MEDICAL STAFF
RULES AND REGULATIONS

SOUTH LAKE HOSPITAL

Approved
South Lake Hospital
Board of Directors
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TABLE OF CONTENTS

ARTICLE **PAGE**

ARTICLE **PAGE**

ARTICLE 1

DEFINITIONS

The definitions below apply to the terms used in these Rules and Regulations, in addition to the definitions set forth in the Medical Staff Bylaws:

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

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

(c) "Attending" means an independent licensed practitioner who is a physician, podiatrist, or dentist, has appropriate hospital credentials to treat patients admitted to the Hospital, and is actively involved in the care of a patient.

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

(e) "Responsible Practitioner" means any practitioner who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

(f) "Managing Physician" means the patient's primary treating physician at the Hospital, who shall be responsible for directing and supervising the patient's overall medical care, for the completion of the medical history and physical examination after the patient is admitted, and for communicating the patient's status to the patient, the patient's family or POA (if applicable), and the referring practitioner.

ARTICLE 2

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT AND SERVICES

2.A. Admissions:

(1) A patient may only be admitted to the Hospital by order of a Medical Staff member or other licensed practitioner, in accordance with state and federal law, who is granted admitting privileges.

(2) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.

(3) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

2.B. Responsibilities of Managing Physician:

(1) The Managing Physician will be responsible for the following:

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

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

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

(d) providing necessary patient instructions;

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

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

(2) At all times during a patient's hospitalization, the identity of the Managing Physician will be clearly documented in the patient list in the electronic health record ("EHR"). Whenever the responsibilities of the Managing Physician are

transferred to another physician outside of his or her established call coverage, the identity of the Managing Physician must be updated in the EHR. The Managing Physician who accepts the transfer of care will be responsible for updating the EHR.

(3) Prior to discharge, the Managing Physician (or a physician designee with knowledge of the patient) will complete the physician certification documenting that the inpatient services were medically necessary. The physician certification includes, and is evidenced by, the following information:

(a) authentication of the admitting order;

(b) the reason for the inpatient services (i.e., the provisional diagnosis);

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

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

2.C. Care of Unassigned Patients:

All unassigned patients will be managed in accordance with the Medical Staff Policy on Unassigned Patients.

2.D. Availability and Alternate Coverage:

(1) Attending Physicians will provide professional care for their patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.

(2) The Managing Physician (or his or her designee), as well as other Attending Physicians (as applicable) actively involved in the care of a patient and those physicians on call for the ED and in-house consults, will comply with the following patient care guidelines regarding availability:

(a) Calls/texts from the Emergency Department and/or a Patient Care Unit – must respond by telephone or text message within 10 minutes of being contacted and, if requested, must personally see a patient at the Hospital in accordance with Articles 5 and 6 of these Rules and Regulations;

(b) ICU Patients – Managing Physician must personally see the patient within 12 hours of being admitted to the ICU, unless the patient's condition requires that the physician see the patient sooner;

(c) All Other Admissions – Managing Physician must personally see the patient within 24 hours of admission, unless the patient's condition warrants seeing a patient sooner;

(d) Patients Subject to Restraints or Seclusion – pursuant to Hospital restraint policy, Restraint Use in the Acute Care Setting 200.372.

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

(4) If neither the Managing Physician nor his or her designee is available and care of the patient is compromised, the Chief of Staff will have the authority to call on the on-call physician of the appropriate specialty to attend the patient, and the case will be referred to Quality for review.

2.E. Handoffs:

(1) To provide for continuous care of in-house patients, handoffs must occur between physicians when care of a patient is transferred between them.

(2) The transferring physician retains the responsibility for care of the patient, and must remain reachable, until the receiving physician has been given handoff and accepted care of the patient.

(3) The receiving physician has responsibility to ensure sufficient physician to physician handoff to be able to assume immediate care of the patient.

(4) Handoffs may occur through written or oral communication.

(5) A physician may handoff to an AHP if there is a protocol clearly delineating that practitioner's supervising physician. The physician supervisor of that AHP is ultimately responsible for the care of the patient(s).

(6) A physician may not handoff responsibility for care of a patient to a rounding nurse who is not an AHP.

(7) Automatic transfer of care between physicians working shifts must have a written protocol, approved by the Medical Staff Executive Committee, delineating the method of handoffs and the responsibilities of participating physicians.

2.F. Continued Hospitalization:

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

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

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

(c) plans for post-hospital care.

This response will be provided to the Utilization Review Department within 24 hours of the request. Failure to comply with this requirement will be reported to the President for appropriate action.

(2) If the Utilization Review Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the Attending Physician. If the matter cannot be appropriately resolved, the President will be consulted.

