

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
RANDOLPH HOSPITAL**

RULES AND REGULATIONS

Effective November 24, 2009

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ARTICLE I

GENERAL

1.1. Definitions:

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

1.2. Delegation of Functions:

- (a) Unless otherwise provided, when a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (b) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Officers shall perform the function personally or delegate it to another appropriate individual.

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.
- (b) 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.
- (c) Patients will be classified as outpatient observation or admitted to inpatient status. When placing a patient in observation, the word "admit" should not be used.
- (d) When there is a shortage of beds, patients will be admitted to the Hospital on the basis of the following order of priorities:
 - (1) Emergent;
 - (2) Urgent;
 - (3) Pre-operative; and
 - (4) Elective.

Resource Management, if necessary, will review admissions that do not meet these established criteria.

2.2. Responsibilities of Attending Physician:

- (a) The attending physician will be responsible for the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the portions of the medical record for which he or she is responsible, and necessary patient instructions.
- (b) The "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) Whenever the care of a patient is transferred from one hospitalist to another hospitalist, or from an attending physician to his or her call coverage, verbal communication is sufficient to effectuate that transfer. For all other transfers of care, 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.
- (d) 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.

2.3. 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 the appropriate on-call physician.

2.4. Availability and Alternate Coverage:

- (a) Physicians will provide professional care for their patients in the Hospital by being personally available, or by making appropriate arrangements with an alternate Medical Staff member(s) through call coverage. Call coverage physicians must have appropriate clinical privileges to care for their patients. If the attending physician will be passing the care for a patient to on-call coverage, a verbal transfer of care is sufficient.
- (b) If an attending physician does not participate in an established call coverage schedule with known alternate coverage and is unavailable to care for a patient, or knows that he or she will be out of town, 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.
- (c) The attending physician (or his or her call coverage) will be available to respond by telephone within 10 minutes for priority calls and within 30 minutes for routine calls unless he or she is presently engaged in direct patient care which prevents an immediate response. Generally, after responding by telephone, the attending physician must then be personally present to attend to a patient within 30 minutes. Pathology consultations are required to be present within 45 minutes.
- (d) If an attending physician or his or her call coverage is not available, the Chief of Staff or, if he or she is unavailable, the Chief of Staff-elect or, if neither is available, the Chief Executive Officer or his or her designee 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:

The attending physician will provide whatever information may be requested by Resource Management with respect to the continued hospitalization of a patient. This response will be provided to Resource Management *the following day*. Failure to comply with this requirement will be reported to the service line chair for appropriate action, which could include, if necessary, referral to the Medical Staff Quality Council.

2.6. Internal Transfers:

Except in emergencies, a patient will only be transferred to another level of care with the approval of the attending physician. The order of priority for patient transfers will be as follows:

- (a) Emergency Department to appropriate nursing unit;
- (b) general care to Progressive Care Unit or Intensive Care Unit;
- (c) Intensive Care Unit to Progressive Care Unit or general care; and
- (d) obstetric care unit to general care unit.

ARTICLE III

MEDICAL RECORDS

3.1. General:

- (a) The attending physician 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.
- (b) Only those abbreviations, signs, and symbols authorized by the Hospital's Forms Committee will be used in the medical record. No abbreviations, signs or symbols will be used to record a patient's final diagnoses, any unusual complications, or discharge orders. The Hospital will also maintain a list of abbreviations that are not acceptable for use.

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 11 years and, in the case of a minor, until his or her 30th birthday.
- (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 the Hospital's Release of Information 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.
- (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.

