RULES AND REGULATIONS

OF

PRESTON MEMORIAL HOSPITAL

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ARTICLE I

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT, AND SERVICES

1.1. Admissions:

(a) A patient may be admitted to the Hospital only by a member of the Medical Staff who has been granted admitting privileges and who has received privileges to perform history and physical examinations. All physicians shall be governed by the official admitting policy of the hospital. (*Admission Policy*)

(b) Except in an emergency, all inpatient medical records must include an admitting diagnosis. In the case of an emergency, the admitting diagnosis shall be recorded as soon as possible.

1.2. Responsibilities of Admitting Physician:

(a) The admitting physician will be responsible for the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the medical record, and necessary patient instructions.

(b) Whenever the responsibilities of the admitting physician are transferred to another physician, a note and order covering the transfer of responsibility will be entered in the electronic medical record. The admitting physician will be responsible for verifying the other physician's acceptance of the transfer.

(c) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients, or Hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm.

(d) Each patient will have two patient identifiers whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

1.3. Care of Unassigned Patients:

In the case where a patient who is evaluated by the Emergency Department requires admission and does not have an attending physician with clinical privileges at the Hospital or has not requested that a specific member of the Medical Staff assume his or her care, the patient will be assigned to the appropriate on-call physician. (*Admission from the Emergency Department Policy*)

1.4. Alternate Coverage:

(a) Physicians will provide professional care for their patients in the Hospital by being available or making arrangements with an alternate member who has appropriate clinical privileges to care for their patients.

1.5. Continued Hospitalization:

(a) The attending physician will be required to routinely document the need for continued hospitalization. The attending physician's documentation must contain:

(1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the Hospital; and

(3) plans for post-hospital care.

(b) Upon request of Case Management, the attending physician will provide written justification of the necessity for continued hospitalization for any patient. The physician should include an estimate of the number of additional days of stay, the reason for continued stay, and plans for post-hospitalization care.

ARTICLE II

MEDICAL RECORDS

2.1. Form and Retention of Records:

(a) A medical record must be maintained for each inpatient and outpatient.

(b) The attending physician will be responsible for the preparation of a timely, complete, accurate, legible, and preferably electronic medical record for each patient under his or her care. This responsibility cannot be delegated.

(c) Only authorized individuals may make entries in the medical record.

(d) Medical records must be retained in accordance with the applicable *Record Retention Schedule Policy*.

(e) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Hospital policy.

(f) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

2.2. Content of Record:

(a) Medical records must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(b) Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures.

(c) Unapproved symbols and abbreviations shall not be used in the Medical Record. (*Acceptable Abbreviations Policy*)

(d) All medical records, except for a short form medical record, must document the following, as appropriate:

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

(2) documentation and findings of assessments;

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

(4) diagnosis, diagnostic impression, or conditions;

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

(6) goals of the treatment and treatment plan;

(7) diagnostic and therapeutic orders;

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

(9) progress notes made by authorized individuals;

(10) reassessments and plan of care revisions;

(11) relevant observations;

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

(13) consultation reports;

(14) allergies to foods and medicines;

(15) medications ordered or prescribed;

(16) dosages of medications administered (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(17) medications dispensed or prescribed on discharge;

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

(19) complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;

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

(21) final diagnosis with completion of medical records within time period designated by medical staff policy.

(e) Medical records must contain, as applicable, the following information:

(1) patient's name, sex, address, date of birth, and name of authorized representative;

(2) legal status of patients receiving behavioral health care services;

(3) patient's language and communication needs;

(4) evidence of known advance directives;

(5) evidence of informed consent when required by Hospital policy;

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

(7) patient-generated information (e.g., information entered into the record over the internet or Patient Portal).

(f) A short form medical record may be used for patients who are in the Hospital less than 48 hours, except in the case of maternity and newborn infants. A short form medical record shall contain at a minimum the following:

(1) documentation of a history and physical;

(2) diagnosis; and

(3) any treatment and services provided.

(g) Medical records must contain evidence of:

(1) a medical history and physical examination completed no more than 30 days before or 24 hours after admission. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission; and

(2) an updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission. This updated examination

must be completed and documented in the patient's medical record within 24 hours after admission and prior to the start of a surgical procedure.

