Sterling, Colorado

RULES AND REGULATIONS OF THE MEDICAL, DENTAL AND PODIATRIC STAFF

SECTION 1
GENERAL MEDICAL REQUIREMENTS

A. **Admissions:**

1. **General:**

a. Patients may be admitted to the hospital only by those Medical Staff members who have specifically delineated admitting privileges.

EXCEPTION: Another Medical Staff member, with limited privileges, may admit a patient "for another physician", if this second physician (1) has delineated admitting privileges, and (2) agrees to assume care of the patient being admitted by the first physician.

The intent of this exception is, for example, to allow an emergency department physician to admit "to the patient's primary physician", or an "on call" physician to admit "for the patient's primary physician", or a member of a group practice to admit for another member of that group, etc.

b. At the time of admission, the name of the admitting Medical Staff member must be delineated in writing. This "admitting" physician then becomes the patient's "attending" physician except where the admission falls into the category under the exception to A.1.a above, in which case, the "second" physician is the patient's "attending" physician.

c. At the time of admission, the patient's provisional diagnosis must be delineated in writing.

d. The attending physician must physically assume care of the patient within 24 hours of the time of admission, and the date and time of this initial visit must be documented in the medical record in the minimum form of a progress note.

EXCEPTION 1: In the event that an "on call" physician (who might be the "admitting" but not the "attending" physician, see 1.A.b above), with appropriate privileges, is actively caring for the patient, this 24 hour time limit for the attending physician to assume care may be extended to 48 hours. However, if the attending physician has not assumed care by 48 hours, then a "new" attending physician, with appropriate privileges and with the patient's permission, may be delineated in writing. This "new" attending physician must then assume active care within the 24 hour limit.

The intent of this exception is to assure that at the end of 48 hours of care being rendered by an "on call" physician, that a specific decision is made regarding which Medical Staff member is primarily responsible for the care of the patient, and if this "attending" physician responsibility continues to rest with the "on call" physician, then the "attending" physician responsibility shall be assumed by this "on call" physician (or transferred to another physician).

EXCEPTION 2: At such time that a patient is admitted (or transferred to the Intensive Care Unit, the attending physician must physically assume care of the patient within 4 hours of the time of admission (or transfer), and the date and time of this initial visit must be documented in the medical record in the minimum form of a progress note (see above exception regarding the time limits for the assumption of care by the attending physician from and "on call" physician).

e. H&Ps performed up to thirty days before admission may be used in the medical record. All history and physical reports completed prior to the patient's admission must be updated within 24 hours of the patient's admission and prior to surgery.

   Contents of H&P:

   For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal, or epidural anesthesia, the H&P must include the following documentation as appropriate:

   1. Medical history
   2. Physical examination: current physical assessment
   3. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
   4. Initial plan: statement of the course of action planned for the patient while in the hospital. For obstetrical patients (inpatient):
   5. If there is a prenatal record available at the time of admission, completion of the "Provider History" section of the "Labor-Delivery Summary" will constitute an appropriate H&P
   6. If there is no prenatal record available, a complete H&P must be documented.

f. A medical record shall be initiated, and shall include at a minimum, those requirements specified in 1.B.

g. In the event that a patient presents to the emergency department for treatment, and in the judgment of the emergency department physician needs admission to the hospital, and if said patient has "their own physician" on the Medical Staff of Sterling Regional MedCenter, then "their own" physician shall assume the care of the patient, or care shall be assumed by this physician's "on call" physician until the primary physician assumes direct care, again adhering to the provisions of A.1.d above.

EXCEPTION: If said patient does not have "their own physician" on the Medical Staff of Sterling Regional MedCenter, then the emergency department "on call" physician shall assume the care of said patient, with the patient's permission, in accordance with the above rules.

a. **Obstetrics:**

b. Same as A.1.a above.

e. Same as A.1.b above.

f. Same as A.1.c above.

1. The attending physician must physically assume care of the patient within 6 hours of the time of admission and the date and time of this initial visit must be documented in the medical record in the minimum form of a progress note.

EXCEPTION: Same as Exception 1 to A.1.d above, substituting 6 hours for 24 hours.

