UPMC MEMORIAL HOSPITAL
MEDICAL STAFF
RULES & REGULATIONS
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These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the bylaws also apply to the Rules & Regulations and proceedings hereunder.

**ARTICLE I**

**CLINICAL DEPARTMENTS**

1.1 Department of Anesthesiology
1.2 Department of Cardiovascular Medicine
   1.2(a) Cardiac and Thoracic Surgery
   1.2(b) Cardiac Electrophysiology
   1.2(c) Interventional Cardiology
   1.2(d) Non-interventional Cardiology
   1.2(e) Vascular Surgery
1.3 Department of Emergency Medicine
   1.3(a) Observation Medicine
1.4 Department of Family Practice
   1.4(a) Family Practice
   1.4(b) Pediatrics
   1.4(c) Neonatology
1.5 Department of Medicine
   1.5(a) Allergy
   1.5(b) Dermatology
   1.5(c) Endocrinology
   1.5(d) Gastroenterology
   1.5(e) Hematology/Oncology
   1.5(f) Infectious Diseases
   1.5(g) Internal Medicine
   1.5(h) Neurology
   1.5(i) Nephrology
   1.5(j) Psychiatry
   1.5(k) Pulmonary
   1.5(l) Rheumatology
1.6 Department of Obstetrics & Gynecology
   1.6(a) Gynecologic Oncology
   1.6(b) Gynecologic Surgery
   1.6(c) Obstetrics
   1.6(d) Urogynecology
1.7 Department of Orthopedic Surgery
   1.7(a) Orthopedic Surgery
1.7(b) Physiatry
1.7(c) Podiatry

1.8 Department of Surgery
1.8(a) Colon and Rectal Surgery
1.8(b) General Surgery
1.8(c) Neurologic Surgery
1.8(d) Ophthalmologic Surgery
1.8(e) Oral and Maxillofacial Surgery
1.8(f) Otorhinolaryngologic Surgery
1.8(g) Pathology
1.8(h) Pediatric Surgery
1.8(j) Plastic and Reconstructive Surgery
1.8(k) Trauma Surgery
1.8(l) Urologic Surgery

1.9 Department of Radiology
1.9(a) Nuclear Medicine
1.9(b) Diagnostic Radiology
1.9(d) Interventional Radiology
1.9(e) Radiation Oncology
ARTICLE II
ADMISSION & DISCHARGE OF PATIENTS

2.1 ADMISSION OF PATIENTS

The admission policy is as follows:

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

2.1(b) A patient may be admitted to the hospital only by an attending member of the Medical Staff. The privilege to admit shall be delineated, and is not automatic with Medical Staff membership. All practitioners shall be governed by the admitting policy of the hospital. Physician assignment of patients within services shall be on a rotational basis.

2.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.

2.1(d) Emergency Department physicians who are board certified in emergency medicine by the American Osteopathic Board of Emergency Medicine or the American Board of Emergency Medicine are not required to maintain BLS, ACLS or PALS certification. Board Eligible Emergency Department Physicians and allied health professionals assigned to the Emergency Department shall be required to maintain documentation regarding current BLS, ACLS and PALS certification.

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

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

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

(2) The Chief of Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or
(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the President to provide care for the patient.

2.2. **ADMITTING POLICY**

Priorities for admission are as follows:

2.2(a) **Emergency Admissions**

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

2.2(b) **Preoperative Admissions**

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

2.2(c) **Routine Admissions**

This will include elective admissions involving all services.

2.2(d) **Question of Validity**

If any questions as to the validity of admission to the facility should arise, the subject shall be referred to the Chief of Staff for assistance.

2.3 **PATIENT TRANSFERS**

2.3(a) Transfer priorities shall be as follows:

1. Emergency Department to appropriate patient bed;
2. From any department to CCU in an emergency;
3. From CCU to the operating room or other procedure area in an emergency;
4. From any department to Skilled Nursing Facility;
5. From obstetric patient care area (unit) to general care area when medically indicated; and
6. From temporary placement in an inappropriate area to the appropriate area for that patient.
2.3(b) No patients will be transferred between departments without notification to the Attending Physician.

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

2.4 SUICIDAL PATIENTS

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

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

2.4(b) The hospital social worker should be consulted for assistance; and

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

2.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

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

2.5(b) If any questions as to the validity of discharge from the facility should arise, the subject shall be referred to the Physician Advisor for assistance.

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

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

(2) Estimate of additional length of stay the patient will require; and
(3) Plans for discharge and post-hospital care.

Upon request of the Utilization Management Committee or other committee responsible for case management, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within a reasonable period of time. Failure to comply with this policy will be brought to the attention of the MEC for action.

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

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

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

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

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

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

2.6 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the Attending Physician, another member of the Medical Staff, the Emergency Department Physician or the medical examiner, as appropriate. Such pronouncement shall be documented in the patient’s medical record.

2.7 AUTOPSIES

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with applicable state regulations governing the performance of autopsies by the Medical Examiner/Coroner. If an autopsy is indicated, the Attending Physician should request permission from the family or guardian for a complete or limited autopsy. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record. Autopsies to be performed by the medical examiner/coronor shall be governed by applicable state law.
2.8 **UNANTICIPATED OUTCOMES**

In the event of an unanticipated outcome or adverse event, the patient’s treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital’s Never Events Policy.
ARTICLE III
MEDICAL RECORDS

3.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

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

3.2 ADMISSION HISTORY

The requirements for admission, history and physical examinations are as outlined in the Medical Staff Bylaws, Article III, Medical Staff Membership, Section 3.3(n).

3.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam containing the information outlined in Section 3.3(n) of the Medical Staff Bylaws must be recorded before all surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient. When a history and physical examination, pertinent laboratory, x-ray and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the Attending Physician documents that such delay would be a threat to the patient’s health.

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

3.4 PROGRESS NOTES

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

3.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within twenty four (24) hours after completion of surgery. An operative progress note must be entered immediately, and before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

3.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation in those circumstances outlined in the mandatory consultation policy of this hospital. Consultations shall be obtained through written order of the Attending Physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

3.7 OBSTETRICAL PATIENT HISTORIES

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

3.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of rubber stamp signature is not acceptable under any conditions.

Notwithstanding anything contained herein, all orders for medications and all other services shall be documented using an electronic system that supports clinical decision-making when that electronic system is available for use at the Hospital. Such electronic system, when available, will be accessible at the point of care and remotely, through a secure process. Electronic system orders shall be authenticated through the use of an electronic-signature process consistent with applicable legal and accreditation requirements and as specified in these Rules & Regulations and hospital policy.
3.9 **ABBREVIATIONS/SYMBOLS**

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

3.10 **FINAL DIAGNOSIS**

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

3.11 **REMOVAL OF MEDICAL RECORDS**

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

3.12 **ACCESS TO MEDICAL RECORDS**

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

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

Persons not otherwise authorized to receive medical information shall require written consent of the patient, his/her guardian, his/her agent or his/her heirs.

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

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.
3.13 **PERMANENTLY FILED MEDICAL RECORDS**

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

3.14 **ORDERS**

3.14(a) **Written/Verbal/Telephone Treatment Orders:** Orders for treatment shall be in writing, dated, timed and authenticated. Except for CRNAs in states that have opted out of the CMS supervision requirement, orders for treatment and care of patients may not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician.

Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to a qualified person. A qualified person shall be defined as: Registered Nurse or a Graduate nurse being supervised by a Registered Nurse. The following are defined as Qualified Persons who may accept verbal orders relating to their area of practice: Licensed Practical Nurse approved to administer medications (successfully completed the PinnacleHealth Memorial Hospital Educational Resources Medication Examination); Registered physical, occupational and speech therapists; respiratory therapist; pharmacist (drugs only); Registered Cardiovascular Invasive Specialist (RCIS); paramedic practicing under § 117.30 (relating to emergency paramedic services) and CRNAs. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than twenty-four (24) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

Verbal orders will generally not be accepted for chemotherapy drug orders, investigational drug, device or procedure protocols, orders to withhold (including Do Not Resuscitate orders) or withdraw life support. Withdrawing of life support will only be implemented with an order written and authenticated by the prescribing practitioner AND in accordance with applicable hospital policies regarding advanced directives.

Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by the physician as prescribed in Article III, Section 3.2 of these Rules & Regulations.
3.14(b) Standing and Preprinted Orders and Order Sets:

(i) Standing Orders: In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed annually by the physician and the Utilization Management Committee. Standing orders shall be dated and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

(ii) Evidence Based Order Sets: Use of preprinted and electronic order sets that are consistent with nationally recognized and evidence-based guidelines will be permitted in this facility subject to approval by the Medical Staff as outlined below. The Medical Staff delegates to the Medical Executive Committee the responsibility for approval of Evidence-Based Order Set templates, in consultation with nursing and pharmacy leadership. Evidence based order set templates shall be periodically reviewed to determine the continuing usefulness and safety of the orders, and may be updated from time to time in order to track regulatory agency requirements, patient safety requirements, and other appropriate changes. The Medical Staff delegates to the Medical Executive Committee in consultation with nursing and pharmacy leadership the responsibility for approving all updates. All such orders shall be dated, timed and authenticated in the patient’s medical record pursuant to the requirements of these Rules and Regulations by the ordering practitioner or another practitioner responsible for the care of the patient and authorized to write orders by Hospital policy and state law.

3.14(c) Previous Orders: All previous orders are canceled when patients go to surgery.

3.14(d) Illegible Treatment Orders: The practitioner’s orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3.15 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within seven (7) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending. Observation cases require a discharge note.
3.16  **DELINQUENT MEDICAL RECORDS**

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his/her incomplete medical records every seven (7) days. At the fourteenth (14th) day for any incomplete medical records, the letter will include a warning that the record(s) will be delinquent at twenty-one (21) days and the physician’s privileges will be suspended if any records become delinquent.

3.16(a) **Suspension.** A chart which is not completed within twenty-one (21) days of discharge will trigger suspension of the responsible physician’s privileges. When a staff member is notified of suspension, the staff member may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner’s or other Attending Physician’s name. Any exceptions must be approved by the Chief of Staff and the President.

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

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

3.16(d) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the MEC for further action.

3.17  **ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES**

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

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

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.
3.18 CLOSING OR RETIREMENT OF AN INCOMPLETE MEDICAL RECORD

It is the policy of PinnacleHealth Memorial Hospital that all medical records are to be completed timely, in accordance with applicable regulations. In any case wherein an incomplete medical record becomes delinquent, and the hospital has diligently pursued reasonable efforts to facilitate the completion of the record(s) by the provider(s) concerned, the HIM Director will execute the procedure established in this policy in order to close the record(s).

3.18(a) The HIM Director will notify the provider(s) concerned of all incomplete medical records and make arrangements for the completion of the record(s).

Note: Services provided/ordered must be authenticated by the rendering/ordering provider.

(i) If the record(s) is/are electronic and the provider(s) can still be contacted, the incomplete portions of the electronic record(s) will be printed and sent to the provider(s) by registered mail for completion. A prepaid return envelope will be included and the provider(s) will be asked to return the completed record(s) within 72 hours of receipt. Electronic access can be reinstated to the Electronic Medical Record if the system concerned has the functionality to place the incomplete record in an External Review Queue.

3.18(b) For hospital record(s) that cannot be completed, or have not been completed within 30 days after becoming delinquent, the HIM Director will notify the Medical Executive Committee (MEC) or Chief of Staff (CoS). The MEC and CoS will be provided information detain the number of attempts and action(s) taken to have the provider complete the record.

3.18(c) The MEC or Chief of Staff will review the HIM Director’s request to close the record(s). The MEC’s approval/disapproval of the request and any additional actions directed will be recorded in the committee’s minutes. If approved, the MEC or CoS will complete the Administrative Closure for Incomplete Medical Record form.

3.18(d) The Administrative Closure for Incomplete Medical Record form will be scanned into the Electronic Medical Record system.

3.18(e) The Administrative Closure for Incomplete Medical Record form will be a permanent document in the medical record.

3.18(f) The HIM Director will close the encounter, if the record is electronic.

3.19 ADMINISTRATIVE CLOSURE OF CPOE

In a case where a Computerized Physician Order Entry (CPOE) order must be administratively closed in the patient record, the Health Information Department must follow this policy.

The need to close CPOE record administratively may be due to:

- Death of clinician
- Duplicate order
- Chose wrong communication type
- Patient discharge before order was voided
- Miscellaneous physician
• Serious illness of the physician
• Departure from the area of the physician
• Retirement or resignation of the physician

3.19(a) Upon validating the need to close the CPOE record, the HIM Director will complete the Administrative Closure for Incomplete CPOE form. Once the form is complete with all required signatures, HIM will scan a copy of the form into the medical record.
ARTICLE IV
GENERAL CONDUCT OF CARE

4.1 GENERAL CONSENT FORM

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

4.2 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed on the hospital formulary. Drugs and medications not on the formulary may be approved for dispensing as outlined in hospital policy. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC. The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

4.3 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e., ex bient patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Medications ordered to be “held” will be discontinued after twenty-four (24) hours in the absence of a “resume” order. The physician must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.
4.4 AUTOMATIC STOP ORDERS

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotic Surgical Prophylaxis</td>
<td>48 hours</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>7 days</td>
</tr>
<tr>
<td>Sedatives, Hypnotics</td>
<td>7 days</td>
</tr>
<tr>
<td>Anticoagulants (Exempt: Aq. Heparin SQ prophylactically)</td>
<td>7 days</td>
</tr>
<tr>
<td>Narcotics</td>
<td>7 days</td>
</tr>
<tr>
<td>Oxytocis</td>
<td>24 hours</td>
</tr>
<tr>
<td>Oral</td>
<td>One time</td>
</tr>
<tr>
<td>Inj</td>
<td></td>
</tr>
<tr>
<td>Antineoplastics</td>
<td>According to protocol or 5 days</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>30 days</td>
</tr>
</tbody>
</table>

All other medications shall have a stop date of 30 days. Physicians will be notified within 48 hours before an order is automatically discontinued.

4.5 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he/she shall call this to the attention of his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

4.6 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the attending physician or his/her designated alternate at least daily and more frequently if their status warrants. Patients admitted to Critical Care and Medical/Surgical Floor should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than six (6) hours after admission or sooner if warranted by the patient’s condition. Allied Health Professionals such as physician assistants or advance practice nurses with appropriate privileges may round on patients as a supplement to, but not in lieu of, daily rounding by the attending licensed independent practitioner.

