RULES AND REGULATIONS OF THE MEDICAL STAFF

ST. JOSEPH'S HOSPITAL CHIPPEWA FALLS, WISCONSIN

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RULES AND REGULATIONS OF THE MEDICAL STAFF

I. PREAMBLE

The Staff of St. Joseph's Hospital has adopted the following rules and regulations as being necessary for the proper conduct of the clinical work of the hospital. A healthy spirit of cooperation and communication between physicians, supporting services, and Administration is considered essential for furthering the prime mission of the hospital - patient care. All practitioners accepting appointment to the medical staff of the hospital shall be required to abide by these rules and regulations as a condition of their appointment.

II. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents, including these Rules and Regulations, are set forth in the Medical Staff Bylaws.

III. ADMISSION OF PATIENTS

A. St. Joseph's Hospital shall accept patients for care and treatment according to its bylaws, in conformity with applicable state and federal laws, rules and regulations.

B. A patient may only be admitted to the hospital by order of a Medical Staff member [or other licensed practitioner, in accordance with state and federal law] who is granted admitting privileges.

C. Patients under the care of dentists, podiatrists, or other allied health personnel shall have an attending physician to meet their medical needs. The physician shall assume responsibility for the patient's care throughout the hospital stay, including the history and physical examination.

D. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

E. Pediatric patients shall be defined as those patients fourteen years of age and under. Adult patients shall be defined as those patients fifteen years of age and older.

F. The admitting physician or a physician from his/her designated coverage group shall be the attending physician until he or she designates a new attending physician by written physician order. The last attending physician shall be the attending physician or record.

IV. AVAILABILITY OF PHYSICIANS

A. Physicians must assure timely, adequate professional care for their patients in the hospital by being available, or having available an alternate physician with whom prior arrangements have been made and who has at least equivalent clinical privileges at the hospital. Failure of an attending physician to meet these requirements may result in a professional review action.

V. RESPONSIBILITIES OF ATTENDING PHYSICIAN

A. The attending physician shall be responsible for the medical care and treatment of the patient while in the hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the portions of the medical record for which he or she is responsible, and necessary patient instructions.

B. "Attending physician" means any physician on the Medical Staff who is actively involved in the care of a patient at any point during the patient's treatment at the hospital and who has the responsibilities outlined in these rules and regulations. These responsibilities include the preparation of complete and legible medical record entries related to the specific care/services he or she provides.

C. At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician, a note covering the transfer of responsibility shall be entered on the orders of the patient's medical record. The attending physician shall be responsible for verifying the other physician's acceptance of the transfer.

D. The attending physician shall provide the hospital with any information concerning the patient that is necessary to protect the patient, other patients or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

VI. CARE OF UNASSIGNED PATIENTS

A. All unassigned patients shall be assigned to the appropriate on-call physician for unassigned patients.

B. An "unassigned patient" means any individual who comes to the hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the hospital.

C. Attending physicians on the Active Medical Staff or a designee are required to participate on the Unattached Patient Call List. Physicians are scheduled and rotated through on an equal basis. This call list is used when a patient requiring admission does not have a primary care physician. If additional physicians are necessary to properly care for the unassigned patient, it is the responsibility of the physician on call to still admit the patient and then obtain consultation(s) as required. Unassigned patients returning to the hospital for another admission are the responsibility of the physician on call that day.

VII. AVAILABILITY AND ALTERNATE COVERAGE

A. Physicians shall provide professional care for their patients in the hospital by being personally available, or by making arrangements with an alternate member who has appropriate clinical privileges to care for their patients.

B. The attending physician (or his or her alternate) shall comply with the following patient care guidelines regarding availability:

1. Pages from the Emergency Department and/or a patient care unit – must respond by telephone within 15 minutes of being paged and, if requested, must personally see a patient at the hospital within 30 minutes of the request;

2. All other inpatient admissions – must personally see the patient as soon as possible and not to exceed within 24 hours of admission;

3. ICU patients – must personally see the patient within 12 hours of being admitted to the ICU, unless the patient's condition requires that the physician see him or her sooner;

4. Critical care consults – must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., "stat," "urgent," "today," or similar terminology – must also include personal contact by the requesting individual to the consulting physician);

5. Routine consults – must be completed within 24 hours of the request; and

6. Patients subject to restraints or seclusion – pursuant to hospital policy.

C. If an attending physician does not participate in an established call coverage schedule with known alternate coverage and is unavailable to care for a patient, or knows that he or she shall be out of town, the attending physician shall document in the medical record the name of the Medical Staff member who shall be assuming responsibility for the care of the patient during his or her unavailability.

