpreted to mean a doctor of podiatric medicine ("D.P.M.").

(17) "Protocol" means a standardized set of orders that is preselected to treat a specific diagnosis, symptom or test. It doesn't contain any patient specific options except weight based dosing guidelines and is typically based on evidence-based medicine guidelines.

(18) "Standing Order" means a standardized set of orders to be carried out when not in direct contact with an ordering provider. These are prewritten orders to administer medications, obtain a diagnostic test or implement a treatment based on specific symptoms or ordered diagnostic procedures. There are no options to alter the order.

(19) "Unassigned patient" means any individual who comes to the hospital for care and treatment who has not been referred by or has not been the patient of a group/clinic affiliated with a physician on staff at the hospital, or who does not express a desire for the medical services of a particular appointee or whose attending physician or designated alternate is unavailable.

Words used in these rules and regulations shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these rules and regulations.

ARTICLE II

ADMISSION

Section 1. Who May Admit Patients:

(a) A patient may be admitted to the hospital only by physicians, dentists, podiatrists and certified nurse midwives who have been appointed to the Medical Staff and who have been granted privileges to admit patients. All appointees shall be governed by the admitting policy of the hospital.

(b) Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

(c) In conformity with state laws and public health rules and regulations, no patient shall be refused treatment or care because of inability to pay.

Section 2. Admitting Appointee's Responsibilities:

(a) Each patient shall be the responsibility of a designated appointee to the Medical Staff. In the case of a group practice, the appointee who admits the patient shall be considered the responsible, designated Medical Staff appointee. Such appointee shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring appointee and to relatives of the patient.

(b) The attending appointee is responsible for rounding on his or her hospitalized patients at least every day. Psychiatry and Rehabilitation attending appointees must round at least once every other day.

(c) Whenever these responsibilities are permanently transferred to another staff appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record, and the appointee to whom the patient has been transferred shall acknowledge the transfer in a progress note and shall be responsible for the care of that patient until the patient is discharged from the hospital.

(d) The responsible practitioner shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

(e) Precautions shall be taken in the care of potentially suicidal patients, and shall include but not be limited to the following:

(1) Any patient known or suspected to be suicidal shall be referred and admitted to the Behavioral Health Department following stabilization and/or

treatment for existing emergent conditions that may exist. Exceptions to this will be clearly documented in the admitting history and physical and progress notes.

(2) When admittance to the Behavioral Health Department is not possible, the patient shall be referred to another institution where suitable facilities are available. When transfer is not possible, the patient shall be admitted to an area of the hospital with appropriate protective measures taken.

(3) Any Medical Staff appointee must offer any patient known or suspected to be suicidal or harmful to others a consultation by a member of the psychiatric staff. Exceptions to this will be clearly documented in the history and physical and progress notes.

Section 3. Care of Unassigned Patients:

(a) Any patient who presents at the hospital who has not been referred by or has not been the patient of a group/clinic affiliated with a physician on staff at the hospital, and who does not express a desire for the medical services of a particular appointee, the Active Staff appointee on duty in the clinical department shall be assigned to the patient, on a rotational basis, where possible, by the emergency physician on duty.

(b) All Active Staff physicians must take unassigned patients on a rotational basis or find suitable physician coverage for such patients. The monitoring, coordination and enforcement of participation in the call schedule shall be the responsibility of the clinical department chiefs or their designees, with administrative support provided by the Medical Staff Office.

(c) Nothing in this provision shall interfere with the patient's right to request his or her own physician if such a choice is expressed.

Section 4. Dental Patients:

A patient admitted for dental surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending dentist and a physician staff appointee.

(a) Dentist's responsibilities shall include:

(1) a detailed dental history justifying hospital admission;

(2) a detailed description of the examination of the oral cavity and pre-operative diagnosis;

(3) a complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination;

(4) progress notes pertinent to the oral condition;

(5) clinical summary or statement; and

(6) discharge order.

(b) Physician's responsibilities shall include:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to and suitability for anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

Section 5. Podiatric Patients:

A patient admitted for podiatric surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending podiatrist and a physician appointee.

(a) Podiatrist's responsibilities shall include:

(1) a detailed history justifying hospital admission;

(2) a detailed description of the examination of the foot and pre-operative diagnosis;

(3) a complete operative report, describing the findings and technique used. All appropriate tissue shall be sent to the pathologist for examination;

(4) pertinent progress notes;

(5) clinical summary or statement; and

(6) discharge order.

(b) Physician's responsibilities shall include:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

Section 6. Alternate Coverage:

(a) Each Medical Staff appointee shall provide professional care for his or her patients in the hospital by being available or having available an alternate Medical Staff appointee who has clinical privileges at the hospital sufficient to care for the patient, and with whom prior arrangements have been made. Failure to meet the requirements concerning availability may result in a professional review action and may include the loss of clinical privileges.

(b) An attending appointee who will be unavailable for any amount of time shall indicate, in writing on the order sheet of each patient's chart, the name of the staff appointee who will be assuming responsibility for the care of his or her patients during the absence.

(c) "Suitable alternative coverage" means if the attending staff physician is absent or unavailable, that physician must arrange care for patients through clinical department members or through another physician with comparable clinical privileges. The covering physician must be physically available within a reasonable distance and response time.

Section 7. Transfer of Patients:

(a) Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or the attending appointee, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

(b) If the patient is to be transferred to another health care facility, the responsible appointee shall enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

(c) All transfer priorities shall be in accordance with applicable hospital policies. No patient shall be transferred without the knowledge of the responsible appointee.