4.7 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.
4.8 **PATIENT RESTRAINT ORDERS**

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

4.9 **PRACTITIONERS ORDERING TREATMENT**

When a practitioner who is not a member of the Medical Staff orders treatment (i.e., home health, cardiac rehabilitation, physical therapy, chemotherapy), licensure, NPI number (including specialty) and Medicare/Medicaid eligibility will be verified. In addition, it will be confirmed that the practitioner is ordering within his/her scope of practice.

4.10 **MEDICATION RECONCILIATION PHYSICIAN ACCOUNTABILITY**

4.10(a) Definition:

Medication Reconciliation. A formal process of obtaining a complete and accurate list of each patient’s current home medications, including name, dose, frequency and comparing the physician’s admission and/or discharge orders to that list. Medication Reconciliation is a team activity that includes physicians, nurses and pharmacy staff. Discrepancies are brought to the attention of the physician and, if appropriate, changes are made to the orders.

4.10(b) Admission. A patient’s medications will have been reconciled if all medications listed in the history and physical are complete and accurate and have been actively continued, discontinued, held or changed at admission.

4.10(c) Discharge. A patient’s medications will have been reconciled if all medications currently active, as well as the reconciled admission medication list have been actively continued, discontinued, held or changed at discharge. Discharge reconciliation must also include:

- A plan to address home medications that were subject to a formulary change while in the Hospital.
- Provision of the list of medications to be taken after discharge to the patient.
- Provision of the list of medications to be taken after discharge to the next provider of care (if known).

4.10(d) Medication. For purposes of reconciliation, a medication is defined as any prescription drug, over the counter drug or herbal remedy, complementary and alternative medications, nutritional supplements and dietary supplements.

4.10(e) Attending Staff Physician. Primary care or sub-specialty physician in charge of the overall care of a hospitalized patient and who is responsible for coordinating care of the
patient and seeking appropriate consultations for patients being seen by inpatient or outpatient services.

4.10(f) Admitting Physician. Staff physician (primary care or sub-specialty) who makes arrangements to admit and admits a patient to the hospital for care. The admitting physician may or may not be the attending staff physician and may be responsible for the patient’s care throughout the hospitalization (e.g. surgery) or may be providing coverage for another physician who is the primary physician for the patient (night, weekends, holidays).

Purpose:

The purpose of this policy is to standardize the accountabilities of physicians, nurses and pharmacy staff at each point in the medication reconciliation process. By having standardized policies related to medication reconciliation whenever possible, redundancies in processes will likely be reduced.

Policy:

PinnacleHealth Memorial Hospital is dedicated to providing a care strategy that promises high reliability of patient care that is consistent, safe, timely and effective. Physician review of medications at transition points meld with the high reliability care that PinnacleHealth Memorial Hospital is engaged in.

Unless otherwise specified, the attending physician has primary accountability for medication reconciliation functions as outlined in the procedures (below). This accountability may be delegated to another physician or licensed independent provider. The complexity of the patient, the medical condition(s) and/or patient should determine whether or not this function should be delegated.

The following are defined transition points that are changes in level of care requiring Medication Reconciliation along with corresponding accountable physicians:

A. Admission and Discharge Medication Reconciliation. The attending physician is responsible for the reconciliation. In post-operative settings, the surgeon is the first choice for reconciling medications post-operatively and at discharge. In situations where the patient is co-managed by two or more physician specialties, the responsibility for medication reconciliation should fall to that physician specialist who manages the majority of the patient’s medications.

Procedure:

A. General physician responsibilities include:
   1. Final approval and sign off of medications to be administered.
   2. Primary and sometimes secondary review of medications for appropriateness, as well as interactions with the care being provided.
   3. Assist with gathering of current medication information (history).
   4. Assist with patient education.
B. General nursing responsibilities include:
   1. Assist with medication list information gathering (history).
   2. Assist with compilation of patient information, including transfer information and medication reconciliation and appropriate hand-off communication.
   3. Discharge education, including providing the patient with a list of medications to take after discharge.

C. General pharmacy responsibilities include:
   1. Review of appropriateness of medications, dose, redundancies and drug interactions.

D. Responsibilities of all clinicians include:
   1. Understanding the interactions of the care they provide and the medications the patient is taking.
   2. Communicating the medication list to the next provider of care.

4.11 ELECTRONIC HEALTH RECORD POLICY

4.11(a) Purpose

The purpose of this policy is to provide guidance regarding Medical Staff (MS) and Allied Health Professional (AHP) Staff training, usage standards, HIPAA and security compliance, and adoption of the Electronic Health Record (EHR).

4.11(b) Policy

In accordance with a facility approved training program, education pertaining to proper use of the clinical information systems will be a prerequisite to security and maintaining privileges. All MS and AHP are required to complete an introductory educational course as well as required ongoing competency training and evaluations of all EHR modules pertaining to workflow. Failure to complete the initial required training, or failure to complete any updates concerning their workflow by the published deadlines for such training will results in the suspension of clinical privileges until such training is completed. This suspension will apply to any and all activities within the hospital. These activities will include:

- Admitting patients
- Provider services in the emergency department
- Rounding on patients as an attending or consulting provider
- Providing call coverage
- Performing surgical procedures
- Submitting orders in written, verbal or telephone formats
- Admitting under a partner’s or other attending provider’s name

Any surgeries scheduled to take place subsequent to suspension shall be postponed until training is completed. Any exceptions must be approved by the Chief of Staff and the President. The suspended Staff member is obligated to provide
to the hospital President and the Chief of Staff the name of another provider(s) who will take his/her call, emergency room coverage, consultations, and any other services the suspended MS/AHP is privileged to provide. All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

All suspensions concerning this policy will be reported to the Medical Staff Office and to the Medical Executive Committee.

The HIM Director must be contacted prior to re-enabling the practitioner’s access to the EHR.

MS/AHPs who provide patient care averaging less than one patient per month may request the assistance of an experienced user. This request should be made at least 48 hours prior to their anticipated need for access to the EHR whenever possible, and should be directed to the Medical Staff Office.

The MS/AHP will be expected to comply with HIPAA regulations and all hospital policies. He/she will not share passwords and will be required to designate a reason for accessing patient charts where there is no prior relationship and be subject to any and all penalties addressing inappropriate access. The hospital will conduct periodic audit trail reviews and report discrepancies to the compliance department. In regards to remote access for the clinical information systems, MS/AHPs will be responsible for educating their office staffs to HIPAA and privacy requirements. Any breaches, security incidents, and/or unauthorized uses of the clinical information systems shall be reported promptly to the Chief Information Officer.

Only Medical/AHP Staff holding clinical privileges and their office staff will have access to the electronic chart. The Medical Staff Office will regularly update the appropriate departments regarding Staff and accurate medical group listings. The Medical Staff Office will also regularly inform the appropriate departments of Staff who no longer have clinical privileges. There will be a 30 day period after a Medical/AHP Staff member leaves the medical staff to electronically sign any outstanding deficiencies. Office staff access to the EHR will be suspended at the time any associated Staff member loses access if there are no remaining MS/AHP from the same clinic or medical office.

