

**MEDICAL STAFF
RULES AND REGULATIONS**

**GOOD SHEPHERD HOSPITAL
SHELBYVILLE, ILLINOIS,
an Affiliate of
Hospital Sisters Health System**

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ARTICLE I

DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Credentials Policy:

- (a) “Ambulatory Care” means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.
- (b) “Attending Physician” means the patient’s primary treating physician or his or her designee(s), who shall be responsible for directing and supervising the patient’s overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient’s status to the patient, the referring practitioner, if any, and the patient’s family.
- (c) “Practitioner” means, unless otherwise expressly limited, any appropriately credentialed physician, resident, dentist, oral surgeon, podiatrist, or allied health professional, acting within his or her clinical privileges or scope of practice.
- (d) “Responsible Practitioner” means any practitioner 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 Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

2.1. Admissions:

- (a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges. The patient's attending physician will execute, or cause to be executed, all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admission and discharge of patients from the Hospital.
- (b) Patients whose primary reason for admission is medical in nature must be admitted by a physician who has appropriate clinical privileges in medicine to provide the required medical treatment and inpatient care. Patients whose primary reason for admission is surgical in nature must be admitted by a surgeon who has appropriate clinical privileges to perform the required surgical procedure and post-operative care, or by a physician with appropriate clinical privileges in medicine, with consultation by a surgeon.
- (c) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.
- (d) The admitting physician will 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. Patients with suspected or proven cases of infectious, contagious, or communicable disease will be isolated from other patients in accordance with the guidelines established by the Illinois Department of Public Health and also in accordance with Hospital policies and procedures formulated by the Infection Control Committee and adopted by the Medical Staff.
- (e) Laboratory examinations required on all admissions will be determined by the Medical Staff, provided for in a written policy, and consistent with state law and regulations.

2.2. Responsibilities of Attending Physician:

- (a) The attending physician will be responsible for the following while in the Hospital:
 - (1) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in

- the patient's care (including personal communication with other physicians where possible);
- (2) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;
 - (3) communicating with the patient's third-party payor, if needed;
 - (4) providing necessary patient instructions;
 - (5) responding in writing to inquiries from the Professional Review Organization and Utilization Review Committee regarding the plan of care in order to justify the need for continued hospitalization; and
 - (6) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate.
- (b) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer and updating the attending physician screen in the electronic medical record ("EMR").
- (c) Prior to discharge, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification documenting that the inpatient services were medically necessary. The physician certification includes, and is evidenced by, the following information:
- (1) authentication of the admitting order;
 - (2) the reason for the inpatient services (i.e., the provisional diagnosis);
 - (3) the expected or actual length of stay of the patient; and
 - (4) the plans for post-hospital care, when appropriate.

2.3. Care of Unassigned Patients:

All unassigned patients will be assigned to the appropriate practitioner or to the appropriate Hospital service.

2.4. Availability and Alternate Coverage:

- (a) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.
- (b) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:
 - (1) Calls/texts from the Emergency Department and/or a Patient Care Unit – must respond by telephone or text message within 15 minutes of being contacted and, if requested, must personally see a patient at the Hospital within 60 minutes of the request;
 - (2) Patients Admitted from the Emergency Department – must personally see the patient within 24 hours of admission;
 - (3) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission; and
 - (4) Patients Subject to Restraints or Seclusion – pursuant to times established in the Hospital policy on restraints and seclusion.
- (c) All physicians (or their appropriately credentialed designee) will be expected to comply with the following patient care guidelines regarding consultations:
 - (1) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians; and
 - (2) 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).
- (d) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician’s acceptance of the transfer.

- (e) If the attending physician is not available, the President of the Medical Staff, or the Chief Executive Officer will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.5. Continued Hospitalization:

- (a) The attending physician will document, when applicable, the need for continued hospitalization which is beyond the initially assigned length of stay in a manner which complies with the Utilization Review Committee or other criteria on admission certification and length of stay review. This documentation will contain:
 - (1) a written record of the reason for continued hospitalization;
 - (2) the estimated period of time that the patient will need to remain in the Hospital; and
 - (3) plans for post-Hospital care.
- (b) Upon request of the Utilization Review Committee, the attending physician will provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reason therefor. This report will be documented in the patient's medical record within 24 hours after the request is made. Failure to comply with this requirement will be brought to the attention of the Utilization Review Committee and Medical Staff for appropriate action.
- (c) Members of the Medical Staff will comply with all medical review standards and guidelines concerning admission certification and length of stay review in addition to the criteria provided for in the Hospital's current Utilization Review Plan. All utilization review functions at the Hospital will be performed in accordance with the most current Utilization Review Plan.

