MINISTRY SAINT CLARE'S HOSPITAL
WESTON, WISCONSIN

MEDICAL STAFF BYLAWS – APPENDIX B

MEDICAL STAFF RULES AND REGULATIONS

(Approved by MSCH Board of Directors January 6, 2011)

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A. GENERAL PROVISIONS AND AUTHORITY

1. Staff Rules and Regulations

   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 these Bylaws. Such rules and regulations shall be a part of these Bylaws.

2. Definitions

   Terms used in these rules and regulations have the same meaning and definition as those terms are defined in the Medical Staff Bylaws.

3. Smoke Free Environment

   The entire Weston Regional Medical Center is a smoke free campus. All practitioners shall refrain from smoking when on campus.

B. ADMISSION AND DISCHARGE OF PATIENTS

1. Admitting Privileges

   a. A patient may be admitted to the Hospital only by an active, courtesy, or active/provisional member of the Medical Staff with admitting privileges.

   b. Patients admitted to the Hospital shall meet accepted criteria, as set by Medicare and other third party payers, to meet medical necessity requirements for admission or for observation (ambulatory) status. It is recognized that not all patients fit neatly into defined criteria as set by third party payers and, as a result, the physician shall have the ultimate authority to make decisions regarding the admission of patients to the Hospital. All physicians will be expected to work cooperatively with the Utilization Review Committee and hospital staff in compliance with the Utilization Management Plan.

   c. A patient to be admitted on an emergency basis who does not have a private practitioner, may request any privileged practitioner to attend him. Where no such selection is made, a member of the staff who is on call for the Service will be assigned to the patient on a rotating basis. The Service Chief shall provide a schedule for this call assignment. Physicians are required to comply with all aspects of the Emergency Medical Treatment and Active Labor Act (EMTALA) applicable to physicians, which is incorporated herein by reference. A practitioner on call may not refuse care to a patient based on their ability to pay.

   d. Patients shall be admitted regardless of race, color, creed, national origin or their ability to pay. When the Hospital does not provide the services required by a patient or person seeking necessary medical care, or for any reason the patient cannot be admitted to the Hospital, the attending physician and/or Hospital shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

2. Responsibility for Care

   a. A member of the Active, Consulting or Courtesy Medical Staff shall be responsible for the medical care and treatment of each patient admitted to the

i. The practitioner who admits the patient will be considered the attending practitioner unless he formally transfers primary responsibility for treatment decisions, continued need for hospital care and readiness for discharge to another practitioner who has accepted responsibility, and notes such transfer of care in the physician orders.

ii. When care is temporarily transferred to another medical staff member, such as “on-call” during nights and weekends, and a published cross-coverage call schedule is not available to hospital staff, an order specifying the transfer of responsibility shall be entered in the physician orders.

iii. An on-line call schedule shall be available for the various Hospital departments and patient care floors so that Hospital and other personnel can readily determine which practitioner is responsible for any given patient at any time.

iv. All patients in the Hospital must be visited at least once daily by the attending physician or another privileged practitioner assuming the attending physician's responsibilities with the exception of hospital patients under the care of a Medicare-certified hospice program receiving respite care only. In such cases, physician interaction will be determined by the hospice plan of care and patient need.

v. It is the responsibility of a practitioner to arrange for the care of his patients when he is not immediately available. In the event that the practitioner or his alternate does not respond to the emergency need of a patient, the CMO or his designee (Administrator on Call), or the Service Chief shall have the authority to call a qualified member of the Staff to attend the patient.

b. Any patient admitted through the Emergency Room shall be seen by the admitting physician within a period of time appropriate for the illness or injury incurred but never longer than twelve hours post admission. All admissions to a Critical Care Unit should be seen upon admission. Any transfer of a currently admitted patient into a Critical Care Unit will cause the patient to be seen by an attending physician within four hours unless this is clearly related to a pending elective procedure, or there is clear documentation on the chart as to why it is not necessary to see the patient within this timeframe.

c. No practitioner on the Medical Staff shall perform diagnostic or therapeutic procedures or provide medical care for which he has not received privileges.

d. Patients presenting to the Emergency Department identifying a member of the Medical Staff as their primary attending physician for a problem shall be the responsibility of that physician or his designated coverage physician.

i. Physicians who have formally terminated the patient-physician relationship with an individual patient shall be responsible for the

Emergency Department care of that patient for a minimum of 30 days following the delivery of written termination from the physician's practice.

ii. Should a terminated patient present to the Emergency Department at a later date as an unassigned patient and the physician who has previously terminated a physician-patient relationship is on Emergency Department call for unassigned patients, that physician shall be responsible for the care of that patient or for obtaining appropriate alternative coverage for the care of that patient.

3. Provisional Admitting Diagnosis

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

4. Admission Priorities

a. The patient will be admitted on the basis of the following priorities:

A. Elective -- The health of the patient is not in danger by delayed admission. Such patients are usually scheduled several days to several weeks before admission. In consideration of the patient, the Hospital will make every effort to accommodate the patient's desired date of admission. However, when circumstances dictate, admission of patients in this category can be deferred, as they are the lowest admitting priority. All elective admissions shall be scheduled through the Nursing Supervisor or other individuals or departments as designated by the Hospital.

B. Urgent -- Delay in admission beyond several hours might threaten the patient's life or well-being.

C. Emergent -- An immediate threat to the patient's life or well-being exists. This situation warrants the highest admitting priority.

