



GENERAL RULES OF THE MEDICAL STAFF

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**EATON RAPIDS MEDICAL CENTER
GENERAL RULES OF THE MEDICAL STAFF**

DEFINITIONS

The definitions of terms in the Medical Staff Bylaws apply with equal effect in these Rules.

**ARTICLE I
ADMISSION, ALTERNATE COVERAGE, TRANSFER,
DISCHARGE AND DEATH OF PATIENTS**

1.1 HOSPITAL ADMISSION CRITERIA

1.1-1 Categories of Patients Who May Be Admitted. The Hospital may accept all categories of patients except those requiring highly specialized care, equipment or evaluation not available in the Hospital.

1.1-2 Professionals Who May Admit and Care for Patients. Only a Member with admitting Privileges may admit or co-admit a patient to the Hospital. A physician Member, and in some instances, an oral surgeon Member for his/her own patients, shall be responsible for overseeing the general medical care and treatment of every patient admitted to the Hospital. Dental care and treatment may be provided by a dentist who is a Member; podiatric care and surgery may be provided by a podiatrist who is a Member; and Allied Health Professionals may provide care within the scope of their respective Privileges or Scope of Service.

- (a) Emergency Department Physicians serving on the Active or Courtesy Medical Staff shall not be privileged to admit patients to the hospital without additional credentialing to do so. Additional credentialing shall be initiated upon submission of a written request to admit patients by the ED Physician. The credentialing process shall be consistent with the process for physicians who submit requests to modify clinical privileges. Emergency Department Physicians who have been selected to transact all business of the emergency department must have the ability to work with others with sufficient adequacy to assure the Medical Staff and Board of Directors that any patient treated by them in the Emergency Department will be given quality medical care.
- (b) Certain Physicians serving on the Active or Courtesy Medical Staff whose practices do not require admitting privileges shall not be privileged to admit patients to the hospital without additional credentialing to do so. Additional credentialing shall be consistent with of the process outlined above for Emergency Department Physicians. Physicians whose practices do not require admitting privileges include, but are not limited to, those in the following specialties:
 - Anesthesia
 - Psychology
 - Pathology
 - Radiology

1.1-3 Patients with Psychiatric Diagnosis. Patients with a primary diagnosis of mental illness or potentially suicidal shall be referred to an appropriate mental health facility unless they have a serious medical condition requiring the care and facilities of a medical or surgical unit of the Hospital.

- (a) A potentially suicidal patient who presents to the Emergency Department shall be examined and provided stabilizing treatment within the Hospital's capability before the patient may be transferred to another facility.

1.1-4 Admission Information Required of Admitting Member. Within the limits of his/her knowledge regarding the patient's condition, the admitting Member shall be responsible for providing the following information in the patient's medical records:

- (a) Information needed to properly care for the patient being admitted;
- (b) Information needed to protect the patient from him/herself; and
- (c) Information needed to protect Hospital personnel and others from potential problems or dangers presented by the patient.
- (d) The Medical Staff Members are responsible for being aware of victims of abuse. In an effort to safeguard individuals, relevant information shall be collected, and, as legally required, Members shall notify or release information to the proper authority.

1.1-5 Direct Admission of Acute Patients. All direct admit patients who have acute medical problems shall routinely proceed through the Hospital's direct admission process. This requires contact of the Hospital through the nursing supervisor. All direct admissions and transfer patients arriving at the Hospital without going through the direct admission process will be seen and evaluated in the Emergency Department the same as any other emergency patients. Exceptions to this policy include elective surgery cases.

- (a) Patients admitted directly to the inpatient unit will be evaluated by the Emergency Department physician if the patient has not been assessed by a physician within the previous 12 hours, or the admitting physician must meet the patient at arrival and perform an assessment.

1.1-6 Additional Responsibilities of Admitting Member(s). In addition to the responsibilities already outlined in this Section, a Member who admits a patient into the Hospital (or is the patient's attending Member) is also responsible for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The attending Member is required to document the need for hospitalization. A permitted exception to this requirement is the transfer of care on the Internal Medicine Service between rounding

physicians, or between Member partners.

1.1-7 In all physician to physician, or physician to staff communication with regard to patient care, treatment, or services, a standardized, structured format shall be used. This “hand-off communication” shall include, but will not be limited to:

- Patient name
- Chief Complaint/Diagnosis
- Brief pertinent history
- Allergies
- Medications, including pain management/IVs
- Plan of Care

This interaction between the giver and receiver of patient care information will be interactive, with an opportunity to ask and respond to questions.

1.2 PROVISIONAL DIAGNOSIS

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as reasonably possible.

1.3 ADMISSION OF EMERGENCY PATIENTS

1.3-1 "Emergency" Status Must Be Justified. Members admitting patients on an emergency basis shall be prepared to justify that said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

1.3-2 Transfer of Member Responsibilities of Patients Admitted Through the Emergency Department. The patient's admitting Member shall be notified of a proposed admission by the Hospital's Emergency Department physician when a patient is to be admitted through the Emergency Department. The admitting Member and Emergency Department physician will then discuss the case and:

- (a) Agree that the admission is appropriate and proceed to process the patient accordingly, or
- (b) Agree that an alternative patient disposition is appropriate and proceed to process the patient accordingly, or
- (c) Disagree on the appropriate patient disposition. In this case the admitting Member will make the final determination of patient disposition, but only after physically presenting to the Emergency Department and evaluating the patient. The Emergency Department physician shall continue to provide stabilizing treatment while such patient remains physically in the Emergency Department.

1.3-3 Authority of Emergency Department Physician to Require Patient Be Seen by Practitioner. An Emergency Department physician, when (s)he reasonably believes it is necessary, shall have the authority to require that a patient be seen in a timely fashion by a Member with current on-call responsibility who has Privileges appropriate to treat the condition of the patient.

1.3-4 A physician designated to provide emergency care shall follow the guidelines enumerated below:

- (a) Whenever any individual comes to the Hospital's emergency room and a request is made by that individual, or on that individual's behalf for examination and treatment for a medical condition, the physician will provide for an appropriate medical screening examination, within the capability of the Hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an "emergency medical condition" (as defined in Section 1.3-5(b) of these Rules and Regulations) exists.
- (b) If an emergency medical condition exists, the individual shall be either: (a) treated by a physician at the Hospital until the patient's condition is "stabilized" or (b) transferred to another appropriate medical facility pursuant to section 1.3-5(a) of these Rules, unless the individual (or individual's representative) refuses to consent to the examination and treatment (in writing, if possible) after being offered (and informed of the risks and benefits of) the treatment and examination. A patient's condition is deemed "stabilized" if no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, the woman has delivered (including the placenta).
- (c) If the emergency room physician feels that inpatient care is necessary for proper care of the patient, the patient's attending physician shall treat the patient.
- (d) Patients who do not have a physician from the Medical Staff of the Hospital and who require additional care and treatment other than administered by the emergency room physician, shall be assigned to the scheduled Active Medical Staff physician responsible for admitting patients without a family physician, but only after he has been duly informed.
- (e) Patients assigned to the Active Medical Staff physician responsible for admissions from the Emergency Room may be admitted to the service of another physician only by specific order of the Active Medical Staff physician and provided there is a prior agreement between physicians involved concerning each and every patient referred.

In the event that the Active Medical Staff physician, responsible for emergency room coverage, cannot be reached, his "covering" physician shall be called. Should he also be unavailable, the following order of call shall be followed: (1) Chief of Staff, (2) any available staff physician.

