MEDICAL STAFF
RULES & REGULATIONS

of

Memorial Hospital and Health Care Center
Jasper, Indiana

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ARTICLE I:

ADMISSION & DISCHARGE OF PATIENTS

1) A patient may be admitted to Memorial Hospital and Health Care Center only by a Credentialed provider, in accordance with Medical Staff Bylaws.

2) A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital and for prompt completion and accuracy of the medical record. Whenever the overall responsibility for a patient's care is transferred to another practitioner in the attending practitioner's absence, a note conveying the transfer of responsibility shall be entered on the order sheet of the medical record (except in the case of partnerships in which the partners routinely cover for each other).

3) When a patient presents in the Emergency Department for treatment, the Emergency Department practitioner will attend the patient in the Emergency Department and the appropriate admitting practitioner will be responsible for inpatient care if the patient is admitted.

4) A provisional admitting diagnosis shall be provided by the attending practitioner for any patient admitted to the hospital. In the case of an emergency, such provisional diagnosis shall be recorded as soon as possible.

5) Each Medical Staff member or Psychiatric Mental Health Nurse Practitioner (PMHNP) who admits patients to the hospital shall name an alternate to attend his/her patients in his absence. The hospital should be notified of this alternate coverage whenever a practitioner or PMHNP with inpatient privileges will be unavailable for more than 1 hour. If neither the attending, PMHNP nor alternate(s) are available, responsibility for the care of the patient shall be assigned to the appropriate physician on-call for the day, or the chief of the service concerned or designated alternate, or the President of the Medical Staff or designated alternate (in that order). Repeated or willful failure of a provider with admitting privileges to provide alternate coverage will be dealt with by the Medical Staff Executive Committee, and may be grounds for temporary and/or permanent loss of privileges.

6) Each attending practitioner, consultant physician, or PMHNP shall make the initial hospital visit. Subsequent daily visits are required by the attending physician or PMHNP, another member of the Medical Staff, or by an appropriately credentialed Advance Practice Provider (NP/PA). For the Inpatient Rehabilitation Center, a physician must see the patient as often as indicated by the patient's medical condition, but no less than three times per week.

7) A patient shall be discharged only upon the documented order of a credentialed practitioner on the day of discharge. Should a patient leave the hospital against the advice of the attending provider or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the hospital's release form.

8) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge planning shall include, but need not be limited to, the following:

    a) Appropriate referral and transfer plans.

b) Methods to facilitate the provision of follow-up care.

c) Information to be given to the patient or his family or other persons involved in caring for the patient on matters such as patient's condition; his health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complications. This information should be provided by the attending practitioner.

9) A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility and receiving physician have been made and documented on the hospital form(s) used for this purpose. Clinical records of sufficient content to ensure continuity of care shall accompany the patient.

a) When transfer is deemed necessary, the patient must be transferred to a facility that has available space, has agreed to accept the patient, and has personnel qualified to accept the patient.

b) The transfer must be arranged through qualified personnel, and transportation shall be by conveyances that have appropriate life support equipment and personnel.

c) When a patient is transferred in unstable condition, the treating physician must certify the medical necessity for the transfer on the hospital form used for this purpose, saying that the benefits outweigh the risk(s).

d) The risk(s) of transfer must be explained to the patient or representative, who must request (or decline) the transfer in writing, on the hospital form used for this purpose.

e) The certification form(s) for transfer used in this hospital must be signed by the physician who authorized the transfer.

10) Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the patient, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent record of the patient.

11) In the event of a hospital death, the Hospital Death Policy should be followed.

ARTICLE II:

MEDICAL ORDERS

1) Orders must be entered in the electronic health record system or written clearly, legibly and completely. Orders which are illegible will not be carried out until they are understood.

2) All previous orders are cancelled when patients go to surgery.

3) Only those symbols and abbreviations included in the Neil Davis Approved Abbreviations List may be used in the medical record. All final diagnoses and complications are recorded without the use of symbols or abbreviations.

4) Medical Staff appointees, medical associates and medical assistants shall have the authority to enter orders only as permitted by their clinical privileges or scope of practice. All orders must be entered in the patient's record, with appropriate date, time, and authorized signature, either electronically or manually, by the responsible practitioner or his/her designee.

5) Licensed resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the Medical Staff appointee responsible for the patient's care.

6) Verbal orders (either in person or via telephone) for medication or treatment shall be accepted under circumstances when it is impractical for such orders to be given in written manner or electronically entered by the responsible practitioner. Verbal orders shall be taken only by qualified personnel who shall read back and verify the order to the practitioner giving it, thereby verifying its accuracy. The order will be transcribed in the proper place in the medical record of the patient. The order shall include the date, time and signature of the person taking the order and shall be authenticated by the prescribing physician as the physician completes the medical record or before. Orders which are not read back and verified to the prescribing practitioner must be authenticated by the prescribing practitioner or an associate within forty-eight (48) hours.