Section 8. Priorities for Admission:

The admitting office shall admit patients on the basis of the following order of priorities:

(a) **Emergency Admissions** includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. Within twenty-four (24) hours of an emergency admission, the attending appointee shall be required to furnish complete documentation of the need for the admission. Failure to furnish this documentation, or evidence of willful or continued inappropriate utilization of this classification of admission, shall be brought to the attention of the Medical Executive Committee for appropriate action.

(b) **Urgent Admissions** includes non-emergency patients whose admission is considered imperative by the attending appointee. Urgent admissions shall be given priority when beds become available over all other categories except an emergency. All urgent admissions shall be routinely reviewed, and evidence of willful or continued misuse of this classification of admission shall be brought to the attention of the Medical Executive Committee for appropriate action.

(c) **Pre-Operative Admissions** includes patients already scheduled for surgery. If it is not possible to accommodate such admissions, the Director of Surgical Services and Surgery Department Chair or a designee will decide the priority of any pre-operative admission.

(d) **Routine Admissions** includes elective admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the hospital's applicable Hospital policies.

(e) If any question arises regarding the validity of admission to or discharge from the Critical Care Unit, a decision shall be made through consultation with the appropriately designated member or Chairperson of the Critical Care Committee, and such decision shall be reviewed by the Critical Care Committee at its next regularly scheduled meeting.

Section 9. Emergency Admissions:

(a) The history and physical examination must clearly justify an emergency admission and must be recorded on the patient's chart in accordance with the history and physician requirements as defined in the Medical Staff Bylaws. In the case of a psychiatric admission, the initial workup shall also include a mental status examination and proposed treatment plan.

(b) Emergency admission patients who do not have a personal physician with admitting privileges shall be assigned to a Medical Staff appointee with privileges in the specialty to which the diagnosis indicates an assignment is appropriate. The chief of each department or a designee shall provide an assignment call schedule for attendance to such patients. If an assigned appointee is unable to take assignment

when scheduled, it shall be that appointee's responsibility to arrange for a qualified substitute.

(c) Failure of the assigned appointee to respond to an emergency call may result in a professional review action, unless that appointee presents, in writing, an acceptable reason for not attending the patient to the chief of the applicable department and the Chief Executive Officer. An unexcused failure to respond to an emergency call shall be reported immediately to the Medical Executive Committee for appropriate action.

Section 10. Continued Hospitalization:

(a) Upon request, the attending appointee must provide written justification of the necessity for continued hospitalization of any patient , including an estimate of the number of additional days of stay, the reason for such stay, and plans for post-hospitalization care. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure to comply with this requirement shall be brought to the attention of the Medical Executive Committee for appropriate action.

(b) The attending appointee's documentation must contain:

(1) an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the hospital; and

(3) plans for post-hospital care.

(c) If it has been determined that the patient's continued hospitalization is inappropriate but the attending appointee refuses to discharge the patient, both the patient and the attending appointee shall be notified immediately and in writing of the inappropriate stay.

ARTICLE III

MEDICAL ORDERS

Section 1. General Requirements:

(a) Orders must be written clearly, legibly and completely. Orders which are illegible or improperly written shall not be carried out until they are clarified by the ordering appointee and are understood by the nurse.

(b) The use of the terms "renew," "repeat," and "continue" standing alone on orders is not acceptable.

(c) All previous orders shall be canceled when patients go to surgery. Post-operative orders will be written by the surgeon after review of the patient's medical record.

(d) Orders for "daily" tests shall state the number of days and shall be reviewed by the attending physician at the end of the expiration of said days unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format that it was originally recorded if it is to be continued.

(e) Orders for all medications and treatments for all patients shall be under the supervision of the attending appointee and shall be reviewed by the attending appointee in a timely manner to assure discontinuance when no longer needed.

(f) When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten.

(g) No order shall be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

(h) Only those abbreviations, signs and symbols authorized by the hospital shall be used in the medical record. However, no abbreviations, signs or symbols shall be used in recording the patient's final diagnosis or any unusual complications. In addition, the abbreviations, signs, symbols, acronyms and dose designations listed in the policy on unapproved abbreviations shall <u>not</u> be used in any medical record, internal communication, label, or written document that could affect patient care.

<u>Section 2. Who May Write Orders</u>:

(a) Medical Staff appointees and allied health professionals shall have the authority to write orders only as permitted by their licenses and clinical privileges or by their scope of practice.

(b) All orders must be entered in the patient's record, dated, timed and signed by the responsible appointee.

(c) Resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the Medical Staff appointee responsible for the patient's care. This does not prohibit the patient's attending appointee from writing orders without the agreement of the resident.

<u>Section 3. Verbal Orders</u>:

(a) A verbal order (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is impractical for such order to be given in writing by the responsible appointee.

(b) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the medical record of the patient. The individual accepting the verbal order will read the complete order back to the ordering appointee. Acceptance of a verbal order is limited to the following, with noted restrictions:

(1) a physician, dentist or podiatrist with clinical privileges at this hospital;

(2) a professional registered nurse;

(3) a pharmacist who may transcribe a verbal order pertaining to drugs;

(4) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(5) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

(6) an occupational therapist who may transcribe a verbal order pertaining to occupational therapy treatments;

(7) a radiology technician who may transcribe a verbal order pertaining to radiological tests and/or therapy treatments;

(8) designated laboratory personnel who may transcribe a verbal order pertaining to laboratory services; and

(9) designated electrodiagnostics personnel who may transcribe a verbal order pertaining to electrodiagnostic services.

(c) A verbal order shall include the date, time, and full signature of the person to whom the verbal order has been given; shall be dated, timed and countersigned by signature or initials by the prescribing appointee within forty-eight (48) hours of receipt; and shall be permitted for those diagnostic and therapeutic procedures/treatments specifically predefined by the Medical Executive Committee after consultation with each clinical department chair or designee. The failure to authenticate a verbal order shall be brought to the attention of the Medical Executive Committee for appropriate action.

