RULES AND REGULATIONS

OF

FLAMBEAU HOSPITAL INC. MEDICAL STAFF

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RULES AND REGULATIONS

I. GENERAL PROVISIONS AND AUTHORITY.

A. The Medical Staff shall adopt rules and regulations as may be necessary for the proper conduct of its work and to implement more specifically the general principles set forth in the Bylaws of the Medical Staff of Flambeau Hospital Inc. (the "Bylaws"). Such rules and regulations shall be a part of the Bylaws. Rules and Regulations may be amended or repealed at any regular or special meeting of the Medical Staff by two-thirds (2/3) vote of the Active Medical Staff present for adoption. Such changes shall become effective when approved by the governing body.

B. The meetings of the Medical Staff shall be held as provided in Article XIII of the Bylaws at Flambeau Hospital.

C. After each meeting, the secretary of the Medical Staff shall transmit to the Administrator such reports and recommendations as the Medical Staff may wish to make to him, or through him, to the Governing Body. A copy of the minutes of the Medical Staff and the Medical Staff Committee meetings shall be furnished by the Administrator for the permanent hospital file.

II. ADMISSION OF PATIENTS.

A. All services to patients shall be attended by members of the Active, Associate, or Courtesy Staff.

B. Patients shall be admitted in conformity with state laws and with public health rules and regulations. A provisional diagnosis shall be stated before admission. In emergency, the provisional diagnosis shall be stated as soon as possible after admission.

C. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure the protection of the patient from self-harm.

D. Patients seen in the emergency room that the emergency physician feels may need admission, will have their primary care physician (or his designated covering Physician) called to coordinate the admission. The physician who is on house call coverage at the time of the admission will accept unassigned patients.

    1. In coordination with the admitting physician, emergency room physicians are authorized to write initial orders on behalf of that physician. The primary care or house call physician contact will then be considered the admitting physician for the patient and will be the one contacted by nursing staff as clinical needs of the patient require.

2. Timing of the first physician rounds on patients admitted by emergency room physicians will be dependent on the needs of the patient as communicated to the admitting physician from the emergency room physician.

E. Physicians are expected to carry pagers during working hours and must respond to pages within the following timeframes (reference hospital policy 770-H-179 Inpatient Provider Expectations and 770-H-180 Physician Call and Coverage Responsibilities):

Stat Call – respond within five (5) minutes
Regular call – respond within fifteen (15) minutes
ICU – respond within five (5) minutes

1. It is each physician's responsibility to designate another physician to take calls when he is unavailable and to convey this information to the hospital nurse's station.
2. In the event of no response, the Chief of Staff or his designee will be contacted to facilitate continuity of patient care.
3. Attempts to contact the physician will be documented in the electronic medical record.
4. Patient evaluation and rounding are expected to be completed within the timeframes specified in the above referenced policies.

F. Responsibilities of the house physician on call include:

1. Providing care to unassigned patients admitted to Flambeau Hospital from the emergency room.
2. Acting as the attending physician for unassigned patients.
3. Being the first physician called to assist the emergency room physician when an unwieldy influx of patients occur.
4. Being the first physician called when a primary care attending physician covering their specialty area or their own patients cannot be reached.
5. Presenting in-person at the hospital within 30 minutes for emergent patient care needs.
6. Being the physician that the emergency room and inpatient personnel turn to for questions when there are no other logical routes to pursue.

III. PATIENT ORDERS AND MEDICATIONS.

A. Hospital procedures applicable to patients, generally excluding diagnostic and therapeutic, shall be determined in conference between the Medical Staff and the Administrator. They may be changed by the hospital Administrator only after conference with the Medical Staff.

B. All standing or routine orders of a medical nature are the responsibility of the Medical Staff. These orders shall be signed by the attending physician.

C. Restraint devices or seclusion protocols can be used when medically necessary and clinically warranted to prevent a patient from injury to self or others when less restrictive interventions are ineffective or inadequate. Mechanisms usually and customarily employed during medical, diagnostic, or

surgical procedures that are considered a regular part of such procedures do not constitute restraints.

1. A restraint-specific practitioner's order is necessary for restraint or seclusion protocol initiation by hospital personnel, and

2. A new order for continuation of such restraint for behavior management if desired will be reviewed every four (4) hours for adults; two (2) hours for patients ages 9 to 17; and one (1) hour for patients under age 9 and will be written every twenty-four (24) hours.

