MUNSON HEALTHCARE
Cadillac Hospital

Munson Healthcare Cadillac Hospital
The Medical Staff Documents

Part I: Rules & Regulations

Approval:

- **Medical Executive Committee – June 1, 2018**
- **Munson Healthcare Cadillac Board of Trustees – June 5, 2018**

MEDICAL STAFF
RULES AND REGULATIONS
MUNSON HEALTHCARE CADILLAC HOSPITAL

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RULES AND REGULATIONS
MUNSON HEALTHCARE CADILLAC HOSPITAL

I. GENERAL CASE MANAGEMENT

A. Admission and Discharge of Patients

The hospital shall accept patients for care and treatment as requested by members of the Medical Staff based on their assessment of the need for acute inpatient admission or observation status. The admitting member of the medical staff shall designate inpatient or observation status on the patient's initial orders. Any patients that require care or precautions that the hospital cannot provide will be transferred when appropriate arrangements are made.

B. Who May Admit

A patient may be admitted to the hospital by any member of the Active, Community Affiliate, Consulting or Senior Emeritus-Active staff.

C. Medical Staff Responsibilities for Care and Treatment

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, 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. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is resident in the area who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such associate, the President of the hospital, Chairman of the Executive Committee, President of the Medical Staff, or Chairman of the Department concerned, shall have authority to call any member of the active staff in such an event.

D. 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 possible.

E. City Call

A patient to be admitted on an emergency basis who does not have a private practitioner will be assigned to the City Call physician. This on-call physician will also be available to provide necessary inpatient consults as requested by the medical staff for their area of clinical privilege.

F. Information for Protection of Patients and Employees

The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of hospital personnel whenever his/her patients might be a source of danger from any cause whatever. This shall include information regarding communicable, dermatologic or systemic diseases, including active respiratory infections.

G. Admission to Intensive Care Unit

Patients shall be admitted to the ICU upon a physician's order, according to the established admission criteria and bed availability.

Physician Responsibility: The primary (attending) physician shall be responsible for the admission and management of the total care of the patient in accordance with his/her clinical privileges granted by the Board.

H. Discharge of Patients

1. Required Order

Patients shall be discharged only on order of the attending practitioner or his/her designee.

2. Leaving Against Medical Advice

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 and, when possible, an authenticated release obtained from the patient.

I. Timely Discharge

It shall be the responsibility of the attending practitioner or his/her designee to discharge his patients as early as possible in the day.

J. Hospital Deaths

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time.

K. Autopsies

Physicians are especially encouraged to request an autopsy in the following conditions:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complication to the attending physician.

2. All deaths in which the cause of death or a major diagnosis is not known with certainty on clinical grounds.

3. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.

4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.

5. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.

6. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

7. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as, (1) persons dead on arrival at hospitals and (2) deaths in which the patient sustained or apparently sustained an injury while hospitalized.

8. Deaths resulting from high-risk infections and contagious diseases.

9. All obstetric deaths.

10. All neonatal and pediatric deaths.

11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.

12. Deaths known or suspected to have resulted from environmental or occupational hazards.

L. Organ Procurement

It shall be highly appropriate for members of the Medical Staff to encourage patients to donate organs to the various agencies organized for the purpose of sharing to sustain life. In the event the patient or his/her next of kin/significant other has so designated his/her desire to donate any of his/her organs, the appropriate agency shall be contacted.

When a cadaver organ is removed for purposes of donation, an operative report shall be made that shall include a description of the technique used to remove and prepare or preserve the donated organ.

M. Laboratory Work

1. Except in a severe emergency, the results of pertinent laboratory data done by a laboratory accredited by CLIA (Clinical Laboratory Improvement Act) must be documented on the patient's chart prior to the induction of General Anesthesia.

   Depending on the clinical situation, different lab work (or no lab work) may be appropriate or pertinent and that will be left to the discretion of the anesthesiologist.

2. These tests shall be done within an appropriate time interval according to the clinical situation.

3. Specific results of tests done by other than the hospital laboratory may be documented in the History and Physical or Progress Notes section of the patient's chart.

4. Copies of actual test results will be filed in the appropriate section of the patient's chart at the time of admission.

5. All lab work performed during the patient's stay within the facility will be performed through the hospital laboratory.

