

**MEDICAL STAFF  
RULES AND REGULATIONS**

**HANOVER HOSPITAL**

**Approved MEC**

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## ARTICLE 1

### DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Credentials Policy:

- (a) “Ambulatory Care” means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.
- (b) “Ambulatory Care Location” means any department in the Hospital or provider-based site or facility where ambulatory care is provided.
- (c) “Attending Physician” means the patient’s primary treating physician or his or her designee(s) (*e.g., the resident on the attending physician’s service or “on call” for that service or an appropriately privileged allied health professional*), who shall be responsible for directing and supervising the patient’s overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient’s status to the patient, the referring practitioner, if any, and the patient’s family.
- (d) “Practitioner” means, unless otherwise expressly limited, any appropriately credentialed physician, resident, dentist, oral surgeon, podiatrist, or allied health professional, acting within his or her clinical privileges or scope of practice.
- (e) “Responsible Practitioner” means any practitioner who is actively involved in the care of a patient at any point during the patient’s treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

## ARTICLE 2

### ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

#### 2.A. ADMISSIONS

- (1) A patient may only be admitted to the Hospital by order of a Medical Staff member or other licensed practitioner, in accordance with state and federal law, who is granted admitting privileges.
- (2) No member of the Medical Staff may admit a patient to the service of another Medical Staff member without his or her consent.
- (3) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.
- (4) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

#### 2.B. RESPONSIBILITIES OF ATTENDING PHYSICIAN

- (1) The attending physician will be responsible for the following while in the Hospital:
  - (a) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);
  - (b) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;
  - (c) communicating with the patient's third-party payor, if needed;
  - (d) providing necessary patient instructions;
  - (e) responding to inquiries from Utilization Review professionals regarding the plan of care in order to justify the need for continued hospitalization; and
  - (f) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate.

- (2) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record.
- (3) Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer and updating the attending physician screen in the electronic medical record ("EMR").
- (4) For admissions that are 20 days or more, or outlier cases, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:
  - (a) authentication of the admitting order;
  - (b) the reason for the continued hospitalization or the special or unusual services for a cost outlier case;
  - (c) the expected or actual length of stay of the patient; and
  - (d) the plans for post-hospital care, when appropriate.

#### 2.C. CARE OF UNASSIGNED PATIENTS

- (1) All unassigned patients will be assigned to the appropriate on-call practitioner or to the appropriate Hospital service.
- (2) An "unassigned patient" means any individual who comes to the Hospital for care and treatment who does not have a prior relationship with a physician on the Medical Staff, or whose prior attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him or her care while a patient at the Hospital.

#### 2.D. AVAILABILITY AND ALTERNATE COVERAGE

- (1) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.
- (2) The attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:
  - (a) Communication from the Emergency Department and/or a Patient Care Unit – must respond within 15 minutes of being contacted and, if requested,

- must personally see a patient at the Hospital within 45 minutes of the request;
- (b) Patients Admitted from the Emergency Department – must personally see the patient within 12 hours of admission;
  - (c) All Other Inpatient Admissions – must personally see the patient within 24 hours of admission;
  - (d) ICU Patients – must personally see the patient within 12 hours of being admitted to the ICU, unless the patient’s condition requires that the physician see him or her sooner; and
  - (e) Patients Subject to Restraints or Seclusion – pursuant to Article 10 of these Rules and Regulations.
- (3) All physicians (or their appropriately credentialed designee) will be expected to comply with the following patient care guidelines regarding consultations:
- (a) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians; and
  - (b) Critical Care Consults – must be completed within 12 hours of the request, unless the patient’s condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., “stat,” “urgent,” “today,” or similar terminology – must also include personal contact by the requesting individual to the consulting physician).
- (4) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician’s acceptance of the transfer.
- (5) If the attending physician is not available, the Vice President of Medical Affairs or the President will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

## 2.E. CONTINUED HOSPITALIZATION

- (1) The attending physician will provide whatever information may be requested by the Utilization Review Department with respect to the continued hospitalization of a patient, including:

- (a) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);
- (b) the estimated period of time the patient will need to remain in the Hospital;  
and
- (c) plans for post-hospital care.

This response will be provided to the Utilization Review Department within 24 hours of the request. Failure to comply with this requirement will be reported to the Vice President of Medical Affairs for appropriate action.

- (2) If the Utilization Review Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, the Vice President of Medical Affairs will be consulted.

