Presbyterian Hospital of Rockwall

MEDICAL STAFF
RULES AND REGULATIONS

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I. INTRODUCTION

These Rules and Regulations are established to govern the conduct of work of the Medical Staff of Presbyterian Hospital of Rockwall. The Medical Executive Committee has been delegated the authority to adopt these rules and regulations with the final concurrence of the Governing Board.

No regulations, rules or orders, may in any way conflict with any provisions of the Hospital or Medical Staff Bylaws or with any known law or regulation.

Rules and regulations will be reviewed at least triennially, in addition to continually improving or correcting them as time and circumstances may dictate.

For clarity and ease of reading, “Physician” is referred to in the male gender although the physician may be either male or female. In addition, all references to “he/him/his” throughout shall refer to both males and females.

II. ADMISSION AND DISCHARGE

1. The hospital shall accept patients for care and treatment except for the following:

    a. Non-emergency patient who is mentally disturbed whose care and conduct would present a problem regarding their own or other patient's safety, care and comfort.

    b. Patients with critical burns, critical conditions which require tertiary care for pediatrics, patients requiring skilled nursing / long term care and rehabilitation, will be transferred in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements and procedures to the nearest tertiary center unless transfer of the patient is contraindicated in the judgment of the attending physician or the patient or surrogate decision maker objects to the transfer.

2. Patients that are admitted to any unit, other than the Special Care Units as defined in Section XIII, shall be seen by the attending physician no later than twenty four (24) hours of admission.

3. A patient may be admitted to the hospital only by a member of the medical staff with admitting privileges.

4. Except in an emergency situation, no patient shall be admitted to the hospital without a provisional diagnosis or valid reason for admission being stated. In the case of an emergency, this information will be recorded as soon as possible after admission.

4. If the patient is considered to be a source of danger to self or others, the admitting practitioner is responsible for providing such information as may be necessary to protect the patient from self-harm and harm to other patients, staff, or visitors.

5. The following patient admission category priorities shall be observed:

    a. Emergency Admissions
        Patients admitted for emergent situations that are life-threatening or are a threat to the loss of limb.

    b. Direct Admissions
        Patients admitted directly to patient care areas by practitioners. This applies to all departments.

    c. Routine / Elective Admissions
        Patients admitted for routine or pre-scheduled admissions, procedure, and/or treatment.

    d. Transfer Admissions
        Patients received from a referring facility for admit.

6. When a bed shortage for elective or routine cases exists, priority shall be given to members of the active medical staff, subject of course to the needs of the patient in each case.

7. A physician member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital. All patients shall have a complete history and physical performed and recorded in the medical record by a licensed physician (MD or DO).. When an H&P is recorded in the medical record by a resident, intern, medical student, a "house physician" who has been hired for such duty, or by an authorized physician assistant, the physician responsible for the patient's care will countersign the History & Physical as soon as possible but not later than 24 hours after admission and before any elective procedure requiring other than local anesthesia. Dentists, podiatrists, and psychologists shall be responsible for recording in the medical record a history and physical examination relative to the dental, podiatric or psychological problem. Any medical problem present on admission or arising during the hospitalization of a dental, podiatric, or psychological patient shall become the responsibility of a qualified physician.

8. Each member of the medical staff who does not reside and practice within sixty (60) minutes or otherwise maintain a satellite office or place of temporary residence close enough to the hospital to provide continuous care to his hospitalized patients shall specify a member of the medical staff with appropriate privileges who will be available to attend his patients in an emergency. In case of failure to name such a practitioner, the president of staff, the chairman of the appropriate department/service or the hospital administrator (in order of availability) shall have authority to call any qualified member of the medical staff if necessary. Failure of a medical staff member to meet this requirement shall be reported to the medical staff executive committee for any action deemed appropriate.

9. Except as otherwise provided in hospital policies for utilization of intensive care and intermediate care beds, no patient will be transferred within the hospital without the approval of the responsible practitioner, with the exception of a harmful or infectious patient who needs immediate relocation to protect himself or others. In the latter case, the medical director and/or chief of staff will be contacted to approve move if the responsible physician is not available. The responsible practitioner shall be notified as soon as he can be reached.

10. When a patient is being transferred to another hospital, a nursing home, or other health care facility, the responsible practitioner or other individual authorized by hospital policy shall indicate the reason for transfer, the name of the receiving facility, the name of the accepting practitioner, and the status of the patient's stability and shall sign the inter-facility transfer documents.

11. Any patient evaluated in the emergency room or who is being admitted to or is already in the hospital and who is known or suspected to be suicidal, otherwise self-injurious, or has taken a chemical overdose shall have psychiatric consultation. If this consultation is refused by the patient or legally responsible other, the medical record shall indicate that the consultation was recommended, offered, and refused.

12. The patient shall be discharged only on the written order of the responsible practitioner. If a patient leaves the hospital against medical advice (AMA), the patient or legally responsible other shall be requested to sign an AMA release statement. Whether or not such a statement can be obtained must be noted in the patient's medical record along with any reason given, and witnessed by a hospital staff member. An AMA release statement must indicate by the patient's or responsible other's signature

that the patient is voluntarily leaving the hospital against the advice of the practitioner and that in so doing the patient absolves the practitioner and the hospital from any and all direct and indirect consequences even if they occur subsequently. A patient leaving the hospital on his own accord without signing the appropriate document(s) shall be considered to be officially discharged.

13. The responsible practitioner shall make a reasonable effort to discharge patients before 12 p.m. (noon) on the day of discharge.

14. Practitioners shall abide by admitting/discharge requirements that, for their relevance to the subject matter in those sections, have been delineated in other sections of these rules and regulations or applicable hospital policies.

15. Passes for patients are not permitted. A patient may sign out against medical advice. If it is medically necessary to readmit a patient who has left AMA or has eloped, the patient must be readmitted by a physician order or request.

16. Admitting practitioners shall:
    - refer elective cases to the Admitting Office for advance arrangements
    - complete reports required to secure payment of insurance or compensation claims by the hospital
    - record information required for hospital billing
    - adhere to hospital admitting policies and procedures.

III. MEDICAL RECORDS

A. Content of Medical Record

1. The attending practitioner is responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

2. The record shall include:
   - identification data;
   - vital signs;
   - patient complaints;
   - relevant past, family, and psychosocial histories;
   - a system review;
   - current comprehensive history and physical examination;
   - provisional diagnosis or statement of problems;
   - a plan of care; patient orders;
   - all required consents;
   - special reports such as laboratory (clinical lab/pathology), cardiology, radiology services, and other;
   - treatment;
   - progress notes;
   - operative or procedure reports;
   - consultations;
   - condition on discharge;
   - discharge summary; final diagnosis;
   - any patient / family instructions / education; and
   - when performed, an autopsy protocol.

B. History and Physical

1. A complete history and physical examination, performed by a licensed physician (MD or DO), must be recorded in the medical record of all inpatients within 24 hours of admission.

2. For all elective surgical inpatients and ambulatory (same-day) surgery patients (receiving other than local anesthesia) a history and physical must be recorded at the time of admission and prior to the procedure, unless an emergency situation exists.
   - This applies to all patients who undergo surgery or other invasive procedures.
   - Invasive procedures included, but are not necessary limited to, percutaneous aspirations, cardiac and vascular catheterizations, and endoscopies.

C. Pre-operative History and Physicals

1. Pre-operative history and physicals should be dictated 24 hours prior to the time of scheduled surgeries / procedures in order to allow reasonable transcription time.

2. In cases where a complete history and physical is not present in the medical record, the clinical supervisor will request the admitting physician or if unavailable the surgeon to record a pertinent handwritten history and physical in the medical record prior to the induction of anesthesia.
3. Elective inpatient or outpatient surgery (to be performed under other than local anesthesia) will be cancelled or delayed until a pertinent history and physical examination is recorded in the medical record.
4. History and physical must be performed within 30 days of admission. If history and physical is performed greater than 24 hours, but prior to 30 days, a History and Physical Addendum Note or dictated summary of review of History and Physical with new or changed assessed findings will be required. If older than 30 days, a new examination and history and physical is required.

