BEACON HEALTH SYSTEM

THREE RIVERS HEALTH

MEDICAL STAFF RULES & REGULATIONS

MEDICAL STAFF RULES AND REGULATIONS – TABLE OF CONTENTS

MEDICAL STAFF RULES AND REGULATIONS

A. ADMISSON AND DISCHARGE

1. Only practitioners granted Medical Staff membership and clinical privileges may admit patients to this Hospital except as provided in the Medical Staff Bylaws and Rules and Regulations. Only practitioners granted clinical privileges may treat patients at this Hospital. All practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital Dentists with authority to admit patients to the hospital must obtain a physician member of the Medical Staff to perform an admitting history and physical for the patient being admitted.

2. The Hospital shall accept patients for care and treatment except as follows:

(a) Mental health and violent patients are admitted only in case of an emergency and only if there is no other means for their care; and

(b) Patients under the influence of drugs, alcohol, or unknown ingested substances are admitted only in case of an emergency.

3. A physician member of the Medical Staff shall be responsible for the medical care and treatment of each patient 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, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, a progress note covering the transfer, and summarizing the patient's condition and treatment, shall be made, and the practitioner transferring his/her responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service concerned in the treatment of the disease which necessitated admission. In the case of a patient requiring admission who has no practitioner, he/she shall be assigned to the hospitalist.

4. Except in the case of emergency admissions, 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, service record shall accompany the patient to the nursing unit.

5. Each member of the medical staff shall name another member of the medical staff as an alternate to be called to attend his/her patients in an emergency when the attending physician is not available or until the attending physician can be present. In case the alternate is not available, or until the attending physician can be present. In case the alternate is not available, the Administrator or the Chief of Staff shall have the authority to call the on-call physician or any other member of the staff to attend the patient. Failure of a member of the staff to meet these requirements may result in disciplinary action. This list shall be annually completed in the Administrator's office and distributed to all appropriate personnel.

6. Patients shall be discharged from the Hospital only on the order of the patient's attending practitioner or designee. If a patient leaves the Hospital against the advice

of the attending practitioner, or without proper discharge, a notation shall be made in the patient's medical record.

7. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

(a) Emergency

(b) Urgent

(c) Pre-Operative

(d) Routine

8. The patient shall not be transferred within the Hospital without the approval of the attending practitioner or his/her designee. The order of priority for patient transfers shall be as follows:

(a) Emergency service to appropriate nursing unit

(b) From general care unit to intensive care unit

(c) From intensive care to general care unit

(d) From temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit for the patient being transferred

(e) From obstetric care unit to general care unit.

9. Practitioners shall abide by the Hospital's utilization review plan to include:

(a) The appropriateness and medical necessity of admission

(b) Continued stay

(c) Supportive services

(d) Discharge planning

10. In the event of the Hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform to local law.

B. EMERGENCY SERVICES

1. Members of the Active Medical Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.

2. Clinical privileges shall be delineated for all practitioners rendering emergency care in accordance with Medical Staff and Hospital procedures.

3. The Chief of Emergency Services shall have the overall responsibility for emergency medical care.

4. A physician shall be in the Hospital and immediately available for rendering emergency service policies and procedures.
5. The patient's primary care physician shall be notified within 24 hours in accordance with the emergency service policies and procedures regarding notification of admissions and transfers.
6. Emergency service policies and procedures shall be approved by the Chief of Emergency Services, the Medical Executive Committee and Administration.
7. If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency physician, either for observation or for further treatment, the patient shall be admitted in the name of the hospitalist or designee. If, in the judgment of the emergency physician, the physician shall continue to accept responsibility for the patient by physically coming to the Hospital and caring for the patient.
8. Except in cases of minor surgery or closed reduction of fractures or dislocations, surgery shall not be performed in the emergency treatment area. In such cases, only intravenous or intramuscular anesthesia will be used.
9. In cases where the x-ray interpretation of the Radiologist is different from that initially made by the emergency physician, copies of the Radiologist's report shall be made available and brought to the attention of the emergency physician, the patient's private physician, the on-call physician for the day of examination, and the patient.
10. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's Hospital record, if such exists. The record shall include:
    - **(a)** Adequate patient identification;
    - **(b)** Time and means of arrival;
    - **(c)** Pertinent history of the injury or illness including:
        - **(1)** Physical findings
        - **(2)** Vital signs
        - **(3)** Emergency care given prior to arrival at the Emergency Room
        - **(4)** History of allergies
    - **(d)** Description of significant:
        - **(1)** Clinical findings
        - **(2)** Laboratory findings
        - **(3)** X-rays findings
    - **(e)** Diagnostic impression;
    - **(f)** Treatment;

(g) Management plan;

(h) Condition of the patient on discharge or transfer; and

(i) Final disposition, including instruction given to the patient and/or his/her family relative to necessary follow-up care.

