HEARTLAND REGIONAL MEDICAL CENTER
RULES & REGULATIONS

INDEX

HEARTLAND REGIONAL MEDICAL CENTER

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

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. 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.

1.1(c) Practitioners 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 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 other providers admitting to the ICU must either maintain documentation regarding current ACLS certification or must co-manage the case with an ACLS certified Physician. All Anesthesiologists and CRNAs shall be required to maintain ACLS and PALS certification. Any other providers with privileges to perform moderate sedation or anesthesia must likewise maintain ACLS and/or PALS certification.

1.1(e) The management and coordination of each patient's care, treatment and services shall be the responsibility of a practitioner 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 practitioner'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 and a verbal handoff given to the oncoming provider with the opportunity to ask questions.

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, at those times the Practitioner is not readily available. In cases of inability to contact the Attending Practitioner, the following should be contacted, in order of priority listed below:

(1) An alternate Practitioner (preferably a partner, associate or designee of the Practitioner;

(2) The Medical Staff President, 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 CAO to provide care for the patient.

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 the 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 Practitioners attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Medical Staff President 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 in the situation. Appropriate restraints may be used as permitted by these Rules & Regulations. The patient will be afforded psychiatric consultation or other appropriate consultation, as necessary and available;

1.3(b) 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

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 admission, to or 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 Administrative Officer if there is no available Physician Advisor.

1.4(c) The Attending Practitioner is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation should 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 Practitioner 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 Practitioner shall keep the patient and the patient's family informed concerning the patient's condition, throughout the patient's term of treatment. The Attending Practitioner 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 Practitioner, another member of the Medical Staff, the Emergency Department Physician, the medical examiner, or other individual as permitted by State law and Hospital policy, as appropriate. 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 Practitioner must 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 practitioner shall participate in discussion of the outcome or event with the patient, family and/or legal representative, to the extent appropriate under medical staff policy.

ARTICLE II
MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The Attending Practitioner 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 ADMISSION HISTORY& PHYSICAL EXAMINATION

The requirements for admission, history and physical examination are as outlined in the Medical Staff Bylaws.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A history and physical exam, containing the information outlined in the Medical Staff Bylaws, must be recorded before all inpatient surgeries and procedures requiring anesthesia. Each department or service

will determine for its members which outpatient procedures require a history and physical examination as a prerequisite and, if required, the scope of such history and physical. Notwithstanding the foregoing, a history and physical examination shall be required for all invasive operative procedures or procedures requiring anesthesia performed in the outpatient setting. When a history and physical examination, (if required) , pertinent laboratory, x-ray and/or EKG reports are not recorded before a scheduled operation, or any potentially hazardous diagnostic procedure; the procedure shall be canceled unless the responsible practitioner 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 history and physical was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the history and physical. This updated history and physical review and examination information must be documented within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia.

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. The History and Physical 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. If the operative report is not placed in the record immediately after surgery, a progress note shall be entered in the medical record before the patient is transferred to the next level of care. 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 twelve (12) 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 Medical Staff President 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 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 submitted 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.

2.8 CLINICAL ENTRIES/AUTHENTICATION

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

Notwithstanding anything contained herein, all orders 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 and Regulations.

2.9 ABBREVIATIONS/SYMBOLS

Abbreviations and symbols utilized in medical records are to be those approved by the MEC and filed with the Health Information Management Department.

2.10 FINAL DIAGNOSIS

The final diagnosis, pending the results of lab, pathology and other diagnostic procedures, shall be recorded in full. 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 patient. All such projects shall be approved by the MEC, before records can be studied. Subject to the discretion of the Medical Staff President, 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 AMINISTRATIVELY CLOSED MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible Practitioner(s) or is ordered administratively closed by the MEC, the Medical Staff President or CAO; with an explanation of why it was not completed by the responsible Practitioner(s) or AHPs.

2.14 STANDING ORDERS

In order to ensure continued appropriateness, practitioner-specific standing orders shall be reviewed periodically by the Practitioner and the Utilization Management Committee 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.

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, and updates thereto, 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. All such orders shall be dated, timed and authenticated in the patient's medical record pursuant to the requirements of these Rules & 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.

