CHI Health

St. Elizabeth

RULES & REGULATIONS

February 2016

INDEX

RULES AND REGULATIONS
OF THE MEDICAL STAFF
CHI HEALTH ST. ELIZABETH
LINCOLN, NEBRASKA

A. DEFINITIONS

The terms defined in the Bylaws of the Medical Staff of CHI Health St. Elizabeth shall also apply to these Medical Staff Rules and Regulations.

B. ADMISSION AND DISCHARGE OF PATIENTS

1. The Hospital shall accept patients for care and treatment in accordance with the Bylaws of the Medical Staff and the Bylaws of the Governing Board. No distinction shall be made on the basis of color, race, sex, national origin, or disability in the admission or treatment of patients, the accommodations provided, the use of equipment and other facilities or the assignment of personnel providing services. The Hospital makes no distinction on the basis of ability to pay for services in the admission or treatment of patients, the accommodations provided, the use of equipment and other facilities, or the assignment of personnel providing services.
2. A patient may be admitted to the Hospital by a member of the Medical Staff, a physician with temporary privileges, or a Nurse Midwife. All practitioners shall be governed by the official admitting policy of the Hospital. A patient admitted by a Podiatrist requires a member of the Medical Staff designated in the event of a medical issue.
3. A member of the Medical Staff, or a Nurse Midwife, shall visit his/her patients within twenty-four (24) hours of admission, be responsible for providing continuous, quality medical care and treatment for each of his/her patients in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. When the Medical Staff member ¬or Nurse Midwife is to be unavailable for twenty-four (24) hours or greater, these responsibilities may be transferred to another Medical Staff member or Nurse Midwife. The practitioner(s) who will be assuming responsibility for the care of the patient during his/her absence shall be identified.
4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, this statement shall be recorded as soon as possible.
5. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
6. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend him/her. Where no selection is made, the emergency room physician shall assign the case to the appropriate physician next in line on the approved rotation list posted in the emergency room.

7. The Chief Admitting Clerk will admit patients on the basis of the following order of priorities:

    a. Emergency Admissions

    Within forty-eight (48) hours following an emergency admission, the attending/admitting practitioner shall be prepared to furnish to the Performance Improvement Council, which has responsibility for utilization review, a signed, sufficiently complete documentation of the need for the admission. Failure to furnish this documentation upon request or evidence of willful or continued misuse of emergency admissions will be brought to the attention of the Executive Committee for appropriate action.

    b. Urgent Admissions

    This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the Performance Improvement Council to determine priority when all such admissions for a specific day are not possible.

    c. Pre-operative Admissions

    This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of the Department of Surgery may determine the urgency of any specific admissions.

    d. Routine Admissions

    This will include elective admissions involving all services.

8. The admitting practitioner shall be held responsible for providing the information necessary to assure the protection of the patient from self-harm and to assure the protection of others. If the admitting practitioner has reason to believe the patient may require special care to protect the patient from self-harm or harm to others, (s)he is required to provide such information to the administration of the Hospital and to the Chief of Staff.

9. For the protection of patients, the medical nursing staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

    a. Any patient known or suspected to be suicidal shall be admitted to a security room.

    b. Any patient known to be suicidal must have consultation by a member of the psychiatric staff.

10. Admissions to Critical Care Units.

    If any questions as to the validity of an admission to or discharge from the Critical Care Unit should arise, that decision is to be made through consultation with the Chair of the Critical Care Committee or his/her designee and the attending practitioner. Physician response times for the Critical Care Units are as follows:

    a. Unstable Patients must be seen by the attending and/or consulting physician within a reasonable period following admission, depending on patient needs and physician judgment.

    b. Stable patients must be seen by the attending and/or consulting physician within six-eight (6-8) hours.

    Patients admitted through the Emergency Department become the responsibility of the admitting/attending physician or the attending physician designated in accordance with Section B, paragraphs 7 and 8.

All patients admitted to the Critical Care Unit with the following diagnosis must be admitted by or have a consultation with an Internist, Cardiologist or other appropriate specialist. If problems arise obtaining a consultation, the Director of the Critical Care Committee should be contacted.

c. – Myocardial Infarction with shock.

– Myocardial infarction with failure.

– Myocardial infarction with life threatening rhythm disturbance.

d. Pure rhythm disturbance which is life threatening.

- persistent atrial tachycardia
- persistent ventricular tachycardia
- third degree AV heart block

e. Progressively deteriorating patient status as determined by patient's nurse and clinical supervisor. (Director or House Supervisor).

f. Acute life threatening respiratory failure

g. Patients admitted to Pediatric Intensive Care

11. The attending physician is required to adhere to the current utilization review/quality improvement procedures of this Hospital, as approved by the Executive Committee.
12. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and shall be in accordance with Hospital COBRA/EMTALA policies.
13. Attending practitioners are encouraged to discharge patients by 11:00 a.m.
14. In the event of a death in the Hospital, the deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.
15. It shall be the duty of all Medical Staff members to secure meaningful autopsies as described in the Autopsy Policy. An autopsy may be performed only with an appropriate written consent made in accordance with state law. All autopsies shall be performed by a pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours, and the complete protocol should be made a part of the medical record within sixty (60) days.
16. Privileges to perform emergency life-saving procedures are automatically granted to all staff physicians as well as licensed physicians who are currently enrolled in an approved residency program.
17. In accordance with 42 Code of Federal Regulations 489.24 (also known as COBRA/EMTALA), the Hospital when providing emergency services shall take the following measures: provide for an appropriate medical screening examination, provide necessary stabilizing treatment for emergency medical conditions and labor, provide for an appropriate transfer of the individual if the Hospital does not have the capability or capacity to provide the treatment necessary to remove the

emergency medical condition, not delay examination and/or treatment in order to inquire about insurance or payment status, accept appropriate transfers of individuals with medical emergencies if the Hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals, obtain or attempt to obtain written and informed refusal of examination, treatment or appropriate transfer, and not take adverse action against a physician or qualified medical personnel who refuses to transfer an individual with an emergency medical condition, or against an employee who reports a violation of these requirements. For the purpose of these regulations:

a. In accordance with Hospital COBRA/EMTALA policies, a medical screening examination is a process of assessment which begins with the nurse and may progress through ancillary services, the emergency physician on duty, another member of the medical staff, including but not limited to the specialist on call, and/or a qualified evaluator, as defined by Hospital policy, who determines whether or not an emergency medical condition as defined by law exists, and shall include a history and physical examination, diagnostic evaluation and consultation to the extent necessary, within the capability of the Emergency Department and associated Hospital departments to detect an emergency medical condition; and

b. Emergency medical condition as defined by law is a condition manifesting with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the person in serious jeopardy; serious impairment to any bodily functions; serious dysfunction of any bodily organ or part; or a pregnant woman having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery; or that transfer may pose a threat to the health or safety of the woman or the unborn child. Emergency medical conditions always include women in labor*, patients with substance abuse or current intoxication and psychiatric patients that might or could ultimately be a risk to self or others.

