MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

MEDICAL STAFF
RULES AND REGULATIONS

COVENANT MEDICAL CENTER

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ARTICLE I

DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Credentials Policy:

(a) "Admitting Physician" means the physician who orders the admission of a given patient to the Hospital.

(b) "Ambulatory Care" means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.

(c) "Ambulatory Care Location" means any department in the Hospital or provider-based site or facility where ambulatory care is provided.

(d) "Attending Physician" means the patient's primary treating physician or his or her designee(s) (e.g., the attending physician's covering physician or an appropriately privileged allied health professional), who shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring practitioner, if any, and the patient's family.

(e) "Practitioner" means, unless otherwise expressly limited, any appropriately credentialed physician, dentist, oral surgeon, podiatrist, or allied health professional, acting within his or her clinical privileges or scope of practice.

(f) "Responsible Practitioner" means any practitioner who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These

responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND

CARE, TREATMENT AND SERVICES

2.A. ADMISSIONS

(1) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges. All Medical Staff members will be governed by the official admitting policy of the Hospital.

(2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than 24 hours after admission.

(3) Patients will be admitted based on the following order of priority:

(a) **Emergency** – as designated by the attending physician;

(b) **Urgent** – as designated by the attending physician;

(c) **Preoperative Admissions** – includes patients already scheduled for surgery or other special procedures; and

(d) **Routine Elective Admissions.**

(4) With the exception of pediatric trauma, patient under 13 years will not be admitted to the Hospital unless the patient requires services not available at Covenant Children's Hospital. Pediatric trauma patients will be admitted in accordance with established trauma guidelines.

(5) 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.

2.B. EMERGENCY ADMISSIONS

(1) A patient to be admitted on an emergency basis who does not have a private physician may request any Medical Staff member in the applicable department to attend to him/her.

(2) Where no such request is made, a physician will be assigned from the applicable department, on a rotational basis, from a schedule furnished by each Department Chair.

(3) The on-call physician or their call designee will assume responsibility for evaluating and treating any patient accepted while on-call, including patients who arrive at the Hospital after the physician's call time has expired, as well as patients to be seen in the physician's office on the following day or as appropriate.

2.C. ADMISSIONS TO SPECIAL CARE UNITS

(1) Cardiac Care Unit. Patients may be admitted to the Cardiac Care Unit by internists, cardiologists, and cardiovascular surgeons with admitting privileges. Other physicians may admit to these units only with immediate orders for a consultation with an internist, cardiologist, or cardiovascular surgeon.

(2) Intensive Care Units. Patients may be admitted to the Intensive Care Units by any practitioner with admitting privileges. Appropriate consultations are recommended.

2.D. PATIENT TRANSFERS

(1) Patients will be transferred in the Hospital according to the following priorities:

(a) From general care area to Intensive Care or Cardiac Care;

(b) From Emergency Department or Recovery Room to appropriate patient bed;

(c) From any special care unit to a general care area when medically indicated;

(d) From Intensive Care and Cardiac Care unit to general care areas; and

(e) From temporary placement in an inappropriate area to an appropriate area.

(2) All transfers must be ordered or approved by the attending physician. Should an appropriate transfer area not be available, the attending physician may bring this matter to the attention of the CMO.

2.E. ADMISSIONS IN NEED OF MENTAL HEALTH SERVICES

(1) A patient with known or suspected suicidal tendencies will be admitted to the Women's and Children's Mental Health Unit unless the patient's medical condition requires medical stabilization.

(2) For such length of time as a patient with known or suspected suicidal tendencies is required to be on a medical or surgical floor, twenty-four (24) hour nursing companionship will be provided.

(3) Patients with known or suspected tendencies to injure others will be admitted to the Women's and Children's Mental Health Unit unless their medical condition requires medical stabilization.

(4) For such length of time as a patient with known or suspected tendencies to injure others is required to be on a medical or surgical floor, twenty-four (24) hour nursing companionship will be provided. If necessary, law enforcement authorities will be summoned to ensure protection of all concerned.

(5) All patients described in (1) and (3) above will be offered immediate psychiatric care and

the record must contain clear evidence that such referral was offered, whether or not the patient or his family rejects such care.

