MEMORIAL MEDICAL CENTER
RULES & REGULATIONS

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MEMORIAL MEDICAL CENTER

MEDICAL STAFF

RULES & REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder. These Rules and Regulations will be reviewed every two (2) years.

ARTICLE I
ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

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

1.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership. All practitioners shall be governed by the admitting policy of the hospital. The admission order must specify whether the patient is to be admitted as an inpatient or to observation status.

1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of individuals, including but not limited to employees, other patients and the admitted patient.

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

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

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The Department Chair or President of the Medical Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO/CMO to provide care for the patient.

1.2. ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

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

1.2(b) Preoperative Admissions

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

1.2(c) Routine Admissions

This will include elective admissions involving all services.

1.3 PATIENT TRANSFERS

1.3(a) Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;

(2) From any department to CCU in an emergency;

(3) From CCU in an emergency;

(4) From any department to Skilled Nursing Facility;

(5) From obstetric patient care area (unit) to general care area when medically indicated; and

(6) From temporary placement in a care area not requested to the area requested by the provider

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

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

1.4 SUICIDAL PATIENTS

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

1.4(a) A patient suspected to be suicidal in intent shall be admitted to a security room consistent with the patients medical needs. If these accommodations are not available, the patient shall be transferred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. Psychiatric consultation will be required;

1.4(b) The hospital social worker and/or PES should be consulted for assistance; and

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

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

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

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

1.5(c) The Attending Practitioner is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This

report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the Department Chair for action.

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

(1) Conditions that may result in the patient's transfer to another facility or level of care;

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

(4) The anticipated need for continued care following discharge;

(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

1.6 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the Attending Practitioner, another member of the Medical Staff, the Emergency Department Physician or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient's medical record.. If the death was anticipated, due to natural causes, and the patient has a DNR order, a specified registered nurse may pronounce the patient dead.

1.7 AUTOPSIES

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner shall be governed by applicable state law.
OMI is notified of deaths in accordance with administrative policy 15-4 – Autopsy. If the autopsy is OMI mandated, family consent is not required. The attending physician will be notified if an autopsy is requested by OMI or the family. If an elective autopsy is decided upon, family consent is required and arrangements will be made with OMI in accordance with policy 15-4. Autopsies are not performed at Memorial Medical Center

1.8 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patients' treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital's Policy on Disclosure of Unanticipated Outcomes.

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

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

2.2 ADMISSION HISTORY

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician (or other licensed independent practitioner credentialed to perform a history and physical) within twenty-four (24) hours of admission or prior to any procedure requiring sedation or anesthesia, whichever comes first. Oral/maxillofacial surgeons and podiatrists may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the President of the Medical Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring sedation or anesthesia, whichever comes first.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

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

2.4 PROGRESS NOTES

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

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include the name of the responsible practitioner and any assistant practitioner(s) who is/are performing or assisting in the procedure,, a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis, tissue or specimens removed or altered and their disposition and estimated blood loss. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within six (6) hours after completion of surgery. An operative progress note must be entered immediately if the operative report is not placed in the record immediately after surgery. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Department Chair for appropriate action

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through colleague to colleague verbal communication. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

2.7 OBSTETRICAL PATIENT HISTORIES

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

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable

initials or computer key. Fax signatures will be accepted if the practitioner has a signed attestation on file with HIM. The use of rubber stamp signature is not acceptable under any conditions.

2.9 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEC and filed with the Health Information Management Department. Abbreviations and symbols may not be used in the final diagnostic statement or in documentation of an operative procedure.

2.10 FINAL DIAGNOSIS

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

2.11 REMOVAL OF MEDICAL RECORDS

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

2.12 ACCESS TO MEDICAL RECORDS

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the IRB before records can be studied. Subject to the discretion of the IRB, former members of the Medical Staff shall be permitted access to information from the medical records of their patients, covering all periods during which they attended such patients in the hospital.

