MEDICAL STAFF
RULES AND REGULATIONS

ST. FRANCIS
MEDICAL CENTER
TRENTON, NJ

Horty, Springer & Mattern, P.C.
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ARTICLE I
RULES AND REGULATIONS

A. GENERAL
1. The rules and regulations approved by the medical staff and the Board of Trustees are binding on all members of the medical staff.
2. Hospital and medical staff services are available to all persons without regard to race, creed, color, national origin, or financial status.
3. All members of the medical staff are obliged to conform to the established ethics of their profession.
4. All members of the medical staff are obliged to practice medicine in this hospital in strict adherence to the current version of the Ethical and Religious Directives for Catholic Health Care Services and the AMA Code of Ethics.

B. ADMISSION AND DISCHARGE OF PATIENTS
1. A patient may be admitted to the hospital only by a member of the medical staff. All practitioners shall be governed by the official admitting policy of the hospital.
2. The medical staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the executive committee.
3. Patients will be admitted on the basis of the following order of priorities.
   a. Emergency Admissions
      Within forty-eight (48) hours following an emergency admission, the attending practitioner shall be prepared to furnish to the Utilization Management Department upon request documentation of need for this admission. Failure to furnish this documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the executive committee.
b. Urgent Admissions

Shall be reviewed as necessary by the Utilization Management Department or the appropriate departmental chairman to determine priority when all such admissions for a specific day are not possible.

c. Pre-operative Admissions

This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of Surgery may decide the urgency of any specific admission.

d. Routine Admissions

This will include elective admissions involving all services.

4. Private patients shall be attended by their own private physician. Patients seeking admission who have no attending physician shall be assigned to members of the medical staff on-call in the department or section to which the illness of the patient indicates assignment. This on-call duty will be assigned by the rules of the individual department. A practitioner who has continuously been an active member of the medical staff for twenty (20) years may apply for exception from emergency service care responsibilities. This is subject to approval by the department/section based on needs and approval of the executive committee. Under specific circumstances, when no staff attending physician is available, a department chairman, with the concurrence of the executive committee, may assign care of service cases to a member of the courtesy staff.

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

6. In any emergency case in which it appears the patient will have to be admitted to the hospital, the practitioner shall when possible, first contact Bed Assignment to ascertain whether there is an available bed.

7. Practitioners admitting emergency cases shall be prepared to justify to the executive committee of the medical staff and the administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical
examinations 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, but in no instance, later than twenty-four (24) hours following admission.

8. A patient to be admitted on an emergency basis, who does not have a private practitioner or a private practitioner who does not accept the case, will be assigned to a member of the staff on a rotation basis, where possible. The Chairman of each department or the chief of each section shall provide a schedule for such assignments.

9. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

10. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay per disease categories as defined locally and as identified by the utilization management department or medical care evaluation committee of this hospital and approved by the particular clinical department and the executive committee of the medical staff. This documentation must contain:
   a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of patient’s diagnosis is not sufficient.
   b. The estimated period of time the patient will need to remain in the hospital.
   c. Plans for post-hospital care
      Upon request of the Utilization Management Department, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized.

This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the executive committee for action.
11. Before discharge, the attending physician will certify that the inpatient services were medically necessary, as evidenced by: (1) signing, or countersigning, the order for inpatient admission; (2) documenting an admitting diagnosis; (3) documenting the expected or actual length of stay of the patient; and (4) documenting the plans for post-hospital care, when appropriate.

12. For the protection of patients, the medical and 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 must have consultation by a member of the psychiatric staff.

13. Patients shall be discharged only on written order of the attending practitioner. At the time of discharge, the attending practitioner shall see that the record is complete, state his final diagnosis, and sign the record. The order for discharge of a patient shall be signed by the attending practitioner or his designee.

   Patients leaving the hospital against the advice of the attending practitioner or without proper discharge must have a notation of the incident made in their medical record.

14. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee. 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 or his designee. Death certificates shall be signed within twenty-four (24) hours after death.

15. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy at St. Francis Medical Center is encouraged when death occurs under the following circumstances:
   a. Deaths in which autopsy may assist to explain unknown and unanticipated medical complications.
   b. Deaths in which cause of death is not known with certainty on clinical grounds.
   c. Cases in which autopsy may help to allay concerns and provide reassurance to the family and/or the public regarding the death.
d. Deaths of patients who have participated in clinical trials approved by Institutional Review Board.

e. Obstetric deaths.

f. Neonatal and pediatric deaths.

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

h. When jurisdiction has been waived by a coroner:

(1) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.

(2) Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.

(3) Natural deaths subject to, but waived by, a forensic medical jurisdiction, such as deaths occurring within 24 hours of hospital admission, and deaths which the patient sustained or apparently sustained an injury while hospitalized.

