DELTA HEALTH

MEDICAL STAFF RULES AND REGULATIONS

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A. PREAMBLE

These Rules and Regulations have been adopted in accordance with Article XV of the Medical Staff Bylaws of Delta County Memorial Hospital.

They constitute standard operating procedures. Each provider is responsible for becoming acquainted with these rules and regulations as well as policies, procedures, rules and regulations for the various specialty areas in which he or she has privileges. These areas with additional regulations will include the operating room, labor and delivery suites, newborn nursery, intensive care unit, hospital owned clinics, emergency room, and other special treatment areas that may be established within the hospital.

It is expected that each committee of the Medical Staff will draft rules and regulations, duties, and procedures as pertain to the objectives of the committee within the scope and with the limitations set forth in these rules and regulations.

B. MAIL-IN BALLOTS

The procedure to be followed to implement the provisions of Article XIV of the Medical Staff Bylaws concerning the mail-in ballot for purposes of amending the Bylaws is as follows:

1. Two-thirds of the members of the Medical Staff eligible to vote on an amendment to the Medical Staff Bylaws are required for a valid vote. For regular or special Medical Staff meetings, emailed and printed ballots shall be delivered to Medical Staff members eligible to vote on the issue with the specific wording of the proposed amendment at least 30 days prior to the vote.

2. Each member of the Medical Staff shall complete their ballot and deliver it to the Medical Staff Coordinator so that it is received within two (2) days prior to the vote.

3. The ballots shall be counted by the Chief of Staff and the Medical Staff Coordinator and canvassed by the Medical Executive Committee at its next meeting and the results shall be entered into the minutes of that meeting. The ballots shall be retained by the Medical Staff Coordinator in a secure location until the conclusion of the next medical staff meeting.

C. ADMISSION POLICIES

1. The hospital shall accept, at least initially, all patients requiring acute care. These patients will be admitted to the hospital provided the appropriate accommodations and staffing are available.

Operation of the hospital, including admission and treatment, is administered without regard to race, creed, color, religion, national origin, sex, or age.

2. The patient may be admitted to the hospital only by a member of the Medical Staff or Nurse Practitioner. Patients admitted for dental or podiatry services will be admitted under a physician's supervision. Adequate medical survey by a provider, i.e., the medical history, physical examination and recommendations for medical care, will be recorded on each patient prior to dental or podiatry surgery. The dentist or podiatrist will provide a dental or podiatry history and examination of the patient. Indicated consultations will be held in complicated cases. The provider will also be responsible for the post-operative medical or surgical management of each patient.

   All providers shall be governed by the official admitting policy of the hospital.

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

4. A member of the Medical Staff will be responsible for the medical care and treatment of each patient in the hospital, for the prompt and adequate completion of the medical record, for necessary special instruction. The time frame for the first visit for newly admitted patients shall be within 12 hours of admission if not previously seen by the admitting provider on the day of admission. Whenever these responsibilities are transferred to another medical service, an order covering the transfer of responsibility shall be entered in the medical record.

5. An adult patient needing to be admitted on an emergency basis will be admitted by the hospitalist provider on duty, unless the patient’s primary care provider (PCP) specifically requests to admit the patient and provide the patient’s inpatient care. Pediatric patients who have a PCP will be admitted by their PCP or the pediatric provider on call for the PCP. For pediatric patients who do not have a PCP available or have a PCP who does not have admitting privileges, the pediatric provider on call for unassigned patients will admit and provide inpatient care for the patient.

6. Each provider must assure that timely, continuing, and adequate professional care for his or her patients in the hospital is available through their office, either personally or by an alternate provider who has appropriate clinical privileges at the hospital. In cases of a true emergency, any member of the staff or a provider in house can be called upon to care for a patient until such time as the attending provider or their designated alternate arrives to assume care.

7. The admitting provider shall be held responsible for giving such information as may be necessary to ensure the protection of the patient from self-harm and to ensure the protection of others whenever their patients may be a source of danger from any cause whatever.

8. Precautions to be taken in the care of the potentially suicidal patient include:

   A. Any patient known or suspected to have suicidal intent shall be transferred to the area adjacent to the nursing station. The patient shall be removed as soon as possible to another institution where suitable facilities are available.

   B. Inpatient known or suspected to be suicidal should have a mental health consultation as soon as practical.

9. Admissions to Intensive Care Unit. If any question as to the validity of admissions to the ICU should arise, the decision is made through consultation between the attending physician and the ICU Medical Director.

10. On-call Providers who are granted Medical Staff privileges in a department shall be responsible for accepting unassigned patients in that department as part of their responsibility of being on the Delta County Memorial Hospital Medical Staff. This includes patients admitted through the Emergency room as well as to the Medical, Surgical, Obstetric, Gynecology, Pediatric and Newborn services.

D. DISCHARGE POLICIES

1. Patient shall be discharged only on the order of the attending / responsible provider. Should a patient leave the facilities against the advice of the attending / responsible provider, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient should be asked to sign a release of responsibility form.

2. No patient will be transferred to another medical facility until that facility and the receiving provider have been contacted and arrangements have been made for the continuing care of the patient.