   *In the definition of emergency medical condition, "labor" is defined as the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman having contractions is in true labor unless the Labor and Delivery nurse, in collaboration with the physician or nurse midwife, certifies that, after a reasonable time of observation, the woman is in false labor.

18. Each Medical Staff member who elects to see their acute patients in the Emergency Department shall be subject to the COBRA/EMTALA policy and procedures related to private physician's use of the Emergency Department.

C. ALLIED HEALTH PROFESSIONS

1. Definitions

   a. The term "allied health professional staff" means all individuals who have allied health clinical privileges or the right to perform allied health services at the Hospital or an affiliated facility. The allied health professional staff shall be divided into two classifications: "Independent Allied Health Professionals" and "Dependent Allied Health Professionals."

   b. The term "Independent Allied Health Professional" means an individual, other than a non-physician medical provider, who is fully licensed and permitted by law to provide health care services and who has the training and experience necessary to offer health care services to patients with general physician supervision. Examples of individuals who qualify as Independent

Allied Health Professionals include, but are not limited to nurse practitioners*, physician assistants*, nurse midwives**, nurse anesthetists, and clinical psychologists.

* Must be employed by the hospital or a physician having privileges at hospital. Under either circumstance, a practice agreement with a physician having medical staff privileges is required.

** A practice agreement with a physician having medical staff privileges is required.

c. The term "Dependent Allied Health Professional" means an individual who is licensed or certified and permitted by law to provide health care services or who has formal training and experience to offer health care services to patients under a physician's immediate supervision. Examples of individuals who qualify as Dependent Allied Health Professionals include, but are not limited to registered nurses, licensed practical nurses, pharmacists, certified social workers, and audiologists.

d. The term "sponsoring physician or sponsor" shall mean the practitioner or other member of the Medical Staff who requests the services of a Dependent Allied Health Professional and who shall be responsible for the professional and personal conduct of the Dependent Allied Health Professional.

e. The term "Interdisciplinary Practice Committee" shall mean a group of individuals consisting of the Chief Medical Officer, a Dependent Allied Health Professional, and other hospital representatives appointed by the President to review applications from Dependent Allied Health Professionals applying for initial and reappointment privileges.

2. Medical Staff Membership

a. Independent Allied Health Professionals and Dependent Allied Health Professionals shall not be eligible to hold Medical Staff membership. However, Dependent Allied Health Professionals and Independent Allied Health Professionals shall be eligible to apply for clinical privileges pursuant to the process described in these Rules and Regulations. All Independent Allied Health Professionals and Dependent Allied Health Professionals shall abide by the CHI Standards of Conduct. All members of the Hospital's allied health professional staff are required to comply with the Hospital's policy against sexual harassment and its policy on Maintaining Professional Relationships. Complete copies of both these policies and the CHI Standards of Conduct are available in the Human Resource Department.

b. Independent Allied Health Professionals and Dependent Allied Health Professionals shall immediately upon notice of any proposed or actual exclusion from any federally funded health care program disclose to the President, by telephone call and in writing, any notice to the individual or his or her representative of proposed or actual exclusion and/or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

3. Admitting Privileges

a. Dependent Allied Health Professionals do not have authority to admit a patient to the Hospital. However, Dependent Allied Health Professionals may function within the Hospital as follows:

(1) As an employee of the Hospital,

(2) As an independent contractor under the terms of a written agree- ment with the Hospital, or

(3) As an employee or sponsored by a member of the Medical Staff with related clinical privileges, under whose supervision they will function.

b. Independent Allied Health Professionals

Certified Nurse Mid-Wives may admit a non-Medicare OB patient to the Hospital. Certified Nurse Mid-Wives must have a physician co-admit for Medicare patients and GYN cases. Physician Assistants, Advanced Practice Registered Nurses and Psychologists may only co-admit a patient to the Hospital with an Active or Courtesy member of the Medical Staff. Certified Registered Nurse Anesthetists may not co-admit a patient to the hospital.

4. Scope of Service

a. Dependent Allied Health Professionals shall be authorized to perform clinical duties within their scope of service only after approval has been granted and only while under the immediate supervision of a Medical Staff member.

(1) Dependent Allied Health Professionals will be granted approval to perform medical services at the Hospital only after submitting evidence in writing of the training, experience, licensure and demonstrated competency to perform the duties within their requested scope of service and/or any other requirements which may be adopted by the Interdisciplinary Practice Committee in order to evaluate the applicant's qualifications.

(2) Action by the Nebraska State Board of Licensing revoking or suspending a Dependent Allied Health Professional's professional license shall automatically suspend all of his/her hospital privileges.

b. Independent Allied Health Professionals shall be authorized to perform clinical duties only after clinical privileges have been granted.

(1) Independent Allied Health Professionals will be granted privileges to perform medical services at the Hospital and affiliated facilities only after submitting evidence in writing of the training, experience, licensure, and demonstrated competency for each procedure requested by the applicant and/or any other requirements which may be adopted by the Credentials Committee in order to evaluate the applicant's qualifications for clinical privileges, including a report from the National Practitioner Data Bank, Office of the Inspector General and General Services Administration. The procedure to be followed by Independent Allied Health Professionals in applying for clinical privileges shall be as found in these Rules and Regulations.

(2) Action by the Nebraska State Board of Licensing revoking or suspending an Independent Allied Health Professional's professional license shall automatically suspend all of his/her hospital privileges.

c. No Independent Allied Health Professional or Dependent Allied Health Professional applicant who is currently excluded from a health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified to apply for clinical privileges.

d. Upon notice to the President of an investigation or of a proposed exclusion from any health care program funded in whole or in part by the federal government, the Allied Health Professional is subject to automatic temporary suspension of all privileges. Upon notice of an actual exclusion from any health care program funded in whole or in part by the federal government, all privileges of the affected Allied Health Professional shall be automatically suspended.

Independent Allied Health Professionals and Dependent Allied Health Professionals who are excluded from a federally funded health care program shall not have the right to a hearing under this Article regarding the resulting termination of their privileges. However, if the individual immediately notifies the President of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws, a meeting with the President and the Chief of Staff, or their designees, to contest the fact of the exclusion and present relevant information shall be granted upon written request to the President. If requested, such a meeting shall be held as soon as possible but in no event later than five (5) business days from the date of the written request. The President and the Chief of Staff, or their designees, shall determine within ten (10) business days following the meeting and after such follow-up investigation as they deem appropriate, whether the exclusion had in fact occurred, and whether privileges shall be immediately terminated. The determination of the President and the Chief of Staff, or their designees, regarding the matter shall be final, and the Independent or Dependent Allied Health Professional shall have no further procedural rights within the Hospital. The Independent or Dependent Allied Health Professional shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.

An Independent or Dependent Allied Health Professional who does not immediately notify the President of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws shall have his/her privileges terminated, effective immediately, at such time as the President or his or her designee receives reliable information of the individual's exclusion. The Allied Health Professional shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.

