OTSEGO MEMORIAL HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

The Medical Executive Committee shall adopt rules and regulations, as it deems appropriate for the proper conduct of the Medical Staff. Such rules and regulations shall be considered part of the Bylaws, except that they may be amended at any regular meeting of the Medical Executive Committee, without previous notice, by a two-thirds vote of a quorum of the Medical Executive Committee. Amendments shall become effective when approved by the Board of Directors,

A. ADMISSION AND DISCHARGE OF PATIENTS:

1 , A patient may be treated only by staff members who have submitted proper credentials and have been duly appointed to membership on the Medical Staff except as otherwise provided by these Bylaws.

2. The Medical Staff and the Hospital have agreed to function as an Organized Health Care Arrangement (OHCA) for the purposes of complying with the Notice of Privacy Practice requirements of the HIPAA Regulations only. The Medical Staff and Hospital do not, by virtue of this OHCA, accept any liability for the acts or omissions of the other.

3. The Hospital will present a Joint Notice of Privacy Practices (JNPP) in the inpatient, outpatient and long-term care setting. The Hospital will also obtain a signed acknowledgement of receipt of the JNPP or document the good faith effort to obtain a signed Acknowledgment. The Medical Staff, as a result of the OHCA and JNPP, will not be required to present a Notice of Privacy Practices to patients that they see in the inpatient, outpatient, or long-term care setting. The Medical Staff has approved of the content of the JNPP and agrees to abide by the terms and conditions set forth in the JNPP.

4. All patients admitted to the hospital shall have a provisional diagnosis or valid reason for admission. Admissions be monitored according to admission criteria outlined by the Utilization Review/Discharge Planning Department.

5. For medical conditions, a patient admitted to the hospital shall be assigned to the patient's primary care physician. If the patient’s physician does not have admitting privileges, does not provide inpatient medicine, or the patient does not have a primary care physician, the Internal Medicine physician on call (Hospitalist) will be assigned.

6. There shall be a physician specialist on call to the Emergency Department and for each major clinical service (core specialty) provided by the hospital (Internal Medicine, General Surgery, Pediatrics, Obstetrics/Gynecology, Anesthesia and Family Practice with inpatient privileges).

On call core physicians shall be able to and shall arrive within 30 minutes after being summoned for a critical case under normal transportation conditions. Non-core physicians and Orthopedic physicians shall be able to and shall arrive within 60 minutes after being summoned. When on call physicians in both core specialties and non-core specialties are contacted for any case, they are expected to respond within 10 minutes.

7. Each member of the staff who cannot meet the criteria set forth in (6) above shall name a member of the Medical Staff who is resident in the area who may be called to attend his/her patients in an emergency or until he/she arrives. In case of failure to name such associate, the Chief of Staff or Director of the Department concerned, shall have authority to call any member of the active staff in such an event.

8. A physician who will be out of town for over twenty-four (24) hours should indicate in writing the name of the practitioner in a relevant specialty who will be assuming responsibility for the care of his/her patients during his absence.

9. All patients who present to the Emergency Department seeking treatment will be offered an appropriate medical screening exam which will be completed by a physician, physician assistant or nurse practitioner when acting within the scope of their individual specialty or license and following established protocols. Obstetrical nurses, with specific training and documented competency, may perform medical screening examinations for pregnant patients who present to the Birthing Center. An EMT, while in the field, acting within the scope of their specialty or license and following established protocols is authorized to participate in a Medical Screening Exam in consultation with, and as supervised by, the ED physician.

10. Physicians may admit a patient to the service (responsibility) of another physician only when there is a prior agreement and approval of both physicians taking patient preference into account where appropriate (e.g. coverage groups). The physician issuing the order to admit remains responsible for all care rendered to the patient until the attending physician physically attends the patient or issues a verbal or telephone order acknowledging his/her responsibility for the patient's care.

11. Patients may be transferred to the service (responsibility) of another physician only when the physician receiving the patient in transfer acknowledges and agrees to the transfer by written or verbal acknowledgment as stated in (10) above.

12. Patient Transfers: No patient will be transferred without such transfer being approved by the responsible practitioner. No transfer shall occur until the receiving institution/physician has accepted the patient. Appropriate health information will be sent with the patient. COBRA/EMTALA rules and regulations shall be adhered to.