1.3-5 Physician-initiated transfers of patients shall be made to another appropriate medical facility under the following circumstances:

- (a) Such transfer shall only occur: (i) when it is in the best medical interest of the patient, such determination being made by the physician on the basis of screening of patients to identify whether an "emergency medical condition" exists, or (ii) if the patient (or the patient's representative) has requested the transfer (in writing) after being informed of the risks of transfer and the Hospital's obligations under the law.
- (b) An "emergency medical condition" is a condition manifested by acute, severe symptoms that, in the absence of prompt medical attention, could reasonably be expected to place the health of the individual, or a woman in active labor and her unborn child, in serious jeopardy or cause serious impairment to bodily functions or serious dysfunction to any organ. A woman in active labor (having contractions) is considered to fall within "emergency medical condition" when there is inadequate time to effect a safe transfer to another hospital before delivery and the transfer may pose a threat to the health or safety of the woman or unborn child.
- (c) If the transfer is made under section 1.3-5 (a) of these Rules, the transferring physician must certify in writing that, based upon the information available at the time of transfer, all medical benefits reasonably expected from treatment at another facility outweighs the increased risks of transfer. If the physician is not present in the emergency room, other qualified personnel, after consultation with the physician, may sign the certification. If the certificate is signed by personnel other than the physician, the physician must subsequently sign the certification.
- (d) A transfer may not be made under section 1.3-5(a) unless: (i) the receiving facility has available space and personnel to treat the patient and agrees to accept transfer of the patient; (ii) the transfer is effected through appropriate personnel and transportation equipment; and (iii) the Hospital provides receiving facility with the patient's records. Physicians shall document the above, as well as, the stability status of the patient.

1.4 ASSIGNMENT OF ATTENDING MEMBER FOR EMERGENCY PATIENTS

1.4-1 On-Call Assignment: All patients admitted into the Hospital shall be under the supervision of a specified attending Member. A patient admitted on an emergency basis who does not have a Member as his/her personal practitioner may select a Member with the appropriate Privileges. When no such selection is made, or the selected Member is not "on call" and declines to accept the patient, a Member with the appropriate Privileges will be assigned to the patient pursuant to an "on call" roster. Each Service Chief will furnish the Emergency Department, in a timely fashion, rosters of on-call Members from the Service, if applicable, by specialty with sub-designation by general category of Privileges.

1.4-2 On-Call Responsibility: The on-call Member, or his designee, is expected to respond within thirty (30) minutes. If the on-call Member and the Emergency Department physician disagree as to the disposition or plan of care of the

patient, or if requested by the Emergency Department physician to appear in person, the on-call Member or designee will appear within 60 minutes to personally evaluate and care for the patient. If an on-call Member fails to respond to an on-call service request in a timely manner, the behavior will be reported to the Service Chief of the Member or, if he is not available, the Chief of Staff who will arrange for evaluation and/or care of the patient. The Emergency Department physician or designee will promptly notify Risk Management if a patient is transferred because an on-call Member refuses to timely come in and a substitute Member cannot be found. Risk Management will investigate any occurrence related to a potential or actual violation of the on-call protocol in a timely manner when EMTALA rules appear to be infringed. Violations of the on-call protocol will be referred to the MEC for disposition in accordance with the provisions of the Medical Staff Bylaws, Appendices, Rules and Policies.

1.5 CO-ADMISSIONS FOR DENTAL AND PODIATRIC TREATMENT

A patient who is admitted for podiatric or dental treatment shall be co-admitted both by a Member who is a podiatrist or dentist and Member who is a physician who will be responsible for managing the patient's medical condition, except that qualified oral surgeons with appropriate Privileges may independently admit patients without known medical problems, in the event of such co-admission, both the podiatrist or the dentist and the physician shall serve as attending Members within their areas of responsibility.

1.6 COMMUNITY RESPONSIBILITY/ALTERNATE PHYSICIAN COVERAGE

1.6-1 Alternate Designation When Member Is Unavailable. Pursuant to Section 2.2 of these Rules, each Member shall prearrange and designate at least one (1) alternate Member of similar training, Privileges and ability to care for his/her patients when (s)he is unavailable. Each Member shall advise the Medical Staff Office of the identity(ies) of his/her alternate(s). Any Member naming an alternate shall first procure the consent of the alternate Member(s) named. Any alternate Member shall assume all of the duties and responsibilities of the Member for whom (s)he is an alternate in regard to all Hospital patients of that Member, including patients to be seen in consultation. Members may name more than one (1) alternate provided the Member establishes the scope of coverage of each alternate as named. Any Member naming more than one (1) alternate shall designate which of his/her alternatives so named shall be the primary alternate.

1.6-2 Notification of Unavailability. A Member who will be knowingly unavailable for more than eight (8) hours shall, on the order sheet of the chart of each of the inpatients (s)he is attending, indicate in writing, the name of the appropriate alternate Member(s), who will be assuming responsibility for the care of the patient during the absence, the absent Member shall further notify his/her alternate(s) and the designated answering service that (s)he will be unavailable and that his/her alternate(s) will be assuming his/her Hospital responsibilities.

1.6-3 Failure to Name or Inability to Make Contact with Alternate. When a Member is going to be unavailable, in the event another Member is not named as an

alternate, or contact cannot be made with the alternate, any Medical Staff officer or applicable Chief of Service shall have the authority to call any Member of the Active category in order to provide care and treatment to the patient(s) in question.

- 1.6-4 Patient Who Chooses Not to Accept Alternate. When a Member specifies that another Member should admit or treat his/her patients (e.g., due to absence), the involved patient, if (s)he chooses not to be treated by the alternate Member, should be offered the opportunity to select the Member on call or the Member of his/her choice who has suitable Privileges to manage the patient's condition.

1.7 ADMISSION WORK UP

All patients admitted to the Hospital shall have the appropriate testing for their diagnosis.

1.8 ADMISSION HISTORY AND PHYSICAL EXAMINATION

- 1.8-1 History and Physical Examination Required. A history and physical examination shall be completed by a physician, or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record within 24 hours after admission or registration. A completed H&P must also be on the medical record prior to surgery or invasive procedures, or any procedure in which anesthesia or procedural/moderate sedation will be administered.

A legible office or hospital history and physical performed within 30 days prior to admission is acceptable, but no more than 30 days, with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to surgery or a procedure requiring anesthesia services. If there are no changes to the H&P as written, the physician can simply document an update note stating: the H&P has been reviewed, that the patient has been examined, and that the physician concurs with the findings of the H&P completed on the specified date or that "no change" has occurred in the patient's condition since the H&P was completed.

- 1.8-2 Breast Cancer Patients. In compliance with Michigan law, a physician who is administering primary treatment for breast cancer to a patient on the premises of the Hospital, who has been diagnosed as having breast cancer, shall inform the patient orally and in writing, about alternative methods of treatment of the cancer, including surgical, radiological, or chemotherapeutic treatments or any other generally accepted medical treatment. The physician shall also inform the patient about the advantages, disadvantages and risks of each method of treatment and about the procedures involved in each method of treatment. A form signed by the patient indicating that the patient has been given a copy of the Michigan Department of Community Health brochure relating to requirements of this act or a written summary indicating the requirements have been discussed, shall be included in the patient's medical record and a copy appended to the Hospital chart.

- 1.8-3 History and Physical Examination by Dentists and Podiatrists.