## 2.F. INFECTION CONTROL

- (1) All members of the Medical Staff are bound by the Infection Control Policies and Procedures Manual of the Hospital. Each practitioner is responsible for ensuring that every patient with a known or suspected infection is placed on appropriate isolation precautions. Copies of the Infection Control Policies and Procedures Manual will be available at every patient unit and in the Office of the Vice President of Medical Affairs.
- (2) The Infection Control Coordinator or Epidemiologist may order that appropriate cultures be obtained on patients with known or suspected infections in cases of disagreement concerning diagnosis and/or need for isolation. The matter will then be referred to the Department Chair of the attending Medical Staff member for discussion and appropriate action.
- (3) All isolation precaution orders should be reported to the Infection Control Coordinator who has final authority, with the Epidemiologist, in determining appropriate isolation precautions and discontinuation of service.

## ARTICLE 3

### MEDICAL RECORDS

#### 3.A. GENERAL

- (1) The following individuals are authorized to document in the medical record:
  - (a) attending physicians and responsible practitioners;
  - (b) nursing providers, including registered nurses (“RNs”) and licensed practical nurses (“LPNs”);
  - (c) physicians responding to a request for consultation when the individual has clinical privileges;
  - (d) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;
  - (e) volunteers, such as volunteer chaplains, functioning within their approved roles;
  - (f) students in an approved professional education program who are involved in patient care as part of their education process (e.g., acting interns) if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record; and
  - (g) non-clinical and administrative staff, as appropriate, pursuant to their job description.
- (2) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the EMR. Orders will be entered using Computerized Provider Order Entry (“CPOE”). Handwritten medical record entries will be legibly recorded in blue or preferably black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including handwritten entries, must be timed, dated and signed.
- (3) Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

- (4) Only approved standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.
- (5) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy.

### 3.B. ACCESS AND RETENTION OF RECORD

- (1) The Hospital will retain medical records in their original or legally reproduced form for a period of at least seven years from the date of discharge. If the patient is a minor, records will be kept on file until the minor's majority, and then for seven years thereafter. For obstetrical records, the maternal record will be retained until the mother's child reaches majority, and then for seven years thereafter.
- (2) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.
- (3) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Hospital policy.
- (4) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient or another person.
- (5) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).
- (6) Subject to the discretion of the Chief Executive Officer (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

### 3.C. CONTENT OF RECORD

- (1) For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services.
- (2) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. Stamped signatures are not permitted in the medical record.
- (3) General Requirements. All medical records for patients receiving care in the hospital setting or at an ambulatory care location will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
  - (a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
  - (b) legal status of any patient receiving behavioral health services;
  - (c) patient's language and communication needs, including preferred language for discussing health care;
  - (d) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;
  - (e) records of communication with the patient regarding care, treatment, and services;
  - (f) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
  - (g) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
  - (h) allergies to foods and medicines;
  - (i) reason(s) for admission of care, treatment, and services;
  - (j) diagnosis, diagnostic impression, or conditions;
  - (k) goals of the treatment and treatment plan;
  - (l) diagnostic and therapeutic orders, procedures, tests, and results;

- (m) progress notes made by authorized individuals;
  - (n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
  - (o) consultation reports;
  - (p) operative procedure reports and/or notes;
  - (q) any applicable anesthesia evaluations;
  - (r) response to care, treatment, and services provided;
  - (s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
  - (t) reassessments and plan of care revisions;
  - (u) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
  - (v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and
  - (w) medications dispensed or prescribed on discharge.
- (4) Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (a) known significant medical diagnoses and conditions;
  - (b) known significant operative and invasive procedures;
  - (c) known adverse and allergic drug reactions; and
  - (d) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

- (5) Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (a) time and means of arrival;
  - (b) record of care prior to arrival;
  - (c) results of the Medical Screening Examination;
  - (d) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
  - (e) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;
  - (f) if the patient left against medical advice; and
  - (g) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.
- (6) Obstetrics Records. Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
- (a) findings during the prenatal period;
  - (b) the medical and obstetrical history;
  - (c) observations and proceedings during labor, delivery and postpartum period; and
  - (d) laboratory and x-ray findings.

The obstetrical record will also include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

- (7) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (a) history of maternal health and prenatal course, including mother's HIV status, if known;
- (b) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;
- (c) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;
- (d) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay;
- (e) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;
- (f) documentation of infant feeding: intake, content, and amount if by formula; and
- (g) clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

### 3.D. HISTORY AND PHYSICAL

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 9 of the Medical Staff Bylaws.