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

12. All Emergency Department notes must be completed by the practitioner by the end of the practitioner's shift.

13. The emergency service chief shall coordinate the review of emergency service records with the Medical Staff medical records function.

14. The emergency service chief shall be responsible for monthly patient care evaluation studies concerning the quality and appropriateness of patient care.

15. A copy of the emergency service medical record shall accompany patients being admitted as inpatients.

16. Patients with conditions whose definitive care is beyond the capabilities of this Hospital shall be referred to the appropriate facility, when in the judgment of the attending physician; the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to the facilities shall be followed.

17. The emergency service chief shall make certain that emergency service procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.

C. OUTPATIENT SERVICES

1. Licensed Providers and/or Practitioners can order outpatient procedures and/or services to be completed at Three Rivers Health.

2. The Medical Staff delegates to the therapist (Occupational Therapist, Physical Therapist, and Speech-Language Pathologist), upon an order for therapy to evaluate the patients, develop a plan of treatment, and initiate the plan of care prior to the physician signing off. The physician will sign the plan as soon as reasonably possible.

D. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. All non-attending practitioners shall be responsible for the preparation of the appropriate portions of the medical record in a complete and legible fashion for each patient seen. In all cases, the content of the medical record shall be pertinent and current for each patient. This record shall include:

(a) Identification data;

(b) complaint;

(c) personal history;

(d) allergic history;

(e) family history;

(f) history of present illness;

(g) physical examination;

(h) impression and plan,

(i) special reports such as consultations, clinical laboratory and radiology services, and others' professional diagnoses, medical or surgical treatment, operative report, pathological findings,

(j) progress notes,

(k) final diagnosis,

(l) condition on discharge,

(m) summary of discharge note,

(n) and autopsy report when performed.

2. A medical history and physical examination, which is signed or cosigned by a Physician, must be completed in-person and documented for each patient in accordance with the Bylaws, Policies, and Procedures, and as required by Law. In all instances, a history and physical exam must be performed and documented within thirty (30) days prior to date of admission or within twenty-four (24) hours after an admission. If a history and physical is performed and documented in the chart prior to the date of admission, then a thorough updating entry must be provided within twenty-four (24) hours after the admission, which documents/addresses vital signs, systems stability, or other relevant change, and any other information pertinent to the admission. With respect to surgical patients, in all such cases there must be a history and physical workup in the chart prior to surgery, except in emergencies. If the report has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting Physician, which includes vital signs, allergies, and appropriate data.

3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled, unless the attending practitioner states in writing, the indications for surgery, pertinent clinical findings and that there are no contraindications for surgery that such a delay would be detrimental to the patient.

4. Pertinent progress notes shall be recorded daily and be dated and timed on each hospitalized patient.

Exception: Rehab: With regard to patients admitted to the Rehabilitation Pavilion, a physician with special training or experienced in the field of rehabilitation must document entries in the patient's medical record that reflect

frequent and direct, medically necessary physician involvement in the patient's care at least every 2 to 3 days during the patients' stay.

Swing bed: Swing bed patients must be seen every seven (7) days with progress note entries to reflect this.

5. The attending physician shall countersign all orders, the history and physical examination, and the pre-operative notes.

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

7. Operative reports shall contain the following:

(a) Date of operation

(b) Procedure(s) performed

(c) Pre-operative diagnosis (the surgeon is responsible for pre-op diagnosis)

(d) Post-operative diagnosis

(e) Detailed description of the surgical technique

(f) Findings during surgery

Operative reports shall be dictated and on the medical record within 24 hours following surgery.

8. The current 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 written that includes pertinent additions to the history and updated physical findings.

