SCENIC MOUNTAIN MEDICAL CENTER
MEDICAL STAFF
RULES AND REGULATIONS

Article I
Admission and Discharge of Patients

1.1 Admission of Patients

The admission policy is as follows:

1.1(a) Except in emergencies, all patients admitted to the hospital shall have a provisional or admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

1.1(b) Only an attending member of the Medical Staff may admit a patient to the hospital. All Practitioners shall be governed by the admitting policy of the hospital. Those patients not having a physician shall be assigned to a physician and the service as indicated by the patient's illness. Physician assignment of patients, within services, shall be on a rotational basis.

1.1(c) Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self-harm.

1.1(d) Physicians who intend to admit patients to the Critical Care Unit (CCU) are encouraged to have documentation regarding current ACLS certification. ER physicians will be required to show evidence of PALS, ACLS, NRP, and ATLS certification. Upon initial appointment, ER physicians will be given 90 days, after approval of privileges, to obtain NRP certification. Furthermore, NRP is required for physicians requesting newborn privileges. Physicians taking pediatric call will be required to have PALS. CRNA's are required to obtain and maintain ACLS and PALS.CRNA's are also encouraged to have documentation regarding current NRP certification.

1.1(e) Medical Staff members shall be responsible for the medical care and treatment of each hospitalized patient, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, and to relatives of the patient where appropriate. Whenever those 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. Written notice shall also be given to pertinent hospital departments.

1.1(f) Each member of the Medical Staff shall have a member of the Medical Staff who may be called to care for his/her patients in an emergency at those times the Attending Physician is not readily available. In cases of

failure to contact the Attending Physician, the following should be contacted:

(1) An alternate physician (preferably a partner, associate or designee of the Attending Physician);

(2) The Chief of Staff;

(3) The Chief Executive Officer shall have authority to call any member of the Medical Staff to provide care for the patient.

1.2 Admitting Policy

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Within twenty-four (24) hours following all admissions, the Attending Physician shall have a History and Physical dictated documenting the 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 Medical Executive Committee (MEC) for appropriate action.

1.2(b) Preoperative Admissions

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

1.2(c) Routine Admissions

This will include elective admission involving all services.

1.3 Patient Transfers

Transfer priorities shall be as follows:

1.3(a) Emergency Department to appropriate patient bed;

1.3(b) From any department to CCU in an emergency;

1.3(c) From CCU in an emergency;

1.3(d) From any department to Skilled Nursing Facility;

1.3(e) From obstetric patient care area (unit) to general care area when medically indicated;

1.3(f) From temporary placement in an inappropriate area to the appropriate area for that patient. No patient will be transferred between departments without notification to the responsible Practitioner.

1.4 Suicidal Patients

For the protection of the patients, the medical and nursing staff, and the hospital, the care of the potentially suicidal patient shall be as follows:

1.4(a) A patient suspected to be suicidal in intent shall be admitted to a security room. If these accommodations are not available, the patient shall be referred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital as a temporary measure. Appropriate restraints may be used per hospital policy and appropriate physician order. The patient will be afforded psychiatric consultation;

1.4(b) The Hospital Social Services Consultant shall be consulted when necessary for assistance.

1.5 Discharge of Patients

The discharge policy is as follows:

1.5(a) If any questions as to the validity of admission to or discharge from the CCU should arise, the subject shall be referred to the Chairman of the appropriate clinical department for assistance:

1.5(b) The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate.

(2) Estimate of additional length of stay the patient will require;

(3) Plans for discharge and post- hospital care.

Upon request of the appropriate committee, the Attending Physician must provide written justification of the necessity for continued hospitalization of any patient hospitalized longer than specified by the committee, including an estimate of the number of additional days of stay and the reason thereof. This report must be submitted within a reasonable period of time. Failure of compliance with this policy will be brought to the attention of the MEC for action.

1.5(c) Patients shall be discharged only on order of the Attending Physician. Should a patient leave the hospital against the advice of the Attending

Physician or without proper discharge, the Attending Physician shall make a notation of the incident in the patient's medical record.

1.6 Deceased Patient

In the event of a patient death, the deceased patient shall be pronounced dead by the Attending Physician, another member of the Medical Staff, or the ED Physician, who shall document it in the patient's medical record.