No report of any action taken based on an Independent or Dependent Allied Health Professional's exclusion from a health care program funded in whole or in part by the federal government shall be made to the state medical board or the National Practitioner Data Bank, because the action taken is based on the individual's failure to meet or continue to meet a basic qualification for privileges.

5. Insurance

   a. Dependent Allied Health Professionals will be required annually to show evidence of professional liability insurance coverage with an insurance company authorized to sell insurance in the state of Nebraska. The insurance coverage shall be in reasonable amounts as determined by the Governing Body.

   b. Independent Allied Health Professionals will be required annually to show evidence of professional liability insurance coverage with an insurance company authorized to sell insurance in the state of Nebraska. The insurance coverage shall be in reasonable amounts as determined by the Governing Body.

6. Credentialing Process

   a. Dependent Allied Health Professionals

      (1) All Dependent Allied Health Professionals who desire to function within the Hospital shall complete an application form approved by the Interdisciplinary Practice Committee. Such form shall include, but not be limited to, such information as the prospective applicant's Nebraska licensure, if applicable, professional liability insurance status and whether or not the prospective applicant is subject to any actual exclusion from any health care program

funded in whole or in part, by the federal government. This form must be completed in its entirety, signed, and returned by the applicant for consideration by the Interdisciplinary Practice Committee.

(2) All Dependent Allied Health Professionals who desire to function within the Hospital shall complete an application that shall require a resume of the applicant's education, qualifications, experience, training, verification of licensure, certification or registration, information on physical and/or mental health status to determine applicant's ability to practice in accordance with their respective profession, moral and ethical qualifications, proof of malpractice insurance covering the applicant's functions and activities acceptable to the Governing Body, and an appropriate request for either specific allied health clinical privileges or for specific services to be performed, a release from any liability for all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, a release from any liability of all individuals and organizations who provide informa¬tion to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for privileges, including otherwise privileged or confidential information, and such other information as may be required in the review of their application.

(3) The application for a Dependent Allied Health Professional shall also require the employing or sponsoring member of the Medical Staff to sign and endorse on the application the competence of the Dependent Allied Health Professional to perform the duties requested. All such information shall be submitted to the President or his/her designee. The applicant shall have the burden of producing adequate information for the proper evaluation of his/her competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

(4) Dependent Allied Health Professionals shall only provide services as requested by the Hospital in the case of an employee or independent contractor, or as requested by the Dependent Allied Health Professional's employing or sponsoring Medical Staff member.

(5) The President or his/her designee shall verify as nearly as possible all data for its accuracy and completeness and shall submit the information to the Chair of the Inter¬disci¬plinary Practice Committee. All infor¬mation shall be utilized by the Interdisci-plinary Practice Committee in making its recommendation. The recommendation of the Interdisciplinary Practice Committee shall then be transmitted to the President for consideration and decision. If the decision on the application by the President is favorable, the Dependent Allied Health Professional shall be notified accordingly. If the decision of the President is negative, the Dependent Allied Health Professional may request an opportunity to meet with the Interdisciplinary Practice Committee and with the applicant's employing or sponsoring Medical Staff member to discuss the negative decision reached by the President. Following such a meeting, the President shall make a final decision on the application of the Dependent Allied Health Professional. If the final decision reached by the President is negative or if the Dependent Allied Health Professional fails to request a meeting with the Interdisciplinary Practice Committee, the Dependent Allied Health Professional shall have no rights of appeal. The Dependent Allied Health Professional shall be notified by certified mail, return receipt requested, of the action of the President or his/her designee within five (5) days following the date on which action is taken on the matter.

(6) The application from the Dependent Allied Health Care Professional shall also include a statement that the applicant has received and read Section C of these Rules and Regulations and that (s)he agrees to be bound by the terms thereof if (s)he is granted the right to perform medical services and also that (s)he agrees to be bound by the terms thereof without regard to whether or not (s)he is granted the right to perform medical services in all matters relating to the consideration of his/her application.

(7) All requested services and clinical privileges granted to a Dependent Allied Health Professional shall be in accordance with applicable and appropriate licensure, certification, and registration laws.

(8) If a Dependent Allied Health Professional's application has been approved by the President or his/her designee, the initial appointment shall be for one (1) year. Each Dependent Allied Health Professional granted privileges shall be permitted to perform only those services for which they have been trained and for which they have been given authorization under the aforementioned approval process. Applica¬tions for additional services must be submitted in writing and the information shall be provided and the application shall be processed in the same manner as the initial application. Each individual Dependent Allied Health Professional shall be expected to maintain a level of professional competence through continuing education as required by the State of Nebraska, and any other certifying, accrediting, or licensing body to which they are subject and through other means consistent with the provision of quality health care.

b. Independent Allied Health Professionals

(1) All Independent Allied Health Professionals who desire to function within the hospital shall complete an Application Form to identify whether or not they qualify for privileges at the Hospital. If it is determined that the prospective applicant qualifies for privileges at the Hospital, based upon the information submitted on the Application Form, the formal approval process will be initiated. A prospective applicant who does not meet the minimum requirements for privileges, based upon the information submitted on the Application Form, shall be notified of that fact.

(2) The application form shall include a summary resume of the applicant's education, qualifications, experience, training, verification of licensure, certification or registration, information on physical and/or mental health status to determine applicant's ability to practice in accordance with their respective profession, moral and ethical qualifications, proof of malpractice insurance covering the Independent Allied Health Professional's functions and activities acceptable to the Governing Body, and an appropriate request for either specific allied health clinical privileges or for specific services to be performed. The application shall also contain a release from any liability for all representatives of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials, a release from any liability of all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for privileges, including otherwise privileged or confidential information, and such other information as may be required in the review of the application or as set forth in the Medical Staff Bylaws.

(3) The application shall also include a statement that the applicant has received and read Section C of these Rules and Regulations and that (s)he agrees to be bound by the terms

thereof if (s)he is granted clinical privileges or the right to perform services and also that (s)he agrees to be bound by the terms thereof without regard to whether or not (s)he is granted clinical privileges or the right to perform services in all matters relating to the consideration of his/her application.

(4) All requested services and clinical privileges granted to an Independent Allied Health Professional shall be in accordance with applicable and appropriate licensure, certification, and registration laws.

(5) The President or his designee shall verify as nearly as possible all data for its accuracy and completeness, as well as obtain a report from the National Practitioner Data Bank, Office of the Inspector General and General Services Administration and submit the application and all supporting information to the Credentials Committee for evaluation. The recommendation of the Credentials Committee shall then be transmitted to the Executive Committee of the Medical Staff for its consideration and recommendation.

(6) If the recommendation of the Executive Committee of the Medical Staff is favorable, the recommendation shall be submitted to the Governing Body of the Hospital for final action. In the event the recommendation of the Executive Committee is unfavorable, or is contrary to the request of the Independent Allied Health Professional in any respect, the Independent Allied Health Professional shall be notified by the Executive Committee of this decision by certified mail, return receipt requested. Within ten (10) days after the date of mailing of the unfavorable recommendation of the Executive Committee, the affected Independent Allied Health Professional shall have the right to request in writing a meeting with the Executive Committee to discuss its contrary or unfavorable recommenda¬tion. Failure of the affected Independent Allied Health Professional to request such a meeting within such time shall be deemed a waiver of the right to such a meeting.

