MEDICAL STAFF

RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of the Medical Staff organizational activities as well as embody the level of practice that is to be required of each appointee. Adoption of such Rules and Regulations may be necessary to carry out the responsibilities and functions of the medical staff and implement its operations.

Rules and Regulations can be adopted by each clinical service at any regular or special meeting of the clinical service at which a quorum is present of the active and Medical Staff. They will be submitted for approval to the Medical Staff Executive Committee and to the Governing Body.

Amendments to the medical staff policies and procedures, rules and regulations shall be effective when approved by a two thirds (2/3) vote of the MEC and is approved by the Board. The MEC shall distribute a copy of the proposed amendments to the active staff within seven (7) days after the MEC vote. Voting members of the active staff may then submit, within twenty-one (21) days after the MEC meeting, comments to the President of the Medical Staff concerning the MEC's proposed amendments. The President of the Medical Staff will consider any comments that are received from medical staff members and either:

a) Send the proposed amendments back to the MEC for reconsideration: or
b) Forward the proposed amendments, with or without comment, to the Board for review and action.

The MEC may adopt such amendments to the Medical Staff Bylaws, policies and procedures, rules and regulations that are, in the MEC's judgment, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments must be approved by the Board.

ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to St. Mary's Hospital by an appointee qualified under the Medical Staff Bylaws. All admissions shall be governed by the admitting policy of the hospital.

2. Patients admitted to the hospital must at the time of admission have a provisional diagnosis on the record. In case of emergency, such statement shall be recorded as soon as possible and no later than 24 hours after admission.

3. In the case of a readmission of a patient, all previous medical records will be Available for use by the attending physician, regardless of whether the patient is attended by the same physician as during the previous stay.

4. Patients shall not be discharged until a provisional or final discharge diagnosis has been entered in the medical record by ~~of~~ the attending physician. If a patient leaves the hospital against the advice of the attending physician, or without proper discharge, a release form shall be completed, and a notation shall be made on the patient's medical record within 24 hours.

   Responsibilities of Attending Physician:

   (a) Patients admitted to the Hospital must have a specific attending physician of record assigned to them. The attending physician must be a physician member of the Medical Staff with appropriate clinical privileges to care for the patient.

   (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 Medical Staff 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) The attending 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.

   (d) Whenever the responsibilities of the attending physician are transferred to another physician, a note covering the transfer of responsibility will be entered on the order sheet of the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

   (e) If an attending physician or his or her alternate is not available, the Chief Executive Officer or designee, the President of the Medical Staff or the clinical representative of the service concerned will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

5. It shall be the duty of Medical Staff appointees to secure meaningful autopsies whenever possible. An autopsy shall be performed only with written consent signed in accordance of state law. All autopsies shall be performed. Upon family request and at the expense of the family. The hospital may assist with securing a pathologist to perform the autopsy at an off site location.

6. No patient shall be transferred out of or between units without notification of responsible appointee.

7. Care of Unassigned Patients:

   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. All unassigned patients will be assigned to members of the Medical Staff on a rotating basis.

GENERAL PATIENT CARE

1. A general consent form signed by, or on behalf of, every patient admitted to the hospital must be obtained at the time of admission.

2. Except in the case of emergency, a specific consent that informs the patient, or his legal representative, of the nature of and the risks inherent, as well as alternatives, in any special treatment or surgical procedure, shall be obtained.

3. All orders for treatment shall be in writing or entered directly into the hospital information system. It is the expectation, in the interest of patient safety, that CPOE will be utilized preferentially. An order shall be considered to be in writing if dictated to a professional nurse or other authorized person as designated by hospital departmental policy and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. Telephone orders shall be used sparingly and countersigned as soon as possible, but not to exceed 72 hours. (Refer to Physician's Order Hospital Procedure.)

4. Participation in the emergent medical care of unattended patients is incumbent on all appointees of the Active Medical Staff.

5. Any qualified practitioner with clinical privileges in St. Mary's Hospital can be called for consultation within his or her area of expertise.

6. Appropriate consultations shall be obtained by physicians, dentists, or podiatrists in cases in which the patient is not a good medical or surgical risk and in cases in which the diagnosis is obscure, in cases where there is doubt as to the best therapeutic measure to be utilized or where the treatment is difficult, and especially in cases with probable disorders or complications lying within a field other than the one in which the attending physician, dentist, or podiatrist is primarily qualified. (Refer to Consult Policy)

7. In an emergency or when otherwise deemed necessary, consultation may be ordered by the President of the Medical Staff or the Hospital Administrator.

8. Continued Hospitalization:

   (a) The attending physician will provide whatever information may be requested by the Utilization Review Committee (or its designee, e.g., Case Management) 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 will need to remain in the Hospital; and

      (3) plans for post-hospital care.

      This response will be provided to the Utilization Review Committee (or its designee, e.g., Case Management) within 24 hours of the request. Failure to comply with this requirement will be reported to the Utilization Review Committee. Utilization Review Committee may take further appropriate action, including possible referral to MEC.

   (b) If the Utilization Review Committee determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the President of the Medical Staff will be consulted.