ARTICLE III
MEDICAL RECORDS

3.1. General:

- (a) The following individuals are authorized to document in the medical record:
 - (1) attending physicians and responsible practitioners;
 - (2) nursing providers, including registered nurses (“RNs”) and licensed practical nurses (“LPNs”);
 - (3) physicians responding to a request for consultation when the individual has clinical privileges or is an employee or member of the House Staff at the Hospital;
 - (4) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;
 - (5) volunteers, such as volunteer chaplains, functioning within their approved roles;
 - (6) students in an approved professional education program who are involved in patient care as part of their education process (e.g., acting interns) if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record; and
 - (7) non-clinical and administrative staff, as appropriate, pursuant to their job description.
- (b) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the EMR. Orders will be entered using Computerized Provider Order Entry (“CPOE”). Handwritten medical record entries will be legibly recorded in blue or preferably black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including handwritten entries, must be timed, dated and signed.
- (c) Each practitioner will 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.

- (d) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Symbols and abbreviations used in the medical record must be approved by the Medical Staff. An official record of all approved symbols and abbreviations will be maintained on file in the Health Information Services Department. The Medical Staff will periodically review the list and revise when needed.
- (e) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed.

3.2. Access and Retention of Record:

- (a) The Hospital will retain medical records in their original or legally reproduced form for a period of at least ten years from the date of discharge.
- (b) 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.
- (c) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Hospital policy.
- (d) 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 or another person.
- (e) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).
- (f) Subject to the discretion of the Chief Executive Officer (or his or her designee), 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.

3.3. Content of Record:

- (a) For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and

describe the patient's progress and response to medications and services. Medical records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services.

- (b) Medical record entries will 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. Stamped signatures are not permitted in the medical record.
- (c) General Requirements. Documentation in the medical record will be the joint responsibility of the responsible practitioner and the Hospital. All medical records for patients receiving care in the hospital setting will document the information outlined in this paragraph, as relevant and appropriate to the patient's care:
 - (1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - (2) legal status of any patient receiving behavioral health services;
 - (3) patient's language and communication needs, including preferred language for discussing health care;
 - (4) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;
 - (5) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
 - (6) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
 - (7) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
 - (8) allergies to foods and medicines;
 - (9) reason(s) for admission of care, treatment, and services;
 - (10) diagnosis, diagnostic impression, or conditions;
 - (11) goals of the treatment and treatment plan;
 - (12) diagnostic and therapeutic orders, procedures, tests, and results;

- (13) progress notes made by authorized individuals;
 - (14) 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);
 - (15) consultation reports;
 - (16) operative procedure reports and/or notes;
 - (17) any applicable anesthesia evaluations;
 - (18) response to care, treatment, and services provided;
 - (19) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
 - (20) reassessments and plan of care revisions;
 - (21) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
 - (22) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice;
 - (23) medications dispensed or prescribed on discharge; and
 - (24) autopsy findings when the patient dies in the Hospital.
- (d) Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (1) known significant medical diagnoses and conditions;
 - (2) known significant operative and invasive procedures;
 - (3) known adverse and allergic drug reactions; and
 - (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

(e) Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (1) time and means of arrival;
- (2) record of care prior to arrival;
- (3) results of the Medical Screening Examination;
- (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
- (5) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;
- (6) if the patient left against medical advice; and
- (7) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

(f) Obstetrics Records. Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (1) findings during the prenatal period;
- (2) the medical and obstetrical history;
- (3) observations and proceedings during labor, delivery and postpartum period; and
- (4) laboratory and x-ray findings.