### 3.E. PROGRESS NOTES

- (1) Progress notes will be entered by the attending physician (or his or her covering practitioner) at least every 24 hours for all hospitalized patients and as needed to reflect changes in the status of a patient in an ambulatory care setting.
- (2) Progress notes will be legible, dated, timed and authenticated. When appropriate, 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 treatments.
- (3) Progress notes may also be entered by allied health professionals as permitted by their clinical privileges or scope of practice.

### 3.F. AUTHENTICATION

- (1) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE. Signature stamps are never an acceptable form of authentication for written orders/entries.
  - (a) Passwords and e-signature PINS are never to be shared. This prohibition INCLUDES the practice of allowing others to document after another provider has signed in. Even when under direct observation by the person who signed in, this practice is not allowed.

### 3.G. INFORMED CONSENT

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

### 3.H. DELINQUENT MEDICAL RECORDS

- (1) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.
- (2) Medical records will be completed within 30 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete 30 days following discharge, the practitioner will be notified of the delinquency and that his or her clinical privileges will be relinquished in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the practitioner's records are no longer delinquent.
- (3) Failure to complete the medical records that caused the relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.
- (4) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner or it is ordered filed by the Health Information Management Department. Except in rare circumstances, and only when approved by the Health Information Management no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.
- (5) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the Health Information Management Department. The Medical Executive Committee/Vice President of Medical

Affairs/President is authorized to make special exceptions if warranted by the circumstances based upon good cause or hardship due to (1) personal illness or illness of a close family member or (2) absence from the community, provided that the practitioner makes a good faith effort to complete the records prior to leaving the community.

## ARTICLE 4

### MEDICAL ORDERS

#### 4.A. GENERAL

- (1) Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR
- (2) All orders (including verbal/telephone orders) must be:
  - (a) dated and timed when documented or initiated;
  - (b) authenticated by the ordering practitioner, with the exception of a verbal order which may be countersigned by another practitioner who is responsible for the care of a patient and authorized by the attending physician. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and
  - (c) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.
- (3) Orders for tests and therapies will be accepted only from:
  - (a) members of the Medical Staff; and
  - (b) allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.
- (4) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.
- (5) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of

this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

- (6) All orders are automatically cancelled and will be completely reentered when a patient is transferred from one physician to another, when a patient is transferred from the critical care unit, and when a patient emerges from surgery.
- (7) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.
- (8) All orders for medications administered to patients will be:
  - (a) reviewed by the attending physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;
  - (b) canceled automatically when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and
  - (c) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is issued when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.
- (9) All medication orders will clearly state the administration times or the time interval between doses. Each dose of medication shall be entered in the medical record of the patient and authenticated after the medication has been administered. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All as necessary medication orders (also known as PRN) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.
- (10) Following the initial diet order entered by a Medical Staff member or Allied Health Professional Staff member, orders for diets, including the ability to modify the diet based on the needs and current condition of the patient may be delegated to a dietitian, registered and licensed by the Pennsylvania Department of State. A Registered Dietitian writing orders for a patient’s diet shall act under the direction or supervision of a physician member of the Medical Staff.

- (10) Allied health professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders issued by an allied health professional will be countersigned/authenticated by the Supervising/Collaborating Physician as defined in their privilege document and in accordance with State regulations.

#### 4.B. VERBAL ORDERS

- (1) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.
- (2) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law.
- (3) Authentication will take place by the ordering practitioner, or another practitioner who is authorized by the attending physician and responsible for the patient's care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, and (ii) within 24 hours after the order was given for telephone orders.
- (4) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.
- (5) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:
  - (a) an LPN, RN, or an advance practice nurse ("APN");
  - (b) a physician assistant;
  - (c) a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;
  - (d) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;
  - (e) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

- (f) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;
  - (g) a speech therapist who may transcribe a verbal order pertaining to speech therapy; and
  - (h) a dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition.
- (6) The Hospital will periodically monitor and track the use of verbal orders through the review of randomly selected patient medical records.