D. History and Physical Done in Physician's Office

1. History and physical done in the physician's office will be acceptable if the following guidelines are met:
   - The examination must have been done within 30 days of the admission, but with an update within 24 hours of patient encounter.
   - An interval note is recorded at the time of admission.
   - A durable, legible reproduction may be used. All illegible copies shall be subject to rejection and the physician's office notified immediately.
   - The physician will need to sign, date and authenticate the copy.

E. History and Physical for Outpatient Services

1. The medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.
   a. The history and physical will minimally consist of a brief history, including current medications, and a system-specific physical to include a respiratory and cardiac examination.

F. History and Physical for Observation

1. Required pertinent history and focused physical examination is required.

2. An admission note can suffice, or if admitted from the emergency department, the dictation of that encounter can serve as the history and physical.

3. If the observation status changes to a regular admission, a comprehensive history and physical will be completed.

G. Interval Note

1. When a patient is readmitted within 30 days for the same or related condition, an interval admission note stating the reason for readmission and any subsequent changes in the intervening time is acceptable.

2. The physician must state the specific date of the previous admission he is referring to in the interval note.

3. A copy of the original history and physical shall be put in the current record.

H. Documentation for Consultations

1. Consultations shall show evidence or review of the patient's record by the consultant.

2. Pertinent findings on examination and the consultant's opinion and recommendations must be noted.

4. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

5. Rules and Regulations by area shall specify situations in which consultation is required.

I. Progress Notes

1. Transcribed progress notes can be used in lieu of written progress notes only if strict turnaround time of two (2) hours for critical care units and six (6) hours for non-critical care units is met.

2. Pertinent progress notes shall be recorded at the time of observation to provide for continuity of care and transferability.

3. The progress notes should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

4. The patient's clinical problems should be clearly identified and correlated with specific orders as well as test, procedure, and treatment results.

5. Progress notes shall be written at least daily and more often when warranted by the patient's condition.

6. Progress notes shall be legible, dated, timed and signed.

J. Operative Reports

1. A preoperative diagnosis is recorded prior to surgery.

2. Operative reports must be dictated or written in the medical record immediately after surgery and shall contain:
   - name of the primary surgeon and assistant surgeons;
   - procedures performed and description of procedure;
   - a description of the findings;

- estimated blood loss, as indicated;
- any specimens removed; and
- the postoperative diagnosis.

3. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

4. If the operative report is not placed in the medical record immediately after surgery, a post operative progress note, comprehensive enough to permit continuity of care, must be entered in the medical record at the time of completion of the procedure and prior to the patient going to the next level of care.

K. Anesthesia

1. A pre-anesthesia evaluation of the patient by an anesthesiologist will be performed in all elective surgery cases.

2. The pre-anesthesia evaluation will determine the capacity of the patient to undergo anesthesia and will formulate an anesthesia plan for the patient. This evaluation will include, but not limited to:
   - reference to the choice of anesthesia (general, conscious sedation, spinal, other regional, or standby);
   - the patient's allergies and any previous medication;
   - smoking;
   - alcohol use history;
   - other anesthesia experiences;
   - any potential anesthetic problems;
   - plan for anesthesia; and

3. The patient's physical status should be categorized using the ASA classification of the American Society of Anesthesiologists.

4. The anesthesiologist shall record in the medical record:
   - evidence of pre-anesthesia check of the anesthesia machine;
   - monitoring equipment;
   - patient's physiological monitored vital signs;
   - level of consciousness;
   - all anesthesia drugs and agents to be used as well as all pertinent events occurring during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents; and other drugs, intravenous fluids, and blood and blood components.

5. There should be evidence in the medical record that patient discharge from the post-anesthesia recovery unit is based on a physician decision. This may be documented by:
   a. a written physician order;

   b. a recorded verbal physician order; or

c. the recovery / post anesthesia nurse's authorized indication of a physician approval based on the patient's attainment of approved discharge criteria.

6. At least one post-anesthesia visit must be made after an inpatient has left the recovery area (recovery room, special care unit, designated room in nursing unit), at which time a dated and timed note is to be made in the medical record describing the presence or absence of anesthesia-related complications.

7. Medical record information from a post anesthesia recovery area (regardless of type or location) shall include the patient's level of consciousness on entering and leaving the area, the vital signs, medications administered, and when such are in use, the status of infusions, surgical dressings, tubes, catheters, and drains.

L. Discharge Summary

1. A discharge summary shall be written or dictated on all medical records of patients hospitalized more than 48 hours, with the exception of cases of a "minor" nature (e.g., admission for diagnostic study) as specified by the medical staff executive committee.

2. For these excepted categories, a final progress note, including a final diagnosis any pertinent instructions to the patient/family, shall suffice.

3. The discharge summary shall concisely recapitulate:
   - the reason for hospitalization;
   - the significant findings;
   - the procedures performed and treatment rendered;
   - the condition of the patient on discharge;
   - any specific pertinent instructions given to the patient/family or significant other; and
   - final diagnosis.

4. The condition of the patient on discharge shall be stated in terms that permit a specific measurable comparison with the condition on admission.

5. In the event of patient death, a summation statement shall be added to the record either as a final progress note or as a narrative summary, indicating:
   - the reason for admission;
   - the findings and course in the hospital;
   - events leading to death; and
   - cause of death.

   The content of the medical record should be sufficient to justify the diagnosis and to warrant the treatment and hospitalization.

M. Final Diagnosis

1. Final diagnoses, complications and all other treated diagnosis and procedures shall be recorded in full and authenticated by the responsible practitioner at the time of discharge of all patients.

2. Additional diagnosis must also be recorded which may exist prior to the admission of the patient or develop after the patient's admission, but, in either case, must affect the treatment received or the length of stay.

3. This will be deemed equally as important as the actual discharge order.

N. Autopsy

1. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within five (5) days, and the complete protocol shall made part of the record as soon as possible.

O. Authentication of Medical Records

1. All medical record entries shall be dated, timed and authenticated promptly by the individual who is responsible for ordering, providing, or evaluating the service provided.

2. Signatures do not have to be dated if they occur in real time of the entry.

3. Electronic Signatures will be date stamped.

4. Signature stamps will not be accepted under any circumstances. Printed name stamps for legibility may be used in conjunction with physician's actual signature.

5. Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has the legal responsibility for the order or the information bearing his authentication.

P. Electronic Signature

1. A physician desiring to use electronic signature for authentication must provide a letter or signed form (Attachment A) that indicates:

- He / She has a PIN number;
- Is the only individual who uses the PIN number; and
- He / She will not delegate the use of the computerized signature to another.

2. The letter shall be maintained in the physician's credentialing file in the medical staff office.

3. A copy of the request will be filed in the physician signature file in the Health Information Department.

4. Before applying an electronic signature, the physician should review the entry for completeness and accuracy, correcting or modifying it as needed.

5. Correction of errors, adding additional information after an entry has been signed electronically should be done by means of an addendum to the original entry.

6. The addendum should also be signed electronically and date/time stamped.
In no circumstances shall a single electronic signature authenticate all entries in the medical record.

Q. Facsimile Signatures

1. A physician's signature transmitted via electronic facsimile is considered legal and does not require additional authentication.

2. The original document along with the faxed document should be scanned in the hospital medical record.

3. If the documents faxed are for delinquent medical records, the records will remain delinquent until the authenticated documents are returned.

R. Delinquent Medical Records

1. The medical record shall be completed at the time of discharge, including final diagnosis and clinical resume.

2. An automatic suspension of privileges shall be imposed for failure to complete medical records within thirty (30) days of discharge and/or visit. Suspensions will occur on the (1st) first and fifteenth (15th) of each month for all physicians with 30 days of incomplete medical records.

3. A weekly notification will be sent to each physician who has records that are delinquent and/or will be delinquent by the following week. Seven days after receipt of letter if records remain delinquent, suspension of privileges will occur.

4. Should illness or absence prevent the physician from completing his/her records consistent with the above stated timelines, the physician should notify the HIM Department. An extension will be granted not to exceed the length of the illness or absence.

