

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
THE CHRIST HOSPITAL**

**MEDICAL STAFF
RULES AND REGULATIONS**

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ARTICLE I

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) “Acting Intern” means a medical student with primary patient care responsibilities and direct reporting relationships with upper level residents and members of the Medical Staff.
- (b) “Admitting Physician” means the physician who orders the admission of a given patient to the Hospital.
- (c) “Attending Physician” means the patient’s primary treating physician, 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 to the patient’s family.
- (d) “Consulting Physician” means a physician who examines a patient to render an opinion and/or advice to the attending physician (or his or her designee).
- (e) “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.
- (f) “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 II

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT AND SERVICES

2.1. Admissions:

- (a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges or by a Category II practitioner who is permitted to act as a proxy for his/her Supervising/Collaborating Physician. Any such admission order must be co-signed by the Supervising/Collaborating Physician. Where a dental or podiatric practitioner admits a patient having concomitant medical problems, the dentist or podiatrist shall promptly engage an attending physician who shall have responsibility for any medical treatment that may be appropriate during a patient's hospitalization.

- (b) 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.

- (c) Upon receiving an admission order, patients will be admitted on the basis of the following order of priorities:
 - (1) **First Priority** – in-house emergency admissions.

 - (2) **Second Priority** – emergency transfers from another facility.

 - (3) **Third Priority** – non-emergency or elective.

 - (4) **Fourth Priority** – non-emergency, procedure-based admissions.

- (d) General admission orders and a note outlining the next steps in the management and treatment of the patient must be entered within four hours of a patient being admitted.
- (e) All types of admissions must be approved for bed booking by the Admitting/Registration Department, which is overseen by the on-duty nursing supervisor. Urgent/emergent patient transfers will be accepted and triaged through the Hospital's "One Call" system.
- (f) In-house Emergency Department patients for whom no bed is available will remain in the Hospital Emergency Department for monitoring for up to 24 hours. The Emergency Department may issue bridge orders during this time. Once a decision has been made to admit a patient from the Emergency Department, responsibility for the patient will change to the attending physician, who must cosign any bridge orders issued by the Emergency Department physician.
- (g) The admitting physician (or his/her proxy) will provide the Hospital with any information concerning the patient that is necessary to support the medical necessity of the admission, protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.
- (h) Orders to place a patient in observation should be consistent with Section 2.3 of these Rules and Regulations. If the order is inconsistent with these Rules and Regulations, the order will be clarified with the responsible practitioner.

2.2. Restricted Bed Utilization:

Areas of restricted bed utilization and assignment of patients shall be as follows:

- Patients with psychiatric diagnoses only;
- Obstetrical patients, ante-partum, post-partum, and nursery only;
- Intensive Care Units – seriously or critically ill patients requiring specialized care available in intensive care units;
- Rehabilitation Units; and
- Telemetry.

This list of areas of restricted bed utilization may, from time to time, be modified by Hospital administration.

2.3. Observation Status:

- (a) Patients can be assigned to observation status in accordance with CMS guidelines. Observation status will not be used as a substitution for an admission which meets approved admission criteria.

- (b) Assignment of a patient to observation status requires documentation that the patient meets one of the following criteria:
 - (1) the patient's diagnostic evaluation requires more prolonged services than what is typically accomplished in the ED or outpatient setting; or

 - (2) the patient requires monitoring or treatment beyond the usual recovery time due to an unexpected occurrence or complication following an outpatient procedure (e.g., abnormal bleeding, uncontrolled pain, vomiting, and/or delayed recovery from anesthesia).

2.4. Responsibilities of Attending Physician:

- (a) The attending physician will be responsible for the following while in the Hospital:
 - (1) 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);

 - (2) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;

 - (3) communicating with the patient's third-party payor, if needed;

- (4) providing necessary patient instructions;
 - (5) responding promptly to inquiries from Utilization Review professionals, including external Utilization Review physician advisors and case managers, regarding the plan of care in order to justify the medical necessity of the admission and the need for continued hospitalization;
 - (6) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate;
 - (7) initiating discharge planning at the time of admission;
 - (8) determination of status (e.g., observation, inpatient) and recertification of continued hospital stays where such certification is required by regulation or other standards;
 - (9) supervision of residents and allied health professionals, if involved in the care of the patient; and
 - (10) adherence to the Centers for Medicare & Medicaid Services Conditions of Participation.
- (b) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. 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.
- (c) Prior to discharge, the attending physician (or a physician who has been actively involved in the care of the patient) will complete the physician certification documenting that the inpatient services were medically necessary. The physician certification includes, and is evidenced by, the following information:

- (1) authentication or co-signature of the inpatient admission order prior to the patient's discharge from the Hospital;
 - (2) the reason for the inpatient services (i.e., the provisional diagnosis);
 - (3) the expected length of stay of the patient; and
 - (4) the plans for post-hospital care, when appropriate.
- (d) The attending physician is responsible for signing a leave of absence request form and designating the date, time and mode of transportation for the patient to and from the Hospital and to other health care entities when diagnostic tests or treatments that are not available at the Hospital are ordered.

2.5. Care of Unassigned Patients:

- (a) All unassigned patients will be assigned to the appropriate on-call practitioner or to the appropriate Hospital service.
- (b) An "unassigned patient" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose 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.

2.6. Availability and Alternate Coverage:

- (a) 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.
- (b) Absent extraordinary circumstances, the attending physician (or his or her designee) will comply with the following patient care guidelines regarding availability:

- (1) Calls/texts from the Emergency Department and/or a Patient Care Unit – respond immediately (no later than 30 minutes), via phone, to all pages from the Hospital, and appear in person to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient’s condition or (ii) as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Board);
 - (2) Patients Admitted from the Emergency Department – must see the patient within 24 hours of admission or sooner if clinically indicated;
 - (3) All Other Inpatient Admissions – must see the patient within 24 hours of admission;
 - (4) ICU Patients – must see the patient within 12 hours of being admitted to the ICU, unless the patient is being monitored by the eICU practitioners; and
 - (5) Patients Subject to Restraints or Seclusion – pursuant to Article X of these Rules and Regulations.
- (c) 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 arrange for another Medical Staff member to assume 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.
- (d) If the attending physician is not available, the relevant department director or service line executive medical director will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient. In the absence of the department director or service line executive medical director, the President of the Medical Staff or the VP & Chief Medical Officer will be contacted.

2.7. Continued Hospitalization:

- (a) The attending physician will certify and document the medical necessity for continued stays for inpatient psychiatric patients, as defined by CMS and the Ohio Department of Medicaid.

