MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF MONONGALIA GENERAL HOSPITAL

RULES AND REGULATIONS

Approved:

Mon General Medical Staff – March 12, 2014
Mon General Board of Directors – April 1, 2014

TABLE OF CONTENTS

PAGE

I. ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES 1

Section 1.1. Admissions 1
Section 1.2. Responsibilities of Admitting Physician 2
Section 1.3. Care of Unassigned Patients 2
Section 1.4. Alternate Coverage 2
Section 1.5. Continued Hospitalization 2

II. MEDICAL RECORDS 4

Section 2.1. Form and Retention of Record 4
Section 2.2. Content of Record 4
Section 2.3. Medical Orders 8
Section 2.4. Verbal Orders 9
Section 2.5. Standing Order Protocols 10
Section 2.6. Progress Notes 11
Section 2.7. Authentication 11
Section 2.8. Delinquent Medical Records 11

III. CONSULTATIONS 13

Section 3.1. General 13
Section 3.2. Required Consultations 13
Section 3.3. Contents of Consultation Report 14
Section 3.4. Psychiatric Consultations 14
Section 3.5. Surgical Consultations 15
Section 3.6. Mandatory Consultations 15

PAGE

IV. INFORMED CONSENT 16

Section 4.1. Responsibility for Obtaining Informed Consent 16
Section 4.2. Definitions 17
Section 4.3. Who May Consent 17
Section 4.4. Incompetent Patients 18
Section 4.5. Unusual Cases 18
Section 4.6. Refusal to Consent 19

V. DISCHARGE PLANNING AND DISCHARGE SUMMARIES 20

Section 5.1. Who May Discharge 20
Section 5.2. Identification of Patients in Need of Discharge Planning 20
Section 5.3. Discharge Planning 20
Section 5.4. Discharge Summary 21
Section 5.5. Discharge of Minors and Incompetent Patients 21

VI. TRANSFER OR DISCHARGE 22

Section 6.1. Discharge or Transfer 22
Section 6.2. Procedures 22

VII. PHARMACY 25

Section 7.1. General Rules 25
Section 7.2. Drug Preparation 25
Section 7.3. Delivery of Services 26
Section 7.4. Self-Administration of Medication 26
Section 7.5. Stop Orders 27

VIII. SURGICAL SERVICES 28

Section 8.1. Organization and Staffing 28
Section 8.2. Delivery of Service 28
Section 8.3. Dental or Podiatry Care 29

PAGE

IX. ANESTHESIA AND SEDATION SERVICES 31

Section 9.1. Organization and Staffing 31
Section 9.2. Pre-operative Procedures 31
Section 9.3. Monitoring During Procedure 32
Section 9.4. Post-anesthesia Evaluations 33

X. SURGICARE CENTER 35

Section 10.1. Admission and Discharge of Patients 35

XI. EMERGENCY SERVICES 37

XII. RESTRAINTS AND SECLUSION 41

Section 11.1. Use of Restraints and Seclusion 41

XIII. MISCELLANEOUS 45

Section 12.1. Special Care Units 45
Section 12.2. Autopsies 45
Section 12.3. Treatment of Family Members 45
Section 12.4. Orientation of New Physicians 46

XIII. ADOPTION 47

APPENDIX A

APPENDIX B

APPENDIX C

ARTICLE I

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT, AND SERVICES

1.1. Admissions:

(a) A patient may be admitted to the Hospital only by a member of the medical staff or an oral surgeon who has been granted admitting privileges and who has received privileges to perform history and physician examinations on patients without medical problems. All physicians and qualified oral surgeons shall be governed by the official admitting policy of the hospital.

A podiatrist or dentist with clinical privileges, oral surgeons who do not qualify for history and physical privileges, or an oral surgeon who has a patient with medical problems may, with the concurrence of an appropriate physician member of the medical staff, initiate the procedure for admitting a patient. The concurring medical staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the Hospital for pediatric care must be given the same basic medical appraisal as patients admitted for other services.

(b) Except in an emergency, all inpatient medical records must include an admitting diagnosis. In the case of an emergency, the admitting diagnosis shall be recorded as soon as possible.

(c) Patients will be admitted based on the following order of priority:

(1) Emergency – A threat to loss of life or limb, includes obstetrics;

(2) Urgent – Could be a threat to loss of life or limb if not attended to within 48 hours.

(3) Elective – Requires medical/surgical attention, but is not a threat to loss of life or limb.

1.2. Responsibilities of Admitting Physician:

(a) The admitting physician will be responsible for the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the medical record, and necessary patient instructions.

(b) Whenever the responsibilities of the admitting physician are transferred to another physician, a note covering the transfer of responsibility will be entered on the order sheet of the patient's medical record. The admitting physician will be responsible for verifying the other physician's acceptance of the transfer.

(c) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients, or Hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm.

(d) Each patient will have two patient identifiers whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

1.3. Care of Unassigned Patients:

In the case where a patient who is evaluated by the Emergency Department requires admission and does not have an attending physician with clinical privileges at the Hospital, or has not requested that a specific member of the Medical Staff assume his or her care, the patient will be assigned to the appropriate on-call physician.

1.4. Alternate Coverage:

(a) Physicians will provide professional care for their patients in the Hospital by being available or making arrangements with an alternate member who has appropriate clinical privileges to care for their patients.

1.5. Continued Hospitalization:

(a) The attending physician will be required to routinely document the need for continued hospitalization. The attending physician's documentation must contain:

(1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the Hospital; and

(3) plans for post-hospital care.

(b) Upon request of the Care Coordination Department, the attending physician will provide written justification of the necessity for continued hospitalization for any patient. The physician should include an estimate of the number of additional days of stay, the reason for continued stay, and plans for post-hospitalization care.

ARTICLE II

MEDICAL RECORDS

2.1. Form and Retention of Records:

(a) A medical record must be maintained for each inpatient and outpatient.