In case of dispute, practitioners admitting emergency cases shall be prepared to justify to the MMT, the MEC and the administration of the Hospital that the emergency admission was a bona fide one. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's chart upon admission. The same shall apply to scheduling emergency procedures.

5. Need for Continuing Hospitalization

All practitioners shall work cooperatively with and provide documentation to Hospital personnel to assure that all patient admissions meet ongoing medical necessity criteria as set by Medicare and other third party payers.

6. Transfer of Patients

a. Patients who present with an emergency medical condition and who are unstable or in active labor shall be transferred to another facility only when the required medical care cannot be provided at Saint Clare's Hospital and the responsible

physician determines the medical benefits of transfer outweigh the risks of transfer, or when transfer is requested by the patient or the patient's legally responsible representative. The attending/transferring practitioner must facilitate a safe, efficient transfer and is responsible for practitioner-to-practitioner communication and for obtaining the receiving facility's agreement to accept the patient in transfer.

b. No patient shall be arbitrarily transferred to another facility for reasons of inability to pay if Saint Clare's has the facilities to provide the care needed.

c. All patients will receive stabilizing treatment within the Hospital's capacity prior to transfer to another facility so as to minimize the risk to the patient's health. Such stabilization shall include medical evaluation by a practitioner and initiation of treatment to minimize risk to the patient until the transfer is accomplished. All pertinent medical records that are available at the time of transfer will accompany the patient to the receiving facility. The transfer must be effected through qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during transfer. Other records not available at the time of transfer will be sent to the receiving facility as soon as practicable after transfer.

d. Except in emergencies in which the attending/transferring practitioner certifies in writing at the time of transfer that the benefits of transfer outweigh the risk of transfer, the patient will not be transferred without being given a full explanation for the transfer. If the patient is unconscious or incapacitated, the explanation will be provided to the patient's representative or a family member if available.

e. An informed consent will be signed by the patient or patient's legally responsible representative when transfer is arranged. If such consent cannot be obtained, either through refusal or inability to sign, the reason for the lack of consent should be documented in the patient's medical record.

f. If a patient refuses transfer, a statement regarding such shall be placed in the medical record by the attending practitioner or his designee.

g. For purposes of this rule, a transfer occurs when the patient is transported to another facility, whether or not the patient is scheduled to return. Physician offices, other hospitals, ambulatory surgery centers, long-term care facilities and all other entities not operating under the Hospital's provider number and not located on the Hospital's main campus constitute other facilities under this rule.

7. Certification of Death

In the event of a hospitalized patient's death, he shall be pronounced dead by the attending practitioner or by his designee within a reasonable time. A hospice nurse may pronounce (but not certify the cause of) the death of a hospice patient who was under the care of a physician at the time of death and the death was anticipated. The body shall not be released until an entry has been made in the medical record of the deceased by a member of the Medical Staff or his designee and "Record of Death".

8. Discharge Orders

Patients shall be discharged only on the verbal or written order of the attending practitioner or his designee. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge order, notation of the incident shall be

made in the patient's medical record, and the patient shall be asked to sign a refusal of treatment form. If the patient refuses to sign, the refusal should be documented in the medical record.

C. MEDICAL RECORDS

1. Responsibility

   a. The attending practitioner, or a substituting practitioner or health care provider with clinical privileges to do so, shall be responsible for the preparation of a timely, accurate, legible and complete medical record for each patient. The medical record will include, as appropriate, a history and physical examination, provisional diagnosis, plan of action, clinical laboratory results, radiology services results, other diagnostic services results, consultation reports, medical and/or surgical treatment, operative reports, pathological findings, daily progress notes, autopsy report (when performed), discharge summary, definitive final diagnosis and anatomical gift information.

   b. 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. History and Physical (H&P) Examination Requirements

   a. A H&P must be recorded by a member of the active, courtesy, limited or consulting Medical Staff (or provisional members in these categories), or by licensed health care provider granted privileges to do so.

   b. Completion of the H&P may be delegated to a non-privileged provider when a privileged provider reviews the document, assesses the patient to confirm the information and findings, updates information and findings as necessary and signs and dates the H&P as attestation to it being current.

   c. An H&P must be performed and documented for all patients admitted to the Hospital within 24 hours of admission. An H&P is required for both inpatient and medical observation-type (ambulatory) admissions.

   d. An H&P must be performed and documented prior to patients undergoing inpatient or outpatient surgical or other high-risk procedures requiring anesthesia services.

   e. The H&P remains valid throughout the entire hospitalization or procedure.

   f. The H&P may be completed no more that 30 days before admission or surgical or other high-risk procedure requiring anesthesia services. An update to the patient’s condition is required at the time of admission when using an H&P that was performed before admission.

   g. A copy of the H&P as well as the H&P update must be present in the record within 24 hours of admission or prior to surgery or high-risk procedure requiring anesthesia services.

   h. The physician uses his clinical judgment based on his assessment of the patient’s condition, and any co-morbidities, in relation to the reason the patient was admitted or to the surgery to be performed, when deciding what depth of

assessment needs to be performed and what information needs to be included in the update note.

h. If a patient is readmitted for the same or a related condition and has a pertinent H&P done within the preceding 30 days, the H&P requirement may be satisfied by documenting an H&P update and including the prior H&P in the current hospitalization record.

j. If upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that no change has occurred in the patient's condition since the H&P was completed.

