RULES AND REGULATIONS

OF

THE

MEDICAL STAFF

OF

GOOD SAMARITAN HEALTH CENTER

601 CENTER AVENUE SO.

MERRILL, WI 54452

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OF GOOD SAMARITAN HEALTH CENTER

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A. ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall accept patients for care and treatment of all types of disease, insofar as its accommodations, resources and appropriate level of care will permit. Patients may not be denied appropriate hospital care because of the patient's sex, race, color, religion, national origin, ancestry, creed, sexual orientation, marital status, age, newborn status, handicap, source of payment, or on any other unlawful basis.

2. The patient may be admitted to the Hospital only by a member of the Medical Staff with admitting privileges.

3. A 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 to the referring Practitioner and, as appropriate, to authorized relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility on the order sheet of the medical record is encouraged.

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

5. Each Practitioner must assure timely, adequate professional care for his patients in the Hospital by being available or having available an eligible alternate Practitioner with whom prior arrangements have been made, and who has at least equivalent clinical privileges in the Hospital. If a staff member is not immediately available in an emergency, the House Supervisor has authority to call any physician on staff, following Hospital policy.

6. The Medical Staff will comply with all policies and procedures regarding the Emergency Medical Treatment and Active Labor Act (EMTALA). Medical Staff will cooperate with the Hospital to assure that all patients presenting to the Hospital for examination and treatment of an emergency condition and women in active labor will be given at least a medical screening examination to determine their stability and be treated appropriately as indicated by their condition.

7. Patients will be placed according to medical condition, diagnosis and bed availability with the approval of the Practitioner and administration if needed.

8. The admitting Practitioner shall provide the appropriate Hospital staff such information as may be necessary to protect the patient from self harm and to assure the protection of others whenever the Practitioner has reason to suspect his patients might be a source of danger from any cause whatsoever.

9. For the disruptive or physically violent patient, any step necessary to protect the patient, other patients, and staff should be utilized.

10. Suicidal patients are not routinely admitted to the Hospital except those with unstable medical conditions. The focus of care is on stabilization and transfer to an appropriate facility. While hospitalized, any steps necessary to protect the patient, other patients and staff should be utilized.

11. Patient shall be discharged only on order of the responsible Practitioner. Should a patient leave the Hospital against the advice (AMA) of the responsible Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign a release against medical advice form. Any refusal to sign shall be witnessed and noted on the release.

12. In the event of a Hospital death, the deceased shall be pronounced dead by the responsible Practitioner, or his designee, within a reasonable time. Policies with respect to pronouncement of death and release of dead bodies shall conform to local law and Hospital policy.

13. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. Criteria for autopsies include: a) no diagnosis before death; b) intraoperative or postoperative death; c) unanticipated death; and d) death incident to pregnancy. An autopsy may be performed only with a written consent, signed in accordance with State Law or as otherwise allowed by law. All autopsies shall be performed by the Hospital pathologist, or by a Practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours, and the complete protocol shall be a part of the medical record within two months.

14. Routine admission workup will be based on patient condition and respective service or department policies and procedures.

B. MEDICAL RECORDS

1. The responsible Practitioner shall be accountable for the preparation of a timely, accurate, complete and legible medical record for each patient. Its contents shall be clinically pertinent, current and objective. The medical

record will include, as appropriate, identification data, chief complaint, history of present illness, past medical history, family history, social history, review of body systems, physical examination, provisional diagnosis, plan of treatment, clinical laboratory results, radiology services results, other diagnostic services results, consultation reports, medical and/or surgical treatment, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, discharge instructions to the patient, autopsy report (when performed), discharge summary or discharge note and anatomical gift information. Documentation must support the services rendered, substantiate severity of illness, and justify admission of the patient to the Hospital.