- (b) The attending physician will provide whatever information may be requested by the Utilization Review Department with respect to the continued hospitalization of a patient, as defined by CMS, including:
 - (1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

 - (2) the estimated period of time the patient will need to remain in the Hospital; and

 - (3) 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 VP & Chief Medical Officer for appropriate action.

- (c) 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 VP & Chief Medical Officer or President of the Medical Staff will be consulted.

ARTICLE III

MEDICAL RECORDS

3.1. General:

- (a) Medical records will be used and disclosed in accordance with the regulations implementing the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 (the "HIPAA Privacy Rule"), Ohio law, and the Hospital's corresponding privacy policies.

- (b) The following individuals are authorized to document in the medical record:
 - (1) attending physicians and responsible practitioners;

 - (2) nursing providers, including registered nurses ("RNs") and licensed practical nurses ("LPNs");

 - (3) physicians responding to a request for consultation when the individual has clinical privileges or is an employee or member of the House Staff at the Hospital;

 - (4) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, utilization review, and case managers;

 - (5) volunteers, such as volunteer chaplains, functioning within their approved roles;

 - (6) 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

- (7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

- (c) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the electronic medical record ("EMR"). Orders will be entered using Computerized Provider Order Entry ("CPOE"). In extenuating circumstances (i.e., an emergency situation or when the EMR or CPOE function is not available), handwritten medical record entries will be legibly recorded in blue or preferably black ink. All entries, including handwritten entries, must be timed, dated and signed.

- (d) 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.

- (e) Final diagnoses, names of medications prescribed and procedures performed will be recorded in full, without the use of either symbols or abbreviations. The Medical Executive Committee will approve a list of unacceptable abbreviations, as recommended by the Medical Records Committee and the Medical Staff Quality Committee. This list will be incorporated into Administrative Policy 1.05.101. Compliance with the abbreviation list is determined through retrospective records review by the Medical Staff Quality Committee.

- (f) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed.

3.2. Access and Retention of Record:

- (a) Medical records will be retained in accordance with Administrative Policy 2.26.123.

- (b) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with the HIPAA Privacy Rules, Ohio law, and the Hospital's policies pertaining to release of information and medical records.

- (c) 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.
- (d) 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.
- (e) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research Projects 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 Christ Hospital Institutional Review Board (TCHIRB).
- (f) Subject to the discretion of the President & 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.

3.3. Content of Record:

- (a) For every patient treated as an inpatient, a medical record will contain information to justify the medical necessity of the admission, continued hospitalization, and/or surgery or procedure. The medical record will 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.
- (b) 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.
- (c) General Requirements. All medical records for patients receiving care in the hospital setting or at a Hospital-based 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:

- (1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;
- (2) legal status of any patient receiving behavioral health services;
- (3) patient's language and communication needs, including preferred language for discussing health care;
- (4) authenticated or co-signed order for inpatient admission prior to discharge;
- (5) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or do not resuscitate ("DNR") orders;
- (6) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
- (7) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
- (8) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
- (9) allergies to foods and medicines;
- (10) medical necessity evidencing the reason(s) for admission, surgery, procedure, care, treatment, and services;

- (11) diagnosis, diagnostic impression, or conditions;
- (12) goals of the treatment and treatment plan;
- (13) diagnostic and therapeutic orders, procedures, tests, and results;
- (14) progress notes made by authorized individuals;
- (15) 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);
- (16) consultation reports;
- (17) operative procedure reports and/or notes;
- (18) any applicable anesthesia evaluations;
- (19) response to care, treatment, and services provided;
- (20) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
- (21) reassessments and plan of care revisions;
- (22) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
- (23) specific data and information related to any adverse event reports (e.g., fall in the Hospital);

- (24) 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
 - (25) medications dispensed or prescribed on discharge.
- (d) Continuing Hospital-Based Ambulatory Care. For patients receiving continuing Hospital-based ambulatory care services (e.g., chemotherapy, antibiotics, transfusions, etc.), 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:
- (1) known significant medical diagnoses and conditions;
 - (2) known significant operative and invasive procedures;
 - (3) known adverse and allergic drug reactions; and
 - (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.
- (e) 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:
- (1) time and means of arrival;
 - (2) record of care prior to arrival;
 - (3) results of the Medical Screening Examination and stabilizing treatment, where provided;

- (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
 - (5) conclusions at termination of treatment, including final disposition and appropriate transfer, condition, and instructions for follow-up care;
 - (6) if the patient left against medical advice; and
 - (7) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.
- (f) 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:
- (1) findings during the prenatal period;
 - (2) the medical and obstetrical history;
 - (3) observations and proceedings during labor, delivery and postpartum period;
and
 - (4) 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 must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

- (g) 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:

- (1) history of maternal health and prenatal course, including mother's HIV status, if known;
- (2) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;
- (3) 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;
- (4) 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;
- (5) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;
- (6) documentation of infant feeding: intake, content, and amount if by formula; and
- (7) clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3.4. History and Physical:

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

3.5. Progress Notes:

- (a) Progress notes will be entered by the attending physician (or his or her covering practitioner) at least daily under normal circumstances for all hospitalized patients and as needed to reflect changes in the status of a patient in a Hospital-based ambulatory care setting.
- (b) Progress notes will be legible, dated, and timed. 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.
- (c) Progress notes may also be entered by allied health professionals as permitted by their clinical privileges or scope of practice.

3.6. Authentication:

- (a) 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.
- (b) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.
- (c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

Informed consent will be obtained in accordance with Administrative Policy 4.20.136.

3.8. Delinquent Medical Records:

- (a) The Medical Records Department will monitor medical records for deficiencies and delinquencies in accordance with Hospital Administrative Policy Number 2.26.104. The chart completion requirements for Hospital-based ambulatory care will be the same as for other medical records.

- (b) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner or it is ordered filed by the Medical Records liaison (herein defined as the Director of the Medical Records Department who consults, as needed, with the Chair of the Medical Records Committee). Except in rare circumstances, and only when approved by the Medical Records liaison, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

- (c) When a practitioner is no longer a member of the Medical or Allied Health Staff and his or her medical records are filed as permanently incomplete, this will be recorded in the practitioner's credentials file and divulged in response to any future credentialing inquiry concerning the practitioner.

- (d) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the Medical Records liaison.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

- (a) 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 via the CPOE in accordance with Hospital policy.

- (b) All orders (including verbal/telephone orders) must be:
 - (1) dated and timed when documented or initiated;

 - (2) authenticated by the ordering practitioner or, in the case of verbal orders, another responsible practitioner. Orders for inpatient admission must be authenticated prior to patient discharge from the Hospital. 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

 - (3) documented completely. Handwritten orders should only be used under extenuating circumstances and should be documented clearly and legibly. Handwritten 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.