5. A physician will remain in suspension until all his/her delinquent records are completed.

    a. scheduling of new admissions and/or surgery will not be permitted.

    b. Physicians are allowed to provide continued care to current inpatients and patients already scheduled for surgery or to provide care in the case of an emergency.

    c. An ***"emergency"*** being defined as: "a condition in which the life of a patient is in immediate

danger and any delay in administering treatment would add to that danger".

6. In the case of a hospital based (contracted) physician, then suspension of privileges and financial compensation withheld will occur until records are completed.

7. Failure to complete the medical records which caused suspension, after three (3) months from the date of such suspension, shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff. Reapplication to the Medical Staff can be made following completion of all incomplete records. The application process shall proceed in the same fashion as any new application to the Medical Staff.

S. Medical Records Access

1. The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Medical Staff and the Hospital.

2. Subject to applicable laws, Access to medical records for all patients shall be afforded to members of the medical staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients.

3. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

4. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner whether the patient is attended by the same practitioner or by another.

T. Confidentiality and Security of Records

1. The confidentiality of medical records shall be maintained as required by state and federal law.

2. Written consent of the patient is required to release medical information to persons not otherwise authorized to receive this information in accordance with federal, state and local statutes and regulations regarding the release of information.

3. Original records may be removed from the hospital's custody and control only in accordance with a court order, subpoena, or statute.

4. Attending practitioners shall be notified of any record that has been requested by a court order, subpoena or statute.

U. Confidentiality and Security of Records (continued)

5. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period of time to be determined by the Medical Executive Committee.

V. Corrections

1. Electronically signed entries cannot be deleted or altered.

2. If errors are found in the electronic file:
   - Correction will be done by means of an addendum to the original entry.
   - The addendum must also be signed electronically.

W. Abbreviations, Acronyms, and Symbols

1. Only approved abbreviations, acronyms, and symbols shall be used in documenting in the medical record

2. The use of abbreviations is limited and only standard abbreviations are to be considered when documenting in the medical record.

X. Retirement of Records

1. An incomplete record will not ordinarily be filed if the responsible practitioner is still a member of the medical staff or holds clinical privileges in the hospital.

2. No medical staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him.

3. Any practitioner who is removed from the medical staff per the bylaws for delinquent records or who resigns from the medical staff without adequately completing all medical records will not be allowed to reapply for staff membership until such records are satisfactorily completed.

IV. ORDERS

1. All patient orders shall be documented in the medical record.

2. Practitioner orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written shall not be carried out until rewritten properly. The use of "renew," "repeat," “resume”, or "continue" orders is not acceptable. Orders must be specific.

3. All orders will be authenticated by the author (member of medical staff). Orders transcribed incorrectly will be corrected upon discovery.

4. Clinical staff in accordance with their scope of practice may accept written, verbal, and telephone orders from a physician. Verbal orders are discouraged.

5. The person accepting the verbal order must write the order and read said order back to the physician to verify the accuracy of the order. The authorized individual shall document the verified verbal order, indicating the read back verification.

6. Certain categories of verbal orders therapeutic and diagnostic may present a potential hazard to patients and are considered high risk. These high risk orders may be accepted by designated personnel and must be signed within 24 hours. Orders which fall into this high risk category include:
   - Orders for "Do Not Resuscitate" *(can only be accepted by Registered Nurse)*
   - Orders for initial chemotherapy or changes in chemotherapy
   - Orders for blood products
   - Orders to verify patient's home medications that are to be continued in the hospital (that must be individually listed).

7. Approved staff members when functioning within their sphere of competence may accept and transcribe verbal therapeutic and diagnostic orders related to their area of practice. The staff members include:

• Nursing	Registered Nurse, R.N. Licensed Vocational Nurse, L.V.N.
• Pharmacy	Pharmacist, R.Ph
• Cardiopulmonary	Licensed Respiratory Care Practitioner, R.C.P. Registered Respiratory Therapist, R.R.T.
• Cardiovascular	Certified Cardiovascular Perfusionist, C.C.P. Registered Cardiovascular Technician, R.C. V. T.
• Radiology	Registered Technologist, A.R.R.T.
• Laboratory	Medical Technologist, M.T.
• Physical Therapy	Licensed Physical Therapist, P.T.
• Occupational Therapy	Licensed Occupational Therapist, O.T.R.
• Speech Therapy	Certified Clinical Speech-Language Pathologist, CCS/SLP
• Case Management	Registered Nurse
• Social Worker	Licensed Medical Social Worker, LMSW
• Dietary	Registered Dietitian, R.D.

8. Verbal orders will be accepted only from authorized practitioners.

9. All routine and standing orders shall be signed by the responsible practitioner as soon as possible within 24 hours.

10. Unspecified range or variable orders are discouraged. Range orders received will be managed by pharmacy according to approved policies and procedures.

11. All orders shall be cancelled at the time the patient undergoes surgery unless otherwise directed by the responsible surgeon with input from the anesthetist as appropriate. Orders shall be rewritten for patients transferred to a lesser or higher level of care.

12. Any patient with extended stay (7) days will have a medication profile printed and placed on the chart by the pharmacist. The physician will review, indicated medications to be given, write order, date and sign profile.

V. DRUGS AND MEDICATIONS

1. All drugs and medications administered to patients shall have been approved by the Food and Drug Administration. The only exceptions are those drugs administered under an approved protocol for investigational or experimental drug use which has been approved by an Institutional Review Board/Committee (IRB) that is acceptable to the Medical Executive Committee. When certain organic or inorganic substances (such as vitamins, metals, minerals, nutrients, etc.) are used in an unconventional manner, and specifically not defined as a drug or medication, administration of these substances will also be in accordance with an established protocol that has been approved by the medical staff through its designated mechanism. Proprietary remedies should be avoided, and if an attending practitioner orders one for a patient, the pharmacy shall obtain consult with the prescribing physician to determine medication therapy regimen.

2. Investigational or experimental drugs shall be used only under the direct supervision of the principal investigator who shall be a physician member of the medical staff and who is responsible for securing the necessary consents. The investigator shall provide to the hospital administrator or governing body evidence of adequate liability insurance.

3. The protocol for use of an investigational or experimental drug shall be submitted to the Institutional Review Board/Committee which after its evaluation will make its recommendation to the medical staff executive committee. The latter recommendation shall be given strong consideration by the governing body, which has final approval/disapproval authority. However, consistent with applicable state and federal law, the governing body cannot unilaterally approve the use of an investigational drug or device which has not received approval from the Institutional Review Board/ Committee.

4. When nurses are required to administer an investigational drug, they shall be provided access to basic information concerning the drug, including dosage, strengths available, actions and uses, side effects, symptoms/signs of toxicity, and personal safety, if applicable and known.

5. When a patient is admitted while on an investigational drug outside of the hospital, the medication may be continued as follows:
   - A copy of the patient's informed consent must be approved.
   - A copy of the protocol must be submitted to the Pharmacy.
   - The medication must be controlled by the Pharmacy.
   - Medication will be delivered to the Pharmacy and not left with patient or on Nursing unit.
   - All unused drugs must be returned to the investigator / patient.

   The attending physician must be a member of [Presbyterian Hospital of Rockwall] medical staff but the principal investigator need not be a member of the medical staff. The attending physician must provide the pharmacy a photocopy of the patient's informed consent, which will be placed in the chart, and a copy of the protocol to file in the Pharmacy.

6. The pharmacy shall store any investigational drugs used in the hospital and be responsible for labeling and dispensing in accordance with the physician investigator's written orders.

7. Self administration medication by patients shall not be permitted.

8. Medications brought into the hospital with the exception of the following will not be administered.

Topicals not available in Pharmacy	Specialized Eye Drops
Birth Control Pills	Prenatal Vitamins

9. If under unusual circumstances including exceptions in # 8 (e.g. medication is not on formulary, pharmacy is not able to obtain medication, etc.) the patient may receive his own medication. Drugs brought into the hospital by patients may be administered by the nursing staff only if the drugs have been identified by the hospital pharmacist, there is a written order from the responsible practitioner to administer the drugs, the medication is labeled, and the drug is not outdated.

