MUNSON HEALTHCARE CHARLEVOIX HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

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DEFINITIONS

1. **BOARD OF DIRECTORS** means the governing body of the corporation, or, as appropriate to the context, any committee or individual authorized by the board to act on its behalf on certain matters.

2. **CHIEF EXECUTIVE OFFICE**, **CEO**, or **PRESIDENT** means the individual appointed by the board as the chief executive officer to act on its behalf in the overall executive and administrative management of the hospital. The chief executive officer may, consistent with his responsibilities under the bylaws of the corporation, designate a representative to perform his responsibilities under the Medical Staff Bylaws and related manuals.

3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the board to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him/her.

4. **CORPORATION** means Munson Healthcare Charlevoix Hospital.

5. **EXECUTIVE COMMITTEE** means the executive committee of the Medical Staff

6. **EX OFFICIO** means service as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

7. **HOSPITAL** means Munson Healthcare Charlevoix Hospital of Charlevoix, Michigan.

8. **MEDICAL STAFF** or **STAFF** means the component of the hospital chart of organization that stands for all practitioners, as defined in number 15 below, who are appointed to membership and are privileged to attend patients or to provide other diagnostic or therapeutic services at the hospital.

9. **ALLIED HEALTH PROFESSIONAL** means those appropriately licensed professionals in allied medical fields, including dentists, oral surgeons, podiatrists, medical associates, and physician assistants.

10. **AUTHORITIES OF THE MEDICAL STAFF AND BOARD** means any committees, officers, and clinical units of the staff, and the board and any committees or officers thereof, who have defined responsibilities in effecting the particular function or activity that is the subject of the particular provision in which the above defined phrase is used.

11. **MEDICAL STAFF MEMBER IN GOOD STANDING** or **MEMBER IN GOOD STANDING** means a practitioner who has been appointed to the medical staff or to a particular category of the staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws and related manuals or any other policies of the medical staff or hospital.

12. **MEDICAL STAFF BYLAWS AND RELATED MANUALS** means any one or more of the following documents as appropriate to the context:
    - Bylaws of the Medical Staff
    - Medical Staff Credentialing Policy
    - General Rules and Regulations of the Medical Staff

    MEDICAL STAFF BYLAWS or **BYLAWS** means only the first document of those listed above.

13. **MEDICAL STAFF YEAR** means the 12-month period commencing on July 1 of each year and ending on June 30 of the next year.

14. **PHYSICIAN** means an individual with an M.D. or D.O. degree, who is licensed to practice medicine.

15. **PRACTITIONER** means, unless otherwise expressly provided, any physician, dentist, oral surgeon, or podiatrist who either: a) is applying for appointment to the medical staff and for clinical privileges; or b) currently holds appointment to the medical staff and exercises specific delineated clinical privileges; or c) is applying for or is exercising temporary privileges pursuant to Article VIII, Section 3 of the Medical Staff By-laws.

16. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional and exercisable subject to the ultimate authority of the board and to the conditions and limitations imposed in the Medical Staff Bylaws and related manuals and in other hospital and medical staff policies.

17. **SPECIAL NOTICE** means written notification sent by certified mail, return receipt requested.

PART ONE: ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

Within these guidelines, patients are admitted without regard to age, race, creed, color, sex, sexual orientation, national origin, or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the chief executive officer after consultation with the applicable department advisor.

1.2 ADMITTING PREROGATIVES

1.2.1 GENERALLY

Only a member in good standing of the active, associate, or courtesy staff category of the medical staff may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the hospital as may be in effect from time to time. Names of members not in good standing are submitted to the nursing office by administration.

1.2.2 LIMITATIONS FOR ALLIED HEALTH PROFESSIONALS

a) Oral surgeons, dentists, and podiatrists' responsibilities upon admission of a patient for care:

1) Prepare a detailed history justifying hospital admission and enter a detailed description of the examination and pre-operative diagnosis on the patient's record.

2) Complete an operative report describing the technique and findings.

3) Make progress notes as are pertinent to the patient's condition and enter such on the medical record.

4) Provide a clinical resume or complete a summary statement upon discharge.

b) Physicians' responsibilities in relation to such patients:

1) Prepare a medical history pertinent to the patient's general health and a physical examination to determine the patient's condition prior to anesthesia and surgery.

2) Supervise the patient's general health status while hospitalized.

c) Discharge of the patient shall be on written order of the admitting practitioner.

1.3 ADMISSION PRIORITIES

At time of full hospital occupancy or of shortage of hospital beds or other facilities, as determined by the chief executive officer, priorities among the members of the various staff categories for access to beds, services, or facilities for patients of similar status (i.e., elective, urgent, emergency) are as follows:

1.3.1 1) Emergency

2) Urgent

3) Elective

1.3.2 When two or more practitioners with the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received.

1.3.3 The utilization review committee will periodically review "emergent" admissions to identify patterns of possible non-compliance or misuse.

1.4 **TIME OF ADMISSION**

Except in emergency cases, the attending practitioner should arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same admission day surgery, the attending practitioner must comply with hospital policies concerning pre-surgical laboratory tests, documentation, and scheduling.

1.5 **RESTRICTED BED USE AREAS**

Areas of restricted bed utilization and assignment of patients are as follows:

a) A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery.

b) Obstetrical beds are utilized for the care of the prenatal and postpartum patient, and overflow of uncomplicated, non-infectious female surgical patients.

c) Medical/surgical beds are utilized for all age groups requiring hospitalization.