13. The admitting practitioner shall be responsible for giving such information as may be necessary to assure the protection of others whenever his/her patients might be a source of danger from any cause.

14. For the protection of patients, the medical and nursing staffs and the hospital, certain principles are to be met in the care of the potentially suicidal patient: After a patient is medically stable, an assessment will be completed by a qualified mental health professional to determine the continued plan of care for ensuring patient/staff safety. This plan may necessitate a discharge/transfer to a psychiatric inpatient unit, substance abuse unit or home with supervision and follow up counseling within the patient's community. When discharge/transfer is not imminent, the patient may be admitted to the appropriate unit where staff will initiate suicide precautions as ordered by the physician and as outlined in nursing policy.

15. Psychiatric patients will be admitted only when medically unstable. The patient's medical needs will be tended to as the situation demands. Arrangements for transfer to an appropriate facility will be initiated and accomplished when the patient is medically stable.

16. Admissions to Intensive Care Units:
    If any questions as to the validity of admission to or discharge from the intensive care unit should arise, that decision is to be made through the consultation with the Intensive Care Unit Physician Advisor or his/her designee.

    If a critically ill patient needs an ICU bed and such a bed is not available, it is the responsibility of this patient's attending physician to discuss with attending (s) of current ICU patient (s) to request a transfer of a less critical patient out of the ICU. If consensus cannot be reached, the ICU Physician Advisor shall be consulted. If agreement cannot be reached, transfer should be considered.

17. The attending practitioner is required to document the need for continued hospitalization as identified by the Utilization Review/Discharge Planning Department. This documentation must contain an adequate written record of the reason for continued hospitalization.

18. Patients shall be discharged only on the order of the responsible 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.

19. In the event of a patient death within the hospital, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or designee. Exceptions shall be made in those instances of an irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of bodies shall conform to local law. (See Medical Staff No Code Policy and Nursing policy, Death Determination by Registered Nurse.)

20. Every member of the Medical Staff is expected to be actively engaged in securing autopsies. No autopsy shall be performed without proper written consent. All autopsies, on hospitalized patients shall be performed by a pathologist. The attending physician will be notified when the autopsy is performed. The Medical Staff will periodically review and adopt criteria for autopsy. In addition, physicians not comfortable/able to make a determination of the cause of death may elect not to complete the death certificate. In such instances, these cases will become a coroner's case.

B. HEALTH INFORMATION (INPATIENT):

1. 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 physician's responsibility shall include an admission history and physical examination, admitting note, progress notes, non-surgical procedure report, immediate post-procedure note, operative reports when indicated, and a discharge summary.

2. Each patient admitted to or observed in the hospital shall have a medical history and physical examination that includes a provisional diagnosis within thirty days prior to admission or within 24 hours after admission. The history and physical must be performed by a physician, oral surgeon, dentist, or podiatrist credentialed at a Munson Healthcare Facility or affiliate or by a physician assistant or nurse practitioner who has been granted specific privileges to perform the history and physical exam. If the H&P has been performed by a PA or NP, the report must be co-signed by a physician. This report should include all pertinent findings resulting from an assessment of all the systems of the body according to the bylaws.

3. For those patients readmitted for the same condition within 30 days, a legible copy of the previous history and physical examination may be used in the patient's medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission and heart and lung, and any other pertinent exams are performed and documented.

4. A comprehensive history and physical must be completed for all admissions (except true emergencies). When the history and physical examination are not recorded before an elective operation or any potentially hazardous diagnostic procedure, the appropriate department chairman or anesthesiologist shall be notified by the appropriate nursing supervisor. The department chairman or his/her representative will request that the physician write or dictate an adequate history and physical or risk cancellation of the procedure by the chairman or anesthesia provider. Recognizing that the H&P is a critical communication tool, changes will be made to the H&P policy as appropriate for patient safety and efficiency of operation. Refer to the Medical Staff H&P policy for current H&P requirements.

5. Pertinent progress notes shall be recorded at the time of evaluation, sufficient to permit continuity of care. Whenever 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 at least daily. Normal newborns should be evaluated by a physician within 24 hours of birth and appropriate documentation placed in the medical record.