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

10. Consultations specific to the type and the extent shall be held, except in extreme emergencies, under the following conditions:

(a) When the patient is not a good risk for operation or treatment;

(b) In unusually complicated situations where specific skills of other practitioners may be needed;

(c) In cases where the patient's first Caesarean section is being considered;

(d) All curettages or other procedures by which a known suspected normal pregnancy may be interrupted. A negative pregnancy test will be considered a consultation. The following items shall be considered exceptions for waiving the consultation or pregnancy test:

(1) Documentation in the History and Physical that the patient is post-menopausal, regardless of age;

(2) Documentation in the History and Physical that the patient has had her tubes tied;

(3) Documentation in the History and Physical that the patient has had a sub-total hysterectomy;

(4) A previous ultrasound by a Radiologist, or a physician credentialed in pelvic/abdominal ultrasound has been performed within one week prior to surgery;

(5) Recent evidence of products of conception being passed through the cervical opening, or a cervix that is dilated with products of conception in the cervical opening.

(e) Major surgical cases in which the patient is not a good risk or in which the diagnoses or indications for surgery are in doubt;

(f) Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose. That such services were at least recommended must be documented in the patient's medical record;

(g) When requested by the patient or his/her family;

(h) When required by the policy of a special care unit.

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 recommendation. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. Any qualified physician with clinical privileges in this Hospital can be called for consultation.

11. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations and signed by the responsible practitioner at the time of discharge of all patients.

12. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. For all discharge summaries in all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner. All discharge summaries are to be completed (with signature) within 7 days of discharge.

13. If the discharge summary is not completed within 4 days (with signature) after completion of services rendered and/or discharge, the Chief of the Medical Staff will notify each physician, in writing, when he/she has failed to complete discharge summaries within 4 days of discharge. Failure to complete medical records will result

in a monetary assessment of $5.00 per chart per week for all charts that are delinquent.

14. Written consent of the patient is required for release for medical information to persons not otherwise authorized to receive this information.

15. In case of readmission of a patient, all previous records shall be available to be used by the attending practitioner.

16. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's medical record, dated, times, and signed by the practitioner.

17. Symbols and abbreviations may be used only when they have been approved by the Medical Staff.

18. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In any 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 is 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.

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

20. Practitioners shall be responsible for obtaining the patient's informed consent prior to treatment. The patient shall be informed of the nature and risks of the procedure and of the possible alternatives. The patient shall sign the consent form affirming that the practitioner has personally informed the patient prior to the consent space shall be provided on the form for the practitioner to document what was explained to the patient and that the patient understood and agreed to the proposed treatment.

21. The attending practitioner shall be held responsible in all cases, including those in which a Consulting Staff physician is co-managing the case, for the completion of the medical record at the time of the patient's discharge, to include progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory reports have not been received at time of discharge, the medical record will be available in the Medical Records Department. If the discharge summary cannot be

dictated at the time of discharge, a final progress note must be written in the medical record including a discharge diagnosis if it is not recorded on the face sheet.

22. If the medical record is incomplete thirty (30) days following completion of services rendered and/or discharge, the attending physician will be notified in writing that all hospital privileges will be suspended if not completed within seven days.

The Chief of Staff will receive notification of the upcoming suspension with a list of the incomplete charts. The Chief of Staff will review the list of charts and determine if this warrants suspension if not completed within the seven days allowed.

Privileges may be reinstated by the Chief of Staff upon receiving notification from the Health Information Services (Medical Records Department). Health Information Services shall notify physicians routinely of charts that are incomplete following completion of services rendered and/or discharge, with a reminder being sent weekly to the physician.

E. GENERAL CONDUCT OF CARE

1. All orders for treatment shall be writing. A telephone order, shall be considered to be in writing if dictated to a Registered Nurse, Registered Pharmacist, Registered Respiratory Therapist, Certifies Respiratory Therapy Technician, Certified Speech Language Pathologist, Licensed Physical Therapist, or Registered Occupational Therapist, functioning within his/her sphere of competence. All orders, dictated over the telephone will be dictated by the practitioner and read back to the person receiving the order. Each telephone order will be dated, timed and signed by the practitioner, and will identify the person who took the order as well as the person who implemented it. The responsible practitioner shall authenticate his/her telephone orders within 48 hours following the order. Verbal orders are only taken in emergency situations. However, potentially hazardous verbal orders (I.E., restraints, certain medications) shall be authenticated within the established time frame as noted in each respective policy.

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

3. All previous orders are cancelled when patients go from general care to surgery or from general care to a special care unit or from a special care unit to general care or from the obstetric unit to a general care unit.

4. The medical staff of Three Rivers Health is committed to providing a restraint-free environment.

However, when it becomes necessary to use restraints, the least restrictive device will be utilized. The physicians agree to follow the hospital wide policy and procedure on restraints, which outlines when and how restraints may be utilized.

