FORT WAYNE, INDIANA

MEDICAL/DENTAL STAFF
RULES AND REGULATIONS

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ST. JOSEPH HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS

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ST. JOSEPH HOSPITAL

MEDICAL STAFF

RULES & REGULATIONS

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

ARTICLE I
ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

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

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

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

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

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

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

(2) The Chief of Staff, who may assume care for the patient or designate any appropriately trained member of the staff; or

(3) In the absence of the above, any appropriately trained member of the Medical Staff requested by the CEO to provide care for the patient.

1.2 ADMITTING POLICY

Priorities for admission are as follows:

1.2(a) Emergency Admissions

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

1.2(b) Preoperative Admissions

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

1.2(c) Routine Admissions

Patients admitted to general medical/surgical/ pediatric units shall be seen within eighteen (18) hours following admission unless the patient's condition warrants an earlier assessment.

Patients admitted to critical care areas shall be seen by the Attending Physician as follows:

1) Emergent: Condition requires immediate intervention to stabilize patient or prevent loss of life or limb. In emergent cases, patient shall be seen within one (1) hours.
2) Urgent: High level of concern for a health issue that requires diagnosis or intervention, but would not result in loss of life or limb. In urgent cases, patient shall be seen within six (6) hours.

1.2(d) Question of Validity

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

1.3 PATIENT TRANSFERS

1.3(a) Transfer priorities shall be as follows:

(1) Emergency Department to appropriate patient bed;

(2) From any department to ICU/IMC in an emergency;

(3) From ICU/IMC to the operating room or other procedure area in an emergency;

(4) From any department to Skilled Nursing Facility;

(5) From obstetric patient care area (unit) to general care area when medically indicated; and

(6) From temporary placement in an inappropriate area to the appropriate area for that patient.

1.3(b) No patients will be transferred between departments without notification to the Attending Physician.

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

1.4 SUICIDAL PATIENTS

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

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

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

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

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

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

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

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

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

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

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

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

(2) Alternatives to transfer, if any;

(3) The clinical basis for the discharge;

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

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

(6) Written discharge instructions in a form and manner that the patient or family member can understand. For patient discharge orders, if diet and activity is not specified at the time of discharge by the physician, the nurse will include the most recent physician order during hospitalization.

1.6 DECEASED PATIENT

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

1.7 AUTOPSIES

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

An autopsy should be considered in the following situations:

1. Deaths in which the exact cause of death is not known (cause is sufficiently obscured to delay completion of death certificate).
2. Deaths related to a genetically inheritable condition (for purposes of genetic counseling).
3. Deaths in which the autopsy would meaningfully augment medical knowledge.

4. Death incident to or within seven (7) days of obstetrical delivery.
5. Death occurring in patients receiving experimental therapy if autopsy results are considered helpful to evaluation of experimental regimen.
6. When there are concerns about the possible spread of a contagious disease.
7. When death occurs suddenly, unexpectedly, or under mysterious circumstances from apparently natural causes, but does not come under the jurisdiction of a medical examiner or coroner.
8. All neonatal deaths.

1.8 UNANTICIPATED OUTCOMES

In the event of an unanticipated outcome or adverse event, the patients' treating and/or consulting physician shall participate in discussion of the outcome or event with the patient, family and/or legal representative to the extent appropriate under the hospital's Policy on Disclosure of Treatment Outcomes.

1.9 INFORMED CONSENT

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

1.9 (a) Length of Time Consent Valid

A validly executed consent form will be valid for the specific purpose stated therein for a period of thirty (30) days, provided that:

1) The patient expresses no contrary indication; and/or
2) No contrary treatment order has been prescribed by the physician in the interim period
3) Where a validly executed consent exceeds time guideline such consent may only be used if the physician and nurse both document there is no charge of circumstances or contrary expression of the patient.