(4) Deaths known or suspected to have resulted from environmental or occupational hazards.

(5) Deaths within 48 hours of a surgical or invasive procedure.

An autopsy may be performed only with a written consent, signed in accordance with state law. The autopsy permit must indicate if a head autopsy is authorized. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within 48 hours and the complete protocol should be made a part of the record within 60 days. The attending physician must be notified when an autopsy is to be performed on his or her patient.

16. Admissions to Critical Care Units are in accordance with criteria for standards of medical care established by the Medical Staff. All admissions and discharges are subject to review by the Director of the Critical Care Units or his designee.
17. In the event of a bed shortage, priority of admission and discharge will be indicated by a committee consisting of the President of the medical staff and the chairmen of the clinical departments.

C. MEDICAL RECORDS [Prior sections on History & Physical have been moved to Article X of the Bylaws to comply with CMS and Joint Commission requirements.]

1. All practitioners who are granted clinical privileges shall utilize the Hospital’s electronic medical record system and comply with all applicable training and educational protocols that may be adopted by the Executive Committee involving electronic medical records.

2. The medical record shall contain information to justify admission and continued hospitalization, to support the patient’s progress, describing the patient’s progress, describing the patient’s response to medications, response to interventions, care, treatments, discharge plans and test results.

3. All orders for diagnosis and treatment written by unlicensed medical personnel shall be countersigned by a licensed physician. Exceptions shall be if orders for diagnosis or treatment are written by a person authorized in the State of New Jersey to engage in the practice of medicine in the second year of a graduate medical education program or beyond.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily.

5. All operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative notes shall be written in the record and the reports dictated immediately following surgery and the report promptly signed by the surgeon and made a part of the patient’s current medical record. Both must be done on all procedures.
6. Invasive procedure reports should include:
   a. name and hospital identification number of the patient;
   b. date and times of the surgery;
   c. name(s) of the surgeon(s) and assistants or other practitioners who
      performed surgical tasks (even when performing those tasks under
      supervision);
   d. pre-operative and post-operative diagnosis;
   e. name of the specific surgical procedure(s) performed;
   f. type of anesthesia administered;
   g. complications, if any;
   h. a description of techniques, findings, and tissues removed or altered;
   i. surgeons or practitioners’ name(s) and a description of the specific
      significant surgical tasks that were conducted by practitioners other than the
      primary surgeon/practitioner (significant surgical procedures include:
      opening and closing, harvesting grafts, dissecting tissue, removing tissue,
      implanting devices, altering tissues); and
   j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

7. Consultations shall include reason for consult and 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.

8. The supervising physician may clarify and/or change any statement made in the
   medical record by a resident staff member under his supervision. The supervising
   physician shall initial, time and date the change.

9. All clinical entries in the patient’s medical record shall be accurately dated, timed
   and authenticated.

10. Symbols and abbreviations may be used only when they have been approved by the
    medical staff. An official record of the approved abbreviations should be kept on
    file in the Health Information Management Department.
11. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.

12. A discharge clinical summary shall be written or dictated on medical records. All summaries shall be authenticated by the responsible practitioner. The discharge summary must contain the following:
   a. Reason for hospitalization;
   b. Significant findings;
   c. Adverse drug reactions, if present;
   d. Procedures performed and treatment rendered;
   e. Patient’s condition at discharge;
   f. Instructions to patient and family at discharge with follow-up care required; and,
   g. Final diagnosis.
   For patients hospitalized less than 24 hours, a comprehensive progress note may substitute for the discharge summary.

13. The comprehensive discharge note must contain at least the following:
   a. Final diagnosis;
   b. The patient’s condition on discharge;
   c. Medications on discharge;
   d. Discharge instructions; and,
   e. Follow-up care.
   Transfers to acute care facilities, including in-hospital critical care units, should describe patients condition at time of transfer same as above.

14. Written authorization of the patient or authorized representative is required for release of medical information to persons not otherwise authorized to receive this information.

15. All records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. 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.

16. Access to all medical records of all patients shall be afforded to members of the
medical staff for bona fide study and research consistent with preserving the
confidentiality of personal information concerning the individual patients. Such
projects must be consistent with the current medical record policy for chart access.

17. Subject to the discretion of the Chief Executive Officer, former members of the
medical staff shall be permitted access to information from the medical records of
their patients covering all periods during which they attend such patients in the
hospital. Such projects must be consistent with the current medical record policy
for chart access.

18. A medical record shall not be permanently filed until it is completed by the
responsible practitioner or is ordered filed by the Medical Record Committee.

19. All practitioner’s orders, not entered into the Electronic Medical Record (EMR),
are to be written in detail on the order sheet of the patient’s record, dated, signed
by the practitioner; and timed where appropriate.