3. The Medical Staff member must be consulted as soon as possible after initiation of any restraint or seclusion for behavior management by hospital personnel and must see and evaluate the need for restraint or seclusion within one (1) hour of initiation.

D. All medications must be prepared and administered by or under the supervision of appropriately licensed personnel in accordance with applicable law and regulation governing such acts and in accordance with the approved Medical Staff Rules and Regulations.

E. All orders for treatment other than standing or routine shall be in writing or entered electronically for inpatients. Orders dictated over the telephone or given verbally shall be taken by the Registered Nurse, Licensed Practical Nurse, or Physician Assistant and must be signed by the person to whom dictated with the name of the physician per his order or his own name. The attending physician shall sign and date such orders within twenty-four (24) hours. Orders for leather restraints must be issued pursuant to Rule III.C but may be signed within twelve (12) hours.

The primary attending physician or his designee, who has also cared for the patient and is willing to assume responsibility, may sign another provider's telephone, electronic, or verbal orders.

Verbal orders and orders dictated over the telephone may be taken by the following professionals and transcribed by same for their own departments only: Registered Pharmacist, Certified Registered Nurse Anesthetist, Medical Technologists, Medical Lab Technicians, Licensed Physical Therapists, Registered Radiology Technologists (R), (CT), (MR), (M), or (N), Registered Diagnostic Medical Sonographer (ARDMS), or Certified Nuclear Medicine Technologist (CNMT), Certified Respiratory Therapists, and Respiratory Technicians.

Medication orders dictated over the telephone or given verbally shall be taken and may be implemented by an authorized person within his scope of practice. These individuals include: Registered Nurse, Registered Pharmacist, Licensed Practical Nurse, Certified Registered Nurse Anesthetist, Registered Radiology Technologist (R), (CT), (MR), (M), or (N), Registered Diagnostic Medical Sonographer (ARDMS), Certified Nuclear Medicine Technologist (CNMT), Physician Assistant, or EMTs authorized by the state to administer medications under the direction of a physician. Medication orders must be hand- or

electronically-signed by the person to whom dictated with the name of the physician per his order or his own name.

Verbal or dictated orders for medications specific to Respiratory Therapy use can be taken by a Certified Respiratory Therapist or Respiratory Technician, and must be signed by the person to whom dictated with the name of the Physician per his order or his own name.

Licensed Physical Therapists and Registered Radiology Technologists (RT), (R), (CT), (MR), (M), or (N), Registered Diagnostic Medical Sonographer (ARDMS), Certified Nuclear Medicine Technologist (CNMT) can take dictated or verbal medication orders that are part of a routine written standing order, or written standard procedure that has been approved by the Medical Staff.

Verbal orders are to be used infrequently and must be authenticated within 24 hours.

F. Drug Formulary. The Hospital will maintain a listing for drugs (i.e., a drug formulary) which are routinely stocked and available. All drugs and medications on the Hospital's formulary shall be those listed in the latest edition of the United States Pharmacopoeia or American Hospital Formulary Service or other accepted drug compendium or its update and approved by the Pharmacy and Therapeutics Committee. Use of drugs not approved for formulary status (e.g., "non-formulary ") will be managed according to Hospital policy and procedure.
Investigational drugs may be administered in the Hospital consistent with Hospital policy. Controlled drugs, antibiotics, anticoagulants and corticosteroids ordered without a time limit will be subjected to a stop date approved by the Pharmacy and Therapeutics Committee. Drugs shall not be stopped without notifying the attending Practitioner.
Use of a patient's home medications is generally not allowed except in the following circumstance: if the drug in question is non-formulary medication for which the pharmacy does not stock a therapeutic substitute or which cannot be procured within a reasonable amount of time. In such situations, the medication(s) must be positively identified by a pharmacist as to the identity of the drug and its appropriateness, including drug stability and storage. Medications that cannot be identified or verified, or are out of date and appear to be stored inappropriately, will not be used under any circumstances. If a patient's home medications are not used, patients are encouraged to return the medications to home. Storage of patient's own medication during hospital stay is done in accordance with Hospital policy.