PATIENT RIGHTS

1. Patient Rights
   All practitioners shall respect the patient rights as delineated in Hospital policy and in accordance with the Illinois Medical Patient Rights Act 410 ILCS 50.

2. Informed Consent
   The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy 'Informed Consent and "Consent for Procedure" Form.

3. Withdrawing or Withholding Life Sustaining Treatment
   Hospital policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that shall occur when withdrawing or withholding life-sustaining treatment.

4. Do Not Resuscitate Orders
   The Hospital policy on 'Do Not Resuscitate' delineates the responsibilities, procedure, and documentation that shall occur when initiating or cancelling a Do Not Resuscitate order.

5. Disclosure of Unanticipated Outcomes
   The Hospital policy on 'Disclosure of Unanticipated Outcomes' delineates the responsibilities, procedure, and documentation that shall occur when an unanticipated outcome does occur.

6. Restraints and Seclusion
   The Hospital policy on 'Restraints and Seclusion for Hospitalized Patients' delineates the responsibilities, procedure, and documentation that shall occur when ordering restraints or seclusion.

7. Advance Directives
   The Hospital guideline on 'Advance Directives' delineates the responsibilities, procedure, and documentation that shall occur regarding advance directives.

8. Investigational Studies
   Investigational studies and clinical trials conducted at the Hospital shall be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy shall be followed.

MEDICAL RECORDS

1. The attending physician shall be held responsible for the preparation of a complete and legible medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations; clinical laboratory and radiology services and others; provisional diagnosis; medical and surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary of discharge notes; clinical resume; and autopsy report, when performed, if applicable.

   Medical records 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 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.

2. History and Physical

The H & P must be completed and documented within 24 hours following admission of the patient, but prior to surgery or a procedure requiring anesthesia services (including moderate sedation).

History and physical exams performed within 30 days prior to admission may be used if the following requirements are met:

- Physician writes an update note which is written on or attached to the H & P.
- The words "re-examined the patient" must be present. Required by CMS.
- The H & P and any updates/assessments must be included in the medical record within 24 hours of admission, but prior to surgery ot other procedures, whichever comes first.

History and Physical required components: Chief Complaint; Details of Present Illness; Relevant Past, Social and Family History; Physical Examination; Review of Systems; and statement of conclusions.

All medical records will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will 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) patient's language and communication needs;

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

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

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

(f) admitting history and physical examination;

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

(h) diagnosis, diagnostic impression, or conditions;

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

(j) goals of the treatment and treatment plan;

(k) diagnostic and therapeutic orders;

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

(m) progress notes made by authorized individuals;

(n) reassessments and plan of care revisions;

(o) relevant observations;

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

(q) consultation reports;

(r) allergies to foods and medicines;

(s) medications ordered or prescribed;

(t) medications 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);

(u) known long-term medications being taken by the patient, including current medications, over-the-counter drugs, and herbal preparations;

(v) medications dispensed or prescribed on discharge;

(w) relevant diagnoses/conditions established during the course of care, treatment, and services;

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

(y) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care:

(i) a discharge note will be written or dictated on all patients;
(ii) a short stay history and physical can be used for observation patients with an anticipated stay not to exceed 48 hours; however, the final diagnosis must be noted. If such patient's status is changed to inpatient, a complete history and physical is required within 21 hours of the status change;

(z) final diagnosis; and
(aa) whether the patient left against medical advice.

All ambulatory procedures performed in an operating room suite require a complete history and physical with the exception of patients receiving local anesthesia or sedation. Ambulatory patients receiving either local anesthesia or sedation may have a short form history and physical.

Ambulatory procedures not performed in an operating suite which place the patient at significant risk require a short form history and physical.

A short form history and physical must be legible and sufficient in detail to reflect the patient's pertinent history, condition, need for surgery/procedure and plans. The short form history and physical may be dictated or written as a progress note containing the noted elements, however, the review of systems and physical exam may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure to be performed. For outpatients undergoing minor procedures, (i.e. IVP, MRI, CT Scan) a history and physical is not required, but indications for the test/treatment must be clearly documented in the medical record by the physician ordering the test or treatment.

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 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;

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

(e) whether the patient left against medical advice.

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 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.

Progress Notes:

(a) Progress notes will be legibly composed 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. 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.

(b) Progress notes will be legibly written, dated, timed, and authenticated by an attending physician at least daily for all patients who have been admitted to the Hospital.

3. Operative reports shall include a detailed account of the findings at surgery and details of the surgical technique, including the pre and postoperative diagnoses as well as the name of the procedure(s) performed. The surgeon's handwritten postoperative notes must be signed promptly after surgery is completed. All operative reports shall be dictated directly after surgery, with the report signed by the surgeon after transcription is completed, and made a part of the patient's current medical record.

4. All obstetrical records shall 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, and updated as necessary.

5. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

6. Members of the Medical Staff may have access to the medical records of patients for whom the member is the attending physician while the patient is in the hospital, or for whom the member has received a formal request for consult while the patient is in the hospital. Patient consent must be obtained for release of records of non-hospitalized patients to physicians for use in their offices.

