SOUTHEASTERN REGIONAL MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATIONS

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MEDICAL STAFF RULES AND REGULATION

ARTICLE I

INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee (MEC) with the agreement of the medical staff, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. In case of conflict between these Rules and Regulations and the Medical Staff Bylaws, the Bylaws shall prevail. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges. Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws. This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

1.1 DEFINITIONS

"**ADVANCE DIRECTIVE**" means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives include a "Declaration of a Desire for a Natural Death," Do-Not-Resuscitate Orders and similar documents expressing the individual's preferences as specified in the Patient Self-determination Act.

"**APPOINTEE**" means any medical physician, osteopathic physician, dentist, oral/maxillofacial surgeon, podiatrist, psychologist, physician's assistant, certified registered nurse anesthetist, certified nurse midwife or nurse practitioner holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

"**CLINICAL PRIVILEGES**" means the authorization granted to a practitioner to render patient care and includes unrestricted access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

"EMANCIPATED MINOR" means a person who has not yet reached the age of 18 but who has been emancipated by judicial decree by NC Court or marriage

"**EMERGENCY**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

"**FAMILY**" means those persons who play a significant role in the individual's life. This may include persons who are not legally related to the individual.

"**HEALTH CARE AGENT**" means an individual designated in a health care power of attorney, advanced directive or judicial appointment to make health care decisions on behalf of a person who is incapacitated.

"INFORMED CONSENT" means consent obtained after being informed of the nature and risks of the proposed treatment and of the possible alternatives.

"**INVASIVE PROCEDURE**" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

"**LIFE-SUSTAINING PROCEDURE**" means a medical procedure or intervention which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

"**PATIENT**" means any person who has presented for diagnostic evaluation or medical treatment under the auspices of the Hospital.

"**PHYSICIAN**" means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the North Carolina Medical Board and who has a current valid license to practice medicine and surgery in North Carolina.

"STABILIZED" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility. In the case of a pregnant woman who is having contractions, "stabilized" means that the woman has delivered the fetus, (including the placenta).

"**PRACTITIONER**" means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or others who have been granted clinical privileges.

"**SURGEON**" refers to any practitioner performing an operation or invasive procedure on a patient, and is not limited to members of the Department of Surgery.

"**UNABLE TO CONSENT**" or "**INCOMPETENT**" mean unable to appreciate the nature and implications of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition includes minors unless they are married or have been determined judicially to be emancipated or meet other statutory criteria.

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations. In case of a conflict between definitions in this document and the Bylaws, the Bylaws definition shall prevail.

ARTICLE II

ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short term patients for care and treatment provided suitable facilities are available.

a. **Admitting Privileges**: A patient may be admitted to the hospital only by an appointee to the Medical Staff with admitting privileges.

b. **Admitting Diagnosis**: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

c. **Admission Procedure**: Admissions must be scheduled with Patient Registration. Except in an emergency, the admitting practitioner or his designee shall contact Patient Placement to ascertain whether there is an available bed. An order for an elective or routine admission must be made by the attending practitioner and presented to Patient Placement before the time the patient presents himself for admission. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. When a surgical procedure is scheduled the need for and availability of a bed for admission will be determined by Patient Placement on the day of surgery.

2.1.2 Admission Priority

Patient Placement will admit patients on the basis of the following order of priorities:

a. **Emergency Admission**: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available. Evidence of willful or continued misutilization of this category of admission will be brought to the attention of the MEC for appropriate action.

b. **Urgent Admissions**: Urgent admission patients meet the criteria for inpatient admission; however their condition is not life-threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.

c. **Elective Admissions**: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available. This category includes patients scheduled for elective surgery. If it is not possible to handle surgical admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department (ED) for stabilization and transfer to the appropriate treatment area unless an appropriately privileged physician is awaiting the patient's arrival in an

appropriate treatment area. A practitioner shall have the authority to admit a patient to the service of another practitioner only with the consent of the other practitioner. Patients in active labor shall be admitted directly to Labor and Delivery. No patient shall be admitted to any service, except obstetrics, without approval of a medical staff appointee.

After acceptance of a patient from the Emergency Department by a medical staff appointee, the ED physician may write an order on the ED record to admit the patient to that medical staff member's service.

2.2 UNASSIGNED EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the ED, the Hospital must provide for an appropriate medical screening examination with the capability of the hospital's ED, including ancillary services routinely available to the ED, to determine whether or not an emergency medical condition exists.

2.2.1 Definition of Unassigned Patient

Patients who present to the ED and require admission and/or treatment beyond the ability of the ED physician shall have a practitioner assigned by the ED physician based on the unassigned patient call schedule if one or more of the following criteria are met:

a. the patient does not have a primary care practitioner or the primary care practitioner does not indicate a preference for a referral; or
b. the patient's primary care practitioner does not have admitting privileges; or
c. the patient's injuries or condition fall outside the scope of the patient's primary care practitioner and the primary care practitioner does not have a preference for a referral: or
d. the patient is refused care by the physician of choice due to lack of current patient physician relationship (more than three years old) for the presenting condition.