6. An operative report must be dictated immediately after surgery. Reports dictated greater than 24 hours after surgery will be considered delinquent. It will contain the name of the attending surgeon and all assistants, surgical findings, description of the procedures performed, specimens removed, estimated blood loss, complications and post-operative diagnosis. In addition to the dictated note, a brief operative note must also be entered and include pertinent clinical information. A transcribed report will be authenticated and signed by the attending surgeon. Newborn circumcisions can be documented as a progress note.

7. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient and the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

8. The current obstetrical record shall contain a complete prenatal record, if available. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be completed that includes pertinent additions to the history and any subsequent changes in the physical findings.

9. All clinical entries in the patient's medical record shall be accurately timed, dated and authenticated.

10. Symbols and abbreviations may only be used when the meaning can be easily identified from the context in which it is written. The Director of Health Information Management will keep a master list of commonly used symbols and abbreviations on file. The Do Not Use Abbreviations Listing, which is approved by the Medical Staff, must strictly be adhered to.

11. Final diagnoses shall be dictated or recorded in full at the time of discharge or when all diagnostic data are available to the attending physician without the use of symbols or abbreviations and signed by the responsible practitioner.

12. A discharge summary shall be completed on all medical records of patients hospitalized as inpatients. The only exception is for inpatient admissions for normal newborns. Observation and short stay shall require detailed discharge note or dictated summary. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

13. The records of a discharged patient will be completed within a period of time that in no event exceeds thirty days following discharge. The content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result and will include admitting and discharge diagnoses, brief synopsis of events leading to admission, pertinent physical findings and diagnostic study results, synopsis of hospital course including consultations obtained, procedures performed, results of tests and treatments, and any complications. The summary will also include the condition of patient on discharge, and discharge medications and instructions. all summaries shall be authenticated by the responsible practitioner.

14, The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the Health Information Department after discharge. If the record still remains incomplete 15 days after its due date, the Health Information Department shall notify the practitioner. A medical record is considered delinquent if it is not complete beyond 30 days after discharge. Failure on the part of the practitioner to comply with the requests of the Health Information Department to complete the chart within 30 days of discharge may result in suspension of admitting, consulting and surgical privileges. Written or electronic notices of chart delinquency Mill be provided to the practitioner. Suspension of privileges for delinquent records will remain in effect until the records are completed.

15. Written authorization by the patient is required for release of medical information to persons not otherwise authorized to receive this information. A HIPAA compliant authorization form must be completed prior to the release of medical information that is not used for treatment, payment or hospital operations purposes.

16. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away. In case of readmission of a patient all previous records shall be available for use by attending and consulting practitioners. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for disciplinary action. Refer to policy #I-IIPAASEC. 12 for instructions on the removal of electronic records.

17. Those professionals who are involved in the active treatment plan of a patient, including but not limited to, the respiratory therapist, dietician, pharmacist, social worker, nurses, physical therapist, speech language pathologist and occupational therapist are authorized to document any observations, conclusions, and recommendations in the patient's medical record.

18. Those professionals who are involved in the active treatment plan of a patient, including but not limited to, the respiratory therapist, dietician, pharmacist, social worker, nurses, physical therapist, speech language pathologist and occupational therapist are authorized

to document any observations, conclusions, and recommendations in the patient's medical record.

19. Subject to the discretion of the HIPAA Privacy Officer, members of the Medical Staff, shall be permitted access to information from the medical records of their patients. All such projects shall be approved by the Medical Executive Committee before records can be studied. Former members of the Medical Staff may be permitted to access information from the medical records of their patients covering all periods during which they attended such patients.

20. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical records Review Advisor.

C. HEALTH INFORMATION OUTPATIENTS:

1. The medical record for same day procedures requiring general/deep or spinal anesthesia shall include at least:
   a. The patient's informed consent
   b. Preoperative evaluation by the anesthesia provider
   c. Preadmission testing results
   d. Physician orders
   e. Post procedure note by the performing physician
   f. Dictated operative report
   g. Post anesthesia evaluation
   h. The physician's discharge order, discharge note prior to discharge from the hospital which describes the disposition of the patient and completion of discharge instructions.

2. Refer to the H&P policy for current H&P requirements.

D. GENERAL CONDUCT OF CARE:

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. In addition, for special procedures, specific consent must be obtained. See Administration policy on Consents.