2. A completed admission history and physical examination shall be recorded within 24 hours of admission. The extent of the history and physical must meet the minimum Current Procedural Terminology Level I (CPT 99221) Evaluation and Management Service Guidelines. The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). If a history and physical examination meeting the above criteria has been recorded within 30 days prior to admission, a copy of this report may be used in the patient's medical record provided an appropriate assessment, including a physical examination of the patient, is done to update any components of the patient's current medical status that may have changed or address any areas where more current information is needed. This assessment must be completed within 24 hours of admission confirming the necessity for the care is still present and the history and physical is still current. The physician or other individual qualified to perform the history and physical must write an update note addressing the patient's current status and/or any changes in status, regardless of whether there were any changes within 24 hours of admission. This update note must be written on or attached to the history and physical and be included in the record for this admission within 24 hours of admission.

3. All surgical patients will have a written or dictated and transcribed history and physical meeting the above requirements and including all updates and assessments on the chart prior to surgery. In an emergency, a preoperative diagnosis, brief history and appropriate physical exam including heart rate, respiratory rate and blood pressure must be documented as a minimum prior to surgery. Outpatient procedures must meet the History and Physical criteria referenced in Nursing Administration Policy #II 4 24-A, Surgery-Requirements for Patients Undergoing, Section 3.A & B. Before surgery, any indicated diagnostic tests, and a preoperative diagnosis are to be completed and recorded in the patient's medical record. When a history and physical examination is not transcribed before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the responsible physician states in writing that such delay would be detrimental to the patient, or certifies in writing that a history and physical have been dictated but are not

presently available, and that the condition of the patient is suitable for the planned operation/anesthesia. A short form H & P may be completed.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Acute care Inpatients shall be seen and progress notes shall be written by the responsible Practitioner at least daily and as condition warrants on all patients, and specifically on critically ill patients and those where there is difficulty in diagnosis or management of clinical problems.

5. An operative progress note shall include: preoperative diagnosis, postoperative diagnosis, procedures used, name of primary surgeon and assistant, type of anesthesia and estimated blood loss and shall be entered in the medical record immediately after surgery to provide pertinent information for use by any individual required to attend the patient.

Operative reports shall include: preoperative diagnosis, postoperative diagnosis, technical procedures used, name of primary surgeon and a description of the indications and findings. Operative reports shall be written or dictated within 24 hours of the surgery for all surgical patients (whether outpatient or inpatient). The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible.

Any Practitioner who is not in compliance with the foregoing shall be subject to disciplinary action at the discretion of the Executive Committee.

6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinions and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified on the medical record, be recorded prior to the operation.

7. All clinical entries in the patient's medical record shall be accurately time-dated, and authenticated with the name and title of the person making the entry. The responsible Practitioner shall countersign (authenticate) clinical entries when they have been made by Medical Staff affiliates or medical preceptees. Orders must be permanently recorded. Orders recorded in pencil shall not be acceptable at any time. Physicians may countersign each other's orders if they accept full responsibility for the order, including appropriateness of dosage and choice of medication.

8. Symbols and abbreviations may be used which are generally understood and medically accepted. A record of generally used abbreviations is on file in Medical Information, as well as a list of abbreviations and symbols that are prohibited from use.

9. Errors must be corrected in the acceptable format, i.e., a single ~~[black]~~ line drawn through the text accompanied by the word "error". The writer must sign, time, and date all corrections. Scribbling out, write-overs, erasing, or use of white-out or any other form that renders the original writing illegible are not acceptable for correcting medical record documentation. Any addendum shall be denoted as such and time-dated as applicable to reflect when the addendum was actually written, with references, where appropriate, to the date or dates of the chart entries to which the addendum applies.

10. A Practitioner's orders must be permanently recorded and written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the person authorized to execute the order.

11. All final diagnoses, as well as operative procedures performed, are recorded in full, without the use of symbols or abbreviations, dated and signed by the responsible Practitioner.

12. A discharge summary shall be completed for all patients hospitalized over 48 hours. A final summary progress note (including post-discharge instructions) shall be sufficient for medical records of patients not requiring a formal discharge summary. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The discharge summary should concisely summarize the reason for hospitalization, the significant findings, any procedures performed and treatment rendered, the condition of the patients on discharge, and any specific instructions given to the patient and/or family. Pertinent instructions relative to physical activity, diet, medications and follow-up care should be documented. All summaries shall be authenticated by the responsible Practitioner.