(a) An oral surgeon Member who admits a patient without a known medical

problem may perform the history and physical examination on those patients, and may assess the medical risks of the proposed surgical procedure if (s)he has such Privileges. Otherwise, a dentist Member is responsible for that part of his/her patient's history and physical examination directly related to dental services.

- (b) A podiatrist Member is responsible for that part of his/her patient's history and physical examination related to podiatric services.

1.8-4 History and Physical Examination by Others. Other individuals with appropriate Privileges and/or Scope of Practice, and so designated by a Member who

him/herself is qualified to perform the examination, may perform the history and physical examination, provided the findings and conclusions of the designee shall be confirmed and co-signed by the qualified Member.

1.9 PATIENT TRANSFER

1.9-1 Transfers of Inpatients to Other Hospitals. No inpatient shall be transferred to another hospital unless that patient has been seen by the Member ordering the transfer within twenty-four (24) hours, or unless an emergency requires the immediate transfer of the patient. The Member indicates the reason for the transfer in the patient's medical record, and otherwise complies with other Rules and policies concerning transfer.

1.9-2 Types of Situations Requiring Transfer to Other Hospitals. Patients with specific injuries or illnesses in need of specialized services not offered by the Hospital shall be transferred to a hospital providing the needed specialized services. For example, patients who are "critically" burned are appropriate candidates for treatment at institutions other than the Hospital. Transfer of patients directly from the Emergency Department should not occur without the patient first being seen by a physician Member of the Emergency Department.

1.9-3 Transfer of Inpatient from One Hospital Unit to Another. Except in emergency situations, no inpatient shall be transferred from one unit to another within the Hospital without the approval of the patient's attending Member.

1.10 PATIENT DISCHARGE

1.10-1 Written Discharge Orders by Attending Member Usually Required. Subject to those exceptions outlined below, patients shall be discharged only upon written order of a Member, in cases where more than one Practitioner group is involved in the active care of a patient, it is necessary to obtain the approval of the attending Member of record at the time of discharge, and the approval shall be recorded on the order sheet or progress record.

1.10-2 Discharge Order/Instruction Sheet. Where discharge is routine, a discharge order/instruction sheet should be completed prior to the patient's discharge. The discharge order/instruction sheet should include follow-up care, diet, activity, special tests or procedures, and medications. Upon a patient's discharge, and in a effort to provide continuity of care, appropriate

information shall be communicated to other health care organizations which will provide continuing care. The attending physician will be responsible for ordering, participating and documenting the discharge plan for continuity of care.

1.10-3 Discharge Orders Not Required in Specific Circumstances. No written discharge orders are required in the following circumstances:

- (a) When a patient(s) is removed pursuant to a disaster plan;
- (b) When a discharge is issued pursuant to a directive by a designated committee; or
- (c) When a patient leaves the Hospital against medical advice.

1.11 PATIENT DEPARTURE AGAINST MEDICAL ADVICE

1.11-1 Notification and Reporting. Should a patient threaten to leave the Hospital against advice of a Member, AHP, or nurse, or without usual discharge, a notation of the event shall be made in the patient's medical record. The patient's attending Member shall also be notified as soon as practicable of the patient anticipating or actual leaving the Hospital without observing required procedures. Should a patient leave the Hospital against advice, the events/circumstances must be recorded in the medical record and the Against Medical Advice Form must be completed, and include patient's signature whenever possible, and placed in the medical record.

1.11-2 Refusal Form. Patients leaving the Hospital against the advice of a Practitioner or nurse shall be requested to sign the appropriate refusal of care form to be placed in the patient's medical record. A patient's failure or refusal to sign the appropriate refusal of care form shall be recorded.

1.11-3 Limitations on Patient's Right to Discharge Against Medical Advice. A competent patient generally has the right to leave the Hospital against the advice of his/her attending Member. However, the Hospital has the right, in its discretion, not to allow a patient departure under certain circumstances. Further, a patient should not be allowed to leave the Hospital at "anytime" if the attending Member reasonably believes the patient's safety is jeopardized, whether or not the "Against Medical Advice" form is signed. In the event it is reasonably believed patient's safety would be substantially jeopardized by departure from the Hospital, the patient may be restrained upon orders from the attending Member or his/her designee, for a specific, limited time consistent with 2.3 of these Rules.

1.12 INFORMED CONSENT

A competent patient has the right to approve or refuse treatment. Informed consent prior to proposed treatments or procedures shall be governed by the Hospital Informed Consent Policy.

1.12-1 Procedures/treatments requiring informed consent:

- (a) Major or minor surgery which involves an entry into the body,

either through an incision or one of the natural body openings.

- (b) Anesthesia: general, spinal or epidural anesthesia/analgesia, major or minor nerve block, intravenous regional anesthesia, and monitored anesthesia care.
- (c) Non-surgical diagnostic and invasive radiological procedures involving some risk of harm to the patient or that involves risk of change to body structure. This includes, but is not limited to, CT with contrast, MRI, radiation therapy, myelogram, arteriogram, endoscopies, lumbar puncture, bone marrow aspiration, paracentesis, amniocentesis, angiography, and thoracentesis.
- (d) Medical procedures that involve more than slight risk of harm to the patient or which may cause a change in the patient's body, e.g. chemotherapy, and administration of drugs that carry very serious or irreversible side effects.
- (e) Experimental procedures or medications.
- (f) Treatment of patients diagnosed with breast cancer.
- (g) All high risk therapies/drugs.
- (h) Transfusion of blood/blood products.
- (i) HIV testing.
- (j) Off label use of medical devices or medications if there is a potential for significant risk.

1.12-2 The Medical Staff Member or designee who performs or supervises performance of a clinical service or procedure has responsibility for discussing risks and benefits and securing consent for the service or procedure from the patient or the patient's representative. The process for signing of consent forms, including determining when signing is necessary, who may sign, and who must witness the signature, shall be as provided in Hospital policy. The Medical Staff Member should document in the patient medical record that the matter was discussed with the patient or his/her representative, and written consent was obtained. This procedure shall be followed particularly in circumstances when invasive procedures, high risk therapies/drugs, or experimental treatments are contemplated. The patient must be informed regarding investigations, research or other activities related to his care and has the right to refuse to participate in such activities. The medical record entry should contain at least the following:

- (a) Patient diagnosis;
- (b) Nature/purpose of the care to be provided;
- (c) Potential risks/consequences of treatment;
- (d) Potential problems with recuperation;

- (e) Benefits of proposed treatment and probability/likelihood of success;
- (f) Feasible alternatives;
- (g) Prognosis if no treatment is rendered; and
- (h) If appropriate, the need for blood transfusion, risks, and alternative treatments pertinent to the same.
- (i) Names of all physicians performing procedure and what portion each physician will be responsible for.
- (j) Patient opportunity to present questions and have them answered to their satisfaction.

1.12-3 A Medical Staff Member shall follow the Hospital's administrative policy relative to performing scientific investigations, research or other activities relating to a patient's care. The Medical Staff Member shall also follow the procedure outlined in Section 4.2-1 of these Rules and Regulations for review of the investigation, research, or other activity by the Hospital's Ethics Committee as necessary.

1.12-4 Consent for Treatment – Consent for treatment is obtained for routine diagnostic procedures, hospital care and medical treatment (including admission of drugs and routine therapeutics) at the time of admission except in an emergency basis, where authorization is obtained as soon as possible.