2.F. RESPONSIBILITIES OF ATTENDING PHYSICIAN

(1) The attending physician will be responsible for the following while in the Hospital:

(a) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);

(b) personally rounding on his or her patients on a daily basis or arranging for another physician to personally round on the physician's patient on a daily basis;

(c) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;

(d) communicating with the patient's third-party payor, if needed;

(e) providing necessary patient instructions;

(f) responding to inquiries from Utilization Review professionals regarding the plan of care in order to justify the need for continued hospitalization;

(g) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate; and

(h) performing all other duties described in these Rules and Regulations.

(2) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the

attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer and updating the attending physician screen in the electronic medical record ("EMR").

(3) For admissions that are 20 days or more, or outlier cases, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:

(a) authentication of the admitting order;

(b) the reason for the continued hospitalization or the special or unusual services for a cost outlier case;

(c) the expected or actual length of stay of the patient; and

(d) the plans for post-hospital care, when appropriate.

2.G. AVAILABILITY AND ALTERNATE COVERAGE

(1) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.

(2) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:

(a) Calls/texts from the Emergency Department – must respond by telephone or text message within 30 minutes of being contacted and, if requested, must personally see a patient at the Hospital within 30 minutes of the request;

(b) Patients Admitted to an Intensive Level of Care – must personally see the patient within two hours of admission;

(c) All Other Inpatient Admissions – must personally see the patient within 12 hours of admission.

(3) All physicians (or their appropriately credentialed designee) will be expected to comply with the patient care guidelines regarding consultations outlined in Article 6 of these Medical Staff Rules and Regulations.

(4) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

(5) If the attending physician is not available, the CMO, the Chief of Staff, or the administrator on call will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.H. CONTINUED HOSPITALIZATION

(1) The attending physician will provide whatever information may be requested by the Utilization Management Department with respect to the continued hospitalization of a patient, including:

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

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

(c) plans for post-hospital care.

This response will be provided to the Utilization Management Department within one week of the request. Failure to comply with this requirement will be reported to the Leadership Council for appropriate action.

(2) If the Utilization Management Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the CMO may be consulted.

ARTICLE III

MEDICAL RECORDS

3.A. GENERAL

A medical record will be prepared for every patient receiving care at the Hospital. Each practitioner who is involved in the care of a patient will be responsible for the timely, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

3.B. MEDICAL RECORD ENTRIES

3.B.1. Entries:

Electronic entries will be entered through the EMR and/or Computerized Provider Order Entry ("CPOE") in accordance with Hospital policy. Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including handwritten entries, must be timed, dated and signed.

3.B.2. Authentication:

Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for electronic entries. Each practitioner who is authorized to make entries in the medical record will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy. Signature stamps are not an acceptable form of authentication for written orders and other medical record entries. Written signatures must include the responsible practitioner's identification number.

3.B.3. Forms:

All forms and templates used for medical record documentation, both printed and electronic, shall be approved by the Health Information Management ("HIM") Committee.

3.B.4. Abbreviations:

Only generally accepted terminology, definitions, abbreviations, acronyms, symbols, and dose designations shall be used in the medical record. The use of individualized abbreviations is discouraged in order to avoid misinterpretation and confusion regarding the care of the patient.

3.B.5. Clarity, Legibility, and Completeness:

All entries in the medical record shall be clear, legible and complete so that other members of the health care team are able to understand the entry and the author's intentions.

3.B.6. Correction of Errors:

When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial entry. Any error made while entering an order in the CPOE should be corrected by entering another order. Handwritten entries in the medical record will be corrected by making a single line through the original entry and making any necessary addition/correction. Any addition/correction will be timed, dated and signed by the author.

3.B.7. Copying and Pasting:

Copying and pasting between notes is strongly discouraged. In any instance where text is copied from a prior note, it must be properly updated.

3.B.8. Inadequate Information:

When inadequate information is provided in the progress notes on a denied claim, the Utilization Management Department may request that the attending physician submit a written medical justification within 24 hours.

3.C. ACCESS TO RECORDS

3.C.1. Ownership of Record:

Medical records are the physical property of the Hospital and shall not be removed from the premises except by a subpoena, court order or in accordance with federal and state law and Hospital policy. Unauthorized removal of Hospital patient records from the Hospital facilities may be grounds for disciplinary action.

3.C.2. Permanent Filing of Medical Records:

A medical record will not be permanently filed until it is completed by the responsible practitioner, or it is ordered to be filed by the HIM Committee under the direction of the MEC. In rare circumstances the MEC may complete a medical record on an unfamiliar patient in order to permanently file that record.

