LUTHERAN HOSPITAL OF INDIANA
FORT WAYNE, INDIANA

RULES AND REGULATIONS

ADOPTED BY MEDICAL STAFF
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LUTHERAN HOSPITAL
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LUTHERAN HOSPITAL

MEDICAL STAFF

RULES & REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder.

ARTICLE I
ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

1.1(a) Excluding emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership. All practitioners shall be governed by the admitting policy of the hospital. Physician assignment of patients within services shall be on a rotational basis.

1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.

1.1(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of a 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 patient where appropriate. The patient 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 records.

1.1(f) Each member of the Medical Staff with privileges shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of inability to contact the Attending Physician, the following should be contacted, in order of priority listed below:

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The Medical Staff President who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

1.2 PHYSICIAN CLASSIFICATION OR ATTRIBUTION

To ensure consistent physician classification in the medical record for billing, reporting, and patient care.

1.2(a) Definitions

(1) Admitting Physician: The physician who has admitting privileges gives an admitting order for a patient regardless of patient type. Admitting physician can be the same as the attending or it can be different.

(2) Attending Physician: The primary physician who coordinates the patient care and is responsible for the medical portion of the record for each patient, the captain of the patient's stay in the hospital or the outpatient service.

(3) Primary Care Physician (PCP): The physician listed on the patient's insurance cared. If the patient's insurance card does not list a physician, the patient will be asked to provide their primary care physician's name.

(4) Referring Physician: This physician is not caring for the patient but rather referred the patient to another physician for care, e.g., a primary care physician out of the community referred patient to cardiologist for care). This physician should have follow-up communication by the attending physician regarding referral and the course of treatment taken.

(5) Consulting Physician: This physician is asked to provide expertise on the patient's care on an interim basis by the attending physician or other consulting physicians.

(6) Operating Physician: This is primary surgeon of any procedure the patient may have during the stay.

1.2 (b) Procedure for Inpatients

(1) The admitting physician will list the patient status, attending physician and if there is a referring physician on the patient's admitting orders.

(2) Patient Access department will enter admitting, attending, and referring physician upon admission into STAR according to physician orders.

(3) Patient Access department will review insurance card information and enter PCP name into STAR if present. If not present, the patient will need to be interviewed to obtain name of PCP.

1.3 ADMITTING POLICY

All admissions to the hospital shall be arranged through the Stat Transfer Center with the exception of some pediatric patients.

The Level of Care assignment shall be determined by the admitting physician at the time of his/her initial assessment and shall be determined based on information available at the time of the initial assessment. In general, the Level of Care definitions for patients requiring occupancy of an acute bed are as follow:

1.3(a) Outpatient

Medical Observation: Occupancy of an acute bed is required during the time of active, well-defined short-term monitoring, testing, treatment, assessment and/or reassessment performed before the decision can be made to admit as an inpatient or to discharge.

Surgical Observation: Occupancy of an acute bed is required either:

Due to the occurrence of an unexpected prolonged recovery, or an unexpected event during a procedure or recovery from this procedure, which requires further management in an acute bed due to risk, or

Due to need for monitoring longer than the usual recovery period after a non-elective procedure, yet the patient does not meet the definition for inpatient.

Bedded Outpatient: Occupancy of an acute bed is required due to an expected need for monitoring longer than the usual recovery period after an elective procedure, the patient is experiencing no unexpected event, and the patient does not meet the definition for inpatient.

1.3(b) Inpatient

Occupancy of an acute bed is required based on the admitting physician's educated clinical opinion that his/her patient, based on risk and current medical needs, requires inpatient hospital services as defined by an acceptable standard of care.

1.4 TIMELY INITIAL ASSESSMENT OF HOSPITALIZED PATIENTS

Patients admitted to general medical/surgical/pediatric units shall be seen within eighteen (18) hours following admission unless the patient's condition warrants an earlier assessment.

Patients admitted to critical care areas shall be seen by the attending physician as follows:

(1) *Emergent*: Condition requires immediate intervention to stabilize patient or prevent loss of life or limb. In emergent cases, patient shall be seen within one (1) hour.

(2) *Urgent*: High level of concern for a health issue that requires diagnosis or intervention, but would not result in loss of life or limb. In urgent cases, patient shall be seen within four (4) hours.

1.5 PATIENT TRANSFERS

1.5(a) Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;

(2) From any department to a critical care unit in an emergency;

(3) From CRITICAL CARE UNIT 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.

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

1.5(c) When there is no bed available for admission of a patient to an intensive care unit (ICU), and the attending physicians disagree on which patient will be transferred, the following procedure will be followed:

(1) The responsibility for the decision lies with the Chairman of the Critical Care Committee or his designee;

(2) If the attending physician disputes the decision of the committee, the matter shall be referred to the President of the Medical Staff or Chief Medical Officer.