The obstetrical record will also include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

(g) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (1) history of maternal health and prenatal course, including mother's HIV status, if known;

- (2) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;
- (3) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;
- (4) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay;
- (5) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;
- (6) documentation of infant feeding: intake, content, and amount if by formula; and
- (7) clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3.4. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 8 of the Medical Staff Bylaws.

3.5. Progress Notes:

- (a) Progress notes will be entered by the attending physician (or his or her covering practitioner) at least every 24 hours for all hospitalized patients in acute beds, at least every 72 hours for swing beds and in the step-down unit, and as needed to reflect changes in the status of a patient in an ambulatory care setting.
- (b) Progress notes will be legible, dated, and timed. When appropriate, 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.
- (c) Progress notes may also be entered by allied health professionals as permitted by their clinical privileges or scope of practice.

3.6. Authentication:

- (a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE. All signatures, whether written, electronic, or computer-generated, will include the initials of the signer's credentials. Signature stamps are never an acceptable form of authentication for written orders/entries.
- (b) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.
- (c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

3.8. Delinquent Medical Records:

- (a) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital. A committee of the Medical Staff will be responsible for reviewing medical records for completeness, promptness, adequate documentation, and clinical pertinence.
- (b) Medical records will be completed within 15 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete 15 days following discharge, the practitioner will be notified of the delinquency and that his or her clinical privileges have been automatically relinquished in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the practitioner's records are no longer delinquent.
- (c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges two months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.
- (d) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner or it is ordered filed by the Health Information Services Department. Except in rare circumstances, and only when approved by the Health Information Services Department, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

- (e) When a practitioner is no longer a member of the Medical Staff or Allied Health Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the practitioner's credentials file and divulged in response to any future credentialing inquiry concerning the practitioner.
- (f) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the Health Information Services Department.
- (g) The chart completion requirements for ambulatory care will be the same as for other medical records.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

- (a) Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR via the CPOE in accordance with Hospital policy.
- (b) All orders (including verbal/telephone orders) must be:
 - (1) dated and timed when documented or initiated;
 - (2) authenticated by the ordering practitioner. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and
 - (3) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.
- (c) Orders for tests and therapies will be accepted only from:
 - (1) members of the Medical Staff; and
 - (2) allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

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

- (e) All orders are automatically cancelled and will be completely reentered when a patient is transferred from one service to another, when a patient is transferred from the critical care unit, and when a patient emerges from surgery.
- (f) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.
- (g) All orders for medications administered to patients will be:
 - (1) reviewed by the attending physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;
 - (2) canceled automatically when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and
 - (3) 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 issued when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.
- (h) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will 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 will be reentered. All as necessary medication orders (also known as PRN) 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.
- (i) Allied health professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital.

4.2. Verbal Orders:

- (a) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.
- (b) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the

order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.

- (c) Authentication will take place by the ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, and (ii) within 72 hours after the order was given for telephone orders.
- (d) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.
- (e) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:
 - (1) an LPN, RN, or an advance practice nurse ("APN");
 - (2) a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
 - (3) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;
 - (4) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;
 - (5) a radiology or imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may transcribe a verbal order pertaining to tests and/or therapy treatments in their specific areas of expertise;
 - (6) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;
 - (7) a speech therapist who may transcribe a verbal order pertaining to speech therapy; and
 - (8) a dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition.

4.3. Standing Orders, Order Sets, and Protocols:

- (a) For all order sets and clinical protocols, review and approval of the Executive Committee, with input from nursing and the Hospital's pharmacy department when appropriate, is required. Prior to approval, the Executive Committee will confirm that the order set or clinical protocol is consistent with nationally recognized and evidence-based guidelines. The Executive Committee will also

take necessary steps to ensure that there is periodic and regular review of such order sets and clinical protocols. All clinical protocols will identify clinical scenarios for when the protocol is to be used.