2.2.2 Unassigned Call Service

a. **Unassigned Call Schedule**: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Chair, or his/her designee, shall provide the ED and the Medical Staff Office with a list of physicians who are scheduled to take emergency call on a rotating basis. Emergency call shall be from 0800 to 0800 the following day, unless otherwise determined by the department and approved by the MEC.

b. **Response Time**: It is the responsibility of the on-call physician to respond in an appropriate time frame. The on-call physician shall respond to calls from the ED within thirty (30) minutes, and shall arrive at the Hospital to evaluate the patient within 60 minutes or in a time frame reasonably determined by the ED physician in consultation with the on-call physician. If the on-call physician does not respond to being called or paged, the physician's Department Chair, or designee, shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

c. **Substitute Coverage**: It is the on-call physician's responsibility to arrange for coverage and notify the Medical Staff Office if he/she is unavailable to take call when assigned. During non-business hours the on-call physician should notify the organizational manager. Failure to notify the appropriate party of alternate call coverage may result in the initiation of disciplinary action.

d. **Refusal to See a Patient:** If the medical staff physician on call refuses to see the patient, then the chairman of the appropriate Medical or Surgical Department should be called. If he or she is not available, the President or President-Elect of the Medical Staff should be called by the Emergency Services physician.

e. **Relief from Call for Unassigned Patients**: Appointees to the Active Staff who have served 20 years on the Active Staff, shall, upon request, be relieved of all responsibilities for unassigned patients in the Emergency Division. Appointees to the Active Medical Staff whose combined age and years of service on the Active Staff equal 75 have the option to request relief from responsibilities for unassigned patients in the Emergency Division**.** Requests for relief from call responsibilities must be made 180 days in advance but not less than 90 days in advance.

2.2.3 Unassigned Patient Discharges

In cases where the ED consults with the unassigned call physician and no admission is deemed necessary, the ED physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide a timely and appropriate follow-up appointment for the patient following the ED visit.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the ED within 30 days for the same illness will be referred to the assigned practitioner from the initial visit or his/her designee. If the return is for a different problem or more than 30 days after the initial visit the patient shall be assigned to the practitioner taking unassigned call that day, unless the patient expresses a preference for the initial practitioner.

2.2.5 Guidelines for Departmental Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules, regulations, and policies that are binding on the members of their department. The following rules should be used in developing departmental policies regarding unassigned emergency call obligations:

a. Unassigned call duties should be based on the appointee's clinical privileges.

b. When four or more physicians in a particular specialty are on the Active Staff and who are still responsible for unassigned call, it is the responsibility of the physicians in that specialty to provide the Emergency Services Department with continuous on-call coverage by responding as indicated in this document.

c. If there are fewer than four physicians in a particular specialty each of these physicians shall take call at least one-fourth (1/4) of the time, including weekends and holidays.

d. A sub-specialist who sees and treats only patients in his or her subspecialty, and not general medical services in his or her office or at the hospital, will be required to take unassigned call only in their subspecialty. A sub-specialist will be responsible for subspecialty call in the same manner as the other specialties.

e. Unassigned call duties may be divided by division, specialty, or subspecialty.

f. An impairment which is alleged to limit an appointee's ability to provide unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.

g. Departmental rules and regulations concerning unassigned call must be approved by the MEC.

2.2.6 Definition of Qualified Medical Personnel for purposes of EMTALA

a. All individuals presenting to Southeastern Health's dedicated emergency department (as defined by law and in policy) for examination or treatment shall be given an appropriate medical screening examination (MSE) by qualified medical personnel (QMP) to determine if an emergency medical condition exists. QMP include physicians, physician assistants, nurse practitioners, midwives (for labor and delivery patients only), and registered nurses if the nurse is acting within the scope of their license.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities must comply with hospital transfer policies and must meet the following criteria:

a. The patient must be medically stable for transfer or stabilized to the best ability of the transferring facility;

b. The patient's condition must meet medical necessity criteria for inpatient admission;

c. The patient must require, and SRMC must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility; This condition may be waived if the patient requests transfer to this facility;

d. Responsibility for the patient must be accepted by a physician with admitting privileges at SRMC;

e. Availability of an appropriate bed must be verified;

f. Patients may be temporarily sent to another facility for care not available at SRMC and then received back after that care is completed.

2.3.2 Transfers within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. The attending practitioner will be notified of all transfers.

2.3.3. Transfers to Another Hospital

When the hospital does not provide the services required by a patient or by a person seeking necessary medical care, or if for any reason the patient cannot be admitted to the hospital, the hospital or attending physician, or both shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. Patients who are transferred to another hospital must follow the Hospital policy on transfers to ensure EMTALA compliance, as well as all medical staff policies, rules and regulations regarding transfers.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self -harm and to assure the protection of others. Acute care admissions to a non-psychiatric unit of patients who are a danger to themselves or others due to behavioral health issues will not be accepted except for those patients requiring medical stabilization. Once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric unit.

2.5 PROMPT ASSESSMENT

New admissions must be personally examined and evaluated by the attending physician or his/her designated covering physician within 24 hours. Patients admitted to critical care units must be seen within 4 hours. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending practitioner or his or her designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. The discharge instructions may be provided in electronic format at the patient's request. These instructions should include:

a. A list of all medications the patient is to take post-discharge;
b. Dietary instructions and modifications;
c. Medical equipment and supplies, if appropriate;
d. Instructions for pain management, if appropriate;
e. Any restrictions or modification of activity;
f. Follow up appointments and continuing care instructions;
g. Referrals to rehabilitation, physical therapy, and home health services; and
h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGES AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending practitioner (AMA), or without a discharge order, hospital policy shall be followed. The attending physician shall be notified that the patient has left against medical advice.

If the attending physician is present to speak with the patient the attending physician shall carefully explain to the patient the risks to the patient's health posed by such a decision and shall document in the patient's medical record (1) the patient's request to leave against medical advice, and (2) that the patient was informed of the risks posed by such a decision. The patient shall also be asked to sign the hospital's release form, and if the patient refuses, this shall also be documented in the patient's medical record.

