Rules and Regulations

A. *Admission and Discharge of Patients*

1. The Hospital shall admit patients suffering from all types of diseases.

2. A patient may be admitted to the Hospital only by a member of the Medical Staff who has admitting privileges. All practitioners shall be governed by the official admitting policy of the Hospital. Orders written for diagnostic procedures must be justified on the order sheet or progress notes.

3. A member of the Medical Staff shall be responsible for the medical care and treatment of each of their patients in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient, whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the orders.

4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

5. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall when possible first contact the department to be admitted to ascertain whether there is an available bed.

6. A patient to be admitted on an emergency basis who does not have a private practitioner may be discussed with the hospitalist or staff physician on call.

7. Emergency Admissions:
In the event of a shortage of beds, admission would be determined by the Chief of Staff using the following categories:

   a) Urgent Admissions
   This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the Chief of Staff or designee to determine priority when all such admissions for a specific day are not possible.

   b) Pre-operative Admissions
   This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the attending physician may decide the urgency of any specific admission.

   c) Routine Admissions

This will include elective admissions involving all services.

11. Patient Transfers
Transfer priorities shall be as follows:
a) Emergency room to appropriate patient bed.
b) From critical care unit to medical surgical.
c) From temporary placement as a convenience to the patient in ICU to the medical surgical unit.; no patient will be transferred without such transfer being approved by the attending physician.
d) From Inpatient to another facility – Once the attending physician is notified regarding any acute care emergency transfer, they will make appropriate arrangements for the transfer.

12. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of others whenever his patients may be a source of danger from any cause whatever.

13. For the protection of patents, the medical and nursing staffs and the hospital, precautions to be taken in the care of the potentially suicidal patient include:
a) Any patient known or suspected to be suicidal in intent shall be referred/transferred, if possible, to another institution where suitable facilities are available there may be times when the patient will need to be admitted to be stabilized before being referred/transferred. Suicide precautions will be carried out.

14. The attending practitioner is required to document the need for continued hospitalization.

15. Patients shall be discharged only on a written 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. Release from responsibility for discharge form should be signed.

16. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or their designee within a reasonable time.

17. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. (refer to autopsy policy- located in Laboratory Manual)

Criteria for Autopsies:

The Medical Staff should attempt to secure autopsies in all cases of unusual deaths and educational interest. An Autopsy Consent will be obtained from the patient's personal representative. The attending physician will be notified that an autopsy is being performed.

The following criteria should be used:

1. General
   - A. Lack of response or unusual reaction to therapies.
   - B. Unusual or poorly understood disease.
   - C. Investigation of beneficial and/or adverse effects of new therapies, and correlation with clinical diagnostic procedures.
   - D. Identification of possible hereditary or infectious disease.
   - E. Unexpected death or complications in clinical course, including operative/postoperative deaths.

B. *Medical Records*

1. 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. This record shall include identification data; reason for admission; history; physical examination; special reports such as consultation; clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary; and autopsy report when performed. Please refer to the "Record Completion and Content Policy," as well as the "Physician Documentation Requirements" attached to that policy.

2. Basic responsibilities for History and Physicals within 24 hours moved to Bylaws section 2.5 (e).

   A modified History and Physical must be done prior to I.V. Analgesia or Conscious Sedation services and includes the following components: Diagnosis, History of Symptoms, Co-Morbidity Conditions, Mental Status, Allergies and Medication Reactions, Current Medications including dosage, Patient Status (vital signs), Specialty Exam, Past Medical/Surgical History, Review of Systems to include general, heart, and lungs, and General Conditions/Other Systems. Operative purpose, nature, alternatives, consequences, and risks and complications must be explained with patient.

3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

4. Progress Notes should be documented at least daily for observation patients and inpatients with the exclusion of swing bed patients and shall be

sufficient to permit continuity of care and transferability. Whenever 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.

5. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. An immediate post-operative note shall be documented on the chart immediately following the surgical procedure. Operative reports shall be dictated within 24 hours following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.