1.6 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:

1.6(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;

1.6(b) The hospital social worker should be consulted for assistance; and

1.6(c) If the patient presents to the emergency room, the steps set forth in Section 1.6(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.

1.7 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.7(a) Patients shall be discharged only on order of the Attending Physician. 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.

1.7(b) If any questions as to the validity of discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.

1.7(c) The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

(2) Estimate of additional length of stay the patient will require; and
(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

1.7(d) The Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patient's transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

(4) The anticipated need for continued care following discharge;

(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.8 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the Attending Physician, another member of the Medical Staff, the Emergency Department Physician or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient's medical record.

1.9 AUTOPSIES

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed

in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

1.10 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patient's treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital's Policy on Disclosure of Treatment Outcomes.

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record should 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 where appropriate. Such plan of care should be discussed with the patient.

2.2 ADMISSION HISTORY

The requirements for admission, history and physical examinations are as outlined in the Medical Staff Bylaws, Article 3.3(p) and the Medical Staff Policy titled "History and Physical".

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam containing the information outlined in Article 3.3(p) of the Medical Staff Bylaws and applicable Medical Staff Policy must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patient's health.

A history and physical performed within thirty (30) days prior to the procedure may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented prior to the procedure.

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be generated electronically, written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission, unless the patient's condition warrants further progress notes on that date.

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered, and any estimated blood loss. Operative/procedural notes shall be completed immediately following surgery or procedure, and the report made a part of the patient's current medical

record within twelve (12) hours after completion of surgery or procedure. An operative progress note must be entered immediately, and before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery or procedure. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief Medical Officer for appropriate action.

2.6 CONSULTATION REPORTS

The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. If the consultant is making a significant change in diagnosis or recommending a substantial change in treatment course especially if this is urgent, a direct communication with the requesting doctor should take place.

2.7 OBSTETRICAL PATIENT HISTORIES

The history for obstetrical patients, when adequately updated with progress notes setting forth the current history and changes in physical findings, shall be accepted as a valid and actual history and physical throughout the hospital for surgery and other procedures related to obstetrical patients.

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key.

Notwithstanding anything contained herein, all orders for medications and all other services shall be documented using an electronic system that supports clinical decision-making when that electronic system is available for use at the Hospital. Such electronic system, when available, will be accessible at the point of care and remotely, through a secure process. Electronic system orders shall be authenticated through the use of an electronic-signature process consistent with applicable legal and accreditation requirements and as specified in these Rules & Regulations and hospital policy.

2.9 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEC and filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.10 FINAL DIAGNOSIS

The final diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations. It shall also be dated and signed by the responsible practitioner at the time of discharge of all patients.

2.11 REMOVAL OF MEDICAL RECORDS

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records, including imaging films, are the property of the hospital and shall not otherwise be removed from the premises. In cases of patient readmissions, all previous records shall be available for the use of the Attending Physician. This shall apply whether the patient is attended by

the same practitioner or by another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.12 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

Any physician on the Medical Staff may request a release of patient information providing that said patient is under his/her care and treatment. Such releases, as a routine matter, will not require a Release of Information form to be signed by the patient. The intent of this Rule & Regulation is to address a physician's need to have information available in his/her office in order to treat patients who may come to his/her office after having been seen, treated or tested at the hospital.

Persons not otherwise authorized to receive medical information shall require written consent of the patient, his/her guardian, his/her agent or his/her heirs.

Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute, and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

2.13 PERMANENTLY FILED MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or AHP(s) or is ordered filed by the MEC, the Chief of Staff or CEO with an explanation of why it was not completed by the responsible practitioner(s) or AHP(s).

2.14 ORDERS

2.14(a) Electronic/Written/Verbal/Telephone Treatment Orders: Orders for treatment shall be completed by electronic order entry (computer physician order entry-CPOE) by the ordering practitioner. Written orders will be utilized during downtime of the CPOE system and must be dated, timed and authenticated.

Verbal/telephone orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, speech therapists, pharmacists and CRNAs may accept verbal/telephone orders relating to their area of practice. 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/telephone order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal/telephone 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, such as during the next patient visit, and in no case longer than forty-eight (48) hours from dictating the verbal/telephone 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.

Verbal orders will generally not be accepted for chemotherapy drug orders, investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. Withdrawing of life support will only be implemented with an order written and authenticated by the prescribing practitioner **AND** in accordance with applicable hospital policies regarding advanced directives.

Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations.