   Acceptance of a verbal order is limited to only the following personnel with noted restrictions:

   a) A physician, dentist or podiatrist with clinical privileges at this hospital;

   b) A professional nurse;

   c) A licensed practical nurse;

   d) A pharmacist who may transcribe verbal orders pertaining to drugs;

   e) A speech/language pathologist who may transcribe verbal orders pertaining to speech therapy regimens;

   f) A respiratory therapist who may transcribe verbal orders pertaining to respiratory therapy treatments;

g) A dietitian who may transcribe verbal orders pertaining to therapeutic diets, including hyperalimentation, TPN and other items related to the patient's nutritional care throughout the hospitalization;

h) An audiologist who may transcribe verbal orders pertaining to audiology therapy regimens;

i) Radiology technologists who may transcribe verbal orders pertaining to radiology exams.

j) An occupational therapist, occupational therapist assistant, physical therapist, or physical therapist assistant who may transcribe verbal orders pertaining to occupational therapy or physical therapy treatments.

k) A laboratory technologist who may transcribe verbal orders pertaining to the laboratory.

7) All orders for diagnostic testing should contain a diagnosis or indication for the examination.

8) All orders for therapy shall be entered in the patient's record and signed by the physician.

9) Therapeutic diets shall be prescribed by the attending physician in orders on the patient's chart. Orders for diets should be in specific and qualitative/quantitative terms where appropriate. Orders for dietary instructions should be written at least 24 hours prior to discharge whenever possible.

10) Medical orders may be given by facsimile. Faxed medical orders with the physician’s handwritten signature which are dated and timed are considered appropriately authenticated. All other faxed orders must be authenticated by the ordering physician at the time the chart is completed or before. Confirmation phone calls should be placed by the initiating physician's office and/or the receiving hospital department to assure that the faxed order was sent and received.

ARTICLE III:

CONSULTATIONS

1) Any qualified practitioner with clinical privileges in this hospital can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the hospital, the appropriate service chief, or the President of the Medical Staff, or the Hospital President shall at all times have the right to call in a consultant or consultants.

2) Consultation shall be required in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incapable of making a decision. Consultations shall also be required in the following situations:

   a) any treatment or procedure where there is a possibility of interruption of viable pregnancy;

   b) the determination of brain death;

   c) the withholding or withdrawal of terminal care.

3) Consultations are also required in all cases in which, in the judgment of the attending practitioner;

   a) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

   b) there is doubt as to the best therapeutic measures to be used;

   c) unusually complicated situations are present that may require specific skills of other practitioners; or

   d) the patient exhibits severe symptoms of mental illness or psychosis.

4) The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant. Consultations should be completed within 24 hours of the time notification is received by the consultant. Failure to comply with this 24 hour guideline may be referred to the appropriate Medical Staff Department Quality Assessment/Performance Improvement Committee.

5) In certain cases, upon recommendation of the Credentials Committee and Medical Staff Executive Committee, the Board of Directors may require of specified Medical Staff appointees, mandatory consultations in association with exercising clinical privileges in the hospital. Such requirements may apply only during provisional appointment or may be required on a continuing basis following appointment, whichever is specified by the Board of Directors at the time of the practitioner's appointment or reappointment.

ARTICLE IV:

SURGICAL CARE

1) The Chairperson of the Department of Surgery, in cooperation with the Chief of Anesthesia and the Department Director of Surgical Services, has overall responsibility for clinical aspects of medical care in the Operating Suite.

2) The Department Director of Surgical Services (or designated alternate), in cooperation with the Chief of Anesthesia, shall be responsible for scheduling all surgical procedures in the operating rooms. Consideration shall be given to condition of patient, availability of operating surgeon, and availability of anesthesia coverage. Emergency surgery shall take priority over elective cases previously scheduled. The Chairperson of the Department of Surgery shall have final authority in determining priority cases.

3) Except in an emergency, patients shall be admitted to the hospital or registered in the outpatient facility in sufficient time to allow for necessary preoperative testing and/or preparation.

4) Except in emergencies, the history and physical examination or the verification thereof shall be recorded on the medical record prior to surgery, in accordance with the Medical Staff Rules and Regulations. In an emergency, the practitioner shall at least provide a note in the medical record regarding the patient's condition prior to induction of anesthesia and start of surgery.

5) Informed surgical consent shall be obtained prior to any operative procedure in accordance with the Medical Staff Rules and Regulations and applicable laws. All appropriate hospital policies for the Surgery Department including time out will be followed.

6) Outpatient charts must document the discharge physical status of the patient, discharge instructions to the patient, and direct discharge order from the physician.

7) All tissues removed at the time of surgery shall be sent to the hospital pathologist except those tissues specified as routinely exempt from pathological analysis. However, in a case of a tissue routinely exempt from pathological study, the attending physician may request that the tissue be examined by the pathologist if he believes it is indicated.

8) Abortions and operations for the purpose of sterilization and other procedures designed to empty the uterus of a living fetus still attached to the mother shall not be performed in this hospital.

9) Procedures designed to stop hemorrhage - as distinguished from those designed precisely to expel a living and attached fetus - are permitted insofar as necessary, even if fetal death is inevitably a side effect.