3.3. Content of Record:

- (a) 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.
- (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) All medical records will have the following documentation, as relevant and appropriate to the patient's care. This documentation shall be the joint responsibility of the attending physician and the Hospital:
 - (1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
 - (2) patient's language and communication needs;
 - (3) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;
 - (4) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
 - (5) emergency care, treatment, and services provided to the patient before his or her arrival via EMS, if any;
 - (6) admitting history and physical examination;
 - (7) conclusions or impressions drawn from the history and physical examination;
 - (8) diagnosis, diagnostic impression, or conditions;
 - (9) reason(s) for admission of care, treatment, and services;
 - (10) goals of the treatment and treatment plan;
 - (11) diagnostic and therapeutic orders;
 - (12) diagnostic and therapeutic procedures, tests, and results;
 - (13) progress notes made by authorized individuals;

- (14) reassessments and plan of care revisions;
 - (15) relevant observations;
 - (16) response to care, treatment, and services provided;
 - (17) consultation reports;
 - (18) allergies to foods and medicines;
 - (19) medications ordered or prescribed;
 - (20) 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);
 - (21) known long-term medications being taken by the patient, including current medications, over-the-counter drugs, and herbal preparations;
 - (22) medications dispensed or prescribed on discharge;
 - (23) relevant diagnoses/conditions established during the course of care, treatment, and services;
 - (24) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
 - (25) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;
 - (26) final diagnosis; and
 - (27) whether the patient left against medical advice.
- (d) 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 shall be the joint responsibility of the attending physician and the Hospital:
- (1) known significant medical diagnoses and conditions;
 - (2) known significant operative and invasive procedures;
 - (3) known adverse and allergic drug reactions;

- (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations; and
 - (5) whether the patient left against medical advice.
- (e) Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation shall be the joint responsibility of the attending physician 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; and
 - (6) whether the patient left against medical advice.

3.4. History and Physical:

- (a) A pertinent medical history and physical examination will be performed on each patient no more than 30 days before, or 24 hours after, admission, but prior to surgery or a procedure requiring anesthesia (including sedation), by an individual who has been granted privileges by the Hospital to perform histories and physicals. The medical history and physical examination must be documented in the patient's medical record within 24 hours of admission, but prior to surgery or a procedure requiring anesthesia (including sedation).
- (b) A signed and dated medical history and physical examination that has been completed within the 30-day period prior to admission may be used, provided that the patient has been reassessed within 24 hours of the time of admission or registration, but prior to surgery or a procedure requiring anesthesia (including sedation), in order to (1) document any changes in the patient's condition since the date of the original history and physical or (2) state that there have been no changes in the patient's condition.
- (c) When the history and physical examination, as defined in paragraphs (a) and (b) above, is not performed or recorded in the medical record prior to surgery or a procedure requiring anesthesia (including sedation), the operation or procedure will be postponed unless the attending physician states in writing that an emergency situation (loss of life or limb) exists. If it is an emergency situation

and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient's chart.

- (d) The scope of the medical history and physical examination will be appropriate for the services being provided. This examination will include, as pertinent:
 - (1) patient identification;
 - (2) chief complaint;
 - (3) history of present illness;
 - (4) review of systems;
 - (5) personal medical history, including medications and allergies;
 - (6) family medical history;
 - (7) social history, including any abuse or neglect;
 - (8) physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
 - (9) data reviewed;
 - (10) assessments, including problem list;
 - (11) plan of treatment; and
 - (12) if applicable, signs of abuse, neglect, addiction or emotional/behavioral disorder will be specifically documented in the physical examination and any need for restraint or seclusion will be documented in the plan of treatment.
- (e) Any history and physical examination recorded by a resident physician, physician assistant or nurse practitioner will be reviewed, edited, if necessary, and countersigned by the supervising physician.
- (f) A physical examination of all newborns will be completed and recorded in the medical record within 24 hours of delivery.

3.5. Progress Notes:

- (a) Progress notes will be written by the attending physician or his or her covering practitioner. They may also be written by allied health professionals as permitted by their clinical privileges or scope of practice. 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 or placed in observation.

3.6. Authentication:

- (a) Authentication means to establish authorship by written signature with date and time, or computer entry using unique electronic signatures.
- (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 the physician 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 medical record will not be permanently filed until it is completed by the responsible physician, or it is ordered filed by the Medical Executive Committee.
- (b) Medical records will be completed within the following time frames or they will be considered delinquent:
 - (1) history and physical examinations – within 24 hours of admission;
 - (2) full operative procedure report – within 24 hours of the procedure;
 - (3) discharge summary – within 14 days of discharge;
 - (4) dictation of Emergency Department Medical Screening Examination – within 24 hours of conclusion of Emergency Department visit; and
 - (5) total medical record – within 14 days of discharge.