2. All orders for treatment shall be documented. Acceptance of verbal orders is limited to specific personnel functioning within his/her scope of practice as detailed in Physician Medical Staff Orders policy. Verbal orders must be signed within 30 days of discharge. When a verbal order is given, the person receiving the order will repeat the complete order back to the physician, to validate the order was correctly heard or entered. After repeating the order to the physician, the person will complete the appropriate R.A.W. (Reread As Written) process. See Medical Staff policy on orders.

3. The practitioner's orders must be clear, legible and complete. Orders which are illegible or incomplete must be classified or rewritten prior to execution. When patients are transferred

from one department to another, all current orders shall be reviewed and reordered.

4. With the exception of endoscopy, all previous orders are canceled when patients go to surgery.

5. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A-M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in frill accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

6. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

7. Consultation is deemed appropriate in the following situations:
   a. When the patient is not a good risk for operation or treatment.
   b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
   c. Where there is a doubt as to the choice of therapeutic measures to be utilized.
   d. When the level of care exceeds the credentials of the physician caring for the patient.
   e. In instances in which the patient exhibits severe psychiatric symptoms.
   f. When requested by the patient or his family.

8. The Chief of Staff or a Chief of Service may order a consultation on any patient when he deems clinically appropriate.

9. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she will provide written authorization to permit the consultant to attend or examine his patient. The consultant will document his evaluation and opinion in the medical record.

10. Conflicting orders must be clarified with the attending physician.

11. Consultations are necessary when a patient is being declared incompetent. See Administrative policy on Consents.

12. In the case of an emergency or debilitating illness of an attending physician, an Active Medical Staff member shall, at the request of the Chief of Staff or Chief of Service, assist in the care of patients of the incapacitated provider. In the event an Active Medical Staff member cannot or does not respond to a request for assistance, refer to the Administrative Chain of Command policy.

13. Registered Dieticians may prescribe the following nutrition therapies for hospitalized patients:
    a. Diet orders

b. Oral nutrition supplements
c. Lab tests to monitor effectiveness of dietary plans/orders
d. Vitamin and mineral supplements
e. Enteral tube feeding product, rate, method of delivery and/or additional water
f. Parenteral support composition and rate

E. EMERGENCY SERVICES:

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. The record shall include:
   a. _Adequate patient identification.
   b. Information concerning the time of the patient's means of arrival and by whom transported;
   c. Pertinent history of the injury or illness including details relevant to care given the patient prior to arrival at the hospital;
   d. Description of significant clinical, laboratory and x-ray findings;
   e. Diagnosis.
   f. Treatment given;
   g. Condition of the patient on discharge or transfer; and
   h. Final disposition, including instructions necessary for follow-up care and to whom these instructions were provided.

3. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

4 There shall be a plan for the care of mass casualties at the time of any major disaster based upon the hospital's capabilities in conjunction with other emergency facilities in the community. The plan will outline physician assignments and it will be the physicians' responsibility to report to their assigned stations. In the event of a disaster, all physicians of the Medical Staff of the hospital specifically agree to relinquish direction of the professional care of their patients in accordance with the plan.

F. MEDICAL STUDENTS AND RESIDENTS:

1. Medical students may provide patient care in the following manner under the direct supervision of the sponsoring physician: order diagnostic laboratory and radiology tests; record progress notes in the medical record. All of the above documentation must be co-signed by the attending physician within 24 hours. Medical students may write orders but orders will not be implemented until co-signed by the attending physician. Medical students may not write orders for medication or treatment of any kind. They may not

perform procedures, or pelvic exams without the presence of the attending physician. All entries made by a student must be cosigned by the supervising physician. By co-signing a medical student's entry in the medical record the signer is acknowledging that they have performed an independent history and physical and concur with the student's assessment, unless otherwise documented. The medical student's policy also applies to physician assistant and nurse practitioner students.