G. All medical orders for medications, nursing care, diet and activity are automatically discontinued at the time the patient is taken to surgery, transferred from the medical floor to the Intensive Care Unit or transferred out of the Intensive Care Unit to the general medical floor.

    1. Orders for medications, nursing care, diet and activity must be rewritten per the current EMR process in the above situations. A postoperative patient who temporarily is observed in the Intensive Care Unit for the sole purpose of prolonged recovery observation does not have orders

automatically discontinued and therefore the postoperative orders do not need to be rewritten when the patient goes to the medical floor.

2. Antibiotics that are ordered without time limitations will be automatically discontinued after seven (7) days. The attending physician will be notified of the impending expiration twenty-four (24) hours prior to the last dose. Such notification will be in the form of a note attached to the front of the chart.

3. For patients on swing-bed status, notification of the physician will be the responsibility of the swing-bed nurse.

In all other cases, a medication order initiated by the Medical Staff will be discontinued only when specifically ordered to be discontinued. The discontinuation may be included in the original order (i.e. Digoxin 0.25 mg IV q4^{o} x 4 doses) or may be in the form of a second order (i.e. D/C KCl after the 1500 dose). The Medical Staff is strongly encouraged to include a stop time in the original order when medication is of a "toxic or dangerous classification" (i.e. narcotics, sedatives, anticoagulants, antibiotics, antineoplastics, and steroids)

IV. MEDICAL RECORDS.

A. *Responsibility for Completing the Medical Record.*
The attending physician or other qualified individual shall be responsible for recording the chief complaint, present illness, past history, pertinent family and social history, a statement about the results of the physical examination including all positive and negative findings resulting from an inventory of systems, provisional diagnosis, diagnostic and therapeutic orders, clinical observations of progress, results of therapy, conclusions at the termination of hospitalization, and a discharge summary. The record must contain information that justifies admission and continued hospitalization and supports the diagnosis. The other components of a complete medical record, including laboratory and radiology reports, operative reports, consultations, and autopsy reports, where appropriate, are the responsibility of the appropriate physician and service. It shall be the responsibility of the hospital to provide adequate dictation, transcription and medical record services to ensure efficient completion of the medical record.

B. *Medical History and Physical Requirements.*
The medical history and physical examination must be completed no more than 30 days before or 24 hours after an admission. When the medical history and physical examination are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed within 24 hours after admission.

Interval History and Physical. If a patient is readmitted within 30 days for the same or a related condition, an interval H&P may be done which addresses the patient's current status and/or any changes in the patient's status, within 7 days prior to, or within 24 hours after admission. The previous H&P must be brought forward in the electronic health record. The H&P, including all updates and assessments, must be included within 24 hours after admission.

H&P Before Procedures. It is required that there be a complete history and physical work-up in the chart of every patient prior to surgery, except in extreme emergencies. If this has been dictated, but not yet recorded in the patient's chart, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.

See Paragraph O for additional information on status changes.

C. *Informed Consent.*
Documented informed surgical consents are required prior to the operative procedure except in those situations where the patient's life is in jeopardy and suitable consent cannot be obtained due to the condition of the patient.

D. *Definition of Extreme Emergency.*
Extreme emergencies may cause surgery to be performed prior to completion of the preoperative assessment. An extreme emergency is defined as a situation where delay in the needed surgery may cause an increased chance of death to the patient or a worsened outcome pertaining to the problem requiring surgery. This decision is left to the discretion of the attending physician and surgeon.

E. *Countersignatures for Medical Students.*

1. The medical student can take a history, perform an exam, and participate in the medical decision making as part of their learning experience. We can only bill, however, for the services actually provided and documented by the teaching physician.

2. Third year medical student's dictation will not be transcribed or included in the medical record.

3. Fourth year medical students may dictate for the medical record. The student may perform and document the past medical history and review of systems; the documentation must indicate that the information was either reviewed with the teacher or the teacher was present. The teaching physician remains responsible for reviewing the student's note and making corrections as needed.

4. Teaching Physician Requirements:

    a. The history of present illness, exam and medical decision making must be performed and documented by the teaching physician in order to bill.

    b. The provider should also put a substantive note in the chart to confirm presence and direct involvement with the patient. Such things as "seen and agreed with student" would not be sufficient to illustrate the involvement of the provider.

    c. The supervising or collaborating physician would countersign the provider's note and the student's note.