(7) The affected Independent Allied Health Professional shall have the opportunity to appear with a member of the Medical Staff in good standing and/or a local member of his/her profession or organiza-tion at a meeting of the Executive Committee of the Medical Staff to discuss the Executive Committee's recommenda¬tion.

(8) Within ten (10) days after the date of receipt of a request for such a meeting, the Executive Committee of the Medical Staff shall arrange for the meeting and shall, through the President, notify the Independent Allied Health Professional in writing of the time, place, and date of the meeting by certified mail, return receipt requested, or by personal delivery. The meeting date shall be not less than thirty (30) and no more than sixty (60) days from the date of receipt of the request for the meeting.

(9) The meeting shall be informal in nature, and a report of the meeting shall be included with the recommenda¬tion of the Executive Committee to the Governing Body of the Hospital.

(10) Following the meeting, the Executive Committee shall forward to the Governing Body its recommendation for action on the matter. At its next regularly scheduled meeting following receipt of the Executive Committee's recommendation, the Governing Body of the Hospital shall take final action. The Governing Body may accept, reject, or modify the recommendation of the Executive Committee, and its decision shall be a final action and no further appeal will be permitted. The Independent Allied Health Professional shall be notified by certified mail, return receipt requested, of the action of the Governing Body of the hospital within five (5) days following the date on which such action is taken on the matter.

(11) If an Independent Allied Health Professional's application has been approved by the Governing Board, the initial appointment shall be for two (2) years. Each Independent Allied Health Professional granted clinical privileges shall be permitted to perform only those services or clinical privileges for which they have been trained and for which they have been given authorization under the aforementioned approval process. Applications for additional services or additional clinical privileges must be submitted in writing and the information shall be provided and the application shall be processed in the same manner as the initial application. Each individual shall be expected to maintain a level of professional competence through continuing education as required by the State of Nebraska and any other certifying, accrediting, or licensing body to which they are subject and through other means consistent with the provision of quality health care.

7. Temporary Privileges

   a. Upon receipt of an acceptable completed application for specific clinical privileges or specific services and receipt of all requested reference materials for the appropriately licensed, certified, or registered Allied Health Professional, and a condition of emergency need on the part of the sponsoring or contracting physician, the President or his/her designee, may, upon the basis of the information then available which may reasonably be relied upon as to the qualifications, education, competence, ethical standing, and malpractice insurance coverage for the applicant, and with the written concurrence of the Chief of Staff or his/her designee, in the case of an Independent Allied Health Professional, or with the written concurrence of the Chair of the Interdisciplinary Practice Committee, in the case of a Dependent Allied Health Professional, grant temporary privileges to the applicant under the supervision of a physician at the Hospital. Any temporary privileges granted to the applicant may be terminated at any time by either the Chief of Staff or the Chief Executive Officer and, unless earlier terminated by either the Chief of Staff or President, shall automatically terminate ninety (90) days after such temporary privileges are granted. Upon termination, the Chief of Staff shall assign responsibility for the care of a terminated Allied Health Professional's patient(s) to the employing or sponsoring Medical Staff Member in the case of a Dependent Allied Health Professional or, in the case of an Independent Allied Health Professional, to a member of the Medical Staff. The decision to terminate an Allied Health Professional's temporary privileges shall be final and nonappealable.

8. Reappointment Process

   a. After the initial appointment period, each Allied Health Professional authorized to perform health care services or to exercise clinical privileges at the Hospital shall be reviewed biennially for Independent Allied Health Professionals and annually for Dependent Allied Health Professionals in the same manner and under the same procedures as his/her initial appointment and shall be required to submit pertinent information and the required acceptable completed forms for the purpose of determining the granting of specific clinical privileges or specific services to be performed by the Independent or Dependent Allied Health Professional. Such pertinent information shall include information on the Allied Health Professional's current licensure, certification or registration, professional and clinical competence, ethics and conduct, physical and/or mental health status for Allied Health Professionals who are not employees of the Hospital, participation in allied health affairs, compliance with the Rules and Regulations of the Hospital or of the Medical Staff, malpractice experience, including a consent to the release of information from his present and past malpractice insurance carriers, cooperation with Hospital and Medical Staff personnel, use of the hospital facilities, relationship with other practitioners, and general attitude towards patients, the Hospital, and the public, and evidence

of acceptable malpractice coverage. The employing Medical Staff Member of a Dependent Allied Health Professional shall also be required to endorse the Allied Health Professional's competence on an annual review form.

9. Corrective Action

    a. In the event the activities or professional conduct of a Dependent Allied Health Professional are considered to be lower than the standards or aims of the Medical Staff or Governing Body with regard to Dependent Allied Health Professionals or when the activities or professional conduct of a Dependent Allied Health Professional is considered to be disruptive to the operation of the Hospital, or in the event of a written objection received by the Hospital regarding the performance of a Dependent Allied Health Professional, the information shall be forwarded to the Inter¬disciplinary Practice Committee for investigation. The Dependent Allied Health Professional, and his/her employing or sponsoring Medical Staff member, if applicable, shall be notified of the investigation by certified mail, return receipt requested, and, if so desired, shall be given the right to appear before the Interdisciplinary Practice Committee concerning the investiga-tion at a meeting called for that purpose. At the conclusion of the investigation, if the Inter¬disciplinary Practice Committee determines that a Dependent Allied Health Professional's clinical privileges or services provided should be modified, suspended, or terminated in any manner, the Inter¬disciplinary Practice Committee shall forward to the President or his/her designee its recommendation. The President or his/her designee shall take final action on the matter. The decision of the President or his/her designee shall be final, and no further appeal may be taken.

    b. In the event the activities or professional conduct of an Independent Allied Health Professional are considered to be lower than the standards or aims of the Medical Staff or Governing Body with regard to Independent Allied Health Professionals or when the activities or professional conduct of an Independent Allied Health Professional is considered to be disruptive to the operation of the Hospital, or in the event of a written objection received by the Hospital regarding the performance of an Independent Allied Health Professional, the information shall be forwarded to the Executive Committee of the Medical Staff for investigation. The Independent Allied Health Professional shall be notified of the investigation by certified mail, return receipt requested, and, if so desired, shall be given the right to appear before the Executive Committee concerning the investigation at a meeting called for that purpose. At the conclusion of the investigation, if the Executive Committee determines that an Independent Allied Health Professional's clinical privileges or services provided should be modified, suspended or terminated in any manner, the Executive Committee shall forward to the Governing Body its recommendation. The Governing Body at its next regularly scheduled meeting following receipt of the recommendation of the Executive Committee shall take final action on the matter. The decision of the Governing Body on this matter may be to accept, reject, or modify the recommendation of the Executive Committee. The decision of the Governing Body shall be final, and no further appeal may be taken.

