DUPONT HOSPITAL
FORT WAYNE, INDIANA

MEDICAL STAFF RULES AND REGULATIONS

ADOPTED BY MEDICAL EXECUTIVE COMMITTEE
November 27, 2000

AND

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PART I. GENERAL CONSIDERATIONS

1.1 All members of the Medical Staff and any other practitioner granted privileges by the Board shall abide by these Rules and Regulations and all other policies and manuals applicable to Medical Staff members.

1.2 For the purpose of these Rules and Regulations, the following definitions apply:

1.2.A "ACTIVE STAFF" means those Medical Staff members who have declared the Hospital one of their primary hospitals for the practice of medicine and other related hospital activities, and who have been recognized by the Medical Staff by formal review processes to be members in good standing.

1.2.B "ALLIED HEALTH PROFESSIONAL" or "AHP" means any credentialed individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital. For such purposes of the Rules and Regulations, AHP shall be deemed to refer only to advance practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, physician assistants, certified nurse practitioners, certified nurse midwives, certified nurse specialists, and other such professionals. For the purpose of these Rules and Regulations, AHP shall not be deemed to include those non-credentialed individuals shoes appointment and competencies are handled outside the Medical Staff process.

1.2.C "ATTENDING PHYSICIAN" means a patient's admitting physician.

1.2.D "BOARD" means the Board of Directors of Dupont Hospital, LLC.

1.2.E "CHAIRMAN" of a certain committee means the member of the Medical Staff elected by the committee members to the position of Chairman or serving by virtue of these Rules and Regulations or the Medical Staff Bylaws.

1.2.F "DAYS" Unless otherwise specified, any reference to number of days refers to calendar days.

1.2.G "EMERGENCY" means a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger. "Emergency" also has that meaning prescribed by the Emergency Medical Treatment and Active Labor Act (hereafter "EMTALA"), 42 U.S.C. § 1395dd, as the same may be amended from time to time.

1.2.H "HOSPITAL" means Dupont Hospital.

1.2.I "IRB" means the Lutheran Health Network Institutional Review Board.

1.2.J "MEDICAL EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff. The Medical Executive Committee is empowered to act for the Medical Staff as a whole in all matters except as noted in these Rules and Regulations and the Medical Staff Bylaws.

1.2.K "MEDICAL STAFF" means all practitioners who are privileged to attend patients in the Hospital.

1.2.L "PRACTITIONER" means a doctor of medicine, doctor of osteopathy, doctor of podiatric medicine or doctor of dentistry possessing an unlimited license to practice in the State of Indiana.

1.2.M "QUALITY COMMITTEE" means the Staff committee charged with reviewing matters of utilization review, quality management, infection control, pharmacy and therapeutic issues, medical records, and other health care quality and delivery issues, policies and practices.

PART II. ADMISSIONS AND CARE OF PATIENTS

2.1 All admissions to the Hospital shall be arranged through the Patient Registration Department and/or directly through the appropriate clinical unit.

2.2 The type of admission shall be determined by the admitting physician, who will notify Patient Registration that the admission is either emergent, urgent, or elective. A patient may be admitted to the hospital only by a member of the Medical Staff. The privilege to admit shall be delineated and is not automatic with Medical Staff membership.

The management and coordination of each patient's care, treatment and services shall be the responsibility of the physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any referring practitioner and to relatives of the patients where appropriate. The patients shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

2.2.A Emergent. An emergent patient must be admitted to receive emergency services. An admission is considered emergent if, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy;

(2) Serious impairment of bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

An emergent patient is also any person legally entitled to a "medical screening" as these terms are used in EMTALA. See also 2.3 below.

2.2.B Urgent. An urgent patient must be admitted for a prompt diagnostic workup or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner. An admission is considered urgent if delay of medical treatment is likely to result in:

(1) Prolonged temporary impairment;

(2) Increased risk of treatment by the need for more complex or hazardous treatment; or

(3) Risk of development of chronic illness or inordinate physical or psychosocial suffering by the patient.

2.2.C Elective. The health of an elective patient is not endangered by delayed admission. Such patients are usually scheduled for admission several days to several weeks in advance.

2.3 **ADMITTING POLICY**

Priorities for admission are as follows:

2.3(a) Emergency Admissions

2.3(b) Preoperative Admissions

This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.

2.3(c) Routine Admissions

This will include elective admissions involving all services.