F. *Allied Provider Students.*
When an allied provider (AP) student is supervised by an allied provider, the student's note in the medical record must identify both the supervising AP and the supervising physician. The note must clearly indicate both the AP staff member's work and the supervising physician's involvement. The supervising AP must also dictate a note for the work that they performed.

G. *Progress Notes.*
Physician and non-physician notes must provide a pertinent chronological picture of the patient's progress and must be sufficient to delineate the course and the results of treatment. Progress notes shall be dated and timed.

H. *Operative Reports.*
Operative reports shall include a detailed account of the findings at surgery, the details of the surgical technique, name of primary surgeon, assistants, specimens removed, and post-op diagnosis. Operative reports shall be recorded immediately following surgery. The report must be promptly signed by the surgeon and made a part of the patient's current medical record unless special circumstances exist. When the operative report is not placed in the record immediately after surgery, the surgeon must write a progress note providing pertinent information for staff to care for the patient.

I. *Consultation Reports.*
Consultation reports must contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

J. *Emergency Obstetrical/Newborn Documentation*
1. The emergency room record for unplanned obstetrical/newborn patients shall contain:
    a. Patient identification
    b. History of pregnancy
    c. Physical findings
    d. Ancillary test results
    e. Diagnosis
    f. Treatment given
    g. Disposition of the case
    h. Appropriate time notations for admission, physician notification, treatments, medications and disposition

2. Flambeau Hospital personnel will complete a birth certificate for the newborn. In addition, a separate emergency room record and medical history number will be established for the infant.

3. Fetal Death: A separate medical record is not initiated for a fetal death. Fetal death documentation will include the weight and length of the fetus as part of the mother's emergency room record.

K. *Clinical Entries.*
1. All credentialed providers and designated agents of the hospital involved in the care of the patient may make entries in the record as appropriate to their discipline.

2. All clinical entries in the patient's medical record shall be legible, accurately dated, timed, and authenticated with the name and title of the person making the entry.

   a) The primary attending physician or his designee, who has also cared for the patient and is willing to assume responsibility, may sign another provider's telephone, electronic, or verbal orders.

   b) Timing and dating entries are necessary for patient safety and quality of care. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or time lines of various signs, symptoms, or events.

3. Orders, including verbal orders and notes, must be clear and legible. Orders written illegibly or improperly will not be carried out until rewritten or confirmed. Documentation needs to include chronological patient progress, with date and time, route for medications, and parameters set for medications.

L. *Abbreviations and Symbols.*

Symbols and abbreviations may be used only when the medical staff has approved them. For patient safety, abbreviations listed on the dangerous or error-prone abbreviation list shall not be entered into the medical record.

M. *Stamped/Electronic Signatures.*

Electronic or hand-written signatures shall be used to sign orders or documents that are part of a patient's medical record. Stamped physicians' signatures are not allowed. A printed signature stamp shall be used only in conjunction with a hand-written signature for legibility purposes. Individuals authorized to use electronic signatures shall attest in writing that the assigned computer key represents this individual and this individual is the only one who will use that computer key. The signed attestation statement shall be retained in the Health Information manager's office.

N. *Discharge Summary.*

A discharge summary shall be recorded on all medical records, including deaths. The content of the medical record shall be sufficient to justify the diagnoses and warrant the treatment and end result. All discharge summaries shall be authenticated by the responsible practitioner and include the following: the final diagnoses, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family.

A discharge summary discusses the outcome of the critical assess hospital (CAH) stay, the disposition of the patient, and provisions for follow-up care. Follow-up care providers include any post-CAH appointments, how post-CAH patient care needs are to be met, and any plans for post-CAH care by providers such as swing-bed services, home health, nursing homes, or

assisted living. A discharge summary is required following any CAH acute care stay, prior to, and following a swing-bed admission and discharge.

O. *Patient Status Changes.*

When a patient reimbursement status changes from acute care services to swing bed services, each section must contain its own admission and discharge orders, progress notes, nurses' notes, graphics, ancillary support documents, and discharge summaries.

See Paragraph B of this Section for additional information regarding status changes.