10. Summary Suspension

    a. Any one of the following the Chief of Staff, chair of the clinical department which reviews a Dependent or Independent Allied Health Professional's practice, the President, the Executive Committee of either the Medical Staff, the Governing Body, or the Interdisciplinary Practice Committee shall each have the authority, whenever action must be taken immediately in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the

clinical privileges or services provided by any Allied Health Professional, and such summary suspension shall become effective immediately upon imposition.

b. Immediately upon the imposition of a summary suspension, the Chief of Staff or the responsible department chair shall have authority to provide for alternative medical coverage for the patients of the suspended Independent or Dependent Allied Health Professional still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative care.

c. An Independent Allied Health Professional whose privileges have been summarily suspended shall be entitled to request that the Executive Committee of the Medical Staff hold a meeting to review the matter as soon as possible but no later than 30 days thereafter. The Executive Committee shall do so, and at the meeting, the affected Allied Health Professional shall be permitted to make an appearance and discuss the matter before the Executive Committee prior to its taking action. The Executive Committee may sustain the summary suspension, immediately terminate the summary suspension, or modify the summary suspension. The meeting shall be informal in nature, and a report of the meeting shall be included with the Executive Committee's recommendation to the Governing Body.

d. At its next regularly scheduled meeting following its receipt of the recommendation of the Executive Committee, the Governing Body shall take final action. The decision and action of the Governing Body, which may be to accept, reject, or modify the recommendation of the Executive Committee shall be a final action and no further appeal may be taken. The affected Independent Allied Health Professional shall be notified by certified mail, return receipt requested, of the Governing Body's action within five (5) days following the date on which the action is taken on the matter.

e. A Dependent Allied Health Professional whose privileges have been summarily suspended shall be entitled to request that the Interdisciplinary Practice Committee hold a meeting to review the matter as soon as possible but no later than 30 days following the summary suspension. The Interdisciplinary Practice Committee shall do so, and at the meeting, the affected Dependent Allied Health Professional shall be permitted to make an appearance and discuss the matter before the Interdisciplinary Practice Committee prior to its taking action. The Inter¬disciplinary Practice Committee may sustain the summary suspension, immediately terminate the summary suspension, or modify the summary suspension. The meeting shall be informal in nature, and a report of the meeting shall be included with the Interdisciplinary Practice Committee's recommendation to the President or his/her designee.

f. Within thirty (30) days following receipt of the recommendation of the Inter¬disciplinary Practice Committee, the President or his/her designee shall take final action. The decision and action of the President or his/her designee which may be to accept, reject, or modify the recommendation of the Interdisciplinary Practice Committee shall be a final action, and no further appeal may be taken. The affected Dependent Allied Health Professional shall be notified of the President's or his/her designee's action by certified mail, return receipt requested within five (5) days following the date on which the action is taken on the matter.

g. Loss of licensure, certification, or registration by an Allied Health Professional shall automatically suspend all clinical privileges or the right to perform services.

h. Termination of an employing or sponsoring Medical Staff Member's Medical Staff privileges for any reason shall automatically cause loss of the right of the Medical Staff Member's

employee or sponsor Dependent Allied Health Professional(s) to perform any services within the hospital.

1. Quality Improvement

   Allied Health Professionals shall actively participate in the Hospital's quality improvement activities which functions shall be designated by the Performance Improvement Council as defined in the Hospital's Performance Improvement Plan.

2. Register

   A register of all approved Allied Health Professionals shall be maintained by the Hospital.

D. MEDICAL RECORDS

1. All clinical entries in the patient's medical record shall be accurately dated timed and authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.
2. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall include identi- fication data, chief complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services and others, provisional diagnosis, medical or surgical treatment, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge notes, clinical resume, and an autopsy report when an autopsy is performed.
3. History and Physical:
   a. A complete admission history and physical examination shall be recorded, by member of the Medical Staff, or Independent Allied Health Professional with privileges to perform history and physicals or Podiatrists or Oral Surgeons with an M.D. or D.O. degree who have been approved for this privilege by Credentials Committee. The report must be documented and in the patient's medical record within 24 hours after admission, but always prior to a surgical procedure, other high risk procedure as defined by the medical staff, and those procedures which include use of conscious sedation. A History and Physical performed by a non-member of the medical staff, but acting within his/her scope of practice under state law and regulations, may be accepted as long as an update is performed and documented by a member of the medical staff within twenty four hours but prior to a procedure.
      (1) History and physical reports are required for all inpatients (including deaths), observation patients, outpatients undergoing invasive procedures involving significant risk and/or IV sedation, and transfers to acute care facilities.
      (2) A history and physical performed within 30 days prior to admission may be used; however an update to the patient's condition is required if the history and physical was performed more than 24 hours prior to admission.
         (i) For surgical patients, a brief progress note completed by an Anesthesia Provider, Allied Health Provider or the surgeon and documented prior to surgical start time will serve as the required update; however the surgeon retains overall responsibility for the peri-operative care of the patient.
         (ii) For inpatients, daily progress notes serve as this required update.

(3) The report should include chief complaints, history of present illness, relevant past, social and family histories as appropriate to the age of the patient, review of systems, plan of action; and, as required, either a comprehensive or abbreviated physical exam.

(i) Reports may be dictated, or legibly hand written.

(ii) To be acceptable, outside records/reports shall be in a format approved by the hospital, include the required content, and shall be compatible with the current medical records systems.

(iii) All history and physical reports of inpatients (including deaths), observation patients, and transfers to acute care facilities will include a comprehensive physical exam. "Comprehensive" is defined as documented examination of neurological, cardiovascular, pulmonary, abdominal and extremities in addition to the detailed examination of the system(s) identified in the chief complaint and history of present illness.

(iv) For patients undergoing invasive, outpatient type procedures involving significant risk and/or IV sedation (these include GI, vascular and radiology, ambulatory surgical care patients), the history and physical may include an abbreviated examination. This report must include requirements set forth in the Hospital moderate sedation policy. "Abbreviated" is defined as a detailed evaluation of the system(s) identified in the chief complaint and history of present illness in addition to cardiovascular, pulmonary and neurological examination.

b. A short stay history and physical form with an abbreviated examination may be used for patients undergoing invasive outpatient procedures involving significant risk and/or IV sedation, including GI, vascular and radiology, ambulatory surgical care patients, observation patients, excluding deaths and transfers to other acute care facilities, as further defined in the Outpatient Visits Requiring H&P Policy. This report includes requirements set forth in the Hospital moderate sedation policy, or when not otherwise specified, at minimum chief complaint, brief summary of recent illness, abbreviated physical exam and summary, including diagnoses and procedures. The same rules in (a) apply if the short stay history and physical was performed within 30 days of admission.

c. "Comprehensive physical assessment" is defined as documented examination of neurological, cardiovascular, pulmonary, abdominal and extremities in addition to a detailed examination of the system(s) identified in the chief complaint and history or present illness.

d. "Abbreviated examination" is defined as a detailed evaluation of the system(s) identified in the chief complaint and history of present illness in addition to cardiovascular, pulmonary and neurological examination.