Section 4. Orders for Specific Procedures:

(a) All requests for radiological or other special examinations and services shall contain a pertinent clinical statement or specific diagnosis of the reason for the examination. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series.

(b) All orders for therapy shall be entered in the patient's record, dated and timed, and signed or countersigned by the ordering practitioner.

(c) Therapeutic diets shall be prescribed by the attending appointee in written orders on the patient's chart.

(d) All "NO CODE" orders shall be written physician orders pursuant to the hospital policy on Do Not Resuscitate (DNR) orders.

ARTICLE IV

MEDICAL RECORDS

Section 1. General Rules:

(a) A medical record shall be maintained for each patient who is evaluated or treated as an inpatient, ambulatory care patient or emergency patient. The attending appointee shall be responsible for the preparation of a complete and legible medical record for each patient under his or her care. This responsibility cannot be delegated.

(b) The contents of the record shall be pertinent and current. A single attending appointee shall be identified as being responsible for the patient at any given time.

(c) An appointee's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and shall be dated, timed and signed by the attending appointee.

(d) The following requirements shall be enforced by all clinical department chairs:

(1) A complete admission history, provisional diagnosis, and physical examination must be documented on the chart within twenty-four (24) hours following admission of the patient, and prior to any surgery or procedures involving general, regional or monitored anesthesia. Histories and physicals may be performed and pre-operative notes entered into the medical record by residents, but must be countersigned by the attending appointee.

(2) All consultations shall contain the date and time of the consultation and shall be documented on the patient's chart within twenty-four (24) hours of the consultation in accordance with Article V, Section 7 of these rules and regulations.

(3) Progress notes shall be written at least daily on all patients with the exception of psychiatric or rehabilitation patients.

(4) All operations performed shall be fully described by the operating surgeon who shall record information immediately after the procedure consistent with that required in Section 6 of this Article.

(5) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, and the complete protocol shall be made part of the record within sixty (60) days.

Section 2. Authentication:

All entries in the record shall be dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. The person authenticating an entry is either verifying that it is his/her entry or that he/she is responsible for the entry, and that the entry is accurate. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry must be individually authenticated by the legible signature, initials or computer keys of the individual making the entry.

Section 3. Contents:

(a) A complete inpatient medical record shall include:

(1) identification data, including the patient's name, address, the date of birth, and next of kin, as well as a single unit number that identifies the patient and the patient's medical record;

(2) date of admission and discharge;

(3) medical history, including:

(i) the chief complaint,

(ii) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status,

(iii) relevant past, social and family histories,

(iv) appropriate menstrual and obstetrical history in females,

(v) an inventory by body systems, and

(vi) drug sensitivities/allergic history;

(4) provisional admitting diagnosis;

(5) report of a physical examination, including but not limited to vital signs, head, chest, abdomen and extremities, or a note as to the contra-indications for such an examination or valid reasons why the examination was not performed. The physician's assessment shall be completed within twenty-four (24) hours of admission to the inpatient service and prior to any surgery or procedure involving general, regional or monitored anesthesia;

(6) a statement of the conclusions or impressions drawn from the admission history and physical examination;

(7) diagnostic and therapeutic orders;

(8) evidence of appropriate informed consent;

(9) family's or legal representative's expectations for, and involvement in the assessment, treatment, and/or continuous care of a minor or otherwise incompetent patient;

(10) clinical observations, progress notes, nursing notes, consultation reports;

(11) reports of procedures, tests and the results, including operative reports;

(12) reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures; and

(13) conclusions at termination of hospitalization, including the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses, the clinical resume or final progress note, and, when appropriate, the autopsy report.

(b) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Medical Executive Committee. All new forms proposed for use in the medical record shall be submitted to the Medical Records Panel for review. That Medical Records Panel shall recommend to the Medical Executive Committee (or reject) all forms for inclusion in the medical record. Changes approved by the Medical Executive Committee shall not be made until the mechanics of standardization have been accomplished.

(c) The medical record must be maintained intact at all times. Once information has been filed in the record, it should not be removed for any reason.

Section 4 Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the hospital. Progress notes can be written by Medical Staff appointees and allied health professionals as permitted by their clinical privileges or scope of practice, and shall be legible, document the date and time of observation, and contain sufficient information to insure continuity of care at this hospital or other health care facility to which the patient might later be transferred. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. Pertinent progress notes may also be made by residents.

(b) Progress note documentation shall include, but need not be limited to the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(2) any complications, new symptoms or additional diagnoses for which the patient is to be evaluated or treated;

(3) plans for additional workups, consultations, or definitive treatment(s); and

(4) discharge planning.

(c) If the patient's condition is stable and unchanged, a statement documenting such shall be adequate.

Section 5. Surgical Records:

(a) Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery, or the operation shall be automatically canceled:

(1) verification of patient identity;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(4) provisional diagnosis;

(5) laboratory test results;

(6) consultation reports;

(7) voluntary consent form signed by the patient or the patient's legal representative verifying that the physician has explained the procedure and its risks, benefits and alternatives, and an anesthesia consent form signed by the patient or the patient's legal representative. A member of the hospital staff shall serve as a witness to the voluntary consent of the patient;

(8) x-ray reports, if applicable; and

(9) other ancillary reports, if applicable.

(b) Except in the case of an emergency, the patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received.

(c) In an emergency situation, the attending surgeon shall write a note describing the patient's condition prior to the induction of anesthesia and the start of surgery. If the history and physical have been transcribed but not yet entered in the chart, an admission note and statement to that effect may be entered in the chart by the attending appointee.