3. The death of any patient in the hospital should be determined by the attending provider or their designee. In the event no provider is present in the hospital facility and in expected death, the registered nurse will observe and record changes and/or cessation of vital signs of the patient; immediately report these findings to the attending provider. The attending provider makes the medical diagnosis that the patient has died and gives orders that all treatment be discontinued and the body released to the mortuary. (Documentation by the attending provider will occur as part of the Discharge Summary.)

4. If the provider ordering an autopsy is not the attending provider, then it shall be his/her responsibility to notify the attending provider of the pending autopsy. An autopsy may be performed only with a written consent signed in accordance with state law. All autopsies shall be performed by the hospital pathologist or provider delegated this responsibility. Deaths in which an autopsy should be especially encouraged are as follows:

   a. Cases in which the Coroner has determined not to perform an autopsy, but the attending provider feels strongly that an autopsy is needed, and has received appropriate family permission to have one performed.

b. Deaths in which an autopsy may help to explain unknown and unanticipated medical complications to the attending provider.

c. All deaths in which the cause of death is not known with certainty on clinical grounds.

d. Cases in which an autopsy may help allay concerns of, and provide reassurance to, the family and/or the public regarding the death.

e. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.

f. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

g. Deaths resulting from high-risk infectious and contagious diseases.

h. All obstetric deaths.

i. All neonatal and pediatric deaths.

Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and a complete protocol should be made a part of the record within 7 weeks.

5. A stillborn fetus over 20 week's gestation will require a fetal death certificate.

6. Any infant showing signs of life over 20 weeks gestation requires a birth record and if it dies, a death record.

7. Each patient being discharged shall be given written discharge instructions.

E. MEDICAL RECORDS

1. The attending provider shall be responsible for the preparation of a complete and a legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, chief complaint, psycho-social history, family history, history of present illness, past medical history, physical examinations, special reports such as consultations, clinical laboratory, radiology services, and other reports such as provisional diagnoses, medical or surgical treatment, operative reports, pathological findings, progress notes, final diagnoses, condition on discharge, summary of discharge or discharge notes, clinical resume, and an autopsy report when performed.

2. A complete admission, history, and physical examination shall be entered in the medical record within 24 hours after admission and before inpatient or outpatient surgery or endoscopy is performed, except in emergencies where delay might endanger the life of the patient. In these cases, a note shall be placed in the chart regarding the need to

proceed and this information shall be completed immediately upon completion of the emergency procedure. This report will include the complaints, history of present illness, personal history, family history, all pertinent findings resulting from the assessment of all systems of the body, and physical examination. Exception to this requirement for a complete history and physical examination will be as follows:

a. In the case of obstetrical patients: A legible copy of the current prenatal record which includes a complete history and documented evidence of care and supervision during the prenatal period will suffice. The history and physical must be updated by the physician at the time of admission, and may be included in the delivery or admission note.

b. When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available, such as a copy of the original on the chart or the unit record available.

c. A copy of the complete history and physical examination performed in another hospital when the patient has been transferred directly to this hospital and the care is continuous with appropriate transfer notations appended.

d. If a complete History and Physical examination has been performed by a Medical staff member within 30 days prior to the patient's admission to the hospital, a reasonable, durable, legible copy of this report may be used in the patient's hospital medical record in lieu of a new History and Physical examination report. If the History and Physical examination was performed greater than 1 day (24 hours) prior to admission, the physical examination portion must be updated upon admission to reflect any changes the patient may have.

3. Pertinent daily 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.

4. Operative progress notes shall be entered in the patient's chart immediately after surgery, and shall include name of primary surgeon and assistant(s), findings, technical procedures used, specimens removed, post operative diagnosis, complications and estimated blood loss.

5. Operative reports shall include a detailed account of the findings of surgery as well as the details of the surgical technique. Operative reports shall be dictated immediately following surgery for outpatients as well as inpatients and the report made part of the patient's current medical record.

6. Consultation will show evidence of the review of the patient's problems and pertinent findings on physical examination, the consultant's opinion, 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 emergency situations so verified on the record, be recorded prior to the operation. It is the responsibility of the referring physician to ensure that consultation is provided in a timely fashion. The consultation should be done within 24 hours unless the referring physician agrees to an expanded timeframe.

7. All clinical entries in the patients' medical records, including transcription, shall be legible, dated, timed and authenticated. Authentication means to establish authorship by written signature or identifiable initials.

8. Medical Staff and hospital personnel shall adhere to the exclusion list of “DO NOT USE” abbreviations, symbols and notations.

9. Primary discharge diagnosis shall be contained in the chart at the time of discharge. Full discharge instructions shall be completed and signed by the discharging provider. If necessary, the written instructions will be faxed to the discharging provider to be signed and faxed back to the hospital prior to the patient being discharged.

10. A discharge clinical resume or summary shall be documented or dictated on all medical records of patients hospitalized for 48 hours or more.

    In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible provider.

11. Written consent and authorization of the patient is required for release of medical information to persons not authorized to receive this information.

12. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with court order, subpoena, or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission from the Administrator. In case of readmission of the patient, all previous records shall be available for the use of the attending provider. This will apply whether the patient is attended by the same provider or another. Unauthorized removal of charts from the Hospital is grounds for suspension of the provider for a period to be determined by the Executive Committee of the Medical Staff.

13. Access to medical records of patients shall be afforded to members of the Medical Staff for a bona fide, independent study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied.

14. The attending provider will complete a discharge summary upon discharge of the patient and will record the final diagnosis in the chart. All medical record documentation of discharged patients, including signatures, must be completed no later than 30 days post discharge. If a provider’s medical records are not completed by 14 days post discharge they will receive notification of delinquent medical records by the provider’s preferred means of communication and via the provider desktop in Meditech. If the medical records are not completed by 30 days post discharge, the provider shall be referred to the Medical Executive Committee, via the Chief of Staff, for review and possible formal action.

F. GENERAL CONDUCT OF CARE

1. A consent form for treatment, payment and health care operations signed by or on behalf of every patient admitted to the Hospital must be obtained at time of admission. In cases of true emergency, this consent form shall be signed as soon as possible after stabilization of the patient.

2. Informed consents are required for all patients undergoing surgery, except in cases of emergencies; all people receiving investigational drugs, and for any other high risk procedures for which privileges have been granted.

3. All orders for treatment shall be documented. Verbal or telephone orders shall be considered to be in writing if dictated to a registered nurse, occupational therapist, speech therapist, physical therapist, X-ray personnel, Laboratory personnel, Pharmacist, Respiratory Therapist, Dietitian or approved LPN who receive orders within their scope of practice, and signed by the responsible provider. All orders dictated over the telephone will be dated, timed and signed by the appropriate authorized personnel who dictated with the name of the provider plus his or her own name. The responsible provider or his designee will authenticate verbal/telephone orders within 48 hours after the time the order is made unless a read-back and verify process is used.

   Delta Health policy provides for a read-back and verify process for verbal/telephone orders. A read-back and verify process shall require that the individual receiving the order record it in writing and immediately read-back the orders to the provider or responsible individual, who shall immediately verify the read-back is correct. The individual receiving the verbal/telephone order shall record in writing that the order was read back and verified. If the read-back and verify process is followed, the verbal/telephone order shall be authenticated within 30 days after the date of the patient's discharge.

4. Orders written by a Physician Assistant do not require a countersignature by their supervising physician if all requirements under CMB Rule 400 are fulfilled and documented in the Physician Assistant's credentialing file. In no case will a Physician Assistant practice without a supervising physician who has been accorded privileges in the Hospital.

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

6. Standing or routine orders may be formulated by an individual staff member or committee. When standing orders are applicable to a given patient, they will be copied and become part of the patient's record. They must be dated and signed by the provider.

7. All previous orders are cancelled when a patient goes to surgery.

8. Any qualified provider with clinical privileges in this hospital can be called for consultation within his or her area of expertise.

G. GENERAL RULES REGARDING DRUGS

1. The Hospital maintains a formulary, the contents of which are approved by the Pharmacy and Therapeutics Committee of the Medical Staff. Only drugs that are listed in the formulary are routinely carried in the Pharmacy. A provider wishing to make a permanent change in the formulary should notify the Pharmacy and the change will be considered at the next meeting of the Pharmacy and Therapeutics Committee.

2. Medications taken by a patient while in the hospital must be controlled and documented for legal and medical reasons. Patients who bring in their own medications (OTC supplements, inhalers, etc.) to the hospital must either send them home with a friend or family member or turn them over to a nurse for storage in the Pharmacy until they leave the hospital. When a patient requires the administration of a drug not in the Pharmacy, the Pharmacy may inspect and identify the patient's medications from home or acquire a supply via normal channels for administration through the unit dose system.

3. All orders are automatically canceled at the time of surgery, or upon transfer of a patient into or out of the ICU, with the exception of the readmission for Lidocaine pursuant to ICU policies.

4. In the emergency room, urgently needed medications may be dispensed by the provider in the event the retail pharmacies are closed.

H. LABORATORY

1. Laboratory service shall be provided by the hospital as completely as possible. Tests which cannot be made in the hospital shall be referred to an outside approved laboratory and patients will be charged by the hospital at cost plus a reasonable handling charge.

2. Unless otherwise specified, (i.e., clinical pathways), routine laboratory work for all patients admitted to the hospital will be according to medical necessity.

3. Pre-operative laboratory work, radiological studies, electrocardiogram, etc., may be ordered utilizing the Anesthesia Services Guidelines for pre-operative testing, as referenced by the American Society of Anesthesiologists.

4. Surgical specimens removed at surgery will be submitted for pathological study and report at the discretion of the surgeon.

I. RADIOLOGY

1. All radiological studies will be reviewed by a qualified radiologist who will prepare and sign a formal written report on each imaging study.

2. All radiological requests made by a provider shall contain a concise statement of the reason for the examination.

3. If intravenous injection of any contrast media is to be done for completion of radiological examination, the intravenous injection must be given by a physician or under the direct supervision of a physician by a Radiologic Technologist who has successfully completed appropriate training.