1.7 Autopsies

Autopsies shall be secured by the Attending Physician as required by state law and/or suggested per the Medical Staff autopsy criteria derived from the College of American Pathologists and approved by the Medical Staff per JCAHO standards.

ARTICLE II
MEDICAL RECORDS

2.1 Preparation/Completion of Medical Records

The Attending Physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include identification data, chief complaint, personal history, family history, history of present illness, physical examination, special reports (such as consultations, clinical laboratory, radiology services, etc.), provisional diagnosis, medical or surgical treatments, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, summary of discharge note, clinical resume, and autopsy report, when performed.

2.2 Admission History

A complete admission History and Physical examination shall be recorded within twenty-four (24) hours of admission. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children, or adolescents, the report shall include developmental age, immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the History and Physical shall specifically document the circumstances surrounding the need for additional acute care. Failure to record the patient's History and Physical within twenty-four (24) hours after admission shall result in said Physician being notified that he/she will have twenty-four (24) hours in which to complete the History and Physical. Following this, if the History and Physical remains delinquent, the Chief of Staff (or his/her designee) or the Chief Executive Officer (or his/her designee) may take appropriate steps to enforce compliance.

If the H&P is completed by a licensed independent practitioner who is not a physician, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures. An H&P performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the following: that the H&P is still current; that an appropriate assessment was completed on admission confirming that the necessity for the procedure or case is still present; and that the patient's condition has not changed since the H&P was originally completed.

2.3 Scheduled Operations/Diagnostic Procedures

When a History and Physical examination, pertinent laboratory, x-ray, and EKG reports are not recorded before a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless that Attending Physician documents that such delay would be detrimental to the patient. If a History and Physical examination has been performed within thirty (30) days prior to admission, a durable legible copy of this report may be used in the patient's medical record, provided that the practitioner documents the following: (a) that the patient's condition has not changed since the history and physical was originally completed; and (b) that an appropriate assessment was completed on admission confirming that the necessity for the procedure or care is still present.

2.4 Progress Notes

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 treatments. Progress notes shall be written or dictated at least daily on all patients except on the day of admission.

Progress notes on persons admitted to the SMMC Behavioral Health Unit are required daily for the first five (5) days after admission, then required five (5) out of every seven (7) days thereafter until a stay greater than 20 days, then progress note is required weekly until discharge.

2.5 Operative/Procedural Reports

Operative/procedural reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative/procedural notes shall be written or dictated immediately following surgery, and the report made a part of the patient's current medical record within six (6) hours after completion of surgery. If there is a delay of more than six (6) hours, an operative progress note must be documented. Any Practitioner failing to dictate operative/procedural notes as required herein will be brought to the attention of the Chief of Service or Chief of Staff for his/her appropriate action.

2.6 Consultations

Consultations shall show evidence of a review of patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the 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.

2.7 Obstetrical Patient Histories

The history for obstetrical patients shall be accepted as a valid and actual History and Physical throughout the hospital for surgery and other procedures related to the obstetrical patients when adequately updated with progress notes setting forth the current history and changes in physical findings.

2.8 Clinical Entries/Authentication

All clinical entries in the patient medical record shall be accurately dated and authenticated. Verbal orders/telephone orders shall be authenticated within twenty-four (24) hours as required by Federal Medicare Standards. Authentication will include signature, date, and time of authentication. Authentication means to establish authorship by written signature, identifiable initials or computer key. The use of a rubber stamp or electronic signature is acceptable under the following strict conditions:

2.8(a) When the Practitioner, whose signature the rubber stamp represents, is the only one who has possession of the stamp and is the only one who uses it; and

2.8(b) When the Practitioner places in the administrative offices of the hospital a signed statement to the effect that he/she is the only one who has the stamp and is the only one who will use it.

2.8 (c) When the Practitioner utilizing electronic signature participates in a validation process as approved by both HIM and Administration departments of the hospital

2.9 Abbreviations/Symbols

Abbreviations and symbols utilized in medical records are to be those approved by the Quality Improvement Committee and filed with the Medical Records Department.

2.10 Final Diagnosis

The final diagnosis pending the results of lab, pathology, and other diagnostic procedures shall be recorded in full without the use of symbols or abbreviations, and shall be dated and signed by the responsible Practitioner within a reasonable time of discharge of all patients.