Any physician on the Medical Staff may request a release of patient information providing that said patient is under his/her care and treatment. Such releases, as a routine matter, will not require a Release of Information form to be signed by the patient. The intent of this Rule & Regulation is to address a physician's need to have information available in his/her office in order to treat patients who may come to his/her office after having been seen, treated or tested at the hospital.
Persons not otherwise authorized to receive medical information shall require written consent of the patient, his/her guardian, his/her agent or his/her heirs.

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

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

2.13 PERMANENTLY FILED MEDICAL RECORDS

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

2.14 PRE-PRINTED ORDERS

In order to ensure continued appropriateness, diagnosis/procedure-specific pre-printed orders shall be reviewed at least annually by the appropriate medical staff department. Pre-printed orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Pre-printed orders shall not replace or void those orders written for a specific patient.

2.15 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.16 DELINQUENT MEDICAL RECORDS

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

Every Monday providers will be notified by phone of their delinquent medical records. If these are not completed, the President of the Medical Staff will be contacted and action including summary suspension of privileges for elective admissions may result. The provider will be notified of this suspension and it will remain in effect until the medical records are completed. A provider may have four (4) suspensions during a calendar year (January-December). If he/she exceeds that number of suspensions, he/she will lose their hospital privileges and must reapply.

2.16(a) Suspension. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible physician's privileges. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician must cover Emergency Room call, but may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the President of the Medical Staff.

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

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

2.17 TREATMENT & CARE WRITTEN ORDERS

Orders are to be written using black or blue ink. Orders written by residents must be cosigned by the attending physician within 24 hours.

2.18 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

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

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

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

ARTICLE III
GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

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

3.2 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing. Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R.N. and countersigned by the physician giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists and CRNA's may accept verbal orders relating to their area of practice. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order to the individual and indicate that the individual has confirmed the order. The responsible practitioner shall authenticate and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than seventy-two (72) hours from dictating the verbal or telephone order. Failure to do so shall be brought to the attention of the Department Chair for appropriate action. Verbal or telephone orders may be countersigned by a provider who is covering for the ordering provider or otherwise involved in the patient’s care. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

Verbal orders will not be accepted for chemotherapy drug orders, drotrcogin alfa, investigational drug, device or procedure protocols Telephone orders for Do Not Resuscitate or withdrawl of life support may be given over the telephone only with two (2) nurses witnessing the order(s), in accordance with administrative policy 2-21 Do Not Resuscitate (DNR) These orders must be countersigned within 24 hours.

3.3 ILLEGIBLE TREATMENT ORDERS

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

3.4 PREVIOUS ORDERS

All previous orders, except orders concerning a patient’s advance directive not expressly voided by the patient, are canceled when patients go to surgery.

3.5 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Memorial Medical Center Formulary. Drugs for bona fide clinical investigations may be utilized only after approval by the IRB. Non-forumlary medications may be ordered following the process outlined in administrative policy 14-23 – Medication Management – Selection, Procurement and Storage

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

3.6 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration in accordance with administrative policy 14-24 Medication Management – Ordering and Transcribing. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e., exigent patient need) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty, and shall be returned to the patient upon discharge. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be "held" will be discontinued after twenty-four (24) hours in the absence of a "resume" order. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.
Medications will be ordered and dispensed in accordance with administrative policies 14-22 through 14-28 – Medication Management Policies which are approved through Pharmacy and Therapeutics Committee.

3.7 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor,who will then follow the process outlined in administrative policy 2-16 – Chain of Command.

3.8 PATIENT CARE ROUNDS

Hospitalized patients shall be seen at least daily and more frequently if their status warrants. . Patients admitted to Critical Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than four (4) hours after admission or sooner if warranted by the patient's condition. .

3.9 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.10 RESPIRATORY THERAPY ORDERS

The duration of orders for respiratory therapy concerning ultrasonic nebulization, incentive spirometry, postural drainage and percussion will be discontinued after three (3) days unless otherwise ordered. All other ultrasonic nebulization, incentive spirometry postural drainage and percussion will be discontinued after five (5) days unless otherwise ordered, but not without notification to the Attending Physician.