J. ANESTHESIA

1. Anesthesia privileges will be granted to members of the Medical Staff and Certified Registered Nurse Anesthetists who qualify as provided in the Bylaws. Physicians requesting Anesthesia / Conscious – Moderate Sedation privileges shall be asked to provide proof of competency. A certification or the Self-Study Module in Conscious Sedation training / education is required.

2. The Surgery Committee Chairman (Chief of Surgery) has oversight of policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of provider who is permitted to provide anesthesia services that are subject to the anesthesia administration requirements.

3. Anesthesia personnel, nurse, or MDA on call will be called for nonscheduled and/or emergency surgery and operative obstetrical procedures and shall respond within 30 minutes.

4. Only nonflammable anesthetics may be used.

5. The pre-anesthetic evaluation of the patient will be made by the anesthesia service, with appropriate documentation of pertinent information relative to the choice of anesthesia and the procedure anticipated, and the patient's understanding and consent. This evaluation will include the patient's personal, medical and family history, especially pertaining to anesthetic experiences or allergies, and any pertinent laboratory and/or x-ray findings. Beyond the review of systems, the evaluation should include airway assessment, drug/tobacco/alcohol use, and herbal use.

6. The anesthetist will review the patient's condition immediately prior to induction of anesthesia. This will include a review of the chart with regard to completeness, pertinent laboratory data, time of administration and dosage of pre-anesthetic medications, and an appraisal of any changes in the patient's condition, as compared to that noted on previous visits.

7. The anesthetist will monitor and record all events taking place during the induction of and maintenance of anesthesia/sedation and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fractions.

8. Following the procedure for which the anesthesia was administered, the anesthetist will accompany the patient to the post-anesthesia area and will remain with the patient as long as is necessary. The person recovering the patient will be advised of any specific problems presented by the patient's condition.

9. An anesthetist will perform and document a post-anesthesia evaluation within 48 hours after surgery (for inpatients only) with specific reference to the presence or absence of anesthetic related complications. An attempt will be made by the nursing staff to call outpatients the day following their surgery to determine if post-anesthesia complications exist.

10. All surgical cases resulting in anesthesia complications will be reviewed by the Anesthesia Subcommittee.

K. SURGERY, OBSTETRICS AND MEDICINE

1. Privileges, if requested, will only be granted to members of the Medical Staff who qualify under the provisions of Section 3.2 of the Medical Staff Bylaws.

2. For the purpose of gaining experience to qualify for initial privileges, or the advancement of privileges, and in order to assure documentation of same, it will be the responsibility of any provider desiring additional privileges to obtain preceptorship from a physician who maintains privileges and appropriate competency in the desired procedure.

3. Standing orders may be used by providers for surgical, obstetrical or medicine patients. They should be reviewed periodically and be revised when appropriate. Diagnostic procedures, treatment, and drug orders not included in the standing orders will be written as required.

L. SURGERY / INPATIENT MEDICINE:

1. Written, signed, informed surgical consent will be obtained prior to surgery except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The patient must know who, among the physicians attending him, the operating surgeon is and must consent specifically to be operated on by this operating surgeon. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian or next of kin, these circumstances should be fully documented in the patient's medical record. A consultation in such instances is advisable before the emergency surgery is initiated if time permits. If more than one surgery is performed during the patient's stay in the hospital, a patient consent must be obtained for each surgery performed.

2. Elective surgeries will be scheduled through the Surgery Department according to an approved scheduling policy.

3. Surgeons will be in the operating room and ready to commence operation at the time scheduled. If the surgeon is more than 20 minutes late, the surgery may be rescheduled after consultation with the person administering anesthesia.

4. In cases where the operating surgeon is not the attending physician, the operating surgeon will examine the patient pre-operatively and write a consultation stating his findings and preoperative diagnosis.

5. Except in emergencies, the pre-operative diagnosis, the history and physical examination, any laboratory tests and/or imaging studies must be recorded in the patient's medical record prior to any surgical procedure. If not recorded, the operation will be canceled. In the emergency, the provider will make at least a comprehensive note regarding patient's condition prior to induction of anesthesia and the start of surgery.

6. Immediately following surgery, the surgeon will: a) chart a written post-operative note, and b) dictate the full operative report. All operations performed will be fully described by the operating surgeon within 24 hours following surgery.

7. All surgical cases resulting in infectious complications will be reported to and tracked by the Safety / Infection Control Committee. Those surgical cases resulting in other complications shall be reviewed by the Surgery/Anesthesia/Inpatient Medicine Service Committee, in accordance with other Performance Improvement requirements.

M. OBSTETRICS:

1. Obstetrical care will be provided by the patient's physician, or by pre-arrangement, by another physician with obstetrical privileges in the hospital. A patient who presents at the hospital in labor who does not have a private physician will be assigned to the staff physician who is on call for Obstetrics.

2. Standing orders may be used by providers for obstetrical and pediatric patients. They should be reviewed periodically and be revised when appropriate. Diagnostic procedures, treatment, and drug orders not included in the standing orders, will be written as required.