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

1.10 PATIENT REQUESTS AND REFUSAL OF TREATMENT

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

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

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, radiology services, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, legal status of patients receiving mental health services, adverse drug reactions, if any, clinical resume except for short stays and OB's, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report, when performed. The record shall also contain a report of any emergency care provided to the patient; evidence of known advance directives; documentation of consent; and a record of any donation of organs or tissue or receipt of transplant or implants. The record shall also contain a written plan of care, treatment and services appropriate to the patient's needs, identifying the patient's needs, goals, timeframes, settings, and services required to meet the patient's needs. Such plan of care shall be discussed with the patient and shall be revised as necessary, and where appropriate, consider strategies to limit the use of restraints and/or seclusion of the patient. If doubt exist as to who the attending practitioner is, the admitting practitioner listed on the face sheet will be responsible for completing the chart.

2.2 ADMISSION HISTORY

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

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

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

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

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. (Exception: Behavioral Health which requires a progress note at least every forty-eight (48) hours and at least five of every seven days and TCU which requires a progress not at least once per

month). The written admission note shall serve as the progress note for the day of admission, unless the patient's condition warrants further progress notes on that date**.**

2.5 OPERATIVE/PROCEDURAL REPORTS

Operative/procedural reports shall include a preoperative diagnosis, a detailed account of the findings at surgery, name and the details of the surgical technique, postoperative diagnosis and tissue or specimens removed or altered. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within twenty-four (24) hours after completion of surgery. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis

2.6 CONSULTATIONS

It will be the responsibility of the Attending Physician or surgeon to obtain consultation. Consultations shall be obtained through written order of the Attending Physician or AHP. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. If the consultant is making a significant change in diagnosis or recommending a substantial change in treatment course especially if this is urgent, a direct communication with the requesting physician is strong encouraged.

Consultations shall be accomplished in a timely manner and with appropriate communication and documentation.

(a) Timeliness

(1) *Emergent:* Condition requires immediate intervention to stabilize patient or prevent loss of life or limb. Patient shall be seen within one (1) hour. In emergent cases, physician-to-physician communication is required.

(2) *Urgent*: High level of concern for a health issue that requires diagnosis or intervention, but would not result in loss of life or limb. In urgent cases, patient shall be seen with six (6) hours. In urgent cases, physician-to-physician communication is required.

(3) *Non-Urgent:* Expertise of consultant is required, but clinical course will not be affected within 18 hour time frame. In non-urgent cases, patients shall be seen within 18 hours.

(4) *Operative procedures:* When operative procedures are involved, the consultation note shall be recorded prior to the operations, except in emergency situations so verified on the record.

2.7 OBSTETRICAL PATIENT HISTORIES

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

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written and verbal orders, shall be accurately dated, timed and authenticated. The use of rubber stamp signature is not acceptable under any conditions. Notwithstanding anything contained herein, all orders for medications and other services shall be documented using an electronic system that supports clinical decision-making when that electronic system is available for use at the Hospital. Such electronic system, when available, will be accessible at the point of care and remotely, through a secure process. Electronic system orders shall be authenticated through the use of an electronic-signature process consistent with applicable legal and accreditation requirements and as specified by these rules and regulations and hospital policy.

2.9 ABBREVIATIONS/SYMBOLS

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

2.10 FINAL DIAGNOSIS

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

2.11 REMOVAL OF MEDICAL RECORDS

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

2.12 ACCESS TO MEDICAL RECORDS

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

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

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

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

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

2.13 PERMANENTLY FILED MEDICAL RECORDS

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

2.14 ORDERS

2.14 (a) Electronic (CPOE)/Written/Verbal/Telephone Treatment Orders

Computer Patient Order Entry (CPOE): To increase patient safety and quality and to improve efficiency of order completion, orders for treatment shall be directly entered into the electronic medical record. Handwritten orders may be accepted in an emergency situation, during computer down time or other circumstances in which it would be impractical or impossible to enter electronically.

Written/Verbal/Telephone Treatment Orders: Verbal orders are discouraged except in emergency situations. A verbal or telephone order shall be dictated to an RN and signed by the RN and countersigned by the physician giving the order. Medical students (with co-signatures of supervising physician), Pharmacists, Respiratory technicians, Radiology technicians, Behavioral Health Therapists/counselors, Case managers, Social Service, Dieticians, Medical technicians, Trained laboratory professionals, Rehab therapists and CRNAs may accept verbal orders relating to their area of practice.