ARTICLE 3

MEDICAL RECORDS

3.A. General:

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

(a) Attending Physicians and other practitioners with appropriate privileges involved in the care of the patient;

(b) nursing providers, including registered nurses ("RNs") and licensed practical nurses ("LPNs") making entries appropriate to their scope of practice and privileges;

(c) physicians with clinical privileges responding to a request for consultation;

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

(e) volunteers, such as volunteer chaplains, functioning within their approved roles;

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

(g) a non-AHP rounding nurse making an entry as a scribe for their supervising Attending Physician who dictated the note to the rounding nurse regarding the physician's personal evaluation of the patient. A non-AHP rounding nurse may only make entries in the medical record as a scribe, and may not enter a note that reflects their personal evaluation, assessment, or plan, even if discussed with or approved by their supervising physician; and

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

(2) Entries will be made in the medical record consistent with Hospital policy, Documentation of Patient Care 200.311. Electronic entries will be entered through the EHR. Orders will be entered using Computerized Provider Order Entry ("CPOE") whenever possible. Orders may be given orally only as per

Hospital policy, Verbal/Telephone orders 200.250. Handwritten medical record entries will be legibly recorded in blue or preferably black ink, and may be used where paper-based documentation has been approved by the Hospital (e.g., documentation of informed consents) or when is otherwise appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available). All entries, including handwritten entries, must be timed, dated and signed.

(3) Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(4) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

(5) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy, Documentation of Patient Care 200.311. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed.

3.B. Access and Retention of Record:

(1) Medical records are the physical property of the Hospital. They will be maintained and retained in accordance with federal and state laws and Hospital policies. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

(2) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Hospital policy, Access to Protected Health Information and Other Records by Patient or Legal Representative 100.200.

(3) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless such a release would have an adverse effect on the patient as determined by the Managing Physician, Chief of Staff, and President.

(4) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(5) Subject to the discretion of the President (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

3.C. Content of Record:

(1) For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services.

(2) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policy, Documentation of Patient Care 200.311. Stamped signatures are not permitted in the medical record.

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

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

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

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

(d) evidence of informed consent when required by Hospital policy Informed Consent process 200.644 and, when appropriate, evidence of any known advance directives;

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

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

(g) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies to foods and medicines;

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

(j) diagnosis, diagnostic impression, or conditions;

(k) goals of the treatment and treatment plan;

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

(m) progress notes made by authorized individuals;

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

(o) consultation reports;

(p) operative procedure reports and/or notes;

(q) any applicable anesthesia evaluations;

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

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

(t) reassessments and plan of care revisions;

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

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

(w) medications dispensed or prescribed on discharge;

(x) if the patient was delivered to the Hospital by ambulance, a copy of the state required EMS report;

(y) social work services reports, if provided;

(z) autopsy findings, when performed;

(aa) certifications of transfer of the patient between hospitals; and

(bb) routine inquiry form regarding request for organ donation in the event of the death of the patient.

(4) Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) known significant medical diagnoses and conditions;

(b) known significant operative and invasive procedures;

(c) known adverse and allergic drug reactions;

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

(e) clinical observations, including the results of treatment;

(f) referrals to and communications with practitioners or providers of services internal or external to the Hospital;

(g) growth charts for children and adolescents as needed when the service is the source of primary care; and

(h) immunization status of children and adolescents and others as determined by law and/or Hospital policy.

(5) Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) time and means of arrival;

(b) record of care prior to arrival;

(c) results of the Medical Screening Examination;

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

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

(f) documentation notes of procedures and other aspects of emergency care adequate for continuity of care upon admission;

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

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

(6) Obstetrics Records. Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) findings during the prenatal period;

(b) the medical and obstetrical history;

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

(d) laboratory and x-ray findings.

The obstetrical record will also include a complete prenatal record, if available. The prenatal record may be a legible copy of the Attending Physician's office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

(7) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) history of maternal health and prenatal course, including mother's HIV status, if known;

(b) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;

(c) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;

(d) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining Hospital stay – provided that for any infant who was a term delivery, has no complications other than newborn physiologic jaundice, and is discharged within 36 hours of birth, the birth and discharge examinations can be the same;

(e) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;

(f) documentation of infant feeding: intake, content, and amount if by formula; and

(g) clinical course during Hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3.D. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 16 of the Medical Staff Bylaws.

3.E. Progress Notes:

(1) Progress notes will be entered by the Attending Physician (or his or her covering practitioner) at least every 24 hours for all hospitalized patients and as needed to reflect changes in the status of a patient in an ambulatory care setting.

(2) Progress notes will be legible, dated, and timed. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

(3) Progress notes may also be entered by allied health professionals as permitted by their clinical privileges or scope of practice.

3.F. Pathology Reports:

(1) The pathologist is responsible for the preparation of a descriptive diagnostic report of gross specimens received from surgical procedures and of autopsies performed. These reports will be authenticated by the pathologist and made a part of the medical record.

(2) When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three days, and the complete protocol should be made a part of the medical record within 60 days. The pathologist shall sign these reports.

3.G. Radiology Reports:

The radiologist is responsible for the preparation of all radiology reports of examinations performed. These reports will be signed by the radiologist and made a part of the medical record.

3.H. Authentication:

(1) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE. Signature stamps are never an acceptable form of authentication for written orders/entries.

(2) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy, Issuance, Distribution and Protection of User Access Codes, Proximity Cards, and Omnicell Access 100.104.

(3) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.I. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's policy on Informed Consent process 200.644 and documented in the medical record.

The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate, including use of blood products. The physician, podiatrist or dentist who informs the patient and obtains the consent should be identified in the medical record.