- (b) If the use of an order set has been approved by the Executive Committee, the order will be initiated for a patient only by an order from a practitioner responsible for or involved in the patient's care in the Hospital and acting within his or her scope of practice. Orders initiated by a clinical protocol will be deemed to have been initiated by a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.
- (c) When used, order sets must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.
- (d) For purposes of this Section, a clinical protocol is defined as a course of treatment which may be initiated by a member of the Hospital's clinical staff (e.g., a nurse) without a prior specific order from the treating physician/practitioner when a patient's condition meets certain pre-defined clinical criteria. An order set consists solely of menus of treatment or care options for common clinical scenarios designed to facilitate the creation of a patient-specific set of orders by a physician or other qualified practitioner authorized to write orders.
- (e) The attending physician must also acknowledge and authenticate the initiation of each standing order, order set, or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.

4.4. Self-Administration of Medications:

- (a) The self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:
 - (1) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;
 - (2) a practitioner responsible for the care of the patient has issued an order permitting self-administration;
 - (3) in the case of a patient's own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and
 - (4) the patient's first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.

- (b) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).
- (c) All self-administered medications (whether Hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.
- (d) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

4.5. Stop Orders:

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders and automatically discontinued as follows:

- (a) Narcotics, including narcotic epidurals – 48 hours.
- (b) Patient controlled analgesia – 48 hours.
- (c) Toradol – 72 hours.

The prescribing practitioner will be notified within 12 hours before an order is automatically stopped.

4.6. Orders for Drugs and Biologicals:

- (a) Inpatient orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

4.7. Inpatient orders for Radiology and Diagnostic Imaging Services:

- (a) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other practitioners authorized by the Medical Staff and governing body to order services.

- (b) Orders for radiology services and diagnostic imaging services must include:
 - (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

4.8. Orders for Outpatient Services:

- (a) Outpatient orders for physical therapy, rehabilitation services and treatments, laboratory, imaging, or other diagnostic services and administration of medications or biologics may be performed when ordered by providers who do not currently have clinical privileges and are not affiliated with the Hospital in accordance with Medical Staff policy. Refer to Hospital policy on Non-Staff Provider Approved Orders.
- (b) Orders for outpatient services must be submitted on a prescription pad, letterhead, an electronic order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual; and (iii) the type, frequency, and duration of the service, as applicable.

ARTICLE V
CONSULTATIONS

5.1. Requesting Consultations:

- (a) The attending physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant. The attending physician will provide authorization in the patient's medical record to permit another practitioner to provide the consultation, except in an emergency.
- (b) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for critical care consults, the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.
- (c) Where a consultation is required for a patient in accordance with Section 5.3 or is otherwise determined to be in patient's best interest, the Chief Executive Officer or the President of the Medical Staff shall have the right to call in a consultant.

5.2. Responding to Consultation Requests:

- (a) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.
- (b) For non-critical care consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the consult must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner.
- (c) The physician who is asked to provide the consultation may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame; alternatively, the Supervising Physician must document timely concurrence with consultation by countersigning the consultation note as entered by the Advanced Practice Provider and/or Dependent Provider.

- (d) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician.
- (e) Once the consulting physician is involved in the care of the patient, the attending physician and consulting physician are expected to review each other's notes in both the electronic and paper charts on a daily basis until such time as the consultant has signed off on the case or the patient is discharged.

5.3. Recommended and Required Consultations – General Patient Care Situations:

- (a) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient lacks decisional capacity.
- (b) Except in emergency cases, consultations are required in all cases in which, in the judgment of the attending physician:
 - (1) there is undiagnosed critical illness in a patient who is becoming progressively worse, or critical illness in the patient with favorable prognosis but who is not responding to accepted therapy; or
 - (2) unexpected critical complications which appear to have arisen during diagnostic or therapeutic procedures, and which may require management expertise either not possessed or not being provided by the attending practitioner.

Additional requirements for consultation may be established by the Hospital as required.

5.4. Mental Health Consultations:

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

5.5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, will be entered in the patient's medical record. If a relevant consultation has not been communicated, surgery

and anesthesia will not proceed, unless the attending physician states in writing that an emergency situation exists.

5.6. Content of Consultation Report:

- (a) Each consultation report will be completed in a timely manner and will 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," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record. The recommendations of consultants will not justify violations of the Ethical and Religious Directives for Catholic Hospitals.
- (b) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.7. Concerns:

- (a) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify the Director of Nursing, the Chief Executive Officer, and/or the President of the Medical Staff who, in turn, will contact the attending physician. If a consultation is not thereafter ordered by the attending physician, and where circumstances justify such action, the President of the Medical Staff may request a consultation. The Chief Executive Officer should consult with the President of the Medical Staff to be sure that the care is appropriate.
- (b) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the President of the Medical Staff.