10) Uterine curettage may be performed following a complete or incomplete abortion if the fetus and/or placental tissue has been passed, or if fetal demise has been proven by ultrasound or clinical laboratory findings. A verbal or written statement verifying this as well as appropriate ultrasound and/or laboratory evidence to support the diagnosis of an incomplete or missed abortion, signed by the attending physician must appear in the patient's medical record. In cases of anembryonic gestation (blighted ovum) or cases of abnormally rising hCG (human chorionic gondadotropin) and ultrasound evidence of a non-viable pregnancy, a

confirmatory report from the hospital radiologist, a clinical laboratory or another obstetrician-gynecologist with privileges at Memorial Hospital must appear in the patient's medical record.

11) All female patients from the age of onset of menses to menopause admitted for surgery (including all procedures involving anesthesia) shall have a pregnancy test completed prior to surgery except in cases of Caesarean section, documented incomplete abortion, or prior documented hysterectomy.

12) The provision of surgical care shall be in accordance with the established policies and procedures of the Surgical Services Department.

ARTICLE V:

ANESTHESIA SERVICES

1) The operating surgeon shall be on the hospital campus (the main hospital building) prior to the induction of anesthesia for any patient. At the discretion of the responsible anesthetist, and with the appropriate communication from the surgeon, the following anesthesia techniques may proceed prior to the operating surgeon's arrival on the hospital campus: induction of regional anesthesia, major or minor nerve blocks, and labor epidurals.

2) In any surgical case, the surgeon may be asked to assist or supervise the positioning of the patient on the operating table. The surgeon must always be readily available to assist in the event of an emergency and must not be engaged in any activity that would prevent him/her from immediately assisting in an emergency situation that might occur with the patient.

3) The medical record must contain evidence of a preanesthetic evaluation done prior to the patient's arrival in the operating suite, except in the case of an emergency surgery. The preanesthetic note should be made according to the recommendations of the American Society of Anesthesiologists (ASA), and should include physical evaluation of the patient relative to the planned surgical procedure, assignment of an ASA physical classification, and the planned anesthetic management.

4) The preanesthetic note should also include a history of medications taken by the patient, previous anesthesia experience, and any anticipated anesthetic problems. The surgeon is responsible for documenting current history and physical findings on the chart; this history and physical should be available to the anesthesiologist making the preanesthetic evaluation.

5) The anesthesiologist/CRNA shall maintain a complete intra-operative graphic record (and, where necessary, a narrative record) of all events taking place during induction, maintenance and emergence from anesthesia. This record will conform to the recommended guidelines of the ASA and the American Association of Nurse Anesthetists (AANA).

6) Inpatients will have a post-anesthesia evaluation note recorded in the chart by an anesthesiologist or CRNA within twenty-four hours after surgery (or OB delivery).

7) The provision of anesthesia services shall be in accordance with the established policies and procedures of the Surgical Services Department.

8) An anesthesia provider who is a member of the Medical Staff shall have responsibility for programmatic management of anesthesia services.

ARTICLE VI:

DENTAL SURGERY

1) A patient admitted for dental surgery is the dual responsibility of the attending dentist and the patient's primary care provider or other designated credentialed practitioner.

2) Prior to any dental surgery, a Dentistry History and Physical Form must be completed, which contains elements of responsibility by both the dentist and primary care provider including:

   a. Pertinent Medical and Dental history

   b. Pertinent examination

   c. Pre-operative diagnosis

   d. Course of action

3) The dentist should complete an operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

4) The dentist is responsible for writing a discharge order, complete with patient instructions and follow up.

5) If a patient requires hospitalization following a procedure, an appropriately credentialed practitioner will be consulted.

6) The provision of surgical care shall be in accordance with the established policies and procedures of the Surgical Services Department.

ARTICLE VII:

CRITICAL CARE SERVICES DEPARTMENT

1) The Co-Chairpersons of the Critical Care Services Committee (appointed Chairperson and Medical Director of Trauma Services), in cooperation with the Department Director of Critical Care Services, have overall responsibility for clinical aspects of medical care in the Critical Care Services Department (intensive care unit and telemetry).

2) Patients to be considered for admission to the Critical Care Services Department are those with serious medical or surgical conditions or complications.

3) When a request for an admission to the Critical Care Services Department is made and in the of a bed shortage, conflicting requests for admission which cannot be resolved by the nursing staff will be resolved by one of the Co-Chairpersons of the Critical Care Services Committee.

4) The provision of medical care in the Critical Care Services Department shall be in accordance with the established policies and procedures of the Department.

ARTICLE VIII:

OBSTETRICAL CARE

1) The Chief of Obstetrics shall be a member of the Medical Staff, have privileges for obstetrical care, and shall have responsibility for programmatic management for obstetrical unit services.

2) The physician is expected to keep in contact with the obstetrical department when his patient is in labor. The physician is to remain readily available when induction of labor is being carried out, in accordance with departmental policies.

3) Contagious patients are not to be admitted to the obstetrical ward unless in active labor with a viable fetus where proper precautions should be taken.

4) On all Rh negative eligible mothers, the physician must write orders for Rh Immune Globulin (RhoGam) to be given or not to be given.

5) Pathological examination of placentas and/or umbilical cords will be done on vaginal or surgical deliveries only when the attending physician orders it to be done.

6) In any open intra-abdominal surgical procedure, or any surgical procedure with unusual hazard to life, there must be a qualified surgical assistant present and scrubbed. (A "qualified" surgical assistant is defined as a medical assistant who has been granted privileges to assist surgeons in the operating room).