- (c) The use of summary (blanket) orders to resume previous medications is not appropriate without an appropriate reconciliation.

- (d) 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 reevaluated in the EMR to determine if it is to be continued.
- (e) All orders are reconciled 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.
- (f) 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.
- (g) All orders for medications administered to patients will be:
 - (1) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit);
 - (2) reviewed by the attending physician or his or her designee on an ongoing basis to assure the discontinuance of all medications no longer needed;
 - (3) reconciled at transfers between services or levels of care and at discharge; and
 - (4) automatically cancelled after an invasive or surgical procedure if intended for intraprocedural use.
- (h) All medication orders will clearly state the administration times or the time interval between doses. If an order is stopped because it was not specifically prescribed as to time or number of doses, a new order must be placed in order to resume the medication. All PRN medication orders must be qualified by specifying time intervals and/or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

- (i) Allied health professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. Orders issued by an allied health professional will be countersigned/authenticated in accordance with their clinical privileges.
- (j) An order written by a resident does not need to be countersigned/authenticated; however, an order written by an acting intern will be countersigned/authenticated by a resident or member of the Medical Staff prior to being executed.

4.2. Inpatient Orders:

- (a) Inpatient admission orders should follow the requirements outlined in Section 2.1.
- (b) Inpatient orders will be accepted only from practitioners and acting interns. Any such order must be within the scope of practice, delineated clinical privileges and approved protocols of the practitioner writing the order.

4.3. Outpatient Orders:

- (a) Orders for outpatient services may be ordered (and patients may be referred for Hospital outpatient services) by a practitioner where the practitioner is:
 - (1) responsible for the care of the patient (i.e., treating the patient in the office, clinic, or other setting);
 - (2) licensed in, or holds a license recognized in, the state where the practitioner is treating the patient (e.g., where the order is from non-affiliated practitioners), and satisfies any additional requirements with respect to licensure that may be imposed by any state or other governmental agency;
 - (3) acting within the practitioner's scope of practice under the law in the state where the practitioner is treating the patient; and

- (4) authorized by the Medical Staff to order the applicable outpatient services pursuant to Hospital policy.
- (b) If the ordering practitioner is not affiliated with the Hospital (i.e., is not on the Medical Staff and has not been granted clinical privileges that include the ordered service), the order must be submitted on a prescription pad, letterhead, or an electronic order form which includes the following:
- (1) practitioner's printed or typed name, telephone number, and signature;
 - (2) patient's name;
 - (3) requested outpatient service;
 - (4) reason for ordering the outpatient service (i.e., diagnosis, signs, symptoms, or ICD-9-CM diagnosis code); and
 - (5) date of the order.

Upon receipt of the order, the practitioner's office will be contacted to obtain licensure numbers, UPIN, NPI, Medicare and Medicaid numbers or any other applicable identifying numbers and information. The practitioner's status will then be verified with state licensing bodies and applicable federal and state regulators, such as the HHS/OIG List of Excluded Individuals/Entities. In the event the practitioner's status cannot be verified, orders may not be accepted from that practitioner.

- (c) A practitioner must be a member of the Medical Staff with appropriate clinical privileges to order blood products administration, infusion therapies, and dialysis/apheresis.
- (d) The following are examples of exceptions to this Section that apply to Medicare beneficiaries because Medicare does not require an order to provide the following services: screening mammography, influenza virus vaccine and its administration, and pneumococcal pneumonia vaccine ("PPV") and its administration. Please note, however, that other entities and regulations, including The Joint Commission and the

Medicare Conditions of Participation, may have additional requirements beyond the scope of this policy that should be followed.

4.4. Verbal Orders:

- (a) A verbal order (via telephone or in person) for medication, biological, or treatment will be used to meet the urgent care needs of the patient when it is not feasible for the ordering practitioner to immediately communicate the order in written or electronic form, in accordance with Administrative Policy 2.43.140.
- (b) All verbal orders will include the date and time of entry into the medical record and identify the names of the individuals who gave, received, and implemented the order. All verbal orders will 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.
- (c) A verbal admission order must be authenticated by the admitting physician prior to the patient's discharge from the Hospital. Authentication of all other verbal orders will take place by the ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, within 30 days of discharge.
- (d) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.
- (e) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:
 - (1) registered and licensed practical nurses;
 - (2) pharmacists;
 - (3) respiratory therapists;
 - (4) physical therapists;
 - (5) occupational therapists;
 - (6) registered dieticians;

- (7) speech pathologists;
- (8) registered imaging technologists; and
- (9) certified sleep technologists.

4.5. Standing Orders, Order Sets, and Protocols:

- (a) For all standing orders, order sets and protocols that permit treatment to be initiated without a prior specific order from the attending physician, review and approval of the Medical Executive Committee and the Hospital's nursing and pharmacy departments is required. Prior to approval, the Medical Executive Committee will confirm that the standing order, order set, or protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is a periodic review (i.e., not sooner than one year and not later than three years) of such 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.
- (b) If the use of a standing order, order set or written 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 practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.
- (c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.
- (d) 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.

4.6. Self-Administration of Medications:

Where permitted, the self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will be addressed in accordance with applicable Hospital policy.

4.7. Stop Orders:

- (a) 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 and the order does not contradict any medication use policy established by the Pharmacy and Therapeutics Committee.
- (b) Drugs for which automatic stop orders have been determined by the Pharmacy and Therapeutics Committee (or its designee) should be on a currently maintained list, available to all practitioners in the Hospital. This list will be maintained by the Pharmacy Department. Examples include, but are not limited to, epidural solution and TPN solution orders, which will be discontinued after 24 hours.

4.8. Orders for Drugs and Biologicals:

- (a) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.
- (b) 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.

4.9. Orders for Radiology and Diagnostic Imaging Services:

- (a) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other practitioners authorized by the Medical Staff to order services.
- (b) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

ARTICLE V

CONSULTATIONS

5.1. Requesting Consultations:

- (a) Practitioner-to-practitioner contact is encouraged whenever a consultation is requested.
- (b) Requests for consultations shall be ordered in the EMR by a member of the requesting care team (i.e., the attending physician, his or her Category II practitioner, or a resident) and in accordance with the following communication guidelines:
 - **Routine Consults** – In addition to entering the reasons for the consultation request in the EMR, a member of the requesting care team will make reasonable attempts to personally contact the consulting physician to discuss all routine consultation requests.
 - **Urgent Consults** – For urgent consults, the attending physician must personally speak with the consultant to provide the patient’s clinical history and the specific reason for the urgent consultation. The physicians will agree on the time frame for the consultation based on the needs of the patient.
- (c) Failure by an attending physician to follow the communication guidelines described in this Section may be reviewed through the appropriate Medical Staff policy.
- (d) A physician who is asked to provide a consultation must confer with the attending physician before making his or her own request for a consultation with another physician.