II. MEDICAL RECORDS

A. Record Content

The attending practitioner shall be responsible for a complete and legible medical record for each patient. Its content shall be pertinent and current. The record shall include:

- identification data
- legal status of patients receiving mental health services
- emergency care prior to arrival
- patient assessment
- medical history & physical examination
- diagnosis or impression
- reasons for admission
- treatment plan
- evidence of known Advance Directives
- physician orders
- procedures and test results
- operative and other invasive procedures
- progress notes

- reassessment
- clinical observations
- patient's response to care
- consultation reports
- all medication administered
- referrals made to community agencies
- discharge instructions
- discharge summary
- autopsy report when performed

B. Authentication

All medical record entries are dated**,** timed and authenticated and their authors identified.

1. Use of Signature Stamp

Medicare requires a legible identifier for services provided/ordered. The method used shall be documented or an electronic signature (stamp signatures are not acceptable) to authenticated an order or other medical record documentation for medical review purposes.

2. Abbreviations

Symbols and abbreviations may be used only when they have been approved by the medical staff. The official record of approved abbreviations shall be the current edition of Stedman's Abbreviations, Acronyms & Symbols and will be available in all clinical departments.

C. Reports

1. History and Physical Examination

A history and physical examination is required for all inpatients, ambulatory surgeries and observation patients. A complete history and physical examination shall be completed no more than thirty (30) days prior to or twenty-four (24) hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services.

When using a history and physical from a non-credentialed practitioner, the credentialed practitioner must:

a. Review and authenticate the history and physical

b. Determine if the information is compliant with the organization's defined minimal content

c. Obtain missing information through further assessment

d. Update information and findings as necessary including:

- addition of absent or incomplete required information
- documenting a description of the patient's condition and course of care since the history and physical examination was performed
- Signature, date, and time on any document with updated or revised information as an attestation that it is current.

Readmissions – A history and physical from another admission can be used if it is less than 30 days old. When this copy is used, all changes that have occurred must be documented in the medical record as an addendum.

History and Physical Update – An updated examination of the patient, including any changes in the patient's condition, be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

- The update note must document an examination for any changes in the patient's condition since the patient's history and physical was performed that might be significant for the planned course of treatment.

- If, upon examination, the licensed practitioner finds no change in the patient's condition since the history and physical was completed, they may indicate in the patient's medical record that the history and physical was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the history and physical was completed.

- Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requirement anesthesia services.

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

Inpatient and Observation Bed Patients:
The history and physical for all inpatient and observation patients shall include the following:

- Chief complaint
- Details of present illness
- Past history
- Social history
- Family history

- Medications
- Allergies
- Review of systems
- Physical exam
- Admitting diagnosis
- Treatment plan
- Problem List

Ambulatory Patients:
Ambulatory patients including those undergoing a surgical, diagnostic or therapeutic procedure or in the hospital or observation require a relevant history and physical to be recorded in the medical record. A relevant history and physical includes, at a minimum:

- Indications for the procedure or observation
- Diagnosis/impressions
- Allergies
- Mental status
- Treatment plan
- Medications
- Clinically pertinent positive and negative findings

Emergencies:
In an emergency, when there is no time to record the History and Physical examination, a note documenting the preoperative diagnosis is recorded prior to the procedure. The History and Physical must then be documented within twenty-four (24) hours. Following the procedure, the attending practitioner will document that delaying the procedure to document the History and Physical would have been detrimental to the patient.

2. Progress Notes

Pertinent progress notes for inpatients and observation patients shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes shall be documented at least daily on all patients by the attending physician or his/her designee. Another physician or an allied health provider with credentials may document a progress note in lieu of the attending physician.

Documentation that the risks and benefits of the operative procedure have been discussed with the patient must be included in the progress notes or the history and physical.

3. Surgical and/or Procedures Reports

Operative reports shall be dictated/documented and authenticated in the medical record immediately after surgery. If there is a delay in placing the report in the

record (i.e., transcription/filing), then an operative progress note must be entered immediately. This progress note must include:

- Name of the primary surgeon and all assistants
- Findings
- Technical procedures performed
- Specimens removed
- Pre- and post-operative diagnoses
- Estimated blood loss

4. Obstetric Record

The current obstetrical record shall include a complete prenatal record. 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 documented that includes pertinent additions to the history and any subsequent changes in the physical findings.