7) The provision of obstetrical services shall be in accordance with the established policies and procedures of the Department of Women/Infant Services.

ARTICLE IX:

NURSERY AND NEWBORN CARE

1) The Chief of Nursery/Pediatrics shall be a member of the Medical Staff, have privileges for neonatal care, and shall have responsibility for programmatic management for neonatal unit services.

2) A physician on-call schedule for the nursery shall be posted in the nursery to provide nursery care for any newborn whose regular physician is:

   a) not on the staff of this hospital; or
   b) does not have nursery privileges.

3) The on-call schedule is NOT meant to provide routine coverage for out-of-town physicians. Each physician with privileges in the nursery should provide an alternative physician to deal with emergency situations in the newborn nursery when the patient's physician is not available. The Chief of Nursery/Pediatrics will be consulted in situations where both the patient's physician and the alternate physician are unavailable.

4) All newborn infants shall have a complete physical examination by a physician while in the nursery. Any infant who displays medically significant abnormal signs at any time shall be examined by a physician as soon as possible.

5) The physician to be in charge of the infant and the nurse in charge of the nursery shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants and especially for high-risk infants is to be initiated in the delivery area, with constant observation of newborns for distress. The term "high-risk infant" means any infant who manifests or is likely to manifest persistent and significant signs of distress.

6) Appropriate prophylactic ophthalmic medication shall be administered to each newborn, as required by law, as soon as practicable after birth. If the parent or guardian of the newborn child objects on the ground that the prophylactic treatment conflicts with the parent's religious beliefs or practices, prophylactic treatment shall be withheld, and an entry in the child's hospital record indicating the reason for the withholding treatment shall be made and signed by the attending physician and the parent or guardian.

7) The provision of nursery and newborn care shall be in accordance with the established policies and procedures of the Women/Infant Services Department.

ARTICLE X:

EMERGENCY SERVICES

1) The Medical Director of Emergency Services, in cooperation with the Department Director of Emergency Services, has overall responsibility for clinical aspects of medical care in the Emergency Department.

2) General anesthesia shall not be administered in the Emergency Department.

3) Patients registered into the Emergency Department for treatment must be seen by a practitioner before dismissal from the department (unless directly admitted to the hospital or transferred to an observation bed by a staff practitioner with admitting privileges, unless the patient leaves AMA).

4) If a registered Emergency Department patient is transferred to another acute care facility, such transfer should be carried out in accordance with the provisions of Article I (Admission & Discharge of Patients) of these Rules and Regulations, as well as in accordance with the EMTALA requirements of COBRA-1986, and any amendments thereof.

5) The provision of emergency services shall be in accordance with the established policies and procedures of the Emergency Services Department.

6) In the event of a disagreement between the Emergency Department practitioner and a staff practitioner/hospitalist as to whether or not a patient requires admission, the staff practitioner/hospitalist is required to report to the Emergency Department to physically assess the patient prior to a final decision being made. Any unresolvable issues will be taken to the appropriate Medical Director or Medical Staff Leader.

7) EKGs completed on Emergency Department patients in the Emergency Department are to be interpreted/dictated by the end of the shift when the test occurred.

ARTICLE XI:

MEDICAL RECORDS

1) When a patient presents to Memorial Hospital and Health Care Center (MHHCC), the attending physician(s) or practitioners shall be responsible for the completeness of the medical record.

2) A medical record is not considered complete until it includes an admitting diagnosis(es); final diagnosis(es); complications, if any; identification of consultants, if any; listing of operative procedures performed, if any; condition on discharge; reason(s) for blood transfusion, if any; and discharge summary or discharge note.

   All other items listed in this paragraph shall be completed within 7 (seven) days after discharge or the chart will be considered delinquent.

3) Other data which may be included in the medical record are as follows: (history and physical examination, progress notes, consultation reports, operative reports, delivery notes, and pathology reports).

History and Physical Examination and Report

4) The medical history and physical examination shall be entered in the medical record within 24 hours of the patient's admission or the chart will be considered delinquent. The history and physical examination and report must be completed by a physician, oral/maxillofacial surgeon, dentist, podiatrist, Advance Practice Nurse (APRN), or Physician Assistant credentialed to do so. When the report is completed by an Advance Practice Nurse or Physician Assistant, it must be co-signed by the supervising physician for the Physician Assistant or by the physician with whom the Advance Practice Nurse has a collaborative practice agreement, unless the APRN has admitting privileges. Students and residents in appropriate training programs may perform the history and physical if preceptored and countersigned by a Practitioner on the Medical Staff.

5) The medical history and physical examination shall include all pertinent history and findings resulting from an assessment of all the systems of the body. At a minimum, the history and physical must include the details/history of present illness, past medical history, pertinent social and family history, review of systems, relevant physical examination, conclusion/impression, course of action and any pertinent immunizations (particularly for pediatric patients).

   If a complete history and physical examination has been performed and made a part of the medical record up to 30 days prior to the patient's admission or registration to the hospital, a reasonably durable, legible copy of this record may be used in the patient's hospital medical record in lieu of a newly recorded admission history and physical examination, provided this report was recorded by a member of the Medical Staff. In such instances, an addendum to the history and physical must be completed within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. The update note must document an examination for any changes in the patient's condition since the time that the history and physical was performed that might be significant for the planned course of treatment. If a complete history and physical examination has been performed and made part of the medical record greater than 30 days prior to the patient's admission to the hospital, a new complete history and physical must be completed.