2. Residents may provide patient care in the following manner under the direct supervision of the sponsoring physician: obtain histories and perform physical examination and record same on chart; order diagnostic laboratory and radiologic testing; order medications and treatments, round on patients and record progress notes. All of the Resident Physician' s documentation and orders must be signed by the sponsoring physician within 24 hours or prior to discharge for patients who are admitted to the hospital for less than 24 hours. Orders by Resident Physicians may be carried out prior to obtaining the signature of the sponsoring physician. All procedures performed by Resident Physicians will be carried out according to the policy on Supervision of Resident Physicians.

G. SPECIAL CARE UNITS:

1. For special care units including intensive care, recovery room, labor, deliver and nursery, appropriate committees of the medical staff shall adopt specific policies/regulations. These regulations shall be subject to approval of the Medical Executive Committee and the Board of Directors.

2. The intensive care unit physician advisor shall be nominated by the Chief of the Medical Staff for a two-year term. The advisor will oversee performance improvement activities and ensure that the policies of the unit are adhered to.

H. SURGICAL SERVICES:

1. The Surgical service section will develop at various times rules, regulations and policies with regards to, but not limited to the following issues:
   a. Scheduling
      1) Block scheduling
      2) Urgent and emergent scheduling
      3) Start time
      4) Scheduling conflicts
   b. Preoperative issues
      l) Laboratory studies
      2) Cardiopulmonary studies
      3) History and physicals
      4) X-rays

   c. Requirements prior to anesthesia and operation
      1) Pre-operative documentation

2) Preoperative anesthetic evaluation
3) Identification of patient and operative site

d. Safety Issues
1) Contaminated cases
2) Environmental control
2) Radiation safety
3) Time outs/Checklists

2. Specimens removed at time of operation except those exempted by the medical staff shall be sent to the hospital pathologist. The pathologist shall make examinations necessary to arrive at a pathologic diagnosis and submit a signed report of findings. Placentas may be submitted for pathologic analysis at the request of the delivering physician.

Foreign bodies should be submitted for pathological evaluation any time there may be a medical legal question.

3. Informed consent Mill be obtained prior to all invasive procedures. Documentation of this consent should be signed by the patient or legal representative except in case of an emergency. The physician is responsible for obtaining informed consent.

4. All female patients ages 10-55 undergoing surgery are required to have a pregnancy test (UCG — urine pregnancy test or HCG — blood pregnancy test) with results documented on the medical record within 24 hours prior to surgery unless infertile by previous hysterectomy. This requirement may be waived according to medical staff judgement with an appropriate notation in the medical record by the medical staff waiving the test.

5. Except in cases of medical necessity, patients for elective operations shall be admitted the morning of surgery.

6. General Surgeons, Orthopedic Surgeons, Urologists, Vascular Surgeons, Obstetricians, Gynecologists, Otolaryngologists, Gastroenterologists, Plastic Surgeons, Ophthalmologists and other qualified Physicians are permitted to supervise a CRNA administering anesthesia in any and all procedures.

7. After administration of anesthesia, the CRNA or anesthesiologist is required to visit the patient post-operatively, make a post-anesthetic evaluation, and record same in the medical record, as specified in the Anesthesia Department Policy and Procedure Manual. The patient may be

discharged from outpatient surgery after meeting established criteria and/or being visited by the practitioner.

8. Inpatients admitted for dental or podiatric care are the dual responsibility of the dentist or podiatrist and a physician member of the Otsego Memorial Hospital medical staff.

a. Dentist or podiatrist responsibility:
1) Detailed dental or pediatric history justifying hospital admission,

2) Detailed description of the oral cavity or feet and preoperative diagnosis.
3) Complete operative report describing findings and techniques. In cases of dental extraction, the dentist should clearly state the number of teeth and fragments removed. All appropriate tissues and fragments should be sent to the hospital pathologist for examination.
4) Progress notes as pertinent.
5) Discharge summary when warranted.

b. Physician responsibilities:

1) Medical history pertinent to patient's health.
2) Physical exam to determine the patient's condition prior to anesthesia or surgery.
3) Supervision of patient's general health while hospitalized.
4) Discharge of the dental or podiatric patient will be at the written order of the dentist or podiatrist and/or physician involved.

I. POLICIES:

All physicians will abide by all Board, Hospital, and Medical Staff Policies.

REVIEWED AND APPROVED BY THE MEDICAL, EXECUTIVE COMMITTEE

Nathan Mann, DO — 1/31/2022

Chief of Staff — Date