2.14(b) Standing and Preprinted Orders and Order Sets:

(i) Standing Orders: In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed annually by the physician and the Utilization Review Committee. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

(ii) Evidence Based Order Sets: Use of preprinted and electronic order sets that are consistent with nationally recognized and evidence-based guidelines will be permitted in this facility subject to approval by the Medical Staff as outlined below. The Medical Staff delegates to the MEC the responsibility for approval of Evidence Based Order Set templates, in consultation with nursing and pharmacy leadership. Evidence based order set templates shall be periodically reviewed to determine the continuing usefulness and safety of the orders, and may be updated from time to time in order to track regulatory agency requirements, patient safety requirements, and other appropriate changes. The Medical Staff delegates to the MEC in consultation with nursing and pharmacy leadership the responsibility for approving all updates. All such orders shall be dated, timed and authenticated in the patient's medical record pursuant to the requirements of these Rules and Regulations by the ordering practitioner or another practitioner responsible for the care of the patient and authorized to write orders by Hospital policy and state law.

2.14(c) Previous Orders: All previous orders are canceled when patients go to surgery.

2.15 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The death summary, when necessary, must be completed within 48 hours. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.16 DELINQUENT MEDICAL RECORDS

Refer to Medical Staff Policy titled "Medical Record Delinquency" for detailed information on facilitative remedies, corrective action, and suspension.

2.17 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".

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.

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.

2.18 DISCHARGE SUMMARY

A discharge summary shall be written, dictated or completed electronically on all medical records of hospitalized patients. All summaries shall be authenticated by the responsible practitioner and shall include the following:

(1) Name and age of the patient
(2) Dates of admission and discharge
(3) Reason for admission
(4) Significant findings
(5) Procedures performed and treatment rendered
(6) Final diagnosis
(7) Condition of patient at discharge with specific measurable comparison with the condition on admission
(8) Specific patient instructions given to patient and/or family
(9) Instructions relating to physical activity, medication, diet and plans for the follow-up

2.19 FINAL PROGRESS NOTES

A final progress notes may be substituted for the discharge summary in the case of patients with problems of a minor mature who require less than a forty-eight (48) hour period of hospitalization, and in the care of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note shall include the patient's final diagnosis, and any instructions given to the patient and/or family, and the patient's condition on discharge.

2.20 OBSTETRICAL RECORDS

Obstetrical records shall include all available prenatal information. The prenatal record may be a legible, durable original or copy of the attending practitioner's office or clinic record transferred to the Hospital before admission. It should be made available to the hospital at 37 weeks' gestation. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

ARTICLE III
GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The patient business office should notify the Attending Physician whenever such consent has not been obtained. When so notified it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

3.2 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the attending physician or his/her designated alternate at least daily and more frequently if their status warrants. Patients admitted to Critical Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than six (6) hours after admission or sooner if warranted by the patient's condition. Allied Health Professionals such as physician assistants or advance practice nurses with appropriate privileges may round on patients as a supplement to, but not in lieu of, daily rounding by the attending licensed independent practitioner.

3.3 CONSULTATIONS

When further expertise is required for the benefit of optimal patient care, consultations shall be obtained through order of an attending physician or AHP. Consultations shall be accomplished in a timely manner and with appropriate communication and documentation.

3.3(a) Timeliness

(1) *Emergent*: Condition requires immediate intervention to stabilize patient or prevent loss of life or limb. Patient shall be seen within one (1) hour. In emergent cases, physician-to-physician communication is required.

(2) *Urgent*: High level of concern for a health issue that requires diagnosis or intervention, but would not result in loss of life or limb. In urgent cases, patient shall be seen within 4 hours. In urgent cases, physician-to-physician communication is required.

(3) *Non-Urgent*: Expertise of consultant required, but clinical course will not be affected within 18 hour time frame. In non-urgent cases, patients shall be seen within 18 hours.

(4) *Operative procedures*: When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

3.4 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief Medical Officer. If the circumstances are such as to justify such action, the Chief Medical Officer may request a consultation.

3.5 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.6 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed on the hospital formulary. Drugs and medications not on the formulary may be approved for dispensing as outlined in hospital policy. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.
The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

3.7 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital with him/her, those medications which are in oral solid dosage forms, in the original prescription container and within date may be administered by the nursing staff only if the physician indicates in the order for such medication that the home supply may be used in the hospital and if the pharmacist has made a positive identification of the medication and verified appropriateness for use in the hospital. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.8 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, TJC standards, and all hospital policies pertaining to restraints and seclusion.

3.9 PRACTITIONERS ORDERING TREATMENT

When a practitioner who is not a member of the Medical Staff orders treatment (i.e., home health, cardiac rehabilitation, physical therapy, chemotherapy), licensure and Medicare/Medicaid eligibility will be verified. In addition, it will be confirmed that the practitioner is ordering within his/her scope of practice.