2.11 Removal of Medical Records

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. In the case of re-admission of a patient, all previous records shall be available for the use of the Attending Physician. This shall apply whether the same or another Practitioner attends the patient. Unauthorized removal of records from the hospital is grounds for suspension of the Practitioner for a period to be determined by the MEC of the Medical Staff.

2.12 Access to Medical Records

Current members of the Medical Staff shall be afforded access to medical records consistent with state and federal law and hospital policies. Subject to the discretion of the Chief of Staff, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

Any physician on the Medical Staff may request a release of patient information for a patient currently under the physician's care to the extent necessary for the care of the patient. Such releases, as a routine matter, will not require a Release of Information Form to be signed by the patient. The intent of this Rule and Regulation is to address a physician's need to have information available at his or her office to treat patients who may come to his or her office after having been seen and treated or who have had tests at the hospital.

Written consent of the patient or other legally authorized person, such as his/her guardian, his/her agent, or his/her heirs is required for release of medical information to persons not otherwise authorized to receive this data without consent under state or federal law.

The Director of Information Services is responsible for maintaining policies concerning the release of medical records, including records of mental health treatment, substance abuse, and HIV status, that are consistent with state and federal law.

2.13 Permanently Filed Medical Records

A medical record shall not be permanently filed until it is completed by the responsible Practitioner(s) or is ordered by the MEC, the Chief of Staff, or the Chief Executive Officer with an explanation of why the responsible Practitioner(s) could not or did not complete it. Permanently filed medical records may be destroyed in accordance with Hospital policies concerning the retention and destruction of medical records.

2.14 Standing Orders

A Practitioner's standing order shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner. Standing orders shall not replace or void those orders written for a specific patient.

2.15 Completion of the Medical Record

The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis. The written or dictated clinical resume shall be completed as stated in Article II, Section 2.16. When final laboratory or other essential reports have not been received at the time of discharge, annotation shall be written or dictated that the information is pending.

2.16 Delinquent Medical Records

If any staff member fails to complete the medical records of a patient within twenty-three (23) days after the patient's discharge, the Chief of Staff shall give the staff member written notice (either by personal delivery or by certified mail, return receipt requested) that such records must be completed within seven (7) days after the date of the notice, upon penalty of temporary suspension. If the staff member fails to complete such records within the seven (7) day period, a temporary suspension of all privileges may be imposed by the Chief of Staff. Such suspension shall be effective as of the first day after the expiration of the seven (7) day period and shall continue until the medical records in question are completed. Such temporary suspension shall include all admitting and clinical privileges, scheduling of elective operations and assisting at elective operations.

2.17 Treatment and Care Written Orders

Orders for treatment and care of patients may not be written by Allied Health Professionals or other personnel, except CRNAs, unless such personnel writes the order(s) under the supervision of the Attending Physician, who is required to cosign the orders, except orders written for a patient being admitted or admitted to the SMMC Behavioral Health Unit which do not require co-signature or additional endorsement.
Preoperative orders must be cosigned prior to being followed unless the orders are verbal orders given by the Physician as prescribed in Article III, Section 3.2 of these Rules and Regulations. CRNAs may write orders related to the provision of anesthesia if a physician has written an order for the CRNA to provide anesthesia services. Such orders written by CRNAs do not require cosignature.

ARTICLE III
GENERAL CONDUCT OF CARE

3.1 General Consent Form

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 patient business office should notify the Attending Physician 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.

3.2 Written/Verbal/Telephone Treatment Orders

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to an RN and signed by the RN and countersigned by the physician giving the order.

Registered physical therapists, lab technicians, x-ray technicians, respiratory therapy technicians, pharmacists, dietitians, and CRNAs may accept verbal orders relating to their area of interest. All verbal and telephone orders shall be signed by the qualified person to whom it is dictated with the name of the Practitioner per the recipient's own name. The date and time of the order shall be noted. The responsible Practitioner shall authenticate and date any order as soon as possible, such as during the next patient visit, and in no case longer than the thirty (30) day chart completion period. Failure to do so shall be brought to the attention of the MEC for appropriate action. All medication orders shall be authenticated by the prescribing practitioner as soon as possible, such as on the next patient visit, but in no case longer than the thirty (30) day chart completion period. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

3.3 Illegible Treatment Orders

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.

