Rules & Regulations of the Medical Staff of St. Mary Medical Center

RULES & REGULATIONS

Section l. GENERAL

1. The Rules and Regulations approved by the Medical Staff and the governing body 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, sexual preference, handicap or national origin.

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 Ethical & Religious Directives for Catholic Health Care Facilities.

5. All members of the Medical Staff are obliged to participate in an ongoing program of continuing education consistent with guidelines set forth by the American Medical Association or respective national or local organizations.

6. Members of the Active Medical Staff are obligated to serve on the Emergency Room on-call roster as scheduled by the Department Chair and in conjunction with the Departmental Rules & Regulations.

Section 2. ADMISSION & 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. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports on the condition of the patient, of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, the original attending physician shall obtain the commitment of the new attending physician to accept the case, and a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3. 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 case of an emergency, such a statement shall be recorded as soon as possible.

4. In any case of emergency, in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

5. Practitioners admitting emergency cases shall be prepared to justify to the Medical 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 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 to him/her. Where no such selection is made, a member of the active or associate staff on duty in the department or service will be assigned to the patient, on a rotation basis, where possible. The chairperson of each department shall provide a schedule for such assignments.

7. Each member of the staff shall always arrange for the proper professional care of his/her patients.

8. The chief admitting clerk will admit patients on the basis of the following order of priorities:

    a. Emergency Admission: Within 24 hours following an emergency admission, the attending physician shall sufficiently document in writing the need for the 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 Medical Executive Committee for appropriate action.

    b. Urgent Admissions: This category includes those designated by the attending practitioner and shall be reviewed as necessary to determine priority when all such admissions for a special day are not possible.

    c. Pre-operative Admissions: This includes all patients already scheduled for surgery.

    d. Routine Admissions: This will include elective admissions involving all services.

9. Patient transfers: Transfer priorities shall be as follows:

    a. Emergency room to appropriate patient bed.

    b. From obstetric patient care area (unit) to general care area, when medically indicated.

    c. From intensive care unit to general care area.

    d. From cardiac care unit to general care area.

    e. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

    No patient will be transferred without such transfer being approved by the responsible physician.

10. 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/her patients might be a source of danger from any cause whatever.

11. For the protection of patients, the medical and nursing staff and the hospital, certain principles are to be met in the care of the potentially suicidal patient:

a. Any patient known or suspected of being suicidal in intent shall be admitted to the medical-surgical nursing unit until the patient can be transferred to another institution where suitable facilities shall be attended at all times.

b. Any patient known or suspected of being suicidal must have consultation by a member of the psychiatric staff.

12. Admissions to intensive and cardiac care units: if any questions as to the validity of admission or to discharge from the intensive care unit or the coronary care unit should arise, that decision is to be made through consultation with the chairman of the Special Care Committee or his/her designate.

13. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay and approved by the particular clinical department and the Medical Executive Committee of the Medical Staff. The documentation must contain:

    a. An adequate written record of the reason for continued hospitalization.

    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 Quality Management Services, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

14. Patients shall be discharged only on the order of the attending practitioner or by the Nurse Practitioner (NP) or Physician Assistant (PA) with the supervision of the attending.

15. It shall be the responsibility of the attending practitioner to write discharge diagnosis on patients on the day prior to discharge whenever possible. Patients should be checked out with the cashier and leave the hospital by 11:30 a.m. whenever possible.

16. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. When possible, he/she shall notify the family and sign the death certificate. 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/her designee. Policies with respect to the release of dead bodies shall conform to local law.

17. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. Autopsy at St. Mary 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 Boards.

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, including radiology.

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 2 months.

Section 3. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

   This record shall include identification data, 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 report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the

systems of the body.

If a complete history has been recorded and a physical examination performed prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff within thirty days prior to the patient's admission to the hospital. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded.

3. Patients undergoing both inpatient and outpatient emergent and non-emergent operative and/or other invasive procedures shall have, prior to the procedure, a plan of care formulated and documented that includes an assessment of the patient relative to the acuity needs, plan for the operative or other invasive procedure, and a plan for the level of post-procedure care.

   When the history and physical examination are not recorded before an operation or invasive procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient and has documented a brief note which includes the pre-op diagnosis and planned procedure.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. 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 treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problems.

5. Operative/invasive procedure reports should be dictated or written in the medical record immediately after surgery and should contain a description of the findings, the technical procedures used the specimens removed the post-operative diagnosis and the names of the primary surgeon and any assistants.

