The
Rules and Regulations

of the
Medical Staff Bylaws
of
Hutchinson Health

MEDICAL STAFF BYLAWS - RULES AND REGULATIONS

Hutchinson HEALTH

Date Reviewed/Revised: 10/10/2017 by: Medical Staff
Date Approved: 10/24/2017 by: Governing Board

TABLE OF CONTENTS

Article I. Purpose and Use of Rules and Regulations

Purpose: Generally these Rules and Regulations are intended to establish guidelines for the conduct of and processes relating to Physicians and other Practitioners who have applied for or have been granted Medical Staff appointment and/or clinical privileges by the Governing Body. Nothing in these Rules and Regulations is intended or shall be deemed to exercise control, supervision or direction over the provision of medical services in the Hospital or System by Practitioners who have been granted Medical Staff appointment and/or clinical privileges by the Governing Body. These Rules and Regulations are intended to establish guidelines for the provision of professional services in the Hospital and System.

Intent: These Rules and Regulations are intended to inform appointees to the Hospital's Medical Staff and other Practitioners with clinical privileges of the policies, procedures, rules, regulations, guidelines and requirements that apply to them. There are additional policies, procedures, rules, regulations, or guidelines and requirements which apply to such Medical Staff appointees and Practitioners with clinical privileges. Hutchinson Health will supply initial appointees and Practitioners with a copy of the Medical Staff Bylaws. It is the sole responsibility of each Medical Staff appointee and Practitioner with clinical privileges to read, understand and abide by all Bylaws, policies, procedures, rules, regulations, guidelines and requirements of the Hospital, System and Medical Staff.

Interpretation: By submitting an application for staff membership and/or privileges, every applicant, Medical Staff appointee and recipient of clinical privileges agrees that these Medical Staff Bylaws and all other policies, procedures, rules, regulations, guidelines and requirements of the Hospital, System and Medical Staff are subject to the interpretation of the Medical Executive Committee, the Hospital's and System's administration, and, ultimately, the Governing Body, in its sole discretion. This Policy is not intended and shall not be construed as a contract between the Hospital and its Medical Staff or with any individual Practitioner granted privileges hereunder.

Enabling Procedures: These Rules and Regulations are part of the Medical Staff Bylaws of the Hospital and are intended to establish guidelines for the provision of certain professional services in the Hospital and System. The definitions as set forth in the Bylaws are hereby incorporated by reference herein as though fully set forth, unless the context clearly requires otherwise.

Article II. Patient Contacts

A. In order to be eligible for Active Staff status, an appointee must, in the opinion of the Medical Executive Committee, regularly admit, attend or be involved in the treatment of patients at the Hospital. Guidelines for regular contact will include, in part, a minimum of twenty-five (25) patient contacts per year or a presence in the Hospital a minimum of twelve (12) times per year.

B. In order to be eligible for Courtesy Staff status, an appointee should not, in the opinion of the Medical Executive Committee, regularly admit, attend or be involved in the treatment of patients at the Hospital. Courtesy Staff members must, however, have at least one (1) patient contact during each appointment period to be eligible for reappointment unless the Courtesy Staff member is a member of a medical group that regularly provides services in the Hospital. Courtesy Staff members must also maintain (or demonstrate a reasonable expectation that the appointee will maintain) Active Staff status elsewhere as required under Article II, Part C of the Medical Staff Bylaws. Physicians who have contact with greater than twenty-five (25) patients per year or who are present in the Hospital more than twelve (12) times per year will be strongly encouraged to apply for Active Staff status.

C. For the purpose of determining staff status, "patient contacts" shall mean such activities as inpatient admissions, emergency services visits, consultations, clinic visits, outpatient surgeries or procedures, treadmill tests, and interpretation of radiology procedures.

D. Exceptions may be made by the Medical Executive Committee for medical groups that regularly provide services at the Hospital in accordance with Article II of the Medical Staff Bylaws or where the Medical Executive Committee deems active status at another facility is not necessary.