9. Under no circumstances will the hospital pharmacy relabel medications obtained from other sources or brought from home.

10. For each medication, the administration times or the interval between doses must be clearly stated in the order.

11. The use of "prn" and "on call" in a medication order must be qualified.

12. All preprinted / standing and routine orders (particularly those involving medications) shall be initially evaluated, and, if approved, shall be evaluated periodically thereafter by the Departmental / Pharmacy and Therapeutic Committee and / or the Medical Executive Committee.

13. When a medication ordered is not in the pharmacy, the pharmacist shall have the authority to substitute the same drug that has a different brand name or a generic drug in the same dosage, after informing the attending practitioner, and unless specifically otherwise ordered.

14. Drug samples shall not be distributed in the hospital. Sample drugs brought into the hospital shall be controlled through the pharmacy, particularly non-formulary drugs.

16. Practitioners shall abide by drug and medication requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these rules and regulations and applicable medical staff and hospital policies. In particular, reference is made to the "Surgical Care," "Special Care Units," "Orders," sections of these rules and regulations.

17. When, in the opinion of the nursing staff or the pharmacist, a drug dosage ordered represents a potential hazard (e.g., excessive dose, incompatibility problem, contraindicated for patient's condition) to the patient, and the prescribing practitioner disagrees, the chairman of the department/service to which the practitioner is assigned or the president of staff shall be consulted, and if he also agrees that the administration of the drug as ordered is potentially hazardous, the attending practitioner may be required to administer the drug personally and submit a written prescription to the pharmacy separate from that of the order sheet.

18. When medications are prescribed for a patient at time of discharge, the patient will be informed in writing of potential significant adverse drug-food interaction(s). This may be done by the responsible practitioner, a pharmacist or the discharging nurse. Since the discharging nurse is usually involved, the responsible physician must indicate to the nurse the discharge medications being prescribed. The

provider's indication that the patient received and understood the information should be documented in the patient's medical record along with the patient's signed acknowledgment of receipt of the information.

19. Practitioners shall abide by drug and medication requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these rules and regulations applicable medical staff and hospital policies.

20. A patients' current medications, upon entry to facility, will be obtained and documented. This list will be compared to the medications prescribed during hospital stay and will be communicated to the next provider of service when the patient is transferred to another setting, service, practitioner or level of care within or outside the organization. Upon discharge the patient will be informed in writing of his / her medications that have been reconciled throughout his / her stay.

21. The Medical Staff Executive Committee may restrict the use of a specific drug or class of drugs, either entirely or for use only in stated conditions or for use only on the consent of the Medical Executive Committee.

22. Emergency drug carts / trays or emergency drug storage areas shall be checked by appropriate individuals at least once per shift (while area is open for clinical care), and after each use to assure that all items are available and in usable condition. In addition there must be a system that assures the continued integrity of the cart / tray or emergency drug storage area contents between periods of use.

VI. CONSULTATIONS

1. The attending practitioner is responsible for requesting consultation when indicated and for documenting reason for consult. The attending practitioner will provide written authorization to permit another practitioner to attend or examine the patient except when a bona fide emergency precludes this being done.

2. Any qualified practitioner with clinical privileges in this hospital may be called by the practitioner responsible for the patient to provide consultation within the consultant's area of expertise.

3. When the required consultative expertise is not available through the existing medical staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by granting temporary privileges to a qualified practitioner who is not currently a staff member as provided in the medical staff bylaws.

4. Consults should be obtained when specific areas of expertise are needed to properly take care of the patient. If the attending physician does not have the credentials to manage the circumstance, then a consult would be required.

5. Consultation reports shall show evidence that the consultant has examined both the patient and the medical record, and shall include the consultant's findings and recommendations. A limited statement such as "I concur" generally would not constitute an adequate consultation report. Except in emergency situations, so verified in the medical record, a consultation relative to an operative or potentially hazardous procedure shall be recorded prior to the surgical or other procedure being performed.

5. Forms for requesting radiology and pathology services shall be filled out adequately, indicating the reason for the request and relevant clinical information.

VII. GENERAL REQUIREMENTS

1. Written consent of the patient is required for release of medical information to individuals not otherwise authorized to receive this information.

2. In addition to a general consent obtained by the hospital at the time of the patient's admission, specific consent must be obtained as required by law prior to diagnostic or therapeutic interventions. The attending and/or treating practitioner is responsible for documenting in the medical record the information provided to the patient relative to the intervention anticipated. Exceptions to obtaining the patient's timely consent are limited to emergency and other situations defined in the hospital's informed consent policy. All regulatory requirements relating to disclosure shall be followed. Both the patient and responsible practitioner will sign the consent form prior to diagnostic and therapeutic intervention to indicate the practitioner has personally provided specific information, including the risk, benefits and alternatives of the intervention, on which the patient has based his consent.

3. Qualified members of the medical staff present in the hospital shall respond to an emergency code, such as one requiring cardiopulmonary resuscitation, so that a qualified physician is on site to participate and give any needed direction.

4. In the event of a patient death in the hospital, the deceased shall be pronounced dead by a physician, nursing director or house supervisor. The body shall not be released until a death note is completed and placed in the medical record of the deceased.

5. All medical staff members shall report questionable deaths and secure meaningful autopsies whenever possible. Autopsies shall be performed only on appropriate written consent and in accordance with state law.

   A. A medical staff member is required to report a death to the medical examiner in the following circumstances:

      When cause of death is questionable. A questionable cause of death includes, but is not limited to, the following:

      1) Cases in which the deceased is dead on arrival (DOA).

      2) Cases in which an individual expires within 24 hours following admission to the emergency room or ward.

      3) When death is, or is suspected to be, from accidental, suicidal or homicidal causes, no matter how long the person has been hospitalized or has survived the injuries. The time span may run for minutes to years.

      4) Cases of anesthetic deaths, including those under the initial induction and those who do not recover following anesthesia.

      5) Deaths that occur during or immediately following any diagnostic or therapeutic procedure in the hospital.

6) Any death where the disease process responsible is either work-related or suspicious of being aggravated or accelerated at work.

7) Stillbirths and neonatal deaths when maternal injury has occurred or is suspected either prior to admission or during delivery.

8) Maternal deaths, whether during or following delivery and including any death where abortion is suspected either prior to admission or during delivery.

9) The death of a person in custody or under confinement.

10) Any death of a known or suspected IV drug user.

11) Any death of a child younger than six (6) years old.

B. Medical Staff members may not require an autopsy, but an autopsy may be of benefit and should be considered in the following circumstances:

1) The patient following surgical or other invasive procedure where a fatal outcome was felt to be highly unlikely or unexpected altogether.

2) Death following drug reaction or other adverse occurrence.

3) Unexpected death within 24 hours of admission.

4) Unexpected outpatient or emergency death

5) Family request.

All autopsies shall be performed by a pathologist, preferably the hospital pathologist or staff member unless by law the autopsy comes under the jurisdiction of the Medical Examiner/Coroner. All autopsies require the consent of the next of kin, unless ordered by the medical examiner.

6. All practitioners shall participate in patient discharge planning in accordance with the utilization review plan or other written requirements.

7. All practitioners shall comply with requirements of the hospital's Incident / Occurrence Screening / Risk Management Program.

8. When medical record entries are authorized to be made by allied health professionals, the supervising practitioner shall countersign the entries as required by medical staff bylaws.

9. All practitioners are responsible for participating in case of a declared disaster and cooperate with the disaster plan. They shall participate in disaster drills as necessary.

10. Patients will be restrained for the protection of self or others in compliance with applicable laws. When use of restraints is indicated, justification for such use and a time-limited signed order by the physician noting both start and end times will be present and used only after other alternative methods has been attempted. The order should be signed immediately, but in no case later than 12 hours. If verbal order is given for initiating a restraint, it may only be received by a Registered Nurse.

11. The ordering of any baseline admission testing (e.g., laboratory, X-ray, electrocardio-gram, etc.) shall be the responsibility of the attending practitioner on an individual patient basis.