3.11 PATIENT RESTRAINT ORDERS

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

3.12 PRACTITIONERS ORDERING TREATMENT

Licensure and Medicare/Medicaid eligibility will be verified for all practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner's Medical Staff status or lack thereof.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

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

4.2 ADMISSION OF DENTAL AND PODIATRIC CARE PATIENT

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

4.2(a) Dentist's and Podiatrist's Responsibilities

The responsibilities of the dentist and podiatrist are:

(1) To provide a detailed dental/podiatric history justifying hospital admission;

(2) To provide a detailed description of the examination of the oral cavity/involved extremity and preoperative diagnosis;

(3) To complete an operative report following Article II 2.5describing the finding and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, excluding teeth and foreign objects, shall be sent to the hospital pathologist for examination;

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

(5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

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

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

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

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

4.3 INFORMED CONSENT

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, invasive diagnostic procedures, and other high risk treatments (as provided by administrative policy 6-1 Consent and/or state law) except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient only after the risks and benefits of the procedure, alternative treatment methods, consequences of nontreatment, unanticipated outcomes and other information necessary to make a fully informed consent has been explained to the patient by the responsible physician. After informed consent has been obtained by the surgeon, the (nurse, physician, etc., depending on state law) shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

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

4.4 PATIENT REQUESTS AND REFUSAL OF TREATMENT

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

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

4.5 EXAMINATION OF SPECIMENS

Specimens, excluding teeth and foreign objects removed during a surgical procedure, shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff, and documented in the OR Rules and Regulations.

4.6 ELECTIVE SURGERY SCHEDULING

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

Scheduling

(1) The first case of the day will start at 0730, except on designated *0800 Start Days* which are scheduled a year in advance for OR personnel education/staff meetings and occur no more than twice monthly. "0730 Start" is defined as; patient on the OR table, Anesthesiologist

ready to start induction or regional anesthesia, supplies/instruments opened and set-up. Deviations from this standard will be recorded/reported and acted upon by the Department of Surgery Chairman.

(2) All urgent and emergent cases are scheduled through the Medical Director by notifying the OR desk, extension 2254, or Hospital Operator.

(3) Elective cases are scheduled through the OR Scheduling Office 0830-1700 Monday-Friday 521-5288, except on MMC observed Holidays/Eves. Calls are taken as received and/or can be called to answering machine 521-5058. All cases scheduled by phone will be followed by fax of **scheduling form.** Elective line-ups will be confirmed by *return* of the **scheduling form** to Surgeon's office by fax before the date of surgery. FAX number is 521-5323. The Surgeon's line-up is available to be faxed to his office after 1400 the day before surgery date.

(4) Surgeon's requesting **Block Time** must send a formal *written* request to the OR Committee. These requests should include the Surgeon's preference for day of the week, AM or PM, and alternate choices as well. The OR Committee at each meeting considers these requests. Meeting dates and agendas are available through Medical Staff Office.

(5) **Block Time** *drops* 48 hours prior to start of the block, except for Cysto and Hearts, which drop at 24 hours. It is the Surgeon's responsibility to drop Block Time one week ahead of planned time off, to prevent negative input on utilization scores. In other circumstances if Block Time is voluntarily dropped 24 hours before automatic drop consideration will be given by the OR Committee before negative input on utilization scores. Blocks dropped *automatically (at 24/48 hours)* will have a negative impact on block utilization scores.

(6) Utilization scores will be brought to the OR Committee at each meeting for review and scores less than 50% over a 30-day period will receive a written warning that the Block is in jeopardy. If the utilization does not improve over the next 30 days the Block will be reduced or re-allocated by the OR Committee.

(7) MMC recognizes six Holidays each year, New Year's, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas. As the Holidays change the hours of operation of the OR Scheduling Office, Surgeon's offices will be notified by letter at least one week in advance of changes as they pertain to scheduling of their Blocks.

(8) Scheduled elective cases should be started at the appropriate time of day to be completed by 1800. If a surgeon is more than thirty (30) minutes late to start their case, the case will be postponed to the end of the add on list for that day

(9) OR Committee, Anesthesia Department and available OR Staff determine the number of rooms available Monday through Friday with limited scheduled OR Staff available 1500-2300. Limited OR Staff is available Saturday and Sunday 0700-1500. All other hours are covered by on-call staff and are allowed 30 minutes to be *at work.* Call the Hospital Operator to get in contact with the Medical Director and AOD during these hours for emergency cases.