1.13 PATIENT DEATH

1.13-1 Pronunciation of Death. If a patient dies, the patient shall, within a reasonable time, be pronounced dead by the attending Member, medical examiner, or his/her designee within a reasonable time according to Hospital policy.

1.13-2 Brain Death Protocol. Brain death is defined as the permanent cessation of all centers of the brain as evidenced by neurological assessment and neurodiagnostic tests. The acceptable processes for making that determination will be set forth in a Hospital policy on Brain Death.

1.13-3 Obtaining Autopsies. It shall be the duty of all Members to secure autopsies whenever possible. Findings from autopsies are used as a source of clinical information in quality improvement activities. Unless otherwise required by the County Medical Examiner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. Meaningful autopsies shall be those in situations in which an autopsy may help explain unknown or unanticipated medical conditions or diagnosis. Also included are cases which an autopsy may allay concerns of the family and/or public as well as potentially the recipients of transplant organs.

The Medical Staff, with the appropriate hospital staff, shall develop and use criteria that identify deaths in which an autopsy should be performed in accordance with the Hospital's administrative policy and state law requirements regarding performance of autopsies. The Administrative policy

on Autopsy Guidelines defines the criteria guidelines in all deaths and the mechanism for documenting permission to perform an autopsy. In addition, Medical Staff members may request performance of patient autopsies, with appropriate consent. A memorandum is posted or emailed for all Medical Staff members as the system for notifying them, specifically the attending physician, when an autopsy is being performed and/or case review.

- 1.14-4 Withdrawing or Withholding Services. "Do not resuscitate" (DNR) and other orders limiting treatment modalities shall be governed by Hospital policies on these subjects.

ARTICLE II PATIENT MANAGEMENT, CONSULTATION AND UTILIZATION

2.1 DAILY PATIENT VISIT

A hospitalized patient in an acute care unit shall be visited at least daily by his/her attending Member or designee who is a Member. Evidence of these daily visits shall appear in the patient's medical record.

2.2 RESPONSE TO PATIENT NEEDS

- 2.2-1 Special Request for Patient Visit. Any Member requested by a nursing supervisor or administrator to come to the Hospital to attend his/her patient, whether that patient be an inpatient or outpatient, shall comply with that request as soon as possible having due regard only to the immediate needs of other patients under his/her care, consistent with 1.6-1.

If attendance by the attending Member is impossible within a reasonable time having due regard to the condition of the patient as described by the person communicating the request, then the attending Member shall instruct the nursing supervisor to call his/her alternate who shall then come to the Hospital as soon as possible to attend to the patient in question. If the attending Member or his/her alternate are both unable to come to the Hospital to attend to the patient in a timely fashion, then the nursing staff shall notify the appropriate Chief of Service or the Chief of Staff. The person contacted shall then be responsible for arranging the immediate attendance of the Member in order to meet the needs of the patient in question.

- 2.2-2 Medical Staff Members shall refer to policies and procedures developed by the Medical Staff, and seek the assistance of others, e.g. the Hospital's Ethics Committee, regarding "no code" decisions, withdrawal and/or withholding of life-sustaining treatment.

- 2.2-3 Medical Staff Members shall also recognize the rights of patients to become involved in their own care including the right to refuse treatment. See P/P 1.38 Rights and Responsibilities of Patients.

2.3 PHYSICAL RESTRAINTS

2.3-1 Medical/Surgical Restraints. Restraints may be used to provide effective medical treatment and promote healing as well as prevent interruption or interference with diagnostic measures or treatment when less restrictive intervention have been determined to be ineffective. Restraints include standard practice protective/therapeutic devices related to medical, dental, standard practice.

2.3-2 Behavioral Restraints. Restraints may be used to manage behavior when there is an imminent risk of a patient harming himself/herself, staff, or others and less restrictive, non-physical interventions were attempted but ineffective.

2.3-3 Use of Restraints and Protective Devices. Use of restraints and protective devices shall be governed by Hospital policy.

2.4 CONSULTATIONS

2.4-1 Consultation Request Responsibility. It is the responsibility of the attending Member to order a consultation whenever indicated or required. The request may be accomplished by contacting the consultant personally. This may also be carried out by written order directing the Hospital staff to contact the consultant. Under these circumstances, the attending Member will make it clear in the orders or in a progress note that a consultation was requested, what problem the consultant is to address, and in what time frame the consultation should occur.

The request for consultation must include the level of participation. i.e. consultation only, consultation and treat, consultation and assume care.

The requesting physician must document his/her awareness of the completed consultation.

2.4-2 Scope of Consultation. Any qualified Member with clinical Privileges in the Hospital can be called for consultation. Except in an emergency, consultation should be considered in the following situations:

- (a) When the patient may not be a good risk for surgery or treatment;
- (b) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
- (c) Where there is uncertainty as to the choice of therapeutic measures to be utilized;
- (d) In complicated situations where specific skills of other Members may be needed;
- (e) In instances in which the patient exhibits several psychiatric or substance abuse symptoms;
- (f) When requested by the patient or his/her family;

(g) Where there is a question of potentially criminal conduct;

2.4-3 Responsibility of Consultant. A consultation shall be performed within twenty-four (24) hours of its request or at a time otherwise agreeable between the attending Member and the consultant. All consultations shall include the performance and recording of a patient examination, as well as the recording of the consultant's overall impressions and recommendations into the patient's medical records. The consultant's record summarizing his/her findings and recommendations is to be prepared as soon as possible, but not later than twenty-four (24) hours after the consultation has taken place. When a surgical procedure is recommended, this recommendation must be placed on the patient's chart prior the commencement of the recommended surgery unless the operation is of an emergency nature.

2.4-4 Administrative Consultation. As provided in the Bylaws, the CEO, Chief of Staff or a Chief of Service may initiate an administrative consultation requirement as to a particular patient, certain particular patients or all patients of a Member, when it is determined that the interest of the Hospital or the welfare of a patient or patients of a Member requires such action. Such consultation requirement may include proctoring, co-management or other conditions or limitations upon practice in the Hospital. Initiation of an administrative consultation should be preceded by the notification of the CEO and notification of either the Chief of Staff or applicable Chief of Service. Where obtaining such prior concurrence is not possible due to the matter requiring that immediate action be taken, concurrence should be obtained as soon as reasonably possible thereafter.

2.4-5 Nurse Initiation of Consultation. If a nurse has any reason to doubt or question the care provided to any patient, and believes that consultation is needed and has not been obtained, the nurse shall notify the nursing supervisor who, if warranted, may in turn notify the appropriate nursing director. If warranted, the nursing director may notify the Chief of Service or designee, in which the Member has Privileges. If warranted, the Chief of Service may directly request consultation, in conformance with 2.4-4.

25 REFERRALS

2.5-1 Nutritional Screen. A formalized nutritional screening program has been developed by Hospital dietitian which incorporates objective based criteria to identify patients at nutritional risk. The nutritional screen will be performed on both adult and pediatric patients. As a result of the screening process, the Hospital dietitian will perform a nutritional assessment and make necessary recommendations for nutritional care in a time frame and manner outlined in Hospital policy.

2.6 UTILIZATION

The attending Member of an inpatient is required to document the need for continued hospitalization. As a minimum, this documentation should contain the following:

(a) An adequate written 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;
 - (c) Plans for post-hospitalization care.

ARTICLE III

ORDERS BY MEMBERS, STUDENTS AND ALLIED HEALTH PROFESSIONALS

3.1 WRITTEN ORDERS

3.1-1 All orders for diagnostic tests/procedures must include a diagnosis and/or clinical sign(s)/symptom(s) to support medical necessity for each test.