3. Admission History and Physical Exam Content Requirements

a. An admission H&P must include, **at a minimum**:

- Identification data – patient age, gender
- Chief complaint or reason for admission
- History of the present illness
- Past medical history
  - Medications with current dosages
  - Allergies / sensitivities
  - Medical and surgical history
  - Social history
  - Family history
- Review of systems pertinent to reason for admission
- Physical Exam pertinent to reason for admission; mental status, heart and lungs
- Results of diagnostic studies
- Conclusion/impression/diagnostic considerations
- Plan of care

4. Procedure/Surgical History and Physical Content Requirements

a. *No anesthesia, local or topical anesthesia, level I minimal sedation/anxiolysis*
Patients undergoing invasive or potentially hazardous procedures without anesthesia, under local or topical anesthesia, or with level I minimal sedation/anxiolysis must have, at a minimum, a *basic assessment* that includes:

- documentation of an indication for the procedure;
- any known allergies, any history of medication reactions, a list of current medications with dosages;
- an assessment of mental status and site-specific exam.
- additional documentation is at the discretion of the practitioner as appropriate to the patient's medical condition.

b. The history and physical exam content for this level procedure is not required to be dictated as long as it is documented in the medical record by a licensed practitioner prior to commencement of the procedure. For patients requiring only a basic assessment, an H&P update is not required upon admission.

c. *Moderate (conscious), level II, or deep sedation/analgesia*

Patients undergoing invasive or potentially hazardous procedures under moderate (conscious), level II, or deep sedation/analgesia, level III, need documentation that includes:

- *basic assessment* as defined above
- heart and lungs exam by auscultation
- assessment of co-morbid conditions, including sleep apnea
- History of adverse anesthesia or sedation events
- ASA classification
- Airway assessment (Mallampati class)
- Additional documentation at the discretion of the examining provider

Documentation requirements for this level procedure are met using the age appropriate Procedural Sedation Assessment/History & Physical form. H&P content requirements for this level procedure may also be met using a dictated H&P, however, updated to meet procedural sedation and H&P update documentation requirements.

d. *Monitored Anesthesia Care (MAC), Regional, Spinal or General Anesthesia*
Patients undergoing invasive or potentially hazardous procedures under Monitored Anesthesia Care (MAC), Regional, Spinal or General Anesthesia shall have documentation that includes:

- *basic assessment* as defined above
- assessment of co-morbid conditions
- documented past medical history
- review of systems
- site-specific exam
- heart and lungs exam by auscultation

H&P documentation for this level of procedure shall be met with a dictated history and physical exam, or using the H&P short form in the event of an emergency.

e. In emergency situations where there is inadequate time to record the required level of H&P exam and documentation, a brief note including the pre-procedural diagnosis, indications and plan will be recorded prior to such procedure followed by the full documentation as soon as the provider is able following the procedure.

f. When the above documentation requirements are not on the chart before the procedure, it shall be canceled unless the practitioner states in writing that such delay would be detrimental to the well-being of the patient.

5. <u>History and Physical Exam Review</u>

a. History and physical examination documentation will be reviewed, as part of the Performance Improvement Plan, to address presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information documented in the medical record.

b. Results will be reported by practitioner and as aggregate and provided to the Service Chief. The Service Chief will share the results with the practitioner; results will also be reviewed by the Service Chief and Medical Management Team at time of reappointment. In addition, the Performance Improvement Committee will receive a report on medical histories and physical examination

documentation. Refer to Performance Improvement and Patient Safety Plan for data collection process, reporting, and analyzing results.

6. Obstetrical and Newborn H&P Requirements

For obstetrical and newborn H&P requirements see "Obstetrical and Newborn Records."

7. Informed Consent

Informed consent is obtained and documented in the accordance with Saint Clare's Hospital policy. The physician will discuss with the patient the nature of the proposed care, treatment, services, medications, interventions or procedures; potential benefits, risks, or side effects, including potential problems related to recuperation; the likelihood of achieving care, treatment and service goals and reasonable alternatives; the relevant risks, benefits, and side effects related to alternatives and the possible results of not receiving care, treatment and services, and identification of the individuals who will be performing significant surgical tasks. The physician will document that he/she discussed the above with the patient. The physician's documentation may state that a discussion occurred per Saint Clare's Hospital Policy, without having to include all of the above elements.

8. Operative and Procedure Reports

a. Operative or procedure reports should be dictated immediately after an operation or other high-risk procedure. This report shall contain documentation of the name(s) of the licensed practitioner who performed the procedure and his/her assistants, the name of the procedure performed, a description of the procedure, findings of the procedure, estimated blood loss, specimens removed, a preoperative diagnosis, and the findings or postoperative diagnosis. Practitioners are allowed up to 24 hours following the procedure for dictation of the operative report before the report is considered deficient.

b. A postoperative/procedure progress note is entered in the medical record immediately after the procedure before the patient is transferred to the next level of care. If the physician accompanies the patient to the next level of care, the note is recorded when the physician separates from the patient. The progress note includes the date and time of entry into the record, the name of the primary surgeon and assistants, the procedure performed and the findings, a postoperative diagnosis, specimens removed and their disposition, and estimated blood loss.