- (c) If the record remains incomplete 14 days following discharge, the physician will be given a first written notice of the delinquency. If the record remains incomplete 21 days following discharge, the physician will be given a second written notice of the delinquency. If the record remains incomplete 28 days following discharge, the physician will be given a third and final written notice of the delinquency and notified that his or her clinical privileges will be automatically relinquished on day 30 of the delinquency, in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the physician's records are no longer delinquent.
- (d) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.
- (e) When a physician is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the physician's credentials file and divulged in response to any future credentialing inquiry concerning the physician.
- (f) Any requests for special exceptions (e.g., vacations, CME, leave of absence) to the above requirements will be accommodated by the medical records department. It is the responsibility of the physician to keep the medical records department informed of such circumstances.
- (g) Except in rare circumstances, and only when approved by the Medical Executive Committee, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

- (a) All written orders will be dated, timed, and authenticated at the time of entry by the ordering practitioner. All verbal orders (via telephone or in person) will be dated and timed at the time of entry into the record and then authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy.
- (b) All orders for imaging studies will include the pertinent clinical indications *and laterality when applicable*.
- (c) Orders will be entered 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. Any order recorded by a resident physician, physician assistant or nurse practitioner will be reviewed and countersigned by the supervising physician.
- (d) Orders for tests and therapies will be accepted only from:
 - (1) members of the Medical Staff;
 - (2) Allied Health Professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses; and
 - (3) other individuals not on the Medical Staff, upon verification of their licensure and Medicare exclusion status.

Drugs and biologicals are addressed in the Pharmacy Article and may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

- (e) The use of the terms "renew," "repeat," "resume," and "continue" with respect to previous medication orders is not acceptable.
- (f) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be rewritten in the same format in which it was originally recorded if it is to be continued.

- (g) Orders for all medications and treatments will be under the supervision of the attending physician and will be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.
- (h) All orders are automatically cancelled and will be completely rewritten when a patient emerges from surgery.
- (i) All orders for medications administered to patients will be reviewed by the attending physician at least weekly to assure the discontinuance of all medications no longer needed.
- (j) 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 pursuant to the Hospital Automatic Stop Orders Policy. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be rewritten. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.
- (k) Allied Health Professionals may be authorized to write medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders written by a Category II Allied Health Professional will be countersigned/authenticated by the supervising physician by the close of the medical record.

4.2. Verbal Orders:

- (a) A verbal order (via telephone or in person) for medication or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the responsible practitioner.
- (b) Verbal orders will include the date and time of entry into the medical record, will be written in blue or preferably black ink, and will identify the names of the individuals who gave, received, and implemented the order.
- (c) For verbal orders, or for the reporting of critical test results over the telephone, the complete order or test result will be verified by having the person receiving the information record and "read-back" the complete order or test result.
- (d) All verbal orders will be countersigned/authenticated with date and time by the ordering physician, or a practitioner who is authorized by the ordering physician and who is knowledgeable about the patient's condition, within 48 hours.
- (e) The following are the personnel authorized to receive and record verbal orders:

- (1) a member of the Medical Staff or Category II Allied Health Professional;
 - (2) a licensed nurse (registered nurse, licensed practical nurse, nurse practitioner);
 - (3) a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
 - (4) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;
 - (5) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;
 - (6) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;
 - (7) a speech therapist who may transcribe a verbal order pertaining to speech therapy; and
 - (8) a dietician who may transcribe a verbal order pertaining to diet and nutrition.
 - (9) *a medical lab technician (MLT), medical technologist (MT) who may transcribe a verbal order pertaining to laboratory tests.*
- (f) End of Life Orders via the telephone will not be accepted or implemented except in accordance with the Hospital's End of Life Decisions Policy.

4.3. Standing Order Protocols:

- (a) The Medical Executive Committee (or its designee) will review and approve any written protocol(s) to be utilized in the Hospital for drugs or biologicals or other forms of treatment, and the circumstances in which a protocol would apply.
- (b) If the use of a written protocol has been approved by the Medical Executive Committee, the protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the Hospital, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications.

