RULES AND REGULATIONS

OF

MON HEALTH MARION NEIGHBORHOOD HOSPITAL

11/19/2021

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ARTICLE I

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT, AND SERVICES

1.1. Admissions:

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

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

1.2. Responsibilities of Admitting Physician:

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

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

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

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

or providing any other treatments or procedures.

1.3. Care of Unassigned Patients:

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

1.4. Alternate Coverage:

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

1.5. Continued Hospitalization:

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

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

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

(3) plans for post-hospital care.

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

ARTICLE II

MEDICAL RECORDS

2.1. Form and Retention of Records:

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

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

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

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

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

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

2.2. Content of Record:

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

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

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

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

(2) documentation and findings of assessments;

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

(4) diagnosis, diagnostic impression, or conditions;

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

(6) goals of the treatment and treatment plan;

(7) diagnostic and therapeutic orders;

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

(9) progress notes made by authorized individuals;

(10) reassessments and plan of care revisions;

(11) relevant observations;

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

(13) consultation reports;

(14) allergies to foods and medicines;

(15) medications ordered or prescribed;

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

(17) medications dispensed or prescribed on discharge;

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

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

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

(21) final diagnosis with completion of medical records within time period designated by medical staff policy.

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

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

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

(3) patient's language and communication needs;

(4) evidence of known advance directives;

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

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

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

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

(1) documentation of a history and physical;

(2) diagnosis; and

(3) any treatment and services provided.

(f) Medical records must contain evidence of:

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

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

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

(1) known significant medical diagnoses and conditions;

(2) known significant operative and invasive procedures;

(3) known adverse and allergic drug reactions; and

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

2.3. Medical Orders:

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

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

(c) The use of the terms "renew," "repeat," "resume," and "continue" with respect to previous orders is not acceptable.

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

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

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

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

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

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

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

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

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

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

2.4. Verbal Orders:

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

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

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

(1) a member of the Medical Staff;

(2) a professional nurse;

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

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

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

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

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

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

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

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

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

2.5. Standing Order Protocols:

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

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

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

2.6. Progress Notes:

(a) Progress notes shall be written by the physician and allied health professionals, as permitted by their clinical privileges or scope of practice. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

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

2.7. Authentication:

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

(b) All entries in the medical record must be dated, timed, and authenticated by the person making the entry. Each entry must be individually authenticated per policy.

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

2.8. Delinquent Medical Records:

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

(b) Each medical record, including short stay medical records, will be dictated following discharge within the timeline specified per the Medical Records Content and Revisions Policy (MS-006). If the record is incomplete after the time specified per policy after discharge, the medical records department will notify the physician, in writing, of the due date for completing the record. If the record remains incomplete, the physician will be notified in writing of the delinquency and that his or her clinical privileges have been automatically relinquished. The relinquishment will remain in effect until all of the physician's records are no longer delinquent.

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

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

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

ARTICLE III

CONSULTATIONS

3.1. General:

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

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

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

(d) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse will notify his or her superior who, in turn, may refer the matter to the Hospital Administrator. The Hospital Administrator may bring the matter to the attention of the Section Chief in which the member in question has clinical privileges. Thereafter, the Section Chief may request a consultation after discussion with the attending physician.

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

3.2. Required Consultations:

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

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

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

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

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

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

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

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

3.3. Contents of Consultation Report:

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

3.4. Psychiatric Consultations:

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

3.5. Mandatory Consultations:

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

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

ARTICLE IV

CONSENTS, PERMITS, AND LEGAL AFFAIRS

4.1 Consents and Permits:

(a) Emergent Consent

Consent to treatment in the emergency department must be signed when patients present to the emergency department seeking treatment unless Implied Consent applies. In the emergency department under consent to treatment, patients do not need to sign for informed consent for medical or surgical treatment provided except for specific procedures such as the usage of procedural sedation or the administration of thrombolytics which do require Informed Consent.

(b) General Consent

General consent to medical or surgical treatment must be signed when patients are seen as outpatients or are admitted to the Hospital. It provides a record of consent to routine services and medical treatment. A general consent cannot be used as a consent for specific procedures.

(c) Informed Consent

(1) Responsibility for Obtaining Informed Consent:

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

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

- a consent form verifying that the physician has explained the procedure, including its risks, benefits, and alternatives, will be presented to the patient or the patient's legal representative by a member of the hospital staff. The hospital staff member will only

serve as a witness to the patient's voluntary consent, acknowledged by the patient's signature on the consent form;

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

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

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

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

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

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

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

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

- has been or is married; and/or
- has been declared emancipated by a court.

(3) Who May Consent:

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

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

- emergencies;
- minors seeking treatment for venereal disease, substance or alcohol abuse, or AIDS; and
- pregnant minors seeking care related to their pregnancy.