Article III. Admission and Discharge of Patients

A. The Hospital shall accept all patients for care and treatment, except as determined by the Hospital's and System's policies.

B. A patient may be admitted as an inpatient to the Hospital only by a member of the Medical Staff or Practitioner who has been granted privileges to admit within his/her scope of practice by the Medical Executive Committee. Only psychiatrists can admit patients to the Inpatient Mental Health Unit and generally will not be granted privileges to admit patients to the medical unit.

C. A member of the Medical Staff shall be responsible for the continuous medical care and treatment of each patient in the Hospital, for supervising other Practitioners as required by applicable law, for the prompt completeness and accuracy of the medical record or necessary special instructions, for care coordination, and for transmitting reports of the patient's condition to the referring Practitioners and to the relatives of the patient.

    1. Whenever these responsibilities are transferred to another Medical Staff member, written documentation of the transfer shall be entered in the patient's record.

    2. Each member of the Medical Staff shall make arrangements for coverage of his/her hospitalized patients in the Medical Staff member's absence. Such arrangements shall include ensuring on-call coverage for patients presenting to the Hospital.

D. Any patient to be admitted on an emergency basis, who does not have a private or regular physician, will be assigned to the member of the Active Medical Staff who is on call for emergency patients.

E. The Medical Staff shall define the criteria to be used to implement patient admission priorities and the proper review of those priorities. Such priorities shall include emergency admissions, preoperative admissions and routine admissions.

    1. Emergency admissions: This includes all admissions classified as an emergency by the admitting physician. For the purpose of this section, "emergency" is defined as a condition in which serious permanent harm would result to a patient if treatment is delayed or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

    2. Preoperative admissions: This includes all patients already scheduled for surgery who are not included in the above category.

    3. Routine and other elective admissions: This includes all other routine or elective admissions that are not included in any of the above categories.

F. The admitting Physician shall be responsible for sharing with appropriate Hospital staff information known to Physician that may be necessary to protect the patient from self-harm, and to protect others, whenever the patient might be a source of danger to self or others.

G. Except in an emergency, no patient shall be admitted to the Hospital unless a provisional diagnosis and valid reason for admission has been stated in the patient record.

H. The attending Physician is required to document the need for continued hospitalization. This documentation must contain a record of the reason for continued hospitalization and plans for post-hospital care.

I. Patients shall be discharged only upon an order of the attending Physician or an authorized Practitioner. Should the patient leave the Hospital against the advice of the attending Physician, or without proper discharge, a notation of the event shall be made in the patient's medical record. If a patient is transferred from the Hospital to another facility for any reason, arrangements and provisions will be made for the safe transfer and transportation according to the policies of the Hospital.

J. In the event of a death, the deceased shall be pronounced dead by the attending Physician or other Practitioner as determined by Hospital policy. Policies with respect to the release of deceased patients shall conform to local law.

1. It shall be the responsibility of all Medical Staff members to secure autopsies whenever they are required by law or deemed appropriate according to these Rules. Physicians should attempt to obtain an autopsy in all cases of unusual deaths and deaths of medical-legal and educational interest. Such circumstances shall include, but not be limited to:

    a. Unanticipated death;

    b. Deaths occurring while the patient is being treated under a new therapeutic regimen;

    c. Death due to obscure or unclear etiology or where admission time was insufficient to identify etiology;

    d. Intraoperative or intraprocedural death or death occurring within 48 hours of surgery or an invasive procedure;

    e. Death occurring incident to pregnancy or delivery, within 30 days of date of delivery;

    f. Deaths occurring in the Mental Health Unit; and

    g. All deaths of infants or children (including suspected sudden infant death syndrome).