D. If an attending physician or his or her alternate is not available, the Chief Executive Officer or the President of the Medical Staff shall have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

VIII. CONTINUED HOSPITALIZATION

A. The attending physician shall provide whatever information may be requested by the Utilization Management Department with respect to the continued hospitalization of a patient, including:

1. an adequate 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 shall need to remain in the hospital; and

3. plans for post-hospital care.

This response shall be provided to Utilization Management within 24 hours of the request. Failure to comply with this requirement shall be reported to the Medical Executive Committee for appropriate action.

IX. ADMISSION PRIORITIES

A. The priority of admission of patients to the hospital shall be as follows:

1. Emergency Admissions - Within 12 hours following an emergency admission, the attending physician shall furnish on the patient's chart a signed, sufficiently completed document of the need for admission. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission shall be brought to the attention of the Medical Executive Committee for the appropriate action.

2. Urgent Admissions

3. Preoperative Admissions

4. Elective Admissions

X. INTENSIVE CARE UNIT ADMISSIONS

A. In the event beds are not available in the Intensive Care Unit, patients shall be admitted to, or transferred from the unit on the basis of procedures approved by the Intensive Care Medical Director.

XI. DISCHARGE OF PATIENTS

A. Who May Discharge:

1. Patients shall be discharged only upon the written order of the attending physician. Should a patient insist on leaving the hospital against medical advice, 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.

2. At the time of discharge, the attending physician shall review the record for completeness, state the principal and secondary diagnosis (if one exists) and authenticate the entry.

B. Identification of Patients in Need of Discharge Planning:

1. All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning shall be identified at an early stage of hospitalization.

2. Criteria to be used in making this evaluation include:

(a) functional status;

(b) cognitive ability of the patient; and

(c) family support.

C. Discharge Planning:

1. Discharge planning shall be an integral part of the hospitalization of each patient and an assessment shall commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. The attending physician is expected to participate in the discharge planning process.

2. Discharge planning shall include determining the need for continuing care, treatment, and services after discharge or transfer.

D. Discharge Summary:

1. A concise, dictated discharge summary shall be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner

who agrees to assume this responsibility. All discharge summaries shall include the following and must be completed within 14 days of discharge:

(a) reason for hospitalization;

(b) significant findings;

(c) procedures performed and care, treatment, and services provided;

(d) condition and disposition at discharge;

(e) information provided to the patient and family, as appropriate;

(f) provisions for follow-up care; and

(g) discharge medication reconciliation.

2. A short stay form may be used to document the discharge summary for routine obstetrics admissions, a patient discharged from antepartum service, a patient admitted to observation status, a patient admitted for less than 48 hours, and a newborn services short admission for less than 48 hours. A final handwritten summary progress note, antepartum discharge summary, newborn discharge summary or short stay summary form shall be dictated.

E. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care shall be discharged only to the custody of parents, legal guardian, 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.

F. Discharge Instructions:

1. Upon discharge, the attending physician, along with the hospital staff, shall educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

2. Upon discharge, the patient and/or those responsible for providing continuing care shall be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative shall be provided appropriate language resources to permit him or her to understand.

3. The attending physician, along with the hospital staff, shall also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

4. When continuing care is needed after discharge, the attending physician, along with the hospital staff, shall provide appropriate information to the other health care providers, including:

   (a) the reason for discharge;

   (b) the patient's physical and psychosocial status;

   (c) a summary of care provided and progress toward goals;

   (d) community resources or referrals provided to the patient; and

   (e) discharge medications.