2. Same as A.1.e above.

3. In addition to the requirements specified in 1.B, the hospital "obstetrical" medical record shall include, when available, a complete prenatal record. Prenatal record may be a legible copy of the attending physician's office record, transferred to the hospital no later than 24 hours after delivery. This prenatal record shall contain, at a minimum, the following:

a. Name and address of the attending physician.

b. Patient's full name and date of birth.

c. The progress of the patient over the prenatal course (for which records are available to include:

1. appropriate weights and measurements

2. appropriate blood pressure readings

3. copies of appropriate laboratory records to include the following:

4. ABO and Rh

g. Antibody screen (and antibody identification if positive)

3. Rubella

a. Syphilis serology

These laboratory records must include the name and address of the laboratory performing the work as well as the date of the testing and the patient's name. In the event that these records do not include this information, or the work was not done at a laboratory approved by the U.S. department of Health and Human Services, the above testing will be performed by the hospital laboratory when requested by the nursing service under the authority of this standing order.

b. Same as A.1.a above.

c. **Surgery**

d. Same as A.1.a above.

e. Same as A.1.b above.

f. Same as A.1.c above.

1. Same as A.1.d above.
2. Same as A.1.e above.
3. In addition to the requirements specified in 1.B, the following additional requirements apply to "surgical" patients undergoing operative procedures (also see Section 2 for anesthesia requirements):
4. The individual practitioner who is responsible for the patient shall record and authenticate in the medical record a preoperative diagnosis prior to the initiation of the operative procedure.

g. The above individual shall record (or dictate, see exception below) and authenticate in the medical record a complete history and physical examination prior to the initiation of the operative procedure.

EXCEPTION 1: In the event that the history and physical examination have been completed and dictated but they have not been transcribed into the medical record by the time of the initiation of the operative procedure, then the above individual shall make a written entry in the medical record indicating that the history and physical examination have been completed and dictated.

EXCEPTION 2: In the event that the history and physical examination have not been dictated or recorded in the medical record by the time of initiation of a non-elective operative procedure, and in the opinion of the above individual that delaying the initiation of the procedure to complete the above requirement would be detrimental to the patient's welfare, then the above individual shall record this opinion in the medical record before the initiation of the procedure.

B. Immediately following an operative procedure, an operative report (i.e., "Op Note") shall be dictated or written in the medical record, and shall include the name of the primary surgeon and any assistant(s), a description of the findings, the technical procedures used, the specimen(s) removed and the post operative diagnosis. If the

operative report is dictated, then, at a minimum, a brief operative note shall be written in the medical record immediately following the completion of the procedure.

1. All previous orders are canceled when patients go to surgery and must be renewed.
   a. Same as A.1.g above.
   b. **Medical Records:**
   c. **General**: An initial assessment, and documentation of such, shall be completed as specified below, such documentation to be made a part of the medical record at the time of this initial assessment.
2. A complete/appropriate history and physical examination shall be completed as delineated in A.1.e, A.2.e or A.3.e above as appropriate.

   EXCEPTION: If a complete history and/or physical examination has been obtained within a week prior to admission, such as in the office of a physician staff member, then a legible copy of this report may be used in the patient's hospital medical record, provided there have been no subsequent changes or the changes have been recorded at the time of admission.
3. A statement of the conclusion(s) or impression(s) drawn from the above history and physical examination shall be included in the medical record.
4. A statement of the course of action planned for the patient while in the hospital shall be included in the medical record.
5. **Orders**: All orders shall be in writing, signed and dated by the ordering practitioner.

   EXCEPTION: Orders may be verbally transmitted to those members of the hospital staff authorized by the hospital to receive and transcribe orders. The orders will be counter signed by the ordering practitioner prior to the record being considered complete. This countersigned provision applies only to those instances in which a medical record is maintained.

   NOTE: Standing orders, when needed and appropriate, shall be formulated and approved by the appropriate clinical committee, and before institution, must be reviewed and approved by the Executive Committee. When standing orders are instituted, this should not be construed to mean that the attending practitioner has a mandatory requirement to use them, but rather is free to use any or all of said standing orders as that practitioner deems appropriate for the clinical situation. However, when said standing orders are used, they must be signed and dated by the practitioner, just as for any other orders, and if 1 or more, including all, of the standing orders are not appropriate for that particular situation, such order(s) must be "lined out" and initialed by the practitioner.

   The concept, or purpose, behind said standing orders is to reflect an awareness by the Medical Staff that types of patients, or patients with a particular diagnosis, generally require the same type(s) of treatment, medications,

monitoring, etc., and because of this, the Medical Staff feels that these patients should generally be treated in this standard (i.e., "standing orders") manner.