2. The following deaths must be reported by the attending Physician to the coroner for investigation:

    a. Violent deaths, whether apparently homicidal, suicidal, or accidental, including but not limited to deaths due to thermal, chemical, electrical or radiational injury, and deaths due to criminal abortion, whether or not self-induced;

    b. Deaths under unusual or mysterious circumstances; and

    c. Deaths of persons whose bodies the Physician knows are to be cremated, dissected, buried at sea or otherwise disposed of so that the bodies will later be unavailable for examination.

3. Other than coroner's cases, an autopsy may be performed only with the written consent from legal next of kin, signed in accordance with the laws of the State of Minnesota. In cases where sudden infant death syndrome is suspected, the attending Physician shall notify the child's parents or guardian that an autopsy is essential to establish the cause of death as sudden infant death syndrome. Provisional and anatomic diagnosis shall be recorded on the patient's medical record within forty-eight (48) hours and the completed final report should be made a part of the patient record within two months. Results of autopsies performed may be reviewed through the peer review process of the appropriate Medical Staff service committee.

Article IV. Medical Records

A. All medical records must be promptly completed following the patient's discharge or outpatient encounter and in all cases must be completed within thirty (30) days following discharge or outpatient encounter unless otherwise stated in the timeframes listed below.

B. The attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. All entries must be legible and complete, and must be authenticated, dated and timed promptly by the person who is responsible for ordering, providing, or evaluating the service furnished. (Exception: Providers with privileges in radiology may sign transcriptions of dictations done by other providers with radiology privileges in the case of overreads.) The content of the medical record shall be pertinent and current. This record shall include identification data; patient's presenting complaint; pertinent personal, family and social history; present illness; physical examination; documentation of complications, hospital acquired infections and unfavorable reactions to drugs and anesthesia; special reports such as consultations, clinical laboratory, radiology and other imaging and diagnostic services; diagnostic and therapeutic orders; medical and surgical treatment; progress notes; operative reports when indicated; pathological findings when indicated; final diagnosis; condition on discharge; properly executed informed consent forms; discharge summary or death summary; and report of autopsy when performed.

C. A complete **history and physical** should include chief complaint; details of present illness; medical, social and family history; inventory of body systems; comprehensive current physical assessment to include at a minimum an examination of the heart and lungs and at least two other body systems appropriate to the chief complaint and findings from review of systems; impression and plan.

1. Each patient requires a medical history and physical examination no more than thirty (30) days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or any procedure requiring anesthesia.

2. A new history and physical is required if the previous history and physical is greater than thirty (30) days old. History and physicals greater than 30 days old will not be accepted, even with updates.

3. Updates to History and Physicals:

    a. If the history and physical was completed within thirty (30) days prior to admission, an update documenting any changes in the patient's condition must be completed within twenty-four (24) hours after admission or prior to surgery, whichever comes first.
        i. The update must include review of the history and physical documentation, and an appropriate assessment, which should include a physical examination of the patient and an update of any changes in the patient's current medical status or care that may have changed since the prior history and physical or any other areas where more current or complete data is needed. The attending practitioner is expected to review the history and physical prior to admission or surgery.

ii. The attending practitioner may delegate the following duties to a Practitioner with appropriate clinical privileges: conducting an assessment to determine changes since the history and physical and documenting an update. The update must be documented whether or not there have been any changes.
iii. The update must be signed by the attending practitioner.

4. A history and physical may be performed by a Physician or an Allied Health Professional with appropriate privileges.

5. A history and physical completed by a licensed Physician who does not have clinical privileges at the Hospital may be accepted if a Physician or Allied Health Professional with appropriate clinical privileges countersigns the history and physical. The Practitioner who countersigns must confirm the findings, conclusions and assessment of risk prior to major high-risk diagnostic or therapeutic interventions, as defined by the Medical Staff.

6. The history and physical must be present in the chart prior to a procedure.

7. History and Physical Requirements for the **Surgical Patient** (Inpatient and Outpatient Services):

   There must be a complete history and physical in the chart of every patient prior to surgery except in severe emergencies. The preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical or invasive procedure. If they are not recorded, the procedure shall be delayed until such requirements are met.