13. No individual may view or have access to a patient's record unless the performance of their professional duties requires access. The patient's medical record, including all computerized medical information, shall be kept confidential and released only as allowed or required by law. The patient, his legally responsible representative, or any legally authorized person shall have access to the patient's medical record. Written consent of the patient or legally responsible party is required for release of medical information to persons not otherwise authorized to receive this information. Accessing patient health care information in violation of this rule is a violation of professional ethics.

14. Medical records, or portions thereof, may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, statute, or by permission of the President or his designee. All records are the property of the Hospital, and shall not otherwise be taken off premises without permission of the President or his designee. In case of readmission of a patient, all previous records shall be available for use by the Practitioner providing care. This shall apply whether the patient is attended by the same Practitioner or by another. Unauthorized removal of medical records from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Executive Committee.

15. If waiver of individual patient authorization has been approved by the applicable institutional review board or a privacy board in accord with federal privacy regulations and the researcher has made the representations required under the privacy regulations, free access to 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 patient, unless the patient has filed a written objection with the Hospital. All such projects shall be approved by the Executive Committee before records can be studied. Subject to the discretion of the President, 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, so long as the Practitioner is caring for the patient at the time of the request or has the written consent of the patient.

16. A medical record shall not be permanently filed until it is completed by the responsible Practitioner, or is ordered filed by the Executive Committee.

17. A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the Practitioner. Standing orders shall be reviewed by the responsible Practitioner each year, approved or revised as necessary, and signed.

18. The patient's medical record shall be complete at the time of discharge, including all relevant diagnoses, progress notes and discharge summary. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the Medical Information Department. An incomplete record is any medical record which, on the day following discharge or outpatient/ambulatory treatment, is found to have a documented deficiency in either completion of reports or signature. Delinquency is defined as any medical record, except stress tests and holter monitor reports, incomplete 30 days from inpatient discharge or outpatient service date. If a record still remains incomplete 30 days after being placed in the physician's chart completion room, the notification procedure for automatic temporary

suspension of admitting and consulting privileges as allowed in the Fair Hearing Plan is initiated. (The Medical Record Completion Policy is filed in the Administrative Policy Manual and available in the Medical Information Department.)

C. GENERAL CONDUCT OF CARE

1. All members of the Medical Staff of Good Samaritan Health Center shall conduct themselves in a manner respective of the individual person, whether patient, peer or employee, as well as practice according to the mission and philosophy of Good Samaritan Health Center.

2. A general consent form, signed by or on behalf of every patient receiving services from the Hospital, must be obtained at the time of registration, except emergency admissions when the patient is unable to give consent and there is no other person reasonably available who is authorized to consent for the patient. In such cases, signature on the general consent form must be obtained as soon as possible after admission.

3. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if verbally dictated by a Medical Staff member to a registered nurse or other duly authorized person, read back to the ordering Practitioner, and signed by the responsible Practitioner. Registered nurses may receive and transcribe all verbal orders. LPNs, unit clerks and admissions clerks may receive and transcribe orders for diagnostic testing that do not require the administration of medications. LPNs and unit clerks may receive and transcribe activity and per os diet orders per nursing policy. Physician Assistants, laboratory, nutrition services, occupational therapy, pharmacists, radiology, respiratory therapists, physical therapy, social services and speech therapy staff may receive and transcribe orders that are within their scope of responsibility and sphere of competence. All verbal orders shall be promptly transcribed, read back to the ordering Practitioner, and signed by the appropriately authorized person to whom dictated, with the name of the ordering Practitioner per their own name. All verbal and telephone orders shall be recorded, read back to the ordering Practitioner, and promptly authenticated (signature, time, and date no later than 48 hours after entry) by the Medical Staff member responsible for ordering, providing or evaluating the service. Verbal and telephone orders shall be strictly confined to circumstances in which patient care needs require them. In emergency situations or when the physician is not onsite or immediately available and faxing the order is not possible or practical, a verbal order may be utilized.

4. Medical students and Allied Health Professionals may write orders within their sphere of competence, and make entries in the physicians' progress record. Any medication or hazardous procedure orders should be confirmed with the responsible Practitioner prior to initiation. Ancillary services, i.e., dietary,

home health (per contract), hospice, laboratory, nursing service, pastoral care, pharmacy, rehabilitation services (audiology, cardiac rehab, occupational, physical and speech therapies) respiratory care, social services, and x-ray may record progress notes in the physicians' progress record.