This information should include:

(1) Identity of the patient;

(2) The procedure or treatment to be rendered (layman terminology when possible);

(3) The name(s) of the individuals who will perform the procedure or administer the treatment;

(4) The authorization for any required anesthesia;

(5) An indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient by the physician, podiatrist or dentist;

(6) The authorization for disposition of any tissue or body parts as indicated;

(7) The signature of the patient or other individual empowered to give consent (should be witnessed);

(8) The date and time of the consent.

Informed consent must be documented prior to the procedure or treatment.

It is the responsibility of the physician obtaining consent to determine if a patient lacks the capacity to understand their medical condition and proposed treatment to a reasonable degree of medical certainty. If a patient lacks capacity, consent must be obtained from an authorized decision maker, unless an emergency or other exception applies.

Refer to hospital policy and procedures for specific forms of documentation of informed consent for various procedures and treatment.

3.J. Delinquent Medical Records:

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

(2) Medical records will be considered delinquent under the following conditions:

(a) Procedural reports, if not completed within 24 hours after the completion of the procedure;

(b) H&P's, if not completed within 24 hours of the patient's admission;

(c) All other medical records, if not completed within 30 days following the patient's discharge.

(3) If a record becomes delinquent, the practitioner will receive a written warning, either hand delivered or by certified mail, and if the record remains delinquent greater than five (5) days after the practitioner's receipt of the written warning, the practitioner will be notified that his or her clinical privileges and Medical Staff appointment have been automatically relinquished in accordance with the Medical Staff Bylaws. Notice of the automatic relinquishment will also be given to the Chief of Staff, President, and relevant Department Chief. The relinquishment will remain in effect until all the practitioner's records are no longer delinquent.

(4) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges 14 days from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges. Only upon completion of all medical records and payment of the application fee, may the individual then reapply through the Credentials Committee as a new applicant for Medical Staff appointment and clinical privileges.

(5) A Medical Staff member who is ill or on vacation or leave of absence shall not be penalized for having incomplete medical records. The Medical Staff member will be given three (3) days from the time he or she again becomes available to satisfy the 30-day requirement. Extensions shall not apply to absences of less than three (3) days, or in instances where records are delinquent, and physician has been notified prior to departure.

(6) Medical records shall not be filed until complete, except on order of Administration.

(7) When a practitioner is no longer a member of the Medical Staff or Allied Health Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the practitioner's credentials file and divulged in response to any future credentialing inquiry concerning the practitioner.

(8) Any requests for special exceptions to the above requirements will be submitted by the practitioner to Health Information Management, who will then forward with any pertinent comments to the Department Chief for consideration.

(9) The chart completion requirements for ambulatory care will be the same as for other medical records.

ARTICLE 4

MEDICAL ORDERS

4.A. General:

(1) Orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE. Orders given orally may only be done so per hospital policy Verbal/Telephone Orders 200.250. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR via the CPOE in accordance with Hospital policy Documentation of Patient Care 200.311.

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

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering practitioner. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and

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

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

(a) members of the Medical Staff; and

(b) allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

(4) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(5) All orders will be reviewed and reconciled when a patient is transferred from one level of care to a different level, whether the new level is a higher or lower level of care.

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

(7) All orders for medications administered to patients will be:

(a) reviewed by the Attending Physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;

(b) reconciled by the Managing Physician when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

(c) reviewed by the pharmacist before the initial dose of medication per policy, Medication Ordering/Prescribing 200.243.

(8) All medication orders will clearly state the administration times or the time interval between doses.

(9) Abbreviations will not be used for medication names.

(10) Medication orders and chemotherapy orders should include the height, weight, and allergies of the patient, when applicable.

(11) Allied health professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders issued by an allied health professional will be countersigned/authenticated by the Supervising Physician by the close of the medical record.

4.B. Verbal Orders:

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

(2) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy, Verbal/Telephone orders 200.250 and state law.

(3) Authentication will take place by the ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, (ii) within 24 hours for Do Not Resuscitate and restraint orders, and (iii) within 48 hours after the order was given for all other verbal orders.

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

(5) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:

(a) Registered Nurses;

(b) Licensed Practical Nurses;

(c) Physician's Assistants;

(d) Advanced Registered Nurse Practitioner;

(e) Certified Registered Nurse Anesthetist;

(f) Certified/Registered Respiratory Therapists;

(g) Registered Radiologic Technologists;

(h) Registered Physical Therapists, Occupational Therapist, Speech Therapist;

(i) Lab Technician;

(j) Orthopedic Technician;

(k) Registered Pharmacists as orders pertain to medication;

(l) Registered Pharmacy Interns;

(m) Registered dieticians as orders pertain to diet and nutrition intervention;

(n) Case managers as orders pertain to discharge planning; and

(o) Licensed Social Workers, Mental Health Counselors, Marriage/Family Therapists.

4.C. Standing Orders, Order Sets, and Protocols:

(1) For all order sets and clinical protocols, review and approval of the Medical Executive Committee, with input from nursing and the Hospital's pharmacy department when appropriate, is required. Prior to approval, the Medical Executive Committee will confirm that the order set or clinical protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take necessary steps to ensure that there is periodic and regular review of such order sets and clinical protocols. All clinical protocols will identify clinical scenarios for when the protocol is to be used.