   In an emergency, the Physician shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

8. History and Physical Requirements for **Inpatient Mental Health Services**:

   The history and physical requirements for patients receiving mental health services, including psychiatry patients who may require substance abuse services are the same as listed in section C above. Upon admission for inpatients, a Psychiatric First Evaluation will be completed within twenty-four (24) hours of admission.

9. Medical records of outpatients undergoing procedures or diagnostic tests that do not require anesthesia services must include documentation of a physical assessment examination of the chief complaint, excluding all non-invasive tests which require no immediate assessment prior to test.

10. **Obstetrical records** will include a legible copy of the attending Physician's prenatal record, if not already available in the electronic record system. The Practitioner must perform an admission physical examination and medical history, which may reference the prenatal record if a visit occurred in the past 30 days for such items as past history, family history, social history and prenatal course, however, the record must include current physical findings. For patients undergoing a cesarean section or a postpartum tubal ligation, the procedures for surgical patients must be followed.

D. **Progress notes** shall be recorded at the time of observation. Progress notes should give a pertinent, chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Progress notes should be recorded at the time of admission; daily for patients requiring usual care; more frequently if the patient's condition warrants; and at least every three days for patients in the Mental Health Unit.he progress notes should also include an assessment of progress and

periodic review of the treatment plan, as appropriate, and identification of change of attending Physician, consultant for a limited referral and consultant for a referral.

The date written should indicate that all entries are authenticated by the responsible Practitioner. The date must reflect the actual date of documentation; pre-and post-dating of written progress notes is not acceptable. Information not documented at the time of occurrence can be added, but the date of the actual entry should be indicated and, if appropriate, reference made to a previous entry.

E. **Operative reports**, for high risk procedures, shall be dictated or electronically recorded immediately after surgery on all inpatients and outpatients. The operative report must contain the preoperative and post-operative diagnosis; a description of the findings; the technical procedures used; the specimens removed; disposition of specimens; intraoperative complications, unexpected events and estimated blood loss; and the name of the primary surgeon and any assistants. The operative report shall be authenticated by the surgeon and filed in the patient's medical record.

F. Since Hospital Staff treating the patient may rely on the Operative Progress Note to provide care until the Operative Report is transcribed, an **operative progress note** shall be entered in the patient's medical record immediately after high risk surgery and prior to the patient moving to the next level of care. If the surgeon accompanies the patient to the next level of care, the operative progress note may be written or dictated in the new unit of care. The operative progress note will provide pertinent information for any individual required to attend the patient and shall include the preoperative and post-operative diagnosis; a description of the findings; the technical procedures used; the specimens removed; intraoperative complications, unexpected events and estimated blood loss; and the name of the primary surgeon and any assistants. An electronically recorded operative report will fulfill the requirement for an operative progress note if completed and available in the chart within1 hour of the completion of surgery.

G. Practitioners are expected to request an appropriate **consultation** when a clinical problem is outside their scope of expertise or experience or when otherwise required by the Medical Staff, Hospital, or System policies. Examples of circumstances in which a consultation may be appropriate include when the diagnosis is obscure after ordinary diagnostic procedures have been completed, there is doubt as to the choice of therapeutic measures to be used; for high risk patients undergoing major operative procedures; or in situations where specific skills of other physicians may be needed.

When a consultation is requested, the consultant's note shall show evidence of review of the patient's medical record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The consultation note shall be completed within 24 hours of the request of the consultation.

H. All **clinical entries** in the patient's medical record shall be legible, complete, dated, timed, and authenticated by the person responsible for providing or evaluating the service provided. If a correction or deletion is made, a line should be drawn through the incorrect information, and the date and initials of the individual making the correction should be indicated. Incorrect entries shall not be obliterated.