When CPOE is available, electronic order entry will be a condition of securing clinical privileges and re-credentialing. Remote access to order entry will be available. Written orders will not be allowed except during periods of downtime. Units where CPOE has not yet been activated will continue to use their current paper based ordering process.

Verbal orders will only be permitted if the Medical Staff member is involved in an emergent situation, is gloved, or is otherwise occupied with a clinical procedure.

Texting of orders is not allowed.
A scribe* may not write orders nor take verbal orders. Medical Staff are not to share their password with scribes. To do so will be considered a violation of this policy. Scribes may enter information into a patient’s EHR. Medical Record deficiencies will be resolved within the EHR per hospital policy.

Medical Record activities during EHR downtime are governed by hospital downtime policy.

*Definition: Scribes are unlicensed persons hired to enter information into the patient’s chart or electronic medical record at the direction of a licensed physician.

4.12 PRESCRIPTION DRUG MONITORING PROGRAM

Procedure

1.1 All PA licensed prescribers are required to register with the Pennsylvania Prescription Drug Monitoring Program Portal (PA PDMP AWARxE)

1.2 All PA licensed prescribers are required to query the system:

   (a) For each patient, the first time the patient is prescribed a controlled substance by the prescriber, for purposes of establishing a baseline and a thorough medical record; or

   (b) If a prescriber believes or has reason to believe that a patient may be abusing or diverting controlled substances, or

   (c) Each time a patient is prescribed an opioid drug product or benzodiazepine by the prescriber.

1.3 The prescriber shall indicate the information obtained from the PDMP database in the patient’s medical record if:

   (a) the individual is a new patient; or

   (b) the prescriber determines a drug should not be prescribed or furnished to a patient based upon the information from the database

1.4 Prescribers may query the database for:

   (a) an existing patient; and

   (b) prescriptions written using the prescriber’s own Drug Enforcement Agency number.

1.5 Exceptions to the Querying Requirement for Prescribers:
(a) if a patient has been admitted to a licensed health care facility or is in observation status in a licensed health care facility, the prescriber does not need to query the system after the initial query required under the law as long as the patient remains admitted to the licensed health care facility or remains in observation status in a licensed health care facility.

(b) health care practitioners who are providing medication to a patient in the course of treatment while the patient is undergoing care in an emergency department are not required to query the system.

1.6 Prescribers are required to give patients notice that information regarding prescriptions for controlled substances is being collected by the program and that the patient has a right to review and correct information being collected.

1.7 A prescriber will not qualify as a “dispenser” as defined by the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act if the quantity dispensed is limited to an amount adequate to treat the patient for a maximum of five days and does not allow for a refill.
GENERAL RULES REGARDING SURGICAL CARE

5.1 RECORDING OF DIAGNOSIS/TESTS

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

5.2 ADMISSION OF DENTAL CARE PATIENT

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

5.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

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

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

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

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

(5) To provide a clinical summary.

5.2(b) Physician's Responsibilities

The responsibilities of the physician are:

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

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

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

5.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and a physician member of the Medical Staff.
5.3 **ADMISSION OF PODIATRIC PATIENTS**

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

5.3(a) **Podiatrist's Responsibilities**

The responsibilities of the podiatrist are:

1. To provide a detailed podiatric history justifying hospital admission;
2. To provide a detailed description of the podiatric findings and a preoperative diagnosis;
3. To complete an operative report describing the findings and technique. All tissue shall be sent to the hospital pathologist for examination;
4. To provide progress notes as are pertinent to the podiatric condition; and
5. To provide a clinical summary.

5.3(b) **Physician's Responsibilities**

The responsibilities of the physician are:

1. To provide medical history pertinent to the patient's general health, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;
2. To perform a physical examination to determine the patient's condition, which shall be on the patient's chart prior to anesthesia and surgery; and
3. To supervise the patient's general health status while hospitalized.

5.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and Physician.

5.4 **INFORMED CONSENT**

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

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

5.5 PATIENT REQUESTS AND REFUSAL OF TREATMENT

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

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

5.6 EXAMINATION OF SPECIMENS

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

5.7 ELECTIVE SURGERY SCHEDULING

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

5.7(a) Standing Time:

7:30 a.m.

5.7(b) Priority Cases shall include:

(1) Cesarean section;

(2) Open bone work;

(3) Latex allergic patients; and

(4) Contaminated cases last, if possible.
5.7(c) **Scheduling of Cases:**

(1) Elective surgery should be scheduled by **10:00 a.m.** the previous day;

(2) All cases must be scheduled with Operating Room Staff;

(3) All cases must be taken in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-existing priority cases;

(4) If a scheduled case is canceled, the schedule will be moved up to fill the vacancy. New cases will not replace the canceled case. Any other case scheduled by the same surgeon will be added to the end of the schedule.

(5) If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified and consent to the change; and

(6) The start time for a surgery shall be deemed to be the time of incision or invasion. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will then follow other scheduled cases. If the surgeon is more than fifteen (15) minutes late, the OR Supervisor will attempt to contact the surgeon and ascertain when he/she will be available. If the surgeon will not be available within a reasonable period of time, the next scheduled surgery shall commence and the case will be moved to the end of the schedule.

5.7(d) Preoperative workup is as deemed appropriate.

5.8 **POST-OPERATIVE EXAMINATION**

For all outpatient surgery patients discharged from recovery room to home, a post operative examination will be conducted by the surgeon.

5.9 **ANESTHESIA**

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (including deep sedation), regional anesthesia, and general anesthesia. For purposes of this Section, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

5.9(a) Anesthesia services throughout the hospital shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services shall be an Active member of the Medical Staff. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.
5.9(b) The hospital shall maintain policies and procedures governing anesthesia services provided in all hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

5.9(c) Only credentialed and qualified individuals as defined in the policies and procedures of the hospital may provide anesthesia services. The Department of Anesthesia shall approve credentialing guidelines consistent with federal regulations and accreditation standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

Certified registered nurse anesthetists (CRNAs) must provide care under the supervision of a licensed physician. The supervising physician must be physically present in the hospital while such care is provided. It is expected that the supervising physician shall be an anesthesiologist certified by the American Osteopathic Board of Anesthesiology or the American Board of Anesthesiology. If an anesthesiologist cannot provide supervision, such supervision shall be provided by the operating physician or obstetrician. Such supervision by the operating physician shall take place only in an emergency situation and shall not be the routine for the provision of anesthesia services at PinnacleHealth Memorial Hospital.

When supervision of CRNA administering anesthesia services by a practitioner other than an anesthesiologist is required, doctors of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care. Dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law may supervise the qualified CRNA in the administration of regional anesthesia and monitored anesthesia care.

Except when made impractical by the existence of an emergency situation, the CRNA may not induce general anesthesia or sedation until the supervising anesthesiologist or supervising physician has reviewed the pre-anesthetic evaluation and formulated or concurred with the anesthetic plan. The anesthesiologist or supervising physician shall be present in the operating room before the anesthetist may induce anesthesia. The CRNA must ensure that an anesthesiologist is present in the operating room suite while the CRNA performs spinal, epidural or other major regional anesthesia. The CRNA must consult with the anesthesiologist or operating physician prior to administering blood products.