The above is not intended to preclude (or discourage) an individual physician from establishing (and using) "routine" orders for his or her individual patients, and each physician would be free to have these individual "routine" orders preprinted on a form(s) currently prescribed and in use by the hospital for the transcription of orders, without needing to meet the above requirements of approving "standing orders". This is so because these "routine" orders apply ONLY to that particular individual physician. However, as with all order, these individual "routine" orders (which would generally be used to improve that individual physician's administrative efficiency) would continue to require signature, date and time as delineated in B.2 above.

6. **Informed consent**: For all procedures undertaken in the hospital that require the completion of an operative note, the physician doing such procedure(s) shall document in the medical record prior to the initiation of said procedure that "informed consent" was obtained from the patient.

   NOTE: The actual mechanism of documenting such can be done in any number of ways, including the inclusions of the completed hospital informed consent form; the inclusion of the completed form then currently approved by the Executive Committee of the Medical Staff; or, even simply a "progress note" entry into the medical record indicating that informed consent was obtained.

   The intent of this rule is to place the requirement of documenting the obtainment of informed consent upon the Medical Staff member, such that the hospital has the documentation of said consent in the medical record BEFORE any procedure(s) is initiated.

   EXCEPTION 1: When caring for minor children, informed consent must be obtained from the child's parent(s) or legal guardian.

   EXCEPTION 2: In the event the patient's medical situation is of such urgency that the patient's life is in immediate jeopardy and there is insufficient time to obtain properly informed consent (or because of the patient's condition, "truly" informed consent CANNOT be obtained), then the details regarding the lack of informed consent must be fully documented in the medical record.

   NOTE: When dealing with the above "emergency" exception, the practitioner may find it desirable, though he or she is not required, to have a consultant's written opinion of agreement to initiate the procedure in the medical record BEFORE the emergency procedure is initiated.

7. Progress notes: All inpatients shall be "visited" by their attending physician (or "on call" physician in the attending physician's absence) at least once every 24 hours, and a record of this visit, in the minimum form of a progress note, shall be entered into the patient's medical record and signed and dated by the physician making such entry.

EXCEPTION: Patients in the Intensive Care Unit shall be "visited" at least 2 times per 24 hour period, and a record of the visits, as specified above, shall be maintained. In the event that a "consultant" physician is providing the majority of the patient's care in the Intensive Care Unit, this 2 times per 24 hour period requirement may be fulfilled by the consultant, with the attending physician maintaining the minimum 1 visit per 24 hour requirement.

C. **Consultations:** When the attending physician requests a consultation from an individual with appropriate clinical privileges, the consultant shall render a report that contains a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patients' medical record(s).

1. **Abbreviations:** Abbreviations and symbols which have not been approved by the Executive Committee (this list to include the abbreviation or symbol and its respective meaning) shall not be entered into the medical record.
2. **Miscellaneous:** The medical record, as a matter of policy and legality, is the property of the hospital, and as such, no Medical Staff member is permitted to remove any medical record from the hospital without the written approval of the hospital administrator or his designee.

   NOTE: The above rule should not be construed to mean that an attending physician is not allowed to receive a COPY of the medical record (or a part of it) for inclusion, for instance, in that patient's medical record in the attending physician's office.
3. **Discharges**:

1. Authority: All inpatients shall be discharged from the hospital only on the order of the attending physician, or in the event the patient's care was temporarily assumed by an "on call" physician, by order of that associate physician.
2. Discharge Summary: A complete dictated and transcribed discharge summary, to include pertinent data and final diagnosis(s) in standard terminology, shall be completed and signed within thirty (30) days of the patient's discharge from the hospital.

   EXCEPTION: A final progress note, including discharge instructions, may be substituted for the above discharge summary in the case of patients with problems of a minor nature who required less than a 48 hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries.
3. AMA (Against Medical Advice): In the event that a patient leaves the hospital without having been formally "discharged" by the patient's attending physician (i.e., the patient left "AMA"), then the attending physician (or the "on call" physician, as appropriate) shall make an entry in the medical record, in the minimum form of a progress note, explaining as best possible the circumstance(s) surrounding the patient's leaving the hospital. A formal discharge summary, as specified in C.2 above, shall be completed within the normally prescribed time limits.