6. Consultations shall show 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. This 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, except in emergency situations so verified on the record, be recorded prior to the operation.

7. Medical record entries may be made by the following authorized persons: Medical Staff, emergency staff, nursing, dietary, respiratory and physical therapy, pharmacy, social services, laboratory and x-ray technicians.

8. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

9. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. A list of approved and unapproved abbreviations is available for reference.

10. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated, timed and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

11. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over 24 hours and must include: reasons for admission; final diagnosis; treatment; outcome; instructions regarding diet, medication, activity, and follow-up which were given to the patient, family and/or responsible person upon discharge.

12. Written consent of the patient, or the patient's parent if the patient is a minor, or the guardian of the patient if the patient is otherwise incompetent, is required for release of medical record information to persons not otherwise authorized to receive this information.

13. Records may be removed from the hospital only with the approval of the Hospital

administrator. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

14. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered closed by the Medical Executive Committee.

15. Standing orders shall be formulated by Medical Staff Members. These orders shall be dated, timed and signed by the attending physician.

16. All medical records must be completed and documented within 30 days after discharge. All charts which are incomplete thirty days after discharge of the patient shall be considered delinquent. It is the responsibility of the medical staff member to review and complete his/her records. If the record still remains incomplete, the Medical Executive Committee shall notify the practitioner that their privileges to admit patients shall be suspended 15 days from the date of notice, and such practitioner shall remain suspended until the records have been completed. The physician should sign a certified notification for this notice. The Administrator shall be notified of this action; Administration shall notify the appropriate Hospital individuals. Three such suspensions of admitting privileges within any 12-month period shall be sufficient cause for suspension of the Hospital privileges for that practitioner. This information will be reviewed by the Medical Executive Committee for final disposition. If a physician is absent from his practice for health, sabbatical or other extenuating circumstances, this time may be extended.

C. G*eneral Conduct of Care*

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admittance. The Hospital staff should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Hospital staff's obligation to obtain and document proper informed consent before the patient is treated in the hospital.

2. All orders for treatment including narcotics, antibiotics, steroids, tranquilizers and anti-coagulants shall be in writing. A verbal/telephone order shall be considered to be documented if dictated to a duly authorized person functioning within their sphere of competence. The responsible practitioner shall authenticate (sign, date, and time) such orders within 48 hours, and failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

3. Diet orders may be written by the physician, RN, RD, or SLP in accordance to their professional scope of practice.
4. Those persons authorized to take verbal/telephone orders are RN's, LPN's, laboratory technicians, x-ray technicians, Pharmacists, physical/respiratory clinical staff, registered dietitian, social workers, and medical record coders within their individual areas of expertise.

5. If written, the practitioner's orders must be clear, legible, and complete. Orders which are illegible or improperly written will not be carried out until clarified by the nurse. The use of "renew", "repeat" and "continue" orders are not acceptable.

6 All standing drug orders are automatically canceled when a patient undergoes surgery and must be reordered if needed.

7 All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations.

a. Drugs for bona fide clinical investigation may be exceptions. These shall be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug administration.
b. Orders for drugs and treatments may be communicated on pre-printed forms if the physician indicates which individual orders are to be initiated. These orders must be signed, dated, and timed.

8. Consultation on patients in the intensive care unit (ICU) or general hospital is required in the following clinical situations:

a) When the patient requires a specific diagnostic or therapeutic need outside the clinical privileges of the attending physician(s).
b) When it is the determination of the chairman of the appropriate department or the Chief of Staff, that consultation is required to provide appropriate care to the patient.

When a request for consultation is initiated on patients in ICU or the general Hospital, the attending physician should designate on the patient chart which level of consultation is requested:

a) Level I:
Evaluate the patient and the clinical situation, record diagnostic impressions and make recommendations for further evaluation or treatment but do not implement/order any diagnostic studies or treatment measures.
b) Level II:
Evaluate the patient and the clinical situation, record diagnostic impressions and make recommendations for further evaluation

and/or treatment and implement/order any diagnostic studies or treatment measures indicated.

c) Level III:
Evaluate the patient and the clinical situation, record diagnostic impressions and make recommendations for further evaluation and/or treatment, implement/order any diagnostic studies or treatment measures indicated, and assume the primary management of the patient and dictate a narrative summary.

9. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, they shall call this to the attention of their superior who in turn may refer the matter to the VP/CNO. If warranted, the VP/CNO may bring the matter to the attention of the chairman of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chairman of the department or Chief of Staff may themselves request a consultation.

10. The nurse shall ask all competent adult patients, both inpatients and outpatients, if they have any sensitivity to drugs. In case of minors, this information should be elicited from the parent or guardian, whichever the case may be, and in the case of incompetent patients, from the guardian. This information shall be recorded on the patient record by the nurse obtaining the information.

11. Authorization for disposal of amputated parts of the body and/or fetus or fetal parts shall be obtained in writing from the patient, if competent. Otherwise, it shall be obtained from the patient's parent if the patient is a minor, or from the patient's guardian if the patient is otherwise incompetent.

12. In an emergency situation, with clearance of the nurse assigned to the patient, a patient may be temporarily restrained until the attending physician can be reached for an order (refer to Restraints policy #3367).

D. *General Rules Regarding Surgical Care*

1. Scheduling patients for surgery
   a) Advanced scheduling of elective surgery is done through the Surgery Department according to scheduling procedure.
   b) Policies, regulations and rules for the surgical suite are contained in the operating room policy and procedure manual, which is available in the operating suite.

2. Transportation
   a) When transporting patients to and from surgery, side rails shall be used.

3. Intra & Post Operative Infection
   a) Culture and sensitivity is done at the time of surgery when questionable drainage is encountered.
   b) A clean surgery case which develops a purulent drainage from the operative site is classified as a post-operative infection. Cultures shall be taken and infection reports submitted to the Infection Control Committee.

4. Except in severe emergencies, the preoperative diagnosis, history, physical and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient' s condition prior to induction of anesthesia and start of surgery.

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

   A. Dentists' Responsibilities:
      1) A detailed dental history justifying hospital admission.
      2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
      3) A complete operative report, describing the finding and technique. In cases of extraction of teeth the dentist shall clearly state the number of teeth and fragments removed.
      4) Progress notes pertinent to the oral condition.
      5) Clinical resume (or summary statement) as defined in the rules and regulations.

   B. Physicians' Responsibilities:
      1) Medical history pertinent to the patient's general health.
      2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
      3) Supervision of the patient's general health status while hospitalized.

   C. The discharge of the patient may be a written order of the physician or dentist.

6. Informed Consent
   a) Written, signed, informed, surgical consent shall be obtained prior to the operative procedure 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. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

b) Should a second operation be required during the patient's stay in the hospital, a second consent specifically worded shall be obtained. If two or more specific procedures are to be carried out at the same time, and this is known in advance, they shall all be described and consented to on the same form.

7. All tissues removed from operations are sent to pathology unless included on the exempt tissue list. Those tissues that fall under the exempt list will be properly discarded. Authenticated tissue report shall be made a part of the patient's medical record.

E. *Anesthesia Services*

1. The anesthesia provider shall maintain a complete anesthesia record and include documentation of pre-anesthesia assessment, plan of anesthesia, and risk assessment. The post anesthetic follow-up of the patient's condition should be recorded following the stay in the recovery area and should describe the presence or absence of anesthesia, related complications, if any and be timed and dated.

2. Anesthetic agents shall be administered by members of the Medical Staff who have made proper application and have been approved according to the staff regulations, or by a nurse who has been properly trained in anesthesiology and approved by the Medical Staff. In the event a nurse so acts, they shall be supervised by the surgeon and the surgeon shall be responsible for the work of the nurse anesthetist. Only non-explosive anesthetics may be administered throughout the hospital.

