DEACONESS ILLINOS CROSSROADS

Medical Staff Rules and Regulations

DEACONESS ILLINOIS CROSSROADS
RULES & REGULATIONS
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DEACONESS ILLINOIS CROSSROADS
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, the initial patient status (inpatient, outpatient or observation), and a Code status designation. 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 or AHP in accordance with Section 1.1(j)The privilege to admit shall be delineated and is not automatic with Medical Staff or AHP 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, unless otherwise approved by the MEC and Board or required by contractual arrangement. The Emergency Department (ED) physician may not admit a patient to self unless this is an established patient, or this is an established patient of a physician that the ED physician is covering for, and the said ED physician has admitting privileges. The ED physician may, in consultation with an admitting physician, write basic admitting orders for "admission to the service of" the admitting physician. The admitting physician must come in to see the patient within the time frame provided in the Medical Staff Bylaws, Rules and Regulations and shall counter sign the admitting orders.

1.1(c) Individuals 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) Emergency Department providers/physicians must be board certified (or have equivalent education and training) in family practice, emergency medicine, internal medicine or have recent Emergency Department experience consisting of at least 2,500 hours in the previous five (5) year period. Emergency Department Physicians shall be required to maintain documentation regarding current ACLS, and PALS certification.

All hospitalists, anesthesia personnel and critical care providers must maintain documentation regarding current ACLS certification. Anesthesia personnel must also maintain PALS.

To satisfy the requirements for the Hospital's designation as a certified Pediatric Standby Facility in Illinois, the ED physician requirements include the following items:

(1) All physicians shall have training in the care of pediatric patients either through residency training, clinical training, or practice.

(2) All physicians shall successfully complete and maintain current recognition in the AHA-AAP, PALS, ACEP-AAP or APLS. PALS and APLS courses shall include both cognitive and practical skills evaluation.

(3) All physicians caring for children in the emergency department shall have documentation of a minimum of sixteen (16) hours of AMA Category I or II CME every two (2) years in Pediatric Emergency topics. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e. Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit

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

1.1(f) Each member of the Medical Staff shall designate a member of the Medical Staff who may be called to care for his/her patients in an emergency or at those times the practitioner is not readily available. Generally a practitioner is considered unavailable if he/she is unable to be contacted for thirty (30) minutes. In cases of inability to contact the practitioner, the following should be contacted, in order of priority listed below or as appropriate per the Patient's medical condition:

(1) Practitioner's designee(s);
(2) On Call Physician for the specialty
(3) Department Chair;
(4) Chief of Staff;
(5) Administration on Call

1.1(g) The following definitions will be adhered to in this facility:

(1) The practitioner (as described in Section 1.1(b)) who admits the patient is primarily responsible for the patient's care. The practitioner generates data by compiling a history of the patient, performing a physical exam and recording the results. The practitioner also generates data regarding the patient when orders for diagnostic and therapeutic services are made, when the patient's condition and response to treatment are assessed through progress notes, and when the patient's course at the end of the episode of care is summarized. (Taken from Huffman's Health Information Management Manual, 10th Ed.); and

(2) The Emergency Room physician is responsible for any medical treatment given to a patient presenting to the Emergency Department until such time as he or she deems it appropriate to transfer care to the attending physician, a consulting physician or the On-Call physician or another appropriately qualified and privileged practitioner. No patient shall be transferred from the Emergency Department absent an order of the Emergency Room practitioner unless that practitioner has determined that the transfer determination is beyond the scope of his/her expertise, and has requested that the attending, consulting or On-Call physician or another appropriately qualified and privileged practitioner assess the patient for transfer.

1.1(h) The following definition will be followed to designate age groups:

Neonate	=	Newborn to one month
Pediatric	=	One month to fifteen years
Adult	=	> Fifteen years

1.1(i) Physicians and AHPs providing care in the Intensive Care Unit (ICU) shall be required to maintain documentation regarding current ACLS certification.

1.1(j) Notwithstanding any contrary provision in these Medical Staff Rules and Regulations, AHPs with appropriate clinical privileges may admit under his/her name to the extent permitted by State law and pursuant to the following protocols designed to facilitate compliance with the CMS Hospital Conditions of Participation:

(1) AHPs shall practice in accordance with an approved collaboration agreement with a physician member of the Medical Staff/members of the Medical Staff with appropriate clinical privileges (collectively referred to herein as "Collaborating Physician").