7. Access and Retention of Record:

(a) The Hospital will retain medical records in their original or legally reproduced form in accordance with HSHS Records Retention and Disposal Policy #RC-7.

(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 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.

(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 preserving the confidentiality of personal information concerning the individual patients.

(f) 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.

8. With the exception of emergencies, the treating physician shall document that he/she has informed the patient and received consent to perform invasive and other high-risk procedures. This may be documented by signing a statement on a form, or by writing or dictating a note attesting to having provided this education. The written or dictated statement must be present in either the preoperative evaluation, history and physical, or progress note, stating that, as the treating physician, he/she has discussed the following with the patient, answered their questions, and obtained their consent to proceed:

9. Informed Consent:

   Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record that they have discussed the following with the patient.

   - description, in lay terms, of procedure to be performed.
   - potential benefits and risks of the procedure.
   - potential or anticipated post-procedure.
   - expected success rate.
   - expected outcome should procedure be declined.
   - reasonable alternatives to the proposed procedure.
   - name of the physician or other practitioner who has primary responsibility for the patient's care.
   - the identity and professional status of individuals responsible for authorizing and performing procedures or treatments.
   - any professional relationship to another health care provider or institution that might suggest a conflict of interest.
   - their relationship to educational institutions involved in the patient's care.
   - any business relationships between individuals treating the patient, or between the organization and any other healthcare service or educational institutions.

10. The patient's medical record, including but not limited to signatures, progress notes consultation reports, final diagnoses, and discharge summary, shall be completed no later than 30 days post discharge. The practitioner's privileges will be suspended if he/she has records which remain incomplete more than thirty (30) days post-discharge. A medical record shall not be permanently filed until it is completed by the responsible physician or is ordered filed by the Performance Improvement & Quality Committee.

11. A practitioner whose privileges have been suspended for over 30 consecutive days or who has had six (6) or more suspensions in three (3) months due to incomplete medical records will be requested to appear before the Medical Executive Committee.

Orders for Drugs and Biologicals:

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.

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.

Orders for Outpatient Services:

(c) Outpatient orders for physical therapy, rehabilitation services or 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.

(d) Orders for outpatient services must be submitted on a prescription pad, letterhead, or 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.

DISCHARGE

1. Discharge Summaries**:**

Discharge Summaries are to be dictated within fourteen (14) days of discharge. The medical record must be complete, including signatures, within thirty (30) days of discharge. The Discharge Summary must be written or dictated by a member of the medical staff, a nurse practitioner, resident, medical student, or other qualified member of the allied health staff who has been involved in the care of the patient. Discharge summaries completed by a nurse practitioner, resident, medical student, or other qualified member of the allied health staff must be signed by the attending physician to assume responsibility for the credibility of the information.

In all cases, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. A final progress note written the day of discharge which includes final diagnosis, outcome of case, disposition of case and follow-up care provisions is acceptable for patients who are hospitalized for forty-eight (48) hours or less, normal newborns, observation bed patients, and same-day surgery patients. For Skilled Nursing Unit patients who are being transferred within the facility from one level of care to another, a Transfer Summary will be substituted for the Discharge Summary. The Transfer Summary briefly describes the patient's diagnosis, condition at the time of transfer, and the reason for the transfer.

2. Who May Discharge:

   (a) Patients will 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 will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

3. 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.

   (b) Criteria to be used in making this evaluation include:

      (1) functional status;

      (2) cognitive ability of the patient; and

      (3) family support.

4. 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.

   (b) When the Hospital's personnel determine no discharge planning is necessary in a particular case, that conclusion will be noted on the medical record of the patient.

   (c) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

5. Discharge Summary Content:

   (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:

(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 final legibly composed progress note containing the outcome of the hospitalization, disposition of the case and provisions for follow-up care may be substituted for a discharge summary where a patient is seen for minor problems or interventions.

6. Discharge Instructions:

(a) Upon discharge, the attending physician, along with the Hospital staff, will 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 and/or printed 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 attending physician, 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 continuing care is needed after discharge, the attending physician, 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.

REFERENCES: CMS Ref: S&C-02-15 (1/28/02).
ww.cms.hhs.gov/medicaid/ltcsp/012802
JCAHO
Illinois Department of Public Health.
www.idph.state.il.us/rulesregs/77-0250.htm

Medical Records Section revised 4/16/03, 06/05/2012 (Joint commission recommendation)

Medical Executive Committee Approved/Recommended 06/07/2012, 03/08/16

Board of Directors Approved 03/15/16

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

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 assumes responsibility for the patient's care after arrival at that facility.

2. Procedures:

   (a) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The attending physician 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, appropriate information will 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:

      (1) reason for transfer and any significant findings;

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

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

(4) consultation reports;

(5) radiology and laboratory reports;

(6) a record of medications administered to the patient for the seven days before the date of transfer;

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

(8) any known allergies; and

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

(c) When a patient requests a transfer to another facility, the physician 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.