(h) For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, including:

(1) known significant medical diagnoses and conditions;

(2) known significant operative and invasive procedures;

(3) known adverse and allergic drug reactions; and

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

2.3. Medical Orders:

(a) With the exception of downtime episodes, all orders for hospital inpatients, observation patients, extended outpatients, patients in the Emergency Department and in swing beds shall be entered into the Electronic Medical Record (EMR).

(b) All orders, must be dated, timed, and authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy.

(c) Orders must be entered clearly, legibly, and completely. All orders must be authenticated by the individual issuing the order. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering physician and are understood by the appropriate health care provider.

(d) The use of the terms "renew," "repeat," "resume," and "continue" with respect to previous orders is not acceptable.

(e) Orders for "daily" tests will state the number of days and will be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format in which it was originally recorded if it is to be continued.

(f) Orders for all medications and treatments will be under the supervision of the attending physician and will be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

(g) All orders must be completely rewritten or reconciled electronically when a patient is transferred from the critical care unit and when a patient emerges from surgery.

(h) No order will be discontinued without the knowledge of the ordering physician, unless the circumstances causing the discontinuation constitutes an emergency or if are within pharmacy policy/protocol.

(i) All orders for drugs and medications administered to patients will be:

(1) reviewed by the attending physician at least weekly to assure the discontinuance of all drugs no longer needed;

(2) reconciled when the patient goes to surgery; and

(3) reviewed by the pharmacist before the initial dose of medication is dispensed if possible (except in an emergency when time does not permit).

(j) All medication orders must clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or other methods. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten.

(k) A "STOP" order drug policy will be in effect and will apply, among others, to anticoagulants and antibiotics. Orders will be automatically discontinued in accordance with Hospital policy (*Medication Automatic Stop Orders Policy*). This policy will be reviewed annually by the pharmacy department. Notwithstanding the above, a physician is permitted to order any drug for a specific length of time so long as the length of time is clearly stated in the orders.

(l) The physician or APP is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

2.4. Verbal Orders:

(a) A verbal order (either in person or via telephone) for medication or treatment will be accepted only under urgent or emergent circumstances when it is impractical for such an order to be entered electronically (or written if EMR not available) by the responsible practitioner.

(b) Verbal orders shall identify the date and time of entry into the medical record, the names of the individuals who gave, received, and implemented the order, and shall be authenticated promptly, in accordance with time frames established by Hospital policy.

(c) Verbal orders for chemotherapy will not be accepted.

(d) The following are the personnel authorized to receive and record verbal or telephone orders:

(1) a member of the Medical Staff or APP;

(2) a credentialed physician assistant or nurse practitioner as permitted by their clinical privileges and scope of practice;

(3) a professional nurse;

(4) a pharmacist who may transcribe a verbal order pertaining to medications;

(5) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(6) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

(7) a radiology technologist who may transcribe a verbal order pertaining to radiological tests and/or therapy treatments;

(8) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;

(9) a speech therapist who may transcribe a verbal order pertaining to speech therapy;

(10) a nuclear medicine technologist who may transcribe a verbal order pertaining to nuclear medicine;

(11) a diagnostic medical sonographer who may transcribe a verbal order pertaining to diagnostic sonography; and

(12) a certified laboratory technician who may transcribe a verbal order pertaining to laboratory testing.

(e) For verbal or telephone orders or for telephonic reporting of critical test results, the complete order or test result must be verified by having the person receiving the information record and "read-back" the complete order or test result.

2.5. Standing Order Protocols:

(a) For all standing orders, order sets and protocols, review and approval of the Medical Executive Committee is required. Where appropriate, input will be sought from nursing and pharmacy. Prior to approval, the Medical Executive Committee will confirm that the standing order, order sets, and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols. All standing orders, order sets and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

(b) If the use of a standing order, order set or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.

(c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

2.6. Progress Notes:

(a) Progress notes shall be written by the physician and Advanced Practice Providers, as permitted by their clinical privileges or scope of practice. Whenever 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 treatments.