(2) The Collaborating Physician shall remain ultimately responsible for patients admitted by the AHP. Such patients shall be deemed to be under the care of the Collaborating Physician regardless of whether he/she is named on the admission order.

(3) The Collaborating Physician or another physician member of the Medical Staff with appropriate clinical privileges designated by the Collaborating Physician must co-sign all admission orders.

(4) AHPs will document the collaborative arrangement and the name of the Collaborating Physician in the patient's medical record.

(5) Failure to appropriately comply with the requirements under this Section 1.1(j) may result in corrective action against the Collaborating Physician and/or AHP pursuant to the Medical Staff Bylaws.

(6) AHPs shall carry out all applicable responsibilities and requirements of "Physicians", "practitioners", "Attending Physicians", "Medical Staff members", and "attending members of the Medical Staff" regarding admissions as described in this Article, subject to the aforementioned protocols and physician collaboration.

1.2 PATIENT TRANSFERS

1.2(a) Patient transfers will be prioritized based on an evaluation of each patient's needs at the time of transfer.

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

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

1.3 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:

1.3(a) A patient suspected to be suicidal in intent shall be admitted to an appropriate room consistent with the patient's medical needs and hospital policy. 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, while providing all reasonable care appropriate to the situation. Appropriate restraints may be used as permitted by these Rules & Regulations or hospital policy. The patient will be afforded mental health consultation or other appropriate consultation(s) as necessary and available;

1.3(b) The hospital case management department may be consulted for assistance; and

1.3(c) If the patient presents to the emergency room, the steps set forth in Section 1.3(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.

1.4 DISCHARGE OF PATIENTS

The discharge policy is as follows:

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

1.4(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 or to the designated Medical Staff leader and/or Chief Executive Officer if there is no available Physician Advisor..

1.4(c) The Attending Physician is required to document the need for continued hospitalization on a daily basis or 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.

(4) Shall participate in timely and appropriate planning 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.

1.4(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.

1.5 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, the medical examiner, or other individual as permitted by state law,. Such pronouncement shall be documented in the patient's medical record.

1.6 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.

1.7 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 hospital policy.

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, 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.

2.2 HISTORY & PHYSICAL EXAMINATION AND ASSESSMENTS

The requirements for history and physical examinations, updates to such history and physical examinations, and assessments 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, or an appropriate assessment for outpatient surgeries or procedures where permitted by Medical Staff and Board approved policy, must be recorded before all surgical procedures and those tests or invasive procedures requiring anesthesia. When a history and physical examination, assessment, pertinent laboratory, x-ray and/or EKG reports are not recorded before a scheduled operation, invasive or diagnostic procedure requiring anesthesia, the procedure shall be canceled unless the responsible practitioner documents that such delay would be a threat to the patient's health.

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 and discharge. The written admission note or the History & Physical performed on the day of admission 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, estimated blood loss, and tissue or specimens removed or altered. Operative/procedural reports shall be written or dictated and entered immediately following surgery, and before the patient is transferred to the next level of care. An operative progress note must be entered immediately and before the patient is transferred to the next level of care, if the operative report is not placed in the record immediately after surgery. This progress note

shall include the name(s) of the primary surgeon(s) and his or her assistant(s), the procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. The full operative report must be made a part of the patient's current medical record within twenty-four (24) hours after completion of surgery if a progress note is entered immediately following surgery in lieu of the full operative report. Any practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 CONSULTATIONS

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

The Attending Practitioner or surgeon shall obtain consultation in the following circumstances:

A. The patient is high risk for a procedure/treatment and requires medical clearance.

B. The diagnosis is unclear following standard diagnostic procedures.

C. There are questions regarding the choice of therapeutic measures or treatment.

D. Specific skills or expertise of other Practitioners is necessary.

E. The patient or a surrogate decision maker requests a consult or second opinion.

F. The patient exhibits severe psychiatric symptoms.

G. There is a drug or chemical overdose or attempted suicide.

H. Pelvic surgery is contemplated in the presence of a confirmed pregnancy.

Any other circumstance deemed appropriate by the Attending Practitioner or when required by a Hospital or Medical Staff policy.