9. Universal Protocol – Wrong Patient, Wrong Site, Wrong Procedure

Immediately before the start of any operative procedure, including those within the OR or on the inpatient unit, the physician or physician's assistant who is performing the procedure will conduct an out loud final verification of the following criteria:

- Checklist (National Patient Safety Goal 9 A)
- Time out
- Site marking

10. Signatures

All entries in the patient's medical record shall be legible, permanently recorded, dated and timed with the date and time of entry. When the entry is delayed, the date and time

of the event shall be apparent as well as the date and time of the entry into the medical record.

11. Written and Verbal and Telephone Orders

a. Orders for diagnosis and treatment may be given in writing or by spoken word by a practitioner or other individual authorized by the Medical Staff within the scope of his practice (see Allied Health Policy with Ordering and Countersignature Requirement). Use of verbal orders, handwritten orders, or telephone orders are discouraged and reserved for emergency circumstances, when the provider does not have electronic access, information systems are not functional, or the physician is involved in a procedure precluding direct order entry. Use of remote access computerized physician order entry (CPOE) is highly encouraged. All orders must include the medical diagnosis or indication, along with the date, time and the name and title of the ordering practitioner or midlevel provider. All verbal and telephone orders shall be recorded in the medical record and read back to the ordering practitioner or allied health provider by the appropriately authorized person to whom dictated, and then signed by the authorized person along with date, time and the name and title of the practitioner or allied health provider giving the orders. The ordering provider is encouraged to request a "read back" of the verbal order when not initiated by the transcriber. Appropriately authorized person means a registered nurse, licensed pharmacist, physical, occupational or speech therapist, dietician, respiratory therapist, social worker, Radiology staff such as CT Technician, MRI Technician, Nuclear Medicine Technician, Ultrasound Technician, Radiology Technician; and Laboratory staff, such as Phlebotomists, Specimen Processors, Lab Clerks, Medical Technologists, Medical Technicians, and Histotechs.

b. When orders are illegible, unclear or contain a prohibited abbreviation, there is written evidence of confirmation with the ordering provider of the intended meaning before the order is carried out.

c. Verbal and telephone orders for chemotherapy treatments will not be accepted.

d. The responsible provider shall authenticate verbal and telephone orders within 48 hours of when the order was given. The practitioner's signature on the electronic order will be auto-dated and timed. Orders must be permanently recorded in black or blue ink when recorded on paper for scanning. Orders recorded in pencil or in any color ink than black or blue shall not be acceptable at any time.

12. Countersignatures

All dictated reports, electronic orders, discharge notes and/or final progress note shall be countersigned by the supervising physician within 30 days of discharge with the following exceptions:

- A History and Physical must be countersigned within 24 hours of admission.
- The discharge medication list document prepared on hospital discharge by an APNP does not require countersignature.
- Orders from a CRNA do not require countersignature.
- Prescription orders from a PA do not require countersignature.

On the day of discharge, all patients must be evaluated and discharged by the attending physician, evidenced by his/her countersignature on the final progress note or discharge

note, or a separate progress note written by the supervising physician the evening before, or the day of discharge.

13. Standing (Routine) Orders

A practitioner's routine, standing, or pre-written orders, when applicable to a given patient, will be transcribed as electronic orders and then signed and time-dated by the practitioner. A blanket reinstatement of previous orders is not acceptable under any circumstance.

14. Orders Rewritten After Anesthesia and Transfer from a Critical Care Unit

All medication orders shall be cancelled prior to and rewritten after general, spinal or epidural anesthesia and upon transfer to a unit providing a different level of care.

15. Radiology Orders

An order for a radiology examination by the attending practitioner or another individual with privileges to do so shall contain a concise statement of the reason for the examination, along with the name and title of the ordering practitioner.

16. Progress Notes

Daily progress notes shall be recorded in sufficient detail to permit continuity of care and transferability by practitioners and by other individuals who provide direct services to patients. Each of the patient's clinical problems should be clearly identified and discussed in the context of specific tests, treatments, and outcomes. Progress notes shall be entered as soon as possible following patient assessment in digital or text format in the progress notes application in the electronic record. Progress notes shall not be dictated.

17. Consultations

a. Consultation is encouraged when diagnostic studies fail to identify the nature of the patient's problem or when the results of a treatment plan deviate substantially from the range of anticipated results. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise. The attending practitioner or his designee must order the consultation and the reason for the consultation must be documented in the patient’s medical record.

b. The attending practitioner or his designee is primarily responsible for requesting consultation when indicated, except in an emergency.

c. Consultation is required when requested by a mentally competent patient or by the legally responsible party for a patient who is incapacitated or not competent.

d. Consultation is required for each active medical problem or procedure for which the requesting practitioner does not hold clinical privileges.

e. If a nurse or other Hospital health care professional believes that appropriate consultation is needed and has not been obtained, he shall bring the matter in question to the attention of his immediate supervisor who shall then refer the question to the attending practitioner or his designee. If the matter remains unresolved, it may be referred to the appropriate Service Chief. Where

circumstances are such as to justify such action, the Service Chief may then himself request the consultation.

f. It is expected that requests for consultation will be by personal contact between the attending practitioner and the consultant. At the time of such contact, the purpose and urgency of the consultation is to be communicated to the consultant. In addition to personal request, the attending practitioner or his designee shall enter time-dated order for consultation and its purpose on the order section of the patient's medical record.

g. In instances in which the time of consultative evaluation is wholly elective in that its timing has no potential to adversely affect the safety, well-being or the future health of the patient, consultant request may be given by the health unit coordinator at the direction of the attending practitioner or his designee. Hospital protocols specifically set up for these elective communicative purposes shall be followed.