20. The patient’s medical record shall be complete at time of discharge. 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 for thirty (30) days after
discharge. If the record remains incomplete thirty (30) days after all essential
reports have been received and placed on the record, the Health Information
Department will send the practitioner a letter notifying them of the delinquencies.
All concerned departments shall be notified of this action.

If a physician remains on the Delinquent Medical Record List for ninety (90) days,
the Medical Executive Committee may make additional recommendations up to
and including reporting to the Board of Trustees, monetary fine, and suspension.

21. Individuals of legally constituted group practices, who have formally notified the
Chief Executive Officer of this association, have been approved by the Board of
Trustees, and who are responsible for the care of the patient, may sign all aspects
of chart documents for each other. This may include history and physical
examinations, discharge summaries, face sheet, with the exception of operative and procedural reports, which are the sole responsibility of the attending physician performing the procedure.

22. No documents or records will be released from the Medical Staff Office unless all records are completed and recommended fines have been paid.

D. GENERAL CONDUCT OF CARE

1. A member of the medical staff shall be responsible for:
   - medical care and treatment of each patient in the hospital;
   - the prompt completeness and accuracy of the medical record;
   - any and all necessary special instructions on the care of the patient;
   - communicating with the patient, family and referring practitioner;
   - providing written discharge instructions to the patient upon discharge. The discharge instructions are to include, but not be limited to the following items:
     >diet   >activity
     >medication >follow-up

Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

    Formal transfer among members of medical staff in a group or partnership practice who have formally notified the Chief Executive Officer of this association is not necessary.

2. Patients who have been classified in the medical record, by their attending physician, as requiring non-skilled care shall be seen at least twice weekly unless the attending physician, in his professional judgment, determines that the patient’s clinical condition requires that he be seen more often.

3. 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 admission office 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 a procedure, the risks and benefits and alternatives available in any surgical or invasive procedure must be obtained.

If there is a significant life threatening emergency as defined by the attending physician, then he will write a note delineating the emergency so the patient can proceed with the treatment plan. If procedure is done without consent, hospital administration should be notified of such a decision.

4. A verbal order shall be considered to be in writing if dictated to duly authorized person, including registered nurse, pharmacist, physical therapist, respiratory therapist, or registered dietitian, functioning within his/her sphere of competence and signed by the responsible practitioner or appropriate member of the resident staff. All orders dictated over the telephone shall be signed, dated and timed by the appropriate authorized person to whom dictated with the name of the practitioner per his or her own name. The responsible practitioner shall authenticate such orders within 48 hours of being written unless dictated otherwise by state or federal statutes, and failure to do so shall be brought to the attention of the executive committee for appropriate action. Failure to do so shall be brought to the attention of the executive committee for appropriate action.

5. The practitioner’s notes and orders must be contemporaneously written clearly, legibly and completely. The use of “Renew,” “Repeat,” and “Continue Orders” are not acceptable. Abbreviations used are to be those officially accepted by St. Francis Medical Center.

6. All previous orders are cancelled when patients go to surgery.

7. All drugs and medications shall be ordered and administered through the current hospital formulary. Non-formulary medications may be requested according to hospital/pharmacy policy.

Patients who are allowed to use their own medications can do so only with the approval of the physician. Proper notification, if the attending physician deems
it appropriate and consistent with hospital policy, should be indicated on the order sheet.

Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration and guidelines formulated by the Institutional Review Board Committee of the hospital.

Physician has responsibility to document and to report adverse drug reaction to registered nurse on the floor, the pharmacy and/or the ADR Hot Line so that proper reporting mechanism can be ensured per hospital policy.

8. Medication renewal orders for scheduled and non-scheduled medications and intravenous fluids shall be in accordance with state and federal law and the approved recommendations of the pharmacy and therapeutic committee.

9. Consultation is required when:
   - There may be conflict with the Ethical and Religious Directives for Catholic Health Care Services. Consultation is recommended for all procedures involving serious consequences even though such procedures are listed as permissible. Mandatory consultations, prior to surgery, are not required regardless of sex or age if condition is a threat to life;
   - Any pediatric patient, under 18 years of age, is admitted to ICU by a non-pediatrician. This consultation has to be completed by a pediatrician.

10. Consultation should be considered when there is a need for additional information, opinion or assistance in relation to the clinical management or care of the patient.
   a. The attending practitioner is responsible for requesting consultation when indicated and for calling a qualified consultant. He/she will provide a written order on the order sheet to permit another attending practitioner to attend or examine his/her patient, except in emergency. Official consultations between partners in the same specialty are not permitted. When operative procedures are involved, the consultation note, except in an emergency situation shall be recorded prior to the operation.
b. All urgent consultations require the attending to personally contact the consulting physician, to clearly state the nature of the urgency and the time frame the consultation should be held and documented accordingly.

c. Non-emergency consultation should be done within 24 hours unless the consultant notifies the attending when the consultation will be done.