I. **Symbols and abbreviations** will be used in accordance with Hospital and System policy.

J. **Discharge Summary**

1. A **discharge summary** shall be written or dictated on all medical records of inpatients, including patients admitted with an observation status. The discharge summary is a recapitulation of the significant findings, events of the patient's hospitalization, and shall be sufficient to justify the principal and secondary diagnosis and warrant the diagnostic and/or therapeutic management of care rendered. The discharge summary should include the reason for the patient's admission; significant findings; procedures performed and treatment rendered; condition of patient on discharge; instructions to the patient and/or family (patient activity limitations, medications, diet, follow-up appointments, etc.), principal diagnosis and other diagnosis. All patients who die or are transferred to another facility require a discharge summary. Discharge summaries shall be completed within 5 days of discharge.

2. For newborns with uncomplicated deliveries or for patients hospitalized for less than forty-eight (48) hours, a **final progress note** may be substituted for a discharge summary. The progress note documents the patient's condition at the time of discharge, discharge instructions, and required follow-up care.

K. **Outpatient notes** shall be completed within 9 days of the patient visit.

L. **Emergency department** notes shall be completed within 24 hours of the patient visit.

M. **Obstetrical Delivery Notes** shall be completed as soon as possible and no later than 24 hours after the delivery.

N. The **use and disclosure** of individually identifiable health information and patient medical records shall at all times comply with federal and state health information privacy laws and regulations, the System's Notice of Privacy Practices, and the Health Information Services Release of Information Policy. **Written consent or authorization** of the patient or the patient's personal representative shall be required for use or disclosure of individually identifiable health information except as otherwise provided by law.

O. **Original records** may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order Hospital or System policy. All patient records are the property of the Hospital and shall not otherwise be taken away. In the case of readmission of a patient, all previous records shall be available for use by the attending Physician. This shall apply whether the patient is attended by the same Physician or another Physician. Unauthorized removal of records from the Hospital or System is grounds for disciplinary action of the Practitioner for a period to be determined by the Medical Executive Committee.

P. The Medical Staff may have access to patient medical records for bona fide **study and research** as permitted by state and federal health information privacy laws and regulations, the System's Notice of Privacy Practices, and laws regulating human subjects research. All research projects shall be approved by the appropriate Medical Staff Committee or institutional review board before records can be used for research. In accordance with applicable law, other Physicians of good standing may be permitted access to information from the medical records of their patients covering periods during which such patients were in the Hospital.

Q. A medical record shall not be **permanently filed** until it is completed by the attending Physician or is ordered filed by the Medical Executive Committee.

R. **Incomplete charts** will be available electronically and/or paper charts will be available in a stated place in the Hospital after the patient's discharge and shall be subject to rules applicable to incomplete and delinquent records.

Article V. General Conduct of Care

A. Appropriate consent forms signed by or on behalf of every patient admitted to the Hospital shall be obtained at the time of admission.

B. The Physician or Allied Health Professional is responsible for obtaining and documenting informed consent based on the privileges he/she is credentialed to perform including potential risks and benefits of the procedure or treatment; the likelihood of success; potential problems related to recuperation; the possible results of nontreatment; and any significant alternative therapy.

C. Orders:

1. All orders for outpatient treatment shall be electronically recorded or in writing and all inpatient orders should be electronically recorded. All orders shall be dated, signed and timed. Orders must be recorded clearly, legibly and completely. Illegible or improperly written orders will not be carried out until clarified with the ordering Practitioner.

2. Verbal orders, including telephone orders, shall be considered to be in writing if given to a duly authorized person and signed, dated, timed, and authenticated as soon as possible and within 30 days by the Practitioner ordering such treatment. In accordance with applicable law orders may be authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders under applicable Hospital and System policies.

3. Unit secretaries and support technicians may be trained/qualified to accept and transmit **verbal orders.** The following personnel are qualified to accept and transcribe verbal or written orders within their area of specialty: registered nurses, licensed practical nurses, licensed pharmacists; audiologists; respiratory therapists; registered occupational therapists; occupational therapy assistants; registered physical therapists; physical therapy assistants; speech and language pathologists; clinical dietitians; certified registered nurse anesthetists; medical imaging technicians; laboratory technicians; medical assistants; and certified medical assistants. Schedulers may accept verbal orders when needed to clarify or complete orders for outpatient procedures/services.