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or American Medical Association Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

6. All antibiotics will carry an automatic ten (10) day stop order. All narcotic medications, hypnotics and steroids, sedatives, and oxytocics will carry an automatic three (3) day stop order. If the practitioner desires to continue their medications, he/she must reorder them at the end of this period. The attending physician or his/her designee shall be notified by the pharmacist when drugs are due for an automatic stop order.

7. Anticoagulants should only be written for a twenty-four (24) hour period. Unless otherwise specified, they should be stopped automatically at the end of forty-eight (48) hours. The attending physician or his/her designee shall be notified by the pharmacist when drugs are due for an automatic stop order.

8. Any qualified practitioner with clinical privileges at Three Rivers Health can be called for consultation within his/her area of expertise.

9. The attending physician is primarily responsible for requesting consultation when indicated and for calling in qualified consultant. He/She will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency.

10. Medications bought into the Hospital by a patient or his/her family will not be given to the patient during his/her hospitalization stay without the express authorization of the attending physician.

11. Blood which has been cross-matched and is being held for a patient will be held for forty-eight (48) hours at which time the order for the blood will be canceled unless reordered for another forty-eight (48) hours. Blood will not be released without notifying the appropriate physician.

12. Oxygen and respiratory therapy will be administered according to the attending physician's orders. In those cases where duration of treatment is indefinite or unspecified, the physician of record will be notified on the third (3rd) day of treatment for new orders by the fourth (4th) day.

    The physician will write new orders as soon after notification on the third (3rd) day as possible, not to exceed the fourth (4th) day. If new orders are not given, the nurse will contact the physician for orders regarding continuing or discontinuing the respiratory therapy.

13. Consultation Requisition/Request forms for radiology and pathology shall be filled out completely. The attending physician is responsible for providing necessary

clinical data in order to justify the need or the examination. The necessary data may be taken from the order sheet or progress notes by nursing personnel.

14. 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, she/he shall call this to the attention of her/his superior who, in turn, may refer the matter to the Chief Nursing Officer or her/his designee. If warranted, the Chief Nursing Officer may bring the matter to the attention of the attending physician, Chief of the Service, Chief of Staff, or the chief Executive Officer as appropriate. Where circumstances are such as to justify such action, the Chief of Staff may himself/herself request a consultation.

15. Standing orders and/or instruction sheets shall be instituted only after approval of the Executive Committee of the Medical Staff. Such standing orders and/or instruction sheets shall be reviewed by the Service Chief and revised as necessary. All standing orders will be initially signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.

16. Information regarding discharge planning shall be documented in the physician's progress notes not later than three (3) days after admission to the hospital. Changes to the discharge planning shall be duly documented.

F. SURGICAL CARE

1. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure may be canceled, unless the attending practitioner states in writing the indications for surgery, pertinent clinical findings, and that there are no contraindications for surgery, that such a delay would be detrimental to the patient. In all other cases, the responsible nurse shall notify the operation surgeon, preferably not later than the night before surgery is scheduled, and preparation for surgery, including premedication shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time. The history and physical examination must be updated prior to surgery if not performed within 24 hours of admission.

1.1 Those who may perform History and Physical Examination: The medical history and physical examination must be completed and documented by a physician, a podiatrist (if privileges have been granted), a nurse practitioner, physician assistant or certified nurse midwife. History and Physicals performed by the Nurse Practitioner and Physician Assistants require a co-signature of sponsoring physician.

2. All female patients who are between menarche and menopause will have urine pregnancy test on the day of surgery, before going to the operating room. The exception to this is those women who have undergone a pervious sterilization procedure such as hysterectomy, tubal ligation, or bilateral oophorectomy.

NOTE: Menarche is defined as a female whose menses has begun or who has reached the age of 13. The age of menopause is considered to be 50 years old, or when menses has ceased, whether younger or older.

Those females scheduled for elective or diagnostic D&C and/or hysterectomy will have a serum pregnancy test performed as part of their pre-operative lab work

3. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he/she shall be referred to the Medical Executive Committee for action.

4. The Anesthesia Service and/or attending physician is responsible for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia and surgical or obstetrical procedure anticipated.

5. The Anesthesia Service and/or attending physician is responsible for writing a post-anesthetic note after the patient has completed post-anesthesia recover care to include at least a description of the presence or absence of anesthesia-related complications.

6. First Assistant in Surgery:

(a) The operating physician is responsible for determining the need for and level of experience required for a physician first assistant when cases are scheduled.