ARTICLE VI
SURGICAL SERVICES

6.1. Pre-Procedure Protocol:

- (a) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant 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.
- (b) Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:
 - (1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
 - (2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;
 - (3) the attending physician (i.e., surgeon) is in the Hospital; and
 - (4) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in Hospital policy.

6.2. Post-Procedure Protocol:

- (a) An operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:
 - (1) the patient's name and hospital identification number;
 - (2) pre- and post-operative diagnoses;
 - (3) date and time of the procedure;
 - (4) the name of the attending physician(s) and assistant surgeon(s) responsible for the patient's operation;
 - (5) procedure(s) performed and description of the procedure(s);

- (6) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
 - (7) findings, where appropriate, given the nature of the procedure;
 - (8) estimated blood loss;
 - (9) any unusual events or any complications, including blood transfusion reactions and the management of those events;
 - (10) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
 - (11) specimen(s) removed, if any;
 - (12) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and
 - (13) the signature of the attending physician.
- (b) If a dictated report cannot be entered into the record immediately after the operation or procedure, a brief post-op note must be entered by a physician (attending physician or resident only) in the medical record immediately after the procedure. In such situations, the full operative procedure report must be entered or dictated within 24 hours. The brief post-op note will include:
- (1) the names of the physician(s) responsible for the patient's care and physician assistants;
 - (2) the name and description of the procedure(s) performed;
 - (3) findings, where appropriate, given the nature of the procedure;
 - (4) estimated blood loss, when applicable or significant;
 - (5) specimens removed; and
 - (6) post-operative diagnosis.

ARTICLE VII
ANESTHESIA SERVICES

7.1. General:

- (a) Anesthesia may only be administered by the following qualified practitioners:
 - (1) an anesthesiologist;
 - (2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;
 - (3) a dentist, oral surgeon or podiatrist, in accordance with state law;
 - (4) a CRNA who is supervised by the operating practitioner or an anesthesiologist who is immediately available; or
 - (5) an anesthesiologist's assistant under the supervision of an anesthesiologist who is immediately available, if needed.
- (b) An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).
- (c) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal, moderate or conscious sedation, or analgesia via epidurals/spinals for labor and delivery.
- (d) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or conscious sedation, a qualified practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.
- (e) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

- (a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.
- (b) The evaluation will be recorded in the medical record and will include:
 - (1) a review of the medical history, including anesthesia, drug and allergy history;
 - (2) an interview, if possible, preprocedural education, and examination of the patient;
 - (3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
 - (4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
 - (5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and
 - (6) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

- (c) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

- (a) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.
- (b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

- (1) the name and Hospital identification number of the patient;
- (2) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;
- (3) the name, dosage, route time, and duration of all anesthetic agents;
- (4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;
- (5) the name and amounts of IV fluids, including blood or blood products, if applicable;
- (6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and
- (7) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations:

- (a) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 24 hours after the patient has been moved into the designated recovery area.
- (b) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 24-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).
- (c) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
 - (1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
 - (2) cardiovascular function, including pulse rate and blood pressure;
 - (3) mental status;
 - (4) temperature;

- (5) pain;
 - (6) nausea and vomiting;
 - (7) post-operative hydrations; and
 - (8) post-operative abnormalities or complications from anesthesia.
- (d) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists (“ASA”), using a modified Aldrete Recovery Score or similar post-anesthesia recovery scoring system. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.
 - (e) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
 - (f) When anesthesia services are performed on an outpatient basis, the patient will 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 will be reviewed with the patient or the individual responsible for the patient.