(b) The attending physician will be responsible for the preparation of a timely, complete, accurate, and legible medical record for each patient under his or her care. This responsibility cannot be delegated.

(c) Only authorized individuals may make entries in the medical record.

(d) Medical records must be retained in their original or legally reproduced form for a period of at least five years.

(e) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Hospital policy.

(f) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

(g) Only those abbreviations, signs, and symbols authorized by the Medical Staff or that appear in Stedman's Abbreviations, Acronyms & Symbols will be used in the medical record. No abbreviations, signs or symbols will be used to record a patient's final diagnoses, any unusual complications, or discharge orders. An official record of approved abbreviations is listed in the Acceptable Abbreviations Policy (IMC030). The Hospital will also maintain a list of abbreviations that are not acceptable for use.

2.2. Content of Record:

(a) Medical records must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(b) Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures.

(c) All medical records, except for a short form medical record, must document the following, as appropriate:

(1) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(2) documentation and findings of assessments;

(3) conclusions or impressions drawn from the medical history and physical examination;

(4) diagnosis, diagnostic impression, or conditions;

(5) reason(s) for admission of care, treatment, and services;

(6) goals of the treatment and treatment plan;

(7) diagnostic and therapeutic orders;

(8) diagnostic and therapeutic procedures, tests, and results;

(9) progress notes made by authorized individuals;

(10) reassessments and plan of care revisions;

(11) relevant observations;

(12) response to care, treatment, and services provided;

(13) consultation reports;

(14) allergies to foods and medicines;

(15) medications ordered or prescribed;

(16) dosages of medications administered (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(17) medications dispensed or prescribed on discharge;

(18) relevant diagnoses/conditions established during the course of care, treatment, and services;

(19) complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;

(20) discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care; and

(21) final diagnosis with completion of medical records within 28 days following discharge.

(d) Medical records must contain, as applicable, the following information:

(1) patient's name, sex, address, date of birth, and name of authorized representative;

(2) legal status of patients receiving behavioral health care services;

(3) patient's language and communication needs;

(4) evidence of known advance directives;

(5) evidence of informed consent when required by Hospital policy;

(6) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail); and

(7) patient-generated information (e.g., information entered into the record over the Web or in previsit computer systems).

(e) A short form medical record may be used for patients who are in the Hospital less than 48 hours, except in the case of maternity and newborn infants. A short form medical record shall contain at a minimum the following:

(1) documentation of a history and physical;

(2) diagnosis; and

(3) any treatment and services provided.

(f) Medical records must contain evidence of:

(1) a medical history and physical examination completed no more than 30 days before or 24 hours after admission. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission (See Appendix A for countersignature requirements); and

(2) an updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

(g) For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, including:

(1) known significant medical diagnoses and conditions;

(2) known significant operative and invasive procedures;

(3) known adverse and allergic drug reactions; and

(4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

(h) Obstetrical records must include:

(1) A complete prenatal record, which may be a legible copy of the attending physician's office record transferred to the Hospital before admission; and

(2) An admission note that includes pertinent additions to the history and subsequent changes in the physical findings.

2.3. Medical Orders:

(a) All orders, including verbal orders, must be dated, timed, and authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy.

(b) Orders must be entered clearly, legibly, and completely. All orders must be authenticated by the individual issuing the order. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering physician and are understood by the appropriate health care provider.

(c) The use of the terms "renew," "repeat," "resume," and "continue" with respect to previous orders is not acceptable. (The Joint Commission Standard MM.04.01.01 Element of Performance Number 8)

(d) Orders for "daily" tests will state the number of days and will be reviewed by the ordering physician at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format in which it was originally recorded if it is to be continued.

(e) Orders for all medications and treatments will be under the supervision of the attending physician and will be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

(f) All orders must be completely rewritten when a patient is transferred from one physician to another, when a patient is transferred from the critical care unit, and when a patient emerges from surgery.

(g) No order will be discontinued without the knowledge of the ordering physician, unless the circumstances causing the discontinuation constitute an emergency.

(h) All orders for drugs and medications administered to patients will be:

(1) reviewed by the attending physician at least weekly to assure the discontinuance of all drugs no longer needed;

(2) canceled automatically when the patient goes to surgery; and

(3) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, the medication order will be reviewed by the pharmacist as soon thereafter as possible, preferably within 24 hours.

(i) All medication orders must clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or other methods. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten.

(j) See Appendix B for countersignature requirements for physician orders.

<u>2.4. Verbal Orders</u>:

(a) A verbal order (either in person or via telephone) for medication or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the responsible practitioner.

(b) Verbal orders shall identify the date and time of entry into the medical record, the names of the individuals who gave, received, and implemented the order, and shall be authenticated promptly, in accordance with time frames established by Hospital policy but no later than the next time the practitioner who gave the order is physically present at the Hospital.

(c) The following are the personnel authorized to receive and record verbal or telephone orders:

(1) a member of the Medical Staff;

(2) a professional nurse;

(3) a pharmacist who may transcribe a verbal order pertaining to medications;

(4) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(5) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

(6) a radiology technologist who may transcribe a verbal order pertaining to radiological tests and/or therapy treatments;

(7) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;

(8) a speech therapist who may transcribe a verbal order pertaining to speech therapy;

(9) a nuclear medicine technologist who may transcribe a verbal order pertaining to nuclear medicine; and

(10) a diagnostic medical sonographer who may transcribe a verbal order pertaining to diagnostic sonography.

(d) For verbal or telephone orders or for telephonic reporting of critical test results, the complete order or test result must be verified by having the person receiving the information record and "read-back" the complete order or test result.

2.5. Standing Order Protocols:

(a) For all standing orders, order sets and protocols, review and approval of the Medical Executive Committee is required. Where appropriate, input will be sought from nursing and pharmacy. Prior to approval, the Medical Executive Committee will confirm that the standing order, order sets, and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols. All standing orders, order sets and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

(b) If the use of a standing order, order set or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.