(b) Surgeons must arrange for physician first assistance on elective cases that are defined as hazardous. In emergent situations, surgical technicians can be utilized at the discretion of the surgeon.

(c) Hazardous Procedures are defined at the discretion of the surgeon. Hazardous Procedures are required to have a physician first assistant.

(d) If, in the opinion of the operating surgeon and/or the Chief of Surgery, there is in any surgical procedure an unusual hazard to life, there shall be present and scrubbed, as first assistant, a qualified physician.

7. An associate staff member who is classified in a preceptorship or supervisory status for specified surgery privileges must have presented his/her preceptor or qualified assistant for these specified surgery procedures.

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

(a) Dentist's 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 findings and techniques. In cases of extraction of teeth and fragments removed, all tissue including teeth and fragments shall be sent to the hospital pathologist for examination;

(4) The dentist is totally responsible for the oral condition;

(5) Discharge summary.

(b) Physician's Responsibility:

(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.

(4) Physician is not responsible for any dental care.

(c) The discharge of the patient shall be on written order of the dentist or the Medical Staff.

9. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and physician member of the Medical Staff.

(a) Podiatrist's Responsibilities:

(1) A detailed history justifying hospital admission; (Reference: F1.1, Those who may perform History and Physical Examination)

(2) A detailed description of the examination of the feet and pre-operative diagnosis;

(3) A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.

(4) Progress notes;

(5) The podiatrist is solely responsible for the care of the feet;

(6) Discharge summary (or summary statement).

(b) Physician's 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;

(4) Physicians are not responsible for any podiatric care.

(c) The discharge of the patient shall be on order of the attending physician.

10. Written, signed, informed, surgical consent (see: Section "MEDICAL RECORDS" above for details) 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.

11. The Anesthesia Service and/or the attending physician shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow-up of the patient's condition.

12. The rules for the scheduling of elective or non-emergency surgery will be as follows:

(a) The schedule is available for posting of cases at all times.

(b) The following information is required in order to post a case:

(1) The patient's full name

(2) Age

(3) Sex

(4) Surgical procedure

(5) Type of anesthesia

(6) Operating surgeon

(7) Time and initials of person posting the case

(8) Assistant surgeon

(9) Inpatient or outpatient case

(c) After the 8:00 A.M. time slots are filed, the order of cases will be based on the time of the cases posted, availability of assistant surgeon, available operating room personnel, room cleaning, etc., as determined by the operating room Head Nurse.

(d) If cleared in advance with the operating room Head Nurse, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule.

These cases will be scheduled in accordance with the rule (c) and will be done as near to that time as a room in available in the order the case is posted.

The time may be changed if it does not interrupt the normal schedule as determined by the Chief of Surgery.

13. Patients who are admitted to the Hospital more than seven (7) days prior to major surgery shall have a new physical examination to include at least the heart, lungs and other vital signs by the attending practitioner, the operating surgeon, or the anesthesiologist. Proper notes shall be made in the progress notes as to the findings. It shall be the responsibility of the operating surgeon to see that such physical examinations have been completed prior to surgery.

14. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chief of Surgery. It is a requirement that when the entire surgical team consists of non-physicians that arrangements are made to have a physician immediately, readily available to the procedure.

15. Sterilization for the sole purpose of sterilization for either male or female patients may be done at the discretion of the attending physician and the fully informed consent of the patient being sterilized.

G. OBSTETRICAL CARE

1. The current obstetrical records shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital and shall be up-to-date to include findings from the last visit.

2. All patients shall have a complete blood count and urinalysis on admission and should have type and Rh and post-partum hemoglobin or hematocrit on the chart prior to discharge. Rapid plasma reagin will be done on admission on all patients who have not had prenatal care.

3. It is not the intent of these proposed revisions to the Medical Staff Bylaws, Rules & Regulations to limit any physician currently holding OB/GYN privileges as of the 31st day of October 1996 pending review of requested obstetrical privileges by the Medical Executive Committee, the Joint Conference Committee, and the Authority Board.