2.8 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the MEC.

ARTICLE III

MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of the physician components to

ensure a complete and legible medical record for each patient, including completion of all uncompleted areas of dictation transcripts
A complete medical record includes the following:
(1) Identification data;
(2) date of admission and discharge;
(3) history, including:
    (a) chief complaint;
    (b) details of the present illness;
    (c) relevant past, social and family histories, and
    (d) treatment plan.
(4) provisional diagnosis;
(5) physical examination;
(6) diagnostic and therapeutic orders;
(7) evidence of appropriate informed consent and any advance directive;
(8) clinical observations, progress notes, nursing notes, and consultation reports;
(9) reports of procedures, tests, and the results, including:
    (a) pre-operative diagnosis and operative report;
    (b) pathology reports;
    (c) clinical laboratory examination reports;
    (d) medical imaging examination reports; and
    (e) anesthesia records;
(10) final diagnosis, condition on discharge, and summary or discharge note; and
(11) autopsy report, when performed.

3.2 AUTHENTICATION

a. All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means. Electronic signatures are acceptable as long as a list of key codes is maintained under adequate safeguard by hospital administration/designee.
b. The MEC may set requirements for documents that must be electronically authenticated.
c. Each entry must be individually authenticated by the signature or initials of the individual making the entry.
d. Full signature (not initials) is required for Face Sheet.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and write the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

The clarity, completeness, and legibility of medical record documentation may be considered in evaluating the practitioner at the time of reappointment. Practitioners whose medical record entries are habitually unclear, incomplete, or illegible may be subject to one or more of the following corrective actions as determined by the MEC:

a. Required attendance at educational programs on documentation and penmanship as determined by the MEC;

b. A requirement that medical record entries be dictated or recorded by electronic means;

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Standard Abbreviations: Only standard symbols and abbreviations will be used. To be considered "standard," the symbol or abbreviation must be listed in the most recent edition of Stedman's Medical Dictionary. If a non-standard symbol or abbreviation is used, its full meaning must be explained on the same page.

Prohibited Abbreviations, Acronyms, and Symbols: The MEC shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. These will include at a minimum:

- U for Units
- IU for International Units
- QD for Daily
- QOD for Every Other Day
- Trailing Zero (X.0)
- Always Use Leading Zero (0.X)
- MS or MSO4 for Morphine Sulfate
- MGSO4 for Magnesium Sulfate)

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses and procedures on the face sheet of the medical record.

3.5 CORRECTION OF ERRORS

Medical records should not be improperly altered. When it is necessary to correct an error in the handwritten medical record these guidelines should be followed:

a. A single line should be draw through the erroneous entry; under no circumstances should the original entry be obscured;

b. The corrected entry must be authenticated with the practitioner's signature and the date and time.

3.6 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.6.1 Time Limits

Time limits for performance of the history and physical examination are noted in the Medical Staff Bylaws.

3.6.2 Who May Perform and Document the Admission History and Physical Examination

Who may perform the history and physical examination are noted in the Medical Staff Bylaws.

3.6.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

A complete history and physical examination report must meet the criteria and include the elements included in hospital policies.

When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available. Readmissions within twenty-four (24) hours require only a progress note.

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure because a delay to do so could result in harm to the patient, pertinent findings must be documented in a progress note prior to performance of the procedure. The history and physical must then be performed expeditiously as soon as practical.

A focused history and physical examination report, used for outpatient procedures that do not require general anesthesia, should include the following information:

a. Chief complaint or reason for the admission or procedure;

b. A description of the present illness;

c. Past medical history, including current medications, allergies, and current diagnoses;

d. A review of systems relative to the procedure planned;

e. Relevant physical findings, including an evaluation of the cardiac and respiratorysystems;

f. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.6.4 Admitting Practitioner is Responsible for the Admission History and PhysicalExamination

Completion of the patient's admission history and physical examination is the responsibility of the admitting practitioner or his/her designee.

3.7 PREOPERATIVE DOCUMENTATION

3.7.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

a. all procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Radiology Department and Cath Lab (e.g. angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation,

c. electrophysiologic studies, and ablations, and

d. procedures performed in other treatment areas, including those requiring conscious sedation, (e.g. bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central or arterial line insertions, and elective electrical cardioversion).

3.8 PROGRESS NOTES

The attending physician, or his/her designee, will record a progress note each day, and at the time of each patient encounter on all hospitalized patients. Progress notes must document the reason for continued hospitalization and shall contain sufficient content to identify the patient's clinical problems, plan of treatment, as well as results of tests and treatment. Progress notes made by individuals privileged to do so need not be countersigned by a physician. Progress notes on hospice patients not admitted to an acute care unit shall be written as needed based upon the medical necessity and the hospice plan of care for individual patients.

3.9 OPERATIVE REPORTS

Operative reports will be written or dictated and signed within 72 hours after the procedure by the surgeon and made a part of the patient's current medical record. Operative reports will include:

a. the name of the licensed independent practitioner(s) who performed the procedure and any assistants,
b. the name of the procedure performed,
c. a description of the procedure performed,
d. findings of the procedure,
e. any estimated blood loss,
f. any specimen(s) removed, and
g. the post-operative diagnosis.
h. grafts and implants

3.10 OPERATIVE NOTES

A written operative progress note should also be entered in the medical record immediately after surgery by the time the patient is moved to another level of care in order to provide pertinent information for use by any practitioner who is required to attend the patient. Operative notes will include:

a. the name of the licensed independent practitioner(s) who performed the procedure and any assistants,
b. the name of the procedure performed,
c. anesthesia type
d. findings of the procedure,
e. any estimated blood loss,
f. any specimen(s) removed,
g. complications, and
h. the post-operative diagnosis.