Operative Procedures

6) An operative progress note shall be completed immediately following any operative or other high risk procedure (including those in the cardiac catheterization suite) and prior to the patient being transferred to the next level of care and shall include: name of primary surgeon and assistants, findings, technical procedures used, specimens removed, estimated blood loss, and post operative diagnosis.

7) Except in emergencies, the history and physical examination or the verification thereof shall be entered in the medical record prior to surgery, in accordance with the Medical Staff Rules and Regulations. In emergencies, the practitioner shall at least provide a note in the medical record regarding the patient's condition prior to induction of anesthesia and start of surgery.

8) Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be completed and in the medical record within twenty-four (24) hours following an operative or other high-risk procedure (including those in the cardiac catheterization suite) for outpatients as well as inpatients. The report shall be authenticated by the surgeon and made a part of the patient's medical record.

Discharge Summary

9) The discharge summary must include the reason for hospitalization, significant findings, procedures performed and treatment rendered, final diagnoses, patient’s condition at discharge, and instructions given to the patient and/or family, particularly in regard to physical activity, limitations, medications, diet and follow-up care.

10) A discharge summary shall be completed and entered in the medical records of patients hospitalized over 24 hours (except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature, including obstetric evaluations and blood transfusions). These latter exceptions shall be identified by the Medical Staff Executive Committee; and for these, a progress note which documents the patient’s condition at discharge, discharge instructions, and required follow up care shall be sufficient. The discharge summary shall be completed within 7 days of discharge or the chart will be considered delinquent.

Miscellaneous Documentation

11) Consultations shall show evidence of a review of the patient's record by the consultant's opinion and recommendations. This report shall be made 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 notes shall, except in emergency situations so verified on the record, be recorded prior to the operation. Consultation reports shall be completed within 24 hours from the time notification is received by the consultant (consistent with Article III) or the chart will be considered delinquent.

12) The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be entered into the medical record that includes pertinent additions to the history and any subsequent changes in the physical findings or clinical status of the mother and fetus.

13) The medical record for an outpatient service (procedure, surgery, and/or blood transfusion) should include an authenticated Outpatient Record which includes final diagnosis(es), physical findings, details of treatment and disposition. When appropriate, other data attached to the Outpatient Record includes history and

physical examination **(elements required are defined in Item 5 above)**, orders and progress notes, consultation reports, operative reports, laboratory reports, radiology reports, pathology reports, consent forms, and nursing service notes. The Outpatient Record should be completed at the time of outpatient service. The delinquency requirements for outpatient records are the same as detailed above for inpatient records.

14) Reports for studies completed in the Cardiopulmonary Department should be completed within the timeframes established by ICAVL and ICAEL standards for accreditation. Reports for all studies completed in the Cardiopulmonary Department will follow the guidelines for incomplete charts as outline in this Article.

15) The indication (reasons) for blood transfusion, whether inpatient or outpatient, should be documented in the discharge summary or Outpatient Record, respectively.

16) All patient charts must contain successive physicians' notes documenting the progress of the patient's condition through the hospitalization. These progress notes shall be documented on a daily basis.

17) Final diagnosis(es) shall be recorded in full, without the use of symbols or abbreviations, and dated and authenticated by the responsible practitioner.

18) Unless herein specified, all medical record documentation must be completed and authenticated within 7 (seven) days after discharge or the chart will be considered delinquent.

Outpatient Clinic Visit Notes

19) Visits or encounters performed in MHHCC-operated outpatient clinics must be appropriately documented in the medical record by the practitioner providing the clinical services. Documentation shall include the reason for the visit, history of present illness, appropriate physical exam, and final diagnoses. All office encounter notes shall be completed within 48 (forty-eight) hours of the date of service by the service provider. Notes requiring co-signature shall be co-signed within the time frames per MHHCC policy.

Incomplete Charts

20) Practitioners are responsible for the timely completion of all medical records, and will be notified when incomplete medical records are delinquent according to the established Medical Staff Rules and Regulations by Health Information Management or the appropriate Department Leadership. Corrective action for reason of medical record delinquency shall be the overall responsibility of the Medical Executive Committee or its designee, and will be instituted according to the policy on Medical Record Delinquency.

General Information

21) Memorial Hospital uses the Neil Davis Approved Abbreviations List, which is available on the hospital's Intranet/HUB.

22) All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. Authentication means to establish authorship by written signature, identifiable initials, or electronic signature.

23) Release of medical information from any patient's hospital chart shall be done according to the established policies and procedures of the Health Information Management Department.

24) Original medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute, and may only be removed in the custody of a member of the Medical Staff or other authorized individual.

25) Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects (other than those associated with carrying out functions of committees of the Medical Staff) shall be approved by the Medical Executive Committee before records can be studied subject to the discretion of the Chief Executive Officer.