3.C.3. Authorized Individuals:

The following individuals are authorized to document in the medical record:

(a) attending physicians, resident physicians, intern physicians and allied health professionals;

(b) nursing providers, including registered nurses ("RNs") and licensed practical nurses ("LPNs");

(c) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

(d) students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical students, nursing students) if that documentation is reviewed and countersigned in a timely manner by the student's supervisor, who must also be authorized to document in the medical record; and

(e) non-clinical and administrative staff, as appropriate, pursuant to their job description.

3.C.4. Access:

A Medical Staff Member may have access to a patient's medical records without patient authorization when:

(a) The physician is currently involved in the care and treatment of the patient.

(b) Legal action is pending between the patient whose record is being requested and the physician requesting the record.

(c) Review of the medical record is used for Board approved peer or quality review, credentialing, or research.

(d) An employee or agent of the Hospital may have access to medical records only as a function of patient care, billing, or as a review function. Federal and state review agencies and the Joint Commission on the Accreditation of Healthcare Organizations may be authorized to review medical records subject to governing law.

(e) The Hospital chart may not be reviewed by a Medical Staff Member in conjunction with physicians of other hospitals or other medical care institutions. A case presentation without chart review is permissible if the patient's identity cannot be determined.

ARTICLE IV

CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

4.A. CONTENT OF MEDICAL RECORD

4.A.1. General Requirements:

All medical records for patients receiving care in the hospital setting or at an ambulatory care location will document the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(b) legal status of any patient receiving behavioral health services;

(c) patient's language and communication needs, including preferred language for discussing health care;

(d) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or "Do Not Resuscitate" ("DNR") order;

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

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

(g) admitting history (i.e., source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies to foods and medicines;

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

(j) diagnosis, diagnostic impression, or conditions;

(k) goals of the treatment and treatment plan;

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

(m) progress notes made by authorized individuals;

(n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(o) consultation reports;

(p) operative procedure reports and/or notes;

(q) any applicable anesthesia evaluations;

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

(s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(t) reassessments and plan of care revisions;

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

(v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and

(w) medications dispensed or prescribed on discharge.

4.A.2. Financial Information:

The Hospital will maintain financial records separate and apart from the patient's medical records that state total charges and expected sources of payment.

4.A.3. Progress Notes:

(a) Progress notes shall be written by the attending physician or his or her covering practitioner. They may also be written by an Allied Health Professional as permitted by his or her clinical privileges or scope of practice and then reviewed, revised, and cosigned by the attending physician in a timely manner. 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 completed by the attending service at least daily for all patients who have been admitted to the Hospital and shall be dated, timed, and legible.

4.A.4. Consultative Reports:

(a) Consultation reports will be completed in a timely manner and will contain a dictated or legible 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.

(b) When non-emergency operative procedures are involved, the consultant’s report will be recorded in the patient’s medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

4.A.5. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

4.A.6. Informed Consent:

(a) A general consent form for diagnosis or treatment, signed by the patient or legally authorized individual, on behalf of every patient admitted to the Hospital must be obtained at the time of admission. The admitting officer should notify the attending physician whenever such consent has not been obtained.

(b) In addition to obtaining the patient's general consent for diagnosis or treatment, a separate consent that informs the patient of the nature of any special treatment or surgical procedure will be obtained prior to special treatment or surgery.

4.A.7. Operative Procedure Reports:

An operative procedure report must be dictated or written in accordance with Article 7 of these Rules and Regulations.

4.A.8. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient’s medical record on appropriate paper or electronic forms in accordance with Article 8.

4.A.9. Obstetrical Records:

(a) Medical records of obstetrical patients will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

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

(2) findings during the prenatal period;

(3) the medical and obstetrical history;

(4) observations and proceedings during labor, delivery, and postpartum period; and

(5) laboratory and x-ray findings.

(b) The obstetrical record will include a complete prenatal record. The prenatal care record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.A.10. Newborn Records:

Medical records of newborn patients will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) mother's name and hospital identification number;

(b) date and hour of birth;

(c) birth weight and length;

(d) period of gestation;

(e) sex;

(f) condition of infant on delivery (e.g., APGAR score);

(g) record of ophthalmic prophylaxis (or refusal of the same); and

(h) physical examination at birth and at discharge.