2.4 PATIENT TRANSFERS

2.4(a) Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;

(2) From any department to ICU in an emergency;

(3) From ICU to the operating room or other procedure area in an emergency;

(4) From any department to Skilled Nursing Facility;

(5) From obstetric patient care area (unit) to general care area when medically indicated; and

(6) From temporary placement in an inappropriate area to the appropriate area for that patient.

2.4(b) No patients will be transferred between departments without notification to the Attending Physician.

2.4(c) If the Intensive care unit is full and a patient requires ICU care; all physicians attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination, and shall make the decision.

2.5 SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:

2.5(a) A patient suspected to be suicidal in intent shall be admitted to a security room consistent with the patient's medical needs. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded psychiatric consultation;

2.5(b) The hospital Case Manager should be consulted for assistance; and

2.5(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except that the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the hospital's EMTALA policy, that the benefits of transfer outweigh the risks.

2.6 All patients who present to the Hospital and request examination and treatment for an emergency medical condition or active labor must be evaluated for the existence of an emergency medical condition or active labor. Upon determination that an emergency medical condition or active labor exists, all available medical treatment within the capability of the Hospital will be provided to the patient to alleviate the emergency, deliver the child, or transfer the patient to another hospital in accordance with EMTALA and the Hospital's emergency treatment and transfer policies.

2.7 Anyone with admitting privileges shall provide information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever or to assure protection of the patient from self-harm at the time of admission.

2.8 Patients shall be discharged only on written or verbal order of a Medical Staff member. Should a patient leave the hospital against the advice of the Medical Staff member or without proper discharge, a notation of the incident shall be made in the patient's medical record. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.

2.9 **REQUIRED CONSULTATION**

2.9.A Therapeutic abortion may be performed only after consultation with two members of the Active Staff, one of whom may be the attending physician, and only if the following conditions are met:

(1) Diagnosis supporting mother's need for therapeutic abortion has been made by an ultrasound exam or other radiographic study;

(2) Twenty-four (24) hours has elapsed from the time of notification to the patient of the ultrasound exam results;

(3) The patient has been informed of the risks of the intended method of pregnancy termination such as dilation and curettage or prostaglandin induction of labor;

(4) Informed consent is obtained from the patient; and

(5) The elected method is done.

2.9.B All consultations shall be recorded in the medical record.

3.0 **AVAILABILITY**

3.0.A Patients admitted to critical care areas should be seen by the attending physician or their AHP as soon as possible after admission to the unit, but no later than twelve (12) hours after admission or sooner if warranted by the patient's condition. Patients admitted to medical/surgical/pediatric units should be seen within sixteen (16) hours following admission and within twenty-four (24) hours following admission to the nursery unless the patient's condition warrants an earlier visit.

(1) The evaluation and entering of orders shall be performed by a member of the Medical Staff, either as the admitting or consulting physician or by their Allied Health Professional (AHP) who is, at a minimum, a nurse practitioner, physician assistant, or certified nurse midwife.

(2) For direct admissions and admissions following an Emergency Room visit, the evaluation occurring in the office or Emergency Department immediately prior to the admission will suffice if performed by the admitting or consulting physician or their AHP who is, at a minimum, a nurse practitioner, physician assistant, or certified nurse midwife.

(3) Inpatients shall receive visits by physicians or their AHP who is, at a minimum, a nurse practitioner, physician assistant, or certified nurse midwife daily.

3.0.B Physicians or their designee should be available to the Emergency Department within thirty (30) minutes of notification either personally or by phone. Similar availability is expected for any patient who experiences a sudden change in condition.

PART III. DRUGS, ORDERS AND TESTS

3.1 PHARMACY OPERATING POLICIES

3.1.A Hospital Formulary

(1) A listing of all drug formulary items stocked in the Pharmacy, known as the Hospital Formulary, will be maintained on-line as permitted by applicable state and federal statutes and regulations.

(2) Medication orders written for trade-name drugs will be filled with the formulary drug, but not necessarily with the brand name called for under the registered trade name unless the physician specifically writes "Do Not Substitute" on the patient order sheet.

3.1.B Staff physicians are recommended to contact the Director of the Pharmacy, either in person or By using the special request forms which are included in the Pharmacy Catalogue in the nursing stations, when a new drug is to be used in the Hospital prior to its need.

3.1.C Additions and Deletions to the Hospital Formulary

(1) The decision to add or delete a drug from the Hospital Formulary is the responsibility of the Medical Executive Committee with recommendations from the Pharmacy & Therapeutics Committee and the Clinical Services. These decisions shall be based on criteria consistent with scientific information that support basic objectives of the Committee.