(b) Progress notes will be written at least daily for all patients who have been admitted to the Hospital. However, as an exception, for patients in a designated swing bed status, progress notes must be updated within seven (7) days and the daily requirement does not apply.

2.7. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using electronic signatures.

(b) All entries in the medical record must be dated, timed, and authenticated by the person making the entry. Each entry must be individually authenticated per policy.

(c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries must be individually authenticated as set forth in this section.

2.8. Delinquent Medical Records:

(a) It is the responsibility of each physician to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.

(b) Each medical record, including short stay medical records, will be completed following discharge within the timeline specified per policy (*Medical Record Content and Revisions Policy*). If the record is incomplete after the time specified per policy after discharge, the HIM Department will notify the provider, in writing, of the due date for completing the record. If the record remains incomplete, the provider will be notified in writing of the delinquency and that his or her clinical privileges have been automatically relinquished. The relinquishment will remain in effect until all of the provider's records are no longer delinquent.

(c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges within 30 days from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(d) Any requests for special exceptions to the above requirements will be submitted by the provider to the HIM Department and considered by the Medical Executive Committee.

(e) Except in rare circumstances, when approved by the Chief Administrative Officer or the Clinical Affairs Medical Director, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

ARTICLE III

CONSULTATIONS

3.1. General:

(a) Any individual with clinical privileges at the Hospital may be requested to provide a consultation within his or her area of expertise.

(b) The attending physician will be responsible for requesting a consultation when indicated. Providers requesting an emergency (STAT) consultation shall personally contact the consulting physician when practical and feasible.

(c) If the history and physical are not part of the patient's medical record, it will be the responsibility of the attending physician to provide this information to the consultant.

(d) Once a consulting physician is involved in the care of the patient, the attending physician and consulting physician are expected to review each other's notes on a daily basis until such time as the consultant has signed off on the case or the patient is discharged.

(e) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse will notify his or her superior who, in turn, may refer the matter to the Hospital Administrator on call. The Hospital Administrator may bring the matter to the attention of the CAMD, Department or Section Chief in which the member in question has clinical privileges. Thereafter, the CAMD, Department or Section Chief may request a consultation after discussion with the attending physician.

(f) In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Medical Executive Committee, the Board, the Chief Administrative Officer or the Chief of Staff, the appropriate Department or Section Chief will at all times have the right to call in a consultant or consultants.

3.2. Required Consultations:

(a) Consultations will be required in all non-emergency cases whenever requested by the patient or the patient's representative, if the patient is incompetent.

(b) Except in an emergency, consultations are also required in all cases which, in the judgment of the attending physician:

(1) The patient is not a good risk for operation or treatment;

(2) The diagnosis is obscure after ordinary diagnostic procedures have been completed;

(3) There is doubt as to the best therapeutic measures to be used;

(4) Unusually complicated situations are present that may require specific skills of other practitioners;

(5) The patient exhibits severe symptoms of mental illness or psychosis; or

(6) As required by clinical privileges granted to a physician.

3.3. Contents of Consultation Report:

Each consultation report will be completed in a timely manner and will contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.

3.4. Psychiatric Consultations:

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

3.5. Mandatory Consultations:

(a) When, as a result of peer review activities, a consultation requirement is imposed by the Medical Executive Committee, or the Board, the required consultation will not be rendered by an associate or partner of the attending physician unless no other option available.

(b) Failure to obtain mandatory consultations may result in a further professional review action

3.6. Time Limits:

Routine consultation requests should be seen within twenty-four (24) hours, unless prior arrangements have been made between the two physicians involved. Emergency (STAT) consultation requests should be seen as soon as possible (within 30 minutes), with arrangements being made between the two physicians involved.

ARTICLE IV

DISCHARGE PLANNING
AND DISCHARGE SUMMARIES

4.1. Who May Discharge:

Patients will be discharged only upon an order of the attending physician. Should a patient leave the Hospital against the advice of the attending member, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

4.2. Identification of Patients in Need of Discharge Planning:

(a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning shall be identified at an early stage of hospitalization.

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

(1) functional status;

(2) cognitive ability of the patient; and

(3) family support.