3.10 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

Treatment by practitioners of immediate family members or self-treatment should be reserved only for minor illnesses or emergency situations. Practitioners may not self-prescribe or prescribe to immediate family members any controlled substances. Written records must be maintained of any written prescriptions or administration of any drugs. A practitioner may not perform surgery on an immediate family member except in an emergency situation where no viable alternative is available.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

Excluding emergencies, prior to any surgical procedure, a history, physical and other appropriate information, including the preoperative diagnosis and appropriate laboratory tests, must be recorded on the patient's medical record. If not recorded, the operation shall be canceled. In all emergencies, the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

4.2 INFORMED CONSENT

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, and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician. 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. 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. 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.

4.3 PATIENT REQUESTS AND REFUSAL OF TREATMENT

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.

4.4 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in writing.

4.5 SCHEDULING ELECTIVE AND EMERGENCY SURGERIES

Refer to Medical Staff policies titled "Operative/Procedural General Guidelines" and "Scheduling Emergency Surgeries".

4.6 ANESTHESIA

Refer to Medical Staff policy titled "Anesthesia Clinical Service General Policies and Procedures".

4.7 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths, dead on arrival cases, and imminent patient deaths to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.
No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

The attending physician, in collaboration with the designated organ procurement organization, shall determine the appropriate method of notifying the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. Any individual involved in the request for organ, tissue and/or eye donation must be formally trained in the donation request process. The patient's medical record shall reflect the results of this notification.

ARTICLE V
GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Only by those physicians who have training in high risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1(a) Premature infants less than thirty-five (35) weeks gestation, with or without complications;

5.1(b) Premature infants less than 2 kilograms, with or without complications;

5.1(c) All premature infants with complications; and

5.1(d) Full term infants with complications requiring neonatal invasive intervention.

5.2 LABOR AND DELIVERY

Physicians providing pediatric care for newborns delivered via cesarean section or other high risk newborns are required to arrive at the Emergency Department or Labor and Delivery Unit, as applicable, within thirty (30) minutes of initial contact regarding a cesarean delivery or other emergency condition which requires specialized pediatric or neonatal care.

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents to the Emergency Department, she will be assessed by the triage nurse (R.N.) to determine whether the presenting complaint is onset of labor or otherwise pregnancy-related, or a general other complaint unrelated to pregnancy. Patients presenting in labor or with pregnancy-related complaints and meeting the gestational age requirements will be transported to the Labor and Delivery Unit with qualified medical personnel. For patients presenting in labor without complications, the medical screening examination required under Article VI may be performed by a qualified R.N. under the orders of and in telephone contact with the obstetrical physician, where permitted under State law. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the physician concurs with the assessment of the R.N. For patients determined to be in active labor after this screening process is completed by the qualified R.N., or in the event the R.N. feels that the obstetrician's physical presence is necessary to complete the medical screening, the provisions of Section 6.2 regarding consultations, referrals and emergency call shall apply.

5.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.3, above. The nurse shall contact the admitting physician upon any change in the patient's condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within thirty (30) minutes of being requested by the nurse to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants.

5.5 ANESTHESIA SERVICES

The response time for arrival of the CRNA and/or anesthesiologist must not exceed thirty (30) minutes. For patients seeking vaginal birth after previous c-section, appropriate facilities and personnel, including anesthesia and obstetrical surgeon, will be immediately available for emergency c-section.

ARTICLE VI
EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

(1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

(2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician, physician assistant, nurse practitioner, or, in the case of a woman in labor, a registered nurse trained in obstetric nursing where permitted under State law and Hospital policy.

(4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

6.1(b) Stabilization

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

(2) A patient is Stable for Discharge when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or when the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.

(3) A patient is Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

(4) A patient does not have to be stabilized when:

(i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or

(ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.

(5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by an Emergency Department nurse. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(c) Transfer

(1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3) Upon transfer, the Emergency Department shall provide ***a copy of*** appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record.

6.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department, and that person will document the time of the contact in the patient's medical record.

6.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Called the physician's service or other manner as specified by the physician; and

(2) Called once on the physician's pager.

Twenty (20) minutes will be considered a reasonable time to carry out this procedure.

6.2(d) The rotation call list by specialty, containing the names and phone numbers of the on-call physicians shall be kept in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

6.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

6.2(f) All members of the Active and Courtesy Staff shall participate in the on-call backup to the Emergency Department as required by the Board, upon recommendation of the MEC. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active or Courtesy Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in for emergency consult or treatment, they are required to do so within thirty (30) minutes after responding by telephone.

6.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligations therefore, shall be approved by the Board of Trustees and documented in writing.

ARTICLE VII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to bring before the Board formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the CEO, the Board and the community.

7.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular MEC or Medical Staff meeting at which a quorum is 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.

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Rules & Regulations as set forth herein shall be documented by either:

7.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel; or

7.3(b) Restating these Rules & Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which restated Rules & Regulations shall be dated and signed by the Chief of Staff, the CEO, and the Chairperson of the Board of Trustees and approved as to form by Corporate Legal Counsel.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 7.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well being of patients, employees or staff.