(2) Requests for new drugs to be used in the Hospital prior to Medical Executive Committee approval should be made to the Network Clinical Pharmacy Manager, either in person or by letter.

(3) Staff members shall be notified whenever a drug is under consideration for deletion so that they may submit evidence for its retention.

(4) Investigational drugs may be administered following IRB approval and in accordance with IRB guidelines. All investigational drugs are to be dispensed from the Pharmacy Department.

3.1.D The Pharmacy shall maintain an adequate library and an extensive product information file to make information concerning drugs available to staff members.

3.2 Intravenous therapy may be given by a member of the Hospital's registered nursing staff. Intravenous admixtures are to be prepared within the Pharmacy Department under laminar airflow except for emergency situations.

3.3 VERBAL AND TELEPHONE ORDERS

3.3.A Verbal orders regarding medications and nursing functions shall be dictated to registered nurses, registered pharmacists, credentialed respiratory care practitioners (inhalation medications only),

and radiology and nuclear medicine technologists who are administering medications as part of procedural protocol.

3.3.B Verbal and/or telephone orders regarding medications or specific patient care functions may also be taken by a registered nurse or a licensed practical nurse who is providing services as an allied health professional to patients of his/her employer.

3.3.C Verbal and/or telephone orders may be taken by other Hospital associates that relate directly to the care and procedures they provide.

3.3.D The radiology secretary may take orders for procedures. This is followed by a written order from the physician. Radiographic IV contrast materials and radioisotopes are considered ordered when the specific procedure is ordered.

3.3.E Verbal and/or telephone orders may be taken by a licensed/ registered occupational therapist, physical therapist or speech pathologist that relates to these therapies only.

3.3.F A registered dietician may take a verbal and/or telephone order for nutritional aspects of care.

3.3.G Verbal and/or telephone orders are discouraged except in emergency situations. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the practitioner and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate and date any order including but not limited to medication orders as soon as possible, and in no case, longer than thirty (30) days from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

3.4 When there is a need for clarification of the order of an attending physician, the pharmacist receiving the order shall contact the attending practitioner. When the order is clarified, it may be conveyed directly to the nurse by the attending physician or by the pharmacist at the discretion of the attending physician.

3.5 Daily laboratory tests, ordered for an unspecified duration, shall be called to the attention of the attending physician upon the expiration of three (3) days. The attending physician will reorder, change or cancel the test. The exception to this order would be if the physician specifically specifies an expiration of more than three (3) days.

3.6 Medications brought from home by the patient will be dispensed only if the medications are not on the Hospital Formulary or cannot be substituted for a Formulary medication and after the medications are identified by the Pharmacy Department. The physician's order to continue medications from home shall list the specific medication, dosage and instructions. Only FDA approved supplements and medications will be dispensed.

PART IV. MEDICAL RECORDS

4.1 The purposes of the medical record are:

(1) To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;

(2) To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay.

(3) To document communication between the responsible practitioner and any other health professional who contributes to the patient's care;

(4) To assist in protecting the legal interests of the patient, the Hospital, and the responsible practitioners; and

(5) To provide data for use in billing, continuing education, and research.

4.2 The following Hospital Personnel are authorized to document in the medical record:

A. Medical Staff.
B. Medical Residents
B. Medical Students with co-signatures of supervising physician.
C. Consulting Physicians.
D. Radiologist.
E. Pathologist.
F. Physician Extenders with co-signatures of supervising physician.
G. Nursing Staff (RN, LPN, Nurse Externs, Unit Sec., NA).
H. Registered Dietitian or designee.
I. Physical, Occupational, and Speech Therapist.
J. Cardiopulmonary Services (related to Cardiopulmonary, Respiratory, EKG/EEG Services).
K. Radiology Technician (related to Radiology Services).
L. Lab Technician (related to Laboratory Services).
M. Case Manager.
N. Pastoral Care.
O. Medical Technicians.
P. Health Information Services.

4.3 Attending Physician's Responsibilities

4.3.A The attending physician shall be held responsible for the preparation of a complete medical record for each of his patients. A complete medical record shall contain the following:

(1) Identification data (when identification data is not obtainable, the reason shall be entered in the record);

(2) The medical history of the patient;

(3) The report of a relevant physical examination;

(4) Diagnostic and therapeutic orders;

(5) Evidence of appropriate informed consent (when consent is not obtainable, the reason shall be entered in the record);

(6) Clinical observations, including results of therapy;

(7) Results and/or reports of procedures and tests; and

(8) Summary of treatment with final diagnoses and disposition.