(2) If the use of an order set has been approved by the Medical Executive Committee, the order will be initiated for a patient only by an order from a practitioner responsible for or involved in the patient's care in the Hospital and acting within his or her scope of practice. Orders initiated by a clinical protocol will be deemed to have been initiated by a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.

(3) When used, order sets must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

(4) For purposes of this Section, a clinical protocol is defined as a course of treatment which may be initiated by a member of the Hospital's clinical staff (e.g., a nurse) without a prior specific order from the treating physician/practitioner when a patient's condition meets certain pre-defined clinical criteria. An order set consists solely of menus of treatment or care options for common clinical scenarios designed to facilitate the creation of a patient-specific set of orders by a physician or other qualified practitioner authorized to write orders.

(5) Standing order/ sets may be used by individual physicians, podiatrists or dentists after approval by the Executive Committee of the Medical Staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when the Attending Physician does not write specific orders, they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written for the specific patient.

4.D. Stop Orders:

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses may be subject to "STOP" orders and automatically discontinued as per policy, Medication Ordering/Prescribing 200.243.

4.E. Orders for Drugs and Biologicals:

(1) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

(2) All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

(3) Before the administration of any drug, the order must be verified, the patient identified, and the dosage and medication recorded in the patient's medical record.

4.F. Orders for Radiology and Diagnostic Imaging Services:

(1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other practitioners authorized by the Medical Staff and governing body to order services.

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

4.G. Orders for Outpatient Services:

(1) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Medical Staff Bylaws.

(2) Orders for outpatient services must be submitted on a prescription pad, letterhead, or an electronic order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual; (iii) the type, frequency, and duration of the service; and, (iv) diagnosis (and diagnostic code if known), as applicable.

ARTICLE 5

IN-HOUSE CONSULTATIONS

5.A. Requesting Consultations:

(1) The Managing Physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant as set forth in this Article. A consulting physician may only request a consult if approved by the Managing Physician.

(2) An order requesting consultation shall be entered in the patient's medical record, including the reason for consultation.

(3) For a routine consult, either the Attending Physician or allied health professional shall contact the consultant directly by phone or text, in addition to placing a computer order. However, if an AHP requests a consult, the Attending Physician supervising that AHP must be available to speak with the consultant if requested. If both the physician requesting the consult and the physician receiving the consult request have mutually agreed beforehand that an order entered into the hospital EHR is acceptable, then direct communication is not required for each separate consultation request.

(4) For an urgent consult, the Attending Physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.

(5) Procedures for consultation requests originating from the Emergency Department are delineated in Article 6.

5.B. Responding to Consultation Requests:

(1) Any individual with clinical privileges is subject to a request for consultation within his or her scope of clinical privileges.

(a) If a physician is on call as per the ED and In-House Consultation Call List at the time the order is entered into the medical record, then that physician is obligated to respond to the consult request and evaluate the patient in a timely manner;

(b) If the physician who is consulted is not on call per the ED and In-House Consultation Call List, and has no relevant established relationship with the patient, then that physician may voluntarily accept the consult or decline the consult;

(c) If there is a relevant established relationship between the patient and a physician not on call, then that physician (or physician providing coverage for that physician) is obligated to respond to the consult;

(d) Disputes regarding the existence of a prior physician-patient relationship will be referred to the Quality Department for review.

(2) For routine consults, the physician who is asked to provide the consultation ("consultant") is expected to do so within 24 hours of the order entry in the medical record unless a shorter time frame is specified by the individual requesting the consultation.

(3) For urgent consults, the consult must be completed within 4 hours of the request, unless other established protocols dictate a shorter response time, or the requesting physician indicates directly to the consultant that a longer time frame is acceptable. The physician requesting the consult will determine the urgency of the consult.

(4) Disputes regarding whether a consultant has failed to respond within the requested time period or whether a requesting physician has requested an unreasonable urgency or response time will be referred to Quality for review.

(5) The consultant may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. In such case, the Supervising Physician must personally approve and cosign the consultation within twenty-four (24) hours (or more timely in the case of any urgent consultation request). However, the consultant physician must perform the consult personally if so requested by the physician requesting the consult.

5.C. Consults:

(1) Responsibilities of requesting physician:

(a) All consults, whether routine or urgent, must involve direct physician to physician contact (or AHP as per Article 5 of these Rules and Regulations) via secure electronic means or oral communication, in addition to the order being placed in the Hospital EHR. However, if both the physician requesting the consult and the physician receiving the consult request have mutually agreed beforehand that an order entered in the hospital EHR or another form of contact is acceptable, then direct communication is not required for each separate consultation request.

(b) A nurse practitioner may request a consult and contact the consultant physician regarding a consult request, but the supervising physician of that

nurse practitioner must be immediately available if the consultant requests to speak with him or her.

(c) A rounding nurse who is not an AHP may not contact a consultant to request a consult in place of the consulting physician unless the consultant has agreed in advance that such contact is acceptable.