#### 4.C. STANDING ORDERS, ORDER SETS, AND PROTOCOLS

- (1) The Medical Executive Committee and the Hospital's nursing and pharmacy departments must review and approve any standing orders and protocols. All standing orders, order sets, and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.
- (2) The Medical Executive Committee will confirm that all approved standing orders and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that such orders and protocols are reviewed periodically.
- (3) If the use of a standing order or protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a responsible practitioner acting within his or her scope of practice.
- (4) When used, standing orders and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another responsible practitioner.
- (5) The attending physician must also acknowledge and authenticate the initiation of each standing order, order set, or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.

#### 4.D. SELF-ADMINISTRATION OF MEDICATIONS

- (1) The self-administration of medications (either hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:
  - (a) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

- (b) a practitioner responsible for the care of the patient has issued an order permitting self-administration;
  - (c) in the case of a patient's own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and
  - (d) the patient's first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.
- (2) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).
  - (3) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.
  - (4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient for removal from the Hospital. If such removal is not feasible, the drugs shall be stored and returned to the patient at the time of discharge. The patient shall be cautioned concerning outdated or distressed drugs. Controlled substances shall not be returned to the patient without approval of the attending practitioner.

#### 4.E. STOP ORDERS

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders and automatically discontinued as follows:

- (1) all oxytoxics after 24 hours;
- (2) narcotics (BNDD Schedule II) after 48 hours;
- (3) all soporifics and sedatives (BNDD Schedules II, III, IV), anticoagulants, corticosteroids and antibiotics after seven days;
- (4) all other medications after 14 days; and
- (5) inhalation therapy treatments after three days.

The prescribing practitioner will be notified within 12 hours before an order is automatically stopped.

#### 4.F. ORDERS FOR DRUGS AND BIOLOGICALS

- (1) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.
- (2) All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

#### 4.G. ORDERS FOR OUTPATIENT SERVICES

- (1) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.
- (2) Orders for outpatient services must be submitted on a prescription pad, letterhead, electronic or paper order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual (except lab orders which do not need a signature); (iii) the radiological or diagnostic imaging procedure orders as applicable; (iv) the reason for the procedure; (v) the type, frequency, and duration of the service, as applicable.

## ARTICLE 5

### CONSULTATIONS

#### 5.A. REQUESTING CONSULTATIONS

- (1) The attending provider shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant.
- (2) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician to discuss the consultation request. However, for critical care consults, the attending physician must personally speak with the consultant to provide the patient's clinical history and the specific reason for the consultation request.
- (3) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.
- (4) Where a consultation is required for a patient in accordance with Section 5.C or is otherwise determined to be in patient's best interest, the Vice President of Medical Affairs, the President, or the appropriate clinical Department Chair shall have the right to call in a consultant.

#### 5.B. RESPONDING TO CONSULTATION REQUESTS

- (1) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.
- (2) For routine consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For urgent consults, the consult must be completed as soon as possible, unless the patient's condition requires that the physician complete the consultation emergently as determined by the provider requesting consult.
- (3) The physician who is asked to provide the consultation may ask an Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient

within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the Allied Health Professional is sufficient.

- (4) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician.
- (5) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the Professional Practice Evaluation Policy or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation:
  - (a) the physician has a valid justification for his or her unavailability (e.g., out of town);
  - (b) the patient has previously been discharged from the practice of the physician;
  - (c) the physician has previously been dismissed by the patient;
  - (d) the patient indicates a preference for another consultant; or
  - (e) other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (a) – (e)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the Vice President of Medical Affairs, the President, or the appropriate clinical Department Chair can appoint an alternate consultant.

- (6) Once the consulting physician is involved in the care of the patient, the attending physician and consulting physician are expected to review each other's notes in both the electronic and paper charts on a daily basis until such time as the consultant has signed off on the case or the patient is discharged.

#### 5.C. RECOMMENDED AND REQUIRED CONSULTATIONS – GENERAL PATIENT CARE SITUATIONS

- (1) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's personal representative if the patient lacks decisional capacity.

- (2) Except in emergency cases, consultations are required in all cases in which, in the judgment of the attending physician:
  - (a) the diagnosis is obscure after ordinary diagnostic procedures have been completed;
  - (b) there is doubt as to the best therapeutic measures to be used;
  - (c) unusually complicated situations are present that may require specific skills of other practitioners;
  - (d) the patient exhibits severe symptoms of mental illness or psychosis; or
  - (e) the patient is not a good medical or surgical risk.

Additional requirements for consultation may be established by the Hospital as required.

#### 5.D. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

#### 5.E. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the attending physician states in writing that an emergency situation exists.