P. *Delinquent Discharge Summaries.*

A medical record is counted delinquent if a discharge summary or signature is not completed within 30 days after the patient's discharge. Failure to comply may cause suspension of hospital admission privileges until charts are current.

Q. *Access to Medical Information.*

Practitioners and other health care professionals must sign a confidentiality statement before given on-line access to patient health information. Practitioners will be assigned unique passwords to access menus. Passwords are confidential and shall not be disclosed or shared with other users. Practitioners are permitted to access records only in accordance with applicable legal and ethical standards. Logged on computers shall not be left unattended. Log-in/Log-off procedures shall be followed. Failure to comply with this practice may result in disciplinary action.

R. *Consent to Release Information.*

Written consent of the patient or a person legally authorized by the patient is required for release of patient health information to person not otherwise authorized by law to receive this information.

S. *Removing Medical Records from the Premises.*

Medical records may be removed from the hospital jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, or by permission of hospital administration or his designee. Minutes or other documents pertaining to peer review activities, conferences, medical audit activities, or other quality assurance mechanisms are not considered to be part of the medical record and are not to be released from hospital and medical staff jurisdiction, except as required by law.

T. *Medical Record Completion and Filing*

Records shall be completed within 30 days of discharge or death. A medical record shall not be permanently filed until it is completed or is ordered filed by the information management committee.

U. *Preprinted Orders.*

Preprinted orders must be approved by the Information Management Committee for format. Preprinted order sheets must clearly bear the patient's name and medical history number. It must also be clear which orders are to be carried out. Orders which are not necessary should have a

line drawn through to delete the order. Orders with check boxes will not be implemented unless the associated box is checked.

V. *Standing (Routine) Orders*

A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail in the patient's record and are subject to the usual dating and signature requirements.

V. SURGERY.

A. A pre-anesthesia evaluation for each patient for whom anesthesia is contemplated shall be completed by the nurse anesthetist with findings recorded within forty-eight (48) hours before surgery.

B. The postoperative status of the patient shall be evaluated on admission to and discharge from the post-anesthesia recovery area. Findings must be recorded within forty-eight (48) hours after surgery. This includes documentation of vital signs and level of consciousness, intravenous fluids administered, all drugs administered, and any unusual events or postoperative complications and the management of those events. The name of the surgeon responsible for discharge from the recovery room shall be recorded on the recovery room record.

C. A post-anesthetic note shall be made by the nurse anesthetist indicating presence or absence of anesthesia-related complications within 48 hours after surgery.

D. All operations/procedure reports shall be dictated or written immediately after surgery and contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. The surgeon authenticates this report. When there is a transcription and/or filing delay, a comprehensive operative progress note is entered immediately after surgery to provide pertinent information for use by any individual who is required to attend the patient.

E. All tissues and foreign bodies removed from patients of Flambeau Hospital, whether in O.R., E.R., OB, ICU, or on the general nursing floor, shall be submitted to pathology for examination. The only exceptions to this are:
   1. Placentas from normal vaginal deliveries,
   2. Circumcisions from newborn,
   3. Foreign bodies involved in medical/legal cases,
   4. Sutures,
   5. Foreign bodies at the discretion of the physician (fishhooks, glass, metal, etc.), and
   6. Hernia sacs.

F. All specimens submitted to the Flambeau Hospital Laboratory for pathological examination will be submitted to the Pathology Department of Marshfield Clinic.

G. When received by the pathologist, he will determine the extent of examination. Those specimens not ordinarily examined microscopically may be done by special request of the attending physician or surgeon.

H. The following is a list of those specimens that fall into the category of "gross only":
    1. Cataracts
    2. Corneas, except graft failure or those with edema after cataract surgery
    3. Fingernails and toenails
    4. Foreign bodies
    5. Hydrocele tissue
    6. Hydatid cyst of Morgagni
    7. Liposuction material
    8. Meniscal tissue or plica removed at arthroscopy
    9. Non-cancerous intra-abdominal adhesions
    10. Orthopaedic appliances
    11. Parts of skin, muscle, fat, cartilage or bone removed to enhance operative exposure or in the course of plastic reconstructive or similar procedures
    12. Sclera and iris tissue removed during glaucoma surgery
    13. Septal cartilage
    14. Skin removed with scar tissue
    15. Teeth
    16. Tonsils and/or adenoids
    17. Turbinates
    18. Varicose veins
    19. Vitreous matter

I. Surgeons must be in the operating room and ready to commence operations at the time scheduled. After a time lapse of 15 to 20 minutes, the next scheduled case will be started, unless proper notification of the problem has been made to the operating room personnel and the surgeon who has the next case.