1.6 **ADMISSION INFORMATION**

A patient will not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. The admitting practitioner is also responsible for providing the following information concerning a patient to be admitted: any source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

1.7 **TIMELY VISITATION AFTER PATIENT ADMITTED**

The attending practitioner or his/her designee (i.e., another member of the staff in good standing with the requisite privileges to care for the patient) must see the patient within 24 hours of admission.

PART TWO: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 **ASSIGNMENT TO SERVICE**

All patients are assigned to the service concerned with the treatment of the problem or disease which necessitated admission.

2.2 **ATTENDANCE OF PATIENTS**

A patient requesting admission who has no attending physician shall be referred to the physician on duty in the emergency room for an emergency problem, otherwise the patient will be provided with a list of medical staff members available.

PART THREE: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 **GENERALLY**

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 those portions of the medical record for which he/she is responsible, for necessary special instruction, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is affected pursuant to Section 3.2.

3.2 **TRANSFER OF RESPONSIBILITY**

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet, progress notes, and transfer forms.

3.3 **ALTERNATE COVERAGE**

Each practitioner must assure timely, adequate professional care for his/her patients in the hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. Each member of the staff who will be out of town or unavailable in case of emergency must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. In the absence of such designation, the chief executive officer, the chief of staff or the applicable department medical advisor has the authority to call any member of the staff with the requisite clinical privileges. Failure of an attending practitioner to meet these requirements may result in loss of staff membership or such other disciplinary action, as the medical executive committee deems appropriate.

3.4 **OBTAINING NECESSARY ASSISTANCE/RESOLVING QUESTIONS OF CARE**:

The medical staff recognizes its responsibility to provide immediate/timely intervention when an attending or responsible physician is not available or does not respond to nursing or staff requests for patient care assistance. The medical staff also recognizes the need to respond when the quality or appropriateness of care being provided to a particular patient is questioned. The purpose of medical staff intervention is to assure that necessary care is provided and that preventable adverse patient outcomes are avoided.

If a nurse or other healthcare professional determines that intervention is necessary, it shall be brought to the attention of the immediate supervisor whose responsibility is to make appropriate referral to medical staff leadership, i.e., physician service medical advisor within which the practitioner has clinical privileges and/or the chief of the medical staff. Medical staff leadership consulted in these matters is expected to respond in a timely manner. The responding practitioner has authority to review relevant patient information and to act as a consultant or call for a consultation.

It is the responsibility of the responding practitioner to apprise the medical staff executive committee of the intervention. It is the responsibility of the committee to examine the necessity and adequacy of the intervention and the circumstances, which made it necessary. This examination will assist in the evaluating of the system, which has been provided, and in identifying and responding to physician practice problems.

The authority to return the responsibility for the medical care and treatment of the patient back to the original practitioner rests with the medical staff executive committee.

3.5 ALLIED HEALTH PROFESSIONALS

Allied health professionals may treat patients under the conditions provided in Section 8 of the Medical Staff Bylaws and in Section 1.2-3 of these Rules and Regulations. Each allied health professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he/she provides to the patient.

More specifically, oral surgeon, dentist and podiatrist members of the staff are responsible for the following:

a) A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery.

b) A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis.

c) A complete operative report, describing the findings, technique, specimens removed and postoperative diagnosis.

d) Progress notes as are pertinent to the dental/podiatric condition.

e) Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge.

f) Clinical resume or final summary note.

3.6 CONSULTATIONS

3.6.1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated or required pursuant to the guidelines in Section

3.5-2 below. Judgement as to the serious nature of illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the chief of staff or the Executive Committee for action. When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, call or contact the consulting physician, the applicable physician advisor of the department or the chief of staff.

3.6.2 **GUIDELINES FOR CALLING CONSULTATIONS**

Unless the attending practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician is encouraged in the following cases:

a) Any patient known or suspected to be suicidal.

b) When these Rules or the Rules of the clinical unit of the staff require it.

c) Problems of critical illness in which any significant question exists of appropriate procedure or therapy.

d) When there is a question of relating to the risk versus benefit of an operation or treatment.

e) Cases of difficult or equivocal diagnosis or therapy.

f) If required by state law.

g) When requested by the patient or family.

3.6.3 **QUALIFICATIONS OF CONSULTANT**

Any qualified practitioner may be called as a consultant regardless of his/her staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

3.6.4 **DOCUMENTATION**

a) Consultation Request: When requesting consultation, the attending practitioner should indicate in writing on the medical record the reason for the request and the extent of involvement in the care of the patient expected from the consultant, e.g., "for consultation and opinion only," "for consultation, orders, and follow-up re a particular problem."

b) Consultant's Report: The consultant must make and sign a report of his/her findings, opinions and recommendations that reflects an actual examination of the patient and the

medical record. Such report shall become part of the patient's medical record.

c) Attending Practitioner's Response to Consultant's Opinion: In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, he/she shall either seek the opinion of a second consultant or record in the progress notes his/her reasons for electing not to follow the consultant's advice. In cases of required consultation when the attending practitioner does not agree with the consultant, he/she shall either seek the opinion of a second consultant or refer the matter to the applicable department medical advisor. If the attending practitioner obtains the opinion of a second consultant and does not agree with it either, he/she shall again refer the matter to the applicable department medical advisor.

PART FOUR: TRANSFER OF PATIENTS

4.1 INTERNAL TRANSFER

Internal patient transfer priorities are as follows:

a) Emergency patient to an available and appropriate patient bed.

b) From obstetric patient care area to general care area.

c) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

4.2.1 TRANSFER TO ANOTHER MEDICAL CARE FACILITY

Any patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for acceptance by an appropriate physician and the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient, including a list of current medications.