(9) The record shall also contain a written plan of care, treatment and services appropriate to the patient's needs, identifying the patient's needs, goals, timeframes, settings, and services required to meet the patient's needs. Such plan of care shall be discussed with the patient and shall be revised as necessary, and where appropriate, consider strategies to limit the use of restraints and/or seclusion of the patient.

4.3.B Inpatient medical records shall include at least the following:

(1) Identification data including patient's full name, address and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.

(2) An admission note should be present on the chart within 24 hours after admission, which validates the reason for admission and outlines the plan of treatment.

(3) The medical history of the patient shall include the chief complaint; details of present illness including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past medical, social, and family histories; current medications and allergies; and inventory of body systems. For children and adolescents, an evaluation of developmental age factors, immunization status, educational needs, and the family's expectations and involvement should be included, as appropriate. The medical history shall be written or dictated within 24 hours after admission of the patient or prior to surgery or anesthesia and include a statement of conclusions, impressions and course of action plan.

(4) A comprehensive physical examination shall be completed within the first 24 hours after admission to inpatient services.

(a) If a complete physical examination has been performed within 30 days prior to admission by a Medical Staff member, a durable, legible copy of this report may be used in the patient's hospital medical record, but must be updated with current information and examination within 24 hours after admission and/or prior to surgery or anesthesia.

(b) A prenatal office physical assessment must be updated at the time of admission.

(c) In all surgical cases, the medical record should document a current, thorough physical examination prior to the performance of surgery. No operation should proceed until the physical examination, history, and pertinent laboratory work has been done.

(d) The physical exam, at a minimum, must address the heart, lungs, neurological or mental status, and the body system involved in the procedure.

(e) History and physical examination shall be completed by a qualified Medical Staff member who has been credentialed and granted privileges to perform a history and physical examination. History and physical examinations may also be completed by Allied Health Professionals, third year Medical Students, and fourth year Medical Students who are under the direct supervision of a privileges physician.

(5) Diagnostic and therapeutic orders (verbal, standing or written) shall be authenticated by the responsible practitioner in accordance with all applicable federal and state rules and regulations. All verbal and telephone orders shall be read back and verified with the ordering physician. By his/her signature on the medical record, the health care

professional accepting the verbal order acknowledges the repetition and verification of the verbal order. Verbal orders for controlled substances shall be authenticated by the prescribing physician in accordance with all applicable federal and state statutes and regulations.

(6) A discharge order given by a Medical Staff member is required to release a patient. Should a patient leave the hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.

(7) A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high risk treatments (as provided by hospital policy and/or state law) except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient or any person to whom the patient has properly delegated representative authority, only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the person performing the procedure. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form. The informed consent is the responsibility of the physician or the person permitted to perform the procedure to obtain. The medical record shall contain evidence that an informed consent form was signed by the patient or legal guardian and by a witness and shall be made a part of the record before any invasive and/or risk-producing procedure is performed.

Each consent form shall include the name of the hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative; and the signature of the patient or the patient's legal representative. The form must also comply with the requirements of applicable state law.

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient's behalf, must be documented in the patient's permanent hospital record. Patients have the right to request any treatment at any time, and such requests shall be documented in the patient's permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating physician or his/her designee.

(8) Progress notes shall be written or dictated at least daily and reflect the condition of the patient and shall be recorded with sufficient frequency that the notes present a chronological picture and an analysis of the clinical course of the patient.

(9) Consultation reports shall contain the written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

(10) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature.

(11) All treatments, examinations and procedures shall be documented in the medical record within 24 hours of completion.

(12) Clinical laboratory, radiology and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion.

(13) All surgical specimens removed shall be sent to the laboratory, and an acknowledgement that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted (exceptions noted in laboratory policy 2.03)

(14) Operative reports shall be dictated or written immediately after surgery and shall contain a full description of the procedures performed. The operative report shall include date of surgery, preoperative and postoperative diagnoses, technical procedures performed, the specimens removed, and the names of the primary surgeon and any assistant. The completed operative note shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

(15) A pre-anesthesia evaluation shall be completed within twenty-four (24) hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intra-operative anesthesia record during the procedure. A physician credentialed to administer anesthesia shall be responsible for the completion of a post-anesthesia report within 48 hours of the surgery.

(16) The Hospital shall discharge its obligation under all applicable state and federal statutes to identify potential organ and/or tissue donors. When identified, potential organ and/or tissue donors shall be transferred, in accordance with EMTALA, the Hospital's emergency treatment and transfer policies, and all applicable state and federal statutes and regulations, to an appropriate care facility.