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

6. All previous orders are cancelled when patients go to surgery.

7. The Medical Staff shall follow Hospital standards related to prescribing, distributing and administering medications and intravenous therapy. Standards which directly affect patient care are approved by the Medical Staff.

8. A Practitioner is responsible for requesting consultation when indicated. Except in an emergency, permission of the patient shall be obtained and request for consultation shall be documented in the medical record.

9. Practitioners shall take measures to avoid termination of or injury to a viable pregnancy. Before undergoing surgery and/or invasive testing where a pregnancy may be in jeopardy, appropriate documentation relative to woman of childbearing years shall be recorded in the medical record.

10. The respective Service Chief and/or President of the Medical Staff will provide assistance and support to address perceived significant patient care concerns raised by medical and/or Hospital staff.

11. Patients may not visit from one nursing station to another without special permission from the patient's Practitioner.

12. Smoking is prohibited in the Hospital and on the Hospital campus.

13. Active Medical Staff physicians shall maintain CPR certification, with recertification biennially.

14. Practitioners shall honor principles relative to advance directives, the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, and universal precautions, and comply with specific department policies and procedures relative to patient care and treatment, copies of which are filed within the respective department.

15. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia or American Hospital Formulary Service and approved by the Medical Executive Commitee. Investigational drugs must have a protocol approved by the Federal Drug

Administration. Controlled drugs, antibiotics, anticoagulants and corticosteroids ordered without a time limit will be subjected to a stop date approved by the Medical Executive Committee. Drugs shall not be stopped without notifying the Practitioner.

16. An order for a radiology examination by the attending Practitioner or AHP shall contain a concise statement of the reason for the examination, along with the name and title of the ordering Practitioner or AHP. Interpretations of x-rays and other diagnostic imaging studies shall be written or dictated and shall be done and signed by a qualified Practitioner authorized by the Medical Staff to interpret diagnostic imaging studies.

17. Patients have a right to be free from restraints that are not medically necessary. Restraint devices or seclusion protocols can be used when clinically indicated to improve the patient's well being or when 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.

A Practitioner's order is necessary for restraint or seclusion protocol initiation by hospital personnel, and the order may not be made on a standing or PRN basis. If restraint or seclusion is ordered for behavior management, a Practitioner must evaluate the patient within one hour after initiation of the seclusion or restraint. Orders for such restraints are limited to 4 hours for adults, 2 hours for children ages 9 through 17, and 1 hour for children under age 9, but may be renewed for similar time periods for up to a total of 24 hours, at which time the Practitioner must again see and assess the patient before issuing a new order to continue the restraint. A new order for continuation of such restraint if desired may be written after 24 hours. The chart will be stamped with a renewal request in such cases. Orders for restraints will contain specific time limits for use of the restraints in compliance with Joint Commission standards, federal law and Hospital policy.

Patient's rights, dignity and well being are protected during restraint use. The least restrictive safe and efficient restraint method is employed.

18. If a Hospital employee or allied health professional has reason to dispute either the professional conduct of or delivery of patient care by a Medical Staff member, the matter should be brought to the attention and discussed with the Medical Staff member if possible. If the matter remains unresolved after it has been brought to the attention and discussed with the Medical Staff member, or if the employee or AHP is unable to discuss the matter directly with the Medical Staff member, he shall bring the matter to his immediate supervisor who may in turn refer the matter to the appropriate member of Administration (or his designee). If warranted, the Hospital administrator or his designee may bring the matter to the attention of the Medical Staff member's Service Chief,

or in the absence of the Service Chief, or where the Service Chief is the subject of the concern, to the President of the Medical Staff. The administrator and the Service Chief will jointly consider the issue and make any appropriate recommendations to the Medical Staff member. If the issue remains unresolved, the issue may be referred to the Executive Committee or the President for appropriate action.

19. When critical test results are relayed orally to the ordering or attending Practitioner, the person receiving the results must record the results and read back the results so recorded to the person who relayed the results.