5. Discharge Summary

A discharge summary shall be recorded on all patients with the exception of patients hospitalized less than forty-eight (48) hours with only minor problems, normal newborns, and uncomplicated vaginal deliveries. For these cases a progress note containing patient's condition at discharge, discharge instructions and follow-up care will suffice.

The discharge summary must be recorded and authenticated within 15 days from discharge and include the following information:

- The reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- The patient's condition at discharge
- Instructions to the patient/family
- Final diagnosis

6. Anesthesia Record

The anesthesia personnel shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluations and post-anesthetic follow up of that patient's condition.

7. Pathology Record

All tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

8. Autopsy Report

When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within three days, and the complete protocol is included in the record within 60 days.

9. Discharge Instructions

Discharge instructions must be authenticated by the nurse or physician who discharged the patient.

D. Observation Bed Documentation: Observation bed documentation should include the following:

1. Admission Order

An admission order shall be documented to initiate care. This order should specify placement in an observation bed. The order must be dated, timed and document the reason for the observation services.

2. History and Physical

A History and Physical must be performed within twenty-four (24) hours of the admission or may utilize one that has been performed up to thirty (30) days prior to the admission or the outpatient services. The History and Physical must be performed by a practitioner who has been granted privileges to do so. An update to the patient's condition since it was last assessed is required at the time of admission but prior to a procedure when using a History and Physical that was performed before admission. As specified in section C1 above

3. Progress Notes

Progress notes for observation beds shall be dated, timed and authenticated. They shall be recorded with sufficient frequency and content to specify rationale for care and response to care provided. Observation status is approved or denied on an hourly basis, therefore, documentation must reflect the need for continued care at observation status. Any diagnostic/lab results not directly related to the reason for observation status must also be addressed. As specified in section C2 above.

4. Documented Plan for Appropriate Follow-Up Care

There must be documentation of the plan for follow-up care after discharge in the form of a short stay discharge note.

5. Discharge Order

A timed, dated and authenticated discharge order is required to release the patient from observation services.

E. Definition of Delinquent Medical Record/Report

For CMS and Joint Commission reporting requirements, a medical record is considered delinquent when it has not been completed within thirty (30) days from discharge.

F. Confidentiality, Ownership/Release

Documented consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. The referring physician may receive copies of medical information.

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 without permission of the President /HIS Director. In case of readmission of the patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the medical staff.

Free access to all medical records of all patients 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. Subject to the discretion of the President , former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

G. Definition of Completed Medical Record

A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical resume or progress notes, and when all final diagnoses, procedures and any complications are recorded (without use of symbols or abbreviations on final diagnoses).

A record may be reviewed and considered incomplete if found to be lacking sufficient detail to allow accurate and complete billing and quality review. This includes completion of all electronic portions of the record as standardized by the institution to meet requirements imposed by various regulatory agencies.

A medical record shall not be considered complete until it is completed by the responsible practitioner(s). If the responsible practitioner is not able to complete the record, the Department Chairman or Medical Staff President will be asked to complete the record. If this is not done, the chart will be filed as incomplete. A quarterly report of this activity will be reported to the Performance Assessment, Maintenance, and Improvement (PAMI) Committee.

H. Suspension for Medical Record Delinquency

1. Incomplete Medical Records

All portions of each patient's medical record shall be completed within fifteen (15) days after the patient's discharge. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in;

a) the record being defined as delinquent; and
b) notification to the practitioner.

2. Delinquent Medical Records

a) Failure to complete all aspects of any patient's delinquent medical record within seven (7) additional days after documented notice that the record is delinquent (see 1) above, shall result in a loss of privileges to admit elective patients, schedule elective surgery or anesthesia or schedule diagnostic or therapeutic procedures. Ten such suspensions in a rolling 12-month period shall result in suspension of medical staff membership and all clinical privileges. If a practitioner's medical staff membership and/or clinical privileges are automatically suspended, the Medical Staff President shall notify the practitioner of the suspension in writing. The practitioner does not have the right to Due Process. Membership and/or clinical privileges will be reinstated once the records have been reported as completed by Medical Records.