4.7 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, they may be discharged when criteria approved by the medical staff are met.

4.8 ANESTHESIA

Responsibility for the overall management of sedation or anesthesia lies with the physician or licensed independent practitioner responsible for the anesthesia service.

Only qualified individuals as defined in the policies and procedures of the hospital may provide moderate or deep sedation or anesthesia. Other qualified individuals who meet the privileging criteria may administer moderate sedation in accordance with hospital policy.

The anesthesiologist shall maintain a complete sedation or anesthesia record including evidence of pre-sedation or pre-anesthesia evaluation used to determine whether the patient is an appropriate candidate for the planned sedation or anesthesia. Also included in the record shall be a pre-sedation or pre-induction evaluation and a post-sedation or post-anesthesia follow-up of the patient's condition by the anesthesiologist upon admission to and discharge from the post sedation or post-anesthesia recovery area. The post-sedation or anesthesia follow-up shall include documentation of the patients response to care.

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

The anesthesiologist will review and document the patient’s condition immediately prior to induction.

The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary.

4.9 ORGAN & TISSUE DONATIONS

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

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

ARTICLE V
GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Only those physicians who have training in high risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

5.1(a) All cesarean sections;

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

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

5.1(d) All premature infants with complications; and

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

5.2 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female at 20 weeks of gestation or more presents to the Emergency Department with an obstetrical complaint, she will be transported to the Obstetrical Department with hospital personnel. In the Obstetrical Nursing Department, a R.N. will initiate the orders of the obstetrician of record, or in the case of a patient presenting with no prenatal care or care by a physician who is not a member of this Medical Staff, the orders of the physician on-call for obstetrics. The medical screening examination required under Article VI may be performed by a qualified R.N. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the physician concurs with the assessment of the R.N. and the patient has had prenatal care under that physician or physician's practice. In cases where the patient has had no prenatal care and/or is unknown to the physician's practice, the on-call physician shall examine the patient prior to a discharge decision and order.

5.3 ANESTHESIA SERVICES

Anesthesia services must be available within thirty (30) minutes after obstetric anesthesia is deemed necessary.

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

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

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

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

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician trained in emergency medicine, or in the case of a woman in labor, a registered nurse trained in obstetric nursing pursuant to hospital policy, Medicare and other applicable federal regulations.

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

6.1(b) Stabilization

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

(2) "Stabilization" is achieved when no material deterioration is likely to result from the transfer or discharge of the individual, or, in the case of a pregnant woman having contractions, when the woman has delivered (including the placenta).

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

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

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

(4) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal

in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(c) Transfer

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

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

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

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

Medical Staff members are expected to comply with all administrative policies and procedures related to EMTALA.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

(1) All members of the Medical Staff at Memorial Medical will have Emergency Department Consultation Call responsibilities for a period of fifteen (15) years.

(2) Recognizing that there are members with highly specialized practices who provide primarily consultation services, Clinical Departments may recommend to the Executive Committee that these members take a separate Medical Center Consultant Call.
   a. The requirements for Medical Center Consultant Call, in terms of length of service, frequency of call, and obligations, except for 4c, will be the same as for the Emergency Department Consultant Call.
   b. These members will be required to respond to the request of attending or admitting members for patients admitted or to be admitted, regardless of pay source.
   c. These members will not be directly responsible for consultation to the Emergency Department, unless they so desire.

(3) The Department Chairman and/or his/her designee will be responsible for the scheduling of the city call for his/her department and submit it to the Medical Staff Office by the 20th of the preceding month.
   a. If the Medical Staff Office has not received the city call schedule by the 20th of the preceding month, the Medical Staff Office will assign call alphabetically.