XII. AUTOPSIES

A. It shall be the duty of all Medical Staff members to attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest and in accordance with state and local laws. The attending physician must be notified when an autopsy is to be performed. Except for Coroner's cases, all autopsies shall be performed by the hospital pathologist. The provisional anatomic diagnoses shall be recorded in the medical record within three days, and the complete protocol should be made a part of the record within sixty days.

B. Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. The attending physician must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the attending physician, an autopsy should not be requested (e.g., the health and welfare of the next-of-kin or religious proscription), this must be documented in the medical record.

C. Any request for an autopsy by the family of a patient who died while at the hospital shall be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient's family or legal guardian. Difficulties or questions that arise with such a request shall be directed to the Chief Executive Officer.

D. The Medical Staff shall be actively involved in the assessment of the developed criteria for autopsies.

XIII. PATIENT DEATHS AND DEATH CERTIFICATES

A. In the event of a patient death in the hospital, the deceased shall be pronounced dead by the attending physician, his or her designee, or the Emergency Department physician, within a reasonable time frame. Death certificates are the responsibility of the attending physician and shall be completed within 24 hours of when the certificate is available to the attending physician.

B. The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the attending physician or other designated member of the Medical Staff.

C. It is the responsibility of the attending physician to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

XIV. MEDICAL RECORDS

A. General:

1. The attending physician shall be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

2. Only authorized individuals may make entries in the medical record. All handwritten entries shall be legible in black ink. All entries must be timed, dated and signed.

3. 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.

4. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible physician at the time of discharge of the patient. The Medical Staff shall periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations shall be kept on file and copies given to the members of the Medical Staff and to the hospital staff as appropriate.

B. Access and Retention of Record:

1. The hospital shall retain medical records in their original or legally reproduced form for a period of at least five years.

2. Medical records are the physical property of the hospital. Original medical records may only be removed from the hospital in accordance with federal or state laws.

3. Timely access to medical records shall be available to physicians to facilitate continuity of care.

4. Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and hospital policy.

5. A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient.

6. Access to all medical records of patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Institutional Review Board (IRB).

7. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the hospital.

C. Content of Record:

1. Medical records shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

2. Medical record entries shall be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the hospital's policies and procedures.

3. All medical records shall document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation shall be the joint responsibility of the attending physician and the hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(b) date of admission and discharge;

(c) patient's language and communication needs;

(d) evidence of informed consent when required by hospital policy and, when appropriate, evidence of any known advance directives;

(e) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(f) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(g) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies to foods and medicines;

(i) reason(s) for admission of care, treatment, and services;

(j) diagnosis, diagnostic impression, or conditions;

(k) goals of the treatment and treatment plan;

(l) diagnostic and therapeutic orders, procedures, tests, and results;

(m) progress notes made by authorized individuals;

(n) medications ordered, prescribed or administered in the hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(o) consultation reports;

(p) response to care, treatment, and services provided;

(q) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(r) reassessments and plan of care revisions;

(s) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;

(t) discharge summary with outcome of hospitalization, final diagnosis, disposition of case, discharge instructions, and whether the patient left against medical advice; and

(u) medications dispensed or prescribed on discharge.

4. For patients receiving continuing ambulatory care services, the medical record shall contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation shall be the joint responsibility of the attending physician and the hospital:

(a) known significant medical diagnoses and conditions;

(b) known significant operative and invasive procedures;

(c) known adverse and allergic drug reactions; and

(d) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

5. Medical records of patients who have received emergency care shall contain the information outlined in this paragraph. This documentation shall be the joint responsibility of the attending physician and the hospital:

(a) time and means of arrival;

(b) record of care prior to arrival;

(c) results of the Medical Screening Examination;

(d) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(e) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care; and

(f) whether the patient left against medical advice.

D. History and Physical:

A History and Physical shall be completed in accordance with the Medical Staff Bylaws and applicable policies and documented in the medical record.

E. Progress Notes:

1. Progress notes shall be written by the attending physician or his or her covering practitioner. They may also be written by allied health professionals as permitted by their clinical privileges or scope of practice. Whenever 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.