215 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 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.

216 DELINQUENT MEDICAL RECORDS

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

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 may not cover Emergency Room call, 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 Medical Staff President and the CAO.

2.16(b) The suspended staff member is obligated to provide to the Hospital CAO and the Medical Staff President; the name of another Practitioner, who will take over 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.

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 CAO, or the chairperson of the Quality Management Committee, or equivalent Medical Staff committee with an explanation of why it was not completed by the responsible Practitioner or AHP.

2.17 TREATMENT & CARE WRITTEN ORDERS

Orders for treatment and care of inpatients may not be written by Allied Health Professionals or other non-practitioner personnel, unless written under the supervision of and cosigned by an appropriate covering Practitioner, except that CRNAs may write such orders without a practitioner's co-signature as are consistent with the anesthesia plan agreed to by a practitioner, to the extent permitted by applicable law, scope of practice, and privileges granted by the Hospital.

Preoperative orders must be cosigned prior to being followed, unless the orders are verbal telephone orders given by the Practitioner as prescribed in these Rules & Regulations.

2.18 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 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. The patient business office should notify the Attending Practitioner 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 WRITTEN/VERBAL/TELEPHONE TREATMENT ORDERS

Orders for treatment shall be in writing, dated, timed and authenticated. Verbal orders are discouraged, except in emergency situations. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. and signed by the R. N. and countersigned by the Practitioner giving the order. Registered physical therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapy technicians, pharmacists 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 Practitioner and indicate that the individual has confirmed the order. The Practitioner 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.

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

3.3 ILLEGIBLE TREATMENT ORDERS

Orders shall be written clearly, completely, and legibly with a black, blue or blue/black writing instrument capable of making legible impressions. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the licensed, registered, or certified professional.

3.4 PREVIOUS ORDERS

All orders are automatically canceled when a patient goes to or from another level of care.

3.5. ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in 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.

3.6 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.

3.7 PATIENT CARE ROUNDS

Hospitalized patients shall be seen each day by the attending practitioner, another practitioner member of the Medical Staff with appropriate clinical privileges designated by the attending practitioner or by an AHP with appropriate clinical privileges as authorized by and under the supervision and direction of the Admitting Practitioner. Patients admitted to Intensive Care Unit (ICU) should be seen by the Attending Practitioner immediately prior to, or within two (2) hours after admission to the Unit, or sooner if warranted by the patient's condition. An admitting note must be written at that time.

Daily hospital visits, documented by appropriate notations in the progress notes of the patient's electronic medical record, are required of the attending/designated practitioner.

Admitting practitioners shall be available to see their patients within sixty (60) minutes, thirty (30) minutes for ICU and Emergency Department patients, if medically necessary. Inability to comply requires physician-to-physician contact for coverage. Similarly, all on-call physicians shall be able to respond within thirty (30) minutes, when medically necessary.

The consultation notes, and follow-up consultation notes, must be completed at or as soon as possible after completing the consultation.

The following requirements shall apply if the attending ~~physician~~ or another physician 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 hour period and the daily rounding is provided by an appropriately credentialed AHP as set forth herein:

1. The attending practitioner 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 practitioner member of the Medical Staff with appropriate clinical privileges designated by the attending practitioner 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 practitioner by the end of the next calendar day.

3. The attending physician or another practitioner 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. It is not permissible for a practitioner to sign out to the rounding AHP.

4. The attending physician or another practitioner member of the Medical Staff with appropriate clinical privileges designated by the attending practitioner 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 practitioner member of the Medical Staff with appropriate clinical privileges designated by the attending practitioner 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 two (2) hours after admission or sooner if warranted by the patient's condition. Thereafter, the attending physician or another practitioner member of the Medical Staff with appropriate clinical privileges designated by the attending practitioner shall personally see patients in the ICU at least once every twenty-four (24) hours.

3. Generally evaluate each patient who has undergone inpatient surgery on postoperative day one. However, otherwise health 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 for the in this Section 3.5 as 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.