26) When a written error is made by a practitioner on a patient's medical record (for example, on a written form used during downtime when electronic medical records are not available), the physician should indicate same by drawing a single straight line through the written error, and placing his/her initials or authentication adjacent to the stricken-out error, along with the date and time. When a physician is utilizing a preprinted order form, orders to be deleted should be drawn through with a single straight line, and the physician should place his/her initials or authentication adjacent to the stricken order, along with the date and time.

ARTICLE XII:

INFORMED CONSENT

Refer to the hospital's policy concerning Informed Consent

ARTICLE XIII:

PHARMACY SERVICES

1) All drugs and medications administered to patients shall be listed in the latest edition of the "United States Pharmacopoeia", "National Formulary", "American Hospital Formulary Service" or "A.M.A. Drug Evaluations" with the exception of drugs for bonafide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and approved by the Pharmacy and Therapeutics/Infection Control Committee.

2) A pharmacist may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the medical record of the patient and properly signed after the drugs have been administered.

3) All drugs and medications administered to patients shall be processed through the Memorial Hospital Pharmacy according to the established policies of the Department. Exceptions for patients who wish to bring their own medications from home must follow the Use of Patient Home Medications policy.

4) Any medication error or apparent drug reaction shall be reported immediately to the physician who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the medical record of the patient. Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible, in order to notify everyone treating the patient throughout the duration of his hospitalization of this drug sensitivity. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the physician and to the Director of Pharmacy Services.

5) Selected groups of medications shall be subjected to an automatic review by Pharmacy to determine the duration of use and stop times. These are included in the Automatic Review of Medication Stop Times policy.

ARTICLE XIV:

LABORATORY AND X-RAY SERVICES

1) Laboratory tests for the patients of Memorial Hospital and Health Care Center shall be performed by the hospital laboratory, or through a certified hospital or certified reference laboratory.

2) Diagnostic radiographs and advanced imaging exams for the patients of Memorial Hospital and Health Care Center shall be performed by the hospital radiology department. These exams shall be interpreted by the hospital radiologist(s) or another appropriately credentialed practitioner, such as studies read intra-operatively by a surgeon. After hours preliminary interpretations are provided by a telerad service and subsequently over-read to provide a final report by an MHHCC radiologist.

3) For any blood transfusions, the medical record shall document pre-transfusion hemoglobin, post-transfusion hemoglobin, and the reason(s) for the transfusion. The post-transfusion hemoglobin must be done by the hospital laboratory. An outpatient record is required on all outpatient blood transfusions.

4) The Laboratory cannot accept verbal phone orders for blood components on outpatients; an authenticated order must be received by the Laboratory before any blood or blood components are ordered (or given).

5) Laboratory orders are ordered individually on each patient's record, rather than as "routine lab".

ARTICLE XV:

PHYSICIANS IN-TRAINING

Medical students, non-licensed graduate physicians, and licensed graduate physicians

1) Physicians in-training at Memorial Hospital and Health Care Center are defined as third and fourth year medical students, non-licensed graduate physicians (interns and non-licensed residents), and licensed graduate physicians (licensed residents). (NOTE: First and second year medical students may only observe in the hospital; they must be under the direct supervision of a Medical Staff physician or department manager whenever observing in the hospital, and are not granted the privileges of clerkship described below).

2) Physicians in-training from any approved university or hospital teaching program may be assigned to a clerkship at Memorial Hospital and Health Care Center upon approval of credentials by the Chief Medical Officer or his designee, and under the direction of a preceptor who shall be a member of the Medical Staff.

3) All physicians in-training serving a clerkship at this hospital shall have adequate liability insurance obtained through their university or hospital teaching program, or personally obtained.

4) The general responsibilities of the physician in-training shall be at the discretion and direction of the assigned preceptor (and/or the preceptor's designated alternate).

5) Physicians in-training may attend patients in the emergency room under the direction of the preceptor and/or the patient's attending physician. They may assist with treatment of minor injuries and diagnostic procedures.

6) Physicians in-training may attend and assist with surgical procedures in the hospital under the direct supervision of the attending surgeon who must be present and scrubbed.

7) Physicians in-training may attend and assist with deliveries or obstetrical procedures in the hospital under the direct supervision of the attending physician who must be in attendance and scrubbed.

8) Histories and physicals, discharge summaries and progress notes may be composed by physicians in-training and shall satisfy the usual medical record requirements. In the case of the medical student or non-licensed graduate physician, such records shall be co-signed by the preceptor physician (and/or alternate). Medical records composed by a licensed graduate physician in-training do not need to be co-signed.

9) Orders from the preceptor physician (or alternate) may be transcribed by the medical student or non-licensed graduate physician, and should be designated as either “verbal orders” or “phone orders” at the time they are written. These orders must be co-signed by the preceptor physician or alternate prior to activation of the orders.

Advanced Practice Provider Students

1) Advanced Practice Provider Students, including Physician Assistant Students, Nurse Practitioner Students, and Nurse Anesthetist Students, are defined as those students who are from any approved university or teaching program who have a written agreement with the hospital for clinical rotations for their students. Advanced Practice Provider Students may be assigned to a rotation at Memorial Hospital and Health Care Center upon approval of credentials by the Chief Medical Officer or his designee, and under the direction of a preceptor who shall be a Member or Associate of the Medical Staff.