12. Clinical laboratory tests shall be done by the hospital or in an outside (reference) laboratory recommended by the director of the pathology and medical laboratory services and approved by the medical staff. Practitioners who have such tests / examinations performed by laboratory sources other than these may enter the results in the history or progress note section of the medical record, but the report itself shall not be considered the official hospital medical record report.

13. The radiology department / service shall provide authenticated reports for all radiologic examinations performed in the hospital and, when requested, for review of examinations performed outside the hospital. In either case, this will provide the official report for the medical record. Otherwise, the attending practitioner may record his own interpretation in the history or progress note section of the medical record. When special cardiovascular radiologic procedures can be properly interpreted only with the findings and observations of the authorized practitioner (e.g., cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.

14. Practitioners requesting diagnostic examinations by the pathologist or radiologist should provide in the written request all relevant information available so as to assist in the determination of an accurate diagnosis/impression and proper use of resources.
    a. Printed instruction sheets or patient care brochures (from clinical departments/ specialties, patient care units, or individual practitioners) provided to patients and/or families either in the hospital or at the time of discharge shall be approved for clinical relevance and patient safety by the medical staff through its designated mechanism. Generally such sheets or brochures should not be used by the practitioner as the sole source of information for purposes of obtaining informed consent.

15. Blood that has been crossmatched shall be held for 48 hours at which time it shall be cancelled unless reordered. Prior to release, the ordering practitioner shall be notified. For cases in which crossmatched blood is frequently ordered but not used, the use of type and screen system should be used instead of crossmatching.

16. Oxygen and respiratory therapy shall be administered in accordance with the responsible practitioner's orders or in accordance with established policy approved by the medical staff through its designated mechanism. In cases where the duration of treatment is not specified or is stated indefinitely, the treatment shall be discontinued unless new orders are written; however, prior to discontinuing the treatment, the nurse or therapist shall notify the responsible practitioner and confirm that the treatment should be discontinued.

17. The Infection Control, through its chairman or physician members, has the authority to institute any appropriate control measures or studies when it is reasonably believed that a danger to patients, visitors, or personnel exists. This includes placing a patient under isolation precautions even though the attending practitioner may not believe such is necessary.

18. Radiographs and pathology slides are the property of the hospital and may be lent to other hospitals, practitioners, or research institutions for valid reasons and only with the written permission of the patient in accordance with the policies, rules and regulations of the radiology and pathology department, the chairman of the appropriate department/service involved, and the hospital administrator.

19. All inpatients shall be visited by their attending practitioner or designee with appropriate privileges at least once every day and this shall be documented in the medical record. If an absence of more than one day is contemplated, the attending practitioner shall arrange for another qualified member of the medical staff to attend the patient, and the nursing staff shall be notified of the name of the practitioner who will be responsible in the interim.

20. Services provided will be provided by all members of the medical staff in a non-discriminatory manner without regard to age, sex, race, color, national origin, handicapping condition, or disability.

21. Mandatory over reads for studies or tests done in the hospital are required for PFTs by a staff pulmonologist, EKGs by a staff cardiologist, and imaging studies by a staff radiologist.

VIII. EMERGENCY SERVICES

1. The emergency medical record shall be part of the patient's hospital medical record.

2. Each emergency medical record shall be signed by the practitioner in attendance that is responsible for its accuracy.

3. There shall be a triage system to identify patients requiring urgent and emergent care are identified and cared for expeditiously.

4. The disposition of each patient shall be a physician responsibility.

5. The emergency room shall not be used for routine outpatient visits.

6. The established list of procedures permitted to be performed in the emergency room shall not be exceeded except in a bona fide emergency.

7. In an emergency case in which it appears that a patient requires admission to the hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

8. When a patient who requires admission on an emergency basis does not have a private practitioner, the patient may select a practitioner from the medical staff in the applicable

specialty/department/service. When no such decision is made, a member of the active staff will be assigned to the patient, on an established rotation or roster basis when possible.

9. Admission of emergency cases must be justified, on request, to the executive committee and/or, when such exists, the utilization review committee. The history and physical examination in the medical record must clearly establish the emergency basis for admission. The term "emergency admission" is not an acceptable reason per se.

10. Attempts to limit the ER for observation status shall be limited to the shortest time possible until the decision to admit, transfer, or discharge is made.

11. The emergency room / department physician on duty will be allowed to leave the emergency room if patient status permits to evaluate inpatients during code emergencies or for pronouncement of patient deaths. In such cases, the emergency physician will provide and document in the patient's medical record only emergency care and will contact the responsible practitioner to determine appropriate treatment or other disposition.

12. The privilege of a staff practitioner to care for his private patient will be maintained and facilitated by making every reasonable effort to contact him unless he has advised the emergency room staff to the contrary. However, care of emergent cases will not be delayed pending contact with or arrival of the private practitioner.

13. Patients and/or responsible others, on leaving the emergency room following evaluation and/or treatment, shall be given written follow-up instructions, to be signed by the patient or responsible other, that he has received and understands the instructions and by the responsible practitioner or ER registered nurse that the patient or the responsible other has received and acknowledges that the patient understands. Any language barrier will be compensated for through use of an interpreter, interpretation line, by instructions written in the patient's language, or by another acceptable system and this will be noted on the instruction sheet.

14. The emergency room physician shall render his interpretation of X-rays in writing, and a copy of this report will be made available to the radiologist. In cases in which the radiologist's interpretation of an X ray differs from that initially made by the emergency physician, a copy of the radiologist's report shall be made available and brought to the attention of the emergency physician and the patient's private practitioner, and the patient shall be informed of the final reading.

15. In addition to the clinical information related to evaluation, treatment, and disposition of the patient, the emergency medical record shall include: the time of the patient's arrival, the means of arrival and by whom transported, any available details of the emergency care rendered to the patient prior to arrival at the hospital, whether (and, if relevant, when and for what) the patient visited the emergency room previously, acknowledgment of any ordered test results, the condition on discharge, and any instructions given to the patient on discharge.

16. Specialist coverage will be provided by medical staff members in accordance with an established roster or on-call system as required by the hospital and/or medical staff policies. When a transportable patient requires medical staff consultation/treatment not available, the patient will be transferred to an appropriate facility as soon as possible, subject to compliance with the hospital's transfer protocol,

regulatory requirements, and subject to having first obtained acceptance by that facility through a physician or other qualified health care provider.

IX. EMERGENCY ROOM BACK-UP PANELS

1. It is the responsibility of each clinical service to assure adequate backup emergency services coverage for a specialty where the Medical Staff and Hospital have agreed that both are able to provide emergency services in a particular specialty. If there is insufficient voluntary coverage, mandatory coverage will be instituted by the appropriate department chief, with the approval of the Medical Executive Committee.

2. On a departmental basis, some departments may elect to require their members to be placed on the Emergency Department call roster. Such decisions should be based upon the department's perception that the roster is sufficiently staffed and only upon ratification of the Medical Executive Committee.

3. The areas of coverage on the ER Call List may include, but not limited to:

- Anesthesiology
- Cardiology
- Internal Medicine
- Obstetrical / Gynecological
- Otolaryngology
- Pulmonary Medicine
- Hand
- General Surgery
- Cardiothoracic Surgery
- Neurovascular Surgery
- Radiology
- Gastroenterology
- Neurology
- Ophthalmology
- Pediatrics
- Oral / Maxillofacial
- Plastic Surgery
- Radiology
- Urology
- Orthopedics
- Vascular Surgery
- Pathology

3. When four (4) members of any given specialty exist, the on call panel will constitute a full month of call rotation.

4. If there are four (4) or less of any one area or specialty, each member of that area or specialty will cover at least seven (7) days of call a month.

5. A practitioner who is scheduled to take Emergency Room (ER) Back-Up call must respond to all calls from the ER by telephone within thirty (30) minutes of a call or page from the ER. If the ER physician determines that the back-up physician must come in and examine the patient, the practitioner scheduled for ER Back-Up call must present to the ER within sixty (60) minutes and examine the patient.