D. Deaths

1. In the event of a hospital death, pronouncement of death shall be made by the Attending Practitioner, or by the "on-call" physician, or by another staff physician when designated by the attending, within a reasonable time period.
2. If the Attending Practitioner, or designee, is not present, two (2) registered nurses will assess the vital signs (BP, apical pulse and aspirations), and will document this in the nurses' progress notes. The registered nurse will place a call to the Attending Practitioner and obtain the Attending Practitioner's order to accept the nurses' assessment of the death, if appropriate.
3. The body shall not be released until an entry has been made and signed in the medical record of the deceased by the medical or nursing staff member who pronounced the death.
4. If no Member or Privileged Practitioner is willing to sign the death certificate, the case will be referred to the Medical Examiner.

SECTION 2

EMERGENCY SERVICES

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accordance with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Medical Executive Committee shall supervise the on-call physician process. The on-call physician is the physician who has been designated by his/her specialty to be responsible for the care of the patients needing that specialty, per the call schedule.
2. Each member of the Medical Staff must assure timely, adequate professional care for his/her patient currently under his/her care presenting themselves to the emergency room by being available or having available an eligible, alternate physician with whom prior arrangements have been made.
3. An appropriate medical record shall be kept for every patient receiving emergency service and incorporated in the patient's hospital record.
4. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.
5. 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.
6. In a disaster, all physicians shall be assigned to posts as needed and it is their responsibility to report to their assigned stations. The chiefs of the clinical services in the hospital will work as a team to coordinate activities and direction. In cases of evacuation of patients from one section of the hospital to another or evacuation from the hospital premises, the chiefs 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 deputy chiefs and alternate in administration are next in line of authority respectively.

7. The disaster plan should be rehearsed at least twice a year or as required by State law or regulations, preferably as a 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 evaluation of patients during drills shall be made.

8. Rules and Regulations for EMTALA Compliance

1. Medical screening exam

A medical screening examination and stabilizing treatment, within the capabilities of Sterling Regional MedCenter, will be provided to all individuals presenting on the hospital campus requesting medical care. Patients sent from outlying areas for diagnostic tests, after regular business hours, will be screened by the Emergency Medicine physician. Professionals designated as Qualified Medical Personnel to conduct medical screening examinations are physicians and, in the case of women in labor, qualified labor and delivery registered nurses.

Emergency Department nursing staff or their designee shall be responsible for an initial triage assessment on every individual who comes into the Emergency Department requesting an examination or treatment.

In the case of a woman >20 weeks pregnant, or presenting with a complaint related to the pregnancy, she will be taken directly to the Baby Suite for a medical screening examination by the labor-qualified registered nurse.

Nursing staff in the ED will then notify the ED physician of the patient's complaint and acuity level. The ED physician will perform a medical screening exam in order of acuity level. Nursing staff may request physician assistance prior to completion of triage assessment if it becomes apparent that the patient needs emergent stabilizing treatment. The ED physician or other designated physician will see all patients presenting to the Emergency Department, except those presenting for scheduled treatments (i.e., IV infusions, cast removal), or if the patient's primary care physician has made arrangements to see the patient in the Emergency Department. If the triage assessment suggests care should not be delayed while waiting for the arrival of the primary care physician, the ED physician will perform the medical screening exam and begin stabilizing treatment. Care can be transferred to the primary care physician when that physician is present in the department

1. Emergency medical condition

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or
4. With respect to a pregnant woman who is having contractions

1. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. That transfer may pose a threat to the health or safety of the woman or the unborn child.

1. On-call schedule

1. Responsibilities of the Medical Staff

The Medical Staff Bylaws, Article 3: Medical Staff Membership, Section 3, Conditions and Duration of Appointment, paragraph D., outline the responsibilities of members of the Medical Staff to participate in the Emergency Department call schedule. The on-call physician is expected to provide services for the clinical privileges he/she holds at the hospital.

The Chair of the Primary Care Committee, or his/her designee, will be responsible for the printing and dissemination of the on-call list for primary care coverage on a yearly basis. It is the responsibility of the committee to develop the on-call list for its committee members in a fair and equitable manner. This responsibility may be delegated to a subspecialty group within the committee.

Specialties other than Primary Care will provide the Emergency Department with their plans for coverage.