4.2.2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or critically ill patient or his family or significant other (SO) is not permitted until a physician has explained to the patient or his/her family or SO the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each case, the appropriate transfer procedure must be utilized to ensure compliance with EMTALA standards. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

PART FIVE: DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

A patient may be discharged only on the order of the attending practitioner. The attending practitioner is responsible for documenting the principal procedures, and additional procedures on the face sheet of the patient's medical record on discharge.

5.2 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and shall provide the patient with explanation of risks and consequences of leaving the hospital against medical advice, if possible. The patient will be requested to sign the appropriate release form, attested by the patient or his/her legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record.

5.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he/she shall so state in writing and the statement must be made a part of the patient's medical record.

PART SIX: ORDERS

6.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be written clearly, legibly, and completely and signed by the practitioner responsible for them. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse, pharmacist, or other approved personnel. It is recommended that the physician attending to patients admitted order the admission or laboratory tests which he/she feels are appropriate, or as addressed in the Rules of the special care unit involved, for the patient.

6.2 STANDING ORDERS

Standing orders for any department or clinical unit may be formulated by the department medical advisor of the unit in consultation with the medical staff executive committee or specialty committee, i.e., surgical committee, ER committee, etc., the nursing service, and the appropriate representatives of administration. Additional standing orders may be formulated by a member of the medical staff, subject to the approval of the applicable department medical advisor and the medical staff executive committee. All standing orders shall be listed on a physician's order sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. Standing orders shall be considered as a specific order by the attending practitioner for the patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow.

6.3 VERBAL ORDERS

6.3.1 BY WHOM AND CIRCUMSTANCE

Telephone or other verbal orders may be taken only by a practitioner or a registered nurse, except that the following personnel, if approved in accordance with hospital policy, may take verbal orders for medication, treatment, and/or procedures within their respective areas of practice and which they will prepare, deliver, or perform: registered pharmacist, respiratory therapist/technician, physical therapist, certified physical therapy assistant, athletic trainer, laboratory technologist/technician, radiology technician, certified registered nurse anesthetist, occupational therapist, speech pathologist, and social worker. Telephone orders will be accepted only from the responsible practitioner and when it is not practical for the order to be given in writing.

6.3.2 DOCUMENTATION

All verbal orders shall be transcribed in the physician's order sheet in the medical record, shall include the date, time, and signature of the person transcribing the order the name of the practitioner, and shall be countersigned by the prescribing practitioner at the earliest opportunity. All verbal orders shall be read back to the prescriber.

6.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

An allied health professional (AHP) may write orders only to the extent, if any, specified in the position description developed for that category of AHPs and consistent with the scope of services individually defined for him/her.

6.5 AUTOMATIC CANCELLATION OF ORDERS

Medication orders shall be automatically stopped if not renewed at least every 30 days. All scheduled II controlled substances and all narcotics will be discontinued if not renewed every 96 hours. All medications for a patient undergoing a surgical procedure shall be automatically stopped after surgery and require further authorization from an approved prescribing practitioner for continued use.

6.6 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS

Blood transfusions and intravenous infusions must be started by the attending practitioner or by a registered nurse who has the requisite training and has been credentialed to do so in the hospital. The order must specifically state the rate of infusion. Intravenous sedation must be given by a practitioner who has been credentialed to do so.

6.7 CONSCIOUS SEDATION

Conscious sedation is a state produced by a pharmacological agent for the purpose of diagnostic and/or therapeutic procedure. The patient has a minimally depressed level of consciousness that retains the patient's ability to maintain a patent airway independently and continually and respond appropriately to physical and/or verbal stimuli.

IV conscious sedation is approved for administration in the emergency room and in the special procedure room located in surgical services. Patients outside these areas must be transferred to one of these areas if IV conscious sedation is required for proper monitoring.

Conscious sedation must be given by a practitioner who has been credentialed to do so.

6.8 SPECIAL ORDERS

6.8.1 Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending practitioner to administer the drugs. If a prescribing practitioner deems that the use of such medications is in the best interest of the patient, an order shall be written on the physician's order sheet, which specifically indicates the use of the patient's personal supply. Such orders shall include the name of the drug, strength, and dosage or instructions. Such medications should be clearly labeled or not administered until they are positively identified by the managing practitioner, an on-call physician, or registered pharmacist. Medication brought in and not used during the hospitalization shall be placed in the patient's locked medication drawer or a suitably secured area on the nursing unit. The medication shall be returned to the patient or family upon discharge.

6.9 FORMULARY AND INVESTIGATIONAL DRUGS

6.9.1 FORMULARY

The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary as approved by the medical staff executive committee. All drugs and medications administered to patients, with the exception of drugs for bona fide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

6.9.2 INVESTIGATIONAL DRUGS

Investigational drugs will refer to those drugs which have not yet been released by the FDA for general use. Investigational drugs are under the strict supervision of the principal investigator who shall be a member of the medical staff and who will assume the burden of securing the necessary consent. Approval for the use of investigational drugs in the hospital may be obtained from the pharmacy and therapeutics committee chairman or chief of the medical staff. The principal investigator or designee will be responsible for providing all protocol information and answering all questions regarding use of the investigational drug. Storing and dispensing of the investigational drug within the pharmacy is strongly recommended.

