Medical Staff Bylaws

Appendix B

Rules and Regulations

CANYON VISTA MEDICAL CENTER
MEDICAL STAFF BYLAWS

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APPENDIX "B" – RULES AND REGULATIONS

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

ARTICLE I - ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

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

(b) A patient may be admitted to the Hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated and is not automatic with Medical Staff membership.

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

(d) Emergency Department Physicians, and physicians providing care in the Intensive Care Unit (ICU), shall be required to maintain documentation regarding current ACLS certification. Physicians admitting to ICU without ACLS certification will be required to co-manage the case with an ACLS certified physician.

(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of a physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any referring practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment and surgical intervention. Whenever a physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

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

1) An alternate physician (preferably a partner, associate, or designee of the Attending Physician);
2) The Chief of Staff who may assume care for the patient or designate any appropriately trained member of the staff; or
3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

(g) The physician certification must be completed, signed, dated, and documented in the medical record prior to discharge unless otherwise permitted by law. This requires authentication of the order for inpatient admission prior to discharge.

1.2 ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Within twenty-four (24) hours following all admissions, the Attending Physician shall have a history and physical dictated documenting the need for the admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) Preoperative Admissions

This includes all patients scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery may decide the urgency of any specific admission.

1.2(c) Routine Admissions

This will include elective admissions involving all services

1.3 PATIENT TRANSFERS

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

1.3(b) If the critical care unit is full and a patient requires ICU care; all physicians attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chief of Staff may consult any appropriate specialist in making this determination and shall make the decision.

1.4 SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staff, and the Hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a) A patient suspected to be suicidal in intent shall be admitted to an appropriate room consistent with the patient's medical needs and Hospital policy. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or Hospital policy. The patient will be afforded psychiatric consultation.

1.4(b) The Hospital case manager should be consulted for assistance; and

1.4(c) If the patient presents to the emergency room, the steps set forth in Section 1.4(a) shall be followed, except that the patient shall not be transferred absent an appropriate medical screening examination, any necessary stabilizing treatment, and a certification, pursuant to the Hospital's EMTALA policy, that the benefits of transfer outweigh the risks.

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

1.5(a) Patients shall be discharged only on order of the Attending Physician. Should a patient leave the Hospital against the advice of the Attending Physician or without proper discharge, a notation of the incident shall be made in the patient's medical record by the Attending Physician. The discharge process and corresponding documentation shall provide for continuing care based on the patient's assessed needs at the time of discharge.

1.5(b) If any questions as to the validity of admission to or discharge from the facility should arise, the subject shall be referred to the Department Chair for assistance.

1.5(c) The Attending Physician is required to document the need for continued hospitalization prior to

expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate.
(2) Estimate of additional length of stay the patient will require; and
(3) Plans for discharge and post-hospital care.

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

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

(1) Conditions that may result in the patient's transfer to another facility or level of care.
(2) Alternatives to transfer, if any.
(3) The clinical basis for the discharge.
(4) The anticipated need for continued care following discharge.
(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and
(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6 DECEASED PATIENT

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

1.7 AUTOPSIES

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

1.8 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patients' treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the Hospital's Policy on Patient Notification of Unanticipated Outcomes and No Harm Events (RISK101).

ARTICLE II - MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

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

The Medical Record shall include Computerized Physician Order Entries as required by these Rules & Regulations in order to be considered complete

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have a complete admission history and physical examination as required by the Medical Staff Bylaws.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam must be recorded before all inpatient surgical and diagnostic procedures, and before all outpatient surgical procedures. Each department, upon MEC approval, shall determine whether a history and physical exam must be recorded before outpatient diagnostic procedures. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patient's health.

2.4 PROGRESS NOTES

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

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within six (6) hours after completion of surgery.

An operative progress note must be entered immediately, and before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this Hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. The report shall be made a part of the patient's record.

2.7 OBSTETRICAL PATIENT HISTORIES

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

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately and promptly dated, timed, authenticated and legible. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of a rubber stamp signature is not acceptable.

2.9 ABBREVIATIONS/SYMBOLS

MEC will approve a list of abbreviations and symbols for the “do not use” list. Abbreviations and symbols listed on the “do not use” list may be utilized in medical records. This list shall be filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.10 FINAL DIAGNOSIS

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

2.11 REMOVAL OF MEDICAL RECORDS

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

2.12 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual

patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the Hospital.

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

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

2.13 PERMANENTLY FILED MEDICAL RECORDS

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

2.14 STANDING ORDERS

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

2.15 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge, provided, however, inpatient admission orders must be completed in accordance with the Inpatient Order for Patient Status Policy. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.16 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every seven (7) days. At the twenty-first (21st) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at thirty (30) days and the physician’s privileges will be suspended if any records become delinquent.

2.16(a) Suspension. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible physician’s privileges. When a staff member is notified of suspension, the staff member may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner’s or other Attending Physician’s name. Any exceptions must be approved by the Chief of Staff and the CEO.