3. Patient-Physician Relationships:

(a) The attending physician will assist in the transfer of patient care responsibilities to another physician whenever (1) the attending physician requests to no longer provide medical services for a particular patient, or (2) when the patient or the patient's family requests another physician.

(b) When a physician determines that he or she can no longer provide medical services for a patient, he or she will notify the patient of that decision and provide the patient with sufficient time in which to secure a physician willing to accept this responsibility. The time frame may vary, but should not be longer than 30 days unless agreed upon by both parties. The physician should provide such medical records as are requested and necessary for the accepting physician to provide continuing care.

(c) When a patient or patient's family requests to have medical care transferred to another physician, they are responsible for securing a physician willing to accept and provide medical services, and for requesting the transfer of written medical records. If the patient or family has secured an accepting physician prior to notification of the attending physician, the transfer may occur as soon as reasonably possible, if both physicians concur, or at the time in the future in which the accepting physician has stipulated.

(d) If a physician chooses to close his or her practice while hospitalized patients remain in his or her care, it is the responsibility of the physician to notify the patients and to contact a consenting and acceptable physician to provide continuing medical services during the remainder of the hospitalization

AUTOPSIES

1. Every member of the medical staff shall be actively interested in securing autopsies whenever a death occurs that meets the following criteria. All autopsies shall be performed by a hospital pathologist or by a physician to whom the hospital pathologist may delegate the duty.

2. Indications for Performing Autopsies:

   a) Deaths in which an autopsy may help explain unknown and unanticipated medical complications to the attending physician.

   b) All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.

   c) Cases in which autopsy may help allay concerns of, and provide reassurance to, the family and/or the public regarding the death.

   d) Unexpected or unexplained deaths during the following: any dental, medical or surgical procedure and/or therapies.

   e) Deaths of patients who have participated in clinical trials approved by the Institutional Review Board.

   f) Unexpected or unexplained deaths that are apparently natural and not subject to forensic jurisdiction.

   g) Natural deaths that are subject to, but waived by a forensic medical jurisdiction, such as persons dead on arrival at hospital; deaths occurring in hospitals within 24 hours of admissions; and deaths in which the patient sustained an injury while hospitalized.

   h) Deaths resulting from high-risk infections and contagious diseases.

   i) All obstetric deaths.

   j) All perinatal and pediatric deaths.

   k) Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have bearing on survivors or recipients of transplant organs.

   l). Deaths known or suspected to have resulted from environmental or occupational hazards.

Autopsy Reports

When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within two (2) working days, and the complete protocol should be made part of the record within forty-two (42) days with rare exceptions for complex cases.

CLINICAL SERVICE LINE RULES AND REGULATIONS

EMERGENCY SERVICES CLINICAL SERVICE LINE

A. 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.

1. A patient admitted through the Emergency Department who does not have a private physician or dentist will be assigned a member of the active Medical Staff according to the Emergency Call policy.

2. It is the attending physician's or dentist's responsibility to obtain appropriate consultation for his/her patient.

3. A patient, who presents to the Emergency Room, shall be under the care of the Emergency Department physician until the patient's private physician, or an on-call physician, assumes responsibility. The patient is considered to be "stable" when the treating physician has determined with reasonable clinical confidence, that the patient's emergency medical condition has been stabilized so that further deterioration would not reasonably be expected.

4. For Obstetric related emergencies, a physician or qualified labor nurse shall perform a screening examination to determine whether the patient has an emergency medical condition. If a nurse performs a screening examination, a physician will be notified of the screening examination results.

    a. A patient, who presents to the Emergency Room, shall be evaluated by an Emergency Room Trauma Nurse for non-obstetric conditions warranting immediate care by a physician.
    b. Patients who are less than 20 weeks gestation will be triaged and admitted to the Emergency Department. A qualified labor and delivery registered nurse may evaluate patients who are more than 20 weeks gestation and whose complaint relates to or may relate to the pregnancy.

MATERNAL CHILD CLINICAL SERVICE LINE – OB/GYN

Physicians providing medical care to Obstetrical/Gynecological patients shall follow policies formulated by the Maternal Child Clinical Service Line-OB/GYN for the care of these patients.

A. GENERAL

1. All policies and procedures of the Maternal Child Clinical Service Line-OB/GYN are subject to the approval of the Medical Staff Executive Committee and the Governing Body.

2. The membership of the service line shall consist of members of the Medical Staff appointed thereto and actively engaged in the practice of Obstetrics and Gynecology.

3. The Maternal Child Clinical Service Line-OB/GYN shall hold routine meetings to review and analyze the work of the department, with special emphasis on complications, operative deliveries, morbidity, mortality, and peer review.

4. Each member of the department shall file with the Chairman of the department, the name of two physicians to attend his cases in the event he is not available or able to attend.

5. Forceps, other than for low application cases (head visible between contractions), and vacuum extraction shall not be utilized except by an OB consultant or by others who have been awarded specific privileges theretofore.

6. Each physician shall be held responsible for accurate and complete records for all of his patients. Prenatal records shall be sent to the Labor Department prior to delivery.

7. Cesarean Sections shall be performed only by those practitioners specifically approved as Obstetrics Consultants and those practitioners who are actively engaged in the practice of Obstetrics and have been granted privileges theretofore, except in an emergency.