4. When the history and physical examination is not recorded on the chart before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled, unless an emergency condition exists and the physician documents such in the medical record.

5. A physician member of the Medical Staff shall countersign the history, physical examination, preoperative notes, operative report, and discharge summary when they have been recorded by a medical student, physician assistant student or advanced practice registered nurse student. The timeliness of this authentication shall be in accordance with medical record policies adopted from time to time by the Hospital, but not to exceed thirty (30) days after the time of discharge.

6. Inpatients require that pertinent progress notes sufficient to permit continuity of care shall be recorded daily, except when not observed on the day of discharge, by the attending physician or his Medical Staff member designee or his appropriately credentialed and designated Nurse Practitioner, Physician Assistant or Nurse Midwife. The progress note should reflect any change in condition and results of treatment. The patient's clinical problems should be clearly identified in the progress notes and correlate with specific orders as well as results of test and treatment. Progress notes recorded by medical students shall be countersigned or a separate entry made referring to the findings by the supervising physician. This does not change the requirement that a member of the Medical Staff, or a Nurse Midwife, shall visit his/her patients within twenty-four (24) hours of admission as stated in Section B.3.

7. An operative progress note must be written or authenticated in the chart immediately upon completion of the surgery/procedure, before the patient is transferred to the next level of care and must include at minimum; the name of the primary surgeon, any assistants, brief comment of procedure performed and findings, estimated blood loss, specimens removed, and the post operative diagnosis.

   Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated or legibly hand written for outpatients as well as inpatients, immediately after surgery, but not to exceed twelve (12) hours following the surgery. The report shall be signed by the surgeon and made a part of the patient's current medical record. Any practitioner who continuously fails to dictate operative reports within medical record policies, may be suspended from operative privileges upon recommendation by the Executive Committee of the Medical Staff. Suspension will include all operative privileges except for any patients who have already been scheduled for surgery.

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

9. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. For obstetrical patients other than C-sections, if a complete prenatal record is attached, an interval note may be substituted for the history and physical. Except in emergencies, a complete current history and physical is necessary for patients undergoing C-sections.

10. Medical Staff members will abide by guidelines for abbreviations and policy for unsafe abbreviations.

11. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and shall be dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

12. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetrical deliveries, normal newborn infants, and patients with problems of a minor nature. For these latter inpatient type visits, a final summation-type progress note shall be sufficient. The contents of the summation progress note

shall include, at a minimum; the reason for the hospitalization; significant findings; procedures or significant treatment performed; the patient's condition upon discharge; and, any applicable follow up instructions. All summaries shall be authenticated by the responsible practitioner.

13. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

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

15. Access to medical records or any patient protected health information shall be afforded to members of the Medical Staff for a bona fide study and research when access is consistent with the HIPAA requirements. Access to patient protected health information for former members of the Medical Staff shall be subject to the discretion of the President and shall be consistent with HIPAA requirements.

16. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee upon recommendation of the Medical Record Committee.

17. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and authenticated by the practitioner.

18. The patient's medical record shall be complete at time of discharge, including progress notes, final diagnosis, and dictated clinical resume. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the Health Information Management Department and shall be completed in accordance with medical record policies adopted from time to time by the Hospital, but not to exceed thirty (30) days after time of discharge. The physician could be subject to automatic suspension of their clinical privileges for failure to comply with medical record policies. In the event of any changes in medical record policies, written notice shall be sent to all members of the medical staff at least sixty (60) days before implementation.

    An incomplete medical record shall be considered delinquent when any portion of the record is incomplete. A practitioner with records which are delinquent for histories and physicals, operative reports, final summaries, or signatures, shall be notified that (s)he has delinquent records.

19. Records of Hospice Inpatients shall require the same level of physician documen-tation for history and physical, progress notes, procedures and discharge summary as a general acute care admission. Records of Respite Inpatients shall require only a physician's order for admission.

20. Suspension of clinical privilege includes the following restrictions:

    a. The practitioner may not admit patients to the Hospital. The practitioner may schedule patients after (s)he was notified of the pending suspension, but the practitioner may not schedule patients after the practitioner is placed on the suspension list. In the case of an emergency, permission to admit patients must be granted by the Chief of Staff or his/her designated officer.

b. The practitioner may not perform procedures. The practitioner may schedule patients after (s)he was notified of the pending suspension, but the practitioner may not schedule patients after the practitioner is placed on the suspension list. In the case of an emergency, permission to perform procedures must be granted by the Chief of Staff or his/her designated officer.

c. If a practitioner has been suspended for four (4) consecutive weeks or five (5) times in a calendar year, (s)he shall be notified that (s)he has been suspended indefinitely and can only be reinstated by an appeal to and an appearance before the Executive Committee of the Medical Staff

E. GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure must be obtained. Appropriate forms for such consents shall be adopted with the advice of legal counsel.
2. All orders for treatment shall be in writing. A verbal or telephone order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence. All verbal and telephone orders must be dated and timed when taken. All such orders must also be signed, dated and timed by the physician who originated the order, or by another willing member of the medical staff, nurse practitioner or physician assistant. Hospital personnel authorized to accept verbal or telephone orders and therapeutic outpatient orders needing a physician’s signature are identified in the Physician Order policy.
3. The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
4. All previous medication orders are canceled when patients go to surgery and blanket orders such as “resume pre-op medications” are not acceptable.
5. A practitioner's order for the use of restraints or seclusion must be verbal or written and must be time limited in accordance with established Hospital policy.
6. All drugs and medications administered to patients shall be those listed in the latest edition of any of the following: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or American Medical Association Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in Investigational Drugs in Hospitals and all regulations of the Federal Food and Drug Administration. The Pharmacy Committee shall develop a method to control the use of dangerous and toxic drugs, including drugs brought into the Hospital by patients.
7. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.
8. Except in an emergency, consultation is required in the following situations:
    a. When the patient is not a good risk for operation or treatment;

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

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

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

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

f. When requested by the patient or family.

In addition, requirements for consultation shall be specified in each department's Rules and Regulations that shall be approved by the Executive Committee of the Medical Staff.

9. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. The attending practitioner will provide written authorization to permit another practitioner to attend or examine his/her patient, except in an emergency.

10. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, (s)he shall call this to the attention of the nurse's superior who in turn may refer the matter to the Vice President for Nursing. If warranted, the Vice President for Nursing may bring the matter to the attention of the Chair of the department wherein the practitioner has clinical privileges or the Chief of Staff. Where circumstances are such as to justify such action, such Chair or the Chief of Staff may request a consultation.

11. In accordance with the American Medical Association Code of Medical Ethics, members of the Medical Staff are discouraged from treating themselves or members of their immediate family (parents, children, siblings or spouse), performing elective surgical procedures (including the administration of general anesthesia) or serving as attending or consulting physician for the medical care of immediate family. They shall exercise prudence when observing procedures done by other physicians on family members in order to avoid disruption. In obstetrical cases, the regular rules for family observers shall apply. This shall in no way be construed to prohibit emergency care of family members.