4.3. Discharge Planning:

(a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. When the Hospital's personnel determine no discharge planning is necessary in a particular case, that conclusion must be noted on the medical record of the patient.

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

4.4. Discharge Summary:

(a) A concise discharge summary providing information to other caregivers and facilitating continuity of care shall include the following:

(1) reason for hospitalization;

(2) significant findings;

(3) procedures performed and care, treatment, and services provided;

(4) discharge medication(s)

(5) condition at discharge; and

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

(b) The discharge summary shall be recorded by the discharging physician unless documentation in the physician discharge note states otherwise. Countersignature requirements for discharge summaries appear in *Medical Record Content and Revisions Policy*.

(c) For patients who are being transferred to a nursing facility, another hospital, or an acute rehabilitation center, the discharge summary must be completed at the time of transfer.

4.5. Discharge of Minors and Incapacitated Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

4.6 Against Medical Advice:

If a patient insists on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record and the patient will be asked to sign a "Discharge Against Medical Advice" form.

ARTICLE V

TRANSFERS

5.1. Transfers from The Hospital:

(a) The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable policy and in compliance with all applicable state and federal laws, such as EMTALA.

(b) Before any such transfer occurs, a physician must see the patient and enter a certification in the patient's medical record indicating that the medical benefits to be received at another medical facility outweigh the risk to the patient of being transferred (including, in the case of a woman in labor, the risks to the unborn child).

5.2. All Other Patient Transfers from The Hospital:

(a) General- The process for providing appropriate care for a patient for all other transfers from the Hospital to another facility includes:

(1) assessing the reason(s) for transfer;

(2) establishing the conditions under which transfer can occur

(3) evaluating the mode of transfer/transport to assure the patient's safety; and

(4) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

(b) Procedures- Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

(i) the reason for the transfer;

(ii) the risks and benefits of the transfer; and

(iii) available alternatives to the transfer.

(c) Provision of Information- When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:

(1) reason for transfer;

(2) significant findings;

(3) a summary of the procedures performed, and care, treatment and services provided;

(4) condition at discharge;

(5) information provided to the patient and family, as appropriate; and

(6) working diagnosis.

(d) Patient Requests- When a patient requests a transfer to another facility, the responsible practitioner will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in 5.2.c. above.

A patient will not be transferred to another facility unless prior arrangements for admission have been made.

ARTICLE VI

PHARMACY

6.1 General Rules:

(a) All drugs and medications administered to patients shall be those listed in the latest edition of: "United States Pharmacopeia", "National Formulary", "Physician's Desk Reference", "American Hospital Formulary Service", or "A.M.A. Drug Evaluation" and Hospital formulary.

(b) The use of investigational or experimental drugs in clinical investigations shall be subject to the rules established by the Medical Executive Committee and the Institutional Review Board and as outlined in the approved Hospital formulary.

(c) The pharmacist may dispense the generic equivalent drug which has been accepted for the formulary by the Medical Executive Committee when a trade name is prescribed. A Medical Staff member may object to the use of the generic equivalent for a particular patient and may request the specific product by directly contacting the Pharmacy.

(d) Medication errors and adverse drug reactions will be immediately reported to the attending physician, the director of pharmaceutical services, and reviewed in accordance with applicable Hospital policy.

(e) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use and routes of administration will be readily available to members of the Medical Staff, APPs, and other Hospital personnel.

6.2 Storage and Access:

(a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.

(1) All medications and biologicals will be kept in a secure area and locked unless under the immediate control of authorized staff.

(2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(3) Only authorized personnel may have access to locked or secure areas.

(b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the CAO.

ARTICLE VII

SURGICAL SERVICES

7.1 Organization and Staffing:

(a) The Operating Room manager will be responsible for the administrative supervision of the operating room and will have the authority to plan and execute the daily operating room schedule in order to make maximum efficient use of the operating room and the anesthesia service.

(b) The surgical service must maintain a roster of physicians specifying the surgical privileges of each physician and the operating room register must be complete and up to date.

7.2 Delivery of Service:

(a) The physician responsible for the patient's care shall thoroughly document in the medical record the provisional diagnosis and the results of any indicated diagnostic tests before the operative procedure.