3. When an obstetric patient presents at the hospital, she will be examined by a registered nurse, and the attending physician or his designee will be called and advised of the patient's condition.

4. In addition to the routine history and physical examination, obstetric patients admitted for care should have pertinent information charted relative to gynecological history including menstrual history, previous pregnancies and deliveries, expected date of delivery, prenatal care, blood type and Rh, and results of serology. A copy of the office obstetrical record will suffice if all this information is contained in it and should be sent to the hospital within three weeks prior to the patient's expected date of delivery, updated with any pertinent changes. The record will become a permanent part of the hospital chart.

5. Appropriate documentation of the labor and delivery should include identifying data: admission data, onset of labor, interval, length and quality of contractions, status of membranes, fetal heart tones, position, relation of presenting part to the ischial spine, dilation of cervix, progress of labor, anesthesia preparation, type of delivery, condition and sex of infant, perineum condition and/or repair, placental delivery, medications, blood loss, and condition of patient at the end of the procedure. This may be on the labor record provided by the hospital or in a narrative report.

6. All obstetrical and pediatric cases resulting in complications will be reviewed by the Obstetric/Pediatric Service Committee. All primary C-Sections shall be individually reviewed for indications and for fetal and maternal morbidity and mortality in accordance with other Performance Improvement requirements.

N. EMERGENCY SERVICES

1. No person shall be denied impartial access to treatment or accommodations which are available and medically indicated. The hospital will provide an appropriate medical screening examination within the capability of the hospital's Emergency Department, for each individual presenting to the Emergency Department seeking medical examination or treatment, to determine if an emergency medical condition exists. The medical screening examination will be conducted by qualified medical personnel to include: physicians, nurse practitioners and registered nurses. Patients determined to have an existing emergency medical condition will not be transferred until stabilized, as pursuant to the Emergency Medical Treatment and Active Labor Act (EMTALA).

2. The RN will see all patients presenting themselves to the Emergency Department for care and will perform triage to rank patients into an appropriate category: Emergent, Urgent, or Non-urgent. Patients who are urgent or emergent will be seen by a provider for a medical screening examination and treatment. The nurse will initiate whatever action is necessary to meet the immediate needs of the patient; utilizing protocols approved by the Medical Staff and will notify the attending provider or the provider on call.

3. Each member of the Medical Staff having admitting privileges must provide for 24 hour emergency care for the patients of his/her practice, either personally or by a designee with at least equivalent clinical privileges.

4. A written, signed, informed consent will be obtained prior to treatment except in those situations wherein the patient's life is in jeopardy and suitable consent cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which the consent cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully recorded in the patient's medical record.

5. The patient's right to privacy extends to the preservation of the confidentiality of their disclosures and should be such that they can communicate with the physician in confidence. To preserve this right, no privileged information will be released to unauthorized individuals without written authorization of the patient or their authorized representative, and only to those specifically identified by the patient to receive the information.

6. A medical record will be kept for every patient receiving emergency or outpatient service. It will become an official hospital record and will contain: adequate patient identification; information concerning the time of the patient's arrival, means of arrival, and by whom transported; pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to their arrival to the hospital; description of significant physical, laboratory, and X-ray findings; and diagnosis and treatment, including instructions given to the patient and/or their family relative to necessary follow-up care. The record will be signed by the attending provider.

7. No elective/urgent general anesthesia or spinal anesthesia may be given in the E.R., except during the course of emergency intubation (i.e., trauma/resuscitative cases).

8. Licensed providers may refer patients to the hospital for treatment and diagnostic procedures on an outpatient basis.

9. Review of the emergency records for their adequacy and evaluation of the medical care provided in the emergency service area will be the responsibility of the Emergency/Trauma Service Committee, in accordance with other Performance Improvement requirements.

10. Whenever a member of the staff in the Emergency Room has reason to believe that the Hospital may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the Emergency Medical Treatment and Active Labor Act, that staff member will report the circumstances to the Hospital Administrator, who will investigate the matter and submit such report to HCFA and/or the State Licensing Authority as he/she deems to be appropriate under the circumstances.

O. INFUSION CENTER

1. Outpatient Services may be ordered by any practitioner responsible for the care of the patient (SS 482.54, CMS- Outpatient Services, 2012);

   - Whom is licensed and acting within their scope of practice in the State where he or she provides care to the patient

   - Whom has been authorized in accordance with the State law in which they practice by the medical staff and approved by the governing body to order specific outpatient services

   - Applies to members of the medical staff who have been granted privileges to order outpatient services, as well as practitioners that are not on the medical staff, but whom meet the criteria for authorization to order outpatient services (outlined above)

2. It is recommended by CMS that direct supervision is performed on all therapeutic services in both hospital outpatient and fee standing settings; although in a small rural hospital, having 100 beds or fewer there are no formally outlined supervision requirements.

   - "Direct" supervision is defined as "the physician or advanced practitioner providing supervision must be "immediately available" and "interruptible" to provide assistance and direction throughout the performance of the procedure; however he or she does not need to be present in the room when the procedure is performed."