3.1-2 A Physician, who is a Member of the Staff, shall co-sign, date and time, within twenty-four (24) hours, all orders by physician assistants, anesthesia provider, and medical and osteopathic residents. Except in an emergency, all orders for medicine, drugs, treatment and therapy shall be:

- (a) In writing;
- (b) Legibly written;
- (c) Signed, dated and timed, by the Member giving the order or co-signed by the Member if given by a resident, student or dependent AHP.
- (d) Standing orders are prohibited in the Hospital.

A verbal or telephone order shall be considered in writing if dictated to an authorized recipient (as provided in 3.2 below), and then signed by the Member or co-signed by the Member as stated above who placed the order. All verbal and telephone orders shall be signed, dated and timed by the Staff Member at the time of the next patient visit. not to exceed forty eight (48) hours. Per protocol orders will be written by a Pharmacist for therapeutic substitution orders, dosage calculations or other information that is not a direct result of talking with the physician.

3.1-3 Authorized Alternate Authentication. In situations where the physician who gave the verbal or telephone order is not subsequently available to sign the order, then it may be signed by any of the following:

- (a) A Member who is a partner or associate of the physician who gave the verbal or telephone order;
- (b) A Member of the practice group if the verbal or telephone order was given by an AHP in the same practice group;

Alternate signatures shall not be used for mere convenience purposes or on a routine basis.

3.2 VERBAL AND TELEPHONE ORDERS

3.2-1 Verbal or telephone order, only in urgent/emergent situations, shall be considered in writing if dictated to an authorized recipient (as provided in item 3.2-2), and then signed, dated and timed by the Staff member who placed such an order.

3.2-2 Recipients of Verbal and Telephone Orders. The following licensed Hospital personnel are authorized to accept verbal and telephone orders:

1. Registered Nurses;
2. Pharmacists (if a medication or medical supply order);
3. Dietitians (if dietary order);
4. Licensed Practical Nurses;
5. Paramedic;
6. Other hospital staff: medical record personnel; radiological technologist; special studies technicians; EKG technicians; respiratory therapists; nuclear medicine technicians; laboratory technologists, technician or phlebotomist; licensed paramedic; physical/occupational therapist may accept verbal orders that pertain specifically to their background and training.

3.2-3 The physician is required to verify all verbal and telephone orders once given to hospital personnel after order is immediately read back to them.

3.2-4 Orders for therapeutic treatment and/or procedures received from physicians not on the Medical Staff must be co-signed by a physician on the Medical Staff who will assume care of the patient during the treatment and/or procedure.

3.3 AUTOMATIC TERMINATION OF MEDICATIONS

3.3-1 Antibiotics Anticoagulants, Schedule II controlled substances and certain other medications have varying automatic stopdays. See Policy No. 13.02.05 for specific expiration dates and notification procedures.

3.3-2 Circumstances Where Other Orders Are Automatically Canceled. All other medication and treatment orders shall be automatically canceled under the following conditions:

- (a) Upon the patient's transfer to the operating room, or any other area of the Hospital for purposes of performing an inpatient operative or surgical procedures;
- (b) Upon the patient being discharged from the Hospital.

3.3-3 Illegible Orders. Orders that are illegible or incompletely written (e.g., fail to clearly spell out the name of the drug, its dosage, frequency of administration, and route of administration) shall not be carried out by the nurse until clarification has been obtained from the ordering Member. Order clarification should be immediately reduced to writing and re-read to the physician per Policy No. 13.02.09.

ARTICLE IV PATIENT DRUGS/MEDICATION

4.1 GENERIC/TRADE USAGE In all cases wherein a Member orders a drug by trade name, the pharmacist may automatically dispense the drug by its generic name unless the attending physician designates next to the name of the drug, "Dispense as written" or "DAW". In all cases wherein the Member names a specific manufacturer when ordering a drug, the manufacturer's drug, if available in the Hospital, shall be dispensed.

4.2 HOSPITAL FORMULARY The Hospital Formulary is prepared and revised by the Pharmacy & Therapeutics Committee responsible for medication safety. No new drug will be admitted into the Hospital Formulary or stocked in the pharmacy, except for controlled research, before it has been authorized for marketing by the Federal Food and Drug Administration. Members will be notified whenever a Hospital-accepted drug is deleted from the Hospital Formulary. In addition, written requests for additions to the Hospital Formulary may be submitted to the pharmacy by any Member for review and approval by the Pharmacy & Therapeutics Committee.

4.2-1 A Member of the Medical Staff requesting use of an investigational drug(IND) for treatment of a specific patient must do the following:

- (a) comply with federal regulations governing the use of investigational drugs as issued by the United States Food and Drug Administration (FDA);
- (b) submit FDA approved protocol to Pharmacy Director. Obtain approval for use of the IND from the Chairperson of the Hospital's Pharmacy and Therapeutics Committee, Chief of Staff, Medical Executive Committee and the President/CEO; and
- (c) follow investigational drug policy #13.03.12 obtaining the required written and informed consent of the patient or patient's legally authorized representative in accordance with federal regulations.

4.2-2 Physicians shall abide by Hospital policies regarding the prescription and order of medication, nutrition requirements, rehabilitative and other ancillary services.

- 4.3 MEDICATION EVENTS** Pursuant to the Public Health Code, and other applicable state and federal statutes and regulations governing care and professional/peer review, all actual or suspected medication errors shall be reviewed by the appropriate committee responsible for medication safety. If investigational medication is involved, the committee assigned institutional review for improvement of patient care purposes shall review all actual or suspected medication errors.
- 4.4 ORDER FORM** Physician orders must be documented only on approved order sets or Physician order forms for his/her hospitalized patients.
- 4.5 APPROVED PHARMACEUTICAL NOMENCLATURE** Symbols and abbreviations may be used only when they have been approved for use by the Hospital's Medical Staff through Policy No. 1.37 (25.09.84). A hospital approved reference book will be used for acceptable abbreviations. An official record of unacceptable abbreviations will be used in all clinical departments and in the Medical Records Department
- 4.6 NON-HOSPITAL DRUGS** Drugs brought into the Hospital by patients shall not be administered for inpatient use unless so ordered by the patient's attending Member. In order to minimize the possibility of drug overdose or unsuspected drug reaction, prescription drugs known to be possessed by patients at the time of or during admission shall be secured by the Hospital staff until patient discharge, unless otherwise ordered by the attending Member. If there is reason to believe an admitted patient has illegally obtained prescription drugs or illicit drugs, the drugs will be secured by Hospital staff; the attending Member and the nursing supervisor for the shift and unit shall be promptly notified and they shall make such further investigation or take such action, which is deemed appropriate under the circumstances.
- 4.7 SELF-ADMINISTRATION OF MEDICATIONS** Self-administration of medications by patients may be permitted according to the Hospital policy.
- 4.8 BLOOD ADMINISTRATION**
- 4.8-1 Type and Cross-Match Blood. Procedures for type and cross-match of blood and administration of blood shall be those set forth in Hospital policies. However, in the event of a bona fide emergency wherein type and cross-match procedures cannot be completed, appropriate uncrossed cells may be administered on order of the treating physician. The treating physician shall document his/her accountability on the transfusion records, and the Laboratory shall complete the type and cross-match procedure for future units.
- 4.8-2 Blood Identification. Identification of the donor's blood and intended recipient must be documented accordingly on the transfusion record. Only physicians, anesthesiologists, registered and licensed practical nurses may identify blood.
- 4.8-3 Safety Precautions. Safety precautions shall be taken in accordance with Hospital policy on Blood Administration.
- 4.8-4 HIV (Human Immuno-deficiency Virus) Testing Policy. Testing for HIV is designed to diagnose current HIV infection in an individual. HIV testing is appropriately performed for the purpose of making a diagnosis, answering a patient's questions whether (s)he is infected, conducting follow-up after potential

exposure has occurred or screening blood, organs, or other body substances prior to donation. Routine testing of patients should not be used as means of reducing the risk of exposure to HIV. The HIV policy and procedures of the Hospital also apply to the Medical Staff.