2.16(b) The suspended staff member is obligated to provide to the Hospital CEO and the Chief of Staff the name of another physician who will take over the care of his/her hospitalized patients, take his/her call, emergency room coverage, consultations and any other services that physician provides.

2.16(c) All Hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

2.16(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO and/or their designee, or the chairperson of the Code of Conduct Committee, or equivalent Medical Staff committee.

2.17 TREATMENT & CARE WRITTEN ORDERS

Orders for admission of patients may not be written by Dependent Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician.

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

2.18 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

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

To correct or amend an entry, the author should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made.

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.19 COMPUTERIZED PHYSICIAN ORDER ENTRY

CPOEs shall be utilized by providers to the extent available and operational.

ARTICLE III - GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

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

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed, authenticated, and legible. Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNAs may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has

written or otherwise recorded the order and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate, time and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than twenty-four (24) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

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

3.3 ILLEGIBLE TREATMENT ORDERS

The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3.4 PREVIOUS ORDERS

All previous orders are canceled when patients go to surgery.

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.

The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

3.6 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route, and frequency of administration. Drugs shall be dispensed from and reviewed by the Hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the Hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from Hospital dispensing criteria. When the patient brings medication to the Hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.7 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the

Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

3.8 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the attending physician or his/her designated alternate within twenty-four (24) hours of admission. During their admission, patients will be seen at least daily or more frequently if their status warrants. Unstable patients admitted to the ICU should be seen by the Attending Physician or his/her designated alternate immediately. Stable patients admitted to the ICU will be seen no later than thirty (30) minutes after admission or sooner if warranted by the patient's condition.

3.9 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care. In case of failure to name such a staff member, the Chief of Staff or the CEO and/or designee shall have the authority to call any member of the staff to provide necessary care.

3.10 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, Joint Commission standards, and all Hospital policies pertaining to restraints and seclusion.

3.11 PRACTITIONERS ORDERING TREATMENT

Licensure and Medicare/Medicaid eligibility will be verified for all practitioners ordering treatment (i.e. Labs, Rehabilitation Services or Wound Care), regardless of the practitioner's Medical Staff status or lack thereof. Orders for outpatient services may only be made by practitioners who are (1) responsible for the care of the patient; (2) licensed in, or holds a license recognized in, the jurisdiction where he/she provides care to the patient; (3) acting within his/her scope of practice under State law; and (4) authorized by the Medical Staff to order the applicable outpatient services under a written Hospital policy that is approved by the Board. This includes both practitioners who are on the Hospital Medical Staff, as well as other practitioners who are not on the Hospital Medical Staff, but who satisfy the Hospital's policies for ordering applicable outpatient services.

3.12 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

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

ARTICLE IV - GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

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

4.2 ADMISSION OF DENTAL CARE PATIENT

A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the Medical Staff.

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

(1) To provide a detailed dental history justifying Hospital admission.

(2) To provide a detailed description of the examination of the oral cavity and preoperative diagnosis.

(3) To complete an operative report describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the Hospital pathologist for examination.

(4) To provide progress notes as are pertinent to the oral condition; and

(5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

(1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery.

(2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the Attending Physician.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

(1) To provide a detailed podiatric history justifying hospital admission.

(2) To provide a detailed description of the podiatric findings and a preoperative diagnosis.

(3) To complete an operative report describing the findings and technique. A tissue shall be sent to the Hospital pathologist for examination.

(4) To provide progress notes as are pertinent to the podiatric condition; and

(5) To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician are:

(1) To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery.

(2) To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and

(3) To supervise the patient's general health status while hospitalized.

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

4.4 INFORMED CONSENT

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high-risk treatments (as provided by Hospital policy and/or state law) except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient, or any person to whom the patient has properly delegated representative authority, only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of care, and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician. After informed consent has been obtained by the surgeon, the physician shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

Each consent form shall include the name of the Hospital where the procedure is to take place; the name of the specific procedure for which consent is being given; the name of the responsible practitioner who is performing the procedure; a statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient’s legal representative; and the signature of the patient or the patient’s legal representative. The form must also comply with the requirements of applicable state law.

4.5 PATIENT REQUESTS & REFUSAL OF TREATMENT

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient’s behalf, must be documented in the patient’s permanent Hospital record.

Patients have the right to request any treatment at any time, and such requests shall be documented in the patient’s permanent chart. However, such requests may be declined if determined to be medically unnecessary by the treating physician or his/her designee.

4.6 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a

pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff and documented in writing.

4.7 ELECTIVE SURGERY SCHEDULING

In order to reduce patient anxiety resulting from a long wait, reduce staff overtime for elective work and allow time for possible emergencies, the following guidelines will be used for scheduling elective surgeries. Emergency procedures shall take priority above all other cases.

4.7(a) Standing Time:

07:00 a.m.