Section 6. Operative Reports:

(a) A brief operative report shall be handwritten in the medical record immediately after operative and other high-risk procedures before the patient is discharged or transferred to another setting. The post-anesthesia recovery room is considered part of the surgery setting. The post-procedure note shall contain:

(1) a description of the surgery and related findings;

(2) estimated blood loss;

(3) any specimens removed;

(4) the postoperative diagnosis;

(5) the complications encountered; and

(6) the names of the primary surgeon and any and all assistants.

(b) A detailed operative report shall be dictated promptly following surgery, and the completed operative report shall be authenticated by the surgeon and filed in the patient's medical record as soon as possible after surgery. When the operative report

is not placed in the medical record immediately after surgery, a progress note shall be entered immediately.

Section 7. Anesthesia Note:

A separate pre-anesthesia and post-anesthesia evaluation shall be documented in the medical record of all patients undergoing surgery and shall specifically include, but not be limited to, information relative to the choice of anesthesia for the procedure anticipated, any unusual risk possibilities, and where relevant, previous drug history and other anesthetic experiences. At least one post-anesthesia note shall describe the presence or absence of anesthesia-related complications.

Section 8. Pathology Reports and Disposition of Surgical Specimens:

(a) All appropriate specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnosis.

(b) The pathologist shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within twenty-four (24) hours of completion, if possible.

(c) Foreign bodies and objects may be referred to the hospital pathologist at the option of the attending surgeon.

(d) The disposition of surgical specimens, whether discarded or submitted to pathology, shall be recorded in the operative record.

Section 9. Obstetrical Records:

The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending appointee's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. Except in emergencies, a complete history and physical examination shall be recorded in the medical record of obstetrical patients undergoing major surgery.

Section 10. Medical Information from Other Hospitals or Health Care Facilities:

Upon written authorization of the patient, the Health Information Management Department shall transmit information to other hospitals or healthcare facilities requesting data concerning the patient's previous admissions, record name, birthdate and dates of previous hospitalization. Similarly, the Health Information Management Department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient. Information received in response to said request shall not become part of the patient's medical record at this hospital unless authenticated by the attending appointee as part of the current medical record.

Section 11. Discharge Summaries:

(a) A discharge summary must be recorded for all patients whose length of stay exceeds forty-eight (48) hours, all deaths and complicated cases. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and any complications experienced, shall be recorded on the Discharge Summary, using acceptable disease and operative terminology that includes topography and etiology as appropriate ("Standard Nomenclature of Diseases and Operations"). The Discharge Summary shall be dated, timed and signed by the attending appointee.

(b) A discharge summary shall be completed on all patients being transferred to another facility within twenty-four (24) hours of transfer and within fourteen (14) days for all other discharges.

(c) A final progress note, including diagnosis, condition at discharge, medications at discharge, discharge instructions and required follow up care, may be substituted for the discharge summary in the case of the following categories of patients:

(1) those with problems of a minor nature who require less than 48 hours of hospitalization;

(2) normal newborn infants;

(3) patients having uncomplicated vaginal deliveries.

(c) The discharge summary shall include:

(1) the reason for hospitalization;

(2) the significant findings;

(3) any complications;

(4) the procedures performed and treatment rendered;

(5) the condition of the patient on discharge; and

(6) any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care.

(d) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

(e) When preprinted instructions are given to the patient or the patient's representative, a copy will be placed in the patient's medical record.

(f) All discharge summaries shall be authenticated by the attending appointee.

Section 12. Delinquent Medical Records:

(a) The elective and emergency admitting privileges of a Medical Staff appointee, except with respect to those patients already in the hospital, shall be automatically relinquished for failure to complete medical records in accordance with applicable Bylaws, regulations and other relevant hospital policies, after notification of delinquency by the Medical Staff Office, unless the appointee is without fault in causing the delinquency.

(b) Each medical record shall be completed within fourteen (14) days following discharge. An appointee who has not completed his or her medical records within fourteen (14) days after discharge shall be considered delinquent and written notice of such automatic relinquishment shall be forwarded to the affected appointee by the Medical Staff Office with notification to the appropriate clinical department chairperson. Such relinquishment shall continue until all the delinquent records are completed.

(c) Failure to complete the medical records that caused automatic relinquishment of elective and emergency admitting privileges within sixty (60) days from the date of the first notification of relinquishment shall result in automatic resignation from the Medical Staff.

(d) No Medical Staff appointee or other individual shall be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

Section 13. Possession, Access and Release:

(a) All medical records are the physical property of the hospital and shall not be taken from the confines of the hospital, except in specific situations, and only with the permission of the CEO, and then only when accompanied by a person designated by the CEO. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the

attending appointee. Unauthorized removal of a medical record from the hospital by an appointee shall constitute grounds for a professional review action by the Medical Executive Committee.

(b) In cases of readmission of a patient, all previous records shall be available for the attending appointee's use. This shall apply whether the patient is attended by the same appointee or another appointee.

(c) No patient record shall be removed from the Health Information Management Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the CEO or a designee.

(d) Upon written approval of the Institutional Review Board (IRB), access to the medical records of all patients shall be afforded to Medical Staff appointees in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

(e) Subject to the discretion of the CEO, former Medical Staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Any publication of compiled data from the hospital's patient medical records is forbidden without written approval of the CEO.

(f) Written consent of the patient is required for release of medical information to those not otherwise authorized to receive information.

(g) Any record taken out of the Health Information Management Department for the purpose of patient readmission shall be returned with the current record upon discharge of the patient.

Section 14. Filing of Medical Record:

A medical record shall not be permanently filed until it is completed by the attending appointee or is ordered filed by the Medical Records Panel.

ARTICLE V

CONSULTATIONS

Section 1. General:

(a) The attending appointee or designee shall be responsible for requesting consultation when indicated and for calling in a qualified consultant.

(b) Requests for a consultation shall be documented in the patient's medical record. If the history and physical are not part of the patient's medical record, it shall be the responsibility of the appointee or designee requesting the consultation to provide this information to the consultant.