4.A.11. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

4.A.12. Outpatient Service Records:

(a) If needed the medical records of patients who have received ambulatory care services will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation is the responsibility of the outpatient physician:

(1) identification data, including the patient's name, sex, address, date of birth, marital status, religious preference and name of authorized representative;

(2) date and time of arrival;

(3) date and time of departure;

(4) service date;

(5) known significant medical diagnoses and conditions;

(6) known significant operative and invasive procedures;

(7) known adverse and allergic drug reactions;

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

(9) principal and other diagnoses;

(10) treatment plan;

(11) procedures performed;

(12) expected source of payment;

(13) disposition of patient;

(14) medical history, including: immunization record, screening tests, allergy record, nutritional evaluation, neonatal history for pediatric patients;

(15) physical examination report;

(16) consultation reports;

(17) clinical notes, including dates and times of visits;

(18) treatments and instructions, including notations of prescriptions written, diet instructions, if applicable, self-care instructions;

(19) reports of all laboratory tests performed, reports of all X-ray examinations performed, written record of preoperative and postoperative instructions;

(20) operative report on outpatient surgery, including preoperative and postoperative diagnosis, description of findings, techniques used and tissue removed or altered, if appropriate;

(21) anesthesia record, including preoperative diagnosis, if anesthesia is administered;

(22) pathology report, if tissue or body fluid was removed;

(23) clinical data from other providers;

(24) referral information from other agencies; and

(25) all consent forms.

(b) Clinical documentation for ambulatory care services should be completed on the day of the patient visit but no later than 48 hours from the visit.

4.A.13. Emergency Care:

Medical records of patients who have received emergency care should contain the information outlined in this section, as relevant and appropriate to the patient's care. The emergency record shall be documented at the time of service but no later than immediately following

discharge/transfer of the patient from the Emergency Department. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(b) patient's language and communication needs, including preferred language for discussing health care;

(c) time and means of arrival;

(d) record of care prior to arrival if known and relevant;

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

(f) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his arrival at the Emergency Department;

(g) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;

(h) treatment given, if any;

(i) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

(j) if the patient left against medical advice; and

(k) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

4.B. TIMELINESS OF DOCUMENTATION

(1) It is the responsibility of any practitioner involved in the care of a patient to prepare and complete medical records in a timely fashion in accordance with these Rules and Regulations and all other relevant policies of the Medical Staff.

(2) Medical records will be completed within 30 days following the patient's discharge or they will be considered delinquent. After 30 days the practitioner's name will appear on the Medical Records Suspension List, and the Medical Records Department will inform the practitioner of the delinquency by either voice telephone call, telephone message, or text message.

(3) If the medical records are still delinquent on day 52 (22 days on the Medical Record Suspension List), the Medical Records Department will notify the Section Chief. The Section Chief will talk to the provider about the delinquent medical records either in person or by phone. The Section Chief will then text confirmation of this conversation to the Head of Medical Records.

(4) If the medical records are still delinquent on day 60 (30 days on the Medical Records Suspension List), the Medical Records Department will notify the Department Chair. The Department Chair will talk to the provider about the delinquent medical records either in person or by phone. The Department Chair will then text confirmation of this conversation to the Head of Medical Records. Also on day 60 the Medical Records Department will send a letter via certified mail to the provider about the delinquent medical records and place a copy in the practitioner's file.

(5) If the medical records are still delinquent on day 75 (45 days on the Medical Records Suspension List), the Medical Records Department will notify the Chief Staff. The Chief of Staff will talk to the provider about the delinquent medical records either in person or by phone. The Chief of Staff will then text confirmation of that conversation to the Head of Medical Records. Also on day 75 the Medical Records Department will send a letter via certified mail to the provider about the delinquent medical records and place a copy in the practitioner's file. The Medical Records Department will inform the provider via text or phone call that the letter has been sent.

(6) If the medical records are still delinquent on day 90 (60 days on the Medical Records Suspension List), the Medical Records Department will notify the MEC that the practitioner is now subject to an automatic relinquishment of privileges pursuant to 6.E.1 of the Credentials Policy unless the Leadership Council recommends a waiver due to unforeseen circumstances such as military deployment, the death of an immediate

family member, a health issue, or some other circumstance that prevents the practitioner from handling their affairs in a timely manner.

(7) If a physician has any questions about completing medical records or needs help, he or she can contact the Head of Medical Records or the Chief of Staff.

(8) When a physician is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the physician's credentials file.

ARTICLE V

MEDICAL ORDERS

5.A. GENERAL

(1) Orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE, except when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR.