7.5. Minimal, Moderate or Conscious Sedation:

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

7.6. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges, who has had specialized preparation and/or experience in anesthesia services or who has completed a residency in anesthesiology, and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE VIII

PHARMACY

8.1. General Rules:

- (a) Orders for drugs and biologicals are addressed in the Medical Orders Article.
- (b) Blood transfusions and intravenous medications will be administered only on the order of a physician in accordance with state law and approved Hospital policies and procedures. The physician ordering the blood transfusion should indicate in the patient's medical record the reason for the patient's transfusion.
- (c) Adverse medication reactions, transfusion reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.
- (d) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.
- (e) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, or the American Hospital Formulary Service.
- (f) The use of investigational or experimental drugs in clinical investigations will be used in accordance with the Statement of Principles involved in the use of investigational drugs in hospitals and all regulations of the Food and Drug Administration.
- (g) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

8.2. Storage and Access:

- (a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.
 - (1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

- (2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.
 - (3) Only authorized personnel may have access to locked or secure areas.
- (b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

ARTICLE IX

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

Restraints, seclusion, and behavior management programs will be governed by the Hospital Policy addressing restraints, seclusion, and behavior management.

ARTICLE X

EMERGENCY SERVICES

10.1. 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, 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 circumstance is medically significant to the provision of appropriate care to the patient.

10.2. 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 an Emergency Department physician with appropriate clinical privileges or a Registered Nurse under the direction of such physician, except that only a physician shall conduct the medical screening examination on the following patients: OB patient presenting with obstetrical complaints, pediatric patients with triage level of 1 or 2, and adult patients with a triage level of 1.
- (b) The results of the medical screening examination must be documented within 48 hours of the conclusion of an Emergency Department visit.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.1. Who May Discharge:

- (a) Patients will be discharged only upon the order of the attending practitioner.
- (b) At the time of discharge, the discharging practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.
- (c) If a patient insists on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

11.2. Identification of Patients in Need of Discharge Planning:

- (a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.
- (b) Criteria to be used in making this evaluation include:
 - (1) functional status;
 - (2) cognitive ability of the patient; and
 - (3) family support.

11.3. Discharge Planning:

- (a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will 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, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.
- (b) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

11.4. Discharge Summary:

- (a) A concise, dictated discharge summary will 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 will include the following and must be completed within 15 days of discharge:
 - (1) reason for hospitalization;
 - (2) significant findings;
 - (3) procedures performed and care, treatment, and services provided;
 - (4) condition and disposition at discharge;
 - (5) information provided to the patient and family, as appropriate;
 - (6) provisions for follow-up care; and
 - (7) discharge medication reconciliation.
- (b) A discharge progress note may be used to document the discharge summary for normal obstetrical deliveries, normal newborn infants, and ambulatory care patients, and for stays of less than 48 hours.
- (c) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

11.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will 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 will so state in writing and the statement will become a part of the permanent medical record of the patient.

11.6. Discharge Instructions:

- (a) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.
- (b) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or

representative will be provided appropriate language resources to permit him or her to understand.

- (c) The responsible practitioner, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.
- (d) When the Hospital determines the patient's transfer or discharge needs, the responsible practitioner, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.
- (e) When continuing care is needed after discharge, the responsible practitioner, along with the Hospital staff, will provide appropriate information to the other health care providers, including:
 - (1) the reason for discharge;
 - (2) the patient's physical and psychosocial status;
 - (3) a summary of care provided and progress toward goals;
 - (4) community resources or referrals provided to the patient; and
 - (5) discharge medications.

ARTICLE XII

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

12.1. Transfer:

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

- (a) assessing the reason(s) for transfer;
- (b) establishing the conditions under which transfer can occur;
- (c) evaluating the mode of transfer/transport to assure the patient's safety; and
- (d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

12.2. Procedures:

- (a) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:
 - (1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
 - (2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;
 - (3) 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
 - (4) 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.

- (b) When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:
 - (1) reason for transfer;
 - (2) significant findings;
 - (3) a summary of the procedures performed and care, treatment and services provided;
 - (4) condition at discharge;
 - (5) information provided to the patient and family, as appropriate; and
 - (6) working diagnosis.
- (c) When a patient requests a transfer to another facility, the responsible practitioner will:
 - (1) explain to the patient his or her medical condition;
 - (2) inform the patient of the benefits of additional medical examination and treatment;
 - (3) inform the patient of the reasonable risks of transfer;
 - (4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
 - (5) provide the receiving facility with the same information outlined in paragraph (b) above.