3. Anesthetic records shall be completed and signed before the anesthesia provider leaves the Surgery Department.

4. When necessary, the anesthesia provider, shall be expected to make a pre-operative examination and shall write the premedication orders.

5. The anesthesia provider shall accompany the patient to recovery room following surgery.

F. *Emergency Services*

1. Administration shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of the clinical privileges for all physicians who render emergency care. The Medical Staff shall credential providers that provide medical coverage in the emergency services area.

Addendum:

The Medical Staff and Department of Medicine/FP/ER/Pediatric Committee shall have overall responsibility for quality of emergency care. The Active Medical Staff shall act in a back-up capacity for ER during disaster situations or if the Emergency Operation Plan is activated. A doctor on the active medical staff can be excused by the Chief of Staff for valid health reasons if he/she so desires.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the inpatient's hospital record, if such exists. The record shall include:
   a) Adequate patient identification.
   b) Information concerning the time of the patient's arrival, means of arrival and who transported the patient.
   c) Pertinent history of injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.
   d) Description of significant clinical, lab and imaging findings.
   e) Diagnosis.
   f) Treatment given.
   g) Condition of the patient on discharge or transfer.
   h) Final disposition including instruction given to the patient and/or their family, relative to necessary follow-up care.

2. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

3. There shall be a periodic review of emergency room medical records by the Department of Medicine/FP/ER/Pediatric Committee to evaluate quality of emergency care. Reports shall be submitted to the Medical Executive Committee of the Medical Staff quarterly. Medical records shall review the records for their adequacy as documents. The review committee shall utilize them for medical care evaluation purposes and refer selected clinical situations to the applicable department for definitive review. Records of all patients dying within 24 hours of admission to the emergency services shall routinely be reviewed.

4. Refer to The Hospital's Emergency Operations Plan for any mass casualties or disaster.

G. *Critical Care Unit*

1. Purpose:
   a) The function of this unit is to concentrate in one service area those patients who are critically or seriously ill and who require and will benefit from a great amount of highly skilled nursing care and close, if not constant, nursing observation.

2. Physical Facilities:
   a) The critical care unit has a capacity of four beds. Each bed is equipped with

a wall unit containing oxygen, suction outlet and sphygmomanometer. Each bed is monitored.

b) The nursing station is in the center of the unit for ready observation and is equipped with a central monitor having alarms and EKG write-out system.

c) Emergency equipment such as defibrillator, ventilator, ancillary emergency equipment is available in the unit.

3. Administration of the Unit:

a) The department of medicine evaluates the quality of care with the responsibility of making recommendations for improvement in care and in recommending necessary equipment and supplies.

4. Staffing:

a) The unit will be staffed by registered nurses trained and oriented in critical care nursing and cardiopulmonary resuscitation according to standards established by the Nursing Department.

b) Other personnel who work in the unit will be specifically oriented and trained for their work in the unit. They will work under the supervision of the critical care nurse.

5. Admissions:

a) Admission or transfer to the critical care unit is made by the physicians by direct communication with the nursing staff. The nurse then notifies the admitting office of admission and in what bed the patient will be placed.

b) Suggested criteria for admission (may include but not limited to):

1) Acute Myocardial Infarction.
2) Cardiac Dysrhythmia - life threatening.
3) Acute respiratory distress.
4) Acute congestive heart failure.
5) Severe hypertension (malignant).
6) Hemorrhage.
7) Shock (Carcinogenic, Hypovolemic, Neurogenic, or septic);
8) Multi-system injury.
9) Drug intoxication.
10) Renal Failure.
11) Surgical ICU patients.
12) Status Epilepticus.
13) Diabetic Keto-acidosis.

6. Establishing Priority

a) If there is no bed available and another patient needs intensive care, the nurse manager or staff nurse will contact the attending physician of the patient who seems most ready to be transferred out of CCU.

b) The two physicians will be responsible for determining which patient needs the critical care unit care.

c) If the transfer question is unresolved, the final decision and authorization will be made by the chairman of the Department of Medicine/FP/ER/Pediatrics.