F. CONSCIOUS SEDATION

All members of the Medical Staff who provide any level of Conscious Sedation shall be required to comply with the Hospital's policy on Conscious Sedation.

G. GENERAL RULES REGARDING SURGICAL CARE

1. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

2. The care of a surgical patient by a non-physician medical provider is a dual responsibility involving the non-physician medical provider and a physician member of the Medical Staff. The physician member must be the admitting physician.

a. Non-physician medical provider responsibilities:

(1) Detailed history justifying Hospital admission;

(2) A detailed description of the examination of the anatomic structures specific to the area of practice and preoperative diagnosis;

(3) A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue excluding teeth and fragments shall be sent to the Hospital pathologist for examination.

(4) Progress notes as are pertinent to the patient's condition; and

(5) Clinical resume or summary statement.

b. Physician's responsibilities:

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

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

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

c. The discharge of the patient shall be on written order of the dentist, podiatrist, or physician member of the Medical Staff.

3. A written, signed, and informed surgical consent shall be obtained prior to an operative procedure except in those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor patient in which consent for surgery cannot be immediately obtained from the minor's parents, guardian, or a person holding an appropriate power of attorney, these circumstances should be fully explained on the patient's medical record. In emergencies involving an unconscious adult or a mentally incompetent adult patient in which consent for surgery cannot be immediately obtained from a guardian or a person holding an appropriate power of attorney, these circumstances should also be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Should a second operation be required during the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time, and it is known in advance, the procedures may all be described and consented to on the same form.

4. The anesthetist/anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow up of the patient's condition.

5. In any surgical procedure with unusual hazard to life there must be a qualified assistant present and scrubbed.

6. All tissues removed during an operation with the exception of cataracts, stapes, orthopedic prostheses and appliances, foreign bodies, electively removed skin scars, debrided skin, normal placentas, teeth, bunions, bone from the first rib, hernia sacs, turbinates, palatial tissue, foreskin of infants, traumatically injured members that have been amputated, arthroscopy shavings, and portions of bone removed to enhance operative exposure (except first rib resection) shall be sent to the Hospital Pathologist who shall make such examinations as (s)he may consider necessary to arrive at a tissue diagnosis when pathology examination is not indicated. An authenticated report of the Hospital Pathologist's findings on tissues removed during operations and sent to the Hospital Pathologist for examination, shall be made a part of the patient's medical record.

H. EMERGENCY SERVICES

1. For purposes of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the Emergency Department physician on duty and/or specialist on call is hereby designated as a person qualified to conduct the medical screening examination required under the EMTALA. All patients presenting for emergency care shall receive a medical screening examination.

2. Medical Staff members, except as otherwise provided in the Medical Staff Bylaws and or Rules and Regulations, are required, on a rotational basis in their area of practice, to provide for any patients presenting to the Emergency Department who do not have a primary care physician. The on-call physician is responsible for the care of the patient through the episode that created the current medical condition as an inpatient, observation patient, in the Emergency Department or in the physician's office post-discharge, regardless of financial status or ability to pay. Unassigned patients who receive inpatient Hospitalist care will be referred to a physician for follow-up care at discharge based on the Emergency Department Primary Care rotating schedule at the time of admission. The time frame for follow-up is defined by the Emergency Department Physician or the Hospitalist in their discharge instructions. The Emergency Department will inform an unassigned patient and the assigned physician's office in writing of the expectations that the assigned physician will see the patient on at least one occasion for the particular medical condition involved, regardless of means or ability to pay. The assigned physician is not required to assume ongoing future care for the patient unless mutually agreed upon by the assigned physician and the patient.

3. All Active Medical Staff members who take Emergency Department call are expected to provide, or arrange to provide, consultative services (both inpatient and emergency department) when on call for the Emergency Department. Orders for consultations must include the name of the person being consulted, the problem to be addressed by the consultant and the urgency of the consultation. Provider to Provider/Designee communication is required for urgent or emergent consultations, requiring the patient to be seen by the consulting provider within a reasonable period of time, depending on patient need and physician judgment, mutually agreeable to both parties. If a non-physician provider performs the initial evaluation of the patient, the consulting physician must see the patient within 24 hours of the initial request. For non-emergent consultations, the provider/designee will perform the initial evaluation within a 24-hour time frame. It may be appropriate for a patient to be seen in an outpatient setting following discharge from the hospital/emergency department, if the provider requesting the consultations agrees that would be an acceptable option.

   Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the medical record. When operative procedures are involved, and there has been a consultation, the consultation note shall, except in emergency, be on the medical record prior to the operation.

4. When an on-call Practitioner is contacted by the Emergency Department and requested to respond for an Emergency Medical Condition, the Practitioner must do so within 30 minutes. 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:

   a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. serious impairment to bodily functions; or

c. serious dysfunction of any bodily organ or part.

Whether or not an Emergency Medical Condition exists is the final determination of the Emergency Department physician.

In a situation that does not meet the definition of an Emergency Medical Condition, the Emergency Department physician will consult with the on-call Practitioner to determine, based on the patient's condition, the appropriate time the patient is to be seen by the Practitioner without compromising the patient's health.

5. The Department of Emergency Medicine shall be composed of physicians with privileges to provide emergency services who will work closely with the administrative director of emergency medicine.

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

   a. Adequate patient information;

   b. Information concerning the time of the patient's arrival, means of arrival, and by whom transported;

   c. Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his/her arrival at the Hospital;

   d. Description of significant clinical, laboratory, and roentgenologic findings;

   e. Diagnosis;

   f. Treatment given;

   g. Condition of the patient on discharge or transfer; and

   h. Final disposition, including instruction given to the patient and/or the patient's family regarding necessary follow-up care.

7. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

8. There shall be a monthly review of Emergency Department medical records by the Department of Emergency Medicine Committee and by appropriate clinical departments to evaluate quality of emergency medical care. Reports shall be submitted to the Executive Committee of the Medical Staff. Medical records should first be reviewed for their adequacy as documents. If the contents reasonably reflect what has transpired, the Department of Emergency Medicine Committee can then utilize them for medical care evaluation purposes and refer selected clinical situations to the applicable departments for definitive review. In addition, the records of those deceased on arrival patients and those who die in the Emergency Department or within twenty-four (24) hours of admission shall be routinely reviewed.

9. If a physician on call is not available for his/her assigned on call rotation, it will be his/her responsibility to provide a consenting replacement who shall be a fully credentialed and appropriately privileged member of the Medical Staff. The Hospital is to be notified in advance when such a change of schedule involves a replacement who is not a member of the physician's core call group.