5.2. Responding to Consultation Requests:

- (a) 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 will respond to the request either in person or via technology-enabled direct communication and

evaluation (i.e., text or other EMR physician communication). In either case, the individual responding to a request (“consulting physician”) is expected to respond in accordance with the following patient care guidelines:

- (1) **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
 - (2) **Urgent Consults** – must be completed within the time frame agreed upon by the attending physician and the consulting physician.
- (b) The consulting physician may ask a Category II practitioner with appropriate clinical privileges to see the patient, gather data, order tests, and develop an assessment and plan. However, an evaluation by a Category II practitioner will not relieve a consulting physician of his or her obligation to personally see the patient within the time frames outlined in this section, **unless** the physician ordering the consultation specifically approves of the consultation being performed by a Category II practitioner.
- (c) 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 (or his or her designee) through a note in the EMR or by a phone call or text message.
- (d) Failure to respond to a request for a consultation in a timely and appropriate manner may be reviewed through the appropriate Medical Staff policy unless one of the following exceptions applies to the physician asked to provide a consultation:
- (1) the physician has a valid justification for his or her unavailability (e.g., out of town);
 - (2) the patient has previously been discharged from the practice of the physician;
 - (3) the physician has previously been dismissed by the patient;

- (4) the patient indicates a preference for another consultant; or
- (5) 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 (1)-(5)), then the requesting physician will find an alternate consultant. If the attending is unable to do so, then the VP & Chief Clinical Officer, the President of the Medical Staff, or the appropriate service line executive medical director can appoint an alternate consultant.

- (e) 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.
- (f) 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 service line medical director, the President of the Medical Staff, or the VP & Chief Clinical Officer.

5.3. Recommended Consultations – General Patient Care Situations:

- (a) Consultations are recommended in all cases in which, in the judgment of the attending physician:
 - (1) there is doubt as to the best therapeutic measures to be used;
 - (2) the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - (3) complications are present that may require specific skills of other practitioners;

- (4) they are requested by the patient or family, or the patient's representative if the patient is incompetent; or
 - (5) they are indicated for the clinical specialty in admission to special care units.
- (b) The President of the Medical Staff, the VP & Chief Clinical Officer, and the applicable service line medical director shall each also have the right to call in a consultant where a consultation is determined to be in the patient's best interest.

5.4. Mental Health Consultations:

A mental health consultation and treatment will be requested for and offered to all patients who are determined to be a potential danger to self and/or 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.

5.5. Content of Consultation Report:

- (a) 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.
- (b) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record or verbally communicated and documented with a note following the discussion between the requesting and consulting physicians 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.

ARTICLE VI

SURGICAL SERVICES

6.1. General:

- (a) Operating rooms will be assigned to clinical service areas according to patient and procedure volumes.
- (b) Non-emergency cases, or elective cases, must be scheduled through Surgical Booking. Emergency cases are booked through the OR charge nurse on duty. Where the booking of an emergency procedure displaces a previously scheduled non-emergency case, the attending physician on the displaced case will be notified.
- (c) If there are more emergency cases for which booking is requested than available capacity allows, the practitioners requesting the emergency booking will communicate and work collaboratively to prioritize the appropriate procedure order based on patient acuity. If the practitioners requesting the emergency bookings are unable to reach agreement on the appropriate priority, the service line executive medical director(s) will be consulted, as necessary, to establish the appropriate procedure order. If the service line executive medical director(s) is unable to establish an appropriate procedure order, the issue may be escalated to the President of the Medical Staff, who, in such case, will make the final decision regarding the procedure order.

6.2. Pre-Procedure Protocol:

- (a) Except in an emergency situation, the attending physician (i.e., surgeon) is responsible for ensuring the following documentation is in the Hospital medical record prior to transport to the operating room: (i) the provisional diagnosis and the results of any relevant diagnostic tests and alternative treatments; (ii) documentation indicating medical necessity for the procedure, as applicable; (iii) a properly executed informed consent; and (iv) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies. The informed consent may be obtained by a responsible member of the House Staff.
- (b) 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:

- (1) the attending physician (i.e., surgeon) is in the Hospital; and
- (2) the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Hospital’s Universal Protocol Policy.

6.3. Post-Procedure Protocol:

- (a) If the full operative report is not placed in the medical record immediately after surgery, for example due to transcription or filing delay, then a brief post-op note must be dictated or entered by a physician (attending physician or resident only) into the EMR immediately after the procedure and before the patient is transferred to the next level of care, to provide pertinent information for anyone required to attend to the patient. Practitioners are strongly encouraged to use the template that is in the EMR for this purpose. The brief post-op note will include:
 - (1) the names of the physician(s) responsible for the patient’s care and physician assistants;
 - (2) the name and description of the procedure(s) performed;
 - (3) findings, where appropriate, given the nature of the procedure;
 - (4) estimated blood loss, when applicable or significant;
 - (5) specimens removed;
 - (6) post-operative diagnosis; and
 - (7) variation from planned procedure.

- (b) The full operative procedure report must be documented and entered into the record within 24 hours under normal circumstances. The full operative procedure report shall include:
- (1) the patient's name and Hospital identification number;
 - (2) pre- and post-operative diagnoses;
 - (3) date and time of the procedure;
 - (4) the name of the attending physician(s) and assistant surgeon(s) responsible for the patient's operation;
 - (5) procedure(s) performed and description of the procedure(s);
 - (6) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
 - (7) findings, where appropriate, given the nature of the procedure;
 - (8) estimated blood loss;
 - (9) any unusual events or any complications, including blood transfusion reactions and the management of those events;
 - (10) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
 - (11) specimen(s) removed, if any;
 - (12) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(13) the signature of the attending physician.

6.4. Specimens:

- (a) Specimens will be submitted to the Pathology Department according to Hospital Administrative Policy Number 5.9.205. The Pathology Department may exempt certain tissues from submission for pathological evaluation (see Hospital Administrative Policy Number 5.9.205 for current list). All specimens must be properly handled and labeled.
- (b) At the discretion of the Division Chief of Pathology, any tissue or subsequently prepared glass slides may be analyzed by an external consultant pathologist. In such situations, both the Hospital pathology report and the outside consultant pathologist report will be made a part of the patient's medical record.
- (c) Removal of specimens or glass slides from the Hospital is expressly forbidden without the knowledge and consent of the Division Chief of Pathology. Any permitted removal will proceed according to Pathology Department procedure.