All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient's name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the physician and indicate that the individual has confirmed the order. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate and date any order, including but not limited to medication orders, as soon as possible, such as during the next patient visit, and in no case longer than forty-eight (48) hours from dictating the verbal order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

Orders for treatment and care of patients entered by properly credentialed Allied Health Professionals do not require a co-signature as long as they are acting within their approved scope of practice. All Allied Health Professional progress notes, history/physical examinations, discharge summaries and consultations must indicate the name of the collaborating physician.

2.14(b) Standing Orders and Preprinted and Electronic Order Sets

(i) Standing Orders: Standing orders are developed by the professional members of a healthcare entity. Standing orders are a group of orders that apply to all or almost all patients of a like category, relating to routine care or standard treatment measures. (Exceptions include patients with a positive history of MRSA and Parental preference not to administer immediate new born treatments.) The use of standing orders must be

documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care or other patient safety advances.

a. Standing orders may be implemented with an order to initiate.
b. Physician must authenticate the orders according to hospital policy.
c. A copy of the orders must be present in the patient'

Standing orders must be approved for use in this facility by the Medical Executive Committee. Standing orders should be reviewed at least annually.

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

2.14(c) **Illegible Treatment Orders**

When accepting handwritten orders, the practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

2.15 COMPLETION OF MEDICAL RECORDS

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated discharge summary shall be completed within twenty (20) days of discharge. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.

2.16 DELINQUENT MEDICAL RECORDS

The Health Information Management (HIM) will review for delinquent/incomplete medical records weekly on Wednesdays. A record shall be considered incomplete when any portion requires completion by a practitioner. A record shall be considered delinquent when it remains incomplete more than twenty (20) days after discharge and/or requires an H & P, Surgery Report or Psych Evaluation that has not been completed within 24 hours.

2.16 (a) Delinquency Queue: Practitioners should monitor their queue in Physician Portal to ensure that they have completed all necessary documentation.

2.16 (b) Suspension List: After review of delinquencies each week, HIM will create a suspension list of any practitioner who has items considered delinquent. All hospital departments shall be notified of a suspension to enable the enforcement of the suspension.

2.16 (c) Suspension: A chart which is not completed within twenty (20) days of discharge will trigger suspension of the responsible physician's privileges. When a staff member is notified of suspension, the staff member may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended physician may not cover Emergency Room call, may not provide coverage for partners or other physicians, nor admit under a partner's or other Attending Physician's name. Any exceptions must be approved by the Chief of Staff and the CEO.

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

2.16 (e) A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the appropriate department chair, the CEO, or the chairperson of the Quality Council, or equivalent Medical Staff committee.

2.16 (f) Any physician who remains on suspension for seven (7) calendar days or longer will be referred to the Chief of Staff for review and possible further action by the MEC.

2.17 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

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

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

Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.18 DISCHARGE SUMMARY

A discharge summary shall be written or dictated on all medical records of hospitalized patients. The Attending Physician can designate properly credentialed Allied Health Professionals to complete the discharge summary if it is included in their scope of practice. All summaries shall be authenticated by the responsible practitioner or their designee and shall include the following:

(1) Name and age of the patient
(2) Dates of admission and discharge
(3) Reason for admission
(4) Significant findings
(5) Procedures performed and treatment rendered
(6) Final diagnosis
(7) Condition of patient of discharge with specific measurable comparison with the condition on admission
(8) Specific pertinent instructions given to patient and/or family

(9) Instructions relating to physical activity, medication, diet and plans for the follow-up
(10) A death summary must be completed on every deceased patient.

2.19 FINAL PROGRESS NOTE

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a forty-eight hour (48) period of hospitalization, and in the care of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note shall include the patient's final diagnosis, and any instructions given to the patient and/or family, and the patient's condition on discharge.