(c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

2.6. Progress Notes:

(a) Progress notes shall be written by the physician and allied health professionals, as permitted by their clinical privileges or scope of practice. 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 treatments.

(b) Progress notes will be written at least daily for all patients who have been admitted to the Hospital.

2.7. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using electronic signatures.

(b) Signature stamps will only be used when the individual whose signature the stamp represents provides the medical records department with a signed statement to the effect that he or she is the only one who has the stamp and is the only one who will use it. There will be no delegation of the use of a signature stamp to another individual.

(c) All entries in the medical record must be dated, timed, and authenticated by the person making the entry. Each entry must be individually authenticated within 48 hours.

(d) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries must be individually authenticated as set forth in this section.

2.8. Delinquent Medical Records:

(a) It is the responsibility of each physician to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.

(b) Each medical record, including short stay medical records, will be dictated within 21 days following discharge. If the record is incomplete 14 days after discharge, the medical records department will notify the physician, in writing, of the due date for completing the record. If the record remains incomplete 28 days following discharge, the physician will be notified in writing of the delinquency and that his or her clinical privileges have been automatically relinquished. The relinquishment will remain in effect until all of the physician's records are no longer delinquent.

(c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(d) Unique delinquency requirements applicable to pre-surgical H&Ps are located in Section 8.2(b) of these Rules and Regulations.

(e) Any requests for special exceptions to the above requirements will be submitted by the physician to the medical records department and considered by the Executive Committee.

(f) Except in rare circumstances, when approved by the Chief Executive Officer and the Chief of Staff, no physician or other individual will be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

ARTICLE III

CONSULTATIONS

3.1. General:

(a) Any individual with clinical privileges at the Hospital may be requested to provide a consultation within his or her area of expertise.

(b) The attending physician will be responsible for requesting a consultation when indicated. Physicians requesting an emergency (STAT) consultation shall personally contact the consulting physician when practical and feasible.

(c) If the history and physical are not part of the patient's medical record, it will be the responsibility of the attending physician to provide this information to the consultant.

(d) If a nurse employed by the Hospital 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, that nurse will notify his or her superior who, in turn, may refer the matter to the Director of Nursing Services and/or Vice President of Patient Services. The Director of Nursing Services and/or Vice President of Patient Services may bring the matter to the attention of the Chairman of the Section in which the member in question has clinical privileges. Thereafter, the Chairman of the Section may request a consultation after discussion with the attending physician.

(e) In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Executive Committee, the Board, the Chief Executive Officer or the Chief of Staff, the appropriate clinical service chief will at all times have the right to call in a consultant or consultants.

3.2. Required Consultations:

(a) Consultations will be required in all non-emergency cases whenever requested by the patient or the patient's representative, if the patient is incompetent.

(b) Except in an emergency, consultations are also required in all cases which, in the judgment of the attending physician:

(1) The patient is not a good risk for operation or treatment;

(2) The diagnosis is obscure after ordinary diagnostic procedures have been completed;

(3) There is doubt as to the best therapeutic measures to be used;

(4) Unusually complicated situations are present that may require specific skills of other practitioners;

(5) The patient exhibits severe symptoms of mental illness or psychosis; or

(6) As required by clinical privileges granted to a physician.

3.3. Contents of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record.

(b) Where non-emergency operative procedures are involved, the consultant's report or conclusion must be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

3.4. Psychiatric Consultations:

Psychiatric consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

3.5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, the anesthesiologist or anesthetist will ascertain that an adequate notation of the consultation, including relevant findings and reasons, appears in the patient's medical record. If it does not so appear, surgery and anesthesia will not proceed. It is the responsibility of the surgeon to confirm the consultation has occurred.

3.6. Mandatory Consultations:

(a) When, as a result of peer review activities, a consultation requirement is imposed by the Executive Committee, or the Board, the required consultation will not be rendered by an associate or partner of the attending physician.

(b) Failure to obtain mandatory consultations may result in a further professional review action.

ARTICLE IV

INFORMED CONSENT

4.1. Responsibility for Obtaining Informed Consent:

(a) The Hospital's admission consent form must be signed by the patient or the patient's representative at the time of admission. The admitting office shall notify the attending physician whenever such consent has not been obtained.

(b) After admission, it shall be the responsibility of the attending physician to obtain consent from the patient in the following circumstances:

(1) a consent form verifying that the physician has explained the procedure, including its risks, benefits, and alternatives, will be presented to the patient or the patient's legal representative by a member of the hospital staff. The hospital staff member will only serve as a witness to the patient's voluntary consent, acknowledged by the patient's signature on the consent form;

(2) the patient's voluntary consent to the administration of anesthesia will be witnessed by a member of the hospital staff after verification that the anesthesiologist has explained the risks, benefits, and alternatives of the anesthesia to be provided.

(c) Except in emergencies, a failure to include a completed consent form in the patient's medical record prior to the performance of a surgical or diagnostic procedure shall automatically cancel the surgery or procedure.

(d) Whenever the patient's condition prevents the obtaining of consent, every effort shall be made and documented to obtain the consent of the patient's representative prior to the procedure or surgery, and such effort shall be documented in the patient's medical record. Any emergencies involving a minor or otherwise incompetent patient in which consent for surgery cannot be immediately obtained from parents, legal guardian, durable power of attorney, or appropriate next of kin should be fully explained on the patient's medical record and attested to by another physician. If possible, a consultation shall be obtained before any operative procedure is undertaken.

(e) Should a second operation be required during the patient's stay at the Hospital, a second consent shall be obtained. If two or more specific procedures are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

4.2. Definitions:

The following definitions shall be applied when obtaining consent to treatment:

(a) "Informed Consent" means consent obtained from the patient or the patient's representative after being informed by the attending physician of the nature, benefits, risks and alternatives to the proposed treatment.

(b) "Emergency" means a situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent would further jeopardize the life, health or safety of the patient.