6.5. Outside Pathology Consultations:

If the attending physician desires a consultation with another pathologist, discussion with the responsible pathologist will ensue and, after a proper release form is received to permit the consultation, the responsible pathologist will send the appropriate tissue and/or slides to the designated consultant. Both pathologist reports will be made a part of the patient's medical record.

6.6. Intraoperative/Intraprocedural Pathology Consultations:

Physicians requiring an intraoperative/intraprocedural pathology consultation will call the Pathology Department and have a pathologist visit the OR/procedure area. The consultation may involve discussion, gross examination, and/or microscopic examination. A written record of any such consultation will be made at the time of the consultation on the pathology requisition form and will be included as part of the final pathology report which will be made a part of the medical record.

ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

- (a) “Anesthesia” herein defined refers to general anesthesia, major regional anesthesia and monitored anesthesia care. Anesthesia may only be administered by the following qualified practitioners:
 - (1) an anesthesiologist;
 - (2) a CRNA who is supervised by an anesthesiologist who is immediately available;
or
 - (3) an anesthesiologist’s assistant (“AA”) who is supervised by an anesthesiologist who is immediately available.

- (b) Moderate (also known as conscious) sedation and deep sedation are not anesthesia as herein defined, but are defined in their corresponding policy. Because it is not always possible to predict how an individual patient will respond to moderate or deep sedation, a qualified practitioner must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than intended. A qualified practitioner for these levels of sedation is a doctor of medicine (“M.D.”) or doctor of osteopathy (“D.O.”), dentist, oral surgeon or podiatrist with the appropriate clinical privileges, who is performing in accordance with the appropriate Hospital policies and state law.

- (c) Major regional analgesia (e.g., labor epidurals or continuous peripheral nerve blocks for post-operative analgesia) is not anesthesia as herein defined. These may be placed/initiated by the providers in 7.1(a) above and then monitored in the appropriate manner by members of the nursing staff in accordance with Hospital policy.

7.2. Pre-Anesthesia Procedures:

- (a) 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.

- (b) The evaluation will be recorded in the medical record and will include:
 - (1) a review of the medical history, including anesthesia, drug and allergy history;

 - (2) an interview, if possible, preprocedural education, and examination of the patient;

 - (3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

 - (4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

 - (5) 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

 - (6) 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 (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) 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.

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

7.3. Monitoring During Procedure:

- (a) 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.

- (b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:
 - (1) the name and Hospital identification number of the patient;

 - (2) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

 - (3) the name, dosage, route time, and duration of all anesthetic agents;

 - (4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

 - (5) the name and amounts of IV fluids, including blood or blood products, if applicable;

 - (6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

 - (7) 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.

7.4. Post-Anesthesia Evaluations:

- (a) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

- (b) 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 48-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).

- (c) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
 - (1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

 - (2) cardiovascular function, including pulse rate and blood pressure;

 - (3) mental status;

 - (4) temperature;

 - (5) pain;

 - (6) nausea and vomiting; and

 - (7) post-operative hydrations.

- (d) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the ASA using a modified Aldrete Recovery Score, or similar 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.
- (e) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
- (f) 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.

7.5. Minimal, Moderate or Conscious Sedation:

All patients receiving moderate (conscious) or deep sedation will be monitored and evaluated before, during, and after the procedure by an appropriately privileged practitioner according to the appropriate Hospital policy.

7.6. Department Director of Anesthesia Services:

Anesthesia services will be under the direction of a board certified anesthesiologist (M.D. or D.O.) who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE VIII

RULES FOR INTENSIVE CARE UNITS

8.1. General Information:

- (a) The intensive care units (collectively, "ICU") include the following: Medical Intensive Care (MICU); Surgical Intensive Care (SICU); Cardiovascular Intensive Care (CVICU) and Electronic Intensive Care (eICU).

- (b) The following are procedures that may be safely done in an ICU unit:
 - (1) Tracheotomy;
 - (2) Bronchoscopy;
 - (3) External Pacemaker;
 - (4) Peritoneal Dialysis;
 - (5) Hemodialysis;
 - (6) Burr holes and Intracranial pressure monitors;
 - (7) Swan-Ganz catheter insertion;
 - (8) Hemodialysis shunt;

- (9) Insertion of chest tubes (thoracotomy);
- (10) Cut downs;
- (11) Insertion of arterial and venous lines;
- (12) Intra-aortic balloon pump, insertions and removals;
- (13) Lung biopsy;
- (14) Spinal catheter insertion;
- (15) Mediastinal irrigation;
- (16) Intubation;
- (17) Paracenteses; and
- (18) Thoracenteses.

- (c) Notwithstanding the foregoing, where the attending physician, through the exercise of good clinical judgment, determines in an emergent setting that a patient's interests would be best served by performing a procedure other than those listed in an ICU setting, that procedure may be performed.

8.2. The eICU:

- (a) The eICU system is a patient monitoring station capable of observing and evaluating many critically ill patients in the Hospital's ICU from another location. The eICU practitioners continually monitor clinical, physiologic, and laboratory data of patients in the monitored ICU, with the capacity to detect changes in the patient's condition allowing the Hospital to optimize interventions to benefit the patient's condition.

- (b) The eICU program tracks the vital signs and test results, creating an EMR for the ICU patient. An abstracted form of the admission notes and attending physician progress notes are made part of the EMR, and other notes and orders are monitored by the eICU system to attempt to ensure that any and all interventions are consistent with the overall plan of care. The EMR is also available for viewing and data entry in the actual ICU. Consequently, attending and consulting physicians may write their notes directly into the EMR, in order to facilitate communication between the eICU practitioner and the attending physician.
- (c) Patients admitted to the Hospital's ICU units will be monitored in the eICU. The eICU program acts in a manner analogous to a vigilant nurse or practitioner, normally alerting the eICU practitioner regarding any potentially life-threatening change in the patient's status or newly reported critical test results. If it appears that the danger to life is immediate, the eICU practitioner will attempt to intervene and provide appropriate medical interventions until on-site physicians are able to treat the patient at the patient's bedside. The eICU program will also assist the eICU practitioner in attempting to maintain the care plan of the attending physician and to initiate treatment for new situations that may develop. If the intervention and/or change in the patient status is major, the eICU practitioner may initiate the intervention and document the intervention in the patient's medical record or notify the attending physician. If a change in the patient's status appears to require a change in the plan of care, the eICU practitioner will contact the attending physician who will determine any changes in treatment.
- (d) The eICU system does not place verbal orders on a chart. Rather, all eICU-generated orders will be timed, dated, and electronically signed by the eICU practitioner. All such orders will be accompanied by a timed, dated, and electronically signed progress note by the ordering physician describing the circumstance and the reason for the order. Both the order and the progress note will be placed in the chart, becoming part of the permanent medical record.