3.4 Previous Orders

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

3.5 Administration of Drugs/Medication

All drugs and medications administered to patients shall be those listed in the Formulary of American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the appropriate committee performing the pharmacy and therapeutics function and the MEC of the Medical Staff.

3.6 Ordering/Dispensing of Drugs

The Physician must order by name, dose, route, and frequency of administration. Drugs shall be dispensed from the hospital pharmacy. The patient's clearly identifiable drugs may be administered as ordered by the Physician and upon discharge all medications shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his/her decision shall be binding. Physicians should refrain from writing orders for bedside (unsecured) medications.

3.7 Automatic Stop Orders

The Pharmacy will follow a Medical Staff Approved Protocol that includes:

3.7(a) The policy applies to the following drugs/drug classes:

Anti-Infectives (excluding topical ..... 10 days
Controlled Drugs (Schedule II) ..... 5 days

Controlled Drugs (Schedule III – V)..... 5 days
Anticoagulants ..... 5 days
Corticosteroids (excluding topicals)..... 5 days
Oxytoxics .....24 hours
IV Solutions..... 30 days
Gentamicin and Amikacin..... 5 days
Toradol..... 5 days

3.7(b) Cancellation of Orders when patient undergoes surgery. Current drug orders shall be automatically canceled when a patient undergoes surgery. The prescriber shall write new orders. Notations such as “continue previous orders” shall be clarified.

3.8 Ordering of Consultation

The Attending Physician is responsible for ordering a consultation.

3.8(a) With respect to seriously ill patients for whom diagnosis is obscure or when there is doubt as to the most appropriate therapeutic measures to be used, consultation is recommended. Judgement as to the serious nature of the illness and question of doubt as to diagnosis rests with the attending physician. It is the duty of the Medical Staff, through its department chairs and the MEC, to evaluate whether staff members contact consultants when appropriate. The Chief of Staff and department chairs shall at all times have the right to call in a consultant or consultants when they reasonably believe it is necessary for patient care. In an urgent or emergency situation it should be the responsibility of the attending physician to contact the consultant physician ‘person-to-person’ in order to communicate the need and urgency of the consultation.

3.8 (b) 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, he/she shall inform his/her supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall inquire of the Attending Physician concerning the doubt or question. If the matter is not resolved, the Chief Nursing Officer may contact the chair of the department in which the Practitioner has clinical privileges The department chair may request a consultation. The department chair may also contact the Chief of Staff for guidance.

3.9 Patient Care Rounds

Hospitalized patients shall be seen daily and as frequently as their status warrants, , Behavioral Health Unit patients shall be seen daily for the first five (5) days following admission and then five (5) out of every seven (7) days until after 21 days then they must be seen at least weekly by the Attending and always as their status warrants, and patients in the Skilled Nursing facility shall be seen weekly and/or as frequently as their status warrants by the Attending Physician or his/her designated alternate.

Allied Health Professionals such as Physician Assistants or Advance Practice Nurses with appropriate privileges may round on patients as a supplement to, but not in lieu of, daily rounding by the Attending Physician, except on the SMMC Behavioral Health Unit AHPs may round as a substitute for the attending as assigned by their supervising member of SMMC Medical Staff and within their scope of privileges.

3.10 Attending Physician Unavailability

Should the Attending Physician be unavailable, his/her designee will assume the responsibility for patient area.

3.11 Respiratory Therapy Orders

The duration of orders for respiratory therapy for post- surgery intermittent positive pressure breathing, ultrasonic nebulization, incentive spirometry, postural drainage and percussion will be discontinued after three (3) days unless otherwise ordered. All other intermittent positive pressure breathing, ultrasonic nebulization, incentive spirometry, postural drainage and percussion will be discontinued after five (5) days unless otherwise ordered, but not without notification to the Attending Physician.

3.12 Patient Restraint Orders

Restraint orders will adhere to and be consistent with hospital policy as approved by the Department of Medicine.

3.13 Practitioners Ordering Treatment

Licensure will be verified for all practitioners ordering treatment (i.e. home health, cardiac rehabilitation, physical therapy, chemotherapy), regardless of the practitioner's Medical Staff status or lack thereof. Verification may be performed through any reliable means including obtaining a copy of the practitioner's license or through electronic mechanisms established by the Texas State Board of Medical Examiners or other state licensing agencies.