ARTICLE V

CONSULTATIONS

5.1. General:

- (a) Any individual with clinical privileges at the Hospital may be requested to provide a consultation within his or her area of expertise, and these individuals will respond appropriately as a condition of their Medical Staff appointment.
- (b) The attending physician will be responsible for requesting a consultation when one is indicated for the appropriate care of a patient. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will personally contact the consulting physician in order to provide the clinical history and the specific reason for the consultation request.
- (c) 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 the unit or designee or house supervisor, who in turn will contact the attending physician. The Director of the unit may bring the matter to the attention of the service line chair in which the member in question has clinical privileges. Thereafter, the service line chair or Chief of Staff may request a consultation after discussion with the attending physician.
- (d) In circumstances of grave urgency, or where consultation is required by these Rules and Regulations, or where a consultation requirement is imposed by the Medical Executive Committee, the appropriate service line chair will at all times have the right to call in a consultant or consultants.

5.2. Contents of Consultation Report:

- (a) Each consultation report will be completed in a timely manner *before discharge* and will contain a dictated or legible written opinion and recommendations by the consultant that reflects, 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.
- (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.

5.3. Required Consultations:

Except in an emergency, appropriate consultations are required in all cases which, in the judgment of the attending physician:

- (a) the patient exhibits severe symptoms of mental illness or psychosis; or
- (b) when a patient has attempted suicide or has taken a chemical overdose (in which case a crisis intervention assessment and treatment will be requested, offered to, or arranged).

Additional requirements for consultation may be established by the Medical Staff.

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). 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 written notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation is not available for review, surgery and anesthesia will not proceed.

5.6. Mandatory Consultations:

- (a) When, as a result of peer review activities, a consultation requirement is established by the Professional Practice Evaluation Committees, the Medical Executive Committee, or the Board, the required consultation will not be rendered by an associate or partner of the attending physician unless this is specifically permitted when the consultation requirement is established.
- (b) Failure to obtain required consultations may result in a further professional review action.

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 the provisional diagnosis and the results of any indicated diagnostic tests, a properly executed informed consent, and a complete history and physical examination (or completed short-stay form, as appropriate), prior to the patient's transport to the operating room, except in emergencies. Any pre-operative notes recorded by a resident physician, physician assistant, or nurse practitioner will be reviewed, edited, if necessary, and countersigned by the supervising physician.
- (b) 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) the attending physician is in the Hospital; and
 - (3) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Hospital Patient Identification Site Marking Time Out Universal Protocol Policy.

6.2. Post-Procedure Protocol:

- (a) For every procedure performed in an operating room and/or under sedation, a progress note containing the following information will be entered in the medical record immediately after the procedure:
 - (1) preoperative diagnosis;
 - (2) postoperative diagnosis;
 - (3) procedure;
 - (4) findings;
 - (5) specimen(s) removed;
 - (6) estimated blood loss;

- (7) type of anesthesia;
 - (8) complications; and
 - (9) name of surgeon(s)/assistant surgeon(s).
- (b) A full operative procedure report for these invasive procedures will then be dictated or legibly handwritten within 24 hours of the procedure, and authenticated by the attending physician. The report will record:
- (1) pre- and post-operative diagnoses;
 - (2) date of the procedure;
 - (3) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient's operation;
 - (4) procedure(s) performed and description of the procedure(s);
 - (5) description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;
 - (6) findings;
 - (7) estimated blood loss;
 - (8) any unusual events or complications, including blood transfusion reactions and the management of those events;
 - (9) the type of anesthesia/sedation used;
 - (10) specimen(s) removed, if any; and
 - (11) a description of any prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

6.3. Outpatient Surgery and Procedures:

- (a) Patients will not be accepted for outpatient surgery or procedures if it is expected that a blood transfusion may be necessary during surgery secondary to inoperative blood loss.
- (b) All outpatient procedures involving moderate or deep sedation require the patient to be accompanied by or have someone available to drive him or her home on the day of the procedure.