   - "General" supervision is defined as "a physician or advanced practitioner must be available by telephone to provide assistance and direction, if needed."

The Oncologist will provide <u>direct</u> supervision and if the Oncologist is not available, the Hospitalist/ ED physician will provide <u>general</u> supervision.

3. A licensed practitioner (Hospitalist or ED physician) will be immediately available to staff during normal business hours to provide direction for emergency care for patients undergoing treatment in the Infusion Center, as needed.

4. Patients that are only insured in the state that they reside or have a state provided insurance that does not cover out of state practitioners, then a co-signature will be required by a practitioner within the State of Colorado.

P. <u>CLINICAL SERVICES</u>

1. Each calendar year the Chief of Staff shall be responsible for assigning medical staff members to clinical service committees representing the various medical services provided within the hospital.

   Each committee shall elect a chairperson who shall preside over the meetings for two years. A representative of each service committee will be assigned to the Medical Executive committee. These committees will meet as they deem appropriate to provide oversight of care in their respective clinical areas, which includes, but is not limited to aspects of peer review / chart review, policies and procedures, approval and formulation of clinical pathway orders and other provider order sets, review of current clinical issues regarding patient care / treatment and patient / medication safety issues.

   a. The **SURGERY/ ANESTHESIA / INPATIENT MEDICINE SERVICE COMMITTEE** shall deal primarily with surgical care involving operative/invasive treatment and inpatient medical services. The committee shall oversee the care provided in the areas of anesthesia, the blood bank and transfusions and histology/pathology. The committee shall also oversee the care provided in the areas of pharmacy and therapeutics, cardiopulmonary and respiratory therapy, radiology, laboratory, and cardiac rehabilitation.

   b. The **OBSTETRICAL/PEDIATRIC SERVICE COMMITTEE** shall deal primarily with patients requiring obstetrical and pediatric care.

   c. The **EMERGENCY/TRAUMA SERVICE COMMITTEE** shall deal primarily with the medical care provided to those patients who are seen in the Emergency Room.

   d. **The OUTPATIENT MEDICINE SERVICE COMMITTEE** shall deal primarily with outpatients seen in the primary care, obstetric, pediatric and mental and social work health clinics and who receive outpatient hospital services such as home health, wound care, cardiopulmonary rehabilitation and physical/occupation therapy. The Committee shall also oversee care provided in the areas of assisted senior care and other ancillary services of primary outpatient care.

2. If within the structure of the specific Clinical Service Committee there is an identified concern regarding a provider's clinical performance, the committee may request further review by way of a "Focused Review". The Committee in consultation with the Quality Services Director will determine the type of focus review (retrospective, concurrent or proctoring), timeframes for the review and use of external peer review, which could include, but is not limited to provider request or lack of similar peers to perform the review. Information from the provider's ongoing evaluation is also utilized. The provider whose performance is being reviewed will be included in the process as deemed appropriate by the specific Clinical Service committee. Initiation and results of a "focused review" will be communicated to the Medical Executive Committee by the Chairman of the specific Clinical Service Committee, along with any recommendations to resolve performance issues and/or actions taken. If necessary any further recommendations or communication will be determined by the Medical Executive Committee. It will be the responsibility of the Committee Chairman to ensure recommendations and any required changes are implemented and communicate these to the provider.

Q. CONSULTATIONS

1. Except in an emergency, consultation is recommended in the following instances:

   a. When the patient is a poor risk for operation or treatment;

   b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

   c. Where there is doubt to the choice of therapeutic measures to be utilized;

   d. In unusually complicated situations where specific skills of other providers may be needed;

   e. In instances in which the patient exhibits severe psychiatric symptoms.

2. Except in an emergency, consultation is required in the following instances:

   a. When requested by the patient or his family;

   b. In any case where there is a question of criminal action.

3. Consultants: A consultant shall be Board Eligible/Certified in the area or for the procedure for which opinion is sought and, in cases where consultation is required by these Rules and Regulations, it is recommended that the consultant not be a member of the same practice group as the requested physician.

4. Essentials of a Consultation: It is desirable that a consultation include examination of the patient and the record. A written opinion signed by a consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in life-threatening emergencies, shall be recorded prior to the operation.

5. Responsibility for Requesting Consultation: The attending provider is primarily responsible for requesting consultations when indicated. The Medical Executive Committee may require consultation for any patient when the best interest of the hospital and the patient may be so served. The Chairman of Service Committee may make such a recommendation to the Medical Executive Committee.

6. Consultations Initiated by the R.N.'s: If a registered nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the Director of Nursing Service. If warranted, the Director of Nursing may bring the matter to the attention of the appropriate Chairman of Service Committee, and shall also notify the attending provider of this action. The Chairman of Service Committee may then require the attending provider to obtain appropriate consultations.

7. Consultation by Mental Health Professionals: The "supervision or direction of a physician member of the Medical Staff" required for Allied Health Professionals pursuant to Section 9.1.4 (1) of the Medical Staff Bylaws, as applied to a Mental Health Professional who is requested to conduct a mental health consultation, shall be provided by the requesting provider on a case by case basis. It is not necessary that the same physician provide the "supervision or direction" in every case.