2) All Advanced Practice Provider Students serving a clerkship at this hospital shall have adequate liability insurance obtained through their university or teaching program, or personally obtained.

3) All Advanced Practice Provider Students must complete the application provided by the Medical Education Office, including all required documentation, immunizations, N95 mask fit testing, and other requirements as outlined in the Medical Education Student policy.

4) The general responsibilities of the Advanced Practice Provider Students shall be at the discretion and direction of the assigned preceptor (and/or the preceptor's designated alternate), within the guidelines set forth in the Agreement.

5) Advanced Practice Provider Students may attend patients in the emergency room, hospital clinical units, and outpatient clinics and departments under the direction of the preceptor and/or the patient's attending physician.

6) Advanced Practice Provider Students may attend and assist with surgical procedures in the hospital under the direct supervision of the attending surgeon who must be present and scrubbed.

7) Histories and physicals, discharge summaries and progress notes may be composed by Advanced Practice Provider Students and shall satisfy the usual medical record requirements. They shall be co-signed by the preceptor physician or practitioner (and/or alternate).

8) Advanced Practice Provider Students may not write or transcribe orders.

ARTICLE XVI:

LEVEL OF RESUSCITATION ORDERS

1) The philosophy of Memorial Hospital and Health Care Center and its Medical Staff is to provide dignity in impending death by adhering to the wishes of the patient and by instituting only medically appropriate care.

2) Medical Staff should refer to the hospital's policy concerning Resuscitation Orders.

ARTICLE XVII:

DETERMINATION OF BRAIN DEATH

Medical Staff should refer to the hospital's policy concerning brain death.

ARTICLE XVIII:

WITHHOLDING OR WITHDRAWAL OF LIFE PROLONGING CARE

Medical Staff should refer to the hospital's policy concerning Withholding or Withdrawal of Life Prolonging Care.

ARTICLE XIX:

AUTOPSIES

1) Autopsies are considered to be an important aspect of clinical medicine and a request for postmortem examination should be considered in the following situations:

   a) Unanticipated death;

   b) Death occurring while the patient is being treated under a new therapeutic trial regimen;

   c) Intra-operative or intra-procedural death;

   d) Death occurring within 48 hours after surgery or an invasive or diagnostic procedure;

   e) Death incident to pregnancy or within seven days following delivery;

   f) All deaths on the psychiatric service;

   g) Any death where the cause is sufficiently obscured to delay completion of the death certificate;

   h) Death in infants or children with congenital malformations.

2) An autopsy may be performed only with a written consent, signed in accordance with State law. Medical Staff Appointees should refer to the Hospital Autopsy Procedure Policy.

ARTICLE XX:

CORONER'S CASES

Medical Staff should refer to the hospital's policy concerning coroner's cases.

ARTICLE XXI:

ORGAN DONATION

All requests for organ donation should follow the hospital's policy concerning organ donation.

ARTICLE XXII:

RESTRAINT USE:

1) Restraint is any method of physically restricting a person's freedom of movement, physical activity, and normal access to the body. The term "restraint" includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method, physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body. A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

2) Policies on restraint use vary depending on the indication for use and the department in which the patient is located. Medical Staff should refer to the organizational Restraint Use policy and associated departmental policies.

ARTICLE XXIII:

SECLUSION:

1) Medical Staff should refer to the hospital's policies on seclusion, as these may differ based on the department in which the patient is located.

ARTICLE XXIV

HOSPITAL PRACTITIONER ASSISTANCE COMMITTEE

To improve the quality of care and promote the competence of the Medical Staff, there is hereby established a Hospital Practitioner Assistance Committee (hereby referred to as the Committee) within Memorial Hospital and Health Care Center. The Medical Staff of Memorial Hospital and Health Care Center hereby establishes the Committee as a peer review committee. This committee is entirely independent of any other committee, and entirely separate from any disciplinary or enforcement activities, established or authorized by these Bylaws. Members of the Medical Staff, Hospital personnel, or any other caring and interested persons are encouraged to report to the Committee any instance of suspected functional and professional impairment because of alcoholism, drug dependence, or mental, physical, or aging problems that have or could give rise to injury to a patient. If the Committee finds the complaint non-conclusive, this information is reported to the original complainant who is informed that he/she may, if desired, report the complaint to the appropriate Medical Staff disciplinary committee, county medical society, or other authorities. The Medical Staff, including all licensed independent practitioners, will periodically receive education about illness and impairment recognition issues specific to licensed independent practitioners (at risk criteria).

Policies - The Committee shall have no disciplinary powers and will act as the physician's advocate. All contacts of sources of information, including physicians and other licensed independent practitioners seeking referral or referred for assistance, except as limited by law, ethical obligation or when the health and safety of a patient is threatened shall be confidential.