(a) CLASS I

(1) Significant experience or a minimum of three months structured graduate training in OB/GYN. In addition to demonstrated competence in the care of the following conditions:

aa) Normal antepartum and post-partum care;

ab) Normal labor and delivery;

ac) Low forceps delivery which is defined as follows:

ad) "Low forceps is the application of forceps after head has become visible; the skull has reached the perineal floor, and the sagittal suture is in the antero-posterior diameter of the pelvis."

ae) Episiotomy and repair;

af) Repair of lacerations of the perineum which do not involve the anal sphincter, rectum, urethra, or broad ligaments of vaginal fornices;

ag) Dilatation and curettage;

ah) Incision and drainage of Bartholin abscesses;

ai) Marsupialization of Bartholin cysts;

aj) Assistance in common surgical procedures.

(b) CLASS II

(1) Requires additional structured training beyond Class I, or demonstrated competence in the care of the following conditions:

aa) Pregnancy-induced hypertension;

ab) Conization of the cervix;

ac) The use of oxytocins or drugs having this action for augmentation of labor and/or induction of labor.

(c) CLASS III

(1) Requires one of the following:

aa) Satisfaction completion of formal residency training in Obstetrics and Gynecology, and a member of the active, associate, courtesy, or consulting staff;

ab) Certification by the American Board of Obstetrics and Gynecology;

ac) Has determined his/her ability in Obstetrics and Gynecology, and has requested advancement and privileges in writing to the Medical Executive Committee;

ad) Privileges include care of the following conditions:

i. Caesarean Section;

ii. Failure to progress in labor;

iii. Abnormalities of fetal position or presentation including breech presentations, transverse lie, persistent occiput posterior, deep transverse arrest, etc.;

iv. Pre-eclampsia and eclampsia;

v. Third trimester bleeding

vi. Post-partum hemorrhage;

vii. Third degree perineal laceration or extensive vaginal or cervical injury;

viii. Ruptured membranes for more than 12 hours, and delivery not imminent;

ix. Manual removal or placenta;

x. Gynecological laparoscopy;

xi. All operative gynecological procedures not listed under Categories I and II;

xii. All gynecological procedures associated with hemorrhage and/or shock;

xiii. Laser Surgery;

xiv. All curettages or other procedures by which a known or suspected normal pregnancy may be interrupted. A negative pregnancy test will be considered a consultation.

NOTE: Privileges to perform gynecological laser surgery will be granted only after the candidate has presented to the Medical Executive Committee evidence of satisfactory completion of a formal training program in gynecological laser surgery. In addition, before full privileges are granted, a minimum of 10 cases must be satisfactorily performed under the supervision of the preceptor appointed by the Service Chief of Chief of Staff.

(d) REQUISITES

(1) All physicians meeting those conditions for Class I privileges may be granted those privileges;

(2) Physicians requesting approval to manage patients in Class II must submit documentation to the Medical Executive Committee to substantiate their training and demonstrated competence before being granted Class II privileges;

(3) Physicians requesting Class III privileges must, for a period of not less than one year, be monitored to demonstrate their ability to manage patients falling into class III. The number of the cases will be delineated by the Medical Executive Committee;

(4) All physicians not Board Certified in Obstetrics/Gynecology, or an active candidate for Board Certification in Obstetrics/Gynecology must consult with:

aa) A Board Certified OB/GYN, or

ab) An active candidate for Board Certification in OB/GYN;

for any Class III patient.

It is the intent that consultations be provided by the Three Rivers Health physicians. If the consultation is provided by a certified OB/GYN not regularly involved in patient care at Three Rivers Health System, Inc a written copy of the consultation must be on the chart.

4. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours.

5. All obstetrical medical records shall have complete prenatal histories and physical examinations.

6. Oxytocic drugs shall be used in the following manner:

(a) Intravenous oxytocin shall be initiated with the physician present;

(b) Intravenous oxytocin for induction of labor shall be administered by piggyback;

(c) Only one elective induction shall be scheduled at a time. Oxytocin Challenge tests will be considered as one of the elective inductions. Elective inductions may be scheduled by calling the labor and delivery nurse;

(d) The reason for induction of labor shall be documented.

7. Patients having Caesarean sections or post-partum tubal ligations shall have an updated history and physical examination. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.

(a) Abortions will not be done in this hospital solely on patient's request or demand.

(b) Abortions may be done for therapeutic reasons

(c) The reasons for the abortion must be clearly documented in the medical record.

(d) Consultations for an abortion are required with two consulting physicians, one of which must be an obstetrician.

(e) All abortions done will be reviewed by the tissue and transfusion function.

H. NEWBORN/PEDIATRIC CARE

1. All newborn orders must be itemized, including orders for formula and care of the newborn, and signed by the physician.