#### 5.F. CONTENT OF CONSULTATION REPORT

- (1) Each consultation report will be completed in a timely manner and will contain a dictated or legible written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable

consultation report. The consultation report will be made a part of the patient's medical record.

- (2) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

#### 5.G. CONCERNS

- (1) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify his or her nursing supervisor who, in turn, will contact the attending physician. If a consultation is not thereafter ordered by the attending physician, the nursing supervisor may then bring the matter to the attention of the Department Chair in which the member in question has clinical privileges. Thereafter, the Department Chair or Vice President of Medical Affairs may request a consultation after discussion with the attending physician.
- (2) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the applicable Department Chair, the President, or the Vice President of Medical Affairs.

## ARTICLE 6

### SURGICAL SERVICES

#### 6.A. PRE-PROCEDURE PROTOCOL

- (1) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.
- (2) Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:
  - (a) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
  - (b) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;
  - (c) the attending physician (i.e., surgeon) is in the Hospital;
  - (d) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as outlined by Hospital policy and protocol;
  - (e) recording of consultation reports;
  - (f) confirmation and documentation of drug sensitivities; and
  - (g) verification (and documentation of this verification in the medical record) of the identity of the patient after the patient has been placed on the operating table.

#### 6.B. POST-PROCEDURE PROTOCOL

- (1) An operative procedure report must be completed immediately after an operative procedure and entered into the record. The operative procedure report shall include:
  - (a) the patient's name and hospital identification number;
  - (b) pre- and post-operative diagnoses
  - (c) date of the procedure;

- (d) the name of the attending physician(s) and assistant surgeon(s) responsible for the patient's operation;
  - (e) procedure(s) performed and description of the procedure(s);
  - (f) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
  - (g) findings, where appropriate, given the nature of the procedure;
  - (h) estimated blood loss;
  - (i) any unusual events or any complications, including blood transfusion reactions and the management of those events;
  - (j) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
  - (k) specimen(s) removed, if any;
  - (l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and
  - (m) the signature of the attending physician.
- (2) If an operative report cannot be entered into the record immediately after the operation or procedure, a brief post-op note must be entered by a physician or Advanced Practice Clinician in the medical record immediately after the procedure. In such situations, the full operative procedure report must be entered or dictated within 24 hours. The brief post-op note will include:
- (a) the names of the physician(s) responsible for the patient's care and physician assistants;
  - (b) the name and description of the procedure(s) performed;
  - (c) findings, where appropriate, given the nature of the procedure;
  - (d) estimated blood loss, when applicable or significant;
  - (e) specimens removed; and
  - (f) post-operative diagnosis.

## ARTICLE 7

### ANESTHESIA SERVICES

#### 7.A. GENERAL

- (1) Anesthesia may only be administered by the following qualified practitioners:
  - (a) A board eligible or board certified physician anesthesiologist.
  - (d) a CRNA who is supervised by the operating practitioner or an anesthesiologist according to current CRNA privileges as granted. or
  - (e) supervised nurse trainees under continuous direct supervision by an anesthesia provider located in the same room.
- (2) An anesthesiologist is considered “immediately available” when needed by a CRNA under the anesthesiologist’s medical direction only if he/she is physically located in reasonable proximity within the hospital and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).
- (3) “Anesthesia” means general or regional anesthesia (which includes the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks), monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal, or moderate or conscious sedation.
- (4) Because it is not always possible to predict how an individual patient will respond to minimal, moderate or conscious sedation, a qualified practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.
- (5) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

#### 7.B. PRE-ANESTHESIA PROCEDURES

- (1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services. In addition, immediately prior to the induction of anesthesia, a review of the patient’s condition will be performed and include a review of the patient’s

medical record with regard to completeness, pertinent laboratory data, time of administration, and dosage of preanesthesia medications, together with an appraisal of any changes to the condition of the patient, as compared with that noted on the patient's medical record.