5.9(d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the hospital. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, this record shall include a pre-anesthesia evaluation, an intraoperative record, and a postanesthesia evaluation.
Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthetist or anesthesiologist will reevaluate and document the patient’s condition immediately before administering moderate or deep sedation or anesthesia, as such terms are defined by the accreditation standards.

The individual who administered the patient’s anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital, must also perform a postanesthesia evaluation of the patient and document the results of the evaluation no later than forty-eight (48) hours after the patient’s surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than forty-eight (48) hours, as addressed in hospital policies and procedures. For those patients who are unable to participate in the postanesthesia evaluation, a postanesthesia evaluation should be completed and documented within forty-eight (48) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

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

5.9(f) The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary. Thus, the response time for arrival of the qualified anesthesia provider must not exceed twenty (20) minutes.

5.10 **ORGAN & TISSUE DONATIONS**

The hospital shall refer all inpatient deaths, emergency room deaths, dead on arrival cases, and imminent patient deaths to the designated organ procurement agency and/or tissue and eye donor agency in order to determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

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

The attending physician, in collaboration with the designated organ procurement organization, shall determine the appropriate method of notifying the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. Any individual involved in the request for organ, tissue and/or eye donation must be formally trained in the donation request process. The patient’s medical record shall reflect the results of this notification.
ARTICLE VI
GENERAL RULES REGARDING OBSTETRICAL CARE

6.1 HIGH-RISK PEDIATRIC CARE

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

6.1(a) All cesarean sections;

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

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

6.1(d) All premature infants with complications; and

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

6.2 LABOR AND DELIVERY

Physicians providing pediatric care for newborns delivered via cesarean section or other high risk newborns are required to arrive at the Labor and Delivery Unit, as applicable, within thirty (30) minutes of initial contact regarding a cesarean delivery or other emergency condition which requires specialized pediatric or neonatal care.

6.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents to the Emergency Department, she will be assessed by the triage nurse (R.N.) to determine whether the presenting complaint is onset of labor or otherwise pregnancy-related, or a general other complaint unrelated to pregnancy. Patients presenting in labor or with pregnancy-related complaints and meeting the gestational age requirements will be transported to the Labor and Delivery Unit with qualified medical personnel. For patients presenting in labor without complications, the medical screening examination required under Article VI will be performed by a physician. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the physician concurs with the assessment of the R.N. and the patient has had prenatal care under that physician or physician’s practice. In cases where the patient has had no prenatal care and/or is unknown to the physician’s practice, or in the case of a patient presenting with complications, the on-call physician shall examine the patient prior to a discharge decision and order. For patients determined to be in active labor after this screening process is completed by the provisions of Section 7.2 regarding consultations, referrals and emergency call shall apply.
6.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

Any patient admitted directly to the Labor and Delivery Unit for onset of labor by order of her treating physician or otherwise shall undergo the screening described in Section 5.3, above. The nurse shall contact the admitting physician upon any change in the patient’s condition or deviation from the standard course of labor progression. The physician shall be required to come to the Hospital within thirty (30) minutes of being requested by the nurse to come to the Hospital due to a change in condition or deviation from the standard course of progress. A patient admitted to the Labor and Delivery Unit should be seen by the Attending Physician at any time that her condition warrants, but in any event no later than twelve (12) hours after admission.

6.5 ANESTHESIA SERVICES

Anesthesia services must be available within thirty (30) minutes after obstetric anesthesia is deemed necessary. For patients seeking vaginal birth after previous c-section, appropriate facilities and personnel, including anesthesia, will be immediately available for emergency c-section.
ARTICLE VII
EMERGENCY MEDICAL SCREENING,
TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

7.1 SCREENING, TREATMENT & TRANSFER

7.1(a) Screening

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

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

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician or, in the case of a woman in labor, a registered nurse trained in obstetric nursing where permitted under State law and Hospital policy.

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

7.1(b) Stabilization

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

(2) A patient is Stable for Discharge when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or when the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.

(3) A patient is Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient’s medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.
(4) A patient does not have to be stabilized when:

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

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

(5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual’s refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient’s refusal in the patient’s chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

7.1(c) Transfer

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

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

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

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

7.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

7.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient’s medical record.
7.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department, and that person will document the time of the contact in the patient’s medical record.

7.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the physician in the hospital;
(2) Called the physician at home;
(3) Called the physician at his/her office; and
(4) Called once on the physician’s pager.

Twenty minutes will be considered a reasonable time to carry out this procedure.

7.2(d) The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient’s request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may not refuse to respond. The Emergency Department physician’s determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the President for further action and may constitute grounds for revocation of the physician’s Medical Staff appointment and clinical privileges.

7.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient’s assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician’s office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician’s responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

7.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department as required by the Board, upon recommendation of the MEC. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital’s obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital’s ability to fulfill its obligations as outlined above.

Physicians called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, they are required to do so within
twenty (20) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within twenty (20) minutes of initial contact.

7.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligations therefore, shall be approved by the Board of Trustees and documented in writing.
ARTICLE VIII
TEACHING RESPONSIBILITY: HOUSE STAFF PATIENT CARE

8.1 All patients admitted to PinnacleHealth Memorial Hospital shall be included in the teaching program unless objected to by the patient, by the patient’s parent or guardian or by the attending physician.

8.2 All patients shall be admitted to the service of a member of the Medical Staff of PinnacleHealth Memorial Hospital regardless of ability to pay. That physician is professionally and morally responsible for the care rendered to that patient, for documentation in the medical record (countersign resident entries) and for supervision of any and all care, which may be rendered by the residents.
ARTICLE IX
MEDICAL STAFF CONFIDENTIALITY POLICY

9.1 Definitions

9.1(a) “MEDICAL STAFF INFORMATION” means:

(1) Written Medical Staff Information – all written documents maintained by or on behalf of the Medical Staff of the Hospital, including, but not limited to, all written Peer Review Information, Practitioner Files, and minutes and reports of committees and departments; and

(2) Oral Medical Staff Information – any and all discussions and/or deliberations regarding credentialing, quality assessment/performance improvement, peer review or other Medical Staff matters that take place at or on behalf of the Hospital.

9.1(b) “PEER REVIEW INFORMATION” means Medical Staff Information that relates to credentialing, quality assessment/performance improvement and peer review.

9.1(c) “PRACTITIONER FILE” means all Peer Review Information maintained in an individual practitioner’s credentials file.

9.2 Scope
This policy shall apply to all Medical Staff Information.

9.3 Delegation of Responsibilities
Whenever this policy gives a person, committee or office responsibility for a function, the person, committee (through its chair) or office (through its director) may delegate that responsibility to one or more qualified designees.

9.4 Confidentiality Principles
Confidentiality is critical to enhancing quality patient care and to legal protections for the Hospital and Medical Staff members. It is the policy of the Hospital to maintain, to the fullest extent possible, the confidentiality of all Medical Staff Information. Therefore:

9.4(a) Disclosure of Medical Staff Information is permitted on as described in this Policy.

9.4(b) Peer Review Information shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any Peer Review Information (discussions or documentation) outside of official meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities;
(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the President or by legal counsel to the Hospital.