Seven days equals one episode for each delinquency.

A five-day allowance will be given to complete charts following vacations or illnesses.

I. Consent Form

A general consent form, authenticated by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. If unable to get consent at the time of admission, the customer access representative will follow up with the patient as soon as the patient/designee is able to sign.

J. Orders - All orders for treatment shall be documented.

1. Verbal Orders

A verbal order shall be considered to be documented if dictated to a duly authorized and licensed person functioning within his or her sphere of competency and authenticated, dated and timed by the responsible practitioner or other practitioner responsible for the care of the patient. All orders dictated over the telephone shall be authenticated, dated and timed by the appropriately authorized person to whom dictated with the name of the practitioner per his or her own name. All verbal orders shall be authenticated, dated and timed by the

responsible practitioner or other practitioner responsible for the care of the patient.

The personnel authorized to transcribe verbal orders shall consist of the following:

- Rehabilitation Therapist
- Respiratory Therapist
- Radiology Technologist
- Dietitian - Registered
- Pharmacist
- Registered Nurse
- Laboratory Personnel
- Occupational Therapist
- Speech Pathologist

2. Orders Must be Legible

The practitioner's orders must be documented clearly, legibly and completely. The nurse must contact the physician for clarification of orders, which are illegible or ambiguous.

3. Surgery Cancels all Previous Orders

All previous orders are reviewed when patients go to surgery for procedures where patients receive general, regional or spinal anesthesia. Orders will be reviewed for changes in patient conditions post surgery. This does not apply to surgery where local or IV sedation is used.

K. Authorization to Document in Patient's Record

The following departments/caregivers will be authorized to document in the patient's record:

- Medical Staff
- Nursing
- Psychologists
- Pharmacy
- Dietary
- Social Work
- Home Health/Hospice
- Radiology
- Cardiopulmonary
- Cardiac Rehabilitation
- Rehabilitation Services
- Spiritual Care
- Case Managers
- Coding

- Patient Financial Staff
- Customer Access Representative

L. Patients Admitted for Dental Care (are subject to the same admission/documentation requirements as patients admitted for medical/surgical care.)

1. Dentist's/Oral Surgeon's responsibilities:

a) A detailed dental history justifying hospital admission;
b) A detailed description of the examination of the oral cavity and pre-operative diagnosis;
c) A complete operative report, describing the finding and technique. In cases of extraction of teeth the dentist/oral surgeon shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination;
d) Progress notes as are pertinent to the oral condition;
e) Discharge Summary.

2. Physician's responsibilities:

a) Perform a medical history and physical examination to determine the patient's condition prior to anesthesia and surgery. Current histories and physicals pertaining to a dental patient's admission may be completed by any physician observation a current license to practice medicine in the State of Michigan;
b) If the medical condition of a patient admitted for oral surgery becomes unstable or uncontrolled or if a new medical condition arises, that medical condition must be managed by a physician with appropriate privileges.

3. The discharge of the patient shall be a documented order of the dentist/oral surgeon member of the Medical Staff.

M. Patients Admitted for Podiatric Care

Doctors of Podiatric Medicine may independently perform all or part of the admission medical history and physical examination. High-risk patients require confirmation or endorsement of the history and physical by a qualified allopathic or osteopathic physician.

N. Emergency Record

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:

1. Adequate patient identification

2. Information concerning the time of the patient's arrival, means of arrival and by whom transported

3. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital

4. Description of significant clinical, laboratory and diagnostic findings

5. Diagnosis

6. Treatment given

7. Condition of the patient on discharge or transfer

8. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care

9. Notation of patient leaving against medical advice if applicable

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

III. CONSULTATIONS

A. When Consultation is Required

Except in an emergency, consultation is required in the following situations:

1. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed

2. Where there is doubt as to the choice of therapeutic measures to be utilized

3. In unusually complicated situations where specific skills of other practitioners may be needed

4. When the medical condition is outside the scope of the physician's privileges

5. When requested by the patient or one who has medical guardianship

B. Consultation Procedure

1. The attending staff member shall request the specific type of consultation

Routine	Completed within twenty-four (24) hours or within the time frame

	determined by discussion between the referring physician and the consultant
Urgent	Completed within twelve (12) hours
Emergent	Completed STAT