(b) A complete history and physical examination, as outlined in the Medical Staff Bylaws and *Medical Record Content and Revisions Policy*, and properly executed informed consent form must be in the patient's chart prior to the scheduled start time of surgery, except in emergencies.

(c) Properly informed consent is required on each and every patient. Except in the case of emergencies, this consent is to be obtained from the patient or his or her legal representative.

(d) There must be adequate provisions for immediate post-operative care.

(e) Unless otherwise specified by policy, all tissues removed during the operation shall be sent to the hospital pathologistwho shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record. (*Exception Tissue for Pathology Policy*)

(f) In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

(g) An operative procedure report must be performed immediately after an operative procedure and must record:

(1) the name of the primary surgeon/physician(s) and his assistants;
(2) the date of the procedure(s)

(3) procedure(s) performed and description of the procedure(s);

(4) findings;

(5) estimated blood loss;

(6) specimens removed; and

(7) post-operative diagnosis.

If a full report cannot be entered into the record immediately after the operation orprocedure, a post procedure note containing the above information must be entered in the medical record immediately after the procedure.

(h) The completed operative procedure report must be authenticated by the physician responsible for the care of the patient and made available in the medical record within 24 hours after the procedure (if a post procedure note is alternatively used).

(i) The use of approved discharge criteria to determine the patient's readiness fordischarge must be documented in the medical record.

7.3 Dental or Podiatry Care:

(a) If the patient is under the supervision of a podiatrist or an oral surgeon without history and physical privileges, or if the patient to be admitted has medical problems, then the responsibility for the patient is a dual responsibility involving physician members of the Medical Staff.

(b) If an oral surgeon has received privileges to perform the history and physical forthe patient and has determined that the patient does not have any medical problems, then the oral surgeon may admit the patient without a concurrent physician.

(c) A detailed operative report must be prepared by the dentist/podiatrist/oralsurgeon.

(d) Progress notes must be written giving pertinent information about the affectedarea.

(e) The written discharge order and any required discharge summary are the responsibility of the dentist/podiatrist/oral surgeon.

(f) The physician's responsibilities are:

(1) a medical history pertinent to the patient's general health;

(2) a physician examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

ARTICLE VIII

ANESTHESIA AND SEDATION SERVICES

8.1 Organization and Staffing:

(a) The organization of anesthesia services must be appropriate to the scope of theservices offered. Anesthesia must be administered only by:

(1) a qualified anesthesiologist;

(2) a Doctor of Medicine or Osteopathy (other than an anesthesiologist) with appropriate clinical privileges;

(3) a dentist, oral surgeon, or podiatrist who is qualified to administeranesthesia under state law; or

(4) a certified registered nurse anesthetist (CRNA) who is supervised by the operating practitioner or an anesthesiologist who is immediately available.

(b) A sufficient number of qualified staff (in addition to the individual performing theprocedure) must be present to evaluate the patient, help with the procedure, provide the sedation and/or anesthesia, and monitor and recover the patient.

(c) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, anxiolysis, moderate sedation, or analgesia via epidurals/spinals for labor and delivery.

(d) Because it is not always possible to predict how an individual patient will respond to anxiolysis or moderate sedation, a qualified practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

8.2 Pre-operative Procedures:

(a) The following must occur before the operative and other procedures, or theadministration of moderate or deep sedation or anesthesia occurs:

(1) the anticipated needs of the patient are assessed to plan for the appropriatelevel of post-procedure care;

(2) preprocedural education, treatments, and services are provided accordingto the plan for care, treatment, and services;

(3) a licensed independent practitioner, with appropriate clinical privileges,plans or concurs with the planned anesthesia before sedating or anesthetizing a patient;

(4) the patient is identified by the circulating nurse and the anesthetist byanswering to his or her spoken name and date of birth and checking the patient's arm bracelet;

(5) patient is not anesthetized until the surgeon is in the hospital and his or herwhereabouts are known to the OR Coordinator and/or the OR Nurse Manager; and

(6) the patient is reevaluated immediately before moderate or deep sedation and before anesthesia induction to assess the patient's mental status, perform an examination specific to the proposed procedure and to any co-morbid conditions, document the results of an auscultatory examination ofthe heart and lungs, and assess the patient's general health.