8. The obstetric anesthesia service should be supervised by an anesthesiologist. A qualified MD or CRNA should be readily available in any emergency to administer an appropriate anesthetic and maintain support of vital functions.

9. A physician or qualified labor nurse shall perform a screening examination to determine whether the patient has an emergency medical condition. If screening is performed by a nurse, a physician will be notified of the screening examination results.
   a. a "qualified labor nurse" is a registered nurse with a minimum of one (1) year experience in labor;
   b. all ancillary services routinely available within the hospital at the time of the examination, including any on-call physicians, shall be utilized;

c. any pregnant patient presenting without previous prenatal care will be screened by a physician.

B. POLICIES FOR THE CONDUCT OF THE MATERNITY DIVISION

1. This department and all associated personnel shall observe the minimum State of Illinois Rules and Regulations regarding OB departments.

2. Upon admission, the patient shall be checked by the nurse and a report made to the attending physician.

3. Continuous electronic fetal monitoring (external and internal capabilities) should be available, together with personnel trained to correctly interpret fetal status in all obstetrical units. Monitoring should be employed in the initial assessment of all patients and continuously employed in high risk patients. NOTE: all patients should not necessarily be continuously monitored, but high risk patients should be monitored continuously.

4. The nurse or attending physician should be with the patient constantly during the second stage of labor.

5. Induction or augmentation of labor with Oxytocin may be initiated only after the responsible physician has examined the patient, determined that induction or augmentation is beneficial to the mother or fetus, and recorded the indication and a plan of action. For use of Pitocin for augmentation and induction of labor, an OB/GYN consult is required,
except for augmentation of labor when cervix dilation is greater than 7 cm. The patient should be examined vaginally by a physician or qualified nurse immediately prior to initiating Oxytocin infusion.

   The use of Pitocin > 24 mu. may be utilized under the following conditions:
   a. physician must be in the hospital and immediately available;
   b. a written order is required;
   c. one/one nursing is required.
   Personnel who are familiar with the effects of Oxytocin and able to identify both maternal and fetal complications should be in attendance while Oxytocin is being administered. A qualified physician shall be readily accessible to manage any complications that may arise during infusion. (Readily accessible will be defined as in immediate phone contact and present within the confines of Decatur proper.)

6. Each postpartum patient shall be observed during the recovery period by appropriate personnel with special attention to the blood pressure, pulse, height and consistency of the uterine fundus and amount of vaginal bleeding, and patient shall be observed as closely as possible thereafter when moved to the general floor.

7. The labor and delivery record shall be written and/or dictated immediately following delivery.

8. The newborn infant(s) shall be examined by the physician in attendance for any gross abnormalities and if any are present, the pediatrician or physician caring for the baby shall be notified immediately.

9. Any material deviation from the Rules on Accepted Obstetrical Procedure and Practices will be reported immediately by the personnel in charge to the Chief Executive Officer, to the Chairman of the department or, in his absence, to the President of the Medical Staff.

10. On patients > 26 weeks gestation, twenty (20) minutes base fetal monitoring strips should be obtained on all outpatients who come in for observation. Fetal heart tones shall be established in patients < 26 weeks gestation.

11. The monitoring strip must be interpreted on a timely basis.

12. The obstetrician should manage high-risk obstetric patients when local facilities and staff are adequate to insure optimal outcome for the mother and infant. When it seems likely that the neonate will require intensive or specialized care not locally available, the obstetrician should consider transferring the mother to allow delivery in a hospital with a neonatal intensive care unit, except in emergency situations.

13. Vaginal births after Cesarean Section: the following guidelines are adopted by the Obstetric and Gynecology Departments of St. Mary's and Decatur Memorial hospitals. They are based on ACOG Practice Bulletin Clinical Management Guidelines for Obstetrician-Gynecologists Number 54, July 2004.

    a. a woman with one or more Cesarean Sections with low transverse incisions may attempt a vaginal birth with the mutual agreement of the woman and her obstetrician;
    b. a previous classical uterine incision is a contraindication to labor;
    c. professional and institutional resources must have the capacity to respond to acute intrapartum obstetric emergencies, such as performing Cesarean delivery within thirty (30) minutes from the time the decision is made until the surgical procedure is begun, as is standard for any obstetric patient in labor;
    d. a physician who is capable of evaluating labor and performing a Cesarean Section delivery shall be in charge of or consulted for the care of the patient and shall be readily available. (Readily available shall be defined as in immediate phone contact and present on campus.)

14. Consultation to St. John's Hospital will be required if patient is < thirty-four (34) weeks. (Refer to Letter of Agreement.)

15. Physicians providing medical care to obstetrical/gynecological patients shall follow policies formulated by the Department of Obstetrics and Gynecology for the care of these patients.

16. Major obstetrical procedures and complications must have timely and adequate consultation with the Chairman of the OB/GYN Department or one of the duly appointed department consultants, whose findings shall be recorded in the patient's medical record.