3.8 ATTENDING PRACTITIONER UNAVAILABILITY

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

3.9 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, Joint Commission standards, CMS Conditions of Participation and all medical staff policies pertaining to restraints and seclusion.

3.10 PRACTITIONERS ORDERING OUTPATIENT TREATMENT

When a practitioner who is not a member of the Medical Staff orders outpatient treatment (i.e., home health, cardiac rehabilitation, physical therapy, chemotherapy), the following information will be verified; the provider is responsible for the care of the patient, licensed in the state where he/she sees the patient, is Medicare/Medicaid eligible, and is ordering within his/her scope of practice.

3.11 PRACTITIONERS PROVIDING CARE TO RELATIVES

Consistent with the AMA Code of Medical Ethics, members and practitioners with privileges shall not treat themselves or admit, consult on, prescribe for, provide care to or attend members of their immediate families at the Hospital, except in case of emergency.

3.12 PRACTITIONERS PROVIDING CARE IN EPIDEMIC CONDITIONS

In case of pandemic/epidemic, or other emergency or disaster declared by the Hospital, rationing or prioritizing of care, including scheduling or procedures, to be provided by or under the supervision of medical staff members, will be guided by protocols adopted by the Board after recommendation by the Medical Executive Committee. Redeployment of members to provide services other than their regular specialty-based practice may be facilitated through granting temporary privileges. Members' compliance with Hospital restrictions on use of resources and restriction of scheduling surgery, other procedures, with the exception of gross negligence, will be indemnified by the Hospital.

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 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, which shall be on the patient's chart, prior to induction of anesthesia and start of surgery;

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

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

4.2(c) Discharge of Patient

The discharge of the patient shall be the dual responsibility of the dentist member of the Medical Staff and the Attending Physician.

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.

(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, which shall be on the patient's chart prior to induction of anesthesia and start of surgery;

(2) To perform a physical examination to determine the patient's condition, 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) Discharge of Patient

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, 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 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 medical 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 – all specimens removed during a surgical procedure in the operating rooms, delivery rooms, emergency rooms, or anywhere else in the hospital shall be sent to the pathologist for evaluation with the exception of:
4.6(a) medical appliances/implants
4.6(b) foreign bodies, i.e., bullets, knives, etc., given directly to law enforcement officers:
4.6(c) placentas (surgeon discretion)
4.6(d) teeth, provided the number, including fragments, is recorded in the medical record;
4.6(e) foreskin (infant);
4.6(f) lens;
4.6(g) bone fragments;
4.6(h) toenails, fingernails;
4.6(I) scars lipoma, and hernia sacs at surgeon's discretion
4.6(j) and others determined by the Medical Staff.

4.7 OPERATING ROOM ATTIRE

Minimum attire in the Operating Room will be cap, gown, gloves, and mask on all open cases. A cover coat will be worn over scrubs, when leaving the department.

4.8 CASE REVIEW

The Surgery Committee shall have oversight of surgical case review and review of invasive procedures performed in the Hospital.

4.9 OR VISITORS

The operating room is a restricted area, in which the patient's privacy must be protected. Any visitor to observe a patient's surgery must be an education reason for being present and be approved by the

physicians in attendance and the OR Manager or designee. No more than two (2) visitors are to be in the operating room, at one time, and only at the discretion of the physicians and personnel involved. An authorized visitor may include:

4.9. (a) medically oriented students; who are presently enrolled in a program;
4.9. (b) physicians and surgical assistants
4.9. (c) nursing personnel and nursing students, who have educational reasons for viewing surgery;
4.9. (d) manufacturer representatives for special equipment or instrumentation usage;
4.9. (e) a significant other in attendance at c-sections;
4.9. (f) forensic personnel

4.10 POST-OPERATIVE EXAMINATION

For all outpatient surgery patients discharged from recovery room to home, a postoperative examination will be conducted by the surgeon and documented in the medical record.

4.11 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.

4.11(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 Allied Health Professional who provided the anesthesia services.

4.11(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.

4.11(c) Only credentialed and qualified individuals may 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 Directors.

Certified registered nurse anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations. 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.

4.11(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, 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 and documented sooner than forty-eight (48) hours, as addressed in Hospital policies and procedures. For those patients who are unable to participate in the 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.