(b) A pre-anesthesia evaluation shall be recorded in the medical record by an individual qualified to administer anesthesia immediately prior to surgery. (42 C.F.R. 4 85.639 (b) of the Medicare Conditions of Participation) The evaluation will include information to determine the capacity of the patient to undergo anesthesia and to formulate an anesthesia plan, a review of objective diagnostic data, an interview with the patient regarding his or her medical, anesthetic and drug history, a review of the patient's physical status, and the name of the physician or other licensed independent practitioner who has concurred with theselection of anesthesia or sedative.

8.3 Monitoring During Procedure:

(a) All patients shall be monitored during the procedure and/or administration of moderate or deep sedation or anesthesia. Appropriate methods shall be used to continuously monitor oxygenation, ventilation, and circulation during proceduresthat may affect the patient's physiological status.

(b) Monitoring shall be at a level consistent with the potential effect of the procedureand/or sedation or anesthesia.

(c) All events taking place during the induction and maintenance of, and the emergence from, anesthesia and sedation, shall be documented in the medicalrecord, including:

(1) the dosage and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(4) unusual events during the anesthesia period; and

(5) the status of the patient at the conclusion of anesthesia.

8.4 Post-anesthesia Evaluations:

(a) Patients shall be monitored immediately after the procedure and/or administrationof moderate or deep sedation or anesthesia.

(1) A post-anesthesia follow-up report must be completed and documented by an individual qualified to administer anesthesia prior to discharge from surgery and anesthesia services. CMS CAH Interpretive Guidelines 485.639(b)

(2) A post-anesthesia evaluation note will be documented in the

patient's medical record by an individual qualified to administer anesthesia prior to discharge, whether the patient is an inpatient or outpatient.The post-anesthesia evaluation note will include at a minimum:

(i) Cardiopulmonary status;

(ii) Level of consciousness;

(iii) Any follow-up care and/or observations; and

(iv) Any complications occurring during post-anesthesia recovery.

(b) The number of post-anesthesia visits will be determined by the status of the patient in relation to the procedure performed and anesthesia administered. The anesthesiologist or anesthetist will examine the patient early in the post-operativeperiod and once after complete recovery from anesthesia. Complete recovery willbe determined by the clinical judgment of the anesthesiologist or anesthetist, or the discharging surgeon.

(c) Patients shall be discharged from the recovery area and the Hospital by a qualifiedlicensed independent practitioner or according to rigorously applied criteria approved by the clinical leaders. Post-operative documentation shall record the patient's discharge from the post-sedation or post-anesthesia care area and record the name of the individual responsible for discharge.

(d) Patients who have received sedation or anesthesia in an outpatient setting shall bedischarged to the company of a responsible, designated adult.

(e) When surgical or anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that includeinformation about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

(f) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic

procedures are considered lifesaving.

ARTICLE IX

EMERGENCY SERVICES

9.1 General

Emergency services and care will be provided to any person who comes to the emergency department, as that term is defined in the EMTALA regulations, whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency care will be provided without regard to the patient's insurance status, economic status, or ability to pay for medical services.

9.2. Medical Screening Examinations

(a) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel ("QMP") who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

(1) Emergency Department:
(2) Members of the Medical Staff with clinical privileges in Emergency Medicine;
(3) other Active Staff members; and
(4) appropriately credentialed APPs.

9.3 Documentation Requirements

(a) An appropriate medical record shall be kept for every patient receiving care in the Emergency Department. The record shall include:

(1) Adequate patient identification;

(2) Information concerning the time of the patient's arrival, means of arrival, and by whom transported;

(3) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;

(4) Description of significant clinical, laboratory, and roentgenologic findings;

(5) Diagnosis;

(6) Treatment given or offered;

(7) Condition of the patient on discharge or transfer; and

(8) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

(d) Each patient's medical record shall be signed by the provider in attendance that is responsible for its clinical accuracy.