(c) An attending appointee requesting a consultation will have direct communication with the consultant.

(d) If a registered nurse employed by 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, that nurse shall notify the nursing supervisor who, in turn, may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer may, if warranted, bring the matter to the attention of the chair of the clinical department in which the appointee in question has clinical privileges. Thereafter, the chair of the department may request a consultation after discussion with the attending appointee.

Section 2. Who May Give Consultations:

Any individual with clinical privileges at this hospital can be asked for consultation within his or her area of expertise. In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Credentials or Medical Executive Committee, the President of the Medical Staff, the appropriate clinical department chair, the CEO or the Board shall at all times have the right to call in a consultant or consultants.

Section 3. Recommended Consultations:

(a) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient is incompetent.

(b) Consultations are also recommended in all cases which, in the judgment of the attending appointee:

(1) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(2) there is doubt as to the best therapeutic measures to be used;

(3) unusually complicated situations are present that may require specific skills of other practitioners;

(4) the patient exhibits severe symptoms of mental illness or psychosis;

(5) the patient is not a good medical or surgical risk; or

(6) there is a question as to whether the patient's condition may be the result of criminal conduct on the part of the patient or others, e.g., gunshot wound, knife wound, battered spouse or child activity.

(c) Consultations shall also be required when clinical departments, including clinical department rules and regulations, so require.

(d) Additional requirements for consultation may be established by the Medical Executive Committee and/or hospital as required.

Section 4. Psychiatric Consultations:

Psychiatric consultation and treatment shall be requested for and offered to all patients who present self-destructive behavior, i.e., attempted suicide, chemical overdose, etc. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

Section 5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, the surgeon shall ascertain that an adequate notation of the consultation, including relevant findings and reasons, appears in the patient's medical record. If it does not so appear, surgery and anesthesia shall not proceed.

Section 6. Mandatory Consultations:

(a) When a consultation requirement is imposed by the Credentials or Medical Executive Committee, pursuant to the Policy on Medical Staff Bylaws, or by the Board, the required consultation shall not be rendered by an associate or partner of the affected appointee.

(b) Failure to obtain required consultations may constitute grounds for a professional review pursuant to the Medical Staff Bylaws.

Section 7. Contents of Consultation Report:

(a) Each consultation report shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur" shall not constitute an acceptable consultation report. The consultation report shall be made a part of the patient's medical record.

(d) Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the operation. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

ARTICLE VI

INFORMED CONSENT

Refer to the Hospital policy on Informed Consent.

ARTICLE VII

PHARMACY

Section 1. General Rules:

(a) All drugs and medications administered to patients shall be:

(1) listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service," "A.M.A. Drug Evaluations," or "New and Nonofficial Drugs." Drugs for bona fide clinical investigations whose use is in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals," the regulations of the federal Food and Drug Administration, and approved by the Pharmacy and Therapeutics Committee and/or Institutional Review Committee shall be excepted;

(2) reviewed and reordered by the attending appointee at weekly minimum of every 21 days to assure the discontinuance of all drugs no longer needed. Exceptions to this rule shall be those specified in Medication Management Stop Orders Policy, which restrict the stop date on certain specific drugs for shorter periods of time;

(3) cancelled automatically when the patient goes to surgery; and

(4) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit.) In cases when the medication order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, the medication order shall be reviewed by the pharmacist as soon thereafter as possible, preferably within twenty four (24) hours.

(b) All medication orders must clearly state the administration times or the time interval between doses.

(c) A pharmacist may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the patient's

medical record noting date and time, and properly signed after the drugs have been administered.

(d) Self-medication by patients shall not be permitted, unless written in the orders by the attending appointee.

(e) The pharmacist may dispense the generic equivalent drug which has been accepted for the formulary by the Pharmacy and Therapeutics Committee when a trade drug name is prescribed, but is not in the hospital formulary. An appointee may object to the use of the generic equivalent for a particular patient and may request the specific product by underlining the drug's trade name or noting the name of the manufacturer. An appointee must be notified by the hospital pharmacy prior to the substitution of any equivalent generic drug for a specific trade name drug.

(f) All orders for antibiotics must state if they are being administered for therapeutic, prophylactic or empiric purposes.

Section 2. Unapproved Use of Approved Drugs:

(a) Commercially available drugs which are not prescribed according to FDA-approved packaging literature shall technically become investigational drugs. When the Director of the Pharmacy and the Chairperson of the Pharmacy and Therapeutics Committee are made aware of drugs prescribed for non-FDA-approved uses, they consider the matter.

(b) If the use is generally recognized by physicians in the relevant clinical specialty, no approval by the Pharmacy and Therapeutics Committee shall be required provided that the drug is already available on the Hospital formulary.

(c) If the use is not commonly recognized, the prescribing physician must present references from the medical literature to the Pharmacy and Therapeutics Committee to substantiate the prescribing practice.

(d) The Pharmacy and Therapeutics Committee may approve or disapprove the practice or may require the physician to obtain informed consent prior to initiating therapy.

Section 3. Patient's Own Drugs:

If patients bring their own drugs, vitamins or herbal/nutritional supplements to the hospital, these drugs shall not be administered unless the attending appointee has written an order for their administration. If the drugs are not ordered by the attending appointee, they shall be packaged, sealed and returned to the patient or given to the patient's legal representative at the time of discharge from the hospital. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall not be returned to the patient without approval of the attending appointee.

Section 4. Medication Errors; Adverse Reactions:

(a) Any medication error or apparent drug reaction shall be reported immediately to the appointee who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record.

(b) Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity, and to prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the appointee and to the director of pharmaceutical services. Unexpected or significant adverse reactions shall also be reported promptly to the Food and Drug Administration (FDA) and to the drug manufacturer as required.