(c) "Emancipated Minor" means an individual over the age of 16 years who is living as an adult or who:

(1) has been or is married; and/or

(2) has been declared emancipated by a court.

4.3. Who May Consent:

(a) A competent adult or emancipated minor may authorize any medical or surgical procedure to be performed on his or her body, and the consent of no other person shall be required or shall be valid. Emancipated minors can consent on their own behalf and on behalf of their children.

(b) Written consent shall be obtained from the parents or legal guardian of a non-emancipated minor before any surgical or medical procedure is performed on the minor, except in the following cases, in which minors may consent for their own care:

(1) emergencies;

(2) minors seeking treatment for venereal disease, substance or alcohol abuse, or AIDS; and

(3) pregnant minors seeking care related to their pregnancy.

(c) Written or telephone consent shall also be obtained in all non-emergency situations from the legal representative of any incompetent adult before any surgical or medical procedure is performed.

4.4. <u>Incompetent Patients</u>:

Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a patient has been declared incompetent by a court, a consent form signed by the court-appointed legal guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the patient involved, the consent of the patient's legal representative shall be obtained.

4.5. <u>Unusual Cases</u>:

(a) When questions arise regarding patient consent or when unusual circumstances occur not clearly covered by these rules and regulations, the attending physician shall promptly confer with hospital management concerning such matters. The Hospital will make every effort to assist the attending physician in obtaining the required consent and provide information relative to such matters. However, it is the ultimate responsibility of the attending physician to comply with the requirements contained in these rules and regulations.

(b) Telephone consent shall be permissible when a delay in obtaining consent on behalf of an incompetent individual or a minor would result in harm to the individual, or where it is impractical to obtain a written consent to convey the information necessary to make an informed consent in person.

(1) In such a case, the physician who will perform the procedure or provide the treatment shall, in the presence of at least one witness who is on the line with the physician, convey the information via telephone at the same time. If telephone consent is given, the physician giving the information must document in the medical record exactly what was told to the patient's

representative and must date/time and sign such notation. The witness shall sign the note as well, certifying that he or she heard the information being transmitted by the physician and heard the patient's representative give consent.

(2) If telephone consent is granted, it will be noted in the patient's medical record.

(c) Clinical Services may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such form shall become effective when approved by the Executive Committee.

4.6. Refusal to Consent:

(a) A patient or, if incompetent, the patient's representative retains the right to refuse medical treatment, even in an emergency situation. If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form should be executed and, if possible, signed by the patient. Such form(s) shall be kept in the patient's medical record.

(b) Any patient with psychiatric problems who refuses to consent to care may be held at the Hospital in an appropriate observation or treatment area for a designated period of time if such psychiatric hold is determined to be in the best interest of the patient and meets applicable state law/regulation criteria for such detention.

ARTICLE V

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

5.1. Who May Discharge:

Patients will be discharged only upon an order of the attending physician. Should a patient leave the Hospital against the advice of the attending member, or without proper discharge, a notation of the incident will be made in the patient's medical record, and the patient will be asked to sign the Hospital's release form.

5.2. Identification of Patients in Need of Discharge Planning:

(a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning shall be identified at an early stage of hospitalization.

(b) Criteria to be used in making this evaluation include:

(1) functional status;

(2) cognitive ability of the patient; and

(3) family support.

5.3. Discharge Planning:

(a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. When the Hospital's personnel determine no discharge planning is necessary in a particular case, that conclusion must be noted on the medical record of the patient.

(b) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

5.4. Discharge Summary:

(a) A concise discharge summary providing information to other caregivers and facilitating continuity of care shall include the following:

(1) reason for hospitalization;

(2) significant findings;

(3) procedures performed and care, treatment, and services provided;

(4) condition at discharge; and

(5) information provided to the patient and family, as appropriate.

(b) The discharge summary shall be recorded by the discharging physician unless documentation in the physician discharge note states otherwise. Countersignature requirements for discharge summaries appear in Appendix C.

5.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

ARTICLE VI

TRANSFER OR DISCHARGE

6.1. Discharge or Transfer:

(a) The process for ensuring continuing care after transfer or discharge includes:

(1) assessing the reason(s) for transfer or discharge;

(2) establishing the conditions under which transfer or discharge can occur;

(3) assessing how to shift responsibility for a patient's care from one clinician, organization, organizational program, or service to another (which could include transferring complete responsibility for the patient and his or her care to others or referring the patient to others, such as one or more agencies or professionals, to provide one or more specific services);

(4) evaluating mechanisms for internal and external transfer; and

(5) ensuring that both the hospital initiating the transfer and the organization receiving the patient assume accountability and responsibility for the patient's safety during transfer.

(b) Patients will be transferred or discharged, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

6.2. Procedures:

(a) Patients shall be transferred or discharged to another level of care, treatment, and/or services, different professionals, or different settings based on the patient's needs and the Hospital's capabilities. The physician shall:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients, in a timely manner, of the need to plan for a discharge or transfer to another organization or level of care;

(3) involve the patient and all appropriate licensed independent practitioners, staff, and family members involved in the patient's care, treatment, and services in the planning for transfer or discharge;

(4) provide the following information to the patient whenever the patient is transferred or discharged:

(i) the reason for the transfer;

(ii) available alternatives to the transfer; and

(iii) in the case of discharge, the anticipated need for continued care;

(5) initiate the discharge planning process early in the care, treatment, and services process;

(6) educate the patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated;

(7) arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated; and

(8) give written discharge instructions, in a form the patient can understand, to the patient and/or those responsible for providing continuing care.

(b) When patients are transferred or discharged, appropriate information related to the care provided shall be exchanged with other service providers, including:

(1) the reason for transfer or discharge;

(2) the patient's physical and psychosocial status;

(3) a summary of care provided and progress toward goals; and

(4) community resources or referrals provided to the patient.

(c) In-house transfer priorities shall be as follows:

(1) Emergency Department to an appropriate patient bed.