6.4. Surgical Specimens:

- (a) Unless otherwise exempt by law, all specimens removed during a surgical procedure will be properly labeled and immediately sent to the laboratory for examination by the pathologist. The specimen will be accompanied by pertinent clinical information, including: preoperative diagnosis and history, procedure, specimen, and postoperative diagnosis. The pathological report will be made a part of the patient's medical record.
- (b) The following classes of specimens are, by law, exempt from examination by a pathologist:
 - (1) cataracts, orthopedic appliances, foreign bodies, synthetic materials, portions of rib removed to enhance operative exposure, tissue graft material;
 - (2) therapeutic radioactive sources;
 - (3) traumatically injured body parts that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;
 - (4) foreign bodies (e.g., bullets) that for legal reasons are given directly to chain of custody (law enforcement representative);
 - (5) specimens known to rarely if ever show pathological change and the removal of which is highly visible post-operatively, such as foreskins from infant circumcision;
 - (6) grossly normal placentas; and
 - (7) teeth, providing the number, including fragments, is recorded in the medical record.
- (c) The following classes of specimens are to be submitted to pathology but will generally be subjected to gross inspection only:
 - (1) tonsil under 18 years of age and non-recurrent;
 - (2) adenoids;
 - (3) foreskin of adults;
 - (4) hernial membrane;
 - (5) non-neoplastic bone pathology where the diagnosis is readily evident by gross inspection;

- (6) vaginal mucosa removed in plastic repair procedures;
 - (7) gangrenous extremities;
 - (8) calculi;
 - (9) toenails and fingernails;
 - (10) intrauterine contraceptive devices;
 - (11) teeth, ribs, foreign bodies, or orthopedic appliances when sent to pathology;
 - (12) products of conception with fetus or fetal parts;
 - (13) nasal cartilage;
 - (14) varicose veins; and
 - (15) abdominal skin scars from previous surgery.
- (d) All specimens removed at operation and all specimens obtained from a patient will be the property of the Hospital.

ARTICLE VII

ANESTHESIA/SEDATION SERVICES

7.1. Pre-Anesthesia/Sedation Procedures:

- (a) A pre-anesthesia/sedation evaluation will be recorded in the medical record by an individual qualified to administer anesthesia or sedation within 48 hours prior to an inpatient procedure. The evaluation will include information to determine the capacity of the patient to undergo anesthesia or sedation and to formulate an anesthesia/sedation plan, a review of objective diagnostic data, an interview with the patient regarding his or her medical, anesthetic and medication history, a review of the patient's physical status, and documentation relating to informed consent regarding anesthesia or sedation.
- (b) The patient will be reevaluated immediately before moderate or deep sedation and/or before anesthesia induction in order to confirm that the patient remains able to proceed with care and treatment.
- (c) All obstetrics patients who undergo caudal, spinal, saddle block, or epidural anesthesia should have an IV started prior to the administration of the anesthesia.

7.2. Monitoring During Procedure:

- (a) All patients will be monitored during the procedure and/or administration of moderate or deep sedation or anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.
- (b) Monitoring will be at a level consistent with the potential effect of the procedure and/or sedation or anesthesia.
- (c) All events taking place during the induction and maintenance of, and the emergence from, anesthesia or sedation, will be documented legibly in the medical record, including:
 - (1) the dosage and duration of all anesthetic agents;
 - (2) other medications, intravenous fluids, blood or blood products;
 - (3) the anesthesia/sedation technique(s) used;
 - (4) unusual events during the anesthesia or sedation period;
 - (5) the status of the patient at the conclusion of anesthesia or sedation; and

- (6) documentation of transfer of care to another Medical Staff member at the end of anesthesia or sedation.

7.3. Post-Anesthesia Evaluations:

- (a) Post-anesthesia/sedation evaluation and follow-up will be conducted upon completion of the procedure and when the patient is suitable for discharge from the appropriate recovery area. *All post-anesthesia evaluations must be completed and documented within 48 hours after the procedure. When anesthesia has been administered, the post anesthesia evaluation note will be documented in the patient's medical record by an individual qualified to administer anesthesia.*
- (b) Patients will be discharged from the recovery area by a qualified practitioner or according to criteria approved by the anesthesiologist. Post-operative documentation will record the patient's discharge from the post-sedation or post-anesthesia care area and record the name of the individual responsible for discharge.
- (c) Patients who have received sedation or anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
- (d) When surgical or anesthesia/sedation 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.