(17) A discharge summary shall be written or dictated after issuing a discharge order or within 30 days following discharge. It should concisely document the reasons for admission, the principal and additional or associated diagnoses, the procedures performed, the treatment rendered, the condition of the patient at discharge, and any specific instructions given to the patient and/or family. For hospitalizations under 48 hours, routine vaginal deliveries and normal newborns, the final progress note may serve as a discharge summary. However, it must contain:

(a) the outcome of the hospitalization;

(b) disposition of the case;

(c) instructions given and provisions made for follow-up care, and;

(d) must include the discharge diagnosis.

(18) In the event of death, a final progress note or summary is required which shall indicate the reason for admission, the findings, the course in the Hospital, and events leading to death.

(19) Final diagnoses, operations and procedures shall be documented sufficiently that they can be accurately coded in ICD-9-CM codes. Abbreviations and symbols utilized in medical records are to be those approved by the MEC ad filed with the Health Information Services Department. No abbreviations are acceptable in final diagnoses, operations and procedures. Members will cooperate with the Health Information Management department when requested to provide additional or clarifying information needed for accurate coding.

(20) The attending Medical Staff member shall legibly sign, initial, or electronically sign all entries which he/she makes in the medical record. Use of rubber stamp signatures is prohibited. In addition, he/she shall countersign any face sheet, surgery report, and/or delivery record completed by the resident. Entries consisting of the history and physical, consult notes, progress notes and discharge summary documented by an Allied Health Professional shall be countersigned by the attending physician. All entries made by a rounding nurse/nurse extender shall be countersigned.

(21) All entries in the medical record must be signed, dated and timed. Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated, timed and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of correction fluid/ribbon. To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made. Text editing through the electronic medical record system is also acceptable. Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

4.3.C Ambulatory Surgery/Observation medical records shall include the following:

(1) Identification data including patient's full name, address and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.

(2) The medical history and physical examination shall be completed prior to administration of general anesthesia or emergency treatment and shall comply with the provisions of Section 4.3.B (3 and 4) of these Rules and Regulations.

(3) A discharge order given by a Medical Staff member is required to release a patient.

(4) The informed consent is the responsibility of the attending physician to obtain and shall comply with the provisions of Section 4.3.B(7) of these Rules and Regulations. The medical record shall contain evidence that an informed consent has been obtained by the attending physician or other treating physician before any major procedure. The informed consent form shall be signed by the patient or legal guardian and by a witness and shall be made part of the record before any major procedure is performed.

(5) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature. Staff physicians, residents, 3rd and

4th year medical students, qualified oral surgeons, nurse practitioners (NP), physician assistants (PA), and NP / PA students are the only individuals competent to write or dictate the medical history and physical examination.

(6) All treatments, tests, examinations and procedures shall be documented in the medical record within 24 hours of their completion.

(7) Clinical laboratory, radiology and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion. Reports from approved laboratories outside the Hospital are acceptable in lieu of tests performed inside the Hospital. Laboratory procedures must be done within five days prior to treatment.

(8) All surgical specimens removed shall be sent to the Laboratory, and an acknowledgment that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted.

(9) Operative reports shall be dictated or written immediately after surgery and shall contain a full description of the procedures performed. The operative report shall include date of surgery, preoperative and postoperative diagnoses, technical procedures performed, the specimens removed, and the names of the primary surgeon and any assistant. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

(10) A preanesthesia evaluation shall be completed within 48 hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intraoperative anesthesia record during the procedure. The physician administering the anesthesia shall be responsible for the patient meeting established postoperative criteria for discharge.

(11) Discharge instructions shall be given to the patient and/or family as necessary, especially for emergency and surgical patients. A copy of the discharge instructions shall be retained in the patient's medical record.

(12) The original autopsy report shall be made a part of the patient's record. The provisional anatomic diagnosis should be recorded in the medical record within three days, and the complete protocol should be made part of the record within 60 days of completion.

(13) Final diagnoses, operations and procedures shall be coded in ICD-9-CM codes. No abbreviations are acceptable in final diagnoses, operations or procedures.

(14) The attending physician shall legibly sign, initial, or electronically sign all entries which he/she makes in the medical record. Use of rubber stamps signatures is prohibited. In addition, he/she shall countersign any surgery report completed by the resident. All entries made by non-physician agents of the attending physician shall be countersigned.

(15) All entries in the medical record must be signed, dated and timed.