J. A surgical assistant may be a licensed physician, physician assistant, nurse, surgical technician, or qualified aide who has been granted privileges to assist. The use of a surgical assistant is at the discretion of the attending surgeon.

K. Every physician asking for surgical privileges in this hospital will be under the supervision of the Chief of Surgery until required competence is demonstrated.

L. Surgical procedures performed by dentists and podiatrists will be under the overall supervision of the Chief of Surgery.

    1. A podiatrist or dentist may initiate with concurrence of a staff physician the procedure for admission for all patients. If the podiatrist or dentist writes the admission order, the staff physician must cosign the order.

    2. The condition of patient on admission shall be documented by nursing staff.

    3. Copies of pertinent laboratory and/or x-rays performed outside the hospital that document the admitting diagnosis and necessary surgical procedure should be included in the hospital record.

4. The podiatrist or dentist shall be responsible for documenting that portion of the history and physical exam related to podiatry or dentistry. The physician shall be responsible for documenting the remainder of the history and physical.

5. Prior to discharge, a staff physician must examine any patient who has received other than local anesthesia.

6. There must be a discharge order for all patients. If the podiatrist or dentist writes the discharge order, the staff physician must cosign the order.

7. Written instructions for follow-up care shall be documented by the podiatrist or dentist and shall be given to the patient or responsible family member and shall include directions for obtaining an appropriate physician for postoperative problems.

8. The podiatrist or dentist shall document the condition of the patient on discharge.

9. The podiatrist or dentist must document the final diagnosis.

10. There shall be documentation by the nurse during the course of treatment of the outpatient surgical patient.

M. All inpatient surgeries, outpatient surgeries, and endoscopies must be scheduled with the Surgery Department. The physician scheduling the surgery will be responsible for notifying the Surgery Department.

N. The medical record documents a current, thorough physical examination prior to the performance of surgery on all cases utilizing other than local anesthesia. On cases utilizing local anesthesia a relevant history of the illness or injury, and physical findings must be documented. The physician's orders should designate whether the procedure is to be done on an inpatient or an outpatient basis so that appropriate charges are rendered the patient. The pre-surgical evaluation and physical examination must accompany the physician's orders when presented to the admitting desk. If the pre-surgical evaluation and physical examination are dictated but not in the chart, a physician note should accompany the orders stating the patient is satisfactory for surgery.

1. Convenience for the patient will be first and foremost. When possible, the physician should recommend that the patient have his preoperative work-up (laboratory, x-ray, EKG, etc.) completed prior to the scheduled surgery date. Should this option be unsuitable to the patient, the physician should inform the patient to arrive at the hospital, at a minimum ninety (90) minutes prior to the time of surgery.

O. Documentation of History and Physical and Preoperative Work-Up.
1. When a surgery is scheduled, the following information must be documented by the surgical registered nurse or technician receiving the surgical request from the surgeon:

a. The date and time the request to schedule a surgery was made by the surgeon.
b. The surgeon's name.
c. The name of the procedure.
d. The name of the patient.
e. The patient's work and home phone number.
f. The patient's age.
g. The choice of anesthesia.
h. The date and time the surgery is to be performed.

2. Surgeries should be scheduled with sufficient time to allow for unexpected events causing surgery overrun.

3. The surgeon must properly explain an informed consent.

4. Orders received from the surgeon should state the specific testing to be performed by the ancillary departments.

5. The definition of the start time for surgical cases has been standardized. For example, if the surgeon requests that a surgery begin at 9:00 a.m., then 9:00 a.m. represents "knife" time. It does not represent the time the patient leaves the medical floor or arrives in the surgical department.

6. Patients requiring respiratory therapy evaluation/instruction should be referred to the hospital at least one (1) but not more than seven (7) days prior to surgery.

7. Pertinent laboratory testing should ordinarily be performed at least one (1) but not more than thirty (30) days prior to surgery or as indicated by system guidelines adopted by the Medical Staff.