(d) For urgent consult requests, the requesting physician will attempt to contact the consultant immediately upon placing the order in the computer. If the consultant does not respond to a text, then it is the requesting physician's responsibility to contact the consultant by phone or in person. If the consultant does not respond by phone, then it is the requesting physician's responsibility to leave a voice message and to escalate the notification per policy, Change in Patient Condition, notification 200.216, if indicated by the patient's condition.

(e) The requesting physician must communicate both the patient condition warranting the consult and expectation of the consult (e.g., patient with abnormal EKG; request cardiac evaluation for procedure).

(f) For routine consult requests, the time to respond to the consult begins when the order is entered into the Hospital EHR, regardless of whether direct contact with the consultant was delayed by preference of the consultant.

(g) Urgent consult requests will be called immediately upon entry into the Hospital EHR.

(h) The requesting physician will only request urgent consults when the patient condition warrants consultant care in less than 24 hours.

(i) Disputes regarding the appropriateness of consult requests, the urgency assigned to consults by the requesting physicians, or the distribution of consults by requesting physicians will result in review by Quality Committee.

(2) Responsibilities of consultant:

(a) Physicians who are on call for the ED are also on call for inpatient consults.

(b) On-call physicians must respond immediately, either in person or by electronic device, to all requests for consults, unless the consult request states an immediate response is not necessary.

(c) An AHP may respond to a consult, but the supervising physician must be available upon request of the consulting physician.

(d) An AHP may evaluate patients when consults are requested as per established protocol.

(e) A rounding nurse who is not a certified nurse practitioner may not respond to a request for a consult, except to take a message when the consultant is involved with a patient and temporarily unavailable.

(f) A rounding nurse may not evaluate the patient when a consult is requested.

(g) Physicians who are on call must remain immediately reachable for both routine and urgent consults. If involved in a procedure or situation where it is expected that a phone cannot be answered, or an immediate response cannot be given, the consultant's phone must be handed to a responsible provider who can answer calls or otherwise respond so that the contact has been made. If a voice mail is left because the on-call physician did not answer the phone, the responsibility for immediate follow-up remains with the consultant. However, if indicated by patient condition, the physician requesting the consult should follow hospital policy, Change in Patient condition, notification 200.216, regarding escalation of contact efforts to ensure patient safety and timely evaluation and treatment.

(h) For routine consults:

(1) The consultant must evaluate the patient within twenty-four (24) hours from the time the order is placed in computer.

(2) When a consult request is entered into the EHR, the 24-hour response time begins from the time the order is placed in the computer, not when contact is made with the consultant.

(i) For urgent consults:

(1) On-call physician, or physician not on call but who accepts an urgent consult, must evaluate the patient within four hours from the time the order is placed in computer, unless the consultant is involved in a procedure with another patient. In that case, the consultant responsible for an urgent consult must make immediate contact to discuss the earliest time the consultant can evaluate the patient. The inability of the on-call physician, when consulted urgently, to evaluate a patient within four hours should be a rare occurrence.

(2) After hours urgent consults must have immediate contact between requesting physician and consultant, in addition to an order entered into the Hospital EHR.

(j) When a consult is entered into the computer, and direct contact has been made, the consultant physician on call, or consultant physician not on call but who accepts the consult, retains responsibility as a consultant for that condition in that patient throughout the admission, regardless of whether the consult is subsequently cancelled. However, if the consult is cancelled prior to contact having been made between the requesting physician and the consultant, then no consultant responsibility ensues. If the consult request is cancelled after contact has been made between the requesting physician and the consultant, then that consultant retains responsibility as a consultant for that that condition in that patient if during that same admission a new consult is placed for that same condition.

(k) Physicians not on call have no responsibility to respond to, or accept, a request for consult, unless an applicable prior physician-patient relationship has been established either through relevant prior contact with patient or relevant prior consult request when on call.

(l) All physician providers while on call, actively participating in the care of an in-house patient, or covering for a physician actively participating in the care of an in-house patient, whether the Managing Physician or consultant, must remain immediately available by their personal mobile phone.

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

(n) Declining a consult:

(1) A physician not on call, and who has no applicable physician-patient relationship with patient, has a right to decline a consult request, either directly or by not responding to the request. It is recommended for declinations to be direct if possible so that requesting physician can request a timely consult by another physician.

(2) An on-call physician may decline a consult if the scope of the consult request is beyond the scope of the consultant physician's privileges. On-call physicians are responsible for consults within the scope of their privileges unless that scope has been limited in

writing through the credentialing process and with approval of the MEC.

(3) An on-call physician may decline a consult if an applicable physician-patient relationship has already been clearly established between the patient and another consultant of the same specialty.

(4) If it is unclear which physician has consultant responsibility, the department chief will attempt to mediate. The Chief of Staff will make the final decision, if necessary, and the case will subsequently be referred to the Quality Committee for review.

(o) Disputes regarding the appropriateness of a consultant's response to a consult request or the response time of a consultant to consult request will result in review by Quality Committee.

(3) Responding to Codes and in-house emergencies:

Codes and in-house patient care emergencies will be responded to by the ED physician on call, the in-house Hospitalist, and Intensivist (if in-house). The Intensivist or Hospitalist will manage the resuscitation. If necessary, the ED physician will provide emergency support as needed. The Managing Physician will also be notified.