3.11 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed to include the date and time of the consultation and signature of the consultant and placed on the patient's chart within the time frame specified by the physician ordering the consult and no later than 24 hours.

If the report is not on the chart within the prescribed time, an explanatory note should be recorded in the chart. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation.

3.12 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record, and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical for uncomplicated vaginal deliveries if it is legible and complete. A complete H & P will be required upon admission if the patient has not received prenatal care, there has been no recent evaluation that the progress of pregnancy has been normal, or new risk factors have been identified. If the office prenatal record is used as the history and physical examination, an update must be performed as described in the Bylaws.

3.13 FINAL DIAGNOSES

The final diagnoses will be recorded in full dated and signed by the attending physician at the time of discharge, transfer, or death of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient's record. Once the pending diagnostic information has been received and a definitive diagnosis has been made, the practitioner will be required to document the diagnostic findings and final diagnosis in the patient's medical record.

3.14 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries will be authenticated by the attending physician or his/her designee.

a. **Content**: A clinical summary will be written or dictated upon the discharge or transfer of hospitalized patients. The discharge summary is the responsibility of the attending physician and will contain:

    1. Reason for hospitalization;
    2. Summary of hospital course, including significant findings, the procedures performed, and treatment rendered;
    3. Condition of the patient at discharge;
    4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
    5. Final diagnoses.

    a. When preprinted instructions are given to the patient or family, the record should so indicate and a copy of the instruction sheet used should be a part of the medical record.

b. **Short-term Stays**: A discharge summary is not required for uncomplicated vaginal deliveries or normal newborn infants, provided the discharging physician enters a final progress note or completes a Discharge Form documenting:

   1. The condition of the patient at discharge; and
   2. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

c. **Deaths**: A clinical summary is required on all inpatients who have expired and will include:

   1. Reason for admission;
   2. Summary of hospital course; and
   3. Final diagnoses.

d. **Timing**: A Discharge Summary must be entered in the medical record in a timeframe complying with HIM standards.

3.15 DIAGNOSTIC REPORTS

Diagnostic tests (including but not limited to radiologic imaging, EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read and reported by the physician scheduled to provide the interpretation service within 24 hours. Failure to provide prompt interpretation shall be reported to the department chair and may result in disciplinary action.

3.16 ADVANCED PRACTICE PROFESSIONALS

The attending or supervising physician will review and authenticate all entries made in the medical record by the Advanced Practice Professional within 48 hours. Departments or sections may request from the MEC a longer time period for system or staffing reasons. The signature signifies that the attending or supervising physician has reviewed the patient's medical record and approved the care rendered by the Advanced Practice Professional and is not a countersignature authenticating the entry.

3.17 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

a. **Access to Old Records**: In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended by the same practitioner or by another practitioner.

b. **Unauthorized Removal of Records**: Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the MEC.

c. **Access for Medical Research**: Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must

have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

d. **Access for Former Members**: Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

e. **Access for Patients**: When a patient requests access to his/her medical record access will be granted in accordance with hospital policy as approved by the medical staff.

3.18 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner as determined by Health Information Management or is ordered filed by the MEC.

3.18.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record by the attending physician or his/her designated covering physician within 24 hour of admission;

b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure. An updated patient examination must be documented on the chart within 24 hours of surgery;

c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering physician within 24 hours of an obstetrical admission

d. An Operative Note must be entered in the medical record by the performing practitioner immediately following the surgery or procedure;

e. An Inpatient Progress Note must be recorded and authenticated by the attending physician or designated covering practitioner at the time of each encounter, and on a daily basis;

f. An Emergency Department Record must be completed by the responsible practitioner within 24 hours of the encounter;

g. A Consultation Note must be completed by the consulting physician within 24 hours of the consult request;

h. A Diagnostic Report must be completed by the interpreting physician within 24 hours of the test or procedure;

i. A Discharge Summary must be entered in the medical record by the attending physician or his/her designee within 14 days of an inpatient or observation discharge, transfer, or death; and

j. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary. Following discharge, the patient's medical record will be held in the Health Information Management Department to allow receipt and insertion of pertinent reports. A medical record shall not be permanently filed until it is determined complete by the Health Information Services Department or ordered by the MEC.

k. These records are available upon request. Handwritten records will be placed in the appropriate practitioner's incomplete record area for completion. Electronic records must be completed electronically.

3.18.2 Voluntary Relinquishment of Clinical Privileges for Incomplete Records

A practitioner will be declared delinquent if his/her medical records are not complete within the time periods specified in Section 3.18.1. After the practitioner has been declared delinquent s/he will be notified of the delinquency. If all delinquent records have not been completed one week after notification, his or her clinical privileges shall be considered to be voluntarily relinquished with the exception of emergency admissions/procedures and unassigned call responsibilities [See Section 2.2]. Inpatient and outpatient procedures scheduled prior to the practitioner being placed on the suspension list will be honored; however, no new procedures will be scheduled until all delinquent records are complete. The practitioner will be notified by the Health Information Management Department prior to the relinquishment to give the practitioner an opportunity to complete his/her record(s). This relinquishment of clinical privileges shall continue until all delinquent records are completed.