- (2) The evaluation will be recorded in the medical record and will include:
  - (a) a review of the medical history, including anesthesia, drug and allergy history;
  - (b) an interview, if possible, preprocedural education, and examination of the patient;
  - (c) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
  - (d) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);
  - (e) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and
  - (f) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (a) and (b) must be performed within the 48-hour time frame. The elements in (c) through (f) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

- (3) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

#### 7.C. MONITORING DURING PROCEDURE

- (1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.
- (2) All events taking place during the induction, maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

- (a) the name and Hospital identification number of the patient;
- (b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;
- (c) the name, dosage, route time, and duration of all anesthetic agents;
- (d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;
- (e) the name and amounts of other drugs or IV fluids (including blood or blood products, if applicable);
- (f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and
- (g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

#### 7.D. POST-ANESTHESIA EVALUATIONS

- (1) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an anesthetist no later than 24 hours after the patient has been moved into the designated recovery area.
- (2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 24-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).
- (3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
  - (a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
  - (b) cardiovascular function, including pulse rate and blood pressure;
  - (c) mental status;

- (d) temperature;
  - (e) nausea and vomiting;
  - (f) the presence or absence of any post-operative abnormalities or complications;
  - (g) post-operative hydrations; and
  - (h) the general condition of the patient.
- (4) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists (“ASA”), using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.
  - (5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
  - (6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

#### 7.E. MINIMAL, MODERATE OR CONSCIOUS SEDATION

All patients receiving minimal, moderate or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner in accordance with the hospital’s “*Procedural Sedation by Non-Anesthesia Providers*” policy.

#### 7.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges, who is certified by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or is in the certification stream and has successfully completed an approved residency training program in anesthesiology. The director is responsible for the following:

- (1) establishment of criteria and procedures for the evaluation of the quality of all anesthesia care rendered wherever it is required in the Hospital;
- (2) recommending what equipment is necessary for administering anesthesia and related resuscitation efforts;

- (3) development of Hospital rules concerning anesthesia safety;
- (4) participation in the Hospital's program of cardiopulmonary resuscitation, if any; consultation on management of acute and chronic respiratory insufficiency; and, where appropriate, consultation on other diagnostic and therapeutic measures;
- (5) participation, where appropriate, as instructor in the Hospital's program of continuing education in cardiopulmonary resuscitation, respiratory therapy, and the use of related equipment;
- (6) planning, directing and supervising all activities of the anesthesia service; and
- (7) evaluating the quality and appropriateness of anesthesia patient care.

## ARTICLE 8

### PROCEDURES FOR OBSTETRICAL CARE

#### 8.A. ADMISSION

- (1) Obstetrical patients may be admitted on a 24-hour basis via the emergency department or admitting office. Nursing personnel shall notify the attending physician when the patient is admitted.
- (2) In the event a pregnant patient is admitted to a department other than the Department of Obstetrics and Gynecology, a consultation is required with a member of the Department of Obstetrics and Gynecology unless the responsible practitioner has obstetrics privileges.

#### 8.B. REQUIRED LABORATORY PROCEDURES

A standard OB panel, including HIV, should be performed prior to admission of the obstetrical patient and recorded on the prenatal record. If not performed prior to admission, then such laboratory procedures must be performed upon admission. Cord bloods shall be sent to the laboratory for all deliveries to determine potential incompatibility when indicated based on maternal blood type.

#### 8.C. VAGINAL EXAMINATIONS

Vaginal examinations shall be performed on obstetrical patients as may be set forth in Hospital policy or as is recognized by ACOG.

#### 8.D. MEDICAL RECORD AND BIRTH CERTIFICATE

- (1) An obstetrical patient's medical record shall include findings during the prenatal period, which shall be available in the obstetrics department prior to the patient's admission and shall include the medical and obstetrical history, observations and proceedings during labor, delivery and postpartum period, and laboratory and x-ray findings.

#### 8.E. IDENTIFICATION

The Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the delivery room, or operating room in the case of a caesarean section.

#### 8.F. RECOVERY ROOM

The attending physician shall remain in the delivery room or operating room area until the patient is stable and admitted to her room or the recovery room. The attending physician shall subsequently examine the patient and issue appropriate orders. If the patient has been admitted to the recovery room, the attending physician shall examine the patient and issue appropriate orders to discharge the patient from the recovery room. In cases of caesarean section, the anesthesiologist is authorized to act on behalf of the attending physician in issuing orders to discharge the patient from the recovery room. If postpartum hemorrhage is observed during recovery, the attending physician shall be notified immediately and shall return to reexamine the patient and to determine the appropriate therapy.

#### 8.G. ATTIRE

Anyone entering the delivery room suite must be properly attired.

#### 8.H. DELIVERY ROOM ROSTER

A current roster of Medical Staff members with obstetrical privileges shall be maintained and made available to nursing personnel. An on-call schedule shall be established and maintained to provide for obstetrical coverage at all times.