(2) SDU/ICU/CCU to appropriate care area.

(3) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

(d) A transfer form will be filled out for all patients being transferred to another hospital. The certification of the risks and benefits may be signed by a physician assistant, nurse practitioner, certified nurse midwife or registered nurse, if done so in consultation with a physician, who will countersign the certification within 24 hours.

ARTICLE VII

PHARMACY

7.1. General Rules:

(a) Whenever available, an on-site pharmacist will prepare intravenous solutions with additives, diluent, or dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. These solutions/doses may be prepared by the appropriate staff or physician whenever the on-site pharmacist is not available, in emergencies, or when preparation by the on-site pharmacist is not feasible (such as when the product's stability is short). Each drug dose will be recorded in the patient's medical record noting the date and time, and properly signed after the drugs have been administered.

(b) The use of investigational or experimental drugs in clinical investigations shall be subject to the rules established by the Executive Committee and the Institutional Review Board and as outlined in the approved Hospital formulary.

7.2. Drug Preparation:

(a) Drugs and biologicals must be prepared and administered in accordance with federal and state laws, the order of the practitioner responsible for the patient's care, and accepted standards of practice.

(b) All orders for drugs and biologicals must be in writing and signed by the practitioner responsible for the care of the patient, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per Hospital policy after an assessment for contraindications. Verbal orders shall only be used in accordance with Section 2.4.

(c) Blood transfusions and intravenous medications must be administered in accordance with state law and approved policies and procedures. If blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel must have special training for this duty.

(d) Transfusion reactions, adverse drug reactions, and errors in administration of drugs must be reported to the attending physician and director of pharmaceutical services, if appropriate, documented in the patient's medical record, and referred to the Hospital's quality assessment and/or performance improvement programs

for investigation using current and readily accessible drug and patient information.

7.3. Delivery of Services:

(a) In order to facilitate the delivery of safe care, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with federal and state law.

(1) All drugs and biologicals must be kept in a secure area, and locked when appropriate.

(2) Drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 must be kept locked within a secure area.

(3) Only authorized personnel may have access to locked areas.

(b) Drugs and biologicals not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time.

(c) Drug administration errors, adverse drug reactions, and incompatibilities must be immediately reported to the attending physician and, if appropriate, to the hospital-wide quality assurance program.

(d) Abuses and losses of controlled substances must be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer, as appropriate.

(e) Information relating to drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration must be available to members of the Medical Staff and other practitioners.

7.4. Self-Administration of Medication:

(a) The self-administration of medications (either hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:

(1) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

(2) a practitioner responsible for the care of the patient has issued an order for their administration;

(3) in the case of a patient's own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and

(4) the patient's first self-administration is monitored to determine whether additional instruction is needed on the safe and accurate administration of the medications.

(b) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(c) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.

(d) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

7.5. Stop Orders:

A "STOP" order drug policy will be in effect and will apply, among others, to depressant and stimulant drugs and antibiotics. Orders will be automatically discontinued on all oxytoxics after 24 hours; narcotics (BNDD Schedule II) after 48 hours; all soporifics and sedatives (BNDD Schedules II, III, IV), anticoagulants, corticosteroids and antibiotics after seven days; and all other medications after 14 days. Inhalation therapy treatments will automatically be discontinued after three days. Notwithstanding the above, a physician is permitted to order any drug for a specific length of time so long as the length of time is clearly stated in the orders.

ARTICLE VIII

SURGICAL SERVICES

8.1. Organization and Staffing:

(a) The Operating Room manager will be responsible for the administrative supervision of the operating room and will have the authority to plan and execute the daily operating room schedule in order to make maximum efficient use of the operating room and the anesthesia service.

(b) The surgical service must maintain a roster of physicians specifying the surgical privileges of each physician and the operating room register must be complete and up-to-date.

8.2. Delivery of Service:

(a) The physician responsible for the patient's care shall thoroughly document in the medical record the provisional diagnosis and the results of any indicated diagnostic tests before the operative procedure.

(b) A complete history and physical examination, as outlined in the Medical Staff Bylaws, and properly executed informed consent form must be in the patient's chart prior to the scheduled start time of surgery, except in emergencies. A surgeon who fails to comply with this requirement three times in a 13-week period will be ineligible to schedule cases in his or her service block for the next 13 weeks (all cases must be scheduled under the 96-hour rule).

(c) There must be adequate provisions for immediate post-operative care.

(d) All tissues removed during the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

(e) An operative procedure report must be dictated or written immediately after an operative procedure and must record:

(1) the name of the physician(s) responsible for the patient's care and assistants;

(2) procedure(s) performed and description of the procedure(s);

(3) findings;

(4) estimated blood loss;

(5) specimens removed; and

(6) post-operative diagnosis.

If a full report cannot be entered into the record immediately after the operation or procedure, a progress note containing the above information must be entered in the medical record immediately after the procedure.

(f) The completed operative procedure report must be authenticated by the physician responsible for the care of the patient and made available in the medical record as soon as possible after the procedure.

(g) The use of approved discharge criteria to determine the patient's readiness for discharge must be documented in the medical record.

8.3. Dental or Podiatry Care:

(a) If the patient is under the supervision of a podiatrist or an oral surgeon without history and physical privileges, or if the patient to be admitted has medical problems, then the responsibility for the patient is a dual responsibility involving physician members of the Medical Staff.

(b) If an oral surgeon has received privileges to perform the history and physical for the patient and has determined that the patient does not have any medical problem, then the oral surgeon may admit the patient without a concurrent physician.

(c) A detailed operative report must be prepared by the dentist/podiatrist/oral surgeon.

(d) Progress notes must be written giving pertinent information about the affected area.

(e) The written discharge order and any required discharge summary are the responsibility of the dentist/podiatrist/oral surgeon.