Any changes made to the on-call list must be immediately updated by the Emergency Department. The final list that includes replacement physician names is sent to and retained in Medical Staff Services for five (5) years.

Unresolved issues regarding call list development will be addressed through the chain of command method (by the committee Chair, then Chief of Staff, then Medical Executive Committee).

All physicians on the emergency call schedule shall respond within 30 minutes and be available within a reasonable amount of time without regard for the financial ability of the patient to pay for services. If the designated on-call

physician does not wish to care for a particular patient it is his/her responsibility to find alternative care for the patient.

Individual physicians may be excused from call responsibilities if:

1. The physician is able to find another physician or physician group to take his/her portion of call responsibility.

2. The Medical Executive Committee grants a waiver.

3. The physician is on a leave of absence or medical leave, or in some other manner is not currently practicing at Sterling Regional MedCenter.

A refusal or failure to timely respond shall be immediately reported on an occurrence report to Risk Management, who will then report the occurrence to the hospital Chief Executive Officer. Failure to respond to on-call duty will be addressed through the peer review process and/or under Article 7, Professional Review Procedures and Corrective Action, Section 2, Corrective Action, of the Medical Staff Bylaws.

1. Role of the Emergency Department

A patient presenting to the Emergency Department for evaluation/treatment will be seen, assessed, and have a medical screening examination by his/her private physician or by the Emergency Medicine physician or qualified medical personnel.

The physician on-call may not refer the emergency cases to his/her office unless a physician/qualified medical personnel has performed a medical screening exam and determined an emergency medical condition does not exist, the patient is stable for discharge, and it is in the patient's best interest to render further care in the office setting.

If Sterling Regional MedCenter does not have access to specialized equipment to fully evaluate and treat the patient that is available in another setting, the physician/qualified medical personnel who performed the medical screening exam may recommend care in another setting.

If a patient or his/her representative refuses a medical screening examination, the Emergency Medicine physician and/or nursing staff will assist and participate in refusal requirements including informing the patient of the hospital's obligation, risks and benefits.

If a particular specialty is not available or the on-call physician cannot respond because of a situation beyond the physician's control (i.e. the physician is performing another operation), the Emergency Department will:

1. Attempt to directly discuss with the on-call physician.
2. If the on-call physician indicates he/she cannot arrange availability, attempt to locate another appropriate physician within the SRM Medical Staff who may be able to care for the patient's complaint.
3. If all reasonable and prudent hospital resource attempts have been exhausted, the Emergency Department will stabilize the patient within its abilities and arrange transfer.

The physician determines if a patient is stable for discharge or transfer. Patients shall be discharged from the Emergency Department only on the order of the Emergency Department physician, or the attending physician or his/her designated alternate physician. Should a patient indicate an intent to leave the hospital against medical advice, a notation of the occurrence shall be made in the patient's medical record, an effort will be made to explain risks of leaving, and the patient will be requested to sign the acknowledgement form indicating that he/she is leaving against medical advice.

1. Coverage by specialty

The following specialties will provide continuous emergency coverage by SRM Medical Staff:

Anesthesiology
Emergency Medicine
Family Practice
General Surgery
Gynecology
Internal Medicine
Obstetrics
Ophthalmology
Orthopedics
Pathology
Radiology

There are specialties for which continuous coverage by SRM Medical Staff may not be available due to the limited number of physicians in that specialty. The physicians in specialties that do not provide continuous coverage will provide a call schedule to the Emergency Department. The Emergency Department may try to contact the physician when they are not on-call, however, the physician is

not obligated to respond. A plan to provide service for each specialty that does not provide continuous coverage will be posted in the Emergency Department.

Procedures to follow should a non-continuous specialist not be available or when the on-call physician cannot respond because of situations beyond his or her control, will be posted in the Emergency Department.

Specialty services offered on a limited outpatient basis at the hospital Specialty Care Clinic are not provided as continuous emergency coverage.

At the discretion of the emergency physician, or in life-threatening situations, attempts may be made to contact physicians who are off call but are appropriate to the needs to patient. Those off-call physicians are not obligated to respond.