(4) Once the call schedule is published, it will be the responsibility of the member assigned to that day to provide coverage for that day if he will be unavailable.
   a. Therefore, in the event of absence or sickness, the assigned Medical Staff member will be responsible to see that his absence is covered for on-call duties, as well as for

inpatient responsibilities, with notification to the Medical Staff Office or the administrative officer for notification of all necessary departments and individuals.

b. Should a member assigned for that day be unavailable and arrangements have not been made for coverage, the Chairman of the Department, his designee, or President of the Medical Staff if he is unavailable, will be notified.

c. The Chairman shall arrange coverage and shall initiate an investigation by the Executive Committee into the member's unavailability.

d. Unless such unavailability in the Executive Committee's judgment is justifiable, the Executive Committee will recommend or undertake action noted in the policies and procedures of the Medical Staff.

(5) No member will be required to take call more frequently than once every fourth night (7 to 8 times per month), unless he volunteers to do so.

(6) The obligation for Emergency Consultation is limited to the following:

a. Any bona-fide emergency as determined by the Emergency Department physician, arising in the Emergency Department for which the Emergency Department physician declares that consultation is indicated.

b. Any bona-fide emergency, as determined by an attending physician, arising for a hospitalized patient or a patient in the Emergency Department for which consultation is deemed necessary as requested by the attending physician.

c. If the Emergency Department physician believes that there is an urgent need for follow-up, but not an emergent need for treatment, the member on-call may be consulted at the judgment of the Emergency Department physician.

1. The member so contacted, if deemed appropriate by the Emergency Department physician, may agree to see the patient in his office in follow-up rather than seeing the patient at that time in the Emergency Department.

d. Patients who require routine care will be provided with a list of physicians.

e. These consultations should be accomplished in a professional fashion by direct physician-to-physician contact.

(7) If a member assigned to take Emergency Department or Medical Center Call fails to respond to a request for consultation, the Emergency Department Physician or the attending physician shall notify the appropriate Department Chairman or the President of the Medical Staff who will request an Executive Committee investigation.

a. If, after investigation, it is believed the member on-call did not respond as required by these Policies and Procedures, the Executive Committee will recommend or take appropriate action per the policies and procedures of the Medical Staff.

b. Such an instance or instances may lead to a recommendation for revocation of privileges and membership.

(8) If a patient's condition warrants consultation or care not available at that time here at the Medical Center, the Emergency Department physician will arrange a transfer, as consistent with federal and state statutes.

(9) If a Clinical Department or specialty in a department is able to provide 100% Emergency Department or Medical Center call coverage, then its own rules concerning consultant call can apply, as outlined in the Department's Rules and Regulations.

a. In the event that this is not possible, then all members of the Clinical Department or Specialty must adhere to the fifteen (15) year responsibility.

ARTICLE VII
GENERAL RULES FOR COMMITTEES

7.1 APPOINTMENT OF MEDICAL DIRECTORS

In order to provide proper Medical Staff guidance and direction to certain hospital services, the President of the Medical Staff will appoint specially trained Medical Directors. Said Medical Directors will have acquired experience and demonstrated competence related to the care provided by that service. These services shall include, but shall not be exclusive of the following:

7.1(a) Cardiac Catheterization Lab;

7.1(b) Cardiology – Special Services – ECG, Echo, Stress;

7.1(c) Special Services - Neurology;

7.1(d) Continuing Medical Education.

7.1(e) Endoscopy

7.1 (f) Physical Rehabilitation Services

7.1 (g) Respiratory Therapy

7.1 (h) Vascular Laboratory

7.1 (i) Dialysis

Said Medical Directors shall participate in the Medical Staff's Performance Improvement functions. Their responsibilities will include duties such as interpretations, policy and procedures, consultations and performance improvement activities.

ARTICLE VIII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

8.1 DEVELOPMENT

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

8.2 ADOPTION, AMENDMENT & REVIEWS

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

8.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

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

MEDICAL STAFF RULES & REGULATIONS
APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____ _____

President of the Medical Staff Date

BOARD OF TRUSTEES:

By: _____ _____

Chairman Date

MEMORIAL MEDICAL CENTER:

By: _____ _____

Chief Executive Officer Date

APPROVED AS TO FORM:

By: _____ _____

Corporate Legal Counsel Date