### ARTICLE 9

#### PHARMACY

#### 9.A. GENERAL RULES

- (1) Orders for drugs and biologicals are addressed in the Medical Orders Article.
- (2) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.
- (3) Adverse medication reactions, transfusion reactions, and errors in administration of medications will be immediately documented in the patient's medical record and reported to the attending physician, the practitioner who ordered the medication or transfusion (if different than the attending physician), the director of pharmaceutical services, and, if appropriate, the Hospital's quality assessment and performance improvement program. Copies of records of all adverse drug reactions and drug sensitivities shall be maintained in the pharmacy for two years.

- (4) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.
- (5) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, or the American Hospital Formulary Service.
- (6) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Medical Executive Committee and the Institutional Review Board.
- (7) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

#### 9.B. STORAGE AND ACCESS

- (1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.
  - (a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.
  - (b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.
  - (c) Only authorized personnel may have access to locked or secure areas.
- (2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

## ARTICLE 10

### RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

Restraints, seclusion, and behavior management programs will be governed by the Hanover Hospital Restraint and Seclusion Guidelines and any other applicable restraint protocols and/or policies.

## ARTICLE 11

### EMERGENCY SERVICES

#### 11.A. GENERAL

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

#### 11.B. MEDICAL SCREENING EXAMINATIONS

- (1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:
  - (a) Emergency Department:
    - (i) members of the Medical Staff with clinical privileges in Emergency Medicine;
    - (ii) other Active Staff members;
    - (iii) Residents; and
    - (iv) appropriately credentialed allied health professionals.
  - (b) Labor and Delivery:
    - (i) members of the Medical Staff with OB/GYN privileges;
    - (ii) Residents;
    - (iii) Certified Nurse Midwives with OB privileges; and

- (iv) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.
- (2) The results of the medical screening examination must be documented within 48 hours of the conclusion of an Emergency Department visit.

#### 11.C. ON-CALL RESPONSIBILITIES

It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Hospital policies and procedures.

## ARTICLE 12

### DISCHARGE PLANNING AND DISCHARGE SUMMARIES

#### 12.A. WHO MAY DISCHARGE

- (1) Patients will be discharged only upon the order of a responsible practitioner.
- (2) At the time of discharge, the discharging practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.
- (3) If a patient insists on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

#### 12.B. IDENTIFICATION OF PATIENTS IN NEED OF DISCHARGE PLANNING

- (1) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.
- (2) Criteria to be used in making this evaluation include:
  - (a) functional status;
  - (b) cognitive ability of the patient; and
  - (c) family support.

#### 12.C. DISCHARGE PLANNING

- (1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.
- (2) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

#### 12.D. DISCHARGE SUMMARY

- (1) A concise, discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed within 48 hours of discharge
  - (a) reason for hospitalization;
  - (b) significant findings;
  - (c) procedures performed and care, treatment, and services provided;
  - (d) condition and disposition at discharge;
  - (e) information provided to the patient and family, as appropriate;
  - (f) provisions for follow-up care; and
  - (g) discharge medication reconciliation.
- (2) A discharge progress note may be used to document the discharge summary for normal obstetrical deliveries, normal newborn infants, and ambulatory care patients, and for stays of less than 48 hours.
- (3) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

#### 12.E. DISCHARGE OF MINORS AND INCOMPETENT PATIENTS

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

#### 12.F. DISCHARGE INSTRUCTIONS

- (1) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient (or his or her family or other persons involved in caring for the patient) with information regarding his or her condition, his or her health care needs, and why he or she is being discharged. The responsible practitioner should educate that patient about how to obtain further care, treatment, and services to

meet his or her identified needs, when indicated. Information should also be provided on the amount of activity for the patient to engage in; any necessary medical regimens (including drugs, diet, or other forms of therapy); and procedures to follow in case of complications.

- (2) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.
- (3) The responsible practitioner, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.
- (4) When the Hospital determines the patient's transfer or discharge needs, the responsible practitioner, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.
- (5) When continuing care is needed after discharge, the responsible practitioner, along with the Hospital staff, will provide appropriate information to the other health care providers, including:
  - (a) the reason for discharge;
  - (b) the patient's physical and psychosocial status;
  - (c) a summary of care provided and progress toward goals;
  - (d) community resources or referrals provided to the patient; and
  - (e) discharge medications.