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

(d) Incompetent Patients:

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

(e) Unusual Cases:

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

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

(i) In such a case, the physician who will perform the procedure or provide the treatment shall, in the presence of at least one witness who is on the line with the physician, convey the information via telephone at the same time. If telephone consent is given, the physician giving the information must document in the medical record exactly what was told to the patient's representative and must date/time and sign such notation. The witness shall sign the note as well, certifying that he or she heard the information being transmitted by the physician and heard the patient's representative give consent.

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

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

(f) Refusal to Consent:

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

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

(g) Implied Consent

In an emergency that threatens the life or health of a patient, when the patient is unable to consent, treatment without a written consent is authorized by law under the doctrine of implied consent. This is based on the theory that if the patient were able to, or if a legal representative were present, such consent would be given. Proceed as follows:

(1) Determine whether the treatment is required immediately and is necessary to prevent deterioration or aggravation of the patient's condition. This may be a matter of first aid or temporary medical care in lieu of surgery, or actual surgical or orthopedic procedures. Treat the emergency only.

(2) Assess the possibilities of obtaining the necessary written consent, weighed against the possibility that delay would jeopardize the health of the patient.

(h) Patient Refusing to Take Medical Advice

All patients leaving against medical advice must be asked to sign a special release form. In cases where patients cannot sign, the signature of the nearest relative or guardian must be obtained. Notation should also be made in the medical record. If the patient or family refuses to sign the form, then the physician must document the encounter and patient's refusal in the medical record.

4.2 Other Legal Affairs:

(a) Service of Legal Papers

When members of the Medical or APP Staff are served any legal paper concerning their clinical activities at the Hospital, they should immediately notify the Medical Staff President and Legal Counsel.

(b) Contact by Investigator

A physician contacted by any government or private investigator regarding patient care activities within the Hospital should contact Hospital Administration before submitting to questioning.

(c) Findings Reportable to Government Agencies

Physicians are responsible for reporting a variety of diseases and crime-related wounds and injuries to the police, Coroner, or other government agencies.

ARTICLE V

DISCHARGE PLANNING
AND DISCHARGE SUMMARIES

5.1. Who May Discharge:

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

5.2. Identification of Patients in Need of Discharge Planning:

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

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

(1) functional status;

(2) cognitive ability of the patient; and

(3) family support.

5.3. Discharge Planning:

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

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

5.4. Discharge Summary:

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

(1) reason for hospitalization;

(2) significant findings;

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

(4) condition at discharge; and

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

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

5.5. Discharge of Minors and Incompetent Patients:

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

ARTICLE VI

TRANSFER OR DISCHARGE

6.1. Discharge or Transfer:

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

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

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

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

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

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

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

6.2. Procedures:

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

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

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

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

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

(i) the reason for the transfer;

(ii) available alternatives to the transfer; and

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

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

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

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

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

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

(1) the reason for transfer or discharge;

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

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

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

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

ARTICLE VII

EMERGENCY SERVICES

7.1 Eligibility

(a) All patients seeking emergency care (presenting for a non-scheduled visit) will be given, at a minimum, a medical screening examination. This examination may be done by appropriately privileged Medical Staff and/or Advanced Practice Provider Staff as outlined in the Patient Transfer, Emergency Screening and Examination and Emergency Medical Condition Requirements Policies.

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

7.2 Staffing

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

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

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

(3) Emergency service physicians do not have admitting privileges. In emergencies, emergency service physicians may treat in-

patients. Emergency service physicians may attend any hospital educational program.

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

7.3 Consultations and Transfers

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

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

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

(1) Adequate patient identification;

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

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

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

(5) Diagnosis;

(6) Treatment given;

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

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

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

7.4 Length of Stay in the Emergency Department

(a) When the decision to hospitalize a patient is made, admission should be carried out promptly. Workups for admission to the hospital should not be done in the Emergency Department merely for the sake of convenience. It is the policy of the Hospital that extensive evaluations, prolonged periods of observation, and extraordinary procedures or therapy will not be conducted in the Emergency Department.

7.5 Disaster Plan

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

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

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

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

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

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

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

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

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

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

(9) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements

with communications media will help to provide organized dissemination of information.

(i) All physicians shall be assigned to posts either in the Hospital or in the auxiliary hospital, or in mobile casualty stations and it is their responsibility to report to their assigned stations. The Hospital Administrator in the Hospital and the Chief Administrative Officer of the Hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from Hospital premises, the Hospital Administrator 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 Administrative Officer of the Hospital. In their absence, the vice chiefs and alternate in administration are next in line of authority, respectively.

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

ARTICLE VIII

ETHICAL CONSIDERATIONS

8.1 Ethics Consultation

A consultation regarding ethical issues may be requested of the Medical Executive Committee or Ad Hoc Ethics Committee by all appropriate staff, patients, and, when appropriate, family members or surrogate decision-makers. Prior to consultation, the Ethics Committee shall inform the attending physician of the request.