7.4. Moderate Sedation

- (a) *Procedures requiring Moderate ("Conscious") Sedation will be administered in accordance with the Hospital Moderate ("Conscious") Sedation Policy.*

ARTICLE VIII

PHARMACY

8.1. General Rules:

- (a) All orders for medications and biologicals will be in writing, dated, timed and authenticated by the practitioner responsible for the care of the patient, 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.
- (b) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.
- (c) Transfusion reactions, adverse medication reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician and to the appropriate departments and individuals within the Hospital.
- (d) Self-medication by patients will not be permitted, unless written in the orders by the attending physician in accordance with the Hospital Self Administration of Medications at the Bedside Policy.
- (e) 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.
- (f) 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.
- (g) The use of investigational or experimental drugs in clinical investigations will be subject to the Hospital Investigational Drugs Policy, the applicable Institutional Review Board, or rules established by the Medical Executive Committee.
- (h) 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.
- (i) *Off label use of medications will be governed by Hospital Orders Exceeding Dose/Unapproved Route/Indication Policy.*

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 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.

8.3. Patient's Own Medications:

If patients bring their own medications to the Hospital, these medications may be administered if: (i) they are identified by a pharmacist; (ii) the attending physician has written an order for their administration; and (iii) the Hospital Patient's Medications Policy is followed.

8.4. Stop Orders:

A physician 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. Specific stop dates are defined by the Hospital Automatic Stop Orders Policy which lists the class of medications covered with specific stop dates (24 hours, three days, five days, seven days and 14 days).

8.5. Obstetrics:

The use of oxytocic drugs IV or injection for the induction or stimulation of labor will be ordered by the attending physician only when he or she is promptly available during the course of administration of such medication. The current policy "Management of Induction/Augmentation of Labor" will be followed.

ARTICLE IX

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

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

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, 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:

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:

- (a) Emergency Department:
 - (1) members of the Medical Staff with clinical privileges in Emergency Medicine;
 - (2) other Active Staff members; and
 - (3) appropriately credentialed Allied Health Professionals.
- (b) Labor and Delivery:
 - (1) members of the Medical Staff with OB/GYN privileges;
 - (2) other Active Staff members; and
 - (3) Registered Nurses who have achieved competency, in accordance with Labor and Delivery Policies and Procedures.

10.3. On-Call Responsibilities:

- (a) It is the responsibility of the scheduled on-call physician to respond by telephone to calls from the Emergency Department within 10 minutes for priority calls and

within 30 minutes for routine calls. Generally, the on-call physician must be present to personally evaluate an Emergency Department patient within 30 minutes, or unless specifically agreed upon by the Emergency Department physician. Pathology consultations are required to be present within 45 minutes.

- (b) If the Medical Staff Office is closed and the on-call physician cannot meet his or her obligation, the on-call physician should contact the page operator or Emergency Department so that the back-up plan can be implemented, including transfer.
- (c) The Medical Staff Office will prepare the monthly general Emergency Department call schedule. With the exception of the correction of simple or clerical errors, it is the responsibility of the individual physician to make any subsequent changes to the monthly general Emergency Department call schedule. Any changes made should be communicated in writing to the Medical Staff Office. Changes in published call schedules for private patient coverage should be communicated in the same manner.
- (d) If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the Emergency Department physician will determine whether to attempt to contact another specialist on the Medical Staff or arrange for a transfer pursuant to these Rules and Regulations. The name and address of an on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment will be documented in the patient's medical record.

10.4. Transfers:

Patient transfers from the Emergency Department will be made in accordance with Article XII of these Rules and Regulations and Hospital policies and procedures.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.1. Who May Discharge:

Patients will be discharged only upon the written order of the attending physician or physician designee. 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.

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.
- (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.
- (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.