12.3. EMTALA Transfers:

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable EMTALA policy.

ARTICLE XIII

HOSPITAL DEATHS AND AUTOPSIES

13.1. Death and Death Certificates:

- (a) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician, his or her designee, or the Emergency Department physician, within a reasonable time frame.
- (b) The medical certification of the cause of death within the death certificate will be completed by the attending physician (or his or her designee) within 24 hours of when the certificate is made available. The time of death will be certified as accurately as possible.

13.2. Release of the Body:

- (a) 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 his or her designee) or other designated member of the Medical Staff.
- (b) It is the responsibility of the attending physician (or his or her designee) to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

13.3. Organ and Tissue Procurement:

All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital policy.

13.4. Autopsies:

- (a) The Medical Staff should attempt to secure autopsies in accordance with state and local laws, including all cases of unusual deaths and of medical-legal and educational interest. The attending physician (or his or her designee) must be notified when an autopsy is to be performed. The Hospital pathologist will perform all autopsies. Provisional anatomic diagnoses will be recorded in the patient's medical record within 72 hours after the patient's death and a complete autopsy protocol should be recorded within 60 days after patient death unless reasonable reason exists to delay the complete protocol.
- (b) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. The attending physician (or his or her designee) 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 (or his or her designee), an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this should be documented in the medical record.

- (c) Any request for an autopsy by the family of a patient who died while at the Hospital will 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 will be directed to the Chief Executive Officer.
- (d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

13.5. Do Not Resuscitate ("DNR") Policy:

The Medical Staff will administer care in accordance with Hospital policy, for those competent adult patients or the parent of an infant, neonate or minor child who knowingly chooses to forgo treatment.

ARTICLE XIV

PROFESSIONAL BEHAVIOR POLICY

14.1. Definition of Inappropriate Behavior:

Inappropriate behavior, for purposes of this Article, includes, but is not limited to, the following:

- (a) attacks leveled at others that are personal, irrelevant, or go beyond the bounds of fair professional comment;
- (b) impertinent and inappropriate comments or illustrations written in patient medical records or other official documents impugning the quality of care in the hospital or attacking particular Medical Staff members, Hospital personnel, or Hospital policy;
- (c) sexual harassment or improprieties;
- (d) profane or non-constructive criticism addressed in such a way as to intimidate, undermine confidence, belittle, or impute stupidity or incompetence;
- (e) imposing idiosyncratic requirements that have nothing to do with better patient care, but serve only to burden the person with “special” techniques and procedures;
- (f) rude or abusive conduct or language;
- (g) yelling at patients or their families and/or refusing to listen to their legitimate questions and requests;
- (h) negative comments to patients or families about other Medical Staff members, other Hospital personnel, treatment provided to the patient, or the operation of the Hospital; and
- (i) threats and/or physical assaults on Medical Staff members or Hospital personnel.

14.2. Procedure for Addressing Inappropriate Behavior:

- (a) Inappropriate Hospital employee behavior will be handled in accordance with the following procedure:
 - (1) Documentation of the following:
 - (a) A description of the alleged inappropriate behavior;

- (b) the date and time of the alleged inappropriate behavior;
 - (c) the name of the patient, if the behavior affected or involved the patient in any way;
 - (d) the circumstances that precipitated the situation;
 - (e) a description of the alleged inappropriate behavior limited to factual, objective language as much as possible;
 - (f) the consequences, if any, of the alleged inappropriate behavior as it relates to patient care and Hospital operation; and
 - (g) a record of any action taken to remedy the situation, including dates, times, place, action and names of those intervening.
 - (2) The documentation will be submitted to the responsible Hospital supervisor. The supervisor will then evaluate the situation and make a written report which will be handled in accordance with current Hospital personnel policies.
- (b) Inappropriate Medical Staff member behavior will be handled in accordance with the following procedure:
- (1) Documentation of alleged inappropriate behavior and related circumstances will be submitted to the immediate Hospital supervisor who will determine the severity of the incident and if it is deemed to be a major threat to patient care or the ability of the Hospital to operate smoothly.
 - (2) If the supervisor so designates, either at the time of the occurrence or subsequent to the occurrence, the situation will be reported to the Chief Executive Officer or the President of the Medical Staff or both.
 - (3) Further management of the situation will occur in accordance with the options available to Medical Staff leaders and Hospital administration to address and resolve questions that may be raised about members of the Medical Staff and the Allied Health Staff outlined in the Credentials Policy.