2. Progress notes shall be legibly written, dated, timed, and authenticated by an attending physician at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

F. Delinquent Medical Records:

1. 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.

2. 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 by the Medical Staff Office with notification to the appropriate clinical department chairperson. Such relinquishment shall continue until all the delinquent records are completed.

3. 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.

4. 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.

XV. CONSULTATIONS

A. General:

1. Judgment as to the serious nature of the illness and/or a question of doubt as to the diagnosis and treatment of a patient rest with the physician responsible for the care of the patient. However, it is the duty of the organized medical staff, through its Departmental Chairpersons and Medical Executive Committee, to see that those with clinical privileges do not fail to consult as needed.

2. Any individual with clinical privileges at the hospital may be requested to provide a consultation within his or her area of expertise, and shall respond appropriately as a condition of his or her Medical Staff appointment. The time frames within which consultations must be performed are set forth in these Rules and Regulations.

4. If a nurse 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, the nurse shall notify the Chief Nursing Officer/Designee and the attending physician's department chairperson or other Medical Staff Officer. When circumstances are such as to justify such action, the department chairperson may request a consultation after discussion with the attending physician. The Chief Executive Officer shall also be notified by the Chief Nursing Officer/Designee of such cases and shall consult with the department chairperson to be sure the care is appropriate.

5. In circumstances of grave urgency, or where consultation is required by these Rules and Regulations, or where a consultation requirement is imposed by the Medical Executive Committee, the appropriate department chairperson shall at all times have the right to call in a consultant or consultants.

B. Content of Consultation Report:

1. Each consultation report shall be completed in a timely manner and shall contain a dictated or legible 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. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the record, be recorded prior to surgery.

2. When non-emergency operative procedures are involved, the consultant's report shall be recorded in the patient's medical record prior to the surgical procedure. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

C. Recommended Consultations:

Except in an emergency, consultation is recommended with an appropriate specialist in all cases in which, in the judgment of the attending physician:

1. the patient is a poor candidate for the operation or treatment;

2. the diagnosis is obscure after ordinary diagnostic procedures have been completed;

3. there is doubt as to the best therapeutic measures to be used;

4. unusually complicated situations are present that may require specific skills of other practitioners;

5. the patient exhibits severe psychiatric symptoms;

6. it is requested by the patient or family, or the patient's representative if the patient is incompetent;

7. it is indicated for the clinical specialty in admission to special care units;

8. there are major surgical or medical complications that are not responding to treatment;

XVI. MEDICAL ORDERS

A. General:

1. All orders shall be in writing or electronically submitted.

2. All orders for imaging studies shall include the pertinent clinical indications.

3. Orders shall be entered clearly, legibly, and completely. Orders which are illegible or improperly entered shall not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

4. Orders for tests and therapies shall be accepted only from:

(a) members of the Medical Staff;

(b) allied health professionals who are granted clinical privileges by the hospital, to the extent permitted by their licenses; and

(c) other individuals not on the Medical Staff (e.g., locum tenens), upon verification of their licensure and Medicare exclusion status.

5. Blanket orders that do not meet the criteria of a complete order are not acceptable. The use of the terms "renew," "repeat," "resume," and "continue" must be individually clarified with respect to previous medication orders.

6. Orders for "daily" tests shall state the number of days, except as otherwise specified by protocol, and shall be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued shall be rewritten in the same format in which it was originally recorded if it is to be continued.

7. Orders for all medications and treatments shall be under the supervision of the attending physician and shall be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

8. All previous orders are cancelled when the patient transfers to another level of care within the hospital e.g., Surgery to inpatient area - I.C.U., Medical/Surgical/Pediatrics or Birth Center; Medical/ Surgical/ Pediatrics to I.C.U. and visa versa; Labor/Delivery to Post Partum, etc."

9. No parenteral narcotics may be given in the Emergency Room without the patient being evaluated by a physician. The only exception in this case would be if the patient was seen by the physician in the office immediately prior to presentation in the Emergency Room.

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

11. All orders for medications administered to patients shall be:

(a) reviewed by the attending physician routinely to assure the discontinuance of all medications no longer needed;

(b) canceled automatically when the patient goes to surgery; and

(c) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit).