4. When applicable to a given patient, a Physician may initiate routine orders. When initiated, the orders shall be reproduced in detail on the order sheet of the patient's medical record or copy provided, dated, timed and signed by the Physician.

D. All previous orders are canceled when a patient goes to surgery unless there is a written order that specifically indicates otherwise. Minor and low risk procedures as determined in Hospital Policy (e.g., Endoscopy procedures) may be exempt from this rule. Do not resuscitate orders may be suspended during surgery or invasive procedures with or without conscious sedation and recovery from anesthesia. This will be done only after discussion by the attending Physician with the patient or patient's surrogate decision-maker. The conversation will be described in the medical record. The attending Physician will communicate the result of the discussion with the anesthesia staff.

E. Drugs used shall meet the standards of the U.S. Pharmacopoeia, National Formulary or new and non-official drugs, with the exception of drugs being used for bona fide clinical investigation. Policies for handling investigational drugs shall be established by the Hospital and shall meet all of the regulations of the Federal Food and Drug Administration.

F. Medications administration guidelines are as follows and are administered in accordance with the organizational Medication Administration policy:

1. **Drug stop order:** There will be an automatic stop order of ten (10) days on all antibiotics, excluding Zithromax. Controlled substances classes II-V have an automatic stop order of seven (7) days for all patient care areas, unless duration is specified. There will be an automatic stop order of three (3) days on all oxytocics. The physician must rewrite the order if they are to be continued. Reference should be made to the organizational Automatic Stop Orders policy.

2. **Pre-Op Antibiotics:** For scheduled surgeries, whenever there is an order for an antibiotic or bicitra to be given "preop" or "preop in the holding area" it is the practice of HAHC to have the medications administered by the anesthetist preoperatively.

3. **"STAT"** medications are to be given within ten (10) minutes from the time the order is written. "STAT" medications may be taken from Omnicell.

4. **"NOW"** medications are to be given within thirty (30) minutes. "NOW" medications will be delivered by Pharmacy during regular business hours or may be removed from Omnicell after the order has been profiled by a pharmacist.

5. For a **non-specific HOLD order**, the medication is considered discontinued. A new order is required to reinstate the medication.

   For a **HOLD order with "parameters,"** the medication is to be held based on the parameters, as long as the parameters are clear. No further orders needed.

6. **Nothing by Mouth (NPO)**

   a. An NPO order automatically discontinues all oral medications.

   b. Nebulizers and inhalers are not automatically discontinued with an NPO order.

   c. An order of "NPO except meds" does <u>not</u> discontinue any medications.

G. Any Physicians with clinical privileges in the Hospital may be called for consultation within their area of expertise.

   1. Consultation may be obtained from Physicians not on the Medical Staff, provided that appropriate temporary privileges have been granted.

   2. The Medical Staff shall decide medical, surgical, obstetric, special care, psychiatric or other conditions for which consultation is to be obtained.

   3. The attending Physician is primarily responsible for requesting a consultation when indicated.

H. If a nurse or any other health care provider has any reason to doubt or question the care provided to any patient, believes that appropriate consultation is needed and has not been obtained, or has ethical concerns regarding the treatment of a patient, the individual must direct questions to the attending Physician. If the concern is not resolved, it should be presented to the individual's immediate supervisor. It will be the responsibility of that immediate supervisor to contact the appropriate Service Chief and/or the Chief of Staff.

I. Each Active Medical Staff member shall participate in call coverage as required by the Medical Executive Committee and the Governing Body. For specialties in which the Hospital's Medical Staff has two (2) or fewer members, continuous on-call coverage shall not be required.