(2) All orders (including verbal/telephone orders) must be:

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering practitioner, with the exception of a verbal order which may be countersigned by another practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication; and

(c) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

(3) All previous orders are automatically cancelled when a patient goes to surgery.

(4) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.

(5) Orders issued by an Allied Health Professional will be countersigned/authenticated by his or her supervising physician in accordance with Hospital policy and his or her written supervision or collaborative agreement (if any).

5.B. ORDERS FOR TESTS AND THERAPIES

(1) Orders for tests and therapies will be accepted only from:

(a) members of the Medical Staff; and

(b) Allied Health Professionals to the extent permitted by their licenses and clinical privileges.

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

(3) Outpatient orders for physical therapy, rehabilitation, or laboratory services may also be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

5.C. ORDERS FOR MEDICATIONS

(1) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations. When medication is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered.

(2) A notation is to be placed in the chart twenty-four (24) hours prior to indicate that medications will require renewal to be continued. The physician who prescribed the

drug or biological will write renew order or so indicate which of the medications listed he or she wishes to continue, otherwise, there will be an automatic cancellation of these drugs.

(3) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(4) A medication reconciliation should be completed as follows:

(a) at the time of admission – review home medication list and consider the information when writing the admission medication orders;

(b) when transferring a patient to a different level of care – review current medication orders and modify the orders based on the patient's current condition and responses to prior treatment; and

(c) when discharging a patient – review the home medication list and the current medication list when documenting and prescribing the discharge medications.

The individual performing the reconciliation will use the EMR when performing the above. Any medication discrepancies are to be resolved.

(5) Allied Health Professionals may be authorized to issue medication orders as specifically delineated in their clinical privileges.

5.D. VERBAL ORDERS

(1) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.

(2) For orders given over the telephone, the ordering practitioner must identify themselves and their credentials.

(3) All verbal orders will include the date and time of entry into the medical record, identify the names and titles of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.

(4) Authentication will take place by the ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital before the ordering practitioner leaves the patient care area for verbal orders given in person.

(5) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.

(6) Verbal orders may be received and recorded by personnel as authorized by law or their scope of practice.

5.E. SELF-ADMINISTRATION OF MEDICATIONS

(1) The self-administration of medications (either hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:

(a) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

(b) a practitioner responsible for the care of the patient has issued an order permitting self-administration;

(c) in the case of a patient's own medications, the medications will be visually evaluated to ensure integrity; and

(d) the patient's first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.

(2) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(3) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.

(4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

5.F. STOP ORDERS

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders and automatically discontinued as follows:

(1) on all oxytoxics after 24 hours;

(2) narcotics (DEA Schedule II) after 48 hours;

(3) all soporifics and sedatives (DEA Schedules II, III, IV), anticoagulants, corticosteroids and antibiotics after seven days;

(4) all other medications after 14 days; and

(5) inhalation therapy treatments will automatically be discontinued after three days.

The prescribing practitioner will be notified within 12 hours before an order is automatically stopped.

5.G. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

(1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital.

(2) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

5.H. DO NOT RESUSCITATE ("DNR") ORDERS

The Hospital's current Do Not Resuscitate – Impatient Policy is PolicyStat ID: 9914454. The practitioner should contact the Director of Risk Management with any questions about the policy.

5.I. HYPERALIMENTATION ORDERS

All initial hyperalimentation orders will be authenticated by the ordering physician. Subsequent orders for changes and adjustments to the hyperalimentation may be recorded in the physician order section of the medical record by the pharmacist. The attending physician will review and revise (if he or she disagrees with the pharmacist) any changes.

5.J. DISCHARGE ORDER

Patients shall be discharged only upon the order of the attending physician or another physician acting as his/her designee in accordance with Article 12.

ARTICLE VI

CONSULTATIONS

6.A. REQUESTING CONSULTATIONS

(1) The attending physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant.

(2) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. For critical care consults (e.g., "STAT" or "urgent"), the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.

(3) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed under the Professional Practice Evaluation Policy or other applicable policy.

(4) Where a consultation is required for a patient in accordance with these Rules and Regulations or is otherwise determined to be in patient's best interest, the Chief of Staff has the right to call in a consultant.