D. GENERAL RULES REGARDING SURGICAL CARE

1. GENERAL CONSIDERATIONS

a. The operating suite is restricted to authorized personnel.

b. The operating suite is staffed five days a week from 7:00 AM to 3:30 PM. From 3:30 PM until 7:00 AM, and on weekends and holidays, the operating room staff is available on call for urgent/emergency cases.

c. The first elective surgical case may start at 7:00 AM.

d. Street clothes may not be worn past the second set of double doors. Hospital personnel from other areas may pass the restricted area only after they have donned proper attire. Scrubs may not be worn outside the Hospital.

e. Delineation of surgical privileges for each physician is on file in the surgical suite and is referred to when operations are scheduled. Practice is limited to privileges.

f. The operating surgeon shall be responsible for deciding when a surgical assistant is required.

g. All specimens removed in surgery will be examined by the Pathologist following Medical Staff and Pathology guidelines.

h. A sponge count and an instrument count will be done according to the policies and procedures of the Surgery Department. The Surgery Department shall have a policy defining the procedure to be followed in the event of an incorrect sponge or instrument count.

i. No visitors shall be allowed in the Surgical Suite during an operation unless authorized by all of the following: the surgeon in charge, the anesthesia provider, and the operating room supervisor or their designee.

Visitors are defined as anyone not part of the surgical team involved in a particular operation. Authorized visitors shall only be Hospital employees, medical, dental and allied health professional staff members, approved students, and representatives of medical instrument manufacturers. For Cesarean sections, the father and/or significant other will be allowed in the surgical suite. All visitors shall be subject to the authority of the surgeon in charge. All visitors shall be dressed in operating room garb.

2. SCHEDULING OPERATIONS

All surgeons will follow established Hospital policies and procedures for scheduling. These policies and procedures will be reviewed and approved by the Medical Executive as needed.

3. REQUIREMENTS PRIOR TO ANESTHESIA AND OPERATION

a. Patients having surgery will be assessed and prepared by the Medical Staff according to predetermined standards.

b. These predetermined standards are found in appropriate Hospital policies. These policies will be reviewed and approved by the Surgery Service Chief as needed.

c. All patients having a surgical procedure will be properly identified by Hospital policy.

d. All patients having a surgical procedure will have a written, signed informed surgical consent obtained by the surgeon per informed consent policy, except in cases of emergency.

e. There must be a pre-anesthetic note, completed by or countersigned by the operating surgeon or anesthesia provider with findings recorded within 48 hours before surgery. This note will include information relative to the choice of anesthesia anticipated. Every surgical patient shall have a pre-anesthetic visit by the person administering the anesthesia, and a post-anesthetic follow-up examination with findings recorded within 48 hours after surgery.

f. A surgical checklist will be used on all surgical patients to determine if all necessary medical information is readily available prior to taking the patient to surgery.

g. If all above information is not available at the time of surgery, the case may be postponed or cancelled.

4. ANESTHETICS

a. General or regional anesthesia requires examination of the heart & lungs and mental status prior to procedure. Monitored anesthesia care (MAC) requires examination of the heart, lungs and mental status prior to the procedure. Local anesthesia requires a recent clinic note and a description of the operative site and what was removed.

b. Conscious sedation requires examination of the heart, lungs and mental status prior to procedure.

5. INFECTION CONTROL

All surgeons operating at Good Samaritan Health Center will follow current infection control policies. All infection control policies are reviewed and approved by the infection control committee.

6. PATIENTS ADMITTED FOR DENTAL/PODIATRIC CARE

A patient admitted by a general dentist or podiatrist for dental or podiatric care is a dual responsibility, involving the dentist/podiatrist and physician member of the Medical Staff.

a. Dentist/Podiatrist responsibilities:
   1) a detailed dental/podiatric history, justifying Hospital admission.
   2) a detailed description of the examination of the dental/podiatric examination and a preoperative diagnosis.
   3) a complete operative report, describing the findings and techniques. In cases of teeth extraction, the dentist will clearly state the number of teeth and fragments removed.
   4) all tissue, including teeth and fragments, will be sent to the Hospital pathologist for examination.
   5) progress notes as are pertinent to the dental/podiatric condition.
   6) discharge summary or summation progress note including instructions to the patient.
   7) the dentist/podiatrist will notify the attending physician of the patient's planned admission within a reasonable time to allow the attending physician to evaluate the patient.

b. Physician responsibilities:
   1) a medical history pertinent to the patient's general health.
   2) a physical examination to determine the patient's condition prior to anesthesia and surgery.
   3) supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of both the dentist/podiatrist and the physician involved.

d. Orders for preoperative medications are the responsibility of the responsible physician. Postoperative orders are the joint responsibility of the responsible physician and the dentist/podiatrist.