11.4. Discharge Summary:

- (a) A concise, dictated discharge/death 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/death summaries will be completed in 14 days and will include the following:

- (1) reason for hospitalization;
 - (2) significant findings;
 - (3) procedures performed and care, treatment, and services provided;
 - (4) condition at discharge or cause of death;
 - (5) information provided to the patient and family, as appropriate;
 - (6) final diagnosis; and
 - (7) disposition, including discharge medications.
- (b) A final legible progress note may be substituted for a discharge summary only in the case of normal newborn infants, uncomplicated vaginal deliveries, and outpatient observation stays.

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 attending physician 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 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 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 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.

- (e) Discharges from special care units will be completed in accordance with established criteria. The applicable unit director or service line chair may, at his or her discretion, grant exceptions to these criteria.

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 and level of care during 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.

12.2. Procedures:

- (a) Patients will be transferred to another level of care, treatment, and/or services, different professionals, or different settings 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 or level of care;
 - (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;
 - (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:
 - (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 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.

ARTICLE XIII

MISCELLANEOUS

13.1. Autopsies:

- (a) The attending physician should attempt to secure autopsies in accordance with state and local laws. The attending physician and the Primary Care Physician (if different) will be notified when an autopsy is to be performed.
- (b) An attempt to secure an autopsy is made in all deaths that meet the following criteria:
 - (1) unexplained or unexpected deaths occurring during or following dental, medical or surgical diagnostic procedures or therapies;
 - (2) all maternal deaths;
 - (3) all perinateal deaths ≥ 20 weeks or ≥ 500 grams; or
 - (4) deaths associated with any adverse event; i.e., injury, equipment malfunction, drug reaction, etc.
- (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. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer and/or the Chief of Staff.
- (d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

13.2. Medical Examiner Cases:

The following types of death must be reported to the Medical Examiner:

- (a) homicide;
- (b) suicide;
- (c) accident;
- (d) trauma;
- (e) disaster;

- (f) violence;
- (g) unknown, unnatural or suspicious circumstances;
- (h) in police custody, jail or prison;
- (i) poisoning or suspicion of poisoning;
- (j) public health hazard (such as acute contagious disease or epidemic);
- (k) deaths during surgical or anesthetic procedures;
- (l) sudden unexpected deaths not reasonably related to known previous disease; or
- (m) deaths without medical attention.

13.3. Patient 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 *a registered nurse with a written/verbal order by a physician*, within a reasonable time frame. Death certificates are the responsibility of the attending physician and will be completed within 24 hours of when the certificate is available to the attending physician.
- (b) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the attending physician or other designated member of the Medical Staff.

13.4. Treatment of Family Members:

- (a) No member of the Medical Staff will admit, treat or participate in the surgery of a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise approved by the Chief of Staff or the Chief Executive Officer. This prohibition is not applicable to in-laws or other relatives.
- (b) An exception to this prohibition will be made (1) if the patient's disease is so rare or exceptional and the physician is considered an expert in the field or (2) in an emergency where no other Medical Staff member is readily available to care for the family member, and a transfer is believed to be detrimental to the patient's health.

13.5. Orientation of New Physicians:

Each new physician will be provided an overview of the Hospital and its operations. As a part of this orientation, the Medical Records 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.

13.6. Birth Certificates:

Birth certificates are the responsibility of the delivering physician and will be completed within three days of delivery.

13.7. Allocation of Additional Service Line Representatives to the MEC:

In accordance with Section 5.D.1 of the Medical Staff Bylaws, the allocation of additional service line representatives to the Medical Executive Committee will be determined by taking the total number of Active Staff members assigned to the service line divided by the total number of Active Staff members, multiplied by six (6).

ARTICLE XIV

AMENDMENTS

An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to this document shall be provided to each member of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting when the vote is to take place. Any member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee. Adoption of and changes to the Medical Staff Rules and Regulations will become effective only when approved by the Board.

ARTICLE XV

ADOPTION

These Rules and Regulations are adopted and made effective as of November 24, 2009, upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on November 10, 2009:

Chief of Staff

Approved by the Board on November 24, 2009:

Chair, Board of Directors

Revision Dates:
January 26, 2010