2. A physical examination shall be recorded in the medical record of all newborns.

3. CONSULTATION WILL BE OBTAINED FOR THE FOLLOWING CONDITIONS:

(a) Less than 35 week gestation. Pediatrician should attend delivery in addition to monitoring care;

(b) High-risk fetus, such as hydrocephalus, hydrops, congenital heart defect, gastroschisis etc. pediatrician should attend delivery and monitor care.

(c) Hypoglycemia requiring intravenous glucose or any newborn with a blood sugar less than 30.

(d) Respiratory Distress:

(1) Requiring oxygen more than 4 hours;

(2) Increasing oxygen requirement;

(3) Hypoxia not responding immediately to oxygen;

(4) With any evidence of poor perfusion;

(5) Asphyxia requiring drug resuscitation or prolonged bagging.

4. REQUISITES

(a) All physicians not Board Certified in Pediatrics, or an active candidate for Board Certification in Pediatrics, must consult with:

(1) A Board Certified Pediatrician; or,

(2) An active candidate for Board Certification in Pediatrics.

(b) It is the intent that consultations be provided by Three Rivers Area Hospital physicians. If the consultation is provided by a certified Pediatrician not regularly involved in patient care at Three Rivers Area Hospital, a written copy of the consultation must be on the chart within 24 hours.

I. DISASTER PLAN

1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Medical Staff.

2. The disaster plan should make provision within the Hospital for:

(a) Availability of adequate basic utilities and supplies, including water, food and essential medical and supportive materials;

(b) An efficient system of notifying and assigning personnel;

(c) Unified medical command under the direction of the Chief of the Medical Staff of his/her designated substitute;

(d) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care;

(e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;

(f) A special disaster medical record, such as an appropriately designated tag that accompanies the casualty as he/she is moved.

(g) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;

(h) Maintaining security in order to keep relatives in curious persons out of the triage area; and,

(i) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual.

3. All physicians may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of the Medical Staff in the Hospital and the Administrator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of the Medical Staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be joint responsibility of the Chief of the Medical staff and the Administrator of the Hospital. In their absence, the Vice Chief of Staff and alternate in administration are next in line of authority respectively.

4. The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation during drills is optional. A written report and evaluation of all drills shall be made.

J. MEDICAL STAFF CODE OF CONDUCT

Medical Staff members must treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner at all times. Conduct will not be tolerated that negatively impacts the delivery of quality care, interferes with the ability of others to carry out their responsibilities, creates a hostile work environment, disrupts hospital operations or fosters a negative public image of Three Rivers Health.

1. Examples of disruptive conduct include, but are not limited to the following:

(a) Abusive verbal behavior in private or in public to colleagues, hospital staff, patients, families or visitors including threats, discourtesy or criticism with the intent to intimidate, discredit, humiliate or imply stupidity or incompetence.

(b) Inappropriate hostility toward a hospital employee who is attempting to carry out his/her responsibilities by notifying a provider concerning patient care questions/concerns, clarification of orders, notification of lab results, etc.

(c) Aggressive or intimidating physical behavior such as threats of physical violence, assault/battery, throwing of instruments or equipment.

(d) Inappropriate comments verbally or in patient medical records or other official documents impugning the quality of care provided by Three Rivers Health or attacking Medical Staff, hospital staff or hospital policies.

(e) Harassment or any form of retaliation against any person who files a complaint pertaining to Medical Staff conduct or patient care concerns.

(f) Inappropriate profanity, racial/ethnic/religious slurs or similarly offensive language.

(g) Discrimination based on sex, color, race, ancestry, national origin, age, disability, job status or other recognized group status.

(h) Sexual harassment including sexually explicit comments/jokes, sexual coercion, inappropriate comments, touching or gestures.

(i) Unauthorized handling, possession or use of any inappropriate drugs or alcoholic beverages on hospital premises or caring for patients under the influence of controlled substances or intoxicants.

(j) Failure to present oneself with appropriate professional dress or demeanor when dealing with patients, visitors, or other hospital personnel.

(k) Disruptive behavior in medical staff committee or other hospital meetings.

(l) Refusal to attend meetings mandated by hospital administration, the Medical Executive Committee or as required by the Medical Staff Bylaws, Rules and Regulations.

(m) Failure to practice within generally accepted medical practice standards.

(n) Falsification, theft, or destruction of medical or other hospital records.

(o) Unauthorized possession, use, copying or reading of hospital records or disclosure of such information to unauthorized persons.