4.9 SEDATION ADMINISTRATION

Moderate and deep sedation may only be administered by appropriately credentialed Members and as governed by the Hospital Sedation Policy.

ARTICLE V MEDICAL RECORDS

5.1 RESPONSIBLE PARTY

The attending Member is responsible for the overall preparation and timely completion of his/her patient's medical records.

5.2 GENERAL REQUIREMENTS

5.2-1 INPATIENT: The inpatient (or observation status) record shall include identification data, (see 5.3 History and Physical Report Requirements) evidence of informed consent, special reports such as consultations, clinical laboratory and radiology services, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, diagnostic and therapeutic orders, progress notes, final diagnosis, condition on discharge, discharge note or discharge clinical summary and autopsy report when performed.

The inpatient medical history and physical examination must be performed within 24 hours of admission. (An office or previous inpatient History and Physical may be used if it's complete, legible, and within the last 30 days. The previous H&P must also be updated within 24 hours of the admission date.

5.2-2 HOSPITAL OUTPATIENT: The outpatient record shall include, at a minimum, identification data, (see 5.3 History and Physical Report Requirements) the appropriate medical history, relevant physical examinations, diagnostic and therapeutic orders, evidence of appropriate informed consent, clinical observations, reports of procedures and tests, conclusions of evaluation/treatment and discharge instructions.

(The outpatient H&P may not be older than 30 days and a 24 Hour Update must be completed.)

5.2-3 ADMIT NOTE: An admission note must be written in the progress notes when the medical history and physical examination report is not available and in the medical record. This admit note must include pertinent history and physical examination findings and the initial impressions or indication for surgery or admission.

5.2-4 INPATIENT HISTORY AND PHYSICAL EXAMINATION: An appropriate admission medical history and pertinent physical examination shall be recorded within 24 hours of admission. The admitting Medical Staff Member shall sign and/or countersign the History and Physical examination and preoperative note when they have been recorded by a student, resident and/or AHP. When the History and Physical examination is completed before admission, a 24 Hour Update must be completed. The history and physical examination may be performed by any licensed health care professional acting within the scope of his/her license. This report shall include:

- (a) Chief Complaint
- (b) Present Illness
- (c) Personal Past Medical/Surgical History
- (d) Medications
- (e) Family Medical History
- (f) Social History
- (g) Review of Systems
- (h) Physical Examination
- (i) Initial Impression
- (j) Plan

5.2-5 OUTPATIENT HISTORY AND PHYSICAL EXAMINATION: Patients undergoing outpatient invasive procedures with or without use of sedation shall have an appropriate focused medical history and pertinent physical examination which includes: present illness, pertinent past medical history, family history, social history, pertinent physical examination (which must include heart and lungs), pertinent lab and x-ray, impression and plan. The history and physical examination shall be completed no more than thirty (30) days prior to admission and have updated the history and physical of any changes prior to surgery. Use of the 'short stay History and Physical' is encouraged.

5.2-6 H&P 24 HOUR UPDATE FORM: The following must be done and/or documented in the H&P 24 Hour Update if the H&P is 30 days old (H&Ps performed over 30 days prior to admission or outpatient procedure are not acceptable).

- (a) The original H&P must be attached to the 24 Hour Update and may be referenced when updating the history portion.
- (b) The 24 Hour Update exam must be conducted, and documented, to include vital signs, heart, lungs, and procedure-specific exam.
- (c) Impression, plan, signature, and date.

- (d) The 24 Hour Update exam must be performed by a member of the Hospital's Medical Staff or delegated to a dependant practitioner acting within the scope of their hospital Privileges or job description. Delegated 24 Hour Updates must be authenticated by the Medical Staff Member.

5.3 SPECIAL REQUIREMENTS

- 5.3-1 A Service may by MEC approval, in their Service Rules or policy, modify the history and physical examination content requirements.
- 5.3-2 If the history and physical examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be postponed or canceled until the history and physical is on the medical record, unless a life threatening condition exists.
- 5.3-3 A history and physical examination by a licensed practitioner who is not a Member is only acceptable if reviewed and updated by the responsible Member, including an impression and plan (preferably on the 24 Hour update form).
- 5.3-4 If an Internal Medicine consult or an office evaluation is used as the pre-operative or pre-procedural H&P, the document must include all elements as stated in 5.2- 4 or 5.2-5 and the surgeon/procedural physician must document the following:
 - (a) Pre-procedural diagnosis
 - (b) Plan
 - (c) Signature & date

5.4 SURGICAL PROCEDURES

- 5.4-1 An operative and/or procedural report should be dictated or written in the medical record within 6 hours post-procedure and should contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and assistant. The completed report should be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When there is a transcription and/or filing delay, a comprehensive operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for use by any other health care professionals who are required to care for the patient.
- 5.4-2 The operating surgeon may give permission to qualified personnel to observe surgery in the operating room. Prior consent for surgical observations must be obtained from the operating room supervisor and the surgical patient or his/her representative, if necessary.
- 5-4.3 Except in emergencies, the H&P with pre-operative diagnosis, anticipated procedure, and required preoperative testing results must be recorded. If not recorded, the operation will be postponed until the H&P is obtained. In an emergency, the Member should attempt to at least make a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the

operation.

- 5-4.4 In any surgical procedure with an unusual hazard to life or major bodily function, there must be a qualified assistant present and scrubbed. "Qualified assistant" means a graduate student of medicine or osteopathy, another attending surgeon or a trained member of the Allied Health Professional staff.
- 5.4-5 Tissues removed at the operation shall be sent to the Laboratory where an examination will be made to arrive at a tissue diagnosis, exceptions to this requirement are outlined in "Care of Surgical Specimens Policy." The pathologist's authenticated report shall be made part of the patient's medical record.
- 5.4-6 The surgical patient's post-procedure status shall be assessed and documented in his/her medical record. Patients shall be discharged from the post-anesthesia recovery area by a doctor of medicine or osteopathy on the Hospital's Medical Staff, who is qualified to make this determination, or other Staff Members using criteria approved by the Medical Staff.

5.5 REPORTS OF TEST RESULTS

Reports on pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures should be completed promptly and be filed in the record. In addition, all diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record. This may also include any reports from facilities outside of the Hospital, in which case the source facility shall be identified on the report. The attending physician or AHP must document on the test results reports that he has seen these results. Verification can be with full signature and date or initials and date.

Tissue or other substances removed during operations based on Laboratory Policy No. 10.10.04 shall be sent to the contracted Anatomic Pathology Laboratory. The pathologist shall examine, as necessary, such removed tissue or other substance, for the purpose of making a pathological diagnosis. Such diagnosis shall be included in the pathologist's signed and dated report.