3.18.3 Suspension of Medical Staff Appointment

If a practitioner's clinical privileges have been suspended for fourteen (14) consecutive days as described in Section 3.18.2, and the record which caused the suspension has not been completed, his/her Medical Staff appointment will be suspended. The practitioner shall not be allowed to schedule admissions or inpatient/outpatient procedures shall not be allowed to order diagnostic tests or therapeutic procedures, shall not be allowed to evaluate or treat patients in any department of the Hospital, and may not exercise any of the prerogatives of Medical Staff appointment. This suspension of appointment shall continue until all delinquent records are completed. The practitioner may be assessed a fine, as established by the MEC, each day for every record that is not completed. Failure to pay fines assessed for medical record delinquency shall be grounds for suspension and/or termination.

3.18.4 Termination of Medical Staff Appointment

a. Failure to complete a medical record within thirty (30) days of being declared delinquent shall constitute an automatic termination of Medical Staff appointment.

b. If a practitioner's Medical Staff appointment is suspended, as described in Section 3.18.3, six (6) times within any 12 month period, this shall also constitute an automatic termination of Medical Staff appointment.

c. Practitioners whose Medical Staff appointment is terminated pursuant to this section may reapply for appointment after payment of a fee established by the MEC. Automatic termination due to medical record delinquency shall not be reported to the National Practitioner Data Bank or to the State Board of Medical Examiners.

3.18.5 General Rules Regarding Medical Record Delinquency

a. In determining medical record delinquency, considerations will be given for vacations or other extended absences provided that the Medical Staff Office is notified prior to the date of the vacation or absence. A practitioner will not be declared delinquent while on vacation or absence provided that all records are completed at the time the practitioner gives notice of vacation or absence.

b. If a physician demands admission of a patient despite suspension of his or her privileges and appointment, Hospital personnel will direct the physician to contact his or her Department Chair or

the President of the Medical Staff. The Department Chair or President of the Medical Staff may consider allowing the admission in an emergency situation.

c. No references will be provided for any practitioner who leaves the staff until all medical records are complete.

3.19 ELECTRONIC RECORDS AND SIGNATURES

"Electronic signature" means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.20 MEDICAL RECORD FORMS IN PAPER FORMAT

a. **Required-use Forms**: The MEC may adopt and require the use of specific forms in the medical record. Prior to adoption, these forms should be reviewed by the Health Information Management Director.

b. **Practitioner-created Forms**: Forms created by Medical Staff appointees for their individual use may be used in the medical record if they are approved in advance through the process developed by the hospital and approved by the MEC.

c. **Periodic Review**: Medical record forms shall be periodically reviewed. The review date of the form shall be printed on the form, and forms may not be used more than a year after the review date.

ARTICLE IV

STANDARDS OF PRACTICE

4.1 ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The attending physician, or designee, will be responsible for:

a. the medical care and treatment of each patient in the Hospital;

b. making daily rounds; and

c. the prompt, complete, and accurate preparation of the medical record.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record. The hospitalist service may be designated as the attending physician and shall manage attending responsibilities internally.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff appointee, a note covering the transfer of responsibility will be entered as an order in the medical record by the attending physician.

4.2 COVERAGE AND CALL SCHEDULES

Each physician shall provide the Medical Staff Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who shall be responsible for the care of their patients in the Hospital when the physician is not available, and who has sufficient clinical privileges to do so. Each physician is responsible to provide a current and correct call schedule to the Medical Staff Office. Failure to meet the above requirements may result in loss of clinical privileges. An individual who does not wish to arrange coverage for his/her hospital practice must receive special permission from the MEC.

4.3 RESPONDING TO CALLS AND PAGES

Practitioners are expected to responding promptly within thirty minutes to calls from the Hospital's patient care staff regarding their patient.

4.4 ORDERS

4.4.1 General Principles

a. All orders shall be in writing, except as otherwise provided in this document.

b. Orders must be clear and unambiguous.

c. All inpatient orders must be specifically given by a practitioner who is privileged by the Medical Staff.

d. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.

e. Instructions should be written out in plain English. Prohibited abbreviations may not be used.

f. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible signature, date, and time.

4.4.2 Verbal Orders

Verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal orders must comply with the following criteria:

a. The order must be given to an authorized individual as defined in hospital policy.

b. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal orders, like written orders, should be conveyed in plain English without the use of prohibited abbreviations.

c. The order must be read back to the prescribing practitioner by the authorized person receiving the order.

d. All verbal orders must be signed by the ordering practitioner or designee within 48 hours unless State law specifies a different (either shorter or longer) time frame.

e. The following orders may not be given verbally:
   1. Orders for cancer chemotherapy;
   2. A do-not-resuscitate order;
   3. An order to withhold or withdraw life support.

4.4.3 Telephone Orders

Orders dictated over the telephone must comply with the requirements of verbal orders as described in subsection 4.4.2 above.

4.4.4 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;

b. The order is legible, clear, and complete

c. The identity of the patient is clearly documented;

d. The facsimile contains the name of the ordering practitioner, his address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;

e. The original order, as transmitted, is signed, dated, and timed; and

f. The facsimile, as received, is signed by the attending physician or ordering practitioner within thirty (30) days of discharge.

4.4.5 Electronic Orders

The MEC shall develop and maintain policies regarding the use of electronic orders and computerized order entry consistent with federal and state law.