(p) Accessing medical records in an attempt to seek referrals or for any other personal or financial gain.

(q) Failure to complete medical records per Medical Staff rules.

(r) Failure to respond or respond in a timely fashion to calls/pages.

(s) Failure to provide continuous Medical Staff coverage for hospitalized patients.

(t) Failure to communicate pertinent clinical information to a covering provider or when transferring care to another provider.

(u) Failure to evaluate patients with emergent conditions in a timely fashion.

(v) Intentional failure to comply with Medical Staff Bylaws, Rules and Regulations.

(w) Failure to respond in a timely manner to Medical Executive Committee requests/expectations communicated in writing to a practitioner.

(x) Refusal to meet with the Chief of Staff, Three Rivers Health CEO, Medical Peer Review Committee or Medical Executive Committee when requested regarding conduct or clinical care issues.

2. Any person may file a formal complaint/concern concerning Medical Staff clinical care or conduct. Complaints concerning violations of Code of Conduct must be in writing and include the following documentation:

(a) Date and time of the alleged incident

(b) Name of the patient, Medical Staff, employee or other person(s) involved

(c) The circumstances that resulted in the alleged incident

(d) An objective description of the alleged incident

(e) Remedial steps taken including date, time, place, action(s) and name(s) of those intervening. Any meetings between those involved and managers or hospital administration must be documented.

(f) Name and signature of the person writing the report, with time and date of report

3. Code of Conduct violations will be addressed in a firm, fair and equitable manner following processes set forth in the Medical Staff Bylaws and Rules and Regulations. All Code of Conduct complaints will be sent to the hospital CEO and to the Medical Staff Coordinator for evaluation by the Peer Review Committee. The Chief of Staff will review all violations to determine if a response is needed from the involved Medical Staff member prior to review by the Peer Review Committee. The member will be given 14 days to respond to the violation. All violations will then be evaluated by the Peer Review Committee. The committee may request the Medical Staff member attend a Peer Review Committee meeting to discuss the Code of Conduct violation. After appropriate evaluation, the Code of Conduct violation may be dismissed, placed in the member's file for trending or forwarded to the Medical Executive Committee for further disposition.

4. Code of Conduct violations forwarded to the Medical Executive Committee will usually be handled by a series of meetings. A serious Code of Conduct violation may result in disciplinary action at any step in the process. The initial meeting should be collegial and be designed to be helpful to the Medical Staff member and the hospital. Those present will be the member and others designated by the Medical Executive Committee including but not limited to the Chief of Staff, Chairperson of the appropriate department, Three Rivers Health Chief Executive Officer and the Medical Staff Coordinator. The purpose of the initial meeting would be to discuss the circumstances of the problem, to emphasize that such conduct is unacceptable and to elicit an agreement by the member to cease the offending behavior(s).

5. If the behavior persists, a second meeting will be arranged advising the member that such conduct is intolerable and must stop. The Medical Executive Committee may at any time request the member seek outside help such as counseling to aid in the

resolution of his/her Code of Conduct issues. All meetings pertaining to Code of Conduct issues will be documented and followed by a letter from the Chief of Staff to the Medical Staff member summarizing the concerns, discussion and agreements. The Medical Staff member may write a letter of rebuttal at any time in the process which would be brought for discussion to the Medical Executive Committee. All correspondence concerning these meetings would be placed in the member's file. Any member of the Medical Staff may request the Medical Staff Coordinator to view his or her file.

6. If the Medical Staff member does not respond to the above mentioned remediating measures, the Medical Executive Committee may take disciplinary action at any time in the process. Any action that negatively impacts a member's Medical Staff status such as being placed on probation, termination or limitation of privileges would be reported to the National Practitioner Data Bank.

7. A single egregious incident involving Medical Staff conduct or clinical care would go directly to the Medical Executive Committee and could result in summary suspension if the severe nature of the incident creates a condition threatening to the life of any patient or presents the substantial likelihood of immediate injury or damage to the health or safety of a patient or other person(s) or to the reputation of Three Rivers Health. Summary suspension would be reported to the National Practitioner Data Bank. By law, a serious violation of the Code of Conduct can be reported to the National Practitioner Data Bank without any disciplinary action on behalf of the Medical Executive Committee.

K. MISCELLANEOUS

1. Policies and Procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Medical Staff and approved by its Medical Executive Committee and the Hospital's Administration, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of all current directives.

2. Policies and Procedures referred to above, and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedure Manual(s) of the Hospital.