## ARTICLE 13

### TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

#### 13.A. TRANSFER

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

- (1) assessing the reason(s) for transfer;
- (2) establishing the conditions under which transfer can occur;
- (3) evaluating the mode of transfer/transport to assure the patient's safety; and
- (4) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

A patient will not be transferred to another facility unless prior arrangements for admission have been made.

#### 13.B. PROCEDURES

- (1) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:
  - (a) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
  - (b) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;
  - (c) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and
  - (d) provide the following information to the patient whenever the patient is transferred:
    - (i) the reason for the transfer;
    - (ii) the risks and benefits of the transfer; and

- (iii) available alternatives to the transfer.
- (2) When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:
- (a) reason for transfer;
  - (b) significant findings;
  - (c) a summary of the procedures performed and care, treatment and services provided;
  - (d) condition at discharge;
  - (e) information provided to the patient and family, as appropriate; and
  - (f) working diagnosis.
- (3) When a patient requests a transfer to another facility, the responsible practitioner will:
- (a) explain to the patient his or her medical condition;
  - (b) inform the patient of the benefits of additional medical examination and treatment;
  - (c) inform the patient of the reasonable risks of transfer;
  - (d) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
  - (e) provide the receiving facility with the same information outlined in paragraph (2) above.

### 13.C. EMTALA TRANSFERS

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable EMTALA policy.

## ARTICLE 14

### HOSPITAL DEATHS AND AUTOPSIES

#### 14.A. DEATH AND DEATH CERTIFICATES

- (1) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician, his or her designee, or the Emergency Department physician, within a reasonable time frame.
- (2) The medical certification of the cause of death within the death certificate will be completed by the attending physician (or his or her designee) within 24 hours of when the certificate is made available.

#### 14.B. RELEASE OF THE BODY

- (1) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after the completion of a Death Certificate and an entry has been made in the deceased patient's medical record by the attending physician (or his or her designee) or other designated member of the Medical Staff.
- (2) It is the responsibility of the attending physician (or his or her designee) to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

#### 14.C. ORGAN AND TISSUE PROCUREMENT

All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital policy.

#### 14.D. AUTOPSIES

- (1) The Medical Staff should attempt to secure autopsies in accordance with state and local laws, including all cases of unusual deaths and of medical-legal and educational interest. The attending physician (or his or her designee) must be notified when an autopsy is to be performed.
- (2) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. The attending physician (or his or her designee) must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the attending physician (or his or her designee), an autopsy should not be

requested (e.g., the health and welfare of the next of kin or religious proscription), this should be documented in the medical record.

- (3) Any request for an autopsy by the family of a patient who died while at the Hospital (not provider requested) will be honored, if at all possible, after consulting with the pathologist. The arrangement, transport and payment for such autopsies is the responsibility of the patient's family or legal guardian. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer and/or the Vice President of Medical Affairs.
- (4) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

#### 14.E. DO NOT RESUSCITATE ("DNR") POLICY

The Medical Staff will administer care in accordance with Hospital policy, for those competent adult patients or the parent of an infant, neonate or minor child who knowingly chooses to forgo treatment.

## ARTICLE 15

### MISCELLANEOUS

#### 15.A. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS

- (1) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.
- (2) Members of the Medical Staff are strongly discouraged from admitting or performing invasive procedures on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:
  - (a) no viable alternative treatment is available, as confirmed through discussions with the President or the Chief Executive Officer;
  - (b) the patient's disease is so rare or exceptional and the physician is considered an expert in the field;
  - (c) in the Emergency Department where the Medical Staff member is the attending physician or is on call; or
  - (d) in an emergency where no other Medical Staff member is readily available to care for the family member.

This discouragement is not applicable to in-laws or other relatives.

#### 15.B. ORIENTATION OF NEW PHYSICIANS

Each new physician will be provided an orientation to the Hospital and its operations detailing those activities and/or procedures that will help new staff members in the performance of their duties.

#### 15.C. HIPAA REQUIREMENTS

All members of the Medical Staff and Allied Health Staff will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information in accordance with state and federal regulations and Hospital policy.

ARTICLE 16

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 8 of the Medical Staff Bylaws.

ARTICLE 17

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on:

Date: November 14, 2017

\_\_\_\_\_  
President

Approved by the Board on:

Date: \_\_\_\_\_

\_\_\_\_\_  
Chair, Board of Directors