9.4(c) Confidentiality Agreements

All individuals who are involved in Medical Staff activities – Medical Staff members, Hospital employees and members of the community who serve on the Board of Directors or on a Hospital or Medical Staff committee – will sign the confidentiality agreement approved by the Board. Medical Staff members shall sign the confidentiality agreement at the time of initial credentialing and recredentialing. Employees and community members shall sign the confidentiality agreement on an annual basis.

9.5 Location and Security

9.5(a) Minutes and Related Documents

All Medical Staff Information, including minutes and related documents and reports of Medical Staff committees and departments, shall be maintained in an orderly and easily accessible fashion in an appropriate, secure location, under the custody of the authorized Hospital employee. Minutes and related documents and reports of Medical Staff committees and departments shall be maintained indefinitely.

9.5(b) Practitioner Files

All Practitioner Files shall be maintained in an appropriate, secure location designated by the Hospital and the Executive Committee, under the care and custody of the Medical Staff Office. Practitioner Files shall be kept under lock except when the Medical Staff Office is able to monitor access in accordance with this Policy. Practitioner Files shall be retained for as long as an individual is a member of the Medical Staff and for a ten (10) year period thereafter.

9.5(c) Distribution of Peer Review Information

(1) Prior to Meetings

Peer Review Information shall not be routinely distributed to committee or department members in advance of meetings, but shall be made available for their review in an appropriate, secure location, such as the Medical Staff Office or on the Hospital’s intranet or secured internet, in accordance with the terms of this Policy.

If Peer Review Information is ever distributed prior to a committee or department meeting (e.g. detailed report of external review), that information shall be numbered or otherwise identified to ensure that all copies are retrieved and destroyed at the conclusion of the meeting, with only the originals being
kept as the official records. At the time of distribution, the information shall be accompanied by a statement informing the recipient(s) that no copies should be made and that the information must be returned at the relevant meeting.

(2) During Meetings

Peer Review Information distributed during the course of a committee or department meeting shall be numbered or otherwise identified to ensure that all copies are retrieved and destroyed at the conclusion of the meeting, with only the originals being kept as the official records.

9.6 Records of Medical Staff Committees and Departments

9.6(a) Information contained in the minutes of committee and department meetings shall be limited to the following:

(1) date and name of body that is meeting;
(2) list of those in attendance, those absent and any guests or visitors;
(3) notation as to presence or absence of a quorum;
(4) notation that minutes of the previous meeting were read and approved;
(5) identification of any individual who abstained from participation in any action taken or recommendation made;
(6) recommendations or resolutions made or action taken;
(7) a summary of the discussion (only when deemed necessary by the chair, in exceptional circumstances); and
(8) if an adverse professional review action is recommended, the specific reasons and bases for that recommendation.

9.6(b) Meetings shall not be tape-recorded or otherwise mechanically or electronically preserved unless specifically authorized by the Chief Executive Officer, the Chief of Staff or the Chief Medical Officer. If a tape recorder is used or notes are taken by the secretary to facilitate the preparation of minutes, such tape or notes shall be destroyed immediately after the official minutes are prepared, unless specifically directed otherwise by the Chief Executive Officer, the Chief of Staff or the Chief Medical Officer.

9.6(c) Minutes and reports of committees or departments shall be maintained in an especially confidential manner when they pertain to credentialing, quality assessment/quality improvement or peer review matters.
9.7 Corrections or Deletions of Medical Staff Committee and Department Records

Any corrections, deletions or omissions noted prior to the approval and adoption of Medical Staff committee or department minutes shall be made in the minutes prior to signature by the authorized Medical Staff officer. Subsequent to formal adoption of the minutes, corrections or deletions may be made only by means of an addendum to the minutes.

9.8 Access to Medical Staff Information by Individuals Performing Official Medical Staff Functions

The following individuals shall be permitted to access to Medical Staff Information to the extent described:

9.8(a) The Chief Medical Officer and other appropriate Medical Staff Office personnel shall have access to all Medical Staff Information as needed to fulfill their respective responsibilities.

9.8(b) Medical Staff officers shall have access to all Medical Staff Information to the extent necessary for the performance of their duties.

9.8(c) Members of the Medical Staff committees shall have access to the minutes and reports of the committees on which they serve and, when necessary to fulfill their responsibilities, to Medical Staff Information related to the credentialing, quality assessment/performance improvement and peer review of individual practitioners.

9.8(d) Department chairpersons shall have access to all Medical Staff Information relating to the activities of individuals seeking of exercising privileges in their respective departments.

9.8(e) Department members shall have access to the minutes (and related documents or reports) of meetings of the department to which they are assigned.

9.8(f) Consultants engaged by the Hospital to assist the Board, a Medical Staff committee, or a department shall have access to all Medical Staff Information related to the practitioner at issue.

9.8(g) The Director of Quality and other appropriate quality personnel shall have access to the minutes of all regular or ad hoc Medical Staff committee or department meetings and to any Peer Review Information necessary for performance of their functions.

9.8(h) The Board and its designees shall have access to all Medical Staff Information necessary for the performance of official functions.
9.9 Access to Medical Staff Information By Individual Medical Staff Members

A Medical Staff member may attend meetings of committees and departments and may have access to all committee and department files and minutes, including those committees and departments to which the member is not assigned, with the following exceptions:

9.9(a) the member may not attend portions of meetings and may not access Peer Review Information of individual physicians or other practitioners;

9.9(b) the member may not attend meetings of the Credentials Committee or have access to its minutes; and

9.9(c) the member may not attend meetings of the Executive Committee, but the member may have access to its minutes except to the extent that they (i) include Peer Review Information of individual physicians or other practitioners; or (ii) are otherwise determined by the Executive Committee to be confidential.

9.10 Access by Individual Medical Staff Members to Their Own Practitioner Files

General Principles

9.10(a) A Medical Staff member shall be notified and given an opportunity to review and respond in writing to any written communication concerning the individual that is prepared by a Medical Staff leader or a member of the Hospital’s administration and included in the individual’s Practitioner File. The Medical Staff member’s response shall be maintained in the Practitioner File along with the original communication.

9.10(b) In accordance with this Policy, each Medical Staff member shall also be afforded a reasonable opportunity to inspect his/her Practitioner File and make notes regarding it, in the presence of the Medical Staff Office Director, the Chief Medical Officer, an appropriate Medical Staff leader (e.g., Chief of Staff, department chairperson, Credentials Committee Chairperson), and/or the Chief Executive Officer in accordance with the terms of this Policy. In no case shall a Medical Staff member remove the Practitioner File or any portions thereof from the Medical Staff Office or make copies of it, without the express permission of the Chief Executive Officer.

9.10(c) The Chief Medical Officer, the Medical Staff Office Director or their authorized representatives shall correct or delete materials contained in a Practitioner File only after the individual has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Executive Committee and the Chief Executive Officer.
Category 1 Access

A Medical Staff member shall routinely be permitted review the following information, provided an appointment is set up with the Medical Staff Office Director:

- applications for appointment, reappointment and requested changes in staff status or clinical privileges, with all attachments;
- all information gathered in the course of verifying, evaluating or otherwise investigating applications for appointment, reappointment or changes in staff status or clinical privileges (except for confidential reference information obtained from third parties);
- results of queries to the National Practitioner Data Bank;
- any performance improvement trend sheets data, and reports concerning the individual’s practice at the Hospital, including quality profiles;
- any routine correspondence between the Hospital and the Medical Staff member; and
- information concerning the Medical Staff member’s meeting attendance record and compliance with other citizenship requirements.