   The completed operative/invasive procedure report should be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When there is a transcription and/or filing delay a comprehensive operative progress note should be entered in the medical record immediately after surgery in order to provide pertinent information for use by any practitioner who is required to attend to the patient.

6. Consultations show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the reason for the consultation, 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 note shall except in emergency situations so verified on the record, be recorded prior to the operation.

7. Consultations shall be completed and recorded in the patient's record preferably in 24 hours, but no later than within 36 hours of the request.

8. 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.

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

10. Final diagnosis shall be recorded in full and 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.

11. A discharge summary shall be dictated or written on the day of discharge on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by a responsible practitioner. If the practitioner is not the attending physician, he/she must be authorized by the attending physician and must be knowledgeable about the patient: s condition.

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

13. 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 Chief Executive Officer. In care 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 Medical Executive Committee of the Medical Staff.

14. Free 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. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is retired incomplete in accordance with the Medical Records Department Policy and Procedure which addresses the issue.

16. 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 and signed by the practitioner.

17. Medical records of patient discharge shall be completed within 30 (thirty) days following discharge.

Section 4. 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 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 specific treatment of surgical procedure must be obtained.

2. Medication or treatment shall be administered only upon written and signed orders of a physician, dentist, podiatrist, physician's assistant, nurse practitioner, nurse anesthetist, psychologist and midwife acting within the scope of his/her license, granted privileges and protocols, and qualified according to Medical Staff Bylaws. Telephone orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for such orders to be given in written manner by the responsible practitioner.

   Telephone orders shall be taken only by a practitioner, professional nurse, physical therapist, respiratory therapist or a pharmacist who may transcribe oral orders pertaining to drugs, approved in accordance with hospital policy, who shall transcribe the orders in the proper place in the medical record of the patient. The order shall include the date, time and full signature of the person taking the order and shall be countersigned by a prescribing practitioner within 24 hours. If the practitioner is not the attending physician, he/she must be authorized by the attending physician and must be knowledgeable about the patient& s condition.

   Verbal orders for treatment and medication dictated by a practitioner authorized according to Medical Staff Bylaws to personnel qualified according to Medical Staff Bylaws and in the same room as the practitioner shall be accepted in accordance with Medical Staff rules. The person entering verbal orders into a medical record shall sign and date the entry. The practitioner shall authenticate the order within 24 hours. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.

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. The use of "renew," "repeat" and "continue orders" are not acceptable.

4. All previous orders are canceled when patients go to surgery.

5. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigation may be exceptions. These shall be used in full accordance with the statement of principles involved in the use of investigation drugs in hospitals and all regulations of the Federal Drug Administration.

   Narcotics that are ordered without time limitation of dosage shall be automatically discontinued after 7 (seven) days. Orders for anticoagulant drugs will be reviewed for continuance after a period of three days. Orders for all other drugs will be reviewed for continuance after a period of 14 days.

   The use of oxytoxics for induction or stimulation of labor requires specific orders, including dosage and rate of administration, as well as the presence of a physician. All orders for oxytoxic drugs are automatically discontinued after 24 hours.

   Drugs brought into the hospital by patients must be collected, stored and returned to the patient on discharge and on the advice of the attending physician.

6. Any qualified member of the active staff with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

7. The attending practitioner is primarily responsible for requesting consultation when indicated and

for calling in a qualified consultant. He/she will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency.

8. 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, she shall call this to the attention of her supervisor who in turn may refer the matter to the director of nursing service. If warranted, the director of nursing may bring the matter to the attention of the chairperson of the department wherein the practitioner has clinical privileges. Where circumstances are such as justifying such action, the chairperson of the department may himself request a consultation.

9. Compulsory consultations are not required for primary Cesarean Sections but are required before any operations which would result in sterilization in either sex. Consultations with an active member of the obstetrical/gynecological staff is required before any D & E procedure is performed which may interfere with possible viable pregnancy where there have been conflicting reports on pregnancy tests. A D & E may be performed without consultation on an inevitable abortion when the patient is hemorrhaging or when products of conception have been passed and documented. No abortions or procedures for the purpose of sterilization are permitted.

10. Plans for the care of mass casualties and for the evacuation of patients and personnel from the hospital in case of fire or other emergency must be current and practiced at least twice yearly.

Section 5. MEDICAL STAFF MEETINGS

A meeting of the Medical Staff shall take place in December. Notice regarding time and place shall be mailed to each member of the staff at least one week in advance.