2.7 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record, including written, phone and verbal orders, shall be legible, complete, accurately dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. Faxed documents are acceptable and will be honored as record entries provided they are on non-thermal paper, legible, dated, timed and authenticated. The use of rubber stamp signature is not acceptable under any conditions.

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

2.8 ABBREVIATIONS/SYMBOLS

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

2.9 DISCHARGE SUMMARIES

A clinical discharge summary shall be included in the medical records of all patients except those with minor problems who require a less than a 48-hour period of hospitalization, normal newborn infants and uncomplicated obstetrical deliveries. A final progress note may be substituted for the discharge summary for these patients, which shall include the outcome of hospitalization, disposition of the case, and provisions for follow up care.

The discharge summary shall include the reason for hospitalization, procedures performed, care treatment and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow up care. All summaries shall be authenticated by the Attending Practitioner.

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 Practitioner. 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 and/or Facility Privacy Officer, 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 practitioner 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 practitioner'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 ADMINISTRATIVELY CLOSED MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or AHP(s) is administratively closed 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) Written/Verbal/Telephone Treatment Orders: Orders for treatment shall be in writing, dated, timed and authenticated. Except for CRNAs in states that have opted out of the CMS supervision requirement, orders for treatment and care of patients may not be written by Allied Health Professionals or other non-practitioner personnel unless written under the supervision of and cosigned by the Attending Physician. Preoperative orders must be cosigned prior to being followed unless the orders are verbal telephone orders given by a Practitioner as described below.

Verbal orders are discouraged except in emergency situations and the practitioner who gave the orders shall authenticate, date and time any order prior to leaving the area. A verbal or telephone order shall be considered to be in writing if dictated to an RN and signed by the RN and countersigned by the practitioner giving the order. Registered physical, occupational and speech therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists, social workers, counselors and CRNAs may accept verbal or telephone 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 or telephone order back to the practitioner and indicate that the individual has confirmed the order. The practitioner who gave the telephone 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, date and time any order, including but not limited to medications 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 telephone order. Failure to do so shall be brought to the attention of the MEC for appropriate action. Orders for outpatient test require documentation of a diagnosis for which the test is necessary.

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

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

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

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

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

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

2.15 COMPLETION OF MEDICAL RECORDS

Documentation of an episode of care should occur at the time of service, but no later than 24 hours after. Essential reports and diagnostic test results will be completed according to departmental policies. 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 thirty (30) 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

Patient medical records are required to be completed within thirty (30) days of the encounter or discharge. Any record that lacks a history and physical or operative report, if applicable, at the time of discharge is also considered a delinquent record. The Health Information Management Department will provide each practitioner with a list of his/her incomplete medical records at the twenty-first (21st) day and will give the practitioner a warning that the record(s) will be delinquent at thirty (30) days. The practitioner's privileges will be suspended if any records become delinquent at thirty (30) days.

2.16(a) Suspension. A chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible practitioner'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 practitioner shall cover scheduled Emergency Department rotational call commitments. Any admission requirements associated with this commitment, will be assumed by the designated alternate practitioner. The suspended practitioner may not provide coverage for partners or other practitioners, nor admit under a partner's or other Attending Practitioner's name. Any exceptions must be approved by the Chief of Staff and/or the CEO or his/her designee.

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

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

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. 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. Medical record entries may not be deleted, 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.

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.

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 practitioner 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 practitioner 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. The practitioner must document in the medical record a diagnosis, condition, and indication-for-use for each medication ordered.

3.4 PATIENT CARE ROUNDS

Hospitalized patients shall be seen each day by the attending Physician, another physician member of the Medical Staff with appropriate clinical privileges designated by the attending physician, or by an AHP with appropriate clinical privileges as authorized by and under the supervision and direction of the attending physician. Patients may need to be seen more frequently if warranted by the patient's condition or as otherwise specified in this Section 3.5. All daily rounding by the attending physician, his/her physician alternate, and/or appropriately credentialed AHP shall be documented in the patient's medical record with appropriate progress notes as noted in Sections 2.4 and 2.15 of these Rules and Regulations.