ARTICLE IX

PHARMACY

9.1. General Rules:

- (a) Orders for drugs and biologicals are addressed in the Medical Orders Article.
- (b) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.
- (c) 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 director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.
- (d) The pharmacy may substitute an alternative equivalent product (1) 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, or (2) where the alternative is identified as a therapeutic equivalent in accordance with Hospital policy.
- (e) 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.
- (f) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Medical Executive Committee and the TCHIRB.
- (g) 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.

9.2. Storage and Access:

- (a) 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.
 - (1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.
 - (2) 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.
 - (3) Only authorized personnel may have access to locked or secure areas.

- (b) 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 President & Chief Executive Officer.

ARTICLE X

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

10.1. General:

- (a) Restraints or seclusion are never to be used as a means of coercion, discipline, convenience or retaliation and may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff, or others from harm.
- (b) “Restraint” is defined as:
- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or
 - A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from falling out of bed or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

- (c) “Seclusion” is defined as the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

- (d) “Behavioral restraint or seclusion” means the use of a restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

10.2. Orders for Restraints or Seclusion:

- (a) Restraints or seclusion may be ordered by the attending physician or other responsible practitioner who is authorized to order restraints or seclusion by Hospital policy in accordance with state law.
- (b) If a restraint or seclusion is ordered by anyone other than the patient’s attending physician, the attending physician shall be consulted as soon as possible after issuance of the order. This consultation may occur by telephone.
- (c) Orders for restraints or seclusion may not be issued as a standing order or on an as-needed basis (i.e., “PRN”).
- (d) Orders for restraints or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

10.3. Modification of Patient’s Plan of Care:

An order for a restraint or seclusion will result in a modification of the patient’s individual plan of care. The modified plan will identify the intervention selected, patient monitoring, and the frequency of reassessments of vital signs, safety, comfort, mental status, skin integrity, circulation, hydrating, toileting, and readiness for release from restraint or seclusion.

10.4. Notification to Patient and/or Family:

When possible, at the time of the restraint or seclusion, or as soon as possible thereafter, the individual ordering the restraint shall inform the patient, and/or his or her family, of the need for the use of restraint or seclusion, the method selected, and any other pertinent information related to the restraint or seclusion. If an adult patient has objected to having his or her medical condition discussed with his or her family, there will be no discussion with the family.

10.5. Evaluation and Monitoring of Patients Under Restraint or Seclusion:

(a) Face-to-face Evaluation for Behavioral Restraints or Seclusion.

The attending physician or responsible practitioner must physically examine (face-to-face) a patient subject to behavioral restraint or seclusion within one hour after the intervention is initiated, even if the restraint or seclusion has been removed before he or she arrives. The attending physician or responsible practitioner must evaluate:

- (1) the patient's immediate situation;
- (2) the patient's reaction to the restraint or seclusion;
- (3) the patient's medical and behavioral condition; and
- (4) the need to continue or terminate the restraint or seclusion.

(b) Monitoring of Patients with Either a Restraint or Seclusion.

- (1) All patients subject to either a restraint or seclusion must be monitored at least every two hours or more frequently if directed by the attending physician or indicated by the patient's condition.
- (2) Monitoring shall include at least the following: vital signs, safety, comfort, mental status, skin integrity, circulation, hydrating, toileting, and readiness for release from restraint or seclusion.

(c) Monitoring of Patients with Simultaneous Restraint and Seclusion.

Simultaneous restraint and seclusion are only permitted if the patient is continually monitored:

- (1) face-to-face by an assigned, trained staff member; or
- (2) by trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

10.6. Duration and Renewal of Orders for Restraints or Seclusion:

(a) Behavioral Restraints or Seclusion.

Behavioral restraints or seclusion may be issued and renewed in accordance with the following limits for up to a total of 24 hours:

- 4 hours for adults 18 years of age or older;
- 2 hours for children and adolescents 9 to 17 years of age; or
- 1 hour for children under 9 years of age.

After 24 hours, the patient must be seen and assessed by the attending physician or other responsible practitioner who is authorized to order restraint or seclusion by Hospital policy in accordance with state law. After the patient is seen and assessed, a new order for restraint or seclusion may be issued.

(b) Non-behavioral Restraints or Seclusion.

If a patient is not violent or self-destructive, the order for restraints may be issued for a period of up to 24 hours, and renewed at the discretion of the attending physician. The attending physician is not required to be physically present to evaluate the need to renew the restraint. Seclusion should not be used if the patient is not violent or self-destructive.

10.7. Documentation:

When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

- (a) any in-person medical and behavioral evaluation, including the one-hour face-to-face evaluation, if restraint or seclusion was used to manage violent or self-destructive behavior;
- (b) a description of the patient's behavior and the intervention used;
- (c) alternatives or other, less restrictive interventions attempted (as applicable);
- (d) the patient's condition or symptom(s) that warranted the use of the restraint;
- (e) the patient's response to the intervention(s), including the rationale for continued use of the intervention;
- (f) individual patient assessments and reassessments;
- (g) the intervals for monitoring;
- (h) revisions to the plan of care;
- (i) the patient's behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion;
- (j) injuries to the patient, if any;

- (k) death associated with the use of restraint or seclusion;
- (l) the orders for restraint or seclusion and the identity of the attending physician or responsible practitioner who ordered the intervention;
- (m) notification of the use of restraint or seclusion to the attending physician; and
- (n) any consultations.

10.8. Reporting:

- (a) With the exception of deaths described in (b) of this section, deaths that occur while a patient is restrained, within 24 hours after removal from restraint, and within one week after restraint where it is reasonable to assume that the use of restraints directly or indirectly contributed to a patient's death, shall be reported to CMS. Reports of a patient's death, other than those described in (b) of this section, must be made by phone, fax, or other electronic means to the CMS regional office by the close of the next business day. The date and time of the call must be documented in the medical record.
- (b) Patient deaths occurring during the use, or within 24 hours of the removal, of soft-restraints applied exclusively to the patient's wrist(s) will be recorded in an internal log or other system within seven days of the patient's death. The following information will be recorded in the internal log or other system:
 - (1) the patient's name and date of birth;
 - (2) the patient's medical record number;
 - (3) the patient's primary diagnosis(es);
 - (4) the date of the patient's death;

- (5) the cause of death;
- (6) the name of the attending physician or other practitioner responsible for the care of the patient; and
- (7) the date and time the death was recorded in the internal log.