6.10 SPECIAL TREATMENTS/PROCEDURES

6.10.1 PROTECTIVE SAFETY DEVICES

Protective Safety Device (PSD) is defined as a device or mechanism used voluntarily to prevent injury to the patient during medical, diagnostic, or surgical interventions.

Examples of PSD include, but are not limited to, body restraint during surgery, arm restraint during IV therapy, arm restraint during endotracheal intubation, body position restraint during radiological tests, and for supportive or postural care (wheelchairs, bedrails, tabletop chairs, orthopedic appliances, etc.).

A PSD may be applied at any time deemed appropriate by the healthcare worker during medical, diagnostic, or surgical interventions. It is a temporary intervention.

6.10.2 **PATIENT RESTRAINTS**

The term "restraint" includes a physical restraint. A physical restraint is any manual method or physical/mechanical device, material, or equipment attached or adjacent to the patient's body that she/he cannot easily remove and restricts body movement. The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff. A restraint can only be used 1) if needed to improve the patient's well-being and less restrictive interventions have been determined to be ineffective, and 2) in emergency situations if needed to ensure patient or staff's physical safety and less restrictive interventions have been determined ineffective.

An order for the use of a restraint must be obtained immediately upon determining need for use. A physician assessment is needed to determine whether continued restraint is necessary. A restraint order is valid only for the number of hours the physician specified, but no longer than 24 hours. Renewals may be issued daily with physician reassessment. If the behavior that necessitated the restraint order subsides, patients may be released before the end of the period specified by the order. In the case of a restraint used for behavioral management, the order is limited to 4 hours for adults; 2 hours for children/adolescents ages 9-17. The original order may only be renewed (by phone) within these limits for up to a total of 24 hours. Restraints cannot be ordered on a prn basis.

PART SEVEN: INPATIENT MEDICAL RECORDS

7.1 **REQUIRED CONTENT**

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

a) Identification data

b) Personal and family medical histories

c) Description and history of present complaint and/or illness

d) Pain assessment and management history

e) Physical examination report

f) Diagnostic and therapeutic orders

g) Evidence of appropriate informed consent

h) Treatment provided

i) Progress notes and other clinical observations, including results of therapy

j) Final diagnosis without the use of symbols or abbreviations

k) Condition on discharge, including instructions, if any, to the patient or significant other on post-hospital care, including pain management.

7.1.1 The hospital medical records department shall be responsible for placing the following reports and documents in the medical record when appropriate:

a) Special reports, when applicable (such as, clinical laboratory, radiology, EKG, consultation, pre- and post-anesthesia, operative and other diagnostic and therapeutic procedures, etc.)

b) Pathological findings

c) Autopsy report, when available

7.2 HISTORY AND PHYSICAL EXAMINATION

7.2.1 GENERALLY

A complete history and physical examination must be recorded in the chart or dictated within 24 hours after admission of the patient. The attending practitioner must personally write an admission note also within 24 hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. The history and physical examination report must include the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient's emotional, behavioral and social status when appropriate, and all pertinent findings resulting from a comprehensive, current assessment of all body systems and a physical exam. Each instance in which a history or physical examination is not completed will be referred to the Medical Staff Executive Committee.

7.2.2 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

a) External to Hospital: If a qualified member of the hospital's medical staff has obtained a complete history or has performed a complete physical examination within thirty (30) days prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report.

b) On Prior Admission: When a patient is readmitted to this hospital within 30 days for the same or related problem, an interval history and physical examination reflecting subsequent history changes in physical findings may be use, provided the original information is readily available.

7.3 PREOPERATIVE DOCUMENTATION

7.3.1 HISTORY AND PHYSICAL EXAMINATION

Except in emergency situations or unusual circumstances, a medical history and physical examination shall be recorded on the patient's chart before an operation requiring general or standby anesthesia or any potentially hazardous procedure. Operations

requiring only local anesthesia shall have at least a progress note recorded. If, under normal circumstances, the history and physical examinations are not recorded, the procedure shall be canceled, unless the attending physician states in writing that such delay would be detrimental to the patient. Each instance in which a history or physical examination is not completed will be referred to the Medical Staff Executive Committee.

7.3.2 LABORATORY TESTS

Appropriate advance lab tests must be performed within thirty (30) days prior to admission for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia.

7.3.3 PREOPERATIVE ANESTHESIA EVALUATION

The anesthesia provider must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.4 PROGRESS NOTES

7.4.1 GENERALLY

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be written at least daily on acutely and critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem.

7.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

7.5.1 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and special procedure reports must contain, as applicable, a preoperative diagnosis, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. The complete report must be written or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner. If the report is dictated and not immediately transcribed or not written in the record immediately after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient.

7.5.2 TISSUE EXAMINATION AND REPORTS

All tissues removed at operation shall be sent to the Hospital pathologist who shall make such examination as may be necessary to arrive at a pathological diagnosis. An

authenticated report of the pathologist's examination shall be made a part of the medical record. Exceptions to sending specimens removed during a surgical procedure to the laboratory should be made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely employed, and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but are not necessarily limited to, the following:

a) Specimens that, by their nature of condition do not permit examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure.

b) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

c) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.

b) Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

e) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant.

f) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

g) Teeth, provided the number, including fragments, is recorded in the medical record.

When exemptions are not authorized because of federal or state regulations, or the Medical Staff By-Laws, Rules and Regulations, the strictest requirements shall apply.