5.6 LABORATORY TESTING

- 5.6-1 All Members of the Medical Staff shall abide by Hospital administrative policies regarding laboratory services and testing.
- 5.6-2 Laboratory testing must be supported by medical necessity and appropriate test utilization.
- 5.6-3 Requests for laboratory tests must include adequate diagnosis information and the signature of the ordering physician or designee.
- 5.6-4 Verification by the physician of verbal orders or requests for confirmation of orders are to be submitted in writing within 30 days of receipt of the verification request.

5.7 PREANESTHETIC EVALUATION

A preanesthetic evaluation of the patient by an anesthesia provider (or specified others

as provided in the rules for anesthesia) shall occur prior to the administration of an anesthetic. This evaluation shall be recorded in the patient's medical records indicating the type of anesthetic procedure anticipated. Except when an emergency does not reasonably permit, this evaluation shall be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. While the choice of a specific anesthetic agent or technique may be left up to the individual administering the anesthetic, the preanesthesia medical record entry shall refer to the use of general, spinal, or other regional anesthesia. The preanesthesia record entry shall ordinarily include the patient's significant drug history and prior anesthetic experiences, as well as any perceived potential for anesthetic problems.

The patient's physiological status during operative or invasive procedures shall be measured, assessed and documented in the medical record.

5.8 POSTANESTHESIA EVALUATION

The medical record shall contain a recording of postanesthesia visits, including at least one note describing the apparent presence or absence of anesthesia-related complications. A note made in the surgical suite, or in the postanesthesia care unit, does not ordinarily constitute a visit unless it is an outpatient procedure.

5.9 PROGRESS NOTES

Pertinent Progress notes shall be maintained on all patients admitted to the Hospital. Progress notes should be made at least daily on all patients. The progress note shall contain sufficient detail to permit continuity of care, identify current or potential problems and reflect changes in condition as well as results of treatment.

5.10 PATIENT MEDICATIONS/TREATMENT/ORDERS

Patient medications, treatment and orders shall be recorded within a patient's medical records pursuant to these Rules, and in particular Articles III and IV.

5.11 OBSERVATION

Observation is intended for those patients who require evaluation and treatment for an unscheduled event that may not require hospitalization but who do need to be monitored for a short period of time (usually no longer than 24 hours). Admitting orders must be written for observation and not admission. Patients appropriate for Observation are as follows:

- (a) Patients whose presenting diagnosis and/or symptoms may resolve with treatment within 24 hours.
- (b) Patients whose diagnosis is in question and full admission hinges upon a diagnosis;
- (c) Patients who are responding to treatment for their condition and will not need a full admission;
- (d) Patients for whom discharge may be hazardous following emergency treatment or;

- (e) Patients presenting disposition problems

Documentation requirements for observation patients are outlined under 5.2-2 Hospital Outpatient.

5.12 EMERGENCY DEPARTMENT RECORDS

The contents of the emergency department record are the responsibility of the emergency department physician or health care provider rendering treatment to a patient. The emergency department records shall contain:

- (a) Patient identification data,
- (b) Times and means of arrival,
- (c) Chief complaint,
- (d) History of present illness,
- (e) Relevant past history,
- (f) Relevant review of systems,
- (g) Procedures performed with results and treatments rendered,
- (h) Physical examination,
- (i) List of current medications,
- (j) Tests and therapies ordered and provided,
- (k) Discharge condition,
- (l) Diagnosis,
- (m) Disposition,
- (n) Documentation of emergency care provided prior to arrival, if any, and

5.13 CLINICAL ENTRIES

All clinical entries in the patient's medical record shall be legible, accurately dated, and authenticated by written signature, identifiable initials or computer key. The use of rubber stamp signatures is acceptable under the following strict conditions:

- (a) The practitioner whose signature the rubber stamp represents is the only one who uses it; and
- (b) The practitioner places in the Medical Record Department of the Hospital, a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.
- (c) The stamp may not be used to authenticate Birth or Death Certificates.
- (d) Physicians, residents, dentists, podiatrists, nurses, registered pharmacists,

therapists (respiratory, physical, occupational), social workers, dietitians, and physician assistants may make entries in the medical record. Each entry in a patient's medical record must be dated, signed, timed and verified with the name of the author legible.

- €) Where appropriate, medical record documentation shall include the patient or patient's representative's, e.g. family members or surrogate decision-maker, participation in treatment decisions, including advance directives, informed consent, and the withdrawal or withholding of treatment.

5.14 HOSPITAL ABBREVIATIONS/SYMBOLS

In order to avoid misinterpretations, symbols and abbreviations shall only be used in patient's medical record following and pursuant to the Hospital policy approved by the MEC.

5.15 CONFIDENTIALITY AND PRESERVATION OF RECORDS

Subject to the provisions below, all medical records, including x-rays, fetal heart monitor tapes, electrocardiograms, and other diagnostic tapes, are the property of the Hospital and shall not be removed from the Hospital, unless authorized by policy or ordered by a court of competent jurisdiction. Photocopies of a patient's record may be released pursuant to an order from a court of competent jurisdiction or pursuant to proper written authorization from the patient or his/her legal representative.

In the event of a hospitalized patient, all previous records of a patient shall be made available to Hospital personnel and Members involved in the care and treatment of the patient.

Release of copies of medical records to a patient or any third party, including Medical Staff Members, shall comply with HIPAA Privacy/Security rules and Michigan Medical Records Access Act. Protected health information can be released for treatment/payment/healthcare operations without a signed authorization except when patient has specifically requested otherwise, and the Hospital has agreed to the request.

5.16 FINAL DIAGNOSIS

Consistent with Sections 1.10 and 1.14, final diagnoses shall be recorded in full using a recognized system of disease nomenclature, without the use of symbols or abbreviations, dated and signed by the responsible Member(s) at the time of discharge. In the event that the Member is awaiting additional information before recording the final diagnoses, the impression(s) as determined at the time of discharge shall be recorded in the final progress note. In this case, the final diagnoses shall be recorded in the record promptly after necessary information has been collected and becomes available.

5.17 DISCHARGE OR DEATH SUMMARY

A discharge or death summary shall be recorded in the patient's medical records as soon as reasonably possible following the patient's discharge. The summary shall include primary, secondary and tertiary diagnosis, if applicable, as well as the reason for hospitalization, significant findings, procedures performed, care and treatment

provided, course, condition on discharge, instructions on discharge and any other pertinent information or data.

5.18 COMPLETION OF MEDICAL RECORDS

Significant clinical events shall be documented as reasonably soon as possible after occurrence. A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical resume or final progress note; and when all final diagnoses and any complications are recorded, without use of symbols or abbreviations. Members are responsible for the completion of all dictation and notes. Completeness implies the transcription of any dictated record content and its insertion into the medical record. A record shall be completed within 30 days after discharge. Records which remain incomplete after 30 days shall be governed by the Medical Staff Delinquent Medical Records-Course of Action Policy.

5.19 DELINQUENT MEDICAL RECORD POLICY

See Delinquent Medical Records Policy-Course of Action.

In the event a physician expires, becomes mentally incapacitated, or moves away and attempts to locate him/her are unsuccessful, the Medical Staff Executive Committee may direct that the incomplete records be filed.

5.20 MEDICAL RECORDS OF ORGAN DONORS

Members shall cooperate and assist where appropriate with Hospital staff in complying with Michigan statute that requires the Hospital to inquire of the next-of-kin as to whether they will permit organ donation. This will be done according to Hospital policy.