2.20 OBSTETRICAL RECORDS.

Obstetrical records shall include complete prenatal information. The prenatal record may be a legible, durable original or copy of the attending practitioner's office or clinic record transferred to the Hospital before admission. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

2.21 EMERGENCY DEPARTMENT RECORDS

All orders written in the emergency department are written with a frequency of one time unless ordered otherwise.

ARTICLE III
GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT FORM

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

3.2 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed on the hospital formulary Drugs and medications not on the formulary may be approved for dispensing as outlined in hospital policy. Drugs for bona fide clinical investigations may be utilized only after approval by the committee performing the pharmacy and therapeutics function and the MEC.

The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

3.3 ORDERING/DISPENSING OF DRUGS

The physician must order drugs by name, dose, route and frequency of administration. Drugs shall be dispensed from and reviewed by the hospital pharmacist, or as circumstances demand (i.e., exigent patient need, or unavailability of the pharmacist) another qualified health care professional, subject to retrospective review by the hospital pharmacist to determine: the appropriateness of the medication, dose, frequency, and route of administration; therapeutic duplication; real or potential allergies or sensitivities; real or potential interactions between the prescribed medication and other medications, food, and laboratory values; other contraindications; and variation from hospital dispensing criteria. When the patient brings medication to the hospital with him/her, those medications which are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the Pharmacist on duty. Upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding.

3.4 QUESTIONING OF CARE

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

3.5 PATIENT CARE ROUNDS

Hospitalized patients shall be seen by the Attending Physician or his/her designated alternate at least daily and more frequently if their status warrants. Patients in the Skilled Nursing Facility shall be seen monthly and more frequently if their status warrants, by the Attending Physician or his/her designated alternate. Patients admitted to Critical Care should be seen by the Attending Physician or his/her designated alternate as soon as possible after admission to the unit, but in any event no later than six (6)

after admission or sooner if warranted by the patient's condition. If the designated alternate is their AHP, the AHP should be at a minimum a nurse practitioner, physician assistant or clinical nurse specialist.

3.6 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care.

3.7 PATIENT RESTRAINT ORDERS

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

3.8 PRACTITIONERS ORDERING TREATMENT

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

3.9 TREATMENT OF FAMILY MEMBERS OR SELF-TREATMENT

Treatment by practitioners of immediate family members or self-treatment should be reserved only for minor illnesses or emergency situations. Practitioners may not self-prescribe or prescribe to immediate family members any controlled substances. Records must be maintained of any prescriptions or administration of any drugs. A practitioner may not perform surgery or invasive procedures on an immediate family member except in an emergency situation where no viable alternative is available.

3.10 RESIDENTS

The Medical Staff supports medical education through the presence in the hospital of resident physicians properly sponsored by the Fort Wayne Medical Education Program. Residents are approved to practice in the hospital by medical staff acceptance of a standardized set of documents presented by the Fort Wayne Medical Education Program at the beginning of each academic year.

Rules for resident practice in the hospital are contained in the Manual for Residencies of the Fort Wayne Medical Education Program, and in the Resident's Handbook for each individual Residency.

Physicians who participate in the hospital's residency training program must have all of their orders, progress notes, and attestation sheets relating to Medicare beneficiaries countersigned by the physician-resident's physician-mentor.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

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

4.2 ADMISSION OF DENTAL CARE PATIENT

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

4.2(a) Dentist's Responsibilities

The responsibilities of the dentist are:

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

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

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

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

(5) To provide a clinical summary.

4.2(b) Physician's Responsibilities

The responsibilities of the physician are:

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

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

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

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the physician member of the Medical Staff.

4.3 ADMISSION OF PODIATRIC PATIENTS

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist. Podiatrists may complete their focused podiatric H&P but also must obtain medical clearance from a qualified medical staff member. Podiatrists who are granted the specific privilege may perform focused podiatric H&Ps for outpatients. If these patients need to be admitted, the patient's primary care physician or the hospitalist would need to admit the patient.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

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

(2) To provide a detailed description of the podiatric findings and a preoperative diagnosis;

(3) To complete an operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination;

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

(5) To provide a clinical summary.