Article VI. General Rules Regarding Surgical Care

A. Patients scheduled for elective surgery should be admitted in a time frame appropriate for the scheduled procedure. To the extent possible, patients scheduled for surgery may have the required preoperative laboratory work completed twenty-four (24) to forty-eight (48) hours in advance to assure the availability of compatible blood. If the required laboratory work cannot be completed twenty-four (24) to forty-eight (48) hours before surgery, it should be done within seven (7) days of scheduled surgery.

B. A Practitioner qualified to administer anesthesia or sedation shall perform a pre-anesthesia assessment for patients undergoing moderate or deep sedation within twenty-four (24) hours prior to surgery and shall plan the patient's moderate or deep sedation and anesthesia care. An addition in the patient's status or plan of care assessment shall be performed immediately prior to moderate or deep sedation and any changes documented. The history and physical requirements for patients receiving moderate sedation are delineated in the History and Physical Policy.

C. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and a Physician member of the Medical Staff.

1. Dentist responsibility: The dentist shall prepare a detailed dental history justifying the Hospital admission; a detailed description of the examination of the oral cavity and preoperative diagnosis; a compete operative report and progress notes as are pertinent to the oral condition; progress notes as are pertinent to the oral condition; and discharge summary or summary statement. Tissue including teeth and fragments shall be sent to the Hospital pathologist for examination when appropriate per Hospital policy.

2. Podiatrist responsibility: The podiatrist shall prepare a detailed podiatric examination of the feet and preoperative diagnosis; complete operative report; progress notes as are pertinent to the podiatric condition; and discharge summary or summary statement. Tissue removed shall be sent to the pathologist for examination when appropriate per Hospital policy.

3. On-call Physician responsibility: In the cases involving podiatry and/or dental patients that require emergency medical care, an on-call Medical Staff member is responsible to respond in a timely manner.

4. Physician responsibilities: The Physician shall provide a medical history pertinent to the patient's general health; a physical examination to determine the patient's condition prior to induction of anesthesia and the procedure; and supervision of the patient's general health status while hospitalized.

5. The primary care Physician or surgeon on-call will be notified and will assume responsibility in the operating room for patient care if required during podiatry and/or dental surgical procedures.

6. Privileges and supervision: The scope and extent of surgical and invasive procedures that a dentist and/or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges and shall be under the overall supervision of the Service Chief of Surgery and Anesthesia.

D. Informed consent shall be obtained prior to the procedure, prior to anesthesia, and prior to transfusion of blood or blood products, except in those situations wherein the patient's life is in jeopardy. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian or next of kin, the surgeon will fully document the circumstances in the patient's medical record.

E. The anesthetist shall maintain a complete anesthesia record including evidence of the pre-anesthesia assessment, pre-induction or pre-sedation assessment; an intraoperative anesthesia record, and, a postanesthesia assessment, which shall be completed within forty-eight (48) hours following the surgery or procedure.

F. If the anesthetist's orders conflict with those of the attending Physician, it is the responsibility of the anesthetist or anesthesiologist to consult with the attending Physician. Unresolved issues may be directed to the Chief of Service.

G. When appropriate, tissue removed by surgical procedures shall be sent to the Hospital Pathologist, who shall make examination, as he/she may consider necessary, to arrive at a pathological diagnosis. A report shall be made a part of the patient's medical record.

H. Coverage for Surgical Patients: In cases where emergency medical care is required for patients of Physicians who are unable to respond in a reasonably timely manner, the Medical Staff member on-call is responsible to respond in a timely manner.

Article VII. General Rules Regarding Maternal and Child Care

A. Birthing room visitation during labor and delivery shall be determined by the attending Physician after discussion with the patient and Hospital Staff. Attendance at cesarean section deliveries is limited to one support person or significant other according to the policies of the Hospital.

B. A positive identification system between the mother, baby and significant other shall be put into effect before leaving the birthing room after delivery according to policies of the Hospital.

C. When oxytocin or other labor-inducing or augmenting drugs are used for the purpose of induction of labor, the attending Physician will follow the standards established by the Medical Staff.