Section 5. Standing Orders, Protocols, and Order Sets:

(a) For all clinical protocols and standing orders, review and approval of the Medical Executive Committee, with input from Nursing and Pharmacy, when appropriate, are required. Prior to approval, the Medical Executive Committee will also take necessary steps to ensure that there is periodic and regular review of such clinical protocols and standing orders.

(b) A protocol can be initiated by the provider ordering the initiation of a specific protocol. Standing orders can be initiated in the absence of a provider due to the timely nature of their intent. Order sets must be initiated by a provider who makes the requested order selections from the specific order set.

(c) All orders must be authenticated, dated and timed promptly in the patient's medical record by the ordering provider with the exception of standing order for influenza and pneumococcal vaccines which do not require authentication.

ARTICLE VIII

INFECTION CONTROL

(a) All nursing units shall follow the standard procedure for isolation as outlined in the Infection Control Manual which is based on the Centers for Disease Control's Guidelines for Isolation Precautions in Hospitals (CDC Guidelines).

(b) Any patient with a known or suspected communicable disease or infection shall be isolated as required by the Infection Control Manual. The attending physician will be notified. The Chairperson of the Infection Control Panel shall be empowered to order appropriate isolation procedures or epidemiologic investigations as required.

(c) The head nurse of a unit may order a culture of a draining wound. Cultures of draining wounds and stool cultures on patients with unexplained diarrhea may be requested by a department chair in consultation with the Chairperson of the Infection Control Panel or the Infection Control Registered Nurse.

(d) Appointees, employees and other health care personnel with communicable disease processes shall be restricted from patient contact in accordance with CDC Guidelines.

(e) When a cluster of nosocomial infections, including post-operative infections, occur, the Chairperson of the Infection Control Panel shall initiate procedures necessary to investigate and prevent further spread of infection.

ARTICLE IX

GENERAL RULES REGARDING SURGICAL CARE

Section 1. General:

(a) Enforcement of the rules and regulations pertaining to the operating room procedures shall be the responsibility of the Department Chair of Surgical Services and, where appropriate, his/her designee, the operating room supervisor. The operating room supervisor shall have the responsibility for administrative supervision of the operating room and shall have the authority to plan and execute the daily operative schedule.

(b) The operating room schedule shall begin promptly each day. The start time documented for each operation shall be defined as the time of the induction of the anesthetic. When local anesthesia is used, the scheduled time shall be defined as the designated operating time appearing on that day's schedule.

(c) The operating room supervisor shall have the responsibility for designing a schedule based on the maximum efficient use of the operating room and the Anesthesia Service.

(d) Any surgical procedure performed by a surgical resident shall be properly monitored and supervised.

(e) Any personnel with an open infected skin area shall not be permitted to enter the operating room suite.

(f) Any request to observe in the operating room or delivery suite must be approved by the President of the Medical Staff, the CEO or a designee, the Chief Nursing Executive, and the hospital Privacy Officer on a case-by-case basis.

Section 2. Scheduling Surgery:

(a) The presence of all members of the operating team in scrub suits and the patient in the operating room is required at the scheduled time for surgery. The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during and after the operation. If the operating surgeon is more than fifteen (15) minutes late for any scheduled case without contacting the operating room supervisor, that case shall be cancelled and the patient returned to his or her room by the operating room staff. In no case shall anesthesia be started until the operating surgeon is present in the surgical area. The surgical area is defined as the surgical suites and the surgical preparation area. Operating time shall be released promptly when a case is cancelled or the patient and surgical team are not available on schedule.

(b) Specific, contemplated procedures must be designated on the schedule, with the name of the patient, age, diagnosis, and surgical procedure. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case will be done as originally posted or rescheduled. Cases requiring frozen sections should be posted as such at the time the case is scheduled. Infectious or contaminated cases must be posted at the end of the operating room schedule or as otherwise authorized by the operating room supervisor or the supervisor's designee.

(c) An emergency case shall take precedence over an elective surgical case not in progress.

Section 3. Surgical Procedures:

(a) Surgery shall be performed by a surgeon-appointee according to the surgical privileges granted by the Board. If a surgeon attempts to schedule an operative procedure for which no privileges have been granted, the operating room supervisor shall inform that surgeon of the lack of such privileges and immediately notify the Department Chair of the Surgical Service and the CEO of the matter.

(b) In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

Section 4. Anesthesia and Sedation Rules and Records:

(a) The surgeon shall identify the patient using two patient identifiers to include the patient's name and hospital patient identification number prior to administration of the anesthetic and shall remain in the operating room area in operating attire during induction. The operating surgeon may be asked to assist or supervise the position of the patient on the operating table, and must be available in the event of an emergency.

(b) The anesthesiologist shall verify that there has been a recent pre-operative history and physical examination with appropriate laboratory data in the patient's clinical record. The anesthesiologist shall also verify that a pre-anesthesia or pre-sedation (for the use of moderate to deep sedation) evaluation of the patient has been conducted. The evaluation shall include the gathering of necessary information to determine the capacity of the patient to undergo anesthesia and to formulate an anesthesia plan. The evaluation shall include a review of objective diagnostic data, an interview with the patient regarding his or her medical, anesthetic and drug history, a review of the patient's psychological status, and the name of the physician or licensed independent practitioner who has planned, or concurred with the planning of, the anesthesia or sedative.

(c) The anesthesiologist or nurse anesthetist shall review the patient's condition immediately prior to induction of anesthesia or moderate to deep sedation, and shall check equipment, drugs and gas supply.

(d) A record shall be maintained of all events taking place during the induction of, maintenance of and emergence from anesthesia or sedation, including:

(1) the dosage and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(4) unusual events during the anesthesia period; and

(5) the status of the patient at the conclusion of anesthesia.