9.4 Length of Stay in the Emergency Department

(a) When the decision to hospitalize a patient is made, admission should be carried out promptly. Workups for admission to the hospital should not be done in the Emergency Department merely for the sake of convenience. It is the policy of the Hospital that extensive evaluations, prolonged periods of observation, and extraordinary procedures or therapy will not be conducted in the Emergency Department.

9.5 Disaster Plan

(a) Medical Staff is expected to exercise an active role in the Emergency Preparedness Plan. This is through the planning, initiation, and response during an emergency event. Designated Medical Staff are assigned key roles in the Hospital Incident Command Structure (*Incident Command System Policy*) and operate under the job action guidelines for those roles. During an actual emergency event, reporting structures may be altered to comply with the National Incident Management System and local Incident Command System. Staff are expected to comply with training requirements and to respond, when called upon, during emergency events.

(b) There shall be a comprehensive emergency preparedness plan, utilizing an all-hazards approach. This shall follow all Federal, State, and local emergency preparedness requirements. It shall be developed/updated/revised by the designated facility committee.

(c) The emergency preparedness plan (*Management Plan, Emergency Preparedness Policy*) must be reviewed and updated at least every 2 years and must encompass the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach;

(2) Include strategies for addressing emergency events identified by the risk assessment;

(3) Address patient population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans;

(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts or maintain an integrated response during a disaster or emergency situation;

(5) Policies and procedures will be reviewed and updated at least every 2 years to address the following;

- (i) Provision of subsistence needs for staff and patients, whether they evacuate or shelter in place.
- (ii) A system to track location of on-duty staff and sheltered patients.
- (iii) Safe evaluation plans
- (iv) A means to shelter in place for patients, staff, and volunteers who remain in the facility
- (v) A system of medical documentation that preserves patient information, protects confidentiality, and secures and maintains availability of records
- (vi) The use of volunteers in an emergency or other emergency staffing strategies
- (vii) The development of arrangements with other facilities or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services
- (viii) The role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials

(6) A Communication plan (*Communication Plan for Emergency Preparedness Policy*) must be developed and maintained to comply with Federal, State, and local laws and must be reviewed and updated at least every 2 years, including all of the following:

- (i) Names, primary and secondary contact information for staff, contracted service providers, medical staff, other hospitals and facilities, volunteers, Federal, State, tribal, regional, and local emergency preparedness staff and emergency management agencies, and other sources of assistance.
- (ii) Method for sharing information and medical documentation for patients
- (iii) A means, in the event of an evacuation, to release patient information
- (iv) A means of providing information about the general condition and location of patients under the facility's care

(v) A means of providing information about occupancy, needs, and ability to provide assistance to the local authority or Incident Command Center

(7) An emergency preparedness training and testing program will be put in place and be reviewed and updated at least every 2 years. This includes:

(i) Initial Emergency Preparedness training to all new and existing staff, volunteers, or those providing services under arrangement.

(ii) Emergency Preparedness training at least every 2 years and additional training if policies and procedures are significantly updated

(iii) Conduction of Exercises to test the emergency plan at least twice a year including a community-based full-scale exercise or an annual 36 individual facility-based functional exercise (exemptions may apply in the event of an actual emergency). Additional exercise may include a second community or facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop. All exercises must be documented with revisions to the plan as needed.

(8) Emergency and Standby power systems must be implemented, which includes an emergency generator, generator inspection and testing, and emergency fuel supply

ARTICLE X

ETHICAL CONSIDERATIONS

10.1 Ethics Consultation

A consultation regarding ethical issues may be requested of the Medical Executive Committee or Ad Hoc Ethics Committee by all appropriate staff, patients, and, when appropriate, family members or surrogate decision-makers. Prior to consultation, the Ethics Committee shall inform the attending physician of the request.

10.2 Code of Conduct:

The Medical Staff and APPs are expected to comply with the Hospital and Medical Staff codes of conduct.

ARTICLE XI

MISCELLANEOUS

11.1. Special Care Units

For special care units such as recovery rooms, intensive care units of all kinds, coronary care units, and areas of therapy, appropriate committees of the Medical Staff should adopt specific policies. These regulations should be subject to the approval of the Medical Executive Committee and the Board of Directors in the same manner as service rules and regulations.