5.D. Recommended and Required Consultations – General Patient Care Situations:

(1) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient lacks decisional capacity.

(2) Except in emergency cases, consultations are required in all cases in which, in the judgment of the Attending Physician:

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

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

(c) unusually complicated situations are present that would reasonably be expected to require specific skills of other practitioners;

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

5.E. Surgical Consultations:

(1) Whenever a consultation (medical or surgical) is requested regarding surgery, the Attending Physician requesting the consult shall contact the consultant directly unless another form of contact has been agreed upon by both parties in advance. The requesting physician will communicate relevant findings, reasons, and necessary time frame of the consult. If a formal consult is deemed to be necessary or advisable, the consultation should be performed in a timely manner and a notation from the consultant, including relevant findings, will be documented in the patient's medical record. If a requested pre-surgical consultation has been requested but not been completed, surgery and anesthesia will not proceed, unless the Attending Physician states in writing that proceeding without the consultation is in the patient's best interest.

(2) When a pre-surgical consult is requested, it is the responsibility of the requesting physician to relay the proposed time and date of the intended surgical procedure to the consultant physician. If this time frame is shorter than 24 hours, and the consultant is unable to complete the consultation within the requested time frame, then that information will be relayed by the consultant to the requesting physician, who will either change the intended procedure time or cancel the consult request. If the consultant agrees to a time frame shorter than 24 hours, then the consultant is responsible for completing the consult in that time frame.

(3) Pre-surgical consults agreed to but not completed by one hour prior to the scheduled time of the proposed procedure will be referred to Quality for review.

5.F. Content of Consultation Report:

(1) Each consultation report will be completed in a timely manner and will contain a dictated or legible written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.

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

ARTICLE 6

ON-CALL POLICY

6.A. On-Call Schedule:

The schedule for Emergency Department call coverage will be developed consistent with the Medical Staff Policy titled Emergency Call Schedule. The Medical Staff Executive Committee will strive to develop this Policy and oversee the functioning of the on-call schedule as equitably as is reasonably possible among physicians who regularly exercise privileges at the Hospital, including consideration of expectations of the Medical Staff, Hospital management and Board, and community for coverage of specialties represented on the Medical Staff, and the respective responsibilities of physicians in specialties with fewer than five members.

6.B. Response to Call:

(1) When an on-call physician is contacted by the Emergency Department and requested to respond, a timely response by the on-call physician is deemed to be 10 minutes by telephone and 60 minutes for physical presence from the initial call. The Emergency Department physician, in consultation with the on-call physician, will determine whether the patient's condition requires the on-call physician to see the patient as soon as possible. The determination of the Emergency Department physician will be controlling and will be recorded in the medical record.

(2) If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the Emergency Department physician will determine whether to attempt to contact another physician on the Medical Staff or arrange for a transfer pursuant to this Article.

(4) On-call physicians providing coverage at multiple hospitals will be required to arrange for appropriate backup if they are repeatedly unable to provide appropriate coverage at South Lake Hospital.

(5) Members who are on call should not inquire about the individual's insurance status or ability to pay before coming to the Emergency Department. Therefore, Hospital employees will be instructed not to disclose to the on-call physician financial information pertaining to the presenting individual.

6.C. Transfer Arrangements:

(1) When possible, transfer arrangements with another hospital that can provide specialty service should be made to cover that service when there is no on-call physician scheduled to provide coverage at the Hospital. If a patient presents

needing care when a specialty is not covered, the patient will be transferred in accordance with applicable transfer arrangements, in accordance to hospital policy Transfer Process for Patients to other Acute Care Facilities 200.500.

(2) In an effort to reduce the number of cases that will need to be transferred, the Hospital will attempt to keep local Emergency Medical Services informed of the dates and times when certain specialties are not available.

6.D. Concurrent Call/Elective Surgery:

(1) Notwithstanding an on-call physician's obligation to respond when on call, on-call physicians may perform elective surgery or other patient care services at the Hospital while on call. Physicians should give due consideration to limiting the duration of elective cases or arranging for appropriate backup for the duration of the procedures or services when on call.

(2) If there is a limited number of physicians in a given specialty, the Medical Executive Committee may recommend, subject to Board approval, that backup call is not required when a physician is providing simultaneous call, with the understanding that on-call physicians taking simultaneous call are obligated to make every reasonable effort to respond and evaluate patients within the time frames set forth in this Article.

6.E. Follow-Up Care:

An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including one office follow-up visit related to that episode.

6.F. Enforcement of ED Call Responsibilities for EMTALA Compliance:

(1) An on-call physician's unavailability when on call, refusal to respond to a call from the Emergency Department, or any other violation of this Policy is a serious matter. After reviewing the relevant information, if the Medical Executive Committee determines that there is a potential violation of this Article, the physician will be notified and will be afforded an opportunity to meet with the Committee. After this meeting, the Medical Executive Committee will determine whether the physician violated this Article. Confirmed violations of this Article that occur within a four-year time frame will result in the following disciplinary actions:

(a) A first violation will result in a letter of counsel.

(b) A second violation will result in a letter of warning.