8. No patient shall be seen in consultation without the prior knowledge of the attending provider except in unusual circumstances or emergencies.

R. TELEMEDICINE/TELERADIOLOGY

1. For purposes of telemedicine/teleradiology, providers consulted shall be available to consult with members of the Medical Staff on a case by case basis, and shall include providers who independently prescribe/diagnose/treat patients via telemedicine link.

2. Providers who independently prescribe/diagnose/treat patients via telemedicine link are subject to the credentialing and privileging process of the Hospital, and will be considered part of the Consulting Medical Staff**.**

3. For purposes of telemedicine, these providers shall be credentialed as referenced in the Medical Staff Credentialing Manual.

4. For the purposes of teleradiology, these providers do not require the full credentialing process if the contracted teleradiology Service is a CMS/DNV accredited organization.

S. PROFESSIONAL PERSONNEL IN TRAINING

Categories: Professional Personnel in Training are divided into five categories: (a) Medical Residents, (b) Medical Students, (c) Physician Assistant Students, (d) CRNA Students, and (e) Nurse Practitioner Students, all five of whom may carry out their activities under the sponsorship of an Active/Courtesy Staff member subject to any service policies and procedures, and in conformity with the Medical Staff Bylaws, Rules and Regulations.

a) Medical Residents

1. Qualifications. The medical resident must be actively enrolled in an accredited residency program and licensed to practice in the state in which he/she is enrolled. He/She must be sponsored by and be the responsibility of an Active Medical Staff member. Written communication must be received from the Residency Program of attendance by the Credentials Committee which includes verification of attendance and good standing, and a statement that professional liability insurance is provided.

2. Prerogatives. The medical resident must be granted temporary privileges in accordance with the Bylaws. The resident may prepare or perform histories, progress notes, operating reports and physicals within the scope of practice outlining core privileges and procedure guidelines for the resident in training. The supervising physician must be a licensed, physician member of the Medical Staff with related clinical privileges, and must be within telephone reach and able to reach the hospital in an appropriate amount of time specified by the Bylaws. The resident may write orders subject to such orders being reviewed by the sponsoring physician; and may perform procedures under the direct supervision of the sponsoring physician or an appointed physician who has the privileges to perform the procedure in question. If the resident does not have a DEA certificate, all narcotic orders must be co-signed by the supervising physician before the orders are transcribed.

3. Responsibilities. Each medical resident shall discharge his/her responsibility as required in these Bylaws, Rules and Regulations. The resident may be removed from the training program at any time by the sponsoring physician or the hospital Board of Directors, and may access the Fair Hearing Plan under the same circumstances as a member of the Medical Staff.

b) Medical Students

1. Qualifications. The medical student must be actively enrolled in an accredited medical or osteopathic school of medicine. The student must be sponsored by and be the responsibility of an Active/Courtesy Staff member. The sponsoring physician must notify the Medical Staff Office, through written communication, that a medical student is performing a rural rotation at Delta County Memorial Hospital. Application from the student must be received in the Medical Staff Office that includes a letter from the school showing verification of attendance and good standing, and that professional liability insurance is provided.

2. Prerogatives. The medical student may render or perform such services as are required by their approved medical school program. All services rendered or performed shall be under the personal direct and indirect supervision of the sponsoring physician, or an appointed physician who has privileges to perform the procedure or service in question.

3. Responsibilities. Each medical student shall discharge his/her responsibilities as required in these Bylaws, Rules and Regulations. The medical student may be removed from the training program at any time by the sponsoring physician or the hospital Board of Directors without right to access of the Fair Hearing Plan.

c) Physician Assistant Students

1. Qualifications. The physician assistant student must be actively enrolled in an accredited physician assistant training program. The student must be sponsored by and be the responsibility of an Active Staff member. The sponsoring physician must notify the Medical Staff Office, through written communication, that a physician assistant student is performing a rural rotation at Delta County Memorial Hospital. Application from the student must be received in the Medical Staff Office that includes a letter from the school showing verification of attendance and good standing, and that professional liability insurance is provided.

2. Prerogatives. The physician assistant student may render or perform such services as are required by their approved training program. All services rendered or performed shall be under the personal direct and indirect supervision of the sponsoring physician, or an appointed physician who has privileges to perform the procedure or service in question.

3. Responsibilities. Each physician assistant student shall discharge his/her responsibilities as required in these Bylaws, Rules and Regulations. The physician assistant student may be removed from the rural rotation at any time by the sponsoring physician or the hospital Board of Directors without right to access of the Fair Hearing Plan.

d) Certified Registered Nurse Anesthetist Students

1. Qualifications. The certified registered nurse anesthetist student must be actively enrolled in an accredited certified registered nurse anesthetist training program. The student must be sponsored by and be the responsibility of an Active/Courtesy Staff member. The sponsoring physician must notify the Medical Staff Office, through written communication, that a certified registered nurse anesthetist student is performing a rural rotation at Delta County Memorial Hospital. Application from the student must be received in the Medical Staff Office that includes a letter from the school showing verification of attendance and good standing, and that professional liability insurance is provided.