h. Completion of a consultation shall occur appropriate to the seriousness and urgency of the problem being addressed. In all cases, consultation notes shall be dictated within 24 hours of the time the consultation has been performed.

i. It is appropriate that preliminary findings and the recommendations be summarized in a written note on the medical record at the time the patient is seen and/or be communicated directly to the referring practitioner, depending on the urgency and severity of the patient's problems.

j. Consultation notes shall include patient identification data, requesting practitioner, date and time of the consultation, pertinent items from the history of the present illness and past medical history, a directed physical examination if appropriate, pertinent hospital study results, a statement of conclusions or impressions, and recommendations. When potentially hazardous or dangerous procedures are involved, the consultation note shall be written or dictated before any such procedure. A consultation report shall be dictated immediately following the consultative visit and accompanied by a brief progress note summarizing key findings.

18. Obstetrical and Newborn Records

a. The prenatal record shall serve as the history and physical examination on patients with anticipated normal term deliveries. An interval admission note will be entered at the time of admission to update the history and physical exam. If a prenatal record is not available, an admission history and physical must be completed within 24 hours of admission.

b. Patients undergoing Cesarean section require an H & P. The H&P may be completed no more that 30 days before a scheduled surgical procedure. An update to the patient’s condition is required at the time of admission when using an H&P that was performed before admission. Patients undergoing an unscheduled Cesarean section also require an H & P prior to surgery.

c. A copy of the H&P as well as the H&P update must be present in the record prior to surgery. When the above documentation requirements are not on the chart before the procedure, it shall be canceled unless the practitioner states in writing that such delay would be detrimental to the well-being of the patient.

d. Each obstetric patient shall have a complete hospital record which shall include:

- prenatal history and findings, including complications, Rh determination, and other matters essential to adequate care;
- labor and delivery record, including anesthesia;
- practitioner's progress record;
- practitioner's orders;
- medicine and treatment sheet, including nurses notes;
- laboratory or x-ray reports;
- medical consultant's notes;
- estimate of blood loss.

Each newborn infant shall also have a complete hospital record which shall include at least:

- record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth;
- record of physical exam on admission and discharge;
- progress sheet recording medicines and treatments, weights, feedings and temperatures.
- consultant's notes

19. Symbols and Abbreviations

Symbols and abbreviations may be used consistent with Saint Clare's Abbreviations policy. Abbreviations found on the Hospital's prohibited abbreviations list shall not be used in any circumstance. When a prohibited abbreviation has been used in an order, written evidence of confirmation of the intended meaning must be obtained before the order is carried out.

20. Discharge Summary

a. A discharge summary is dictated at the time of discharge on all hospital inpatients with a length of stay greater than 2 calendar days or hospital deaths, except for uncomplicated obstetrical deliveries and normal newborn infants. The summary shall be dictated within no greater than 7 days of discharge.

b. For stays 2 calendar days or less, uncomplicated obstetrical deliveries and normal newborns, a discharge note may serve as the discharge summary and shall include the same content elements as a dictated discharge summary.

c. The discharge summary includes:

- dates of admission and discharge
- reason for admission (history)
- hospital course (significant findings, procedures, complications, consultations, treatments and outcomes)
- patient condition on discharge
- discharge medications
- discharge instructions (activity, diet, follow-up)
- disposition of the patient
- final diagnosis and secondary diagnoses

d. All summaries shall be dictated by the attending practitioner or another licensed health care practitioner privileged to do so, including allied health providers. A

countersignature on the discharge summary is required if the person dictating is not a member of the active or courtesy staff (or provisional members in these categories).

21. Discharge Medications

A list of discharge medications is updated for each inpatient discharge in Medication Manager by the discharging physician. The discharge medication reconciliation process is completed electronically using Medications Manager. Discharge medication reconciliation must occur prior to discharge of the patient. The patient will receive a copy of the home medication list and the list will be transmitted to the next physician of record.

22. Completion of Medical Records: Disciplinary Action

a. Failure to meet documentation time frames will be trended by the Health Information Management department and reported to Medical Staff Services for consideration during reappointment. Habitual noncompliance with documentation practices may be a basis for disciplinary action.

b. All medical records must be completed and signed within 30 days of discharge or death, after which time they will become delinquent. The Health Information Management department will monitor incomplete records and notify physicians via email communication. Suspension of clinical privileges shall occur in form of withdrawal of the practitioner's clinical privileges for noncompliance with Record Completion Policy. The suspension will not affect the privileges to minister to patients already in the Hospital under the care of that practitioner at the time of the suspension. Three such suspensions of privileges within any 12 month period may be sufficient cause for permanent suspension of the practitioner's clinical privileges or other corrective action deemed appropriate by the MEC.

c. In the event a practitioner is unable to complete his/her deficient medical records, a decision to leave the record incomplete permanently would be made by the MEC.

23. Release of Medical Information

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 shall be kept confidential and information disclosed only as allowed or required by law. Written authorization 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 and the law.

24. Access to Medical Information

Practitioners and other health care professionals will sign a confidentiality statement before being given on-line access to patient health information. Practitioners and other health care professionals will be assigned unique passwords and access menus. Passwords are confidential and shall not be disclosed or shared with other users. Practitioners and other health care professionals are permitted to access records only in accordance with applicable legal and ethical standards. Computers are not to be left unattended after entry of the password until proper computer terminal sign-off procedures have been followed. When a practitioner loses or resigns clinical privileges or Medical Staff membership (or is suspended), password and access codes will be immediately deactivated. In the same manner, when other health care professionals

resign their position, their password and access codes will also be immediately deactivated.