ARTICLE XV

MISCELLANEOUS

15.1. Self-Treatment and Treatment of Family Members:

- (a) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.
- (b) A member of the Medical Staff should not admit or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:
 - (1) no viable alternative treatment is available, as confirmed through discussions with the President of the Medical Staff or the Chief Executive Officer;
 - (2) the patient's disease is so rare or exceptional and the physician is considered an expert in the field;
 - (3) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or
 - (4) in an emergency where no other Medical Staff member is readily available to care for the family member.

This prohibition is not applicable to in-laws or other relatives.

15.2. Orientation of New Physicians:

Each new physician and advance practice provider will be provided an overview of the Hospital and its operations. As a part of this orientation, the Health Information Services Department and nursing service will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

15.3. HIPAA Requirements:

All members of the Medical Staff and Allied Health Staff will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information.

15.4. Medical Staff Professional Liability Insurance:

- (a) The minimum requirements for professional liability insurance are as follows:
 - (1) except as otherwise indicated in contracted agreements, maintaining a minimum coverage of \$1,000,000 per occurrence and \$3,000,000 in the annual aggregate for those privileges currently granted to a member with an insurance company acceptable to the Medical Staff Executive Committee and the Board. Shared professional liability limits between physicians are prohibited. The physicians will promptly notify the Hospital in writing of any material modification or cancellation of such insurance. The above-stated liability limits are for the payment of indemnity claims and are exclusive of legal fees and other defense costs. Declining or Eroding Balance Policies are prohibited. If “claims made” insurance is purchased, the physician must provide for the purchase of tail coverage in the event that the “claims made” coverage is discontinued for any reason; or
 - (2) setting up a “self-insurance” fund equal to the amount specified in paragraph (a) above, subject to the approval of the Medical Staff Executive Committee and the Board.
- (b) There shall be available for examination by the members of the Medical Staff evidence of the Hospital medical liability insurance coverage and/or its self-insurance fund.
- (c) All members of the Medical Staff are required to notify the Medical Staff Executive Committee and the President & Chief Executive Officer of the Hospital any time they do not have medical liability insurance coverage for those privileges which have been granted to them at this Hospital.
- (d) A member of the Medical Staff may be allowed to carry claims made medical liability insurance with the following stipulations:
 - (1) Submit documentation from the insurance company as follows:
 - (i) certificate of current insurance;
 - (ii) a statement that the company will notify the Hospital when such coverage is no longer in effect or has been cancelled;
 - (iii) a guarantee to the member that the company will make available a “Tail Coverage” or a “Claims Reporting Endorsement,” or such other acceptable coverage, during and/or at the end of the policy year. This must be guaranteed regardless of whether:

- there are liability cases in progress or settled involving the member;
 - the company drops insuring that member; or
 - the company ceases selling that type of insurance in the state (Illinois, Missouri, etc.); and
- (iv) a guarantee of the costs of such “Tail Coverage” or “Claims Reporting Endorsement” or such other acceptable coverage for the current policy year.
- (2) Escrow fund to be established by the members in the amount established each year under item number (a) above. This would be increased and/or decreased each year according to the cost established at that time.

The procedure for the implementation of this escrow fund and the Rules and Regulations with regard to its operation must be acceptable to the Medical Staff Executive Committee of the Medical Staff and the Board of Directors of the Hospital. Example of one possible inclusion: This fund would be released if the company automatically issues the “Tail Coverage” or “Claims Reporting Endorsement” for such events as retirement for permanent disability or death.

ARTICLE XVI

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 7 of the Medical Staff Bylaws.

ARTICLE XVII

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.

Originally adopted by the Medical Staff:	05/04/2021
Originally approved by the Board:	05/17/2021
Revisions adopted by the Medical Staff:	07/07/2025
Revisions approved by the Board:	08/18/2025