The information contained in the internal log or other system will be made available in either written or electronic form to CMS immediately upon request.

ARTICLE XI

EMERGENCY SERVICES

11.1. General:

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness. 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.

11.2. Medical Screening Examinations:

- (a) Medical screening examinations, within the capability and capacity 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:
 - (1) 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.

(2) Labor and Delivery:

- (i) members of the Medical Staff with OB/GYN privileges;
- (ii) residents;
- (iii) Certified Nurse Midwives with OB privileges; and
- (iv) a trained triage unit nurse operating under the Maternal Fetal Triage Index (“MFTI”) Algorithm approved by the Medical Staff.

- (b) The results of the medical screening examination must be documented within 24 hours of the conclusion of an Emergency Department visit.

11.3. On-Call Responsibilities:

It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Section 2.B.1(a)(5) of the Medical Staff Credentials Policy.

ARTICLE XII

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

12.1. Who May Discharge:

- (a) Patients will be discharged only upon the order of a responsible practitioner.
- (b) At the time of discharge, the discharging practitioner will review the patient's medical record for completeness and provide any other documentation to complete the continuum of care.
- (c) 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.

12.2. Discharge Planning:

- (a) 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.
- (b) Discharge planning will be an ongoing process during a patient's hospitalization. The treatment team will reevaluate the needs of the patient on an ongoing basis, and prior to discharge, as they may change based on the individual's status, including:
 - (1) functional status;
 - (2) cognitive ability of the patient; and

- (3) family support.

- (c) Discharge planning will include determining the need for continuing care, treatment, and services after discharge.

12.3. Discharge Summary:

- (a) A concise, dictated 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.

- (b) Discharge summaries are expected to be completed on the day of discharge, but no later than within seven days of discharge in all cases. All discharge summaries will include the following:
 - (1) reason for hospitalization;

 - (2) significant findings;

 - (3) principal diagnosis and secondary diagnosis (if one exists);

 - (4) procedures performed and care, treatment, and services provided;

 - (5) information provided to the patient and family, as appropriate;

 - (6) disposition at discharge and provisions for follow-up care; and

 - (7) discharge medication reconciliation.

- (c) An abbreviated discharge summary, or “Dismissal Sheet,” may be used to document the discharge summary for routine obstetrics admissions, a patient discharged from antepartum service, a patient admitted for less than 48 hours, and a newborn services short admission for less than 48 hours.
- (d) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

12.4. 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.

12.5. Discharge Instructions:

- (a) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.
- (b) 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.
- (c) 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.
- (d) When the Hospital determines the patient’s 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.

- (e) 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:
 - (1) the reason for discharge;
 - (2) the patient's physical and psychosocial status;
 - (3) a summary of care provided and progress toward goals;
 - (4) community resources or referrals provided to the patient; and
 - (5) discharge medications.

ARTICLE XIII

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

13.1. Transfer:

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

- (a) assessing the reason(s) for transfer;
- (b) establishing the conditions under which transfer can occur;
- (c) evaluating the mode of transfer/transport to assure the patient's safety; and
- (d) 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.

13.2. Procedures:

- (a) 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:
 - (1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
 - (2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

- (3) 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
 - (4) 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.
- (b) When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:
- (1) reason for transfer;
 - (2) significant findings;
 - (3) a summary of the procedures performed and care, treatment and services provided;
 - (4) condition at transfer;
 - (5) information provided to the patient and family, as appropriate; and
 - (6) principal diagnosis and secondary diagnosis (if one exists).
- (c) When a patient requests a transfer to another facility, the responsible practitioner will:

- (1) explain to the patient his or her medical condition;
- (2) inform the patient of the benefits of additional medical examination and treatment;
- (3) inform the patient of the reasonable risks of transfer;
- (4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
- (5) provide the receiving facility with the same information outlined in paragraph (b) above.

13.3. 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 XIV

RESEARCH

14.1. General:

- (a) All research involving human subjects (sponsored or non-sponsored) will be conducted in a manner that minimizes risks to the welfare, health, and safety of the participants. Patient's rights, including the right of privacy, will be preserved, and an informed consent form will be obtained from the patient, or his or her authorized representative, prior to such participation.
- (b) The TCHIRB is designated to oversee research on human subjects conducted by the administration, nursing, medical and resident staff, or involving non-public information held by the Hospital. The purpose of the TCHIRB is to protect the rights and welfare of human subjects participating in research and to ensure that the human research conducted under this Article complies with all federal regulations, including those promulgated by the Department of Health and Human Services and the Food and Drug Administration at 45 C.F.R. §46 and 21 C.F.R. §§50, 56 and 812, and conforms to federal and state laws and the Hospital's policies. The ethical principles are based on the Nuremburg Code, the Declaration of Helsinki, the Belmont Report, and the International Conference on Harmonization (Good Clinical Practices).
- (c) The President & Chief Executive Officer is responsible for the appointment of members of the TCHIRB and the oversight of the TCHIRB. The Hospital may not approve research covered under this Article if it has not been approved by the TCHIRB; however, the Hospital administration may decline to conduct research previously approved by the TCHIRB. Investigators may not begin research involving human subjects until the TCHIRB has approved the study or has determined that it is exempt.

14.2. Prior Review of Proposed Research Projects:

- (a) The Administration of the Hospital will assist in determining the feasibility of protocols or proposals for research. Prior review of any proposed research project involving

human subjects will be obtained from the appropriate service line executive medical director (and division chief, if applicable) to include assurances that:

- (1) the principal investigator has appropriate training and expertise, adequate resources and sufficient time allocation to conduct the research;
 - (2) the research is pertinent to the needs and goals of the institution, service line and community;
 - (3) the research has been found to be acceptable for TCHIRB submission.
- (b) In the case of sponsored research, a contract must be obtained from the investigator and reviewed carefully by the Institutional Official of the Hospital, and must be approved and signed by the President & Chief Executive Officer. Before being submitted to Administration for review, the investigator must assure that the contract or agreement indicates:
- (1) the research will be conducted in accordance with the written protocol, applicable law and the ethical standards of the Hospital, and that the Hospital will not deviate from its policies and procedures at the request of the sponsor;
 - (2) the arrangements for medical care in the case of research-related injuries or adverse reactions is defined;
 - (3) the contract or agreement requires the sponsor report to the research site any findings detected during the monitoring process that could affect the safety of participants or their willingness to continue participation, influence the conduct of the study, or alter the TCHIRB's approval to continue the study;
 - (4) the terms concerning dissemination or publication of the results of the study;
 - (5) how current and past participants are notified if findings from the study indicate increased risk of a problem that was not anticipated at the time of study design;

- (6) the conflicts of interest are addressed appropriately, if applicable; and
- (7) insurance stipulations.