7.6 OBSTETRICAL RECORD

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending practitioner's office or clinic record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

7.7 ENTRIES AT CONCLUSION OF HOSPITALIZATION

7.7.1 COMPLETED MEDICAL RECORD

The principal diagnosis, any secondary diagnoses, comorbidities, complications, principal procedure, and any additional procedures must be recorded in full by the attending practitioner upon discharge. The following definitions are applicable to the term used herein:

a) Principal Diagnosis: The condition established, after study, to be chiefly responsible for

occasioning the admission of the patient to the hospital for care.

b) Secondary Diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

c) Comorbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis and is thought to increase the length of stay by at least one day (for about 75% of the patients).

d) Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required and is thought to increase the length of stay by at least one day.

e) Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.

f) Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

7.7.2 DISCHARGE SUMMARY

a) In General: A discharge summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission.

b) Exceptions: Stays less than forty-eight (48) hours for non-Medicare patients, and normal OB deliveries for newborns.

7.7.3 INSTRUCTIONS TO PATIENT

The discharge summary, discharge instruction sheet, or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, pain management, medication, diet, and follow-up care. If no instructions were required, a record entry must be made to that effect.

7.8 AUTHENTICATION

All clinical entries in the patient's record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.

The following areas of the medical record require the responsible practitioner's signature:

a) All progress notes and orders

b) History and physical examination

c) Immediate pre-operative and post-operative progress notes

d) All operative or special procedure reports

e) Discharge summary

f) Narcotic orders and all other clinical entries, diagnoses, orders, reports, and progress notes personally given or written by him/her.

7.9 **USE OF SYMBOLS AND ABBREVIATIONS**

Symbols and abbreviations should be used only when they have been approved by the medical staff executive committee. An official record of approved symbols and abbreviation is available at each nursing station and the medical records department. This list will be reviewed and approved. A list of abbreviations not recommended for use by JCAHO will also be approved.

7.10 **COMPLETION AND FILING**

All patient records are to be completed within thirty (30) days of discharge. The physician will be given a written notification listing the number of charts incomplete after thirteen (13) days. If still incomplete at the end of thirty (30) days, the chart will be referred to the Medical Staff Executive Committee. Days involved in vacation or illness will not be included in the thirty (30) day period.

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the medical staff executive committee shall consider the circumstances and may enter such reasons in the record and order it filed.

7.11 **OWNERSHIP AND REMOVAL OF RECORDS**

All original patient medical records, including x-ray films, pathological specimens, and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statue, or with the permission of the chief executive officer. Copies of records, films, slides, etc. may be released in accordance with the hospital's release of information policy. Unauthorized removal of a medical record or any portion thereof from the hospital is grounds for such disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the medical staff and board.

7.12 **ACCESS TO RECORDS**

7.7.1 **BY PATIENT**

As permitted and required by state and federal laws and regulations, patients shall be permitted access to information in their medical record, including the right to obtain a copy of a part or all the record.

a) Exceptions: The only exception to this provision is the specific contraindication by the attending physician. Such contraindication shall be noted in the medical record, with supporting reasons. This statement shall specifically include that it is not in the best interest of the patient to have access.

7.12.2 **FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES**

Patient medical records shall also be made available to authorized hospital personnel, medical staff members or others with an official, hospital-approved interest for the following purposes:

a) Automated data processing of designated information

b) Activities concerned with assessing the quality, appropriateness, and efficiency of patient care

c) Clinical unit/support service review of work performance

d) Official surveys for hospital compliance with accreditation, regulatory and licensing standards

e) Approved educational programs and research studies.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.12.3 **ON READMISSION**

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner.

7.12.4 **TO FORMER MEDICAL STAFF MEMBERS**

Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.

7.12.5 **PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES**

Written consent of the patient or his/her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or by law to receive this information.

PART EIGHT: CONSENTS

8.1 **GENERAL**

Each patient's medical record must contain evidence of the patient's or his/her legal representative's general consent for treatment during hospitalization.

8.2 **INFORMED CONSENT**

8.2.1 **WHEN REQUIRED**

The performing practitioner is responsible for obtaining the patient's or his/her legal representative's informed consent of the procedures and treatments listed below:

a) Admission

b) Ambulatory Care

c) Autopsy

d) Disposal of an Amputated Limb

e) Emancipated Minors

f) Experimental Treatments

g) Emergency Room/Clinic Record

h) High Risk Therapies/Drugs

i) Invasive Procedures

j) Investigational Drugs

k) Minors

l) Observation of Surgical Procedure

m) Organ/tissue Donation

n) Physicians Not on the Medical Staff - To Examine a Patient or Administer Treatment

o) Photography

p) Release of Body to the Mortician

q) Release of Records

r) Sterilization of Either Sex

s) Surgery

t) Unconscious Patient, treatment of

u) Blood Administration

8.2.2 **DOCUMENTATION REQUIRED**

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

a) Patient identity

b) Diagnosis

c) Date when patient informed and date when patient signed the form, if different

d) Nature of the procedure or treatment proposed to be rendered

e) Name(s) of the individual(s) who will perform the procedure or administer the treatment

f) Authorization for any required anesthesia

g) Indication that the risks and consequences of the proposed care and of the alternatives available, if any, and the risks/prognosis of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment.

h) Name of the practitioner who informs the patient and obtains the consent.

8.2.3 **SIGNATURES**

An informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative) and witnessed by a legally competent third party.

8.2.4 **EMERGENCIES**

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2-1 without first obtaining informed consent as required therein, treatment may be initiated, and an informed consent obtained as soon as possible. If it is impossible to obtain timely written consent, telephone consent is permissible after all other efforts are exhausted. Such circumstances must be explained in the patient's medical record.