(f) The physician's responsibilities are:

(1) a medical history pertinent to the patient's general health;

(2) a physician examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

ARTICLE IX

ANESTHESIA AND SEDATION SERVICES

9.1. Organization and Staffing:

(a) The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by:

(1) a qualified anesthesiologist;

(2) a doctor of medicine or osteopathy (other than an anesthesiologist);

(3) a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law; or

(4) a certified registered nurse anesthetist (CRNA).

(b) A sufficient number of qualified staff (in addition to the individual performing the procedure) must be present to evaluate the patient, help with the procedure, provide the sedation and/or anesthesia, and monitor and recover the patient.

9.2. Pre-operative Procedures:

(a) The following must occur before the operative and other procedures or the administration of moderate or deep sedation or anesthesia occurs:

(1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedure care;

(2) preprocedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(3) a licensed independent practitioner, with appropriate clinical privileges, plans or concurs with the planned anesthesia before sedating or anesthetizing a patient;

(4) the patient is identified by the circulating nurse and the anesthetist by answering to his or her spoken name and checking the patient's arm bracelet;

(5) patient is not anesthetized until the surgeon is in the hospital and his or her whereabouts are known to the OR Coordinator and/or the OR Nurse Manager; and

(6) the patient is reevaluated immediately before moderate or deep sedation and before anesthesia induction to assess the patient's mental status, perform an examination specific to the proposed procedure and to any co-morbid conditions, document the results of an auscultatory examination of the heart and lungs, and assess the patient's general health.

(b) A preanesthesia evaluation shall be recorded in the medical record by an individual qualified to administer anesthesia at least 48 hours prior to surgery. (42 C.F.R. 482.52 (b) of the Medicare Conditions of Participation) The evaluation will include information to determine the capacity of the patient to undergo anesthesia and to formulate an anesthesia plan, a review of objective diagnostic data, an interview with the patient regarding his or her medical, anesthetic and drug history, a review of the patient's physical status, and the name of the physician or other licensed independent practitioner who has concurred with the selection of anesthesia or sedative.

9.3. Monitoring During Procedure:

(a) All patients shall be monitored during the procedure and/or administration of moderate or deep sedation or anesthesia. Appropriate methods shall be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

(b) Monitoring shall be at a level consistent with the potential effect of the procedure and/or sedation or anesthesia.

(c) All events taking place during the induction and maintenance of, and the emergence from, anesthesia and sedation, shall be documented in the medical record, including:

(1) the dosage and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(4) unusual events during the anesthesia period; and

(5) the status of the patient at the conclusion of anesthesia.

9.4. Post-anesthesia Evaluations:

(a) Patients shall be monitored immediately after the procedure and/or administration of moderate or deep sedation or anesthesia.

(1) A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. (42 C.F.R. 482.52 (b) of the Medicare Conditions of Participation)

(2) Post-anesthesia evaluation and follow-up will be conducted upon admission to and discharge from the post-anesthesia recovery area to evaluate the patient for proper anesthesia recovery. A post-anesthesia evaluation note will be documented in the patient's medical record by an individual qualified to administer anesthesia within 48 hours after surgery. The post-anesthesia evaluation note will include:

(i) the patient's physiological and mental status and pain level immediately following the procedure, including the patient's vital signs and level of consciousness;

(ii) medications (including intravenous fluids) administered, including blood and blood products;

(iii) all drugs administered;

(iv) post-anesthesia visits by the anesthesiologist or anesthetist;

(v) any unusual events or post-operative complications, including any blood transfusion reactions, and the management of those events; and

(vi) the name of the practitioner responsible for discharge.

(b) The number of post-anesthesia visits will be determined by the status of the patient in relation to the procedure performed and anesthesia administered. The

anesthesiologist or anesthetist will examine the patient early in the post-operative period and once after complete recovery from anesthesia. Complete recovery will be determined by the clinical judgment of the anesthesiologist or anesthetist, or the discharging surgeon.

(c) Patients shall be discharged from the recovery area and the Hospital by a qualified licensed independent practitioner or according to rigorously applied criteria approved by the clinical leaders. Post-operative documentation shall record the patient's discharge from the post-sedation or post-anesthesia care area and record the name of the individual responsible for discharge.

(d) Patients who have received sedation or anesthesia in an outpatient setting shall be discharged to the company of a responsible, designated adult.

(e) When surgical or anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

(f) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

ARTICLE X

SURGICARE CENTER

10.1. Admission and Discharge of Patients:

a) The SurgiCare Center shall accept patients for care and treatment on a selective outpatient basis, except for those with diseases or conditions considered incompatible with safe outpatient surgery. Patients may be treated only if they are deemed to be of acceptable status by the appropriate physician(s).

b) A patient may be admitted to the SurgiCare Center only by a qualified staff member who has received privileges in accordance with the qualifications for the Medical Staff membership of the Monongalia General Hospital.

c) In the case of an emergency and/or delayed or unacceptable patient recovery from anesthesia, a patient may be admitted to the Hospital and a provisional diagnosis or valid reason for admission must be stated as soon as possible.

d) In any emergency or other case on which it appears the patient will have to be admitted to the Hospital, the physician shall, when possible, first contact the Hospital admitting officer to secure an available bed.

e) Each physician/staff member must secure timely, adequate professional post-op care for his patients in the SurgiCare Center by being available, or having an eligible alternate physician with whom prior arrangements have been made and who has at least appropriate clinical privileges.

f) Each patient admitted to the SurgiCare Center shall have testing performed on them only on written orders of an involved physician.

g) Only those procedures included on the list of operative and diagnostic procedures shall be performed in the SurgiCare Center.

h) The admitting physician shall be responsible for giving such information and instructions as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others.

i) Patients shall be discharged from the SurgiCare Center only on the written order of a physician. Should a patient leave the SurgiCare Center against the advice of a

physician or without proper discharge, a notation shall be made in the patient's medical record. An AMA form will be completed.

j) Should it become necessary to attend the patient of any physician in an emergency, the SurgiCare Center is free to call in any member of the medical staff after a reasonable effort has been made to locate the attending physician.

k) Patients who are unable to be discharged from the SurgiCare Center 30 minutes prior to the closing of the center will be transferred to the Hospital or other suitable facility.