25. Removal of Medical Records from the Hospital

Copies of medical records may be removed from the Hospital's jurisdiction in safekeeping only in accordance with a court order, or by permission of the COO or his/her 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 the Hospital and/or Medical Staff jurisdiction in response to requests for medical records.

26. Research Using Medical Records

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, access to all medical records of all patients shall be afforded to members of the Medical Staff for a bona fide research study consistent with preserving the confidentiality of personal information concerning the individual patients, unless the patient has filed a written objection with the Hospital. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the COO and the conditions specified above for current members of the Medical Staff, former members of the Medical Staff shall also be permitted access to information from the medical records of their patients for bona fide research study covering all periods during which these patients were in the Hospital.

D. GENERAL CONDUCT OF CARE

1. General Consent Form

A general admission consent form, signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission. When such consent is not able to be obtained at the time of admission, Hospital staff will follow through with attempts to obtain consent at a time the patient is so able to provide it.

2. Drug Formulary

a. 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 drug formulary shall be listed in the latest edition of the United States Pharmacopoeia, the American Hospital Formulary Service, or other accepted drug compendium or its update and approved by the Pharmacy and Therapeutics Committee. 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 practitioner.

b. Investigational drugs (that is, those drugs not approved by the Food and Drug Administration (FDA) but having the status of an investigational new drug (IND) as recognized by the FDA) may be administered in the hospital but must have a protocol approved by the FDA and where appropriate, approved by the local Institutional Review Board (IRB).

c. Use of a patient's home medications is generally not allowed except in the following circumstance: if the drug in question is a non-formulary medication for which the SCH 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. If this Is not possible, the medications are placed in a tamper evident bag, sealed, and retained on the nursing unit. These medications will be returned to the patient at the time of discharge. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall not be returned to the patient without approval of the attending physician.

3. Dangerous Patients

The admitting practitioner shall be held responsible for giving such known information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever he reasonably believes the patients might be a source of danger from any cause whatsoever. The practitioner ordering patient protective devices shall order according to Hospital policy and procedure, including supervision, in accordance with current protocols and applicable professional standards.

4. Suicidal Patients

a. Any patient known or suspected to be suicidal at any time during hospitalization shall be placed under routine special precautionary protocols by attending practitioner order, no matter where in the Hospital the patient is placed, and arrangements will be made as soon as practical for the patient to be evaluated by a qualified practitioner. This may require transfer of the patient to a psychiatric service or facility.

5. Intensive Care Unit Admissions and Discharges

a. A patient may be admitted or transferred to the intensive care unit by any member Medical Staff as permitted by their staff category designation and privileges. Specific ICU admitting privileges are not required; however, when the patient requires care beyond the scope of practice or privileges of the admitting physician, the responsibility for care must be transferred to another member of the Medical Staff qualified and privileged to provide the care required or such a member must be asked to consult on and follow the patient while in the ICU.

b. Questions as to the advisability of admission or transfer to the intensive care unit or the discharge from the ICU shall be resolved through discussions between the attending practitioner and the Service Chief. Should the Service Chief be absent, any physician in the hospitalist program may replace him in that function.

c. Should the intensive care unit be full, priorities for admission, transfer or discharge of patients shall be resolved by discussions between the attending practitioner and the Service Chief. Should the Service Chief be absent, any physician in the hospitalist program may replace him in that function.

6. Autopsies

Autopsies shall be obtained under two circumstances:

Cases in which the attending practitioner (or his designee) and/or the patient's family desires one after a written consent from the “next-of-kin” is obtained by completing the Autopsy Permission/Request Form, in accordance with State law. The cost of an autopsy requested by the physician is the responsibility of the hospital. The cost of an autopsy requested by the family is the responsibility of the family.

In these cases, the autopsy order shall be considered a consultation request of the pathologist, and handled in the same manner as any other consultation request.

Criteria for autopsies requested by physicians and/or family members include, but are not limited to:

1) deaths which are not anticipated;

2) deaths in which the cause is not known with certainty on clinical grounds;

3) unexpected or unexplained deaths during or following any diagnostic or therapeutic procedure;

4) deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards;

5) obstetric, neonatal or pediatric deaths;

6) deaths known or suspected to have resulted from environmental or occupational hazards;

7) deaths in which an autopsy might disclose a disorder which may have a bearing on survivors or recipients of transplant organs.

In those cases fulfilling the criteria of "Coroner's Autopsies" under State law, including:

8) deaths in which there are unexplained, unusual or suspicious circumstances;

9) all homicides and suicides;

10) all deaths during or following an abortion;

11) all deaths following a poisoning;

12) all deaths following an accident;

13) when a physician will not sign a death certificate;

14) in all indeterminate or questionable cases.

a. The attending physician or his designee shall contact the Coroner of Marathon County who shall determine if an autopsy shall be performed and then contact

the appropriate pathologist. The attending physician is informed of autopsies that the hospital intends to perform.

b. Upon completion of the macroscopic portion of the postmortem examination the pathologist shall contact the requesting physician with a verbal preliminary anatomical diagnosis. A preliminary anatomical diagnosis shall be recorded in the medical record within three working days of the completion of the macroscopic autopsy procedure. A complete report shall become a part of the medical record of the deceased within three months.