(c) A third violation will result in a letter of warning and the immediate relinquishment of clinical privileges for 14 calendar days.

(d) A fourth violation indicates an inability or unwillingness to fulfill Medical Staff responsibilities as set forth in the Medical Staff Bylaws and this Article. Accordingly, it will result in the automatic resignation of appointment and clinical privileges, without the right to a hearing or appeal.

(2) A complaint about a physician's failure to comply with this Policy shall be referred to the Chief of Staff and the President for a preliminary review. These individuals shall review the complaint and may discuss it with involved individuals. The complaint and related information shall then be referred to the Medical Executive Committee for a course of action described above, unless the Chief of Staff and the President agree that there is no need for such a referral.

ARTICLE 7

PROCEDURES

7.A. Pre-Procedure Protocol:

(1) The physician performing the procedure will ensure the performance and documentation in the medical record of the following:

(a) a complete history and physical examination (or completed short-stay form, as appropriate);

(b) the provisional diagnosis related to the planned procedure;

(c) a properly executed informed consent;

(d) the results of any relevant diagnostic tests; and

(e) all appropriate plans of care for the patient, including anesthesia and nursing, prior to transport to the procedure room, except in emergencies.

(2) Except in an emergency, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

(a) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(b) pre-procedural education, treatments, and services are provided according to the plan for care;

(c) the physician performing the procedure is in the Hospital; and

(d) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in hospital policy, Site Verification and Time Out Consented invasive procedure, 200.633.

(3) When another physician has completed the H&P on a patient scheduled for a procedure, the physician performing the procedure must still do the following:

(a) introduce himself/herself to the patient prior to the procedure, verify the procedure to be performed and answer any patient questions;

(b) ensure consent is accurate, then sign and date;

(c) mark the surgical site, if appropriate, and ensure agreement with surgical consent;

(d) review the H&P and insert addendum in medical record if additional information needed or inaccuracies noted; and

(e) ensure the surgical diagnosis and planned procedure are noted in the medical record.

7.B. Post-Procedure Protocol:

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

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

(b) pre- and post-operative diagnoses;

(c) date of the procedure;

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

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

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

(g) estimated blood loss, if any;

(h) amount of blood transfused, if any;

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

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

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

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

(m) the patient's condition upon leaving the procedure area; and

(n) the signature of the Attending Physician.

(2) If a full report cannot be entered into the record immediately after the operation or procedure, a brief post-op note must be entered by a physician (Attending Physician or resident only) in the medical record immediately after the procedure. In such situations, the full operative procedure report must be entered or dictated within 24 hours. Operative procedure reports not dictated or otherwise entered into the medical record within 24 hours will constitute a delinquency and be subject to the rules regarding delinquent records in Article 3. The brief post-op note will include:

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

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

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

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

(e) specimens removed; and

(f) post-operative diagnosis.

ARTICLE 8

ANESTHESIA SERVICES

8.A. General:

(1) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal, moderate or conscious sedation, or deep sedation.

(2) General anesthesia, major conductive anesthesia (spinals and epidurals), and monitored anesthesia care (MAC) may only be administered by the following qualified practitioners:

(a) anesthesiologist;

(b) CRNA who is supervised by the operating practitioner or an anesthesiologist who is immediately available;

(3) Deep sedation may only be administered by the following practitioners:

(a) anesthesiologist;

(b) CRNA who is supervised by the operating practitioner or an anesthesiologist who is immediately available; or

(c) Critical Care physician;

(d) ED physician;

(4) Procedural sedation may only be supervised by physicians specifically privileged to do so and according to the Procedural Sedation/Analgesia policy 200.331.

(5) Because it is not always possible to predict how an individual patient will respond to moderate or deep sedation, a qualified practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

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

8.B. Pre-Anesthesia Procedures:

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

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

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

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

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

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

(e) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and

(f) any additional pre-anesthesia data or information that may be appropriate or applicable.

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

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

8.C. Monitoring During Procedure:

(1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

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

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

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

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

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

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

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

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

8.D. Post-Anesthesia Evaluations:

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

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

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

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

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

(c) mental status;

(d) temperature;

(e) pain;

(f) nausea and vomiting; and

(g) post-operative hydration.

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

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

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

8.E. Minimal, Moderate or Deep Procedural Sedation:

All patients receiving moderate or deep sedation will be monitored and evaluated before, during, and after the procedure by a practitioner with appropriate clinical privileges in accordance with applicable policies.

8.F. Direction of Anesthesia Services:

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

(1) organization and oversight of all activities of the anesthesia service; and

(2) evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE 9

EMERGENCY SERVICES

9.A. General:

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

9.B. Medical Screening Examinations:

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

(a) Emergency Department:

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

(ii) other Active Staff members; and

(iii) appropriately credentialed allied health professionals.

(b) Labor and Delivery:

(i) members of the Medical Staff with OB/GYN privileges; and

(ii) Certified Nurse Midwives with OB privileges.

(2) The results of the medical screening examination must be documented upon completion of the examination in the Emergency Department.

ARTICLE 10

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

10.A. Who May Discharge:

(1) Patients will be discharged only upon the order of a responsible practitioner.