ARTICLE XI

EMERGENCY SERVICES

(a) All patients seeking emergency care (presenting for a non-scheduled visit) will be given, at a minimum, a medical screening examination. This examination may be done by an appropriately privileged physician, oral surgeon, physician assistant, nurse practitioner, or certified nurse midwife. In the case of obstetrical patients, a RN may conduct the medical screening examination with consultation by an obstetrician or certified nurse midwife, which may be in person or by phone. (Refer to Administrative Policies: 1) Patient Transfer; 2) Emergency Screening Examination and Emergency Medical Condition Requirements.)

(b) The medical staff shall adopt a method of providing medical coverage in the Emergency Department area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians with overall responsibility for emergency medical care.

(c) An Emergency Department physician shall be a permanently licensed physician whose practice in the hospital is limited to the treatment of Emergency Department patients, solely when on duty in the Emergency Department.

(1) Applications for appointment and reappointments shall be in the same manner as applicants for the active staff. Peer review procedures may be initiated for any emergency service physician, with the right to a hearing and appeal, in accordance with the Credentials Policy for Medical Staff Members.

(2) Clinical privileges - Emergency Service physicians are expected to see all types of patients who come to the Hospital's emergency service. It is recognized that some patients will be seen who require treatment outside the scope of competence and training of the individual emergency service physician. These patients will then be transferred to a physician on the active staff that has the professional competence to treat these patients. An "on-call" rotation list by section shall be provided by the chief of section. In the event that competent care is not available, the patient should be transferred to the proper institution or center for care.

(4) Emergency service physicians do not have admitting privileges. In emergencies, emergency service physicians may treat in-patients. Emergency service physicians may attend any hospital educational program.

(5) Emergency service physicians may not engage in the private practice of medicine while on duty, and members of the medical staff may not sign out to the physicians in the emergency service.

(6) If a stable patient requests, a private physician will be called before the Emergency Department physician sees the patient.

(d) The duties and responsibilities of all personnel servicing patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multi-specialty committee of the medical staff, including representatives from nursing service and hospital administration. When approved by the Medical Staff and by the Board of Directors, it shall be appended to this document.

(e) An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

(1) Adequate patient identification;

(2) Information concerning the time of the patient's arrival, means of arrival, and by whom transported;

(3) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;

(4) Description of significant clinical, laboratory, and roentgenologic findings;

(5) Diagnosis;

(6) Treatment given;

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

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

(f) Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy.

(g) There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes at least five members of the Medical Staff, the director of nursing services or her designee, and a representative from hospital administration. When approved by the Medical Staff and Board of Directors, the plan shall be readily available in the Medical Staff Office.

(h) The disaster plan should make provisions within the Hospital for:

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

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

(3) Unified medical command under the direction of a designated physician;

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

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

(6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved;

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

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

(9) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.

(i) All physicians shall be assigned to posts either in the Hospital or in the auxiliary hospital, or in mobile casualty stations and it is their responsibility to report to their assigned stations. The chief of the clinical services in the Hospital and the Chief Executive Officer of the Hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from Hospital premises, the chief of the clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the service chiefs and the Chief Executive Officer of the Hospital. In their absence, the vice chiefs and alternate in administration are next in line of authority, respectively.

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

ARTICLE XII

RESTRAINTS AND SECLUSION

11.1. Use of Restraints and Seclusion:

(a) Restraint or seclusion may be used only when clinically justified and when alternatives are not effective.

(1) Restraint is defined as:

- any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

- a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(2) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(b) Restraint or seclusion is never to be used as a means of coercion, discipline, convenience, or retaliation. They may only be used to ensure the immediate physical safety of the patient, staff, or others. They must be discontinued at the earliest possible time, regardless of the length of time identified in the original order.

(c) Restraint or seclusion may be used to support or promote healing and/or for the management of violent or self-destructive behavior to prevent harm to self or others.

(d) Restraint or seclusion may only be initiated pursuant to a physician order or order of another appropriately trained licensed independent practitioner ("LIP"). If a physician or other appropriately trained LIP is not available, a registered (professional) nurse may initiate restraint or seclusion because of a significant change in the patient's condition and shall contact a physician or LIP immediately to obtain an order from the practitioner. That order must immediately be recorded in the patient's record.

(e) A physician or LIP must physically examine the patient (face-to-face) within one hour after the restraint or seclusion is initiated and, at that time, place a written order in the patient's record. When restraints or seclusion are used, the physician or LIP must see the patient face-to-face within one hour even if the restraints have been removed before he/she arrives. The physician or LIP:

- reviews the patient's physical and psychological status with the staff;
- works with the patient and staff to identify ways to help the patient regain control;
- makes any necessary revisions to the patient's treatment plan; and
- if necessary, provides a new written order.

(f) Physicians and LIPs shall take into consideration each patient's physical and psychological condition when writing orders for restraint or seclusion. When possible, the method of restraint or seclusion shall be selected so as to minimize any detrimental effect that the patient might experience, and the lowest level of restraint or seclusion shall be implemented. All orders for restraint or seclusion shall be implemented in accordance with safe and appropriate techniques.

(g) When possible, at the time of the restraint or seclusion, or as soon as possible thereafter, the physician or other LIP ordering the restraint or seclusion shall inform the patient and/or his or her family of the need for the use of restraint or seclusion, the method of restraint or seclusion that was selected, and any other pertinent information related to the restraint or seclusion. If the patient has objected to having his or her medical condition discussed with his or her family, there will be no discussion with the family.