7. Restraints

a. Patients have a right to be free from restraints that are not medically necessary. Restraint devices 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 physician/PA/APNP order is necessary for restraint initiation by Hospital personnel and the order may not be made on a standing or PRN basis.

Emergency use of restraints may be initiated by the RN when safety of the patient or others is at extreme risk. The physician must be notified and an order obtained within one (1) hour whether or not the restraint is to be continued. The RN must document an assessment of the behavior necessitating the emergency use of the restraints and the notification of the physician and the order.

For restraint of patients with primary behavioral health needs, the physician/LIP must see the patient within 1 hour of restraint application, and evaluate the appropriateness of the patient placement.

The RN may reassess for continued use beyond the initial time limited order; if clinically warranted the RN may contact the physician/PA/APNP for additional time limited use of restraint and obtain a verbal order. Please refer to Saint Clare's Hospital Restraint Policy for specific detail. The Restraint Policy is in compliance with JCAHO standards, and federal and state regulations.

8. Pre-Sedation/Pre-Anesthesia Assessment

a. Patients undergoing operative or other procedures under moderate or deep sedation shall have a pre-sedation or pre-anesthesia assessment by a licensed independent practitioner (LIP) with appropriate clinical privileges as per the Procedural Sedation Policy. Before sedating or anesthetizing a patient, a LIP with appropriate clinical privileges plans or concurs with the planned anesthesia. The patient is reevaluated immediately before moderate or deep sedation.

b. Patients receiving general, MAC, or regional anesthesia shall have a preanesthetic evaluation by a person qualified to administer anesthesia, with findings recorded within 48 hours before surgery, a preanesthetic visit by the person administering the anesthesia, and an anesthetic record and post anesthetic follow-up examination, with findings recorded within 48 hours after the procedure by the an individual who administered or by a delegated practitioner who is qualified to administer anesthesia.

9. Tissues Removed

a. All tissues removed at any procedure shall be sent to the Hospital pathologists, except those specimens listed as exempt by Hospital Policy - Specimens - Operating Room (25844). The pathologists shall make such examinations as they consider necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

b. The Medical Staff and pathologist together shall determine which tissue specimens require macroscopic examination and which require both macroscopic and microscopic examination.

10. Preventing Fetal Injury

Female patients of child-bearing age shall be evaluated for possible pregnancy before the administration of any drugs or before the performance of any tests, procedures or treatments which might be potentially harmful to the fetus.

11. Diagnostic Imaging Interpretations

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. Emergency interpretation of x-rays and other diagnostic imaging studies shall be available at all times.

12. Dispute Resolution: Resolving Disputes Between Hospital Employees, Allied Healthcare Providers or Paramedical Affiliates and Medical Staff

If a Hospital employee or allied health provider 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 allied health provider 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 Hospital Vice President (or designee). If warranted, the Hospital Vice President or designee may bring the matter to the attention of the Service Chief, or in the absence of the Service Chief, or where the Service Chief is the subject of the concern, to the CMO In the absence of the applicable Hospital Vice President or designee, the supervisor may take the matter to the Service Chief. The Vice President 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 MEC or the COO for appropriate action.

13. Medical Staff Behavior

No Medical Staff member shall harass, verbally or physically threaten or harm or act in a manner which is demeaning to each other, Hospital staff, patients or visitors. All practitioners shall comply with the Medical Staff Code of Conduct. Refer to Section 2.4 of the Medical Staff Bylaws.

14. Advance Practice Nurse Prescribers

An Advance Practice Nurse Prescriber may prescribe or order any patient treatment that is authorized for and in the manner provided in Wisconsin Administrative Code N 8.06.

15. Physician Assistants

A Physician Assistant may prescribe or order any patient treatment that is authorized for and in the manner provided in Wisconsin Administrative Code Med 8.08.

16. Verification of Critical Tests or Critical Test Results

When critical tests or critical test results are relayed orally to the ordering or attending practitioner or designee, the person receiving the results must record the results and read back the results to the person relaying the results so that the information is accurate. Please refer to the Saint Clare's Hospital policy, Compliance Tracking of Critical Test Results (25446).

17. Inpatient and Emergency Department Coverage

a. Each Member of the Staff, or their appropriate designee if such a respondent would be more timely, while "on-call" to provide Emergency Department or inpatient coverage shall be available to respond, "in person" (as defined below), to the emergent or non-emergent needs of both inpatients and the Emergency Department within the Response Time(s) as approved by the MEC.

b. "In person" response shall mean:

i. to a Physician "on-call", the capability to be present in the Emergency Department to begin examination/treatment of a patient.

ii. to a Physician responsible for the care of an inpatient, the capability to be present, personally or through established coverage arrangements with another Member of the Medical Staff, to begin examination or treatment of the patient.

c. The MEC shall establish response times for emergent and routine requests

i. The maximum response time shall be 30 minutes for OB, Anesthesia, Nursery Coverage, and General Surgeons.

ii. Absent such a report, the maximum response time shall be 60 minutes. In establishing such response times, each Service Chief shall consider the capability and resources of the Emergency Department and/or Critical Care Units to address such emergent conditions, and the applicable standards of care for such specialties and subspecialties.

iii. Response times as established shall be designed to minimize patient adverse outcomes and shall be in compliance with all applicable State and Federal laws and regulations.