ARTICLE VI CONFLICT RESOLUTION

6.1 PHYSICIAN AND NURSE ACTION

6.1-1 The Medical Staff generally recognizes its responsibility to provide immediate/timely intervention when an attending Medical Staff Member is not available or does not respond to nursing or staff requests for patient care assistance. The Medical Staff also recognizes the need to respond when the quality or appropriateness of care being provided to a particular patient is questioned. The purpose of Medical Staff intervention is to assure that appropriate care is provided and that preventable adverse patient outcomes are avoided.

6.1-2 After a nurse or other health care professional determines that intervention is necessary and has exhausted available means (e.g., the physician on-call list) to secure physician intervention, he or she shall contact their immediate Hospital supervisor. It is the responsibility of the supervisor to contact the Chief of the service within which the practitioner has clinical privileges and/or the Chief of the Medical Staff. The Chief of Service and the Chief of the Medical Staff shall respond in a timely manner to the supervisor's request. The responding physician has authority to review relevant patient information and to act as a consultant or call for a consultation for the patient involved.

6.1-3 In an emergency, any Medical Staff Member or other health care professional

employed or retained by Hospital may provide patient care necessary as a life-saving measure or to prevent serious harm, regardless of clinical privilege delineation, provided the care is within the scope of the individual's license, registration or certification.

6.1-4 It is the responsibility of the responding practitioner to apprise the appropriate Hospital Peer Review Committee of the intervention. It is the responsibility of the Committee to examine the necessity and adequacy of the intervention, and the circumstances which made it necessary. This examination will assist in evaluation of the process, identification and response to patient care concerns.

6.2 FURTHER ACTION BY THE CEO

If a nursing supervisor or executive continues to believe that further medical review is warranted, after the Chief of Service or Chief of Staff has decided that no further administrative action need be taken, then the nursing supervisor or executive shall so advise the CEO. The CEO in turn may direct that the Chief of Service or Chief of Staff re-review the situation in question.

ARTICLE VII MEDICAL STAFF SERVICE RULES

7.1 INTERPRETATION OF SERVICE RULES MAY SUPERSEDE

7.1-1 Medical Staff Service Rules May Supersede General Rules. These general Medical Staff Rules are intended to be a balance between practical needs, economic limitations and the provision of quality care and treatment for Hospital patients. They may not address a need of or may pose a special unforeseen hardship for a particular Service. Accordingly, these Rules may be waived or superseded by different or more specific rules or policies established for members of a particular Service which are approved in the manner provided for general Rules, and acknowledged by the MEC and/or Board as varying from the general Rules.

It shall then be the responsibility of the Medical Staff Service to present any perceived conflict in Service Rules or policies and general Rules to the MEC for its review and resolution, after seeking from other Service(s) suggestions, commentaries, as well as proposed revisions of the rules in question in order to reduce or eliminate potential conflict.

7.1-2 Perceived Conflict of Rules. In the event there is a perceived conflict between proposed Service rules and general rules of the Medical Staff, it shall then be the responsibility of the Service to present the perceived conflict to the MEC for its review and resolution, after seeking from other Service(s) suggestions, commentaries, as well as proposed revisions of the rules in question in order to reduce or eliminate potential conflict.

7.2 JOINT SERVICE RULES

Nothing shall prohibit two (2) or more Services from performing overlapping services, from establishing joint Service rules, or from incorporating by reference specified rules of another Service (e.g., Service of OB/GYN may wish to incorporate

specific rules already promulgated by the Surgery Service).

ARTICLE VIII MISCELLANEOUS

8.1 SUPERVISION OF STUDENTS

All patient care activities of students in all programs shall be under the supervision of a Member of the Medical Staff. No student shall be assigned responsibilities for the care of a patient not under the care of an attending Member as governed by Medical Staff policy.

8.2 LABORATORY

8.2-1 Laboratory testing shall be provided in the Hospital to ensure as complete service as possible.

8.2-2 The Medical Staff shall approve the reference laboratory (laboratories) for the Hospital.

8.2-3 Tests which cannot be performed in the Hospital laboratory shall be referred to the approved reference laboratory.

8.2-4 Tests done in a practitioner's office may be appended to the medical record provided the tests are done by the reference laboratory approved by the Medical Staff.

8.2-5 Laboratory reports from laboratories not approved by the Medical Staff may not be made part of the patient's medical record but those results may be part of the physician's documentation portion of the record. These results may be appended to the back of the patient's record.

8.3 INFECTION CONTROL

All Members of the Medical Staff shall abide by Hospital rules regarding hand hygiene, isolation and infection surveillance prevention and control procedures, including, but not limited to, sterile techniques used in Hospital operating and emergency rooms, and reporting of infection control concerns.

8.4 EMERGENCY PREPAREDNESS, DISASTER AND LIFE-SAFETY PLANS

Medical Staff Members shall participate in the Hospital emergency Preparedness disaster and life safety plans drills in accordance with the Hospital plan. All staff members, particularly physicians, shall be assigned posts. The physician on-call, along with the Chief of Staff and Emergency Preparedness Coordinator, or Life-Safety Coordinator, shall provide direction. Where appropriate, Medical Staff Members may participate in other plans involving medical equipment or utilities.

8.5 CREDENTIALING FEES

Credentialing fees are assessed and collected, the Hospital shall maintain a separate

accounting of the funds for review by the Medical Staff.

8.6 ADVANCE DIRECTIVES

The advance directives process is initiated during the registration process. Medical Staff Members are responsible for further discussion and documentation, as appropriate, related to advanced directives.

ARTICLE IX

OTHER RESPONSIBILITIES

9.1 TB STATUS REQUIREMENT

All Medical Staff Members and AHPs are required to submit proof of a negative TB test result upon initial appointment to ERMC. Negative TB test results must be within 6 months of the initial application date or, if more stringent, within state and regulatory body guidelines.

9.2 LICENSURE

All Members, with exclusion of Members in the Honorary Staff category shall submit proof of State of Michigan licensure upon expiration and State of Michigan Controlled Substance Licensure and DEA Registration upon expiration, as applicable.

9.3 FAILURE TO SUBMIT DOCUMENTATION

Failure to submit documentation with regards to malpractice insurance, TB verification, licensure, or other required registration or certification will result in further action by the Medical Staff; i.e. summary suspension or other actions by the Chief of Staff or MEC, as provided in the Medical Staff Office policy on maintaining Medical Staff and AHP credentials files.

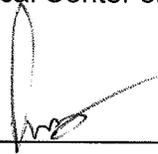
9.4 QUALITY ASSURANCE

The Medical Executive Committee meetings, held in accordance with the Bylaws, shall include a thorough review and analysis of clinical care rendered in the Hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnoses, results of treatment from among elected cases, selected cases discharged since the last meeting, an analysis of clinical reports from the departments, and reports of committees of the Active Medical Staff.

**ARTICLE X
METHODOLOGY FOR AMENDMENT**

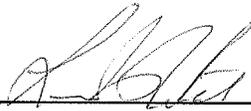
Amendment of these Rules shall be made in conformity with the Bylaws.

The foregoing Medical Staff Rules were APPROVED and RECOMMENDED for Board adoption by the Medical Staff of Eaton Rapids Medical Center on the 17th day of July 2017.



Ashok Gupta, MD
Medical Staff Chief

The foregoing Medical Staff Rules are APPROVED and ADOPTED by the Board of Directors of Eaton Rapids Medical Center on the 28th day of August 2017.



Leonard Peters
Board Chair