(h) An assessment of a restrained or secluded patient's condition shall be made at least once every two hours, and more frequently if directed by the attending

physician or indicated by the patient's condition. When restraints or seclusion are applied for behavioral reasons, the patient must be monitored through continuous in-person observation and an assessment must be documented every 15 minutes. The assessment must be documented in the patient's record and shall address the following: injury associated with the restraint or seclusion, nutrition and hydration, circulation and range of motion in the extremities, vital signs, as appropriate, hygiene and elimination, physical and psychological status and comfort, the possibility of downgrading to a less restrictive method of restraint or seclusion, and readiness for discontinuation of restraint or seclusion.

(i) An order, based on a face-to-face examination by the physician, must be written each calendar day. The order cannot be PRN. Restraints or seclusion used for behavioral reasons shall be limited to emergency use and the patient should be transferred as soon as possible to an appropriate health care facility. The written order for restraint or seclusion is limited to a maximum of:

- Four hours – adults
- Two hours – adolescents, ages nine – 17
- One hour – children under age nine

When the original order expires, a verbal order from the physician or LIP must be obtained to continue the order for four hours for an adult, two hours for adolescents, and one hour for children. At the eighth hour for an adult, fourth hour for an adolescent and second hour for children under nine years of age, the physician or LIP must conduct an in-person evaluation. The cycle for in-person evaluation will continue for as long as restraints or seclusion are required.

(j) The following shall be documented in the patient's medical record:

(1) the one-hour, face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others;

(2) a description of the patient's behavior and the intervention used;

(3) alternatives or other, less restrictive interventions attempted (as applicable);

(4) the patient's condition or symptoms that warranted the use of the restraint or seclusion; and

(5) the patient's response to the interventions, including the rationale for continued use of the intervention.

(k) Reporting:

(1) Except for the deaths described in (2), below, any death that occurs while a patient is restrained or secluded, within 24 hours after removal from restraint or seclusion, and within one week after restraint or seclusion where it is reasonable to assume that the use of restraints or seclusion directly or indirectly contributed to a patient's death will be reported to the Centers for Medicare and Medicaid Services ("CMS"). Reports of a patient's death must be made by phone, fax, or other electronic means to the CMS regional office by the close of the next business day. The date and time of the call must be documented in the medical record.

(2) Patient deaths occurring during the use of, or within 24 hours of the removal of, soft-restraints applied exclusively to the patient's wrist(s) will be recorded in an internal log or other system within seven days of the patient's death. The following information will be recorded in the internal log or other system:

(i) the date and time the death was recorded in the internal log;

(ii) the patient's name and date of birth;

(iii) the date of the patient's death;

(iv) the name of the attending physician or other practitioner responsible for the care of the patient;

(v) the patient's medical record number; and

(vi) the patient's primary diagnosis(es).

The information contained in the internal log or other system will be made available in either written or electronic form to CMS immediately upon request.

ARTICLE XIII

MISCELLANEOUS

12.1. Special Care Units:

For special care units such as recovery rooms, intensive care units of all kinds, coronary care units, newborn nurseries, and areas of therapy, appropriate committees of the Medical Staff should adopt specific regulations. These regulations should be subject to the approval of the Executive Committee and the Board of Directors in the same manner as service rules and regulations.

12.2. Autopsies:

(a) The Medical Staff should attempt to secure autopsies in accordance with state and local laws. The attending physician must be notified when an autopsy is to be performed.

(b) The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by the attending physician or other designated member of the Medical Staff.

(c) Provisional anatomic diagnoses shall be recorded in the medical record within 48 hours and the complete protocol should be made part of the medical record within 30 working days for a simple case and within three months for a complex case.

(d) Death certificates are the responsibility of the attending physician and must be completed within 24 hours of death or birth in the case of fetal death, if the period of gestation is greater than 20 weeks.

(e) The Medical Staff shall be actively involved in the assessment of the use of developed criteria for autopsies.

12.3. Treatment of Family Members:

(a) No member of the Medical Staff will admit or treat a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise

approved by the Chief of Staff or the relevant Department Chief. This prohibition is not applicable to in-laws or other relatives.

(b) An exception to this prohibition will be made if the patient's disease is so rare or exceptional and the physician is considered an expert in the field or in an emergency situation.

12.4. Orientation of New Physicians:

(a) Each new physician will be assigned by the appropriate Department Chief to a member of the Medical Staff for purposes of orientation to the Hospital and its environment.

(b) The Hospital medical records department and nursing service will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties

(c) The Corporate Compliance Officer will orient each new physician as to the Hospital's Corporate Compliance Program.

ARTICLE XIV

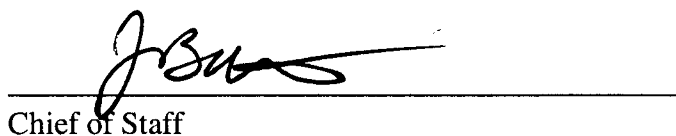
ADOPTION

These rules and regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

They may be amended pursuant to the process set forth in the Medical Staff Bylaws.

Adopted by the Medical Staff on:

Date: 3-12-14



Chief of Staff

Approved by the Board on:

Date: 4-1-14

Chairperson, Board of Directors

APPENDIX A

COUNTERSIGNATURE VS
NO COUNTERSIGNATURE BY STATUS – H&P

STATUS	NEEDS COUNTERSIGNED BY MD	DOES NOT NEED COUNTERSIGNED BY MD
Physician Assistants	X	
Midwives		X
Fellows	X	
Residents	X	
Students	X	
Nurse Practitioners	X	

APPENDIX B

COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS – PHYSICIAN ODERS

STATUS	NEEDS COUNTERSIGNED BY MD	DOES NOT NEED COUNTERSIGNED BY MD
Physician Assistants	X	
Midwives		X
Fellows		X
Residents		X
Students	X	
Nurse Practitioners	X	

APPENDIX C

COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS – DISCHARGE SUMMARY

STATUS	NEEDS COUNTERSIGNED BY MD	DOES NOT NEED COUNTERSIGNED BY MD
Physician Assistants	X	
Midwives		X
Fellows	X	
Residents	X	
Students	X	
Nurse Practitioners	X	