6.B. RESPONDING TO CONSULTATION REQUESTS

(1) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. The individual, or a member of his or her coverage group, will respond to the request. In either case, the individual responding to a request ("consulting physician") is expected to respond in accordance with the following patient care guidelines:

(a) Critical Care Consults (e.g., "stat," or "urgent") must include personal contact by the requesting individual to the consulting physician. The consulting physician

must then complete the consult within a reasonable time based upon the information provided by the individual requesting the consult; and

(b) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians.

(2) The consulting physician may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, an evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame.

(3) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician.

(4) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed under the Professional Practice Evaluation Policy or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation. If a consultation physician is unable to accept the consult for one of these reasons, the consulting physician must inform the requesting physician of that fact:

(a) the physician has arranged for appropriate coverage;

(b) the physician has a valid justification for his or her unavailability (e.g., out of town);

(c) the patient has previously been discharged from the practice of the physician;

(d) the patient requests another appropriate consultant; or

(e) other factors indicate that there is a conflict between the physician and the patient (e.g., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (a)-(e)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the Section Head, the Chief of Staff, or the CMO will appoint an alternate consultant.

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

(6) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the Section Head, the Chief of Staff, or the CMO.

6.C. REQUIRED AND RECOMMENDED CONSULTATIONS –

GENERAL PATIENT CARE SITUATIONS

(1) Consultations are required in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient lacks decisional capacity, after discussing the request with the attending physician.

(2) Except in emergency cases, consultations are recommended in cases in which, in the judgment of the attending physician:

(a) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(b) there is doubt as to the best therapeutic measures to be used;

(c) unusually complicated situations are present that may require specific skills of other practitioners;

(d) the patient exhibits severe symptoms of mental illness or psychosis; or

(e) the patient is not a good medical or surgical risk.

Additional requirements for consultation may be established by the Hospital as required.

6.D. MENTAL HEALTH CONSULTATIONS

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

6.E. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, must be placed in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed unless the attending physician or surgeon states in writing that an emergency situation exists.

ARTICLE VII

SURGICAL SERVICES

7.A. PRE-PROCEDURAL PROCEDURES

(1) The attending surgeon will thoroughly document in the medical record the provisional diagnosis and the results of any indicated diagnostic tests before the operative procedure.

(2) Except in emergencies, a complete history and physical examination and properly executed informed consent form must be in the patient's chart prior to the scheduled start time of surgery. If not recorded, the operation will be canceled. In an emergency, the attending surgeon will make at least a definitive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

(3) 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.

(4) Except in emergencies, all procedures involving laterality will require the attending surgeon's confirmation of the correct site prior to transporting the patient to the Operating/Procedure Room. The attending surgeon will confirm the correct site by signing his initials with an indelible marking pen verifying laterality on the patient within the surgical field. For cases involving identification of levels/sides of the spine, an instrument will be placed at the proposed surgical site and an x-ray taken. The x-ray will be read and reported immediately by a staff radiologist for confirmation.

(5) In all operative and invasive cases, the procedure will not be started until the surgeon, the anesthesiologist, and the circulator have verbally confirmed and recorded the following:

(a) Correct patient;

(b) Correct procedure; and

(c) Correct side/approach, if applicable per Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.

(6) In those patients who are found to be difficult to intubate, and/or in those patients who might be difficult to re-intubate in the event of a medical emergency following extubation, the anesthesiologist or pulmonologist will indicate this fact by placing a colored flag directly on the endotracheal tube at the time of the initial intubation. This flag should be placed in such a manner as to be clearly visible to all those practitioners subsequently involved in the care of the patient.

7.B. POST-PROCEDURAL PROCEDURES –

INPATIENT AND OUTPATIENT

(1) An operative procedure report must be dictated or written immediately after an operative procedure and entered into the record. The operative procedure report shall include:

(a) the patient's name and hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) the name of the attending surgeon and assistant surgeon(s) responsible for the patient's operation;

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

(f) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;

(g) findings, where appropriate, given the nature of the procedure;

(h) estimated blood loss;

(i) any unusual events or any complications (e.g., blood transfusion reactions) and the management of those events;

(j) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

(k) specimen(s) removed, if any;

(l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(m) the signature of the attending surgeon.

(2) If a full operative procedure report cannot be entered into the record immediately after the operation or procedure, a progress note including the following information must be entered into the medical record by a physician (attending surgeon or resident only) immediately after the procedure:

(a) the names of the physician(s) responsible for the patient's care and physician assistants;

(b) the name and description of the procedure(s) performed;

(c) findings, where appropriate, given the nature of the procedure;

(d) estimated blood loss, when applicable or significant;

(e) specimens removed; and

(f) post-operative diagnosis.