4.4 All medical records shall be completed within 30 days of discharge. The Medical Staff encourages members to utilize the Hospital's computerized medical records system to complete records as soon as they are available on-line (usually within three working days of discharge). Regular on-line completion precludes the need for a "catch-up" session each month to avoid suspension.

One week prior to each month's Medical Executive Committee meeting, any physician with records more than 30 days old will receive a letter notifying him/her that failure to complete their records by the date of the meeting will result in reporting to the Committee for their action. On the date of the Medical Executive Committee meeting, the Health Information Services Department will forward a report of the physicians with delinquent medical records to the Committee. Failure to have completed medical records by this date may result in the consideration by the MEC of suspension of the physician's.privileges to admit non-emergency patients and schedule elective procedures.

A letter will be sent from the Medical Executive Committee notifying the physician of the effective date of suspension. Physicians under suspension will be expected to continue care for hospitalized patients as well as Emergency Department patients. Each physician shall remain suspended until all of his/her incomplete records are completed.

Three such suspensions of admitting privileges within any 12-month period shall be sufficient cause for termination of the practitioner's privileges. Such suspension and termination shall not entitle the affected practitioner to an hearing or appeal rights.

4.5 Medical records are the property of the Hospital and shall not be removed except by enforceable subpoena duces tecum, court order or statute.

4.6 Accessibility of the Medical Record

4.6.A Free access to the medical records of all patients shall be afforded to Staff Members for *bona fide* study and research, consistent with preserving the confidentiality of personal information concerning individual patients upon MEC approval.

4.6.B Subject to the discretion of the Chief Executive Officer of the Hospital and as permitted by applicable federal and state laws, rules and regulations, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients, covering all periods during which they were attending such patients in the Hospital.

4.6.C On readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is to be attended by the same physician or another.

PART V. RULES AND REGULATIONS FOR MEDICAL RESIDENTS AND MEDICAL STUDENTS

5.1 Residents shall be subject to the applicable policies, Rules and Regulations of the Fort Wayne Medical Education Program.

5.2 Medical students shall be subject to the following rules:

5.2.A Medical students shall provide services under the direct supervision of their medical education directors and/or the Medical Staff members to whom they are assigned.

5.2.B First and second year medical students' activities shall be limited to the observation of patients and training in the taking of patient histories and the performance of physical examinations.

5.2.C Third and fourth year medical students may take histories and perform physicals, provided that records of such activities are countersigned by an attending member of the Medical Staff. Such students may also assist in surgical, obstetrical, and other invasive procedures, provided that such assistance occurs under the direct and continuing supervision of an appropriately credentialed Staff member.

PART VI. DISASTER PLAN

6.1 All physicians on the Medical Staff accept the duties and responsibilities as outlined in the Hospital's master disaster plan.

PART VII. AUTOPSIES

7.1 Autopsies shall be performed with written consent of a relative or legally authorized agent. All autopsies shall be performed by a Board Certified Pathologist or under the supervision of a Board Certified Pathologist. Gross anatomical diagnoses shall be recorded on the medical record within three (3) days and the microscopic diagnoses shall be made part of the medical record within sixty (60) days.

An autopsy should be considered in the following situations:

1. Deaths in which the exact cause of death is not known (cause is sufficiently obscured to delay completion of death certificate).
2. Deaths related to genetically inheritable condition (for purposes of genetic counseling).
3. Deaths in which the autopsy would meaningfully augment medical knowledge.
4. Death incident to or within seven (7) days of obstetrical delivery.
5. Death occurring in patients receiving experimental therapy if autopsy results are considered helpful to evaluation of experimental regimen.
6. When there are concerns about the possible spread of a contagious disease.
7. When death occurs suddenly, unexpectedly, or under mysterious circumstances from apparently natural causes, but does not come under the jurisdiction of a medical examiner or coroner.
8. All neonatal deaths.

PART VIII. DISTRIBUTION

8.1 A copy of these Rules and Regulations shall be made available to each Staff member, practitioner and person granted privileges in any manner or form by the Medical Staff.

PART IX. AMENDMENT

9.1 Amendment

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

9.2 Responsibilities and Authority

The procedures outlined in the Medical Staff Bylaws and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt, and recommend the Medical Staff Bylaws and amendments thereto, and the circumstances under which the Board may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption, and amendment to the Medical Staff Rules and Regulations.

Approved by the Medical Executive Committee on: March 3, 2014

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Chairman, Medical Executive Committee

Approved by the Board of Directors on: March 11, 2014

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Chairman, Board of Directors