4.3(b) Physician's Responsibilities

The responsibilities of the physician are:

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

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

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

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

4.4 EXAMINATION OF SPECIMENS

Specimens, excluding those listed below shall be evaluated by a pathologist. Each specimen must be accompanied by pertinent clinical information. The following specimens are exempt from pathological review: neonatal foreskin, placenta from normal vaginal delivery. The following specimens will have macroscopic (gross) exam only: teeth, lens (eye), foreign bodies, fingernails/toenails, orthopedic appliances (nails, pins, and screws), nasal cartilage, calculi (stones) from kidneys, urinary bladder, urethra, or ureters, (Chemical stone analysis must be indicated on the pathology requisition.), bunions, skin from plastic surgery revisions (microscopic exam if indicated), bone fragments (traumatic) and ribs from thoracic outlet syndrome. All other specimens will include a macroscopic and microscopic exam.

4.5 POST-OPERATIVE EXAMINATION

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

4.6 ANESTHESIA

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

4.6 (a) Anesthesia services throughout the hospital shall be organized into one anesthesia service under the direction of a qualified physician. The director of anesthesia services shall, in accordance with state law and acceptable standards of practice, be a physician who by experience, training, and/or education is qualified to plan, direct, supervise, and evaluate the activities of the anesthesia service. The director of anesthesia services may be, but is not required to be, an anesthesiologist member of the Medical Staff. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services.

4.6 (b) The hospital shall maintain policies and procedures governing anesthesia services provided in all hospital locations. Such policies and procedures shall indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia. In addition, such policies and procedures shall, on the basis of nationally recognized guidelines, provide guidance as to whether specific clinical applications involve anesthesia as opposed to analgesia.

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

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care must be supervised either by the operating practitioner who is performing the procedure or by an anesthesiologist who is immediately available. An anesthesiologist is considered “immediately available” only if he/she is physically located within the same area as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed. The operating practitioner has the right to request an anesthesiologist in lieu of a CRNA.

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

4.6 (d) The anesthetist or anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the hospital. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, this record shall include a pre-anesthesia evaluation, an intraoperative record, and a post anesthesia evaluation.

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation or anesthesia; as such terms are defined by The Joint Commission.

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

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

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

4.7 ORGAN & TISSUE DONATIONS

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

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

The Attending Physician, in collaboration with the designated organ procurement organization, shall determine the appropriate method of notifying the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. Any individual involved in the request for organ, tissue and/or eye donation must be formally trained in the donation request process. The patient's medical record shall reflect the results of this notification.

ARTICLE V
GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

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

5.1(a) All cesarean sections;

5.1(b) Premature infant's less than thirty-five (35) week's gestation, with or without complications;

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

5.1(d) All premature infants with complications; and

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

5.2 LABOR AND DELIVERY

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

5.3 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

When a pregnant female presents to the Emergency Department, she will be assessed by the triage nurse (RN) to determine whether the presenting complaint is onset of labor or otherwise pregnancy-related, or a general other complaint unrelated to pregnancy. Patients presenting in labor or with pregnancy-related complaints and meeting the gestational age requirements will be transported to the Labor and Delivery Unit with qualified medical personnel. (See policy ER 1004 Evaluation and Treatment of the Pregnant Patient Presenting to the Emergency Department.) All other pregnant females presenting to the Emergency Department, whether complaining of preterm labor or presenting with other complications, will be medically screened and treated as provided in Article VI of these Rules and Regulations. Preterm patients greater than 20 weeks will be treated in the OB unit. For those patients at term who are referred to the Labor and Delivery Unit**,** an RN trained in obstetrics will initiate the orders of the obstetrician of record, or in the case of a patient presenting with no prenatal care or care by a physician who is not a member of this Medical Staff, the orders of the physician on-call for obstetrics. For patients at term and without other complications, the medical screening examination required under Article VI may be performed by a qualified RN under the orders of and in telephone contact with the obstetrical physician, where permitted under state law. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the physician concurs with the assessment of the RN and the patient has had prenatal care under that physician or physician's practice. In cases where the patient has had no prenatal care and/or is unknown to the physician's practice, or in the case of a patient presenting with complications, the on-call physician shall examine the patient prior to a discharge decision and order. For patients determined to be in active labor after this screening process is completed by the qualified RN or in the event the RN feels that the obstetrician's physical presence is necessary to complete the medical screening, the provisions of Section 6.2 regarding consultations, referrals and emergency call shall apply. Where state law does not permit the