ARTICLE IV
GENERAL RULES REGARDING SURGICAL CARE

4.1 Recording of Diagnoses/Tests

Except in emergencies, a history, physical, and other appropriate information including the preoperative diagnosis and appropriate laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In all emergencies, the Practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

4.2 Admission of Dental Care Patient

A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff.

4.2(a) Dentist's Responsibilities:

1. A detailed dental history justifying hospital admission.

2. A detailed description of the examination of the oral cavity and preoperative diagnosis.

3. A complete operative report describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination.

4. Progress notes that are pertinent to the oral condition.

5. Clinical summary.

4.2(b) Physician's Responsibilities

1. Medical history pertinent to the patient's general health shall be on the patient's chart prior to induction of anesthesia and start of surgery.

2. A physical examination report to determine the patient's condition shall be on the patient's chart prior to anesthesia and surgery

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

4.2(c) The discharge of the patient shall be the dual responsibility of the dentist and the Attending Physician.

4.3 Admission of the Podiatric Patient

A patient admitted for podiatric care is the dual responsibility of the podiatrist who is a staff member and the physician member of the Medical Staff designated by the podiatrist.

4.3(a) Podiatrist's Responsibilities

1. A detailed podiatric history justifying hospital admission.

2. A detailed description of the podiatric findings and a preoperative diagnosis.

3. A complete operative report describing the findings and technique. A tissue shall be sent to the hospital pathologist for examination.

4. Progress notes as are pertinent to the podiatric condition.

5. Clinical summary.

4.3(b) Physician's Responsibilities

1. Medical history pertinent to the patient's general health which shall be on the patient's chart prior to induction of anesthesia and start of surgery.

2. A physical examination to determine the patient's condition which shall be on the patient's chart prior to anesthesia and surgery.

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

4.3(c) A discharge for the patient shall be the dual responsibility of the Attending Podiatrist and physician.

4.4 Surgical Consent

A written, informed and signed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient only after the risks and benefits of the procedure, alternative treatment methods and other information necessary to be fully informed has been explained to the patient by the surgeon. After informed consent has been obtained by the surgeon, the nurse shall obtain the patient's signature on the consent form and shall witness the signature. In those emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, such circumstances should be fully explained on the patient's medical record. A consultation in such instances is required before the emergency procedures are undertaken, if time permits. If two (2) or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

4.5 Anesthetist's Records

The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation to determine whether the patient is an appropriate candidate for the planned anesthesia, and post- anesthesia follow-up of the patient condition by the anesthetist on admission to and discharge from the post-anesthesia recovery area. The post-anesthesia exam can be performed by an anesthesiologist, another physician, or an R.N. In cases of outpatient surgery, this post-anesthesia exam may be performed in the recovery room.

4.6 Examination of Specimens

Specimens removed during a surgical procedure shall be evaluated by a pathologist with the exception of teeth and foreign objects. Each specimen must be accompanied by pertinent clinical information. Categories of specimens requiring only a gross description and diagnosis shall be determined by the pathologist and the Medical Staff and documented in writing. Exempt from this policy is non-specimen surgeries, a list of which is maintained by the surgery department supervisor.

4.7 Elective Work Scheduling

In order to prevent patient trauma by a long wait, reduce staff overtime for elective work, and allow time for possible emergencies, the following guidelines will be followed for scheduling elective work:

4.7(a) Standing Time: 7:30 AM

4.7(b) Priority Cases:

1. age 12 and under

2. open bone work

3. Cesarean section

4. Emergency.

5. Contaminated cases last, if possible.

4.8(c) Scheduling of Cases

1. Elective surgery should be scheduled by 3:00 PM the previous day.

2. Scheduled with Operating Room Staff.

3. All cases must be done in the order they are scheduled, whether general or local, inpatient or outpatient, except for pre-exempting priority cases.

4. If a scheduled case is cancelled, the schedule will be moved up to fill the vacancy. Any other case scheduled by the same surgeon canceling will be added to the end of the schedule. The new case will not replace the canceled one.

5. If a surgeon desires to change the order of his/her scheduled cases, any other surgeon who will be affected by the change must be notified.