PART NINE: SPECIAL SERVICES UNITS AND PROGRAMS

9.1 **DESIGNATION**

Special services units and programs include, but are not limited to the following:

a) Emergency Room/Clinic

b) Operating/Post Anesthesia Recovery Room

c) Obstetrical Unit

9.2 **POLICIES**

Appropriate committees and representatives of the medical staff will develop, in coordination with applicable hospital departments, specified policies for the special services units and programs, covering, when applicable such subjects as the responsibility for care of patients in the

unit, criteria for patient admission to the unit, consultation requirements, admission/discharge, transfer protocols, direction/organization of the unit, authority of the physician medical advisor of the unit, special record-keeping requirements, scheduling of patient, etc. The policies of the various units and programs will be coordinated by the medical staff executive committee.

PART TEN: HOSPITAL DEATHS AND AUTOPSIES

10.1 HOSPITAL DEATHS

10.1.1 PRONOUNCEMENT

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

10.1.2 REPORTABLE DEATHS

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local or state law.

10.1.3 DEATH CERTIFICATE

The death certificate must be signed by the attending physician unless the death is a Medical Examiner's case in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician issues the death certificate.

10.1.4 RELEASE OF BODY

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law or state law.

10.2 AUTOPSIES

Every member of the medical staff shall be actively interested in securing autopsies whenever indicated and possible. Proper consent for an autopsy shall be in accordance with applicable state law. All autopsies shall be performed by the hospital pathologist, or by his/her qualified designee.

PART ELEVEN: INFECTION PREVENTION

11.1 CULTURES

All suspected clinically significant infections of the skin or surgical incisions shall be cultured for organism and sensitivity to the organism. Suspected infection of other organs by communicable organisms shall be cultured when practical. Cultures shall be ordered by the physician in charge of the case. The infection preventionist shall call suspected cases of infection to the attention of the attending physician. If the attending physician refuses to order a culture in such cases, this

information shall be given to the chairman of the infection prevention committee who shall then consult with the attending physician and make the final decision concerning ordering a culture.

11.2 **PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES**

Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending physician and consistent with the principles outlined in the Infection Prevention Policy and Procedure Manual of Munson Healthcare Charlevoix Hospital. The infection preventionist may call cases, which may need isolation to the attention of the attending physician. If the attending physician refuses to order isolation, this information shall be given to the chairman of the infection prevention who will consult with the medical advisor of the department involved.

11.3 **REPORTING OF INFECTIONS/COMMUNICABLE DISEASES**

All cases of infection and communicable disease must be reported to the infection prevention committee and the health department. Those found in special service units must also be reported to the medical advisor in charge of the unit. Those found in other areas of the hospital should be reported to the applicable medical advisor. Every staff member should also report promptly to the infection preventionist, infections which develop after discharge, and which might be hospital acquired.

11.4 **GENERAL AUTHORITY**

The infection prevention committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

PART TWELVE: RULES FOR SURGICAL SERVICES AND THE OPERATING AND POST ANESTHESIA ROOMS

12.1 **TIME OF ADMISSION FOR SURGICAL PATIENTS**

Patients for outpatient surgery must be instructed to report to the outpatient admitting department 60 - 90 minutes before a procedure is scheduled.

12.2 **REQUIREMENTS PRIOR TO INDUCTION OF ANESTHESIA AND OPERATION**

13.2.1 **PREOPERATIVE EVALUATION AND DOCUMENTATION**

a) Histories and Physical Examinations: Histories and physical examinations shall be completed in accordance with Section 7.2 and 7.3-l of these Rules and Regulations.

b) Preoperative Visit and Note by Surgeon: Prior to all operations, the operating surgeon shall note in the patient's record:

1) Findings from the history, physical examination, and diagnostic studies supportive of the decision to operate

2) Working diagnoses

3) Procedure anticipated

4) Anticipated risk to patient

5) That the procedure and risks were discussed with the patient

c) Preoperative Anesthesia Evaluation: The nurse anesthetist must document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experiences, any potential anesthetic problems, ASA patient status classification and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

d) Preoperative Orders and Tests: Except in cases of emergency so documented in writing by the operating surgeon, results **from** the following tests performed within the time frame indicated must be on the chart prior to the patient's transfer to the operating area in cases to be done under general, spinal or extensive regional anesthesia:

1) Suggested screening laboratory studies for asymptomatic, **healthy** patients scheduled to undergo peripheral surgical procedures involving no major blood loss are listed in the **Surgical Services Policy and Procedures manual**.

12.2.2 **CONSENT**

Surgical procedures may be performed only upon written informed consent as provided in Part Eight of these Rules and Regulations.

12.2.3 **IDENTIFICATION**

Prior to the induction of anesthesia, the individual responsible for administering anesthesia shall verify the patient's identity using two identifiers and the site and side of the body to be operated upon and ascertain that the information required under Section A-2.2-l and A-2.2-2 is in the patient's record. If the required information is not in the record, the procedure shall be canceled or postponed, unless the operating practitioner states in writing that such a delay would constitute a hazard to the patient. All such cases must be aggregated on a quarterly basis, referred to, reviewed, and acted upon as appropriate by the medical executive committee.

12.3 **ASSISTANTS AT SURGERY**

When major surgery is being performed, there shall always be an appropriately credentialed assistant scrubbed and present throughout the procedure who is capable of protecting the patient in the event of incapacity of the surgeon until a qualified surgeon can be summoned to complete the case. The primary operating surgeon shall determine the level and number of assistants required (e.g., qualified nurse or surgical technician/physician's assistant, qualified surgeon, other qualified physician) commensurate with the procedure, particular medical conditions which the patient may have which require active care during surgery, and any other exceptional circumstances present.