14.3. Approval of Materials Relating to Investigational Drugs or Devices:

The protocol and ancillary materials relating to the clinical trial of any investigational new drug or device (drugs or devices which have not been approved by the Food & Drug Administration for general use and are not yet available through regular channels or interstate commerce) must be approved by the TCHIRB prior to being dispensed, used or administered. Research will be conducted only under the direct supervision of the principal investigator or approved co-investigator who must also be a member of the Medical Staff. Investigational new drugs and devices will be stored and dispensed by the Pharmacy pursuant to Hospital Administrative Policy 4.20.118. The investigator is responsible for the investigational device accountability which includes storage, security, dispensing, administration, return, disposition and records of accountability.

14.4. Access to Medical Records for Research Purposes:

- (a) Investigators/Researchers. Medical records will be made available to investigators or researchers whose written purpose and request for access have been approved by the appropriate service line executive medical director(s). Any research project which would involve patient contact by the researchers must have been approved by the attending physician of each patient participant in the project. The confidentiality of personal information regarding individual patients must be preserved. All persons accessing medical records for research related purposes will do so in compliance with HIPAA and/or other applicable federal, state and local law.
- (b) Students/Trainees. Medical records will be made available to students enrolled in education programs affiliated with the Hospital for use within the Medical Records Department. Students must present proper identification and provide written permission from their instructor and the appropriate service line executive medical director(s). Any data compiled for either educational or research purposes will not include patient or physician identifiers without prior authorization. In case of doubt, the chairperson of the TCHIRB should be consulted.

ARTICLE XV

HOSPITAL DEATHS AND AUTOPSIES

15.1. Death and Death Certificates:

- (a) 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.
- (b) Death certificates are the responsibility of the attending physician and will be completed within 24 hours of when the certificate is available to the attending physician.

15.2. Release of the Body:

- (a) In accordance with Hospital Administrative Policy Number 2.43.129, the body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after 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.
- (b) The attending physician will contact the coroner's office about any relevant death in accordance with Hospital Administrative Policy Numbers 2.43.114 and 2.43.129.
- (c) If the next of kin of the decedent object to the performance of an autopsy by the coroner, the coroner will review the case and make a final determination about whether the autopsy is necessary. In any such case, pursuant to Ohio Revised Code §2108.52, the coroner may, where circumstances so warrant, perform an autopsy without the consent of or over the objection of the next of kin of the decedent.

15.3. Organ and Tissue Procurement:

All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital Administrative Policy Number 2.43.129.

15.4. Autopsies:

- (a) The Medical Staff should attempt to secure autopsies in accordance with Hospital Administrative Policy Number 2.43.114 and state and local laws, including all cases of unusual deaths and of medical-legal and educational interest. The procedure autopsy will be a consultation between the attending physician and the responsible pathologist. The attending physician (or his or her designee) must be notified when an autopsy is to be performed.
- (b) 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.
- (c) Any request for an autopsy by the family of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the pathologist. The 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 President & Chief Executive Officer and/or the VP & Chief Medical Officer.
- (d) When an autopsy is performed, a provisional anatomic diagnosis should be recorded in the medical record of the decedent within two days, and the complete autopsy report should be made part of the medical record within 60 days.
- (e) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

15.5. 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 XVI

MISCELLANEOUS

16.1. Education of Students:

All members of the Medical Staff will cooperate with Hospital administration to facilitate the clinical education of medical students, residents, nurses, and students in other allied health programs at the Hospital.

16.2. Self-Treatment and Treatment of Family Members:

- (a) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

- (b) A member of the Medical Staff should not admit, consult, write orders, or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:
 - (1) no viable alternative treatment is available, as confirmed through discussions with the President of the Medical Staff or the VP & Chief Medical Officer;

 - (2) in the ED where the Medical Staff member is the attending physician or is on call; or

 - (3) in an emergency where no other Medical Staff member is readily available to care for the family member.

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

16.3. Procedures Performed Under Unusual Circumstances:

If a physician desires to perform a procedure under unusual circumstances, for example, on a nursing unit where it is not usually performed, and when a patient's life is not in imminent danger, the decision as to whether or not the procedure may be performed should be made by the physician and the charge nurse on duty. It is the responsibility of the charge nurse on duty to escalate decisions of this nature to the service line executive medical director or division chief for a determination, if the physician and charge nurse on duty have differing opinions, as to the course of action deemed in the best interest of the patient. Where no service line executive medical director or division chief is available, the decision about a procedure to be performed under unusual circumstances should be made by the President of the Medical Staff or his or her designee.

16.4. Sterilization:

Sterilization procedures performed upon both female and male patients are voluntary, or related to pathology encountered within an invasive procedure. Voluntary sterilization procedures are performed for a wide variety of obstetrical, gynecological, medical, surgical and psychiatric indications. A requirement for voluntary sterilization is that the informed consent for sterilization be completed and signed by the patient or a person having the legal authority to offer such consent on behalf of the patient, and also signed by the surgeon performing the sterilization procedure. Also, the surgeon may request a personal letter from the patient giving reasons for requesting the operation and the understanding of its possible failure and complications.

16.5. HIPAA Requirements:

All members of the Medical Staff and Allied Health Staff will adhere to the Hospital policies and procedures regarding HIPAA security and privacy requirements. A practitioner may access, utilize, or disclose protected health information only when the practitioner is directly involved in the patient's care.

ARTICLE XVII

AMENDMENTS

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

ARTICLE XVIII

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.

Originally adopted by the Medical Executive Committee on November 25, 2014 and approved by the Board on January 28, 2015.

Amended: Medical Executive Committee – March 28, 2017.
Board – April 18, 2017.

Amended: Medical Executive Committee – September 26, 2017.
Board – October 18, 2017.

Amended: Medical Executive Committee – February 26, 2019.
Board – February 27, 2019.

Amended: Medical Executive Committee – August 25, 2020.
Board – August 27, 2020.

Amended: Medical Executive Committee – March 22, 2022.
Board – April 1, 2022.

Amended: Medical Executive Committee – August 23, 2022.

Board – September 1, 2022.