11.2 Advance Directives

Advance directives include but are not limited to health care proxy, consent to do not resuscitate (DNR) orders, and living will. Members of the Medical Staff and APPs shall comply with all applicable statutory and regulatory requirements. All members of the Medical Staff shall protect and support the patient's rights to formulate health care proxies and other advance directives. (*Advanced Directives for Healthcare Policy*)

11.3 DNR

All members of the Medical Staff and APPs shall comply with all applicable laws and regulations regarding do not resuscitate (DNR). The attending physician is required to document a patient's eligibility and consent for DNR in the patient's medical record and/or designated DNR form. (*Physician Orders for Scope of Treatment/DNR Policy*)

11.4 Autopsies

(a) The Medical Staff should attempt to secure autopsies in accordance with state andlocal laws. Hospital autopsies are only performed when the cases are not under the jurisdiction of the Medical Examiner. The attending physician must be notified when an autopsy is to be performed.

(b) The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by theattending physician or other designated member of the Medical Staff.

(c) Provisional anatomic diagnoses shall be recorded in the medical record within 24 hours and the complete protocol should be made part of the

medical record within 60 days of the procedure.

(d) The Medical Staff shall be actively involved in the assessment of the use of developed criteria for autopsies.

11.5 Deaths

(a) In the event of a hospital death, the deceased shall be pronounced dead as soon as possible after death or birth in the case of fetal death, if the period of gestation is greater than 20 weeks. The attending physician or his designee is responsible for pronouncement and notifying the next of kin in a timely fashion.(b) The death certification must be signed by the attending physician or covering physician unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner.

(c) Reporting of deaths to the Medical Examiner's office shall be carried out when required by, and in conformance with applicable statute and per policy.

(d) A death summary must be entered into the medical record and must contain the following:

(1) any intervention on the part of the physician, APP, or registered nurse in attendance at the time of death;

(2) physical findings leading to ascertainment of death;

(3) documentation of interaction with family or responsible party regarding an autopsy.(e) The body may not be released until an appropriate entry by the physician has been made and signed in the patient's medical record. The disposition of the body is then in accordance with the patient/family request unless it is a Medical Examiner's case in which state law and policies are followed.

11.6. Self-Treatment and Treatment of Family Members:

(a) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) No member of the Medical Staff or APP Staff will admit, treat, or participate in surgery of a member of his or her immediate family, including spouse, parent, child, or sibling. This prohibition is not applicable to in-laws or other relatives.

(c) An exception to this prohibition will be made if the patient's disease is so rare or exceptional and the physician is considered an expert in the field or in an emergency situation.

11.7. Orientation of New Physicians:

(a) Each new physician will be assigned by the appropriate Department Chief to a member of the Medical Staff for purposes of orientation to the Hospital and its environment.

(b) The Hospital medical records department and nursing service will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties

11.8 Release of Patient Information to Press/Media

The Hospital administration is responsible for initiating and handling all press/media inquiries about patients, clinical developments, research, and all other Hospital matters. All staff members should consult with administration prior to any press contact. (*Media Policy)*

11.9 Legal Affairs:

(a) Service of Legal Papers

When members of the Medical or APP Staff are served any legal paper concerning their clinical activities at the Hospital, they should immediately notify Legal Counsel of the Hospital.

(b) Contact by Investigator

A provider contacted by any government or private investigator regarding patient care activities within the Hospital should contact Hospital Administration and/or Legal Counsel of the Hospital before submitting to questioning.

(c) Findings Reportable to Government Agencies

Providers are responsible for reporting a variety of diseases and crime-related wounds and injuries to the police, Coroner, or other government agencies.

11.10 HIPAA Requirements:

All members of the Medical Staff and APPs will:

(a) adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information; and

(b) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.

ARTICLE XII

ADOPTION

These rules and regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

They may be amended pursuant to the process set forth in the Medical Staff Bylaws.

Adopted by the Medical Staff on:

Date: _____

_____

Chief of Staff

Approved by the Board on:

Date: _____

_____

Chairperson, Board of Directors