Scope of on-call coverage

The on-call physician shall provide coverage as follows:

1. Respond to the Emergency Department and hospital-based consultation issues.
2. Cover hospital admissions appropriate for their specialty.
3. Accept patients admitted on an emergency basis who do not have a physician. The Chief of Staff or his/her designee shall make the final decision in disagreements.
4. Provide outpatient follow-up for Emergency Department patients without physician assignment who may require follow-up for clinical issues that the physician holds privileges for. The physician responsible for follow-up care is designated by the date of the patient's emergency department visit. The expectation is that physicians will see patients referred for outpatient follow-up for the acute presenting problem to the Emergency Department but are not expected to take on patients referred to them through this list as a patient for continuum of care.

2. Transfers

1. Patient transfers within Sterling Regional MedCenter

Transfer priorities within SRM shall be as follows:

1. Emergency Department to appropriate hospital bed.
2. Obstetric patient care area to general care area when medically indicated.
3. Intensive Care Unit to general care area.
4. Temporary placement to an appropriate clinical service area to the appropriate area for the patient.

2. Transfers to another facility

Transfer of patient to another hospital may be considered under the following circumstances:

1. The patient is stable for transfer; or
2. The patient or patient representative requests transfer after being informed of the hospital's obligation to provide stabilizing care; or
3. The physician certifies that the benefits of treatment outweigh the risks, such as where:

    1. the patient requires a higher level of care; or
    2. Sterling Regional MedCenter lacks the capacity to treat or further stabilize the patient.

The transferring physician will consult directly with the receiving physician. The nursing staff will contact the receiving hospital to verify there is a bed available and obtain agreement to transfer the patient. The transfer is effected through appropriate means consisting of the necessary qualified personnel and transportation equipment including the availability of life support measures. The transferring patient is to receive stabilizing treatment within the capability of Sterling Regional MedCenter and its medical staff. The medical staff will assist and participate in transfer requirements in the following ways:

1. Obtaining an informed patient consent to transfer;
2. An explanation of the hospital obligations, the risks and benefits of refusing transfer if the patient refuses transfer;
3. Sending the medical records relating to the emergency medical condition to the accepting facility;
4. If a transfer results from refusal or failure of the on-call physician to come to the hospital within a reasonable period of time, after following the Medical Staff Chain of Command policy, the name and address of the on-call physician will be sent to the accepting facility with the patient.

5. Transfers from another facility

If Sterling Regional MedCenter has the capacity and capability, SRM will accept the appropriate transfer of any stable patient (or unstable patient if the transferring facility lacks the capability to further stabilize the patient) from any referring hospital's emergency, obstetrical, or med/surg department for any patient who requires the specialized capabilities of Sterling Regional MedCenter, regardless of financial consideration or proximity of the other hospital.

SECTION 3

DEATH AND AUTOPSIES

Autopsies are an important part of hospital practice and may provide invaluable feedback information to diagnosticians. In addition, they occasionally help establish the cause of death in cases where such cause is obscure. In recognition of these facts, it is recommended that the Medical Staff request permission for autopsy from the next of kin under circumstances which include, but are not limited to, the following:

1. Unanticipated death.
2. Death occurring while the patient is being treated under an experimental regimen.

A. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
   1. Death incident to pregnancy, or within seven (7) days following delivery.
   2. Death where cause is sufficiently obscure to delay completion of the death certificate.
   3. Death in infants/children with congenital malformations.
   4. Death in cases where radiologic and clinical findings are equivocal.

In addition, certain cases should be referred to the coroner. If accepted by the coroner for investigation, it is not necessary to obtain family permission for the autopsy, although they should be informed in such a way as to secure good will. Cases should be reported to the coroner under the following circumstances:

   5. Death occurring within 24 hours after admission or transfer.
   6. Intraoperative or intraprocedural death.
   7. Death in which there is suspected involvement of alcohol or drugs as a primary contributing factor.

B. Death arising from traumatic, thermal, chemical, or radiation injury.
   1. Death resulting from criminal abortion, including any situation where such abortion may have been self-induced.
   2. Death from a disease which may be considered an unusual hazard or threat to the general public.
   3. Death of a patient under the custody of law enforcement officials.

SECTION 4

ANESTHESIA

The following specific requirements, at a minimum, apply to all inpatients and outpatients at the hospital who receive anesthesia. The individual who is responsible for assuring compliance with these requirements is the individual who is responsible for providing anesthesia.