4.11(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. 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.

4.11(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.

4.12 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.

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
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 or, in the case of a woman in labor, a registered nurse trained in obstetric nursing; where permitted under State law and Hospital policy.

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

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, 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 form. 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 Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

5.1(c) Transfer

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

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

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

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

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/Practitioner/AHP. 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 6.2. if the patient does not have a private provider 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 provider will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the Provider in the Hospital;

(2) Called the Provider at home;

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

(4) Called once on the Provider's pager or cell phone.

Twenty 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 Practitioner, shall be available in the Emergency Department. In the event that the patient does not have a private ~~Physician~~ Provider, the private Provider refuses the patient's request to come to the Emergency Department, or the Provider cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private Provider to provide the necessary consultation or treatment for the patient. A Practitioner 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 Practitioner is required to come in to personally assess the patient. Any such refusal shall be reported to the CAO for further action and may constitute grounds for corrective action under these bylaws.

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

5.2(f) Call responsibilities include availability for consultation with E.D. Physicians, and admission/care of patients without MD on staff or attending MD unavailable. Practitioners are responsible for notifying E.D. on any call "trades", vacation dates, and other out-of-town dates. These changes require physician-to-physician contact and are not automatically covered by the call schedule physician. The Emergency Department Medical Staff call schedule is the official reference for the Hospital.

Practitioners called are required to respond to Emergency Department call by telephone within twenty (20) minutes. If requested to come in, they are required to do so within forty (40) minutes after responding by telephone.

5.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligation therefore, shall be approved by the Board of Directors and documented in writing. As a condition of Medical Staff appointment, all emergency department Physicians and any Practitioner who is or may be required to take unassigned call for Emergency Department patients pursuant to the provisions of the Bylaws, Rules & 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
NURSE PRACTITION/PHYSICIAN ASSISTANT

6.1 NURSE PRACTITIONER/PHYSICIAN ASSISTANT

6.1 (a) Nurse Practitioner/Physician Assistant

(1) Nurse Practitioners/Physician Assistant will work within the scope of training and scope of collaborative agreement and needs; not to exceed the privileges of collaborating/supervising physician.

(2) The collaborative agreement will be a permanent part of the credential file and application process.

(3) History and physicals must be countersigned by the admitting physician. An admission note must be made by the admitting physician within 24 hours.

(4) May write daily progress notes which must be countersigned by the supervising physician each day.

(5) Discharge Summary may be completed after the discharge note has been written by the attending physician. The Discharge Summary must be countersigned by the Supervising Physician.

(6) The APN cannot set out the initial Plan of Care without consultation of the Attending Physician.

(7) All outpatient studies must be performed following guidelines of the Nurse Practice Act

ARTICLE VII
ADOPTION & AMENDMENT OF RULES & REGULATIONS

78.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to bring before the Board of Directors formulated, adopted and recommended Medical Staff Rules & Regulations and amendments thereto, which shall be effective when approved by the Board of Directors. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Chief Executive Officer, the Board of Directors 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 medical staff meeting, at which a quorum is 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 of Directors Medical Staff shall exercise its responsibility in a reasonable, timely, and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency, and of maintaining a harmony of purpose and effort with the Chief Administrative Officer, the Board of Directors and the community. The Rules and Regulations shall be revised periodically 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:

7.3(a) Appending to these Rules & Regulations the approved amendment, which shall be dated and signed by the Medical Staff President, the CAO, and the Chairperson of the Board of Directors; or

7.3(b) Restating these Rules and Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules & Regulations since their last restatement, which have been restated Rules and Regulations, shall be dated and signed by the Medical Staff President, the CAO, and the Chairperson of the Board of Directors.

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 7.2 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 application law or regulation, or to protect the well-being of patients, employees or staff.

MEDICAL STAFF RULES & REGULATIONS
REVISIONS APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____ _____
Medical Staff President Date

BOARD OF DIRECTORS:

By: _____ _____
Chairperson Date

HEARTLAND REGIONAL MEDICAL CENTER

By: _____ _____
Chief Administrative Officer Date