Article VIII. Emergency Services

A. The Medical Staff has a method of providing medical coverage in the Emergency Services area. This plan is in accordance with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all Physicians who render emergency care.

B. No patient requiring emergency medical services shall be denied such services due to the patient's race, religion, color, age, sex, handicap, ability to pay or source of payment.

C. For purposes of the federal Emergency Medical Treatment and Labor Act ("EMTALA"), the following shall constitute Qualified Medical Persons for services within the scope of their licensure, privileges, training and experience:

1. RNs who have Core skills in the Labor and Delivery Department may determine if a patient is in active labor

2. Physician Assistants

3. Licensed Independent Practitioners (including Nurse Practitioners and Nurse Midwives) with appropriate clinical privileges

4. Physicians

D. An appropriate medical record shall be kept for every patient receiving Emergency Services.

Article IX. General Rules Regarding Intensive Care Services

A. Admission to the Intensive Care Unit is based on the patient's need for specialized medical and nursing care management using state of the art cardiovascular, respiratory and hemodynamic monitoring.

B. The following general guidelines will be used to determine admission to, discharge from Intensive Care:

1. Need for cardiac monitoring
2. Need for hemodynamic monitoring or support
3. Stabilization of critically ill patients
4. Need for respiratory support
5. Need for a level of nursing care not available elsewhere in the Hospital. For example, one-on-one care, every-hour glucose monitoring or frequent vital sign monitoring.

C. Patients admitted to Intensive Care Unit for acute MI, cardiac, respiratory or cardiovascular collapse will be seen by a Physician within thirty (30) minutes of admission or as soon as possible thereafter. All other patients admitted to the Intensive Care Unit will be seen by a Physician within two (2) hours unless an admission order accompanies the patient and alternate plans are clearly indicated on the order.

D. Pediatric patients needing intensive care or stabilization prior to transfer to a more advanced or specialized level of care may be admitted to the Intensive Care Unit. All guidelines set forth in the Medical Staff Bylaws will be followed in regards to pediatric patients.

E. When Intensive Care Unit telemedicine monitored beds are available, they will be utilized. The attending Practitioner shall be responsible for approving the level of monitoring and treatment that will be provided by the telemedicine provider under applicable Hospital policies and procedures.

Article X. Attendance Requirements

Active Staff members shall be involved in the activities and decisions of the Medical Staff as demonstrated through attendance at Medical Staff meetings and appropriate committee meetings. Courtesy Staff members are encouraged to attend Medical Staff meetings.

Article XI. Amendments

The Rules and Regulations may be amended only in accordance with the procedures applicable to amendments to the Medical Staff Bylaws and described therein.

REVISION HISTORY:

Revised: 2005 Approved: Medical Staff 07/20/2005, Governing Body: 08/2005
Revised: 2008 Approved: Medical Staff 12/05/2008, Governing Body: 12/16/2008
Revised: 2010
Revised: 2011 Approved: Medical Staff 05/04/2011, Governing Body 05/17/2011
Revised: 2014 Approved: Medical Staff 01/29/2014, Governing Body 02/25/2014
Revised: 2015 Approved: Medical Exec. 12/28/2015, Medical Staff 01/12/2016, Governing Board 01/26/2016
Revised: 2017 Approved by Medical Staff 01/10/2017, Governing Body 01/24/2017

DEFINITIONS:

High Risk Procedure: Any surgical procedure which:

1. Requires any form of anesthesia or sedation other than a local anesthetic
2. Involves a deep body cavity
3. Involves greater than 3 cm incision of the skin
4. Results in >10cc of blood loss
5. Involves advanced line placement
6. Involves any form of endoscopy
7. Involves complex laceration(s)

REFERENCES:

MED Medical Staff Bylaws
MED Medical Staff Bylaws - Appointment, Reappointment and Clinical Privileges Policy
MED Medical Staff Bylaws - Organization and Functions Manual

ATTACHMENTS:

None.