(e) Post-anesthesia evaluation and follow-up shall be conducted upon admission to and discharge from the post-anesthesia recovery area, and shall be documented in the patient's chart by an anesthesiologist or nurse anesthetist within forty-eight (48) hours after surgery. The post-anesthesia evaluation note shall include:

(1) a record of vital signs;

(2) level of consciousness;

(3) intravenous fluids administered, including blood and blood products;

(4) all drugs administered;

(5) post-anesthesia visits by the anesthesiologist or anesthetist; and

(6) any unusual events or post-operative complications and the management of those events.

(f) The number of post-anesthesia visits shall be determined by the status of the patient in relation to the procedure performed and anesthesia administered. The anesthesiologist or nurse anesthetist shall examine the patient early in the post-operative period and once after complete recovery from anesthesia or sedation. Complete recovery shall be determined by the clinical judgment of the anesthesiologist, designated anesthetist, or the discharging surgeon.

(g) When surgical or anesthesia services are performed on an ambulatory basis, the patient shall be provided with written instructions for follow-up care that includes information about how to obtain assistance in the event of post-operative problems. The instructions shall be reviewed with the patient or the individual responsible for the patient.

(h) General anesthesia for surgical procedures shall not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

Section 5. Recovery Room:

(a) The surgeon shall remain in the surgical area until the patient is admitted to the recovery room. Post-operative orders must be written by the surgeon or a qualified designee before the patient leaves the post-anesthesia recovery room suite. The anesthesiologist or, if appropriate, the designated nurse anesthetist shall subsequently examine the patient and write orders to discharge the patient from the recovery room.

(b) At least one (1) professional registered nurse shall be on duty in the recovery room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

Section 6. Operating Room Records:

(a) A roster of appointees currently possessing surgical privileges, with a delineation of the surgical privileges of each, shall be maintained in the surgical suite and be available to the operating room supervisor. There shall be an on-call schedule of surgeons established and posted at each patient unit or other area where surgical patients are admitted, or at the communications center of the hospital to ensure that there is twenty-four (24) hour emergency care or post-operative follow-up care, or both, available.

(b) An operating room register shall be provided and maintained on a current basis. The operating room log or register shall contain:

(1) the date of each operation;

(2) name and number of the patient;

(3) names of surgeons and surgical assistants;

(4) names of anesthetists and type of anesthesia given;

(5) pre- and post-operative diagnosis;

(6) type of surgical procedure; and

(7) the presence or absence of complications in surgery.

(c) The operating room supervisor shall be responsible for and authorized to carry out all orders which will ensure optimal technical procedures. Disputed matters shall be referred to the Department Chair of Surgical Services.

ARTICLE X

RESTRAINT, SECLUSION, AND BEHAVIOR MANAGEMENT

See the Hospital Restraint and Seclusion Policy.

ARTICLE XI

GENERAL RULES REGARDING EMERGENCY CARE SERVICES

Section 1. General:

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

Section 2. Medical Screening Examinations:

(a) Medical screening examinations, within the capability of the hospital, will be performed on all individuals who come to the hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable hospital policies and procedures are defined as:

(1) Emergency Department:

(i) members of the Medical Staff with clinical privileges in Emergency Medicine;

(ii) other Active Staff members;

(iii) appropriately credentialed allied health professionals; and

(iv) in the case of sexual assault, by a SANE forensic nurse under the written physician-directed protocols.

(2) Labor and Delivery:

(i) members of the Medical Staff with OB/GYN privileges;

(ii) certified nurse midwives with OB privileges; and

(iii) registered nurses who have achieved competency in labor and delivery and who have validated skills to provide fetal monitoring and labor assessment.

(b) The results of the medical screening examination must be dictated within 48 hours of the conclusion of an Emergency Department visit.

Section 3. On-Call Responsibilities:

(a) It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with applicable Hospital and HSHS EMTALA and On-Call Coverage policies and procedures.

(b) Such coverage shall be consistent with the hospital's basic plan for the delivery of emergency services, including the delineation of clinical privileges or scope of practice for all health professionals who are authorized to render emergency care.

(c) Other general rules regarding emergency services shall be defined by the Emergency Medicine Department, and approved by the Medical Executive Committee and the Board.

Section 4. Emergency Patient Records:

(a) An appropriate medical record shall be maintained for every patient receiving emergency services and shall be incorporated into the patient's hospital record.

(b) Each patient's medical record shall be signed by the appointee in attendance, who is responsible for its clinical accuracy.

(c) Emergency patient records shall be reviewed regularly by the Emergency Medicine Department and by appropriate clinical departments to evaluate the quality of emergency medical care provided at this hospital.

Section 5. Contents of Emergency Patient Record:

An appropriate medical record shall be kept for every patient receiving emergency services and shall be incorporated into the patient's hospital record. The record shall include:

(a) adequate patient identification;

(b) information concerning the time of the patient's arrival, means of arrival, and identification of the individual or entity transporting the patient to the hospital;

(c) pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to arrival at the hospital;

(d) description of significant clinical, laboratory and radiologic findings;

(e) diagnosis;

(f) treatment given;

(g) condition of the patient on discharge or transfer;

(h) final disposition, including instructions given to the patient and/or the patient's family regarding necessary follow-up care; and

(i) documentation as set forth in these Rules and Regulations if a patient leaves the hospital against medical advice.

ARTICLE XII

DISCHARGE

Section 1. Who May Discharge:

(a) Patients shall be discharged only on a written order of the attending appointee.