6. If neither the patient's attending physician (if the attending physician is on staff) nor the physician on-call timely responds, the ER will do the following:

   a. If the ER can timely locate another physician to assume care of the patient, this other physician will assume responsibility for the patient's care. Efforts to locate a physician may include, to the extent

time permits, proceeding down the ER back-up panel. The appropriate department chair, vice chair and/or a Medical Staff officer will be contacted if a physician is not available within a reasonable period of time (as determined by the patient's condition and any other applicable circumstances).

b. If after contacting the appropriate department chair, vice chair and/or a Medical Staff officer a physician is not available within a reasonable period of time (as determined by the patient's condition and any other applicable circumstances), then the ER physician should determine if the patient should be transferred to another hospital. If time permits under the circumstances, prior to the transfer pursuant to this section (or as soon thereafter as reasonably possible if circumstances did not permit a prior notification), the administrator on-call must be notified. The administrator on-call must review the situation and documentation. The Chief of Staff will be notified whenever a patient has been transferred because of unavailability of a back-up physician and the matter will be reviewed by the Medical Staff.

7. It is the responsibility of every physician on the ER Back-Up Panel to accept ALL patients referred to them for admission and/or consultation by the ER physician.

8. Once the ER Back-Up Panel is distributed, it becomes the responsibility of the physician who is scheduled for ER call coverage to either respond or have arranged for an acceptable alternate physician to provide ER coverage. An acceptable alternate is defined as another member of the Medical Staff with comparable clinical privileges. It is the responsibility of the physician who was scheduled to notify the ER prior to the date coverage is to be provided of the physician who will be providing alternative coverage.

9. A Panel member cannot refuse to respond to a call on the basis of patient's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except the extent that such a circumstance is medically significant to the provision of appropriate medical care to the patient.

10. A physician who is scheduled for ER Back-Up call and is called to come in, must see the patient within a reasonable time even if a consultant is requested and also sees the patient. (Reasonable time is determined by the urgency of the patient's condition.)

11. If the Panel is elective, Panel service is not an obligation, right or clinical privilege. If a physician who is scheduled to provide coverage for an elective Panel fails to respond in accordance with these rules and regulations, even once, that physician may be removed from the Panel, regardless of the reason for such failure to respond. If a physician fails to respond in accordance with these rules and regulations a second time during another interval when the physician was to provide coverage, the physician shall be removed from an elective call panel. A practitioner who is removed from an elective call Panel pursuant to this Section 8., shall not be entitled to a hearing or appellate review in accordance with the Medical Staff Bylaws unless the President of the Medical Staff, as the designee of the Medical Executive Committee determines in accordance with applicable State law, that the removal is for a medical disciplinary cause or reason and is reportable. If the removal from the elective call Panel is not deemed to be disciplinary action by the President of Medical Staff, the physician who is removed from the elective call Panel may request a meeting to discuss the matter formally with the MEC or its designee.

12. If the Panel is mandatory and a physician who is scheduled fails to respond in accordance with these rules and regulations, the failure to respond appropriately, even once, may result in removal from Panel service and termination or suspension of the individual's Medical Staff membership and clinical privileges. A physician whose Medical Staff membership and clinical privileges are terminated pursuant to this Section 9., shall be entitled to a hearing and appellate review accordance with the Medical Staff Bylaws.

13. Panel physicians may be required to provide consultation in the event a current member of the Medical Staff is unable or unavailable to provide consultation for patient who presented to the Hospital in an emergency condition and has not yet been stabilized.

14. Members of the Medical Staff over the age of 60 and who have been active members taking ER panel call for three (3) years may elect to be exempt from taking ER Back-Up Panel.

15. The procedure for developing and distributing the ER Back-Up Panel schedule shall be set forth in the Emergency Room Back-Up Panel Rotation Policy.

16. Any physician resigning from the Emergency Room Back-Up Panel must provide at least ninety-(90)-days notice or arrange for an acceptable alternate physician to provide coverage. Any physician unwilling to honor the existing schedule or that does not arrange for alternate coverage may be resigned not in good standing.

X. OBSTETRICAL CARE

1. Current obstetrical records shall include all relevant prenatal information. The prenatal record may be a legible copy of the attending physician's office record transferred to the hospital before admission, with any pertinent interval history or physical findings updated, in writing, to the time of admission. A copy of the prenatal record for planned deliveries shall be forwarded to labor and delivery by the 36th week of gestation or be available at the time of admission. If there are no changes in such findings, a note to that effect will suffice.

2. Whenever an obstetrical patient undergoes elective surgery under general or spinal anesthesia, there will be a current comprehensive physical examination in the medical record prior to anesthesia/surgery.

3. The obstetrician shall assume complete responsibility for the immediate post delivery care of a newborn unless he has arranged for a pediatrician or other practitioner to be present.

4. Situations that ordinarily necessitate a Pediatrician's attendance at delivery will be defined as:
   - non-elective cesarean sections
   - suspected or confirmed fetal anomalies
   - non-reassuring fetal heart tracings when time permits
   - preterm delivery less than 35 weeks
   - multiple gestation
   - when requested by the attending physician

5. The obstetrician shall assume complete responsibility to communicate with the pediatrician or neonatologist concerning high risk factors, potential complications, and the need for his or her attendance at delivery.

6. Whenever oxytoxics are given for induction or promotion of labor, the oxytoxics shall be administered in accordance with a written procedure, which at a minimum shall specify route and rate and time of administration, dosage, identification of both maternal and fetal complications, skill level of attending nursing personnel, fetal monitoring as required, and the proximity of physician to/in the hospital during the administration.

7. Induction or augmentation of labor with oxytocin may be initiated only after a responsible physician has evaluated the patient, and determined that induction or augmentation is beneficial to the mother or fetus, and established a prospective plan of management.

   A physician or registered nurse will be immediately available while oxytocin is being administered per written nursing oxytocin protocol.

   When oxytocin is used for stimulation or induction of labor, it may be added to the intravenous infusion by a registered nurse in accordance with the physician's order.

   In a delivered patient, oxytocin may be administered by a registered nurse on the written order of the physician.

8. A labor and delivery competent registered nurse shall be responsible for:
   - observing the patient, following her progress in labor,
   - recording all pertinent information on the labor record, and
   - keeping the physician apprised of the patient's status.

9. Fetal / maternal monitoring by auscultation, or electronically will be utilized on all obstetrical patients as delineated by policy.

   Continuous electrical external fetal monitoring shall be done on all patients in active labor unless the responsible physician directs otherwise in writing. When the monitors are attached and operating, individuals qualified to read and interpret them must be present.

   When external monitor tracings result in unclear or scratch readings, consideration should be given to placing internal monitors by the physician and / or based on physician order.

   Fetal heart monitoring strips become part of the medical record of the mother or the baby.

10. When amniocentesis is recommended, the patient shall be informed of the benefits and risks of the procedure and any alternatives. When a patient refuses to have a test or procedure performed, the patient's medical record shall document that the patient was informed and refused.

11. Admission lab work should include hemogram, ABORh, Antibody Screen, RPR, HIV and other laboratory work as prescribed by the physician.

All Rh negative mothers who qualify for Rh(D) Immune Globulin shall have the necessary laboratory procedure ordered. If the patient qualifies as a recipient of Anti-Rh Immune Globulin, it shall be administered with her consent. If the patient refuses the medication, she shall be asked to sign a release. This section shall apply also to any case of abortion.

12. Mechanical rupture of membranes shall be performed only by the attending physician or qualified consultant. Re-examination of the patient is required following membrane rupture, whether spontaneous or mechanical.

13. When a purposeful sterilization procedure is performed primarily or sterilization results from another indicated operation, the responsible physician shall obtain and document in the medical record the patient's or authorized legal representative's informed consent and understanding that restoration of fertility is unlikely. Consent shall be obtained in accordance with state law.

14. A cord blood sample shall be obtained from all delivery cases for the required testing.

15. If the attending physician cannot be contacted when the patient is admitted, the department / service chief or president of medical staff / designee shall be contacted and the case discussed if urgency or emergency dictate such action.

16. The presence in the labor and delivery suite of any individual requested by the patient shall be permitted with the consent of the obstetrician, nurse, and patient. The presence in cesarean section of any individual requested by the patient shall be permitted with consent of the obstetrician, anesthetist, nurse, and patient.