1) Section One - Policy Regarding an Acutely Impaired Physician

   a) When Hospital personnel, a patient, or patient's family expresses concern that a physician appears acutely impaired, the Hospital employee must contact the Department Director or the House Supervisor immediately. The President of the Medical Staff or his/her designee will be contacted immediately and asked to come to the Hospital.

   b) The physician in question will be informed of this procedure by the staff person and informed that this is Hospital procedure. The physician will be requested to wait until the designated superior arrives (i.e., Medical Staff President) at which time a urine drug screen and blood alcohol level will be obtained. Chain of custody procedure will be followed in the collection of urine.

   c) Should the above urine screen and/or blood alcohol level be positive, or if it is negative and/or the designated superior determines the physician to be otherwise psychiatrically and/or physically impaired, the physician in question shall be required to cease patient care immediately. The designated superior will arrange for immediate care of the physician's patients.

   d) All information is to be given to the Hospital Practitioner Assistance Committee for immediate review within three (3) business days. The physician in question should be apprised of this procedure.

   e) The ISMA Physician Assistance Program (PAP) Coordinator and/or Medical Consultant working in conjunction with the Practitioner Assistance Committee will evaluate and investigate the complaint. A course of action will be developed by the ISMA PAP or the Medical Consultant, and the

appropriate Hospital committee will be notified. Options include, but are not limited to the following:

1) If an initial report/reports lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be reinvestigated.

2) If the reports prove substantial and the physician is recommended to undergo an appropriate evaluation by a facility or physician approved by the ISMA Commission on Physician Assistance, the physician must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendations is verified by the physician entering into an evaluation contract with the ISMA PAP.

f) Failure to comply with requests for evaluation or the terms of the contract will result in a report to the Medical Staff Executive Committee of the Hospital and may result in a report to the Indiana Medical Licensing Board.

2) Section Two - Policy Regarding Impaired Physicians - If any Hospital personnel, patient, or patient's family has a reasonable concern that a physician appointed to the Medical Staff is impaired, the following procedures are recommended:

a) A written report of the specific concerns and behaviors shall be given to either the Hospital Practitioner Assistance Committee or the appropriate Hospital physician committee. The anonymity of the individual giving the report may be maintained.

b) If the report clearly suggests impairment, the Hospital committee will contact the ISMA PAP or a Medical Consultant.

c) The ISMA PAP or Medical Consultant, working in conjunction with the appropriate Hospital committee, will evaluate and investigate the complaint. A course of action will be developed by the ISMA PAP or Medical Consultant, and the appropriate Hospital committee will be notified. Options include but are not limited to the following:

1) If an initial report/reports lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be reinvestigated.

2) If the reports prove substantial and the physician is recommended to undergo an appropriate evaluation by a facility or physician approved by the ISMA Commission on Physician Assistance, the physician must agree to follow the recommendation of the evaluation. Consent to undergo evaluation and follow treatment recommendations is verified by the physician entering into an evaluation contract with the ISMA PAP.

d) If treatment is recommended, the physician will sign a contractual agreement.

e) Failure to comply with requests for evaluation or the terms of the contract will result in a report to the Medical Staff Executive Committee of the Hospital and may result in a report to the Indiana Medical Licensing Board.

ARTICLE XXV

HARASSMENT:

Memorial Hospital is firmly committed to maintaining a work place free from any form of harassment, including, but not limited to, harassment or intimidation on the basis of an employee's sex, age, national origin, disability, race, ancestry or color.

Harassment is defined in the hospital's organizational policy entitled Harassment.

1) Disciplinary Action

The following explains what will occur when harassment has been reported which involves a member of the Medical Staff of Memorial Hospital and Health Care Center:

b) The supervisor who received the report will investigate this report in conjunction with Human Resources, gathering information from both/all parties involved. All attempts will be made to assure confidentiality. However, complete confidentiality cannot be guaranteed. The President/CEO of the Hospital or the Medical Staff President will be informed of the incident so that they can monitor for any recurring problems. The following disciplinary action will occur for all identified cases of harassment:

1) First occurrence - Verbal and written notification from the Director of the department where the incident occurred.

2) Second occurrence - Conference with physician, Medical Staff President and a representative from administration. Others that may be invited to participate include the Director of the department where the incident occurred, Human Resources and the employee with the complaint.

3) Third occurrence - The President/CEO of the Hospital will refer the matter to the Credentials Committee for review and as a result of such review, make a recommendation on the matter in accordance with Article 8 of the Medical Staff Bylaws.

c) If at any time during the investigation of an occurrence, the Medical Staff President and President/CEO of the Hospital determine the conduct is more severe or pervasive, they may decide to move immediately to a stronger disciplinary action.

d) An occurrence may be deleted from a physician's record if no further occurrences have been documented within a three-year time period.

ARTICLE XXVI:

ADOPTION AND REVISION

1) These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Rules and Regulations, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the hospital shall be taken under and pursuant to the requirements of these Rules and Regulations.

2) These Rules and Regulations are meant to be consistent with the Medical Staff Bylaws of Memorial Hospital and Health Care Center. In any case of apparent conflict between the two documents, the Bylaws document will take precedence.

3) These Rules and Regulations should be reviewed at least every three years by the Bylaws Committee of the Medical Staff, in accordance with the procedure defined in the Medical Staff Bylaws.

4) These Rules and Regulations may be revised, amended or replaced by the Medical Staff in accordance with the procedure defined in the Medical Staff Bylaws. All such changes shall become effective only when approved by the Board of Directors.

APPROVED BY THE MEDICAL STAFF on November 28, 2023

APPROVED BY THE BOARD OF DIRECTORS on December 7, 2023