7. NON-PHYSICIAN OPERATING TEAM

When the operating/anesthesia team consists entirely of non-physicians (e.g., dentists and podiatrists), there must be a physician in house available in case of an emergency such as cardiac arrest or cardiac arrhythmia. It shall be the responsibility of the operating surgeon to prearrange for a medical physician to be in house and make that name known to the Operating Room Nurse Manager.

E. GENERAL RULES REGARDING EMERGENCY SERVICES

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency service area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Hospital President, in consultation with the President of the Medical Staff, shall appoint a physician who shall have overall responsibility for emergency medical care.

2. An appropriate medical record shall be maintained for every patient receiving emergency services, and be incorporated into the patient's Hospital records, if such exists. The record shall include:
   a. adequate patient identification.
   b. information concerning the time of the patient's arrival, means of arrival and by whom transported.
   c. appropriate time notations, including time of physician's notifications, time of treatments, including administration of medications, and time of patient discharge or transfer from the service.
   d. pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to arrival at the Hospital.
   e. description of significant clinical/laboratory/radiology findings.
   f. final diagnosis, without use of abbreviations.
   g. treatment rendered.
   h. condition of patient on discharge or transfer.
   i. final disposition, including instructions to the patient and/or family relative to necessary follow-up care.

3. Each patient's medical record shall be authenticated by the Practitioner in attendance who is responsible for its clinical accuracy.

4. There shall be routine review of emergency care to evaluate quality of emergency services with reports submitted to the Medical Staff Medicine and Medical Executive Committee. The Medical Executive Committee maintains oversight responsibility for Emergency Services and will investigate problems identified in this process and work with appropriate departments to resolve concerns.

5. Medical records are reviewed for their adequacy as documents as well as for quality of care review purposes with results of selected clinical situations referred to the applicable clinical service for follow-up. Records of individuals who are dead on arrival and those who die in the Emergency Room are routinely reviewed. The records of all patients dying within 24 hours of admission from the Emergency room are routinely reviewed by the appropriate Medical Staff service.

6. The Hospital has a plan for the care of mass casualties in time of disaster and Medical Staff physicians will participate when and as needed. A copy of the plan shall be on file in the emergency area.

F. GENERAL RULES REGARDING SPECIAL CARE UNITS

The special care unit is a facility designed and established to provide specialized care for the acutely ill patient (medical, surgical and cardiac), whereby such patient may receive constant monitoring, coupled with continued specialized medical and nursing observation and a high level of care.

1. The special care unit functions under the direction of the Service Chief who is appointed by the President of the Medical Staff. The Service Chief shall have the following responsibilities:
    a. evaluate the appropriateness of care in the special care unit.
    b. develop rules and regulations for the special care unit.
    c. be available in an advisory capacity to the nursing staff.
    d. be directly involved with nursing administration in determining competency levels and education needs of the special care nursing staff.
    e. evaluate all “Code Blue” cases that occur in the Hospital.
    f. assume the responsibility for carrying out the rules and regulations established by the special care unit policies.
    g. bring to the attention of the Medical Executive Committee any problem arising in the unit, involving the inability to meet accepted standards, not previously resolved through the appropriate chain of command (i.e., supervisor, department director, VP of Patient Care, President, Service Chief) and routine problem-solving techniques.
    h. determine admission/discharge/transfer priority for SCU and telemetry patients.

2. Any physician member of the Medical Staff in good standing with privileges to provide care in the unit may admit to the special care unit.