14. All medication orders shall clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications shall be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped shall be rewritten. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

15. Allied health professionals may be authorized to write medical and prescriptive orders as specifically delineated in their privileges that are approved by the hospital.

B. Verbal/Telephone Orders:

1. The use of verbal/telephone orders is discouraged. If verbal/telephone orders are used, they should be used only infrequently and should be limited to those situations in which it is impossible or impractical for the ordering practitioner to write the order either manually or electronically. The responsible physician shall authenticate such orders within 48 hours.

2. All verbal/telephone orders shall be read back to the person dictating the order to verify accuracy.

3. Only licensed personnel may be authorized to accept verbal/telephone orders, including physical therapists, occupational therapists, speech therapists, respiratory therapists, pharmacists, registered nurses, and registered dieticians.

4. It is legally permissible for a physician to utilize an intermediary in relaying orders, since the intermediary is seen as an agent of the physician, and the order is still construed as the order of the physician. It is within the rights of those receiving the conveyed orders not to accept them, or to clarify the orders directly with the physician if there are any questions.

C. Standing Orders, Protocols, and Order Sets:

1. "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.

2. "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.

3. "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.

4. 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.

5. 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.

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

XVII. MEDICATIONS

A. Medications shall not be left at the bedside except in special cases in which the physician has written this order on the patient's chart.

B. Outside medications shall not be administered unless the drug cannot be obtained by the hospital pharmacy, until it can be obtained by the hospital pharmacy, and only after it has been identified in writing and ordered by the attending physician.

XVIII. CONSENTS

A. Obtaining informed consent is the responsibility of the physician. Informed consent shall be obtained in accordance with the hospital's Informed Consent Policy and documented in the medical record. 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 should notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the physician's obligation to obtain proper consent before the patient is treated in the hospital.

B. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature and risks inherent in any special treatment or surgical procedure shall be obtained.

XIX. EMERGENCY DEPARTMENT SERVICES

A. Emergency services and care shall 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. Emergency services and care shall be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such factors are medically significant to the provision of appropriate care to the patient.

B. Every Emergency Department patient treated as an outpatient or an admission must be seen by a physician prior to leaving the Emergency Room. Exceptions include patients sent in with orders, telephone orders received prior to the patient's arrival, injections, cast removals, or any other situations where there is evidence that the attending physician has seen and evaluated the patient prior to his arrival at the Emergency Room.

C. Physicians treating patients for sexual assault must follow guidelines in the Sexual Assault Protocol, which is on file in the Emergency Room.

D. Medical Screening Examinations

Medical screening examinations, within the capability of the hospital, shall 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:
   (a) members of the Medical Staff with clinical privileges in Emergency Medicine;
   (b) other Active Staff members;
   (c) appropriately credentialed allied health professionals; and
   (d) in the case of sexual assault, by a SANE forensic nurse under the written physician-directed protocols.
2. Labor and Delivery:
   (a) members of the Medical Staff with OB/GYN privileges;
   (b) certified nurse midwives with OB privileges; and
   (c) registered nurses who have achieved competency in labor and delivery and who have validated skills to provide fetal monitoring and labor assessment.

3. In the case of patients presenting to the L.E. Phillips/Libertas Center, the Medical Screening Examination may be performed by registered nurses under the written physician-directed protocols.

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

E. If the Emergency Room physician has evaluated the patient and determined that a patient needs admission but the primary physician (or alternate) does not concur with the recommendation for admission, the primary physician or covering physician must come in to the Emergency Room to evaluate the patient and either admit the patient or arrange for appropriate disposition.

XX. SURGICAL SERVICES

A. Pre-Procedure Protocol:

1. The physician(s) responsible for the patient's care shall thoroughly document in the medical record: (i) the provisional diagnosis and the results of any indicated diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.

2. The physician(s) responsible for the patient's care shall order appropriate laboratory services for each surgical patient.

3. The following shall also occur before the administration of moderate or deep sedation or anesthesia occurs:

(a) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(b) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(c) the attending physician is in the hospital; and

(d) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification process.