18. Patient Care in the Emergency Department

a. Responsibilities

i. The MEC and the Emergency Medicine Division shall have overall responsibility for emergency medical care. The day-to-day medical operation of the Emergency Department is under the direction of the Medical Director of the Emergency Department.

ii. A Physician qualified to provide emergency care shall be present, on duty, 24 hours per day, 7 days a week. The Emergency Department shall have members of the Medical Staff available at all times for consultation in person or telephone, according to published call schedules. The scope of Departments available shall include the management of physical as well as emotional problems and there shall be, at all times, provision for transfer to another facility should the need arise.

iii. A Sexual Assault Nurse Examiner (SANE) will complete an assessment and collect evidence based on established policies and protocols, on any post-pubertal patient. The MD is not required to see these patients unless the nurse identifies there are signs of injuries. The MD will order prophylactic treatment based on established protocols, and the nurse will administer these medications.

The ED physician or pediatrician will complete an assessment on these pre-pubertal patients.

b. Specialty Coverage

The Medical Staff shall adopt a method of providing specialty coverage in the Emergency Departments. This shall be in accord with the Hospital's basic plan for the delivery of such services, including specific delineation of clinical privileges for all Physicians who render emergency care.

c. Policies and Procedures

The duties and responsibilities of all personnel serving patients within the Emergency Department shall be defined in a Procedure Manual relating specifically to these outpatient facilities.

d. On-Call Physician Responsibilities

i. It is the policy of Saint Clare's Hospital to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires that any patient who presents at the Emergency Department must receive an appropriate medical screening examination by a physician or allied health professional as designated by the MEC to determine if that patient has an emergency medical condition. If so, the patient's condition must be stabilized prior to discharge/transfer.

ii. The purpose of this policy is to ensure compliance with EMTALA by explaining the obligations of on-call physicians under the law and under the regulations of the Saint Clare's Hospital MEC.

iii. The on-call physician must come to the main Hospital ED when requested by the ED physician, another physician, or any Hospital employee making the request on behalf of a physician who is not

available to call the on-call physician directly. Seeing the patient in the on-call physician's office or clinic is not an option until the patient is determined to be "stable" or not to have an "emergency medical condition," as those terms are defined under EMTALA.

iv. If the on-call physician disagrees about the need to come to the main Hospital ED, the on-call physician must come to the Hospital and render care irrespective of the disagreement. The on-call physician may address the disagreement with the appropriate individual at the Hospital at a later time.

v. If requested, the on-call physician shall be physically present in the main Hospital ED to assist in providing an appropriate medical screening examination, as well as in the ongoing stabilization and treatment of an ED patient prior to transfer or treatment. The on-call physician shall remain in the ED until released by the ED physician.

vi. The on-call physician shall not consider the patient's financial circumstances or the patient's insurance or means of payment in the decision to respond to, treat, or transfer the patient.

vii. Except under unusual circumstances, the on-call physician must be physically present in the main Hospital ED within 30 minutes of being requested for emergency care. Response time runs from when the ED physician, nurse, or other Hospital worker places the call, not when the on-call physician receives the call.

viii. The on-call physician is not required to interrupt critical care–that is, care that requires his personal management—which he or she is providing to a specific patient. Immediately after the physician finishes caring for the specific patient, he or she will contact the requesting unit, respond if requested, and give an estimated time of arrival.

ix. Unless other arrangements are made, the on-call physician shall provide timely follow-up patient care throughout the episode of illness. The on-call physician may not condition the first follow-up office visit on advance payment or otherwise consider the patient's ability to pay.

x. Any violation of this policy by an on-call physician will be reported to the Service Chief. The Service Chief will notify the CMO.

xi. Except in the case of a flagrant violation, for the first incident, the on-call physician will receive counseling, a rebuke, and an official warning. A copy of the warning will be placed in the physicians Quality file.

xii. If the on-call physician commits a second violation, he or she will be reported to the Service Chief, who will request corrective action. The Service Chief shall also provide a written report to the MEC.

xiii. The MEC may then take action as indicated by the Medical Staff Bylaws. In determining whether a violation is flagrant, the MEC shall consider the total circumstances, including, but not limited to, whether the violation was deliberate, the seriousness of the patient's condition and outcome, and how disruptive the violation was to Hospital operations.

19. Amendment Protocol

a. Rules and Regulations may be amended, adopted or repealed by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists, provided that:

i. the written recommendations of the MMT concerning the proposed amendments shall have first been received and reviewed by the MEC;

ii. notice of all proposed amendments shall be distributed to the Medical Staff at least 30 days prior to the MEC meeting;

iii. any Medical Staff Appointee shall have the right to submit written comments to the MEC regarding the amendment. Such comments shall be addressed to the Chief Medical Officer. All written comments on the proposed changes received prior to the meeting shall be brought to the attention of the MEC before the change is voted upon; and

iv. no such amendment shall be effective unless and until it has been approved by the Board.

b. This policy may not be unilaterally amended. In the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section A.1 of these Rules and Regulations, and after notice from the governing body to such effect, including a reasonable time for response, the governing body may, upon its own initiative, formulate amendments to these Bylaws. In such event, Medical Staff recommendations and views will be carefully considered by the governing body during its deliberations and in its actions.

ADOPTED by the Active Medical Staff of Saint Clare's Hospital of Weston, Inc.

_____ _____

Date Chief Medical Officer

APPROVED by the Governing Body of Saint Clare's Hospital of Weston, Inc.

_____ _____

Date Secretary of the Board