4.7(b) Priority Cases shall be defined by policy Classification of Cases (OR100)

4.7(c) Scheduling of Cases will follow Periop Scheduling policy (POS006):

During business hours, all cases must be scheduled with Periop Scheduling Staff. After hours, scheduling will be performed through the House Supervisor.

4.7(d) Preoperative workup is as deemed appropriate.

4.8 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post-operative examination will be conducted by the surgeon or their designee.

4.9 ANESTHESIA

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (MAC) including deep sedation, regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

4.9(a) Anesthesia services throughout the Hospital shall be organized into one anesthesia service under the direction of a qualified anesthesiologist who is a member of the medical staff.

4.9(b) The Hospital shall maintain policies and procedures governing anesthesia services provided in all Hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

4.9(c) Only credentialed and qualified individuals as defined in the policies and procedures of the Hospital may provide anesthesia services. The Department of Surgery shall approve credentialing guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such

supervision requirements as appear in these Rules & Regulations and the policies and procedures of the Hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care (MAC) must be supervised either by the operating practitioner who is performing the procedure or by an anesthesiologist who is immediately available. An anesthesiologist is considered "immediately available" only if he/she is physically located within the same area as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

When supervision of CRNA administered anesthesia services by a practitioner other than an anesthesiologist is required, doctors of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care (MAC).

4.9(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the Hospital and shall be consistent with the requirements of applicable state law, the Joint Commission and the CMS Hospital Conditions of Participation. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care (MAC), this record shall include a pre-anesthesia evaluation, an intraoperative record, and a post anesthesia evaluation.

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by The Joint Commission.

The individual who administered the patient's anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the Hospital, must also perform a post anesthesia evaluation of the patient and document the results of the evaluation no later than forty-eight (48) hours after the patient's surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than forty-eight (48) hours, as addressed in Hospital policies and procedures. For those patients who are unable to participate in the post anesthesia evaluation, a post anesthesia evaluation should be completed and documented within forty-eight (48) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

4.9(e) The anesthetist or anesthesiologist will be responsible to obtain and document informed consent for anesthesia in the medical record. In order to ascertain the patient's wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the attending physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

4.9(f) The Hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the qualified anesthesia provider must not exceed twenty (20) minutes.

4.10 ORGAN & TISSUE DONATIONS

The Hospital shall refer all inpatient deaths, emergency room deaths and dead-on arrival cases (term birth to age 75) to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

The attending physician shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

ARTICLE V - GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Subject to other state or accreditation requirements, only those physicians or AHPs who have training in neonatal resuscitation and care, with a current Neonatal Resuscitation Program certification from the American Academy of Pediatrics will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1(a) All cesarean sections.

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

5.1(c) Premature infants less than four (4) pounds eight (8) ounces, with or without complications.

5.1(d) All premature infants with complications; and

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

5.2 LABOR & DELIVERY

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

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents unscheduled to the Hospital requesting medical evaluation, regardless of the location to which the female presents, this presentation is considered a presentation for medical screening evaluation (MSE) pursuant to the facility's EMTALA policy. An MSE is required to be conducted face-to-face by a licensed independent provider. In late pregnancy, defined as gestation greater than twenty (20) weeks, the initial triage nurse will consider best location for the MSE to occur. Pregnancy related complaints in late pregnancy may be evaluated in the Hospital's Labor and Delivery Unit, considered an extension of the emergency department for purposes of compliance with EMTALA. The decision regarding best location for the MSE is based upon the patient's gestational age and presenting condition. For those patients who are referred to the Labor and Delivery Unit for MSE, an RN trained in obstetrics, as defined by Hospital policy, will initiate the order of the obstetric provider to determine the onset of labor or obstetrical conditions that may require

immediate medical intervention. For the patient who is determined not to be in active labor, a face-to-face medical screening exam by qualified medical personnel is required to determine the diagnosis and the disposition.

5.4 PATIENTS PRESENTING TO LABOR & DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.2, above. The nurse shall contact the admitting physician upon any change in the patient's condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within thirty (30) minutes upon being contacted by the nurse and requested to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants, but in any event no later than twelve (12) hours after admission.

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

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

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

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

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician, or in the case of a woman in labor, a registered nurse trained in obstetric nursing, where permitted under state law and Hospital policy, who may determine true, false or no labor but may not make a medical diagnosis.

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

6.1(b) Stabilization

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

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

(3) A patient Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any

reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

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

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

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

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

6.1(c) Transfer

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

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

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

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

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

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

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

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

(1) Attempted to reach the physician in the Hospital.
(2) Called the physician at home.
(3) Called the physician at his/her office; and
(4) Called once on the physician's pager.

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

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

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

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

Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, they are required to do so within thirty (30) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within twenty (20) minutes of initial contact.

6.2(g) The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written policy.

ARTICLE VII - ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

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

7.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

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

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the Hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 8.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well-being of patients, employees, or staff.