B. Post-Procedure Protocol:

1. For every procedure performed in an operating room and/or under sedation, a progress note containing the following information must be entered in the medical record immediately after the procedure:

   (a) pre-operative diagnosis;

   (b) post-operative diagnosis;

   (c) procedures performed;

   (d) total tourniquet time (if used);

   (e) specimen(s) removed;

   (f) estimated blood loss;

   (g) type of anesthesia;

   (h) complications; and

   (i) name of surgeon(s)/assistant surgeon(s).

2. A full operative procedure report for these invasive procedures shall then be dictated or legibly handwritten within 24 hours of the procedure, and authenticated by the attending physician. The report shall record:

   (a) pre- and post-operative diagnoses;

   (b) date and time of the procedure;

   (c) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient's operation;

   (d) procedure(s) performed and description of the procedure(s);

   (e) total tourniquet time (if used);

   (f) estimated blood loss;

   (g) any unusual events or complications, including blood transfusion reactions and the management of those events;

   (h) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

(i) specimen(s) removed, if any; and

(j) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

XXI. ANESTHESIA SERVICES

A. General:

1. Anesthesia may only be administered by the following qualified practitioners with appropriate and current clinical privileges:

(a) an anesthesiologist;

(b) an MD or DO (other than an anesthesiologist);

(c) a dentist, oral surgeon, or podiatrist, in accordance with state law; or

(d) a CRNA.

2. "Anesthesia" means general or regional anesthesia, monitored anesthesia care, or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal or procedural sedation, or analgesia via epidurals/spinals for labor and delivery.

3. Because it is not always possible to predict how an individual patient shall respond to minimal or conscious sedation, a qualified practitioner must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

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

B. Pre-Anesthesia Procedures:

1. A pre-anesthesia evaluation shall be performed by an individual qualified to administer anesthesia within 48 hours prior to an inpatient or outpatient procedure requiring anesthesia services.

2. The evaluation shall be recorded in the medical record and shall include:

(a) a review of the medical history, including anesthesia, drug and allergy history;

(b) an interview and examination of the patient;

(c) notation of any anesthesia risks;

(d) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

(e) development of a plan for the patient's anesthesia care; and

(f) any additional pre-anesthesia evaluations that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

3. The patient shall be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

C. Monitoring During Procedure:

1. All patients shall be monitored during the procedure and/or administration of anesthesia at a level consistent with the potential effect of the procedure and/or anesthesia. Appropriate methods shall be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

2. All events taking place during the induction and maintenance of, and the emergence from, anesthesia shall be documented legibly in an intraoperative anesthesia record, including:

(a) the name and hospital identification number of the patient;

(b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

(c) the name, dosage, route, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions, or problems occurring during anesthesia.

D. Post-Anesthesia Evaluations:

1. A post-anesthesia evaluation shall be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area. Where post-operative sedation is necessary for the optimum care of the patient, the evaluation can occur in the PACU/ICU or other designated recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge. The evaluation should not begin until the patient is sufficiently recovered and can participate in the evaluation.

2. The elements of the post-anesthesia evaluation shall conform to current standards of anesthesia care, including:

   (a) respiratory function;

   (b) cardiovascular function;

   (c) mental status;

   (d) temperature;

   (e) nausea and vomiting; and

   (f) post-operative hydration.

3. Patients shall be discharged from the recovery area by a qualified practitioner or according to criteria approved by the clinical leaders. Post-operative documentation shall record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

4. Patients who have received anesthesia in an outpatient setting shall be discharged to the company of a responsible, designated adult.

5. When surgical or anesthesia services are performed on an outpatient basis, the patient shall be provided with written instructions for follow-up care that include 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.

E. Minimal or Procedural Sedation:

All patients receiving minimal or procedural sedation shall be monitored and evaluated before, during, and after the procedure by a qualified practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports, or post-anesthesia evaluations are required.

XXII. RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT

Restraints, seclusion, and behavior management shall be governed by hospital policy.