8. The history and physical examination must be completed within thirty (30) days before the date of surgery, provided any changes that may have occurred are assessed and recorded in the medical record within 24 hours following admission or registration for, but prior to, the surgery.

9. The surgeon is responsible for informing and scheduling his surgical assistant. It is the surgeon's responsibility to notify the surgery department of a delay or cancellation of a surgical case.

10. Breast biopsy cases requiring needle localization should be scheduled at the mutual convenience of the patient, radiology, and surgery department.

11. Patients shall arrive in the operating room hallway or suite one-half hour prior to "knife" time. In the event of an unforeseen delay, it is the operating room's responsibility to contact the surgeon immediately.

12. A member of the surgery department will telephone elective surgical patients one day prior to their scheduled surgery for last minute instructions.

13. The surgical consent form will be signed by the patient and witnessed by staff in the hospital.

VI. CONSULTATION.

A. *Required Consultations.*

1. Consultation with another qualified practitioner is required when the Practitioner does not hold the necessary clinical privileges.

2. Psychiatric consultation and treatment must be requested for, and offered to, all patients who have attempted suicide or threatened suicide, or have taken a chemical overdose. That such services were at least offered must be documented in the patient's medical record

B. *Suggested Consultations.* Consultation with another qualified member of Flambeau Hospital Medical Staff is suggested or recommended when in the judgment of the attending physician:

1. The patient is not a good medical or surgical risk.
2. The diagnosis is obscure.
3. There is doubt as to the therapeutic measure to be utilized.
4. There is a question of criminal action.

C. *Responsibility for Requesting Consultations.* The patient's physician is responsible for requesting consultations when indicated. It is the duty of the Medical Staff, through the Chief of Staff and Medical Executive Committee, to make certain that members of the Staff do not fail in the matter of calling consultations as needed.

D. *Essentials of a Consultation.* A satisfactory consultation includes examination of the patient and the record. The examination may be conducted via telemedicine, if indicated by patient status. A written opinion, including findings, diagnosis and recommendations is recorded and signed by the consultant to be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.

E. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of an individual's training, experience, and competence.

F. In circumstances of grave urgency, the Administrator of the hospital will have the right to call in a consultant or consultants after conference with the Chief of Staff or available members of the Active Medical Staff.

VII. EMERGENCY SERVICE.

A. Emergency service shall be staffed by a designated physician on-call at all times. Provisions for second and third call will be provided as necessary.

B. Physicians granted emergency medicine core privileges and regularly scheduled for coverage must have current BLS (Basic Life Support) certification, and meet the criteria in one of the following:

    1. Current Emergency Medicine board certification from one of the following entities: American Board of Medical Specialties (ABMS), American Association of Physician Specialties (AAPS), American Osteopathic Association (AOA), and have completed at least one ATLS (Advanced Trauma Life Support course; or

    2. Board certified or board eligible in a primary care or surgical specialty, or board eligible in Emergency Medicine, and have current ATLS (Advanced Trauma Life Support) certification. CALS (Comprehensive Advanced Life Support) certification or RTTDC (Rural Trauma Team Development Course) certification shall be acceptable in place of ATLS.

C. Physicians, Nurse Practitioners, and Physician Assistants providing short-term or fill in coverage must have ACLS certification.

D. In all instances, except as noted below, the primary physician on emergency room call will be present in the emergency room to evaluate the patient within fifteen (15) minutes after being notified of the patient's arrival and the registered nurse assessment of the patient's condition. If the registered nurse assessment is that the patient's status is critical or life threatening, the emergency room physician that is in the hospital is expected to be present in the emergency room within five (5) minutes. Registered nurses assigned to staff the emergency room are deemed qualified by the Medical Staff to provide the medical screening examination required under the Emergency Medical Treatment and Active Labor Act (“EMTALA”) to determine whether an emergency medical condition exists.

E. If the ancillary services are ordered by the primary emergency room physician prior to personal evaluation of emergency room patients, the primary physician on-call is expected to be present in the emergency room within five (5) minutes after being notified that such tests have been completed.

F. If the primary emergency room physician is tending to other medical events of higher priority, a triage situation may take place and response time may be delayed. If the primary emergency room physician is detained for a prolonged period of time, he initiates appropriate efforts to arrange for another physician for emergency room coverage.