4.4.6 Cancellation of Orders Following Surgery or Transfer

All previous orders are canceled when the patient:

a. goes to surgery,

b. is transferred from the Rehabilitation unit to an acute care area,

c. is transferred to, and readmitted from, another hospital or health care facility, or

d. is transferred from one level of care to another in the hospital.

New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.7 Drugs and Medications

a. **Hospital Formulary**: To assure the availability of quality pharmaceuticals at a reasonable cost, practitioners shall comply with the formulary system established by the MEC upon the recommendation of the Pharmacy Director or the Pharmacy and Therapeutics (P&T) Committee.

b. **Substitution**: Medication orders written for trade-name drugs may be dispensed as the formulary generic drug unless the physician specifically writes "Do Not Substitute" on the patient order sheet. The MEC (MEC) shall adopt policies concerning automatic therapeutic substitution upon the recommendation of the Pharmacy Director, medical staff and P&T Committee.

c. **Approved Drugs**: Only drugs and medications listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations may be administered to patients in the Hospital, the only exception being drugs for bona fide clinical investigation.

d. **Investigational Drugs**: Investigational drugs shall be used in full accordance with the guidelines established by the Hospital's Institutional Review Board, and shall comply with all regulations of the US Food and Drug Administration and Drug Enforcement Administration.

e. **Controlled Substances**: Only practitioners holding a currently valid DEA (Drug Enforcement Agency) Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category.

f. **Definition of a Complete Medication Order**: All medication orders shall include the drug name, the metric mass or concentration, the dosage form, the route of administration, the schedule of administration, and if appropriate, the date and time of discontinuation. If appropriate, a dilution and rate of administration should be specified. All medication orders that are incomplete will be called to the attention of the ordering practitioner for clarification prior to being dispensed.

g. **Dosing Formats**: SI (metric system) units must be used in medication orders except for therapies that use standard units (such as insulin and vitamins). Exact dosage strengths (such as milligrams) shall be used rather than dosage form units (such as "vials" or "ampules"). Apothecary and avoirdupois system units (i.e., grains, drams, minims, and ounces) shall not be used. A leading "0" must precede a decimal expression of less than one (e.g., 0.5 mL). A terminal "0" (e.g., 5.0 mL) following an integer should not be used. The use of decimals should be avoided when possible (e.g., prescribe 500 mg instead of 0.5 g).

h. **Hold Orders**: Instructions to nursing to "hold" a medication should be specific and must include the name of the medication to hold and the number of doses to hold. If it is uncertain that a medication will be resumed, a "stop" or "discontinue" order should be given.

i. **PRN Orders**: "PRN" or "as needed" orders must be qualified by listing the indication for the medication.

j. **Medication Errors**: The MEC shall adopt policies and procedures that minimize drug errors upon the recommendation of the Pharmacy Director and appropriate P&T and safety committees.

k. **Automatic Stop Orders**: Drugs and biologicals not specifically prescribed as to time or number of doses may automatically be stopped after a reasonable time that is established by the MEC upon the recommendation of the Pharmacy and appropriate P&T and patient safety committees.

l. **Patient's Own Drugs**: If patients bring their own drugs to the hospital, these drugs shall not be administered unless the attending physician has written an order for their administration and the identity of the drug has been verified by a qualified pharmacist. If the drugs are not ordered by the

attending physician, they shall be packaged, sealed, and returned to the patient at the time of his discharge from the hospital

m. **Non-formulary Medications**: The Formulary System does not prevent any member of the Medical Staff from prescribing a non-formulary drug product if required in therapy of an individual patient. Non-formulary medications shall be ordered in compliance with the hospital medication policies.

n. **Addition of Medications to the Formulary:** New medications shall be added to the formulary through the process outlined in the hospital medication policies and approved by the MEC.

4.4.12 "Stat" and Critical Orders

a. "Stat" or "now" orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. "Stat" and "now" orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of "stat" and "now" orders may be grounds for corrective action.
b. Critical orders should be ordered and administered per hospital policy.

4.5 CONSULTATION

a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges. The attending physician will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his/her patient. This request shall specify:

    1. the reason for the consultation;

    2. the urgency of the consultation (emergent – within 1 hour; urgent—within 4 hours; today—before midnight; or routine—within 24 hours); and

    3. whether the attending physician requests the consulting practitioner to only render an opinion, provide treatment in his or her area of specialty, or assume the role of attending physician.

b. When an emergent, urgent or today consult is requested, after it is completed the consultant will call the person who requested the consult or the covering physician to discuss recommendations.

c. Consults will be completed within 24 hours of the formal request unless a later time is agreed to by the consultant and the requesting practitioner.

d. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to his/her manager to be addressed through the nursing chain of authority. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.

e. When requesting emergent, urgent or today consults the requesting practitioner or designee will make direct contact with the consultant

f. If the involved medical staff disagree regarding whether a consultation is needed and are unable to resolve the disagreement the consultation will occur.

g. The medical staff may establish further policies and procedures pertaining to consultation requirements, requests and reports.

4.6 CRITICAL CARE UNITS

Critical care units are the Intensive Care Unit (ICU), the Intermediate Care Unit (IMU) and the Cardiovascular ICU (CVICU).

4.6.1 Critical Care Unit Privileges

The privilege to admit patients to, and manage patients in, critical care units shall be specifically delineated. Decisions regarding the validity of admissions to, or discharge from the ICU and IMU will be made when needed through consultation with the Medical Director for Critical Care for the ICU and IMU and with the patient's attending physician.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician within four (4) hours of admission or transfer. Earlier examination may be required depending on the patient's condition.