MATERNAL CHILD CLINICAL SERVICE LINE - PEDIATRICS

1. Physicians providing medical care to the pediatric patient shall follow the policies formulated by the Maternal Child Clinical Service Line-Pediatrics for the care of these patients.

2. Pediatric patients: all critically ill children with unusual diseases must have timely and adequate consultation with the Chairman of the Pediatric Clinical Service Line or a pediatrician of the attending physician's choice. A record of this consultation must be made a part of the patient's medical record.

3. Newborn nursery: all newborns shall be evaluated by the attending physician of the infant within twenty-four (24) hours.

4. Consultation for premature or ill newborns shall be obtained either from a qualified member of the Pediatrics Clinical Service Line or by transferring a child to a high-risk neonatal center.

DEPARTMENT OF PATHOLOGY

1. The pathologist will provide anatomic pathology examination, including stillborn autopsies, cytologic evaluations, and surgical pathology evaluations in a timely manner, appropriate to the clinical needs. A written report of the pathologist's findings and interpretations will be issued according to the policies and within the established, recommended time frames of the department.

2. The pathologist will participate in an assigned after-hours on-call schedule and will respond to requests for consultation within a reasonable period of time.

3. The pathologist will participate in established departmental, general laboratory, and hospital-wide quality assurance and Total Quality Improvement activities. These activities will include, but not be limited to, participation in departmental quality assurance meetings and review of clinical material as a component of the audit process.

4. The pathologist will render, within the limits of his/her expertise, a consultative opinion on problematic cases presented for intradepartmental review.

5. The pathologist will obtain appropriate intradepartmental and extradepartmental consultation from resources of his/her choice for problematic cases.

INTERNAL MEDICINE CLINICAL SERVICE LINE - PSYCHIATRY

1. Physicians providing medical care to psychiatric patients shall follow policies formulated by the Internal Medicine Clinical Service Line-Psychiatry for the care of these patients.

2. The policies shall conform to the most current revision of the Mental Health Code of the Illinois Department of Mental Health, and the State of Illinois Hospital Licensing Act and Requirements.

3. All Medical Staff members are permitted to treat patients on the Psychiatric Unit, however, there must be a written request for a psychiatric consultation within sixty (60) hours of admission.

4. Non-hospital employed professionals trained in the mental health field and working in the psychiatric service area must have privileges as an Advanced Practice Professional approved through the Medical Staff credentialing process. Guidelines regarding approval of clinical privileges are a part of this department's Rules and Regulations.

SURGERY CLINICAL SERVICE LINE

Physicians providing surgical care to a patient shall follow the policies formulated by the Department of Surgery for the care of these patients.

Surgical Policies and Procedures

All practitioners shall comply with the Hospital's surgical policies and procedures. These policies and procedures shall cover the following: The procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

Anesthesia

Any sedation greater than mild sedation and any anesthesia greater than local anesthesia should only be provided by qualified practitioners who have been granted clinical privileges to perform these services. The anesthesiologist/anesthetist shall maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and anesthesia. The practitioner responsible for the ordering the administration of moderate sedation shall document a pre-sedation evaluation and post-sedation follow-up examination.

Tissue Specimens

Specimens removed during the operation shall be sent to the Hospital pathologist who shall make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report shall be made a part of the patient's medical record.

Verification of Correct Patient, Site, and Procedure

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention shall be identified by an ID wrist band with the patient's name the patient's date of birth. The Hospital policy on 'Surgical/Invasive Procedure Verification' shall be followed.

1. Definitions of Procedure/Case Status.

   a. Elective: “A surgical or invasive procedure that is scheduled and does not require an immediate intervention to prevent loss of limb, organ or body function.”

   b. Urgent: “Intervention is required within twenty-four (24) hours to prevent loss of limb, organ, or body function. Patients classified as inpatients and short stay, requiring surgical intervention, may be defined as urgent.”

   c. Emergent: "An emergency surgical case is defined as any case in which, in the opinion of the attending physician or surgeon, the risk of a delay endangers the patient's life, limb, or organs. The declaration of an emergency shall be appropriately noted in the patient's chart." [1]

   d. Delays: The start of a case **is delayed more than 15 minutes** according to the estimated “in room” time.”

   e. Bump: “A regular scheduled case loses the allocated time slot.”

   f. Cancellations: “Refers only to procedures that are cancelled on the day of surgery.”

   g. Add on Cases: “Scheduling cases after the Scheduling Office is closed or adding cases to the schedule during the day.”

2. Elective

   a. Scheduling process for elective cases to reserve a procedure/case time. Pertinent information required at the time of scheduling includes but is not limited to:

      1) patient's full name with correct spelling;
      2) patient's date of birth;
      3) patient's telephone number;
      4) pre-operative diagnosis, pathology;
      5) complete procedure being contemplated by surgeon including operative site with right, left, bilateral, etc., secondary ("possible") procedure options, with distinct terminology;
      6) patient admission status;
      7) anesthesia preference;
      8) request for specific equipment, instrumentation, laser, implants with vendor and model preferences, medical imaging, and other specialty items;

      9) orthopedic hardware removal or exchange must include vendor/manufacturer information.

   b. A complete history and physical must be recorded on the chart on all patients undergoing surgery prior to transferring the patient to the operating room. Only acute emergencies and local anesthetics shall be the exception. The updated examination may be performed by anesthesia prior to surgery or procedures requiring anesthesia services.