12.4 **TRANSPORT OF PATIENTS**

Patients are transported to the surgical suite on a cart/stretcher with side rails in place. Moving of patients within the surgical suite and in the recovery, room is under the supervision of the operating room nurse in charge of the patient's care.

12.5 **ENFORCEMENT AND INTERPRETATION**

The chief of surgery for the department of surgery is responsible for resolving all questions relating to the day-to-day enforcement of this Part and the over day-to-day functions of the operating rooms. Recommendations for changes in these policies and reports or repeated instances of non-compliance with or abuse of these policies are to be referred to and reviewed and acted upon as appropriate by the surgical committee.

12.6 **OPERATING ROOM**

12.6-1 **SCHEDULE**

Operations are scheduled for the hours of 7:00 a.m. to 4:00 p.m. Monday through Friday, except emergency cases which are done at any time. The operating room supervisor will establish and maintain the schedule.

12.6.2 **RESERVATIONS AND PRIORITY**

The attending surgeon may reserve time on the operative schedule through the operating room supervisor or said supervisor's designee. Elective procedures should be scheduled before 12:30 p.m. on the day prior to surgery. Surgeons scheduling cases first receive priority. Major operations take precedence over minor procedures on the daily schedule. Emergency cases take precedence over all other procedures and are to be performed as soon as an operating room is available. In cases of a dispute as to priority or question as to the status of a claimed emergency, the chief of surgery, or the chief of the medical staff, if the chief of surgery is involved in the dispute or questions, will resolve the issue.

12.6.3 **INFORMATION PROVIDED UPON SCHEDULING**

When scheduling an elective case, the attending surgeon or his/her designee should provide the following information:

a) Name, age and sex of patient

b) Pre-operative diagnosis and complete procedure planned

c) Names of assistant(s), if applicable, or request to the OR to assign a qualified nurse or technician

d) Type of anesthesia

e) Special preps, instruments, procedures, service, or material required

f) Anticipated length of procedure

g) Frozen sample expected

h) Physician providing history and physical

i) Patient's home telephone number

12.6.4 **STARTING TIME FOR OPERATIONS AND CANCELLATION**

All participating personnel must be present at the scheduled time of operation. A delay of 30 minutes will generally be considered sufficient to warrant cancellation of a reservation. Exceptions may be made if the surgeon has notified the operating room that he/she is delayed, and he/she will arrive in time to perform the operation within the scheduled time frame. Alternatively, a new time on the same day may be provided if it is possible to do so without interfering with the other scheduled operations. An attending surgeon who cancels an operation must give timely notification of the cancellation to the operating room and to the unit on which the patient is located.

12.6.5 **ATTIRE**

All personnel entering the operating room are to be dressed in the proper secure suits, caps, masks, boots, and personal protective equipment, i.e., gloves, goggles.

12.6.6 **TRAFFIC PATTERNS**

Operating room traffic patterns must be strictly observed. Personnel not working in the operating suite are to refrain from entering the area. The operating room supervisor is to report all violations to the surgery medical advisor and the chief executive officer.

12.6.7 **UNUSUAL EVENT REPORTING**

Any unusual or unexpected incidents occurring during an operative procedure should be reported to the operating room supervisor. This includes, without limitation, any serious break of sterile technique occurring during a procedure, equipment breakdown or failure during a procedure, instruments or material lost during an operative procedure, and like incidents including any with respect to the procedure itself.

12.7 **POST ANESTHESIA ROOMS**

The post anesthesia care unit is used to care for and observe anesthetized patients until they react, and vital signs are stable. The operating surgeon is responsible for all postoperative orders and specifying for the post anesthesia care unit nursing staff the protocol for patient care and patient status monitoring. Patients are discharged from the post anesthesia care unit only on the order of a physician or in accordance with comprehensive discharge criteria previously approved by the surgical committee and the medical staff executive committee and rigidly enforced.

PART THIRTEEN: GENERAL RULES FOR EMERGENCY CARE SERVICES

13.1 **EMERGENCY SERVICES**

13.1.1 **SCOPE OF SERVICES**

Procedures which require general anesthesia or major surgery may not be performed in the emergency service. These patients must be admitted to the hospital and scheduled for the operating room. Emergency patients who require services beyond the scope of the hospital to provide must be stabilized and referred to an appropriate institution as soon as possible.

13.1.2 **MEDICAL STAFF COVERAGE**

Medical coverage of the emergency services is provided by a rotating schedule of medical staff physicians who have approved clinical privileges to provide emergency services.

13.1.3 **TRANSFER OF PATIENTS**

Transfer of an emergency service patient to another health care agency shall be carried out in accordance with the policies stated in Section 4.2 of these General Rules and Regulations.

13.1.4 **INSTRUCTIONS TO PATIENTS DISCHARGED**

Patients seen in the emergency service who are not either admitted to the hospital or transferred to another health care facility shall be given written instructions regarding their follow-up care. The patient or significant other shall sign a receipt acknowledging delivery and understanding of the instructions. A copy of the instructions and of the signed receipt shall become part of the patient's emergency service record. The instructions must be signed and dated by the practitioner treating the patient.

13.1.5 **LEAVING AGAINST MEDICAL ADVICE**

The policies set forth in Sections 4.2-2 and 5.2 of these General Rules and Regulations shall be followed if an emergency service patient demands discharge and leaves the hospital against the advice of the attending practitioner.