3. All physicians admitting to the special care unit must designate an alternate. Alternates are responsible for the care of the patient only in the absence of the regular physician. If the responsible physician or his alternate cannot be reached, the nurse may, in an emergency, contact in this order: a) the physician on call; b) the Service Chief of the special care unit; c) any physician member of the Medical Staff.

4. All patients in the special care unit must be seen by the responsible Practitioner or his alternate at least daily, and as often as the patient's condition warrants. Patient rounds in the special care unit should be completed early in the morning, preferably prior to other patient rounds. Standardized polices and procedures shall be followed in the special care unit so personnel will become familiar with them and thereby respond efficiently and effectively. The responsible Practitioner has the authority to make reasonable countermanding orders to standard policies, but must use care to avoid unreasonable conflict with special care unit policies.

5. The special care unit nurse has the authority and responsibility to report and discuss orders in conflict with standard policies and procedures with the special care unit Service Chief, who shall use judgment and discuss the matter with the responsible Practitioner. Specific written orders in such situations are essential. Rationale should be documented by the responsible Practitioner.

6. Specific special care unit policy addresses the criteria to be followed for admission and discharge of patients to/from the special care unit.

7. Care team conferences will be held daily, preferably at the completion of patient rounds, on all ventilated patients. It is highly recommended that conferences occur for all critically ill and complex patients.

8. Relatives and/or significant others will be kept updated concerning the patient's general condition. Specific information will be given to the family with the approval of the patient or the patient's Health Care Agent under an effective Power of Attorney for Health Care.

9. A patient log book, containing all pertinent information, is maintained in the special care unit.

G. GENERAL RULES AND REGULATIONS REGARDING POST ANESTHESIA CARE

1. The President of the Medical Staff shall designate a Service Chief for the post anesthesia care.

2. Patients will receive a post anesthesia level of care appropriate to their anesthetic.

3. Patients are released from post anesthesia care by the attending anesthesia provider, or in his absence, by the attending surgeon. Current standards for discharge criteria will be approved and used.

4. All preoperative orders are automatically discontinued when a patient goes to surgery. New orders must be written by the responsible Practitioner.

5. The physician supervising the anesthesia is the responsible physician for post anesthesia care unless responsibility has specifically been designated to another physician and this is identified in the medical record.

6. A registered nurse is assigned to all patients receiving post anesthesia care. The anesthesia staff will not leave the patient unless a post anesthesia care trained RN is present to accept the care of the patient.

7. Visitors are not permitted to visit when patients are receiving post anesthesia care unless they have been granted special permission by the attending surgeon and the post anesthesia nursing staff.

8. A crash cart is available for immediate use.

9. The anesthesia staff will not leave the Hospital if a post anesthesia care patient is unstable and/or is intubated unless the patient is in the SCU and transferred to the care of another physician.

H. GENERAL RULES REGARDING ALLIED HEALTH PROFESSIONAL STAFF

1. Refer to Medical Staff Bylaws 4.10 for general information regarding the practice of independent and dependent Allied Health Professionals. A copy of each Allied Health Professional’s credentials is on file in the Administrative office.

2. Admission and discharge of patients must be under the order of a physician.

3. All orders, written histories, physical examinations, or recorded procedures by dependent Allied Health Professionals must be countersigned by the supervising physician within the period specified in the respective administrative code.

4. Independent and dependent Allied Health Professionals may give orders as delineated by their individual credentials subject to current state law.

5. The supervising physician shall be responsible for all acts, orders and procedures performed by the personnel sponsored. The supervising physician is responsible for promptly informing the President of any termination of employment of the specific dependent Allied Health Professional sponsored by such physician.

I. MEDICAL STAFF MEETINGS

1. The annual meeting of the Medical Staff shall take place in December of each year. Notice regarding time and of place shall be provided to members of the staff at least one week in advance.

2. The President of the Medical Staff shall call regular meetings of the staff each month during the year. Notice regarding time and place shall be provided to members of the staff at least one week in advance.

ADOPTED by the Active Medical Staff of Good Samaritan Health Center of Merrill, Wisconsin, Inc., on _____, 2008

._____
President of the Medical Staff

APPROVED by the Board of Directors on _____, 2008.

_____
President
Good Samaritan Health Center