6. If a surgeon is more than thirty (30) minutes late for a scheduled procedure, the case will follow other scheduled cases. The Operating Room supervisor will then attempt to contact the surgeon and ascertain when he/she will be available and if not within a reasonable period of time, the next scheduled surgery shall commence.

4.7(d) Preoperative work-up is as deemed appropriate.

4.8 Post- Operative Examination

For all outpatient surgery patients who are discharged from the recovery room to home, a post- operative examination will be conducted by a Physician.

4.9 Conscious Sedation

Sedation and analgesia is administered only as provided in the Medical Staff Sedation and Analgesia For Non-Anesthesia Providers Policy and Procedures.

4.10 Invasive Procedures Not Done in the Operating Room

The surgeon or physician who performs outside of an Operating Room Suite when that procedure is customarily performed in an Operating Room Suite is responsible for assuring that the patient receives the same level of care as the patient would if the procedure were performed in an Operating Room Suite, unless the patient has an emergency condition and there is insufficient time to assure that the patient receives such level of care.

ARTICLE V
GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 High-Risk Pediatric Care

Pediatric care for newborns at high risk for complications will be provided only by those physicians who have training in high risk infant resuscitation and care. High risk for this purpose will be defined as:

5.1(a) All cesarean sections.

5.1(b) Premature infants less than thirty-five (35) weeks gestation with or without complications.

5.1(c) Premature infants less than four (4) pounds, eight (8) ounces with or without complications.

5.1(d) All premature infants with complications.

5.1(e) Full term infants with complications requiring invasive interventions.

5.2 Induction of Labor

To provide safe and effective induction/augmentation of labor with the use of Pitocin.

5.2(a) Only one augmentation/induction per day at the discretion of the Charge Nurse. Emergencies will be the only exception.

5.2(b) All inductions will be scheduled the day before. Approval and acceptance of the induction will be determined by the availability of equipment and nursing staff to monitor the patient. In the event of conflict, the OB Nurse Manager will consult with the physician.

5.2(c) Pitocin will not be administered until four (4) hours after the last prostaglandin gel application.

5.2(d) Pitocin will not be administered unless the Physician remains readily available within fifteen (15) minutes of the OB Suite.

5.3 Epidural Anesthesia

The following guidelines will be followed by Anesthesiology, Nursing Service and Pharmacy in the initiation of OB epidurals: The catheter insertion will be performed by an anesthesiologist or CRNA in OB and Labor/Delivery area.

5.4 Medical Screening of the Obstetric Patient

An OB nurse will assess the OB patients when triaged from the Emergency Department when the OB physician is not present. The OB nurse will communicate the patient assessment to the on-call OB or attending OB physician, and will obtain appropriate orders from this physician for further care. If the medical screening by an OB nurse who is qualified to perform a medical screening, reveals no emergency medical condition, the patient may be discharged from the OB service at the request of the on-call or attending OB physician. The on-call OB physician will assume responsibility for the discharge of the patient, if the patient has no OB physician.

ARTICLE VI
EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER & ON-CALL ROSTER POLICY

6.1 SCREENING, TREATMENT & TRANSFER

6.1(a) Screening

(1) Any individual who presents to the Emergency Department of this hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an “emergency medical condition” is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child.

(2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual’s method of payment or insurance status, nor denied on account of the patient’s inability to pay.

(3) All patients shall be examined by qualified medical personnel, which shall be defined as a physician or, in the case of a woman in labor, a registered nurse trained in obstetric nursing where permitted under State law and Hospital policy.

(4) Services available to Emergency Department patients shall include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

6.1(b) Stabilization

(1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.

(2) A patient is Stable for Discharge when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or when the patient requires no further treatment and the treating physician has provided written documentation of his/her findings.

(3) A patient is Stable for Transfer if the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered to be Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

(4) A patient does not have to be stabilized when:

(i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or

(ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification which includes a summary of risks and benefits to this effect.

(5) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(c) <u>Transfer</u>

(1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.

(2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.

(3) Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.

(4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

6.2 CONSULTATIONS, REFERRALS & EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond the capability of the Emergency Department Physician is needed, the patient shall be permitted to request the services of a specific private physician. This request will be documented in the patient's medical record.