Category 2 Access

A Medical Staff member may review Category 2 documents while in the presence of an appropriate Medical Staff leader (e.g., Chief of Staff, department chairperson, Credentials Committee Chairperson), the Chief Medical Officer and/or the Chief Executive Officer. At this meeting, the Medical Staff member shall be shown the document or an appropriate summary of it (but shall not be told the identity of any individual who provided the information unless, in the discretion of those involved in the meeting, revealing the individual’s identity would be conducive to quality and performance improvement and would not result in adverse consequences to the individual(s) or willingness of other individuals to document incidents).

Category 2 documents are the following:

- any reported concerns about the Medical Staff member which are placed into the file, along with any written explanations submitted by the individual;
- any confidential correspondence and/or memos to the file, prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual;
- any periodic review and appraisal forms completed by the appropriate department chairperson, including those completed at the time of appointment or reappointment;
- any routine peer review evaluation forms completed;
- any evaluations or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual;
- confidential reports and/or minutes (redacted) of peer review committees pertaining to the Medical Staff member;
• any correspondence setting forth formal Executive Committee action, including, but not limited to, letters of guidance, warning or reprimand, terms of probation or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits; and
• any written explanation to any of the above submitted by the Medical Staff member.

Category 3 Access

Because of the expectation of confidentiality on the part of individuals who submit Category 3 documents, a Medical Staff member may not have access to these documents, unless (i) the individual providing such information consents to the disclosure, or (ii) the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Medical Staff Bylaws.

Notwithstanding this, a Medical Staff member may meet with an appropriate Medical Staff leader, the Chief Medical Officer, and/or the Chief Executive Officer to discuss any Category 3 information and may review a written summary of the information (provided the summary does not reveal the identity of any individual who submitted the information).

Category 3 documents are the following:

• any and all confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the Medical Staff member’s training, clinical practice, professional competence, or conduct at any other health care facility or medical school; and
• notations of telephone conversations with references and other third parties concerning the Medical Staff member’s qualifications.

Disputes

Should any dispute arise over access to information in a Practitioner File, the dispute shall be resolved by the Chief Medical Officer and the Chief of Staff, after discussing the matter with the Medical Staff member involved, whose decision shall be final and not subject to appeal.

9.11 Disclosure of Medical Staff Information to Individuals or Organizations Outside the Hospital

Reference Requests

9.11(a) Reference requests must be in writing and include the relevant practitioner’s authorization for the release of the requested information.
9.11(b) All requests for references shall be referred to one or more of the following: the Chief Medical Officer, Chief Executive Officer, Chief of Staff or Department Chairperson.

9.11(c) If the reference will be overwhelmingly positive and include no materially negative information, then the Chief Medical Officer, Chief Executive Officer, Chief of Staff or Department Chairperson may release Medical Staff Information in response to an appropriate request from another Hospital, managed care organization or other appropriate entity.

9.11(d) If the reference will not be overwhelmingly positive or will include materially negative information, the Chief Medical Officer, Chief Executive Office, Chief of Staff and/or Department Chairperson may wish to consult with Hospital legal counsel. No information shall be released until the practitioner has provided the Hospital with a signed copy of the Hospital’s release form, pursuant to which the practitioner has authorized the specific disclosure in question. The general authorization for disclosure that is included as part of the Medical Staff application does not suffice for this purpose.

9.11(e) Reference disclosures shall be limited to the information requested and shall be accompanied by a statement that the information is being provided with the expectation that the requesting entity will continue to maintain appropriate confidentiality.

Requests from Hospital Surveyors

9.11(a) Requests for Medical Staff Information from Hospital surveyors from the federal Centers for Medicare & Medicaid Services and/or the state Department of Health shall be immediately referred to the Chief Executive Officer, Chief Medical Officer and Chief of Staff for further disposition in accordance with applicable laws, regulations and/or accreditation standards.

9.11(b) Under no circumstances shall original or photocopied records be removed from the Hospital’s premises, unless there is shown to be explicit statutory or regulatory authority to the contrary, which authority has first been reviewed by legal counsel.
Requests from State Professional Boards

State law permits the State Board of Medicine, the State Board of Dentistry and other state professional licensing boards to subpoena Peer Review Information concerning individual practitioners on the Medical Staff of the Hospital. The Chief Executive Officer, who may consult with Hospital counsel as necessary, must review the request and approve release of the requested records before access is granted. Disclosure shall be limited to the information requested.

Subpoenas

All subpoenas pertaining to Medical Staff Information shall be referred to the Chief Medical Officer or the Chief Executive Officer, who may first consult with the Chief of Staff and legal counsel regarding the appropriate response.

Other Requests

All other requests for Medical Staff Information or portions thereof by persons or organizations outside the Hospital shall be reviewed by the Chief Medical Officer or the Chief Executive Officer. After consulting with legal counsel as necessary, a determination will be made as to what, if any, disclosure is appropriate.

9.12 Sanctions

All suspected breaches of confidentiality or other violations of this Policy by a member of the Medical Staff shall be reported to the Executive Committee. The Executive Committee, or an ad hoc committee appointed by the Executive Committee, shall conduct a prompt inquiry and determine if there has in fact been a violation of any of the provisions of this Policy. If it is determined that a violation has occurred, the committee shall, depending on the nature and severity of the violation:

9.12(a) issue a letter of guidance, counsel, warning or reprimand;
9.12(b) remove the individual from the committee assignment and/or Medical Staff leadership position; and/or
9.12(c) recommend more severe disciplinary action in accordance with the Medical Staff Bylaws, which may include a recommendation to revoke the Medical Staff appointment and clinical privileges of the individual found to have violated this Policy.

Any individual who violates this Policy also risks loss of the protections provided by the Hospital to individuals who act on its behalf, including loss of indemnification for any litigation costs and expenses.

All suspected violations of this Policy by an employee of the Hospital shall be referred to the Chief Executive Office (or designee) for review and appropriate action pursuant to the personnel policies of the Hospital.
ARTICLE X
SEXUAL HARASSMENT

It is the policy of this Hospital that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the Hospital requires all individuals, employees, physicians, and other independent/dependent practitioners to conduct themselves in a professional and cooperative manner in the Hospital.

If an employee fails to conduct himself or herself in the required manner, the matter shall be addressed in accordance with Hospital employment policies. If a physician or other independent/dependent practitioner fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with the appropriate following policy.

10.1 Policy:

The Federal Equal Employment Opportunity Commission has declared that sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Act of 1964. It is and has been the policy of this Hospital that sexual harassment of or by employees, patients, medical staff appointees, and others has no place and will not be tolerated in this Hospital.

Therefore, the Board restates its policy that sexual harassment will not be tolerated and hereby directs the Chief Executive Officer to see that appropriate steps are taken to communicate the Board's intent, as expressed in this policy, to the Hospital's employees, patients, and other medical staff. Specifically, the Chief Executive Officer shall make sure that patients, employees, and medical staff appointees are aware of the Hospital's policy against sexual harassment and that adequate grievance procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur in the Hospital and that prompt action is taken on all complaints that are made.