The Director of Surgery shall have the authority to cancel or delay the surgical procedure if the history and physical is not available on the chart.

c. Scheduling cannot be accepted from any physician whose privileges have been suspended.

d. Pre-surgical processing and registration is required for all elective surgical patients.

e. In cases requiring anesthesia service, the anesthesiologist can use his/her discretion to cancel/postpone the procedure and/or waive diagnostic testing requirements upon personal conversation with the attending surgeon.

Anesthesia inductions or major regional blocks will not proceed until the surgeon is on the premises.

f. Room and staff assignments shall be at the discretion of the Director of Surgical Services.

g. Cases will be scheduled according to the average estimated time for the surgeon and procedure, or the estimated time requested by the surgeon.

h. Inpatients and pediatrics will have precedence over outpatients as a means to resolve scheduling conflicts.

i. Elective cases will not be started if it can be determined that the case cannot be expected to be completed by 1900 hours (7 p.m.) as determined by the Director of Surgical Services.

j. Procedures scheduled as Moderate Sedation/Conscious Sedation and changed to Monitored Anesthesia Care (MAC) after the schedule closed will be performed according to availability of staffing. The case may be delayed or rescheduled to the next earliest time.

k. Any surgeon who disagrees with the decision of the Director of Surgical Services and/or Chairperson of the Department of Surgery, must nevertheless abide by the immediate decision and take his/her objections to the Department of Surgery though the proper channels.

3. Urgent/Emergency

a. Urgent/Emergency cases are scheduled during normal business hours by calling Pre-operative Services.

b. Emergency procedures after 1700 hours (5 p.m.) are scheduled by calling the hospital switchboard operator who contacts the CRNA on call.

c. The OR coordinator will communicate directly with the surgeon regarding specific details, start time, and surgeons affected.

d. The Surgery and Anesthesia Call Team members are only available for emergent cases after 1700 hours (5 p.m.) Monday through Friday.

   The Surgery and Anesthesia Call Team are available for urgent and emergent cases on weekends and holidays.

e. Urgent and emergent cases are appropriately triaged by the anesthesiologist and the attending surgeons, and are ranked by order of priority.

f. Urgent or emergent cases may "bump" (supercede) elective cases. The bumped case may be delayed or rescheduled based on available resources within normal hours of operation. The hospital will make every effort to accommodate all bumped cases.

g. When more than one urgent/emergent case presents with equal precedence, the Department of Surgery Chairperson will determine priority if the surgeons involved cannot resolve the issue.

h. In the event of a new urgent or emergent case which will delay an elective case, the surgeon or designee with the urgent or emergent case must notify the surgeon being delayed.

i. Only emergent cases will be allowed to proceed to the OR when the Surgery Department is on emergency backup powers.

4. Delays

a. When a surgeon delays the start of a case more than 15 minutes according to the estimated "in room" time, the case may be bumped if the delay will affect the cases scheduled to follow.

b. For all cases, if the surgeon finds that he/she will be delayed due to unforeseen circumstances, he/she must notify the Director of Surgery Services or Designee at least thirty (30) minutes prior to the scheduled start time.

   When it is known that the surgeon will be late and that the rest of the schedule will be delayed, all affected surgeons and patients will be notified of this delay as rapidly as possible by the Director of Surgical Services or designee.

c. Operating surgeons who are habitually late without prior valid notice of lateness will be restricted in operating time.

   The Department of Surgery Chairperson will discuss the matter with the surgeon and if the problem is not resolved the surgeon will be invited to attend the next regularly scheduled Department of Surgery meeting to explain why this pattern is persistent.

d. If a surgeon is delayed due to unforeseen circumstances related to the provision of service from the hospital, the Director of Surgical Services or Designee will attempt to notify the surgeon at least 30 minutes in advance. The hospital will make every effort to facilitate the new start time to accommodate the effected surgeon and patient.

5. Bump Procedures

a. Surgeons who bump into the schedule are expected, out of common courtesy, to discuss the bump with the surgeon whose schedule is interrupted. It is required that this conversation take place prior to the bump being allowed to occur. Emergency cases will automatically bump into the schedule.

b. The OR Coordinators will maintain a bump log at the OR desk to record bump cases. This log will include the date, the time the OR was notified of the bump case, the name and medical record number of the patient, procedure to be done, the urgency for OR access, the time the bump case enters the OR, and the time the bumped surgeon is able to resume surgery.

c. Except in true life threatening emergencies, OR's will not be bumped or held open for bump cases which are not ready to come to the operating room. Both the surgeon and the patient should be fully prepared to enter the OR for the bump to occur.

d. All logged bump cases are subject to retrospective review (appeal) at the request of the OR staff, the bumped surgeon, or any other surgeon or anesthesiologist. The person(s) requesting the review will document, in writing, the circumstances of the bump and the reason for requesting the review.

e. The Chief of Surgery, with the assistance of others he appoints, will review all bump cases requested to be reviewed, as well as reports of misbehavior related to the bump process.

f. Suggested penalty for abuse of bump privilege (as determined by Chief of Surgery): surgeon at fault is made first priority bump room next two times in OR.

g. Bumped cases will be given the first available time slot, that does not interfere with other scheduled cases.