13.1.6 **MEDICAL RECORD**

An accurate, legible and complete medical record shall be maintained for each patient seen in the emergency service and shall be incorporated into the patient's permanent hospital record. All prior, pertinent inpatient, emergency and outpatient care records for an emergency service patient shall be available, when requested, to the attending practitioner and other authorized personnel. The record for each emergency service visit must include at least:

a) Adequate identification data, or if not obtainable, the reason is indicated.

b) Time and means of arrival and by whom transported.

c) Pertinent history of the injury or illness and physical findings, including vital signs, and pain level.

d) Allergy history

e) Details of first and/or emergency care given the patient prior to arrival at the hospital.

f) Evidence of appropriate informed consent, or if not obtainable, the reason indicated.

g) Diagnostic and therapeutic orders

h) Treatment given

i) Clinical observations, including results of treatment

j) Diagnosis or diagnostic impression

k) Conclusion at the termination of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and instructions given to the patient and/or significant other for follow-up care.

l) Current medication list.

PART FOURTEEN: GENERAL RULES FOR OBSTETRICAL UNIT

14.1 DESIGNATION AND DIRECTION

A physician medical advisor is designated for the obstetrical care unit by the chief of staff.

14.2 RESPONSIBILITY FOR CARE

The immediate responsibility of directing medical care is that of the attending physician and his/her associates. Delegation of that responsibility may be done via written orders for transfer of services. Each patient admitted must be seen and evaluated in a timely manner. Progress notes need to be written by the attending physician or his/her qualified designee at least once per day or as dictated by the clinical course.

14.3 CRITERIA FOR ADMISSION TO THE OBSTETRICAL CARE UNIT

a) Patients are considered candidates for the OB unit if they are in active labor or have symptoms of any other acute condition pertaining to pregnancy.

b) Common candidate for admission includes:

1) All patients in active labor.

2) Planned Cesarean births.

3) Active vaginal bleeding

4) Preterm labor and/or premature rupture of membranes.

5) Acutely ill obstetric patients.

6) Patients with pre-eclampsia, eclampsia or PIH

7) Pregnant patient following trauma

8) Maternal patient with infection

9) Pregnant patient with diabetes mellitus

10) Patient with intrauterine fetal deaths or spontaneous abortions.

11) All normal and low risk neonates.

12) Neonates returning for phototherapy treatment.

c) Uncomplicated, non-infectious female surgical patients from surgical overflow.

14.4 **BED AVAILABILITY**

When it is vital to admit a patient to the OB unit and a bed is not available:

a) The nursing house supervisor is notified and extra beds outside the obstetrical department will be made available. These beds are made available as deemed appropriate for the uncomplicated post-partum patient.

14.5 **DISCIPLINARY CONTROLS**

The physician advisor of the obstetrical unit may recommend to the medical staff executive committee, disciplinary action for any physician with a pattern of violation of the letter or intent of these obstetrical unit rules and regulations.

14.6 **ORDERS**

The usage of antepartum oxytocics in the Obstetrical Department, for the purpose of induction or augmentation of labor, shall be practiced or administered only when the patient's physician is immediately available to the patient.

PART FIFTEEN: AMENDMENT

15.1 **AMENDMENT**

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by the following mechanism:

a) Proposed changes in the Rules and Regulations shall be presented at a regular meeting for discussion.

b) Action on such changes shall not be taken until the next regular meeting, at which time the proposed change or changes may be amended by a two-thirds vote of the total membership of the Active Medical Staff.

c) Such amendments shall become effective when approved by the Board of Directors.

PART SIXTEEN: ADOPTION

16.1 **MEDICAL STAFF**

These Medical Staff Rules and Regulations were recommended for adoption to the Active Medical Staff by the Medical Staff Executive Committee on October 19, 2021.

These Medical Staff Rules and Regulations were approved by the Active Medical Staff on November 2, 2021.

These Medical Staff Rules and Regulations were approved and adopted on behalf of the Board of Directors on: December 7, 2021.

AMENDMENT

These Medical Staff Rules and Regulations were recommended for amendment on February 5, 2002 by the Active Medical Staff.
The Board of Directors approved these Medical Staff Rules and Regulations for amendment on February 26, 2002.

AMENDMENT

These Medical Staff Rules and Regulations were recommended for amendment on April 6, 1999 by the Active Medical Staff.
These Medical Staff Rules and Regulations were approved for amendment by the Board of Directors on April 27, 1999

AMENDMENT

These Medical Staff Rules and Regulations were recommended for amendment on February 6, 1996 by the Active Medical Staff.
The Board of Directors approved these Medical Staff Rules and Regulations for amendment on February 27, 1996.

AMENDMENT

These Medical Staff Rules and Regulations were recommended for amendment on December 5, 1995 by the Active Medical Staff.
The Board of Directors approved these Medical Staff Rules and Regulations for amendment on _____.

AMENDMENT

These Medical Staff Rules and Regulations were recommended for amendment on July 5, 1994 by the Active Medical Staff.
The Board of Directors approved these Medical Staff Rules and Regulations for amendment on October 25, 1994.

AMENDMENT

These Medical Staff Rules and Regulations were recommended for adoption to the Active Medical Staff by the Medical Staff Executive Committee on: June 22, 1993 and were approved by the Active Medical Staff on: October 5, 1993.
These Medical Staff Rules and Regulations were approved and adopted on behalf of the Board of Directors on: November 23, 1993.