10.2 Procedure to Investigate a Complaint of Sexual Harassment by a Physician:

If any individual working in the Hospital has observed or been the victim of conduct that constitutes sexual harassment, the following steps should be taken:

10.2(a) A written report should be filed with the employee's supervisor who shall forward it to the Chief Medical Officer. The report shall include a factual description of the incident or statement.

10.2(b) If, after a discussion with the individual who filed the report, it is found to constitute a credible report of conduct that constitutes sexual harassment, the Chief Medical Officer shall share the complaint(s) with the Chief of Staff and the Chief Executive Officer.

10.2(c) The physician involved shall be required to meet with Hospital and Medical Staff leadership -- the Chief Executive Officer, the Chief of Staff, and Chief Medical Officer. The physician shall be advised of the complaint(s) and be given an opportunity to respond. If, at the conclusion of that discussion, Hospital and Medical Staff leadership is convinced that the reported acts did occur, the physician shall be advised that such conduct is intolerable and in violation of Federal law.
10.2(d) The physician should, if appropriate, be given an opportunity to voluntarily cease the conduct that gave rise to the complaint and to apologize to the individuals involved.

10.2(e) A refusal to agree to stop the conduct immediately shall result in a formal warning to the physician and a determination of whether summary suspension under Section 8.2 of the Bylaws is necessary to protect Hospital employees until that agreement is obtained. Thus, the physician may not be permitted to enter the Hospital. The Hospital, however, has no choice but to protect its employees from harassing conduct.

10.2(f) The matter shall be reported to the Executive Committee of the Medical Staff along with a brief explanation of the circumstances and the applicable Federal law.

10.2(g) If the individual has agreed to stop such conduct, the meeting shall be followed up with a formal letter of reprimand and warning.

10.2(h) Any further reports of harassment, after the individual has agreed to stop the harassing conduct, may result in exclusion of the individual from the workplace and institution of formal disciplinary action in accordance with the Medical Staff Bylaws.
ARTICLE XI
MEDICAL STAFF STANDARDS OF CONDUCT

The Medical Staff of PinnacleHealth Memorial Hospital has approved the following code of standards in order to assure compliance and integration with the Standards of Conduct of PinnacleHealth Memorial Hospital.

Standard I:
Any act or failure to act, which may prejudice the life, health or safety of anyone within the confines of the Hospital and associated service areas (patients, employees, visitors, physicians) is strictly prohibited.

Standard II:
There will be no unauthorized disclosure of any confidential information involving any patient, employee or member of the Medical Staff. This includes information obtained at various committee meetings of the Hospital and the Medical Staff.

Standard III:
There will be no tolerance of a member of the Medical Staff for possessing, processing, distribution, selling or using controlled substances. Being under the influence of any of these substances anywhere in the facilities of or on the property of PinnacleHealth Memorial Hospital, the PinnacleHealth Memorial Hospital Outpatient Endoscopy Center, and/or the PinnacleHealth Memorial Hospital Outpatient Surgery Center (“Health System property”) is cause for immediate suspension from Medical Staff privileges and may result in removal from the Medical Staff.

Anyone required, for health reasons, to use any controlled substance must disclose such use to the Chief Medical Officer. Certain privileges may be restricted or removed during the period of administration of those substances.

Standard IV:
There will be no tolerance for being under the influence of alcohol while on Hospital or Health System property. No alcoholic substances are permitted on the property with the exception of that which is dispensed by the Pharmacy for a particular patient. Being under the influence of alcohol while on Hospital or Health System property will result in immediate suspension and possible removal from the Medical Staff. Being suspected of alcohol influence may result in an investigation to ascertain if any impairment exists.

Standard V:
Any unethical or immoral conduct or indecent behavior within the premises of PinnacleHealth Memorial Hospital or UPMC PinnacleHealth System or the conviction of any crime of moral turpitude or of any felony is cause for the immediate suspension from the Medical Staff and possible removal from the Medical Staff.

Standard VI:
Abandonment of any patient will not be tolerated. If a physician must be absent for greater than 24 hours, there must be arrangements made in advance for alternate physician coverage.
Refusal to accept any unassigned patient referred through the Emergency Department or Outpatient Clinic will require a complete explanation by the involved physician and may result in an action by the Executive Committee, Chief Medical Officer, or Administration.

**Standard VII:**
Continual or deliberate carelessness or negligence in the performance of one’s duties will be referred to the Chief Medical Officer for corrective action. Endangering others (employees, patients, other physicians or visitors) by reckless disregard of the policies of the Hospital or Health system, especially with regard to infection control, OSHA or HAZMAT issues, will result in corrective action by the Chief Medical Officer and/or the Administration.

**Standard VIII:**
Conduct which may constitute sexual harassment such as unwanted sexual advances, requests for sexual favors or any verbal or physical conduct of a sexual nature is strictly prohibited. The use of sexual favors as a condition of employment or advancement will not be tolerated.

**Standard IX:**
Knowingly concealing the true nature of a patient’s illness (especially contagious diseases) from the Hospital or Health System will not be tolerated. Information supplied by the physician must be as accurate as possible. It is the responsibility of the physician to notify the Hospital or Health System of the potential hazard(s) associated with any patient.

**Standard X:**
Falsifying or altering the medical record of any patient will not be tolerated. There is a procedure to correct any mistaken entries which must be followed.

**Standard XI:**
There will be no tolerance of disruptive behavior by any member of the Medical Staff as it relates to any employee, patient, visitor or other physicians. This includes fighting, loud arguing, vulgar or obscene language, insubordination, and harassment of any nature and intimidation of any associate.

**Standard XII:**
Blatant disregard, destruction, theft or misuse of any Hospital or Health System property will be grounds for corrective action by the Chief Medical Officer or the Administration and may include payment for such property.

**Standard XIII:**
Unauthorized reading, removal or copying of any Hospital documents, including Medical Records, is prohibited.

**CORRECTIVE ACTION MAY INCLUDE VERBAL OR WRITTEN WARNINGS, A SUSPENSION OF STAFF PRIVILEGES FOR A PERIOD OF TIME, OR REMOVAL FROM THE MEDICAL STAFF UNDER THE PROVISIONS OF THE FAIR HEARING PROCESS.**
ARTICLE XII
FIRST ASSISTANTS

1. The Medical Staff determined there are no “hazardous” procedures being performed at PinnacleHealth Memorial Hospital. There are no procedures that require a scrubbed physician first assistant. There are no procedures that require a scrubbed non-physician first assistant.
ARTICLE XIII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

12.1 DEVELOPMENT

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

12.2 ADOPTION, AMENDMENT & REVIEWS

The Rules and Regulations are hereby incorporated by reference as part of the Bylaws, except that such manual may be amended or repealed at any regular or special meeting of the Medical Staff or Medical Executive Committee at which a quorum is present, after a five (5) day notice of changes have been given to the Active Staff. Such changes shall become effective when approved by the Board. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

12.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.
12.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 12.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well-being of patients, employees or staff.
MEDICAL STAFF RULES & REGULATIONS
APPROVED & ADOPTED:

MEDICAL STAFF:

By: ___________________________ ___________________________
    Chief of Staff                          Date

BOARD OF TRUSTEES:

By: ___________________________ ___________________________
    Chairman                          Date

UPMC MEMORIAL:

By: ___________________________ ___________________________
    President                          Date