2. Prerogatives. The certified registered nurse anesthetist student may render or perform such services as are required by their approved training program. All services rendered or performed shall be under the personal direct and indirect supervision of the sponsoring physician, or an appointed CRNA who has privileges to perform the procedure or service in question.

3. Responsibilities. Each certified registered nurse anesthetist student shall discharge his/her responsibilities as required in these Bylaws, Rules and Regulations. The certified registered nurse anesthetist student may be removed from the rural rotation at any time by the sponsoring physician or the hospital Board of Directors without right to access of the Fair Hearing Plan.

e) Nurse Practitioner Students

1. Qualifications. The nurse practitioner student must be actively enrolled in an accredited nurse practitioner training program. The student must be sponsored by and be the responsibility of an Active/Courtesy Staff member. The sponsoring physician must notify the Medical Staff Office, through written communication, that a nurse practitioner student

is performing a rural rotation at Delta County Memorial Hospital. Application from the student must be received in the Medical Staff Office that includes a letter from the school showing verification of attendance and good standing, and that professional liability insurance is provided.

2. Prerogatives. The nurse practitioner student may render or perform such services as are required by their approved training program. All services rendered or performed shall be under the personal direct and indirect supervision of the sponsoring physician, or an appointed physician who has privileges to perform the procedure or service in question.

3. Responsibilities. Each nurse practitioner student shall discharge his/her responsibilities as required in these Bylaws, Rules and Regulations. The nurse practitioner student may be removed from the rural rotation at any time by the sponsoring physician or the hospital Board of Directors without right to access of the Fair Hearing Plan.

T. DISASTER

1. Under conditions of disaster, all members of the Medical Staff of the hospital specifically agree to relinquish direction of the professional care of their patients to the qualified person designated by the Chief of Staff or his designee.

2. In the event of a disaster, in which additional medical staff is needed beyond those already privileged, disaster privileges may be granted by the Administrator or the Chief of Staff. In the absence of either one, the Chief Clinical Officer or the Quality Service Director can assume this responsibility.

3. The Administrator or the Chief of Staff will notify the Medical Staff Coordinator as soon as feasible the names of those individuals granted Disaster Privileges, so that the verification process can begin. This privileging process will be the same as the process for granting temporary privileges as outlined in the Bylaws.

4. The Administrator or the Chief of Staff or designee may grant disaster privileges to medical personnel upon presentation of any of the following:
   a. A current picture hospital ID (another facility)
   b. A current license to practice and a valid picture ID issued by a state federal or regulatory agency
   c. Identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT)
   d. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity
   e. Presentation by current hospital or medical staff member (s) with personal knowledge regarding the provider's identity.

5. Those granted disaster privileges will be provided with a badge for identification of their title, i.e. MD, CRNA, and their specialty, i.e. orthopedics, radiologist.

6. Those granted disaster privileges will be assigned to a medical staff member or a clinical employee.

7. Care provided by those individuals granted disaster privileges will be reviewed once the immediate situation is under control either by the department to which they were assigned or the Quality Services Director.

U. ACCEPTANCE EFFECTIVE DATE, REVISION OF RULES AND REGULATIONS:

1. These Rules and Regulations will become effective when adopted in accordance with current Medical Staff Bylaws.

2. Review and/or revision of these Rules and Regulations will be conducted at appropriate intervals.

REVIEWED BY THE MEDICAL EXECUTIVE COMMITTEE:

Laura McCrackin, M.D., Chief of Staff
Chairman, Medical Executive Committee

Date

REVIEWED BY THE BOARD OF DIRECTORS:

Jean Ceriani, President
Board of Directors

Date

Revised: 6/91, 3/24/94, 10/94, 1/95, 9/96, 6/99, 11/99, 04/00, 07/00, 11/00, 12/00, 02/01, 03/01, 12/02, 06/03, 08/03, 02/04, 07/04,01/17/05. 11/21/05, 12/12/05, 2/20/06, 3/20/06, 03/19/07, 04/16/09… continued below:

Date: Aug 13, 2014	Updated:	E. Medical Records F. General Conduct of Care J. Anesthesia	By: Med Exec Committee
Date: Apr 28, 2015	Updated:	Mail-In Ballots to include Email Physicians / Practitioners to “Providers” Clinical Services – Restructure of Committees	By: Med Exec Committee
Date: May 13, 2015	Updated:	E. Medical Records	By: Med Exec Committee
Date: Jan 10, 2019	Updated:	M. (Now P.) Clinical Services Surgery/Inpatient Services Combined	By: Med Exec Committee
Date: Apr 4, 2019	Updated:	E. Medical Records, 14.	By: Med Exec Committee
Date: Aug 8, 2019	Updated:	Added O. Infusion Center	By: Med Exec Committee
Date: Jul 14, 2021	Updated:	E. Medical Records, 14. F. Physician Assistants, 4.	By: Med Exec Committee