17. General anesthesia shall be administered only by a qualified Anesthesiologist trained in obstetrical anesthesia administration that has been grant medical staff privileges.

18. The fetus will be continually monitored by auscultation or continuous electronic monitor while in delivery suite.

19. All cesarean sections will have a physician and surgical assistant present. Physicians must arrange their own surgical assistant coverage in advance for cesarean sections. The surgical assistant (e.g. a physician, certified first assistant, or in case of an emergency a competent registered nurse of surgical scrub tech) will be notified upon the decision to perform a cesarean section.

20. The obstetrician shall inspect the placenta and cord and record the presence of any apparent gross anomaly. The findings and number of cord vessels shall be recorded.

21. Newborn identification procedures shall be completed prior to the infant leaving the room where the delivery was performed.

22. Unassigned obstetrical patients not in labor will be evaluated and treated in the emergency department. If admission is necessary, they will be admitted to a patient care unit that best meets the need of the patient.

23. Unassigned obstetrical patients greater than 22 weeks and in labor will be transported to labor and deliver for evaluation and treatment. The patient shall remain under the care of the ER physician until the on-call OB physician has been contacted and is physically able to assume care.

24. When the appropriate site of evaluation of a patient is uncertain, the on call OB / GYN shall be contacted for guidance.

25. The emergency department on-call list will function as the OB unassigned list for any pregnant patient without a physician on staff.

26. When there are no complications or contraindications, nursing personnel may perform initial pelvic examinations and contact the physician regarding their findings. The physician should be notified immediately before any exam is performed if there is any unusual bleeding or if there is suspected leakage of amniotic fluid in a preterm patient presenting to Labor and Delivery.

27. The post partum / gyn area may be used for non-obstetric patients during periods of low occupancy. Use of the surgical delivery room for clean gynecologic cases is acceptable when staff and equipment is adequate. Obstetrical patients take precedence over non-obstetrical.

    Non-obstetrical procedures that maybe performed in the surgical delivery suite include the following:
    - Dilatation and curettage for non-infected spontaneous abortions
    - Dilatation and curettage for non-infected gynecological patients
    - Cerclage of cervical incompetence
    - Sterilization

26. A patient having evidence of labor with signs and symptoms of an infectious or contagious disease shall be confined in an isolation room for labor , delivery, and the post partum period; until such time as it can be ascertained that she is no longer a hazard to others. The newborn in this case will be placed in the isolation nursery.

27. Practitioners performing obstetrical deliveries and related procedures shall report to the hospital's infection control surveillance individual any infections that become evident after the patient has been discharged from the hospital.

XI. NEWBORN CARE

1. An initial and a discharge physical examination shall be recorded in the medical record of each newborn.

2. Oxygen shall be begun and stopped only on the written order of a physician except as permitted in emergency situations and/or as defined in a written policy / procedure.

3. PKU / metabolic screening blood testing shall ordinarily be done on all newborns prior to their discharge from the hospital to determine any deficiencies and to comply with legal requirements. If this is not possible because of early patient discharge, the mother shall be given written

instructions as to where and when this procedure is to be done and this will be documented in the medical record.

4. When the mother has a positive serology, the newborn shall have appropriate serology test as required.

5. When the mother is a known drug addict, admits it, or it is strongly suspected, if indicated for the reasons stated, appropriate testing should be performed to comply with the state.

6. A newborn infant's temperature shall be recorded and, if indicated, the newborn shall be placed in a controlled environment immediately.

6. All newborns admitted will have a pediatric physician managing the newborn stay.

7. Neonatologist will manage newborns requiring admission to neonatal intensive care. The following conditions require transfer to the Neonatologist care:
   - Severely ill neonates requiring constant nursing and continuous cardiopulmonary monitoring.
   - Any condition requiring surgery in the newborn period.
   - Symptomatic congenital heart disease.
   - Respiratory distress - persistent oxygen requirement
   - APNEA / Acute Life Threatening Event
   - Newborns requiring parenteral nutrition.
   - Hypovolemia requiring fluid resuscitation.
   - Severely premature neonates 34 weeks and less.
   - Low birth weight neonates less than 2000 grams.
   - Prolonged or recurrent seizures.
   - Suspected NEC.
   - Infants with gross anomalies that prevent normal newborn nursery stay.

9. Normal newborn eye care shall include the use of Erythromycin 0.5% ophthalmic ointment in a ½" line along the conjunctiva of both lower lids within 2 hours of admission.

10. Any newborn delivered prior to the mother's admission to the obstetrical suite shall either room with the mother or be placed in an isolette. Such infants must have appropriate tests ordered as needed.

11. Any mother with an elevated temperature of 101 degrees or more without diagnosis shall not receive her baby until the temperature has returned to normal or the cause has been determined and either treated/resolved or considered not dangerous to the baby.

12. Any newborn who is admitted to the neonatal intensive unit shall be seen by the responsible neonatologist within two (2) hours if infant is not in distress. Neonatologist must see infant within thirty (30) minutes or sooner if fetal distress on admission. When a patient is admitted to the neonatal intensive care unit is not seen by the physician individuals within 20 minutes of admission and an appropriate effort has been made to reach him, the unit medical director or president of medical staff shall be notified by the nursing director, the administrative person on call, or nursing

house supervisor and the director and / or president shall designate a physician to see the patient, and the matter shall be referred to the medical executive committee.

13. Hearing Screens will be performed on all newborns prior to discharge.

XII. SURGICAL CARE

1. All requirements in the "Medical Records" section of these rules and regulations shall apply in the care of surgical patients, particularly with reference to the history and physical examination, the completion of operative reports, and all anesthesia-related requirements. The requirements for informed consent also apply.

2. The responsible practitioner shall record and authenticate a preoperative diagnosis prior to surgery.

3. All required or ordered test reports/results (laboratory, X ray, ECG, etc.) shall be recorded in the medical record prior to the performance of any elective surgical procedure.

4. Ordinarily all specimens removed at surgery shall be sent to the hospital pathologist for evaluation and diagnosis except for authorized exempt specimen (see attachment B) or any authorized specimen exemptions, there must be another suitable means of verification of the removal (e.g., X ray, visual inspection of residual status, etc.); a witnessed statement does not suffice.

5. Discharge of patients from the post anesthesia recovery area shall be based on a physician decision. When discharge criteria are used, and when there is no written discharge order or authenticated verbal order by a physician to release the patient.

6. There shall be a systematic review and evaluation by the patient safety committee or the department of surgery or medical executive committee of all patients who require hospitalization following ambulatory same-day surgery.

7. Ambulatory same-day surgical procedures are limited to only those surgical procedures approved by the medical staff and administration.

8. Patients undergoing ambulatory same-day surgery shall ordinarily fall either into American Society of Anesthesiologist Class I, II or medically stable as determined by the surgeon or anesthesiologist, Class III, IV.

- Practitioners performing surgical procedures shall report any post discharge infections to the hospital's infection control surveillance individual.

- Surgeons must be in the operating room and ready to begin surgery at the time scheduled. In the event that the surgeon is not available at scheduled time, fifteen (15) minutes will be observed prior to one (1) phone call to the surgeon. If after the phone call another fifteen (15) minutes expires the case will be bumped and rescheduled. Only for justifiable reasons will the operating room be held longer than 15 minutes, after the reminder call to the surgeon, which is thirty (30) minutes after the time the case was scheduled.

- Surgery may be scheduled from 7:30 a.m. to 3:30 p.m. on weekdays exclusive of holidays recognized by the hospital. Scheduling is done through centralized scheduling office. After hours, holidays, and weekends, scheduling is done through the nursing house supervisor.