The following requirements shall apply if the attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician does not round on a patient in any given twenty-four (24) hour period and the daily rounding is provided by an appropriately credentialing AHP as set forth herein:

1. The attending physician shall at all times remain responsible for the establishment and implementation of the patient's plan of care. The direction and supervision of the AHP services

outlined herein shall be the responsibility of the attending physician and AHP. Failure to appropriately supervise an AHP shall be grounds for corrective action against both the attending physician and the AHP pursuant to the Medical Staff Bylaws.

2. The attending physician or another physician member of the Medical Staff with appropriate clinical privileges designated by the attending physician must either (i) certify in the medical record that he/she has reviewed and evaluated the AHP's progress notes and other medical record documentation within that twenty-four (24) hour AHP rounding period; or (ii) verbally communicate with the AHP regarding the patient within that twenty-four (24) hour AHP rounding period, such verbal communication to be documented by the AHP and co-signed by the physician by the end of the next calendar day.

3. The attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician must be available to come to the facility if needed at all times.

4. The attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician must come to the facility and assess the patient in person within twenty-four (24) hours (or sooner as warranted by the patient's condition) if requested by the patient, the patient's family, the rounding AHP, and/or any consulting physician or other member of the treatment team.

Notwithstanding the foregoing, the attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician must:

1. Personally evaluate each non-ICU patient and formulate/ratify the plan of care within twenty-four (24) hours of an admission or sooner if warranted by the patient's condition.

2. Personally evaluate each patient in the ICU within six (6) hours after admission or sooner if warranted by the patient's condition. Thereafter, the attending physician or another member of the Medical Staff with appropriate clinical privileges designated by the attending physician shall personally see patients in the Intensive Care Unit at least once every twenty-four (24) hours.

3. Generally evaluate each patient who has undergone inpatient surgery on postoperative day one. However, otherwise healthy patients who are hospitalized for a period of less than forty-eight (48) hours for a routine surgery in which defined clinical pathways are established may be seen on postoperative day one by an appropriately credentialed AHP as set forth in this Section 3.5 so long as the surgeon is available to personally assess the patient if needed.

4. Personally evaluate each patient on the calendar day prior to discharge (or the day of discharge) except as specifically noted above with regard to short stay surgical patients.

5. Personally evaluate each patient within twenty-four (24) hours prior to any transfer of a patient to a different level of care (whether higher or lower) or transfer to another facility.

3.5 ATTENDING PHYSICIAN UNAVAILABILITY

Should the Attending Physician be unavailable, his/her designee will assume responsibility for patient care. For further clarification see 1.1(f).

3.6 PATIENT RESTRAINT ORDERS

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

3.7 PRACTITIONERS ORDERING TREATMENT

When a practitioner who is not a member of the Medical Staff orders outpatient treatment (i.e., cardiac rehabilitation, physical therapy, infusion, chemotherapy), the following information will be verified: the physician or allied health care provider is responsible for the care of the patient, licensed in the state where the physician sees the patient, is Medicare/Medicaid eligible, and is ordering within his/her scope of practice. The order must include or be accompanied by the physician or allied health care provider's office address, telephone number and NPI number.

A Deaconess Illinois pharmacist will review all medication orders and sign the order in the electronic health record to validate his/her verification of the order and ordering practitioner.

In the event of an emergency, the patient will receive treatment according to hospital policies and procedures.

3.8 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. Written records must be maintained of any written prescriptions or administration of any drugs. A practitioner may not perform surgery on an immediate family member except in an emergency situation where no viable alternative is available.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 RECORDING OF DIAGNOSIS/TESTS

Excluding emergencies, all preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record prior to any surgical procedure, in addition to an appropriate history and physical or assessment as required herein. 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 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.

4.3(a) Podiatrist's Responsibilities

The responsibilities of the podiatrist are:

(1) Consistent with the podiatrist's clinical privileges, to perform a comprehensive history and physical as set forth in the Medical Staff Bylaws for ASA Level 1 and ASA Level 2 patients;

(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 for all patients that are not ASA Level 1 or ASA Level 2, and when otherwise necessary based upon the condition of the patient and/or the podiatrist's scope of clinical privileges; 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 for all patients that are not ASA Level 1 or ASA Level 2, and when otherwise necessary based upon the condition of the patient and/or the podiatrist's scope of clinical privileges, 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 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 practitioner. After informed consent has been obtained by the surgeon, the appropriate practitioner in accordance with State law shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery or an invasive procedure and/or blood/blood products cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken, if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

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

4.5 PATIENT REQUESTS AND REFUSAL OF TREATMENT

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

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

4.6 EXAMINATION OF SPECIMENS

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

4.7 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a post-operative examination will be conducted by the physician or the patient will meet established discharge criteria. This will be documented in the medical record

4.8 ANESTHESIA

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

4.8(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 allied health professional who provided the anesthesia services.