In such situations, the full operative procedure report must be entered or dictated within 24 hours.

ARTICLE VIII

ANESTHESIA SERVICES

8.A. GENERAL

(1) Anesthesia may only be administered by the following qualified practitioners:

(a) an anesthesiologist;

(b) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;

(c) an oral surgeon or podiatrist, in accordance with state law; or

(d) a CRNA or a CAA who is supervised by an anesthesiologist who is immediately available.

(2) An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).

(3) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep or moderate sedation. "Anesthesia" does not include topical or local anesthesia, minimal sedation (i.e., a drug-induced state during which patient responds normally to verbal commands and ventilator and cardiovascular functions are unaffected), or analgesia via epidurals/spinals for labor and delivery.

(4) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or conscious 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.

(5) Anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

8.B. PRE-ANESTHESIA PROCEDURES

(1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

(2) The evaluation will be recorded in the medical record and will include:

(a) a review of the medical history, including anesthesia, drug and allergy history;

(b) an interview, if possible, preprocedural education, and examination of the patient;

(c) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(d) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

(e) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(f) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (a) and (b) must be performed within the 48-hour time frame. The elements in (c) through (f) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

(3) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

8.C. MONITORING DURING PROCEDURE

(1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor the patient per current ASA standards.

(2) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(a) the name and Hospital identification number of the patient;

(b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

(c) the name, dosage, route time, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

8.D. POST-ANESTHESIA EVALUATIONS

(1) In all cases a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).

(3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(b) cardiovascular function, including pulse rate and blood pressure;

(c) mental status;

(d) temperature;

(e) pain;

(f) nausea and vomiting; and

(g) post-operative hydrations.

(4) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

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

8.E. MINIMAL, MODERATE OR CONSCIOUS SEDATION

All patients receiving minimal, moderate or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

8.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE IX

STERILIZATION AND TERMINATION OF PREGNANCY

RESERVED

ARTICLE X

PHARMACY

10.A. GENERAL RULES

(1) Orders for drugs and biologicals are addressed in the Medical Orders Article.

(2) Adverse medication reactions and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, is to be administered for the same purpose and in the same manner, and is approved by the ordering physician.

(4) All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations, and hospital formulary. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the FDA.

(5) 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, Allied Health Professionals and other Hospital personnel.

10.B. STORAGE AND ACCESS

(1) 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.

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

(b) 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.

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

(2) 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 CEO.

ARTICLE XI

EMERGENCY SERVICES

11.A. GENERAL

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

11.B. MEDICAL SCREENING EXAMINATIONS

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

(a) Emergency Department:

(i) members of the Medical Staff with clinical privileges in Emergency Medicine;

(ii) other Active Staff members; and

(iii) appropriately credentialed Allied Health Professionals.

(2) The results of the medical screening examination must be documented within 48 hours of the conclusion of an Emergency Department visit.

11.C. ON-CALL RESPONSIBILITIES

It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Hospital policies and procedures.

ARTICLE XII

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

12.A. WHO MAY DISCHARGE

(1) Patients will be discharged only upon the order of the attending physician or another physician acting as his/her designee.

(2) At the time of discharge, the discharging physician will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(3) 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.

12.B. DISCHARGE PLANNING

(1) 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. The responsible practitioner is expected to participate in the discharge planning process.

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

12.C. DISCHARGE SUMMARY

(1) A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All

discharge summaries will include the following and must be completed within 30 days of discharge:

(a) reason for hospitalization;

(b) significant findings;

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

(d) condition and disposition at discharge;

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

(f) provisions for follow-up care; and

(g) discharge medication reconciliation – both prescribed and over the counter.

(2) A discharge progress note may be used to document the discharge information for patients on observation, ambulatory care patients, and for stays of less than 48 hours.

(3) A discharge summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

12.D. DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

12.D.1. Discharge of Minors:

A minor 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 custodian or a court order. If the custodian directs that the 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.

12.D.2. Discharge of Incompetent Patients:

An incompetent patient will be discharged only to the custody of the patient's legal guardian, relative, or other interested person (the "custodian") unless otherwise directed by the custodian or a court order. If the custodian 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.