I. PROFESSIONAL GRADUATE EDUCATION PROGRAM OR CLINICAL ROTATIONS

1. Residents

   a. Residents and students from institutions not having a contractual agreement with the Hospital for their activities must have permission from the appropriate Medical Staff department chair and the Chief of Staff or President of the Hospital before performing any services for any member of the Medical Staff.

   b. Physicians who have graduated from medical school and who are enrolled in an accredited medical residency program are permitted by the Hospital, while under appropriate supervision, to perform functions/procedures without immediate clinical faculty oversight. The supervising physician should consider the resident's level of training, experience, and type of residency program in determining the appropriate supervision for a specific function or procedure. Examples that might fall in this category include, but are not limited to:

      (1) Determine a diagnosis

      (2) Develop a treatment plan

      (3) Determine the disposition of the patient

      (4) Make entries in the progress notes

      (5) Start peripheral IV's

      (6) Prescribe medications and IV solutions

      (7) Write orders (does not require countersignature by a Medical Staff member)

      (8) Suture simple or complex lacerations not involving tendons or major nerves

      (9) Serve as a first assistant in surgery

      (10) Incise and drain abscesses

      (11) Remove non-penetrating corneal foreign bodies

      (12) Perform circumcisions after completing one year of residency training

      (13) Treat uncomplicated minor closed fractures not involving reduction

      (14) Perform history & physical examinations (require co-signature of the Medical Staff member)

      (15) Complete discharge summaries (require co-signature of the Medical Staff member)

      (16) Place central lines

      (17) Skin biopsies

      (18) Paracentesis

      (19) Thoracentesis

      (20) Lumbar Puncture

   c. Medical residents may perform any functions/procedures deemed appropriate by and while under the direct supervision of a clinical faculty member/medical staff member including but not limited to the following:

      (1) Perform flexible sigmoidoscopies with & without biopsy

(2) Perform vaginal delivery & episiotomy & repair

d. Medical residents may perform closure of surgical wounds in the operating room while under the immediate supervision of a clinical faculty member/medical staff member.

e. Medical Residents will receive weekly written notifications from Health Information Management (HIM) when a medical record is incomplete at least seven (7) days from the date of deficiency assignment and will be considered overdue. If the deficiencies remain incomplete after twenty-one (21) days, HIM will send notification for follow-up to the Postgraduate Program Director. The Medical Resident will have seven (7) days from notification by the Program Director to complete all overdue deficiencies. If the deficiencies remain incomplete after the seven (7) days, HIM will send notification for follow-up to the Chief Medical Officer.

Medical records left incomplete by a Medical Resident due to illness, leave of absence or successful completion of the program will be referred to the attending physician for completion and will not be reported to the Program Director.

f. The postgraduate education program director or committee must submit a report annually to the Medical Executive Committee and the Board of Directors about the performance of its residents, patient safety issues, and quality of patient care and must work with the Medical Executive Committee to ensure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

2. Medical and Other Students

a. Medical students and other professional clinical students, for example PA students, etc.) may participate in the care of patients. Such care must always be under the direct supervision of a member of the Medical Staff.

b. Medical Students, Physician Assistant Students and Advanced Practice Registered Nurse Students may:

(1) Enter progress notes in the patient record (must be countersigned by the physician before invasive procedure performed)

(2) Perform post-admission histories and physicals (must be countersigned by the physician before invasive procedure performed)

(3) Write orders (must be countersigned or authorized verbally by a physician, dentist, podiatrist, Advanced Practice Registered Nurse or Physician Assistant with privileges to write orders before implementation).

(4) Perform procedures subject to physician authorization (procedure must be conducted in the presence of a physician with the physician accepting full responsibility for same)

(5) Draw blood (without immediate supervision)

(6) Start IV's (without immediate supervision)

(7) Change Dressings (without immediate supervision)

J. ORGANIZED HEALTH CARE ARRANGEMENT ("OHCA")

The Hospital, members of the Medical Staff and Allied Health Professionals with privileges at the Hospital are required to comply with the Provisions of the Health Insurance Portability and

Accountability Act ("HIPAA) Privacy Rule (45 C.F.R. Parts 160 and 164) relating to the use and disclosure of individually identifiable health information. The Hospital is an integrated health care setting in which the individual receives treatment from not only Hospital personnel but also members of the Medical Staff and Allied Health Professionals with privileges. The Hospital, members of the Medical Staff and Allied Health Professionals operate under an Organized Health Care Arrangement or "OHCA" as permitted under HIPAA to facilitate the use and disclosure of individually identifiable health information in order to provide for efficient delivery of quality health care services.

1. Participants. The participants are the Hospital and members of the Medical Staff and Allied Health Professionals at the Hospital.

2. Hospital. The Hospital consists of the inpatients and outpatients of St. Elizabeth Hospital, the outpatients at St. Elizabeth Medical Plaza and Wound Care Clinic.

3. Scope of OHCA activities. The scope of the OHCA between the Hospital, members of the Medical Staff and Allied Health Professionals is limited to inpatients and outpatients of St. Elizabeth Hospital, the outpatients at St. Elizabeth Medical Plaza and Wound Care Clinic. The OHCA and these Rules and Regulations do not apply to:

   (a) The Practitioner or Allied Health Professional's independent professional services or individual practice's privacy practices. (For example, the OHCA does not apply to the Practitioner's office practice's use and disclosure of its individually identifiable health information that is maintained by the Practitioner's office for treatment, payment and operations).

   (b) Activities unrelated to Privacy Practices. The rule does not imply joint and several responsibilities between Hospital, the Practitioner or Allied Health Professional for the provision of clinical services. The Practitioner or Allied Health Professional is an independent provider of clinical services and these rules and regulations do not alter in any way the independent status of these individuals.

4. Notice of Privacy Practices The Hospital's Notice of Privacy Practices describes the OHCA and its participants and also serves as the OHCA's Notice of Privacy Practices. The Notice of Privacy Practices govern the information practices that Hospital, members of the Medical Staff and Allied Health Professionals agree to comply with for the provision of services to the individual while at Hospital. The Hospital will be responsible for furnishing the individual with the Notice of Privacy Practices and to obtain the individual's written acknowledgement of receipt (or document the reasonable efforts to obtain such and/or reason(s) for not obtaining the acknowledgement.)

5. Records and Designated Record Sets. The Hospital's HIPAA Compliance Plan will determine which records are included as the "designated record sets" and those records that are subject to the HIPAA record retention requirements. The Hospital is responsible for maintaining these records in accordance with the HIPAA record retention requirements.

6. Voluntary Restrictions. Members of the Medical Staff and Allied Health Professionals as participants in the OHCA are prohibited from agreeing to any voluntary restrictions on the use or disclosure of individually identifiable health information that would be binding on other parties to the OHCA. The Hospital has sole authority to determine voluntary restrictions on the use or disclosure of individually identifiable health information and notification of OHCA participants of the voluntary restriction.

7. HIPAA Compliance Plan, Policies and Procedures. The Hospital Compliance Plan, and the policies, procedures, forms and processes developed by Hospital for HIPAA compliance serve as the same policies, procedures, forms and processes and Compliance Plan for the OHCA. Members of the

Medical Staff and Allied Health Professionals in the OHCA shall refer individual requests to rights granted under HIPAA, including rights to access, amendment, accounting for disclosures, voluntary restrictions, and complaints to the Hospital Privacy Official. Hospital Privacy Official is responsible for oversight and implementation if HIPAA compliance.

ADOPTED by the Medical Executive Committee on February 3, 2016

APPROVED by the Governing Body on February 18, 2016