G. Any patient brought to Flambeau Hospital via the ambulance service, with the exception of direct admission patients as determined by the admitting physician, e.g., a nursing home patient, will be seen by a physician in the emergency room, even if the patient's condition warrants that the patient be seen in the clinic. All patients registered as emergency room patients must be seen by a physician in the emergency room. If a physician requests to see a patient in the clinic and the registered nurse assessment concludes that the patient's condition warrants emergency room treatment in the hospital, the physician must see the patient in the emergency room.

H. *Disaster Privileges.*

1. Disaster privileges may be granted when the emergency management plan has been activated, and the Hospital is unable to handle immediate patient care needs.

2. The Administrator (or designee) or the Chief of Staff (or designee) is authorized to grant disaster privileges.

    a. Decisions to grant privileges will be made on a case-by-case basis, at their discretion per Flambeau Hospital Policy and Procedure 770-H-166.

3. In the case of a disaster, any Practitioner, to the degree permitted by his license, regardless of Medical Staff status or clinical privileges, shall be authorized to do everything reasonably necessary to preserve the life or health of a patient.

4. To the extent possible, individuals who receive disaster privileges will be paired with a currently credentialed Medical Staff member and will act under the direct supervision of a Medical Staff member.

5. Verifications, including licensure and education/training, and queries to the National Practitioner's Data Bank and OIG will be performed by the Medical Staff Office as soon as the immediate disaster situation is under control. The form for granting privileges in the event of a disaster will be completed and approved as soon as practicable.

6. Disaster privileges will be granted for the period needed during the disaster, and will automatically terminate at the end of that time. Privileges will be terminated, immediately, upon receipt of adverse information or upon receipt of evidence that the Practitioner is not competent to render services. Termination of disaster privileges does not entitle the Practitioner to a fair hearing.

7. All documentation will be retained in the Medical Staff Office.

VIII. ROLE OF MEDICAL STUDENTS

A. Medical student defined is a third or fourth year student who is an unlicensed practitioner.

B. A physician member of the Flambeau Hospital Medical Staff may utilize medical students as the students participate in rural rotation. The physician will function in the role of preceptor. The physician preceptor assumes the responsibility for the medical student's actions in every situation which occurs within the confines of Flambeau Hospital. The physician holds Flambeau Hospital harmless from liability for any action of the medical student.

C. The medical student must provide evidence that he is adequately insured.

D. The medical student must be under the supervision of a physician member of the Flambeau Hospital Medical Staff. Should the supervision not be direct during certain periods of time, the medical student must be able to contact his physician preceptor readily (i.e. telephone conversation). The medical student must consult with his physician preceptor in every instance prior to the administration of services, and must contact his physician preceptor in all instances to determine what procedures will be rendered.

E. Specifically, should an instance arise when the medical student is on emergency room call and he attends to a patient in the emergency room without the physician preceptor being present, the medical student must document on the emergency room record his name, the time he called or contacted his physician preceptor, and the type of procedure that will be implemented.

F. It is the responsibility of the physician preceptor to determine what procedures a medical student can do in a competent manner. In cases where a procedure is required that the medical student is incapable of rendering, the medical student must notify his physician preceptor at once. The physician preceptor, after having been contacted by the medical student, will attend to the patient immediately.

G. The above provisions shall be presented on a form to be signed by the medical student and physician preceptor to be retained in the student's file.

IX. MISCELLANEOUS

A. Each member of the Active Medical Staff shall be responsible for active participation by being a member of the various Medical Staff committees and must accept his responsibility for attending emergency patients and/or participation in the present system of rotational emergency call.

B. Emergency newborn screening shall be done in accordance with Wisconsin Statute 253.13.

C. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a person legally qualified to give such consent. All autopsies shall be performed by the hospital pathologist or by a physician delegated responsibility by attending physician.

D. All physicians agree to abide by Medicare and Medicaid requirements concerning certification and recertification of the hospital patients admitted by them and within the time limit allocated by those programs.

E. Flambeau Hospital Medical Staff will adhere to all State and O.S.H.A. Regulations that prohibit smoking inside all hospitals. (1991 Wisconsin Act 130.)