8.2 Disclosure of Medical Mistakes / Unanticipated Outcomes

A medical mistake is defined as an act of omission or commission that caused or could cause harm to a patient that would likely be judged wrong by a peer. It is a guideline of the Hospital that physicians will disclose medical mistakes. If a physician believes that he or she has made a disclosable medical mistake, it is the responsibility of the physician to disclose the mistake to the patient or the patient's legally authorized representative as soon as appropriate given the circumstances. If a physician without direct responsibility for the patient is made aware of a medical mistake, this physician should first approach the attending of record. Whether harm occurred or not, further consultation with Hospital staff leadership, risk management, and the relevant quality assurance committee is recommended to prevent future mistakes.

8.3 Code of Conduct:

The medical staff and APP staff is expected to comply to the hospital code of conduct.

ARTICLE IX

RESTRAINTS AND SECLUSION

9.1 Use of Restraints and Seclusion:

(a) All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, that is not medically necessary, or that is imposed by staff as a means of coercion, discipline, convenience, or retaliation. Each patient should be treated with respect and dignity. *(DNV PR.7)* Restraint or seclusion may be used only when clinically justified and when alternatives are not effective.

9.2 Orders:

(a) Restraint or seclusion may only be initiated pursuant to a Medical Staff/Advanced Practice Provider's order. If a Medical Staff/Advanced Practice Provider is not available, a registered (professional) nurse may initiate restraint or seclusion because of a significant change in the patient's condition and shall contact a Medical Staff/Advanced Practice Provider's immediately to obtain an order from the practitioner. That order must immediately be recorded in the patient's record.

(b) When restraints or seclusion are used, the Medical Staff/Advanced Practice Provider must see the patient face-to-face within one hour even if the restraints have been removed before he/she arrives. The Medical Staff/Advanced Practice Provider's:

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

(c) The restraint order must:

(1) Be time limited - time limits for restraint orders are as follows:

(i) For non-violent, non-destructive restraint each calendar day up to 24 hours, and orders must be renewed daily

(ii) For violent, self-destructive restraint:

- Up to 4 hours for adults 18 years and older
- Up to 2 hours for ages 9 to 17 years
- Up to one hour for children less than 9 years

(d) The violent, self-destructive original order may only be renewed in accordance with these limits for up to a total of 24 hours. At the end of the time frame, if the continued use of restraint/seclusion to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, another order is required. A face-to-face evaluation by the Medical Staff/Advanced Practice Provider Staff must be conducted every 24 hours for violent, self-destructive restraints. Prior to writing new order, the Medical Staff or Advanced Practice Provider will document their findings in patient's medical record to support the continued use.

(1) Identify the type of restraint to be used.
(2) Indicate the reason for restraint.

(e) Each episode of restraint/seclusion must be initiated per Medical Staff or Advanced Practice Provider order. If a patient was released from restraint/seclusion and exhibits behavior that can only be handled through the reapplication of restraint/seclusion, a new order must be obtained.

(f) Orders must be automatically discontinued if not renewed.

(g) Orders must never be written as a PRN or as a standing order.

(h) Prior to order expiration, the RN will report to the provider the results of the most recent assessment and request a renewal of the original order for another period. This time cannot exceed the time limits noted above.

(i) Restraints/seclusion will be discontinued at the earliest possible time, regardless of the length of time identified in the order.

9.3 Drugs used as a Restraint:

(a) If the use of the medication for the patient meets the definition of a drug used as a restraint, the assessment, monitoring, and documentation requirements apply. The use of PRN orders is prohibited for drugs of medications that are being used as restraints.

For additional provider, nursing, and ancillary staff responsibilities and other information on Restraints and Seclusion, please refer to Mon Health Policy (ID#9573169) addressing restraints, seclusion, and behavior management.

ARTICLE V

MISCELLANEOUS

9.1. Special Care Units

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

9.2. Treatment of Family Members:

(a) No member of the Medical Staff will admit or treat a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise approved by the Chief of Staff or the relevant Department Chief. This prohibition is not applicable to in-laws or other relatives.

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

9.3. Orientation of New Physicians:

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

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

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

9.4 Release of Patient Information to Press/Media

The Hospital administration is responsible for initiating and handling all press/media inquiries about patients, clinical developments, research, and all other Hospital matters. All staff members should consult with administration prior to any press contact.

ARTICLE VI

ADOPTION

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

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

Adopted by the Medical Staff on:

Date: _____

_____

Chief of Staff

Approved by the Board on:

Date: _____

_____

Chairperson, Board of Directors

APPENDIX A

COUNTERSIGNATURE VS
NO COUNTERSIGNATURE BY STATUS – H&P

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

APPENDIX B

COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS –ORDERS

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

APPENDIX C

COUNTERSIGNATURE VS NO COUNTERSIGNATURE BY STATUS – DISCHARGE SUMMARY

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