11. Resident Supervision – Where residents or medical students are involved, communication process and supervision will take place according to the Medical Education Oversight Committee and the respective resident manuals.

12. Anesthesia Patient Services

a. “Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal, moderate or conscious sedation, or analgesia via epidurals/spinals for labor and delivery.

b. A pre-anesthesia note, reflecting evaluation of the patient and review of the patient record prior to administration of anesthesia, shall be made or certified by the physician administering or supervising the administration of anesthesia and entered into the medical record of each patient receiving anesthesia.

c. Monitoring During Procedure:

(i) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient’s physiological status.

(ii) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(a) the name and Medical Center identification number of the patient;

(b) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;
(c) the name, dosage, route time, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment, and the patient’s status upon leaving the operating room.

d. Post-Anesthesia Evaluations:

(i) In all cases, a post-anesthesia evaluation will be completed and documented in the patient’s medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(ii) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient’s medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient’s inability to participate will be made in the medical record (e.g., intubated patient).

(iii) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
(b) cardiovascular function, including pulse rate and blood pressure;
(c) mental status;
(d) temperature;
(e) pain;
(f) nausea and vomiting; and
(g) post-operative hydrations.

e. Minimal, Moderate or Conscious Sedation:
All patients receiving minimal, moderate or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

13. Plans for the care of mass casualties and for the evacuation of patients and personnel from the hospital in case of fire and other emergency must be current and practiced twice yearly in accordance with Medical Center’s Emergency Preparedness Plan.

14. All tissue and any materials removed at surgery shall be sent to the hospital pathologist who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis and he shall sign his report.

15. Rules for the conduct of members of each department shall be formulated and reviewed annually by each respective department.

16. Restraining Orders
Physical restraints can be used to ensure patient safety or staff safety only after alternative measures were unsuccessful. A physician’s order is required and must be dated, timed and renewed according to applicable policy. The order must include reason, type and duration. (Refer to hospital policy on “Restraints: Use and Applications.”)

17. Every member of the medical staff shall be required to attend meetings concerning quality issues (morbidity/mortality) regarding cases with which he was involved when duly notified by the chairman of his department and/or chief of his section.
These cases may be presented within the respective department, section or multidisciplinary group when duly notified within two weeks.

18. The notice of payment of dues for the year shall go out in February of that year. Any member who has not paid his dues by April 1 of the same year may have all his hospital privileges suspended by the action of the executive committee of the medical staff at their meeting of that month.

Suspension will then become effective three (3) months after the final notice has been mailed and will remain in effect until payment is made.

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

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

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

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

(4) the patient’s first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient’s medical record.

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

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

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

20. Registered Dieticians are authorized to order the following:
Complete nutrition assessments of patients.
Provide instruction/education on appropriate diet (in the absence of a specific diet ordered by a physician) as follows:

1. Provide diet education to adults
2. Provide general diabetes education, not including medication education

Perform anthropometric measurements of patients.
Recommends solutions to patient problems.
Adjust diet orders to meet individual patient's nutrition needs, after consultation with the attending physician.
Conducts and participates in clinical education programs and maintains professional qualification through CME and through professional affiliations.

Reports summarizing the performance appraisals of Registered Dieticians practicing at St. Francis Medical Center will be provided to the Medical Executive Committee on an annual basis by the Clinical Nutrition Manager.
ARTICLE II
ADOPTION

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

Adopted by the Medical Staff:

SEPTEMBER 16, 1997
FRANK A. CLAIR, MD
Date
President of the Medical Staff

Approved by the Board of Trustees:

October 7, 1997
Thomas C. Jamieson, Jr., Esq.
Date
Chairman of Board of Trustees
ARTICLE III
REVISIONS

Approved by Medical Staff – 2/16/1999
Approved by Board of Trustees – 3/9/1999

Approved by Medical Staff – 5/18/1999
Approved by Board of Trustees – 6/15/1999

Approved by Medical Staff – 10/1/2002
Approved by Board of Trustees – 10/8/2002

Approved by Medical Staff – 5/20/2003
Approved by Board of Trustees – 6/10/2003

Approved by Medical Staff – 9/7/2004
Approved by Board of Trustees – 9/14/2004

Approved by Medical Staff – 2/21/2006
Approved by Board of Trustees – 3/14/2006

Approved by Medical Staff – 9/15/2015
Approved by Board of Trustees – 10/12/2015

Approved by Medical Staff – 7/5/2017
Approved by Board of Trustees – 7/11/2017