2. Normally, a consultation will be considered to be routine unless otherwise stated in the chart.

3. The attending physician will call the consultant to request emergent or urgent consultation.

4. The attending staff member and the consultant shall mutually agree whether the consultation shall be informational, co-management, or full management (transfer of patient). This should be clarified in writing in the chart.

   a) The consultation shall be informational if the attending staff member is to keep entire management of the patient.

   b) The consultation shall be co-management if the attending staff member and the consultant will have shared responsibility for management of the patient.

   c) The consultation shall be full management if the consultant is to have care of the patient transferred to his service.

   d) When "consult" is the only word documented on the order sheet, it will be interpreted as co-management where the consultant manages and writes orders only in their area of expertise.

5. Co-management or transfer of care must be agreeable to the consultant. If co-management is agreed upon, the attending staff member can designate, by writing on the chart, which aspects of care should be managed by the consultant and which aspects of care are to be managed by the attending staff member.

6. Disagreements between the attending physician and consultant shall be resolved by the attending physician's Department Chief or the Chief of Staff.

7. Refusal of a consultant to see the patient in a timely fashion (once the consultation is accepted) may result in initiation of corrective action.

8. The consultant must record a summary of his findings and recommendations in a timely manner regardless of whether the patient was seen face-to face or seen via telemedicine link. Consultations shall show 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. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. (Moved from Section II Medical Records, C 4.)

9. When operative procedures are involved, the consultation note shall, except in emergency situations, be dictated or recorded prior to the operation, or the consultant must have spoken directly with the surgeon or anesthesiologist.

IV. GENERAL RULES REGARDING SURGICAL CARE

A. Informed Consent

Documented, authenticated, informed consent shall be obtained prior to the operative and/or invasive procedure 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. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation with another physician in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

B. Starting Time Delayed

Surgeons must be in the operating room and ready to commence operation at the time scheduled. The operating room will not be held longer than 15 minutes after the time scheduled. The Director of Surgical Services and the Chairman of the Surgical Services Department will have authority to enforce this ruling.

C. Qualified Assistant

In any surgical procedure, the surgeon will determine whether qualified technical surgical assistance is needed.

D. Post-Op Medical Management

The surgeon has responsibility for post-operative medical management. This includes patient care and the paperwork involved with the patient. However, if the surgeon signs over care to another provider, and the provider accepts the transfer, it is the provider’s responsibility for patient care and paperwork.

V. EMERGENCY SERVICES

A. Delivery of Services

The Medical Staff shall adopt a method of providing medical coverage in the emergency department. 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.

B. Disaster Plan

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. It shall be developed by a Disaster Planning Committee which includes at least the Chairman of the Emergency Management Committee and the Vice President of Patient Care Services or his/her designee representing hospital administration. The plan shall be approved by the medical staff and governing body and be appended to this document.

The Emergency Management Plan should make provision within the hospital for:

1. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials,

2. An efficient system of notifying and assigning personnel;

3. Unified medical command under the direction of a designated physician (the chairman of the committee or designated substitutes);

4. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care;

5. Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;

6. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved;

7. Procedure for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy;

8. Maintaining security in order to keep relatives and curious persons out of the triage area;

9. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual.

All physicians shall be assigned to posts and it is their responsibility to report to their assigned stations.

The Emergency Management Plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a documented report and evaluation of all drills.

VI. DEPARTMENTAL RULES AND REGULATIONS

Departmental Rules and Regulations shall become a part of the Medical Staff Rules and Regulations upon adoption by the Medical Executive Committee and shall not be inconsistent with the Medical Staff Bylaws or the Rules and Regulations of the Medical Staff or other policies and procedures of the hospital.

VII. ADOPTION AND AMENDMENT

The Medical Staff Rules and Regulations are reviewed periodically by the Medical Executive Committee and revisions are proposed as necessary to reflect current regulatory requirements and practices with respect to medical staff organization and function. Modifications must be communicated to the voting members of the Medical Staff prior to Medical Executive Committee vote through established communication mechanisms. Changes to the Rules and Regulations may be made by the Medical Executive Committee on behalf of the organized medical staff and require Board approval.