9. All surgical procedures will be classified when scheduled for surgery. The classifications of procedures will be as followed:
   - Class I - (Resuscitation) *immediate life or limb threatening condition*
     Cases will be handled on an individual case basis and will take precedence over all other cases.
   - Class II - (Emergency) *life or limb threat to be done within one (1) hour.*
     Emergency surgical cases will take precedence over any other procedure and will be performed within an hour in the first available surgical suite
   - Class III - (Urgent) *has to be done within 6 hours.*
     Urgent cases will be worked into the existing case schedule and performed within 6 hours of notification of need for intervention.
   - Class IV - (Acute) *has to be done within 24 hours.*
   - Class V - (Elective) - *all non-emergent/ urgent or acute cases*
     Elective surgical cases will be pre-scheduled and listed to begin at 7:30 a.m. with succeeding cases listed "to follow." Elective cases will not be listed to start later than 3:00 p.m. Cases will be accepted within the limits of the surgical practitioner privileges cards on file in the surgical suite. Cases will be scheduled in the first-come basis as called in; specific times shall not be routinely observed. Cases shall be booked only for specific patients and not by procedure only.

10. Surgical site verification is performed prior to the surgical procedure according to approved policy and procedure.

11. Prior to the start of any surgical or invasive procedure, the surgeon and surgical team will conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active not passive communication techniques.

12. Physicians and other practitioners shall abide by the OR / hospital rule on use of appropriate attire to include surgical clothes, surgical mask and surgical cap. Surgical mask are to be worn over the nose and mouth and changed at least between each case.

13. Practitioners called to consult in the operating suite shall comply with the OR/hospital dress code referenced in #12 above.

14. If at the end of a surgical procedure, the sponge, sharps, or instrument count is incorrect, the patient must be X-rayed and the film read prior to moving the patient out of the surgical suite, unless the patient's condition dictates otherwise.

15. All patients receiving general, spinal or other major regional anesthesia shall go to the post anesthesia care unit after documenting criteria has been met. Patients receiving only local anesthesia may go to the post anesthesia care unit at the discretion of the anesthesiologist. When the post anesthesia care unit is closed, the same degree of care shall be provided regardless of where the post anesthesia recovery is carried out.

16. The responsible anesthesiologist shall be in constant attendance during the entire procedure. Following the procedure, the anesthesiologist or qualified designee shall remain with the patient as long as required by the patient's condition relative to anesthesia status, and until responsibility for proper patient care has been assumed by another qualified individual.

17. The primary surgeon must remain available to provide continuous care to each of his hospitalized patients. Availability is defined by response time, is based on individual patient conditions and prudent medical judgment reflecting current acceptable standards of care; but in no case will exceed sixty 60 minute travel time. Should a surgeon not be able to provide such care, he shall arrange for and specify in the Physician's Orders of the medical record, a member of the medical staff with appropriate privileges who will be able to attend to his patient. In case of failure to name such a practitioner the president of the medical staff or the hospital president shall have the authority to call any qualified member of the medical staff should he consider it necessary. Failure of the medical staff member to meet this requirement shall be reported to medical executive committee for any action deemed appropriate.

XIII. SPECIAL CARE UNITS

1. Admission and discharge criteria must be approved by the medical staff and shall be adhered to by all practitioners using the unit. Any exception must be approved by the medical executive committee and president of the medical staff.

2. Any physician who has been credentialed by the medical staff to render care to critically ill patients can be the physician of record for patients admitted to the intensive care unit. Patients exceeding four (4) days of stay in ICU, will require consult by a physician who specializes in critical care medicine.

3. The family of patients transferred into the intensive care unit from another area of the hospital shall be notified of the transfer by the attending physician or by the nurse in charge of the unit.

4. When space and staffing permit, elective cardioversion may be performed in the intensive care or cardiac cath unit.

5. Any patient who is admitted to the Intensive Care Unit (ICU) shall be seen by the admitting physician no later than eight (8) hours of admission and no later than twelve (12) hours for Intermediate Care (IMC). When a patient is admitted to either the ICU or IMC Units, and is not seen within eight (8) hours of admission for ICU, and twelve (12) hours for IMC, and an appropriate effort has been made to reach them, the unit medical director or president of medical staff shall be notified by the critical care nursing director, the administrative person on call or nursing house supervisor nurse in charge. The director and / or medical staff president shall designate a physician to see the patient, and the matter shall be referred to the medical executive committee department/service for appropriate action.

6. Terminal patients shall not (ordinarily) be admitted to the intensive care unit. The intensive care unit shall not be used for purposes of post anesthesia recovery only.

7. The unit physician medical director, president of medical staff, or medical executive committee physician designated to provide medical direction to the unit, has the authority to make a final decision

on admissions and discharges when the unit is full and the admission of one or more patients is clinically necessary.

8. Admission and discharge criteria must be approved by the medical staff and shall be adhered to by all practitioners using the intermediate care unit and telemetry. Any exception must be approved by the medical executive committee and president of the medical staff.

9. During high utilization of intensive care, intermediate care, or telemetry, discharge criteria will be followed to facilitate appropriate bed utilization. If availability of beds reaches a critical need, and attempts to facilitate transfers with attending physicians has been unsuccessful, the medical chair or the president of the medical staff will review all patients within the special care services.
An evaluation of the patient status as it applies to the discharge criteria for special units and telemetry will be performed. If patient meets criteria for discharge, the attending physician will be informed an order will be written to transfer the patient to a lower level of care and notification of attending physician will be performed.

XIV. PSYCHIATRIC CARE

1. All patients presenting to the facility will be evaluated and arrangements for transfer to a psychiatric facility for care will be made.

2. Other than in an emergency that threatens harm to self or others by a patient, patients with psychiatric / substance abuse problems shall be placed in restraints or seclusion only after all other lesser restrictive measures has been attempted and on the order of a physician with the reason documented in the medical record. A physician will do a face-to-face assessment within one (1) hour of restraint. A time-limited order noting both start and end times from a physician shall be written.

XV. HOSPITAL EMPLOYEES

Nothing in these rules and regulations shall be construed to interfere with the hospital's right to terminate hospital employees in accordance with hospital personnel policies.

APPROVALS:

These Rules and Regulations are adopted by the Medical Staff

President of Medical Staff _____ Date _____

These Rules and Regulations are approved by the Governing Body

Chairman of the Governing Body Date

Attachment A - Computer Key Signature Authentication

Attachment B - Authorized Exempt Specimen List

Attachment C- List of Governing Body Approved Categories for Allied Health Providers

ATTACHMENT A

COMPUTER KEY SIGNATURE AUTHENTICATION

This is to verify that I have and shall be using, for the purpose of authentication of my medical records:

- ❑ A computer key, which will be used by no one other than me

By signing below, I attest that I will maintain a secure PIN number, and will be the only individual to use the PIN number. I will not delegate the use of the computerized signature to any other person or person(s).

_____
Signature

_____
Date

ATTACHMENT B

AUTHORIZED EXEMPT SPECIMEN LIST

1. Foreign Bodies and surgical devices
2. Amputations of Traumatically Injured Members
3. Foreskin
4. Normal Placentas
5. Teeth, Provided the Anatomic Name or Anatomic Number of Each Tooth or Fragment of Each Tooth, is Recorded in the Medical Record.
6. Toenails / fingernails
7. Portion of Rib Removed to Enhance Operative Area
8. Cataracts
9. Portion of the Iris Removed During Iridectomy
10. Normal Cartilage (Turbinates are not exempt), Bone, or Skin Removed during Any Open Reduction / Wiring of Facial Fractures, or Creation of Nasal Antral Window.
11. Soft Tissue Masses < 3cm
12. Incidentally Removed Tissue

ATTACHMENT C

LIST OF GOVERNING BODY APPROVED CATEGORIES FOR ALLIED HEALTH PROVIDERS

Advanced Nurse Practitioner
Audiologist

Cardiovascular Technician
Certified Registered Nurse Anesthetist
Certified Surgical Technician (CST)
Certified Surgical First Assistant (CSFA)
Clinical Perfusionists

Dental Assistant

Mental Health Counselor

Orthotist / Prothetist
Occupational Therapist
Occupational Therapist Assistant (Certified)

Physician Assistant - Certified (PA-C)
Physical Therapist
Physical Therapy Assistant
Psychologist

Registered Nurse - (Physician Assistant)
Registered Nurse First Assistant (RNFA)
Surgical Technician (ST)