6. Cancellations

a. Cancellations must be reported to the Director of Surgical Services or designee as soon as possible. Every effort will be made to accommodate surgeons following the cancellations as deemed appropriate for efficient flow and utilization of resources.

b. In the event of cancellation, the available time slot will be addressed in the following manner:

(1) the Director of Surgical Services or designee will maintain a list of physicians requesting earlier time slots;

(2) the decision on which cases will move up is based on the urgency of the surgical case, ability to complete the case in the allotted time with available resources on a first-come, first-serve basis.

7. Add on Cases

a. After the Scheduling Office is closed, add on cases are scheduled by calling the hospital operator who contacts the On Call CRNA.

b. The CRNA will document the procedure, patient name, room number and request for a schedule time.

c. The CRNA can only estimate if the requested time will fit into the next day's schedule.

d. All add on cases will be reviewed in the morning and the surgeon will be contacted regarding the actual available start times no later than 0700 (7:00 AM).

e. Add on cases during the day are scheduled by calling Preoperative Services. The surgeon will be called back in less than 30 minutes with the next available time slot that is near as possible to the requested time.

f. Add on cases will not bump regular scheduled cases without following the bump guidelines.

g. All staffing and resource management will be based upon the regular planned schedule. Add on cases will fit into the available resources planned for that day.

h. Add on cases will be offered all available time slots during normal hours of operations.

i. Requests for late starts after 1500 will follow the guidelines for scheduling and will follow all regular scheduled cases.

j. Emergent or urgent cases will automatically bump add on cases.

k. The add on surgeon will be kept updated regarding surgery progress and will be called no later than 30 minutes prior to the next available start time.

REFERENCES: Illinois Department of Public Health, 77 Illinois Administrative Code, chapter 1, subchapter b, Section 250.1250 Surgical Emergency Care, item b.
Illinois Provider Trust C-Section Classification System

FOOTNOTES: (1) C-Sections: Emergent Class I C-Sections should be completed in
Urgent Class II C-Sections should be completed in sixty
(60) minutes or less.

(2) Refer to Medical Staff Rules and Regulations, Medical Records, regarding all medical records related to surgery.

SURGERY CLINICAL SERVICE LINE - DENTISTRY SERVICE

1. A patient admitted for dental care is a dual responsibility of the dentist and a physician member of the medical staff.

    a. Dentists' responsibilities are as follows:

        1. to provide a detailed dental history justifying hospital admission;
        2. to provide a detailed description of the examination of the oral cavity and a pre-operative diagnosis;
        3. to complete an operative report, describing the finding and technique; in cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed; all tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination;
        4. to record progress notes pertinent to the oral conditions; and
        5. to provide a clinical resume.

    b. Physicians' responsibilities are:

        1. to provide a medical history pertinent to the patient's general health;
        2. to perform a physical examination to determine the patient's condition prior to anesthesia and surgery; and
        3. to supervise the patient's general health status while hospitalized.

3. Patients may be admitted directly to the hospital in the name of the dentist when hospitalized specifically for dental treatment and such patients may be discharged by the dentist.

4. Operating room privileges shall be available to the dentists on the same basis as for other surgical procedures.

5. Any special dental records shall be a part of the patient's medical record and subject to the same regulations as other medical records.

SURGERY CLINICAL SERVICE LINE - PODIATRY SERVICE

1. Qualified licensed podiatrists may be granted hospital privileges as a Staff Affiliate by the Board of Directors on the recommendation of the Medical Staff Executive Committee.

2. The delineation of the podiatric clinical privileges shall be based upon the applicant's training, experience, judgment, and demonstrated competence.

3. The scope and extent of surgical procedures that each podiatrist may perform must be specifically defined and recommended in the same manner as for all other surgical privileges.

4. Podiatric surgical procedures undertaken must be under the overall supervision of the Chairman of the Department of Surgery.

5. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician member of the Medical Staff.

    a. Podiatrists' responsibilities are as follows:

        1. to provide a detailed podiatric history justifying hospital admission;
        2. to provide a detailed description of the examination of the extremity and pre-operative diagnosis;
        3. to provide a complete operative report, describing the findings and technique.
        4. to send all tissue to the hospital pathologist for examination;
        5. to record progress notes as are pertinent to the condition; and
        6. to record a clinical resume (or a summary statement).

    b. Physicians' responsibilities are as follows;

        1. to provide a medical history pertinent to the patient's general health;
        2. to provide a physical examination to determine the patient's condition prior to anesthesia and surgery; and
        3. to supervise the patient's general health status while hospitalized.

6. The discharge of the patient shall be on written concurrence of both the podiatrist and the physician member of the Medical Staff.

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.

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