ARTICLE XIII

TRANSFERS TO AND FROM OTHER FACILITIES

13.A. ACCEPTING PATIENT TRANSFERS

(1) When a request is made to accept the transfer of a patient from another facility, the administrator on call shall be contacted to determine whether there is adequate capability and capacity to treat the patient.

(2) If a physician receives a request for a transfer and is unwilling or unable to accept the transfer, the physician must refer the request to the Emergency Department physician or the Transfer Center. The Emergency Department physician or the Transfer Center shall determine whether to accept the transfer.

(3) The Hospital (including the Emergency Department physician and staff physicians) shall not refuse to accept requests for transfers if the patient is in need of the specialized capabilities or facilities available at the Hospital. The only exception to this prohibition is if the Hospital lacks the capacity to safely treat the patient.

13.B. EMTALA TRANSFERS

(1) The transfer of a patient with an emergency medical condition or in active labor 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.

(2) Before any such transfer occurs, the on-call 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).

13.C. ALL OTHER PATIENT TRANSFERS

13.C.1. General:

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

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

(b) establishing the conditions under which transfer can occur;

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

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

13.C.2. 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:

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

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

(c) 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

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

(1) the reason for the transfer;

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

(3) available alternatives to the transfer.

13.C.3. Provision of Information:

When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:

(a) reason for transfer;

(b) significant findings;

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

(d) condition at discharge;

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

(f) working diagnosis.

13.C.4. Patient Requests:

When a patient requests a transfer to another facility, the responsible practitioner will:

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

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

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

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

(e) provide the receiving facility with the same information outlined in Section 13.C.3 above.

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

ARTICLE XIV

HOSPITAL DEATHS AND AUTOPSIES

14.A. DEATH PRONOUNCEMENTS

(1) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician, his or her physician designee, the nurse practitioner, physician assistant, Hospice RN, or Nursing Supervisor within a reasonable time frame.

(2) Hospice nurses may pronounce death only for Hospice patients (specific to agency) with no artificial means of life support.

(3) The Nursing Supervisor, Director of Nursing on-call, or the Palliative Medicine Charge Nurse (on the Palliative Medicine unit only) may pronounce death under the following conditions: attending physician must document anticipated death during this hospitalization (and discussion with family regarding such) in the progress note: an order must be present, signed, timed, and dated prior to time of death: and the patient must have no artificial means of life support (i.e., a ventilator or ECMO).

14.B. RELEASE OF THE BODY

(1) No body shall be released from the Hospital without a signed entry in the medical record by the attending physician (or his or her designee) stating the precise time of pronouncement.

14.C. AUTOPSIES

(1) The Medical Staff should attempt to secure autopsies in accordance with state and local laws. No autopsy shall be performed without written consent of a legal guardian, relative or other interested person. Such consent must be documented in the medical record. Questions should be referred to the House Supervisor or the administrator on call.

(2) Autopsies should be requested in all perinatal and pediatric deaths.

ARTICLE XV

MISCELLANEOUS

16.A. ORIENTATION

All new members of the Medical Staff will be provided an overview of the Hospital and its operations. As a part of this orientation, the Medical Records Department and nursing service will orient new members as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

16.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS

16.B.1. Self-Treatment:

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

16.B.2. Treatment of Family Members:

A member of the Medical Staff should not admit, treat, or participate in the surgery of an immediate family member (i.e., spouse, parent, child, sibling, parent-in-law, son/daughter-in-law, brother/sister-in-law, step-parent, step-child, step-sibling, or other relative permanently residing in the same residence as the member), except in the following circumstances:

(a) no viable alternative treatment is available, as confirmed through discussions with the Chief of Staff or the CMO;

(b) the patient's disease is rare or exceptional and the physician is considered an expert in the field;

(c) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or

(d) in an emergency where no other Medical Staff member is readily available to care for the family member.

16.C. BIRTH CERTIFICATES

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

16.D. INFECTION PRECAUTIONS

Medical Staff members shall abide by Hospital infection control policies regarding universal precaution to prevent transmission of H.I.V., H.B.V., and other pathogens.

16.E. HIPAA REQUIREMENTS

All members of the Medical Staff shall abide by the terms of the Notice of Privacy Practices prepared and distributed to hospital patients as required by the federal patient privacy regulations.

ARTICLE XVII

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XVIII

ADOPTION

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

Adopted by the Medical Staff on:

Date: _____

_____

Chief of Staff

Approved by the Board on:

Date: _____

_____

Chair, Board of Directors