1. There is a pre-anesthesia evaluation of each patient for whom anesthesia is contemplated.

2. Prior to anesthesia, there is a determination, based upon the pre-anesthesia evaluation, that the patient is an appropriate candidate to undergo the planned anesthesia.
3. Immediately prior to the induction of general anesthesia, the patient is reevaluated (pre-induction reevaluation), and equipment, drugs and gas supply are checked.
4. The patient is appropriately monitored during anesthesia.
5. The post operative status (post-anesthesia evaluation) of the patient is evaluated on admission and discharge from the post-anesthesia recovery area.
    a. A practitioner who has appropriate clinical privileges and who is familiar with the patient is responsible for the decision to discharge the patient from the post-anesthesia recovery area or, when the surgical or anesthesia services are provided on an ambulatory basis, from the hospital.

1. The above pre-anesthesia evaluation, determination, pre-induction reevaluation, monitoring, post anesthesia evaluation and discharge shall be documented in the medical record and authenticated by the individual(s) completing the specific requirements.

SECTION 5
IV SEDATION

The granting of physician clinical privileges to perform invasive procedures includes the authorization to order or to administer IV sedation.

SECTION 6
DENTAL AND PODIATRIC ADMISSIONS

A patient admitted to the hospital for dental or podiatric care is a dual responsibility of the dental or podiatric Medical Staff member who has admitted the patient and the physician member of the Medical Staff who was delineated at the time of admission as the responsible physician. The dentist or podiatrist is, by definition, the "admitting" and "attending" practitioner, and as such, is the individual responsible for adherence to the applicable rules and regulations. The following requirements, in addition to the applicable requirements previously delineated, shall apply to dental and podiatric admissions

- **The dentist or podiatrist responsibilities are:**
    - Provide a detailed dental or podiatric history justifying hospital admission.
    - Delineating in the medical record that "Informed Consent" has been obtained from the patient prior to the initiation of any operative procedure (see 1.B.3).

2. Provide a detailed description of the dental/podiatric examination, including when indicated, the initial and final diagnosis, surgery and prognosis.

- A complete operative report.

C. Write orders for services and medications as they relate to the dental/podiatric care rendered.

1. Write progress notes and final summary as they relate to the dental/podiatric care rendered.

a. Write the discharge order. When the patient is being treated for a medical condition, discharge shall be in concurrence with the MD or DO.

- **The MD or DO responsibilities are:**

1. Perform a medical history and physical examination.
1. Provide for overall care of the patient's general health during the hospital stay.
1. Write orders for services and medications for the general care of the patient.

SECTION 7

ALLIED HEALTH PERSONNEL

The following requirements shall apply to any care rendered by allied health personnel to (1) hospitalized patients, or (2) patients undergoing outpatient invasive diagnostic or therapeutic procedures. These requirements are in addition to any specific requirements that have been delineated under the provisions of Article 12 of the bylaws, as well as all other appropriate portions of the rules and regulations.

1. Allied health personnel shall clearly identify himself or herself to hospitalized patients and hospital personnel as to that individual's title (i.e., clinical psychologist, nurse anesthetist, etc.).

1. Allied health personnel may not admit patients to the hospital, although these individuals may admit a patient "for a physician member" of the Medical Staff, similar to the admission exception to 1.A.1.

1. If the history and physical examination of a patient is performed by an allied health individual who has delineated clinical privileges to perform such, then the findings conclusions, and assessment of risk shall be confirmed or endorsed (i.e., countersigned) by a physician member of the Medical Staff prior to any invasive diagnostic or therapeutic intervention, or within 24 hours of admission, whichever occurs first.

1. All entries into the medical record by an allied health individual shall be authenticated by that individual at the time the entry is made. The requirement for signature, date and time shall be the same as for Medical Staff members.

1. All entries into the medical record by an allied health individual shall be specifically reviewed and countersigned by a physician member of the Medical Staff within 24 hours of the entry (also see 3 above).

2.

EXCEPTION: In accordance with the allied health personnel protocol developed in accordance with Article 12 of the bylaws, as well as any specific clinical privileges granted, there may be types of diagnostic or therapeutic interventions that do not require specific review and countersignature (such as ordering or laboratory tests, prescribing of certain drugs such as aspirin, mild hypnotics, etc.), in which case the specific requirement 3 above shall not apply.

Sterling Regional MedCenter
Medical Staff Rules and Regulations

ADOPTED by the Medical Staff on November 16, 2011

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Darrel Fenton, M.D., Chief of the Medical Staff

APPROVED by the Board of Directors of Banner Health on: December 8, 2011