In the event the chairman of the Department of Medicine/FP/ER/Pediatrics and the attending physician are not available, the Chief of Staff will be contacted and will make the appropriate decision.

H. *Medical Orders*

1. Any physician or healthcare provider with a license to practice medicine, osteopathy, podiatry, Dentistry, Chiropractor, Nurse Practitioner or PA or who is a member of the Medical Staff is authorized to order ancillary tests or procedures and receive results from the Gibson General Hospital. If anyone other than the physicians (Patient, Insurance Company, etc.) is to receive the test reports this authorization must be in writing from the physician.

2. Referring Providers A provider who is not a member of the medical staff or not an allied health care provider with clinical privileges who wishes to order an out-patient laboratory test, radiological examination, occupational therapy, physical therapy, or speech therapy for his or her patient to be performed at Deaconess Gibson Hospital will provide his/her office address, telephone number, NPI number, and valid order. This will also apply for orders from a provider for a therapeutic infusion/injection of a substance in the outpatient infusion centers. If the order is for chemotherapy/immunotherapy and is from a referring practitioner that holds clinical privileges at a different Deaconess Health System affiliated facility, the order will be accepted for treatment. A Deaconess employed pharmacist will review the therapeutic infusion/injection order and sign the order in the EHR after the order/process has been verified with the referring practitioner. The referring practitioner cannot provide care/new orders for the patient while receiving treatment at a Deaconess facility in which they do not hold clinical privileges, instead the practitioner providing clinical oversight of the infusion center would be contacted in a needed situation. An IT ticket will be entered by the auth or the scheduler team, and IT Cadence will verify NPI number, current license, and screen exclusion list prior to adding the provider to the system and prior to billing.

I. Dues/Fees

a) The annual dues for all Medical Staff Memberships will be $100 for the Active, Associate, Affiliate, Courtesy, Regional, Consulting, Provisional, Contract, ER, Administrative, and Dental staff. No dues are required for Honorary members.

b) Members whose dues are delinquent after the first quarter shall be notified by the secretary. Members whose dues are still delinquent at the end of the second quarter shall stand suspended from staff at the discretion of the Chief of Staff. Reinstatement shall be contingent upon the payment of delinquent dues and approval of the Board of Trustees. The funds of the Medical Staff shall be held by the treasurer who shall render a complete report at the annual meeting. Appropriation from the funds of the medical staff may be made as follows:

An application fee of $400 will be assessed of Medical Staff and Allied Staff initial applicants, $600 will be assessed of Locum initial applicants, and $170 will be assessed of all reappointment applicants.

1) The secretary-treasurer of the Medical Staff may draw upon the funds for routine office expenditures.

2) The single expenditures of $ 300.00 or over, or recurring expenditures may be made only by the affirmative vote of a majority of the medical staff in any meeting.

J. *Miscellaneous*

1. Safety Committee Recommendations:
   a) All toys shall be approved by the nursing staff - checking for - friction toys and other dangerous toys. Toys left with the patient shall be at the parents own risk.

2. Organ Procurement:
   a) To comply with federal law and conditions of participation:
   Organ, bone, tissue and eye procurement, at or near the time of death, the designated requester shall discuss with the next-of-kin the option to make or refuse to make an anatomical gift. The request will be made with reasonable discretion and sensitivity to family circumstances. Any entry made in the patient's medical record related to request/ declination will include the name and title of the person making the request, and the name, the relationship to the patient, and the response to the request.

   b) Refer to the “Organ/Tissue/Eye Procurement Policy

3. Medical/surgical observation services

Medical/surgical observation services beds are available for occupancy by patients requiring observation and/or treatment for a period of seventy-two or fewer hours according to rules of payer care.

Refer to “Admission to Medical Surgical Observation Area” policy.

4. Additional documentation required to be kept current in the physician file (along with licensure, malpractice, DEA, controlled substance, and reappointment date):
   1) Highly recommend current CPR certification.
   2) Documentation for PPD will follow as specified in Policy 50-01S.