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The MEC shall establish policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by the attending practitioner or his/her designee within a reasonable time per hospital policy as approved by the medical staff. . The attending physician or his/her designee is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.7.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization per hospital policy as approved by the medical staff.

4.8 AUTOPSY

It is the duty of the attending physician or their designee to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico legal or educational interest. Autopsies may be referred to other hospitals per hospital and medical staff policies.

4.9 SUPERVISION OF ADVANCED PRACTICE PROFESSIONALS

4.9.1 Definition of Advanced Practice Professionals

Advanced Practice Professionals, including, but not limited to, Clinical Psychologists, Advance Practice Registered Nurses, and Physician Assistants, are licensed or certified health care practitioners whose license

or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Professionals are defined in the Medical Staff Bylaws. Advanced Practice Professionals may provide patient care only under the supervision of a physician who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership unless membership is allowed by the Medical Staff Bylaws.

4.9.2 Guidelines for Supervising Advanced Practice Professionals

a. The physician is responsible for managing the health care of patients in all settings.

b. Health care services delivered by physicians and by Advanced Practice Professionals under their supervision must be within the scope of each practitioner's authorized practice, as defined by state law and allowed by the hospital and medical staff.

c. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Professional, ensuring the quality of health care provided to patients.

d. The physician is responsible for the supervision of the Advanced Practice Professional in all settings.

e. The role of the Advanced Practice Professional in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the physician and the Advanced Practice Professional.

f. The physician must be available for consultation with the Advanced Practice Professional at all times, either in person or through telecommunication systems or other means.

g. The extent of the involvement by the Advanced Practice Professional in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Professional, as adjudged by the physician.

h. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Professional.

i. The physician and Advanced Practice Professional together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.

j. The supervising physician is responsible for clarifying and familiarizing the Advanced Practice Professional with his or her supervising methods and style of delegating patient care.

k. Each Advanced Practice Professional must document the identity of their supervising or collaborating physician and one or more alternate supervising physician.

4.9.4 Collaborative Practice Agreements

Each Advanced Practice Professional must have on file in the Medical Staff Office written Supervision Agreement, if applicable, that describes all health care-related tasks which may be performed by the Advanced Practice Professional. This document must be signed by the Advanced Practice Professional, the supervising physician, and all alternate supervising physicians. The Supervision Agreement shall be submitted to the Credentials Committee and the MEC for approval before the Advanced Practice

Professional can provide services to patients at the Hospital. The Supervision Agreement, if applicable, must include:

a. the name, license number and addresses of all supervising physicians;

b. the name and practice address of the Advanced Practice Professional;

c. the date the guidelines of the Supervision Agreement were developed and dates they were reviewed and amended;

d. medical conditions for which therapies may be initiated, continued, or modified;

e. treatments that may be initiated, continued, or modified;

f. drug therapies, if any, that may be prescribed with drug-specific classifications; and

g. situations that require direct evaluation by or immediate referral to the supervising physician.

4.9.5 Supervising Physician

An APP may provide services to patients when the supervising physician is more than sixty (60) minutes travel time from the hospital if a backup supervising physician has been assigned and is confirmed to be within sixty (60) minutes travel time. Exceptions to this policy may be approved by the Medical Executive Committee (MEC).

A Medical Staff appointee who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of an Advanced Practice Professional or other dependent health care professional shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.9.6 Medical Record Documentation

Advanced Practice Professionals may enter progress notes and write orders within the scope of their written Supervision Agreement.

4.9.7 Other Limitations on Advanced Practice Professionals

An Advanced Practice Professional may not:

a. provide a service which is not listed and approved in the Supervision Agreement on file in the Medical Staff Office;

b. prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented in the Supervision Agreement; and

c. provide a medical service that exceeds the clinical privileges granted to the supervising physician.

4.10 INFECTION CONTROL

All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties. The admitting practitioner shall be responsible for providing the hospital with such information concerning the patient as may be necessary to protect the patient, other patients or hospital personnel from infection, disease, or other harm.

4.11 CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. The MEC may adopt and require use of evidenced-based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

4.12 COMMITTEE PARTICIPATION

The medical staff shall participate in hospital and medical staff committees as necessary to fulfill those medical staff functions as stated in the Medical Staff Bylaws and required by regulatory agencies. The MEC may commission or decommission medical staff committees as needed to fulfill these functions. The President of the Medical Staff will appoint medical staff members to hospital and medical staff committees in consultation with appropriate medical staff members, unless otherwise allowed in the Medical Staff Bylaws, Rules and Regulations or MEC approved medical staff policies. The medical staff and the hospital may further define the composition and responsibilities of committees and may adjust the names of committees. Committee participation includes, but is not limited to, the following committees:

Cancer Committee

Composition: The Cancer Committee shall be multidisciplinary hospital committee with required members as appropriate to the institution to maintain certification by the American College of Surgeons Commission on Cancer as a Community Hospital Cancer Program.

Responsibilities: The committee provides program leadership with duties as described in the Standards of the Commission on Cancer.

Pharmacy and Therapeutics Committee

Composition: The Pharmacy and Therapeutics Committee shall be a hospital committee and shall consist of at least four (4) members of the medical staff.

Responsibilities: The committee shall be responsible for pharmacy and medication functions outlined in Part IV of the Medical Staff Bylaws.

Infection Control Committee

Composition: The Infection Control Committee shall be a hospital committee and shall consist of at least four (4) members of the medical staff, one of whom is a pathologist

Responsibilities: The committee shall be responsible for those functions pertaining to infection control outlined in Part IV of the Medical Staff Bylaws.