Section 6. GRIEVANCE PROCEDURE

1. If, in the opinion of any member of the Medical Staff, the Medical Staff Bylaws, his/her Departmental Rules & Regulations, and/or policies and procedures are not being appropriately followed, the Member may submit his/her complaint in writing to the Chairperson of his/her department. The written complaint shall specifically state the issue and the reasons why, in the members' opinion, the Bylaws, Rules & Regulations, and/or policies and procedures are not being followed.

2. Within 10 working days of receiving such a letter, the Chairperson of the Department shall respond in writing to the Medical Staff Member regarding his/her decision.

3. If the Medical Staff Member is not satisfied with the response of the Department Chairperson, he/she may request in writing a review of the complaint and response by the President of the Medical Staff. Within 10 working days of receiving such a letter, the President of the Medical Staff shall review the complaint and responses and respond in writing to the Medical Staff Member regarding his/her decision.

4. If the Medical Staff Member isn't satisfied with the response of the President of the Medical Staff, he/she may request in writing a review of the complaint and responses by the Medical Executive Committee. Within 30 working days of receiving such a letter, the Medical Executive Committee will review the responses and respond in writing to the Medical Staff Member regarding their decision. The Medical Staff Member may be invited to the Medical Executive Committee meeting to provide information regarding his/her complaint.

5. If the Medical Staff Member is not satisfied with the response of the Medical Executive Committee, he/she may request in writing a review of the complaint and responses by the Board of Directors. Within 30 working days of receiving such a letter, the Board of Directors shall respond in writing to the Medical Staff Member regarding their decision. The Medical Staff Member may be invited to the Board of Directors' meeting to provide information regarding his/her complaint. The decision of the Board of Directors will be final.

6. Complaints filed and the responses to those complaints will be reviewed by the Medical Executive Committee and the Board of Directors for approval.

Section 7. PEER REVIEW

1. Peers are defined as physicians and allied health professionals with similar specialties (i.e., Medicine, Surgery, Radiology, etc.)

2. Those circumstances requiring peer review are defined in each department's Rules and Regulations.

3. Participants in the peer review process are appointed by the department chairperson. Provision is made for participation in the review process by the individual whose performance is being reviewed.

4. Department peer review activities are conducted on a regular basis as defined by the department.

5. For specific circumstances, peer review panels with appropriate specialty/subspecialty representation are appointed by department chairperson.

6. External peer review with appropriate specialty/subspecialty representation is arranged by the Vice President of Medical Affairs:

    a) If a specialty/subspecialty peer is not available internally.

    b) If the only specialty/subspecialty peer available could be perceived to have a conflict of interest.

    c) At the request of the department chairperson.

7. Peer review is conducted within two months from the time the department chairperson becomes aware that a circumstance requiring peer review has occurred.

8. Opportunities for improvement identified through the peer review process result in:

    a) On the department level: sharing of aggregated data with members at the department meeting. When appropriate, speakers are invited to educate on issues identified through the peer review process.

    b) On the individual level: results of peer review activities are documented in the Physician Profile and are considered for the maintenance of privileges and for the recredentialing process. Corrective actions are in accordance with the Medical Staff Bylaws.

9. Peer review files can only be accessed by people involved in the decision process for credentialing and recredentialing as defined in the Medical Staff Bylaws. Physicians can access their own files

through their department chairman.

Section 8. PHYSICIAN CONTRACTS

1. Medical Staff may authorize the MEC to engage an attorney to advise physician leaders, managers and clinical on-call service providers in their negotiation with the Administration to achieve fair and timely contracts.

Approved by the Board of Directors on September 17, 1976 - Amendments approved by the Board of Directors on: December 20, 1974 -December 19, 1975 - March 19, 1976 – September 17, 1976 - December 17, 1976 -May 20, 1977 - December 16, 1977 - October 20, 1978 - May 18, 1979 – December 14, 1979 - March 20, 1981 - June 18 , 1982 - October 15 , 1982 -December 17, 1982 - June 17, 1983 - December 16, 1983 - November 5, 1984 -May 6, 1985 - January 6, 1986 - April 6, 1987 - October 3, 1989 - July 1 , 1991 - October 8, 1991 - April 6, 1992 - July 6, 1993 - January 3, 1995 - January 2, 1996 – April 1 , 1996 - July 1, 1996 - December 2, 1996 - January 5, 1998 - July 6, 1999 - July 1, 2002 - January 13, 2003 - September 20, 2004 - March 14, 2005 - November 12, 2007, July 11 , 2011 , January 2013 , May 15 , 2014 - July 14, 2015 - July 22, 2016 - June 26, 2020