4.8(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.

4.8(c) Only credentialed and qualified individuals as defined in the policies and procedures of the hospital may provide anesthesia services. The Department of Surgery and/or Medical Executive Committee 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.

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.

4.8(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 anesthetist or anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation or anesthesia; as such terms are defined by The 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 twenty-four (24) hours after the patient's surgery or procedure requiring anesthesia services. Individual patient risk factors may dictate that the evaluation be completed and documented sooner than twenty-four (24) 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 twenty-four (24) hours with notation that the patient was unable to participate, description of the reason(s) therefore, and expectations for recovery time, if applicable.

4.8(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 anesthetist or anesthesiologist or the Attending Physician prior to surgery. As a general rule, DNR orders will be suspended during the operative procedure and the immediate post recovery period. 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.

4.8(f) The hospital must be able to provide anesthesia services within one (1) hour after the determination that such services are necessary.

4.9 ORGAN & TISSUE DONATIONS

The hospital shall refer all inpatient deaths, emergency room deaths, dead on arrival cases, and imminent patient deaths to the designated organ procurement agency and/or tissue and eye donor agency in order to

determine donor suitability, and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

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

Hospital staff, 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
EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

5.1 SCREENING, TREATMENT & TRANSFER

5.1(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.

(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.

5.1(b) Stabilization

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

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

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

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

(i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request and AMA forms. The patient's transfer request as well as the discussion regarding the associated risks shall be clearly documented in the medical record;; 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 nurse or nursing supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

5.1 (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.

5.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

5.2(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. The Emergency Department Physician will utilize the rotation call list as set forth in this Section 5.2(d) if the patient does not have a private Physician who is available and qualified to provide the necessary services.

5.2(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.

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

(1) Attempted to reach the physician in the hospital;

(2) Called the physician at home;

(3) Called the physician at his/her office; and

(4) Called once on the physician's pager.

Thirty (30) minutes will be considered a reasonable time to carry out this procedure.

5.2(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 thirty (30) 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 or designee for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

5.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient upon initial notice of the patient care assignment 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.

5.2(f) All members of the Active Staff shall participate in the on-call rotation for the Emergency Department if and as required by the Board, upon recommendation of the MEC, until the member has served a total of 25 years as a member of the medical staff or attained the age of 60. Participation in the on-call rotation for the Emergency Department is an obligation, but not a right. (Each Active Staff member must establish current competence in and maintain a sufficient breadth of clinical privileges in his/her specialty to meaningfully participate in emergency department unassigned call as required in the Rules & Regulations of the Medical Staff). The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

Physicians called are required to respond to Emergency Department call by telephone within thirty (30) minutes. If requested to come in, they are required to do so within forty-five (45) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within sixty (60) minutes of initial contact.

5.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligations therefore, shall be approved by the Board of Trustees and documented in writing. 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 VI
ADOPTION & AMENDMENT OF RULES & REGULATIONS

6.1 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.

6.2 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 medical staff meeting at which a quorum present and without previous notice, or at any special meeting of the medical staff on notice, by a majority vote of those present and eligible to vote. The Medical Staff must notify the MEC of any proposed changes to the Rules & Regulations prior to approval. All recommended revisions 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 MEC may temporarily alter Rules & Regulations in an urgent situation. The alteration will be formal voted upon at the next general Medical Staff meeting. The Rules & Regulations shall be reviewed and revised periodically

6.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

6.3(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

6.3(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.

6.4 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 6.2 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 and Regulations
Approved and Adopted:

Medical Staff:
Approved by the Medical Executive Committee on _____
Approved by Full Staff on _____

By: _____ Date: _____
Chief of Staff

Board of Directors:
Approved by the Advisory Board on _____
Approved by the Board of Directors on _____

By: **_____ Date: _____**
Chair of the Board of Directors

Deaconess Illinois Crossroads:

By: _____ Date: _____
Chief Administrative Officer