Bylaws Committee

Composition: The Bylaws Committee shall be a medical staff committee and shall consist of at least five (5) members of the medical staff, two of whom shall be past presidents and President-elect of the Medical Staff. This committee will be a medical staff ad hoc committee.

Responsibilities: The committee shall be responsible for the Bylaws functions described in Part IV of the Bylaws.

Critical Care Committee

Composition: The Critical Care Committee shall be a multi-disciplinary hospital committee and shall consist of at least three (3) members of the medical staff.

Responsibilities: The committee has the responsibility for overseeing the care provided in the Critical Care Units. The committee will review the general treatment of individual cases, will develop critical care unit policies, procedures and processes and recommend equipment and medications for use in critical care units

Medical Records Committee

Composition: The Medical Records Committee shall be a hospital committee and shall consist of at least one (1) representative from the medical staff.

Responsibilities: The committee shall be responsible for those medical records functions and Health Information Management functions described in Part IV in the Medical Staff Bylaws.

Surgical Services Committee

Composition: The Surgical Services Committee shall be a hospital committee and shall consist of at least three (3) members of the medical staff.

Responsibilities: The committee has the responsibility of reviewing, developing and implementing operating room procedures, policies and processes; updating operating room policies; and considering issues that pertain to the operating room

Emergency Services Committee

Composition: The Emergency Services Committee shall be a multidisciplinary hospital committee and shall consist of the Director of Critical Care Services and at least one (1) representative from each of the Departments of Medicine and Surgery, the Emergency Services Division, Patient care Services, and medical center management.

Responsibilities: This committee has the responsibility of reviewing, developing and implementing Emergency Department procedures, policies and processes, recommending equipment and medications for use in the Emergency Department, updating Emergency Department policies and considering issues that pertain to the Emergency Department. It also is responsible for those emergency preparedness functions described in Part IV of the Bylaws.

Medical Ethics Committee

Composition: The Medical Ethics Committee shall be a hospital committee and shall consist of at least three (3) members of the medical staff.

Responsibilities/Purpose: This committee shall be responsible for those biomedical ethics functions described in Part IV of the Medical Staff Bylaws.

Practitioner Health Committee

Composition: The Practitioner Health Committee shall be a medical staff committee and shall consist of at least three (3) members of the active medical staff, one from each department and a member of the psychiatry division.

Responsibilities: This committee shall be responsible for those practitioner health functions described in Part IV of the Medical Staff Bylaws.

Utilization Management Committee

Composition: The Utilization Management Committee shall be a hospital committee unless otherwise required by regulatory bodies and shall consist of at least two (2) members of the medical staff.

Responsibilities: This committee shall be responsible for the utilization management functions described in Part IV of the Medical Staff Bylaws.

ARTICLE V PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in Hospital policy.

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Medical Staff and Hospital policy.

5.3 WITHDRAWING AND WITHHOLDING LIFE SUSTAINING TREATMENT

Hospital and Medical Staff policies on withdrawing and withholding life sustaining medical treatment delineate the responsibilities, procedure, and documentation that must occur when withdrawing or withholding life-sustaining treatment.

5.4 DO-NOT-RESUSCITATE ORDERS

The Hospital and Medical Staff policies on 'Do Not Resuscitate' delineate the responsibilities, procedure, and documentation that must occur when initiating or cancelling a Do Not Resuscitate order.

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

The Hospital and Medical Staff policies on 'Disclosure of Unanticipated Outcomes' delineate the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur.

5.6 RESTRAINTS AND SECLUSION

The Hospital and Medical Staff policies on restraints and seclusion delineate the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.7 ADVANCE DIRECTIVES

The Hospital and Medical Staff policies on advance directives delineate the responsibilities, procedure, and documentation that must occur regarding Advance Directives.

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital and Medical Staff policy should be followed.

ARTICLE VI

SURGICAL CARE

6.1 SURGICAL PRIVILEGES

Members of the Medical Staff and other appropriately privileged practitioners may perform surgical or other invasive procedures in the surgical suite or other locations within the Hospital as approved by the MEC.

Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICIES AND PROCEDURES

All practitioners shall comply with the Medical Staff and Hospital surgical policies and procedures. These policies and procedures will cover the following: procedures for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations); emergency procedures; requirements prior to anesthesia and operation; outpatient procedures; care and transport of patients; use of operating rooms; contaminated areas; conductivity and environmental control; and radiation safety procedures.

6.3 ANESTHESIA

Moderate or deep sedation and anesthesia may only be provided by qualified practitioners who have been granted clinical privileges to perform these services per medical staff policy. The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving deep sedation and anesthesia. The practitioner responsible for the ordering the administration of moderate sedation will document a pre-sedation evaluation and post-sedation follow-up examination.

6.4 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens, as defined in pathology policy, are exempt from pathology examination. The pathologist's report will be made a part of the patient's medical record.

6.5 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID wrist band with the patient's name and a second identifier as chosen by the hospital. The Hospital policy on 'Universal Protocol' shall be followed.

ARTICLE VII

RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. Disruptive behavior includes, but is not limited to, behavior that interferes with the provision of quality patient care; intimidates professional staff; creates an environment of fear or distrust; or degrades teamwork, communication, or morale. The Medical Staff and Hospital policy on medical staff professional conduct shall be followed.

7.2 REPORTING IMPAIRED PRACTITIONERS

Reports and self referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall follow the guidelines outlined in the Medical Staff and Hospital policy on practitioner impairment.