XXIII. TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

A. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the hospital to another facility, includes:

1. assessing the reason(s) for transfer;

2. establishing the conditions under which transfer can occur;

3. evaluating the mode of transfer/transport to assure the patient's safety; and

4. ensuring that the organization receiving the patient assumes responsibility for the patient's care after arrival at that facility.

B. Procedures:

1. Patients shall be transferred to another hospital or facility based on the patient's needs and the hospital's capabilities. The attending physician shall take the following steps as appropriate under the circumstances:

   (a) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

   (b) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

   (c) involve the patient and all appropriate practitioners, hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

   (d) provide the following information to the patient whenever the patient is transferred:

      (i) the reason for the transfer;

(ii) the risks and benefits of the transfer; and

(iii) available alternatives to the transfer.

2. When patients are transferred, appropriate information shall be provided to the accepting practitioner/facility, including either a copy of the patient's medical record for the current inpatient admission, or all of the following information:

(a) reason for transfer and any significant findings;

(b) a Medical Staff member's summary of the procedures performed and care, treatment and services provided;

(c) a care plan containing up-to-date information;

(d) consultation reports;

(e) radiology and laboratory reports;

(f) a record of medications administered to the patient prior to the date of transfer;

(g) a Medical Staff member's orders in effect at the time of transfer;

(h) any known allergies; and

(i) information provided to the patient and family, as appropriate.

3. When a patient/authorized decision-maker requests a transfer to another facility, the physician shall:

(a) explain to the patient his or her medical condition;

(b) inform the patient of the benefits of additional medical examination and treatment;

(c) inform the patient of the reasonable risks of transfer;

(d) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(e) provide the receiving facility with the same information outlined in paragraph (b) above.

XXIV. DISASTER PLAN

The medical staff shall participate in developing a plan for the care of mass casualties based upon the hospital's capabilities in conjunction with other emergency facilities in the area. The Disaster Plan shall be rehearsed periodically as required. A written report and evaluation of all drills shall be completed.

XXV. RISK MANAGEMENT

The Medical Staff acknowledges the authority of the Safety Officer, the Risk Manager, and the Laser Safety Officer to enforce the safety regulations at the hospital.

XXVI. AMENDMENTS

A. Amendments to these Medical Staff Rules and Regulations may be proposed as follows:
   1. the Medical Executive Committee may propose amendments to the Medical Staff. Along with any such proposal, the Medical Executive Committee shall make a report and recommendation to the Medical Staff that addresses the pros, cons, benefits, and risks of the proposed amendments.
   2. the Medical Staff may propose amendments directly to the Board. A copy of any such proposals shall be provided to the Chair of the Medical Executive Committee. The Committee shall make a report and recommendation to the Board that addresses the pros, cons, benefits, and risks of the proposed amendments.

B. Proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a simple majority of the votes cast by the voting medical staff at the meeting.

C. The Medical Executive Committee may present proposed amendments to the voting staff by mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 50% of the medical staff eligible to vote.

D. The Medical Executive Committee shall have the power to adopt such amendments to these Rules and Regulations which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

E. All amendments shall be effective only after approval by the Board.

F. If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the Chief Executive Officer within two weeks after receipt of a request for same submitted by the President of the Medical Staff.

G. The Medical Executive Committee is authorized to act on behalf of the Medical Staff regarding amendments to the Rules and Regulations when:

1. Action is necessary to comply with changes in Federal and State laws that affect the Hospital;
2. Action is necessary to comply with State licensure requirements, Joint Commission Accreditation Standards or Medicare/Medicaid Conditions of Participation.

In such cases, the Medical Executive Committee may provisionally adopt and the Governing Body may provisionally approve such amendments without prior approval of the medical staff. In such cases, the medical staff will be immediately notified by the Medical Executive Committee and have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical policy board, the provisional amendment stands until it is ratified by the medical staff. If there is conflict over the provisional amendment, the conflict resolution process will be implemented and, if necessary, a revised amendment will be presented to the Governing Body for action.

XXVII. ADOPTION

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

Adopted by the Medical Staff on: June 26, 2018

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President of the Medical Staff

Approved by the Board: July 12, 2018

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Chairman, Board of Directors