performance of the medical screening examination by an R.N., such medical screening examination shall be performed by a physician.

5.4 PATIENTS PRESENTING TO LABOR AND DELIVERY UNIT

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

5.5 ANESTHESIA SERVICES

Anesthesia services must be available within thirty (30) minutes after obstetric anesthesia is deemed necessary. Thus, the response time for arrival of the anesthesiologist must not exceed twenty (20) minutes. For patients seeking vaginal birth after previous c-section, appropriate facilities and personnel, including anesthesia, will be immediately available for emergency c-section.

ARTICLE VI
EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

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

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

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician trained in emergency medicine or a credentialed nurse practitioner or physician assistant under direct supervision of the emergency physician, unless the patient presents with obstetrical related condition. In the case of a woman in labor, a registered nurse trained in obstetric nursing where permitted under State law and Hospital. Or in the case of a person presenting for a psychiatric disturbances and/or symptoms of substance abuse, a licensed clinician trained in psychiatric assessment pursuant to hospital policy, Medicare or other applicable federal regulations.

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

6.1(b) Stabilization

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

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

(3) A patient Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

(4) A patient does not have to be stabilized when:

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

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

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

6.1 (c) Transfers

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

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

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

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

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record.

6.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department and that person will document the time of the contact in the patient's medical record.

6.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has attempted to reach the physician through all available means.

Twenty (20) minutes will be considered a reasonable time to carry out this procedure.

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

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

6.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department.

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

6.2(g) The system for providing on-call coverage shall be approved by the Board of Trustees and documented by written policy. As a condition of Medical Staff appointment, all emergency department physicians and any physician who is or may be required to take unassigned call for Emergency Department patients pursuant to the provisions of the Bylaws, Rules and Regulations shall be required to receive hospital-sponsored or hospital-approved EMTALA training prior to initial appointment and prior to each subsequent reappointment to the medical staff.

ARTICLE VII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

7.1 DEVELOPMENT

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

7.2 ADOPTION, AMENDMENT & REVIEWS

These rules and regulations shall be considered a part of the bylaws, except that they may be amended or replaced at any regular meeting at which a quorum present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. These actions require the approval of a majority of the Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules & Regulations, taking into account the recommendations of Medical Staff members. The Rules & Regulations shall be reviewed and revised as needed, but at least every two (2) years.

7.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

Each member of the Medical Staff shall be given a copy of any amendments to these Rules & Regulations in a timely manner.

7.4 SUSPENSION, SUPPLEMENTATION, OR REPLACEMENT

The Board reserves the right to suspend, override, supplement, or replace all or a portion of the Rules and Regulations in the event of exigent and compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients. However, should the Board so suspend, override, supplement or replace such rules and regulations, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in the bylaws), and shall thereafter proceed as provided in Section 8.2 for adoption and amendment of Rules & Regulations. If an agreement cannot be reached, the Board shall have the ultimate authority as to adoption and amendment of the Rules & Regulations, but shall exercise such authority unilaterally only when the Medical Staff has failed to fulfill its obligations and it is necessary to ensure compliance with applicable law or regulation, or to protect the well being of patients, employees or staff.

MEDICAL STAFF RULES & REGULATIONS
APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____ Date: ____May 4, 2016_____
Chief of Staff

BOARD OF TRUSTEES:

By: _____ Date: _____May 19, 2016_____
Chairperson

ST. JOSEPH HOSPITAL:

By: _____ Date: _____May 19, 2016_____
Chief Executive Officer