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

10.B. Identification of Patients in Need of Discharge Planning:

(1) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.

(2) Criteria to be used in making this evaluation include:

(a) functional status;

(b) cognitive ability of the patient;

(c) family support; and

(d) patient safety.

10.C. Discharge Planning

(1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.

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

10.D. Clinical Resume/Discharge Summary:

(1) A concise, dictated clinical resume/discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. Clinical resumes/discharge summaries not completed within 30 days of patient discharge will be considered delinquent as per Article 3 of these Rules and Regulations. All clinical resumes/discharge summaries will include the following:

(a) reason for hospitalization;

(b) significant findings;

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

(d) condition and disposition at discharge;

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

(f) provisions for follow-up care; and

(g) discharge medication reconciliation.

(2) A discharge progress note may be used to document the discharge summary for patients with problems of a minor nature that require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or the patient's family.

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

10.E. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that directive will be documented and will become a part of the permanent medical record of the patient.

10.F. Discharge Instructions:

(1) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

(2) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.

(3) The responsible practitioner, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

(4) When the Hospital determines the patient's transfer or discharge needs, the responsible practitioner, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.

(5) When continuing care is needed after discharge, the responsible practitioner, along with the Hospital staff, will provide appropriate information to the other health care providers, including:

(a) the reason for discharge;

(b) the patient's physical and psychosocial status;

(c) a summary of care provided and progress toward goals;

(d) community resources or referrals provided to the patient; and

(e) discharge medications.

ARTICLE 11

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

11.A. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

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

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

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

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

11.B. Procedures:

(1) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:

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

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

(c) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

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

(i) the reason for the transfer;

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

(iii) available alternatives to the transfer.

(2) When patients are transferred, the Managing Physician and consultants will provide appropriate information to the accepting practitioner/facility, including:

(a) reason for transfer;

(b) significant findings;

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

(d) condition at discharge;

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

(f) working diagnosis.

(3) When a patient requests a transfer to another facility, the Managing Physician will:

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

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

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

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

(e) provide the receiving facility with the same information outlined in paragraph (2) above.

ARTICLE 12

HOSPITAL DEATHS AND AUTOPSIES

12.A. Death and Death Certificates:

(1) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the Attending Physician, his or her designee, or the Emergency Department physician, within a reasonable time frame.

(2) The medical certification of the cause of death within the death certificate will be completed by the Attending Physician (or his or her designee) pursuant to state regulation.

12.B. Release of the Body:

(1) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the Attending Physician (or his or her designee) or other designated member of the Medical Staff.

(2) It is the responsibility of the Attending Physician (or his or her designee) to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

12.C. Organ and Tissue Procurement:

(1) All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital policy, Organ and Tissue Donation 200.141.

(2) When a donor organ is obtained from a deceased patient, the medical record of the donor will include the date and time of the patient's death, documentation by and identification of the physician who pronounced death, the method of transfer of the organ, the method of machine maintenance of the patient for organ donation, and an operative report.

12.D. Autopsies:

(1) The Medical Staff should attempt to secure autopsies in accordance with state and local laws, including all cases of unusual deaths and of medical-legal and educational interest. The Attending Physician (or his or her designee) must be notified when an autopsy is to be performed.

(2) Authorization for an autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. The Attending Physician (or his or her designee) must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the Attending Physician (or his or her designee), an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this should be documented in the medical record.

(3) Any request for an autopsy by the family of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient's family or legal guardian. Difficulties or questions that arise with such a request will be directed to the President.

(4) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

ARTICLE 13

MISCELLANEOUS

13.A. Self-Treatment and Treatment of Family Members:

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

(2) A member of the Medical Staff should not admit or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:

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

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

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

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

This prohibition is not applicable to in-laws or other relatives.

13.B. Orientation of New Physicians:

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

13.C. HIPAA Requirements:

All members of the Medical Staff and Allied Health Staff will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information.

13.D. Consideration of Reasonableness of Patient Load:

(1) The MEC will monitor any concerns brought to its attention or to the attention of the Quality Committee or another Medical Staff Committee or Leader regarding

the reasonableness of the number of patients cared for by a managing or consultant physician, consistent with any local and national benchmarks of quality care, the hospital mission, the satisfaction of other physicians involved in the care of patients, and compliance with these Rules & Regulations regarding medical recordkeeping, communications with other physicians and members of the health care delivery team, handoffs, and other applicable provisions.

(2) Exceptional circumstances requiring larger than normally acceptable patient loads per physician must be remedied as soon as reasonably possible, in the reasonable judgment of involved Leaders and the MEC.

(3) Extended circumstances requiring larger than normally acceptable patient care loads must be approved by the MEC, and must be accompanied by a time limited remedy.

(4) To the extent that patient load is a function of the decision-making of group practices, the group leadership, as a condition of medical staff appointment and clinical privileges granted to all group physicians, will cooperate with the MEC in addressing patient load issues.

ARTICLE 14

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 15 of the Medical Staff Bylaws.

ARTICLE 15

ADOPTION

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

Adopted by the Medical Staff on:

Date: 1·23·18

Chief of Staff

Approved by the Board:

Date: 1·25·18

Chairperson, Board of Directors