(b) Should a patient leave the hospital against the advice of the attending appointee, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the hospital's release form indicating that he or she has been informed/advised by the attending appointee to remain a hospitalized patient, but that the patient has decided to leave the hospital against that advice, and thus relieves the attending appointee and the hospital of any further responsibility for his or her care. Should the patient refuse to sign the waiver, such refusal shall be documented in the patient's medical record by the

attending appointee or the nurse on duty. If the nurse on duty makes the notation in the patient's medical record, he or she shall promptly notify the attending appointee.

Section 2. Discharge Planning:

(a) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine that no discharge planning is necessary in a particular case, that conclusion shall be documented in the medical record of the patient.

(b) Discharge planning shall include, but need not be limited to, the following:

(1) appropriate referral and transfer plans;

(2) methods to facilitate the provision of follow-up care; and

(3) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, and the amount of activity the patient should engage in and any necessary medical regimens including drugs, diet, or other forms of therapy. Sources of additional help from other agencies and procedures to follow in case of complications should also be part of the discharge plan. All such information should be provided by the attending appointee.

Section 3. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing *in loco parentis*, or another responsible party, unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

Section 4. Autopsies and Disposition of Bodies:

(a) The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician and the event adequately documented in the patient's medical record within a reasonable period of time by the attending appointee or another designated Medical Staff appointee or resident.

(b) The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by the attending

physician or a designee. Death certificates are the responsibility of the attending appointee and must be completed within twenty-four (24) hours of death or birth in the case of fetal death. Policies with respect to the release of a corpse shall conform to applicable law(s).

(c) It shall be the duty of all Medical Staff appointees to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only with proper consent in accordance with state law and hospital policy. All autopsies shall be performed by the hospital pathologist or a designee. Consent for an autopsy shall be effective only by inclusion of such notation on the appropriate hospital form signed by the appropriate legal representative of the patient. A copy of the autopsy report shall be forwarded to the patient's attending physician and included in the patient's medical record.

(d) Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours, and the complete protocol shall be made a part of the patient's medical record within sixty (60) days.

Section 5. Coroner's Cases:

It is the responsibility of the attending appointee or an alternate to notify the coroner of any case considered a coroner's case.

ARTICLE XIII

OTHER GENERAL RULES

Section 1. Reports:

It shall be the responsibility of each appointee to the Medical Staff to report, in writing, to the President of the Medical Staff or the CEO any conduct, acts or omissions by Medical Staff appointees which are believed to be detrimental to the health or safety of patients or to the proper functioning of the hospital, or which violate professional ethics.

Section 2. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff appointees shall not discuss with any other individuals the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of committees, panels, or departments.

(b) Medical Staff appointees shall not record or otherwise transcribe the proceedings of any meetings without the unanimous consent of all those in attendance.

(c) Written attendance records shall be maintained for all meetings of the Medical Staff, clinical departments, panels and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of

meetings shall reflect the educational programs and, if applicable, clinical reviews conducted at each meeting.

Section 3. Catholic Health Facility Directives:

All Medical Staff appointees and others exercising clinical privileges in the hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any Medical Staff appointee or other person exercising clinical privileges or a scope of practice in the hospital.

Section 4. Orientation of New Medical Staff Appointees:

(a) Each new Medical Staff appointee shall be provided an orientation to the hospital and its environment.

(b) In addition, each new Medical Staff appointee shall be introduced to the various hospital departments by the CEO or a designee.

(c) The hospital Health Information Management Department and nursing service shall orient each new Medical Staff appointee as to their respective areas, detailing those activities and/or procedures that will help new staff appointees in the performance of their duties.

ARTICLE XIV

AMENDMENTS

(a) Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Medical Staff Bylaws.

(b) All proposed amendments to these Medical Staff rules and regulations initiated by the Bylaws Committee or Medical Staff shall, as a matter of procedure, be referred to the Medical Executive Committee. The Medical Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. They shall be voted upon at that meeting provided that they shall have been posted on the Medical Staff bulletin board and/or electronic information system, and/or delivered, either in person or by mail, to each Medical Staff appointee at least fourteen (14) days prior to the meeting. Such postings and/or mailings shall be deemed to constitute actual notice to the person concerned. To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.

(c) The Medical Executive Committee shall have the power to adopt such amendments to these rules and regulations as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board within sixty (60) days of adoption by the Medical Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Medical Executive Committee. Immediately upon adoption, such amendments shall be sent to the CEO and posted on the Medical Staff bulletin board for at least fourteen (14) days.

(d) These rules and regulations may not be unilaterally amended. However, action to amend these rules and regulations may be initiated by the Medical Executive Committee (or by the Board on its own motion, provided that any such proposed amendment is first submitted to the Medical Executive Committee for review and recommendation at least thirty (30) days prior to any final action by the Board on such amendment). Instances in which such action by the Medical Executive Committee (or the Board) shall be warranted shall include:

(1) action to comply with changes in federal and state laws that affect this hospital and the hospital corporation, including any of its entities;

(2) requirements imposed by the hospital's general and professional liability or Director's and Officer's insurance carrier; and

(3) action to comply with state licensure requirements, Joint Commission Accreditation Standards, and Medicare/Medicaid Conditions of Participation for Hospitals.

ARTICLE XV

ADOPTION

These Medical Staff rules and regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, policies, manuals or hospital policies pertaining to the subject matter thereof.

Adopted by the Sacred Heart Hospital Medical Staff:

Date: March 22, 2002

Amendment Adopted by the Sacred Heart Hospital Medical Staff:

Date: March 21, 2003

Amendment Adopted by the Sacred Heart Hospital Medical Staff:

Date: May 12, 2005

Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: April 10, 2002

Amendment Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: April 10, 2003

Amendment Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 13, 2005

Amendments Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 12, 2012

Amendments Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 9, 2015

Amendments Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 13, 2017

Amendments Approved by the Board of Directors of Sacred Heart Hospital of the Hospital Sisters of the Third Order of St. Francis:

Date: July 12, 2018