6.2(b) The physician whom the patient requests shall be contacted by a person designated by the physician in charge of the Emergency Department, and that person will document the time of the contact in the patient's medical record.

6.2(c) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department Physician or Emergency Department designee has:

(1) Attempted to reach the physician in the hospital;
(2) Called the physician at home;
(3) Called the physician at his/her office; and
(4) Called once on the physician's pager.

Twenty minutes will be considered a reasonable time to carry out this procedure.

6.2(d) The rotation call list, containing the names and phone numbers of the on-call physicians shall be posted in the Emergency Department. In the event that the patient does not have a private physician, the private physician refuses the patient's request to come to the Emergency Department, or the physician cannot be contacted within twenty (20) minutes of the initial request, the rotation call list shall be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the rotation list may

not refuse to respond. The Emergency Department physician's determination shall control whether the on-call physician is required to come in to personally assess the patient. Any such refusal shall be reported to the CEO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

6.2(e) The physician called from the rotation schedule shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility may include follow-up care of the referred patient in the physician's office. If, after examining the patient, the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

6.2(f) All members of the Active Staff shall participate in the on-call backup to the Emergency Department as required by the Board, upon recommendation of the MEC. Each Active Staff member must establish current competence in and maintain a sufficient breadth of clinical privileges in his/her specialty to meaningfully participate in emergency department unassigned call as required in the Rules & Regulations of the Medical Staff. The MEC and the Board shall retain ultimate authority for making determinations regarding call requirements based upon the needs of the Hospital and its patients, and upon the Hospital's obligation to ensure that the services regularly available to its Hospital patients are available to the Emergency Department. In the event any physician or specialty represented on the Active Staff is excused from call, the MEC and the Board shall document the reasons, and shall ensure that such decision does not negatively impact upon the Hospital's ability to fulfill its obligations as outlined above.

Physicians, Anesthesiologists, and CRNAs called are required to respond to Emergency Department call by telephone within ten (10) minutes. If requested to come in, Physicians, Anesthesiologists, and CRNAs are required to do so within a reasonable amount of time following the initial contact by telephone.

6.2(g) The system for providing on-call coverage, including specification of which specialties shall cover call and the minimum obligations therefore, shall be approved by the Board of Trustees and documented in writing. As a condition of Medical Staff appointment, all emergency department physicians and any physician who is or may be required to take unassigned call for Emergency Department patients pursuant to the provisions of the Bylaws, Rules and Regulations shall be required to receive hospital-sponsored or hospital-approved EMTALA training prior to initial appointment and prior to each subsequent reappointment to the medical staff.

ARTICLE VII
GENERAL RULES FOR COMMITTEES

7. Appointment of Medical Director

In order to provide proper Medical Staff guidance and direction to certain hospital services, the Chief of Staff will appoint Medical Directors who have received special training, acquired experience and demonstrated competence related to the care provided by that service. These services shall include, but shall not be exclusive of the following:

7.1(a) Emergency

The Medical Directors shall be a senior or active member of the Scenic Mountain Medical Center medical staff and serve on the Emergency Committee. Their responsibilities/duties will include, but not be limited to, interpretations, policy and procedures, consultations, and quality improvement activities.

ARTICLE VIII
ADOPTION AND AMENDMENTS OF RULES AND REGULATIONS

8.1 Development

The Medical Staff shall have the initial responsibility to formulate, adopt, and recommend to the Board the Medical Staff Rules and Regulations and amendments thereto, which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest or providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Chief Executive Officer, the Board of Trustees, and the community.

8.2 Adoption, Amendment and Reviews

The Medical Staff Rules and Regulations may be adopted, amended or replaced by a majority vote of the Medical Staff members eligible to vote who are present and voting at a meeting at which a quorum is present, provided at least five (5) day written notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of a majority of the Board as provided in the Board of Trustees Bylaws. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may initiate revisions to the Medical Staff Rules and Regulations, taking into account the recommendations of the Medical Staff members. In no case may a unilateral decision be made by either the Board of Trustees or the Medical Staff. The Rules and Regulations shall be reviewed and revised as needed, but at least every two (2) years.

8.3 Documentation and Distribution of Amendments

Amendments to these Rules and Regulations as set forth herein shall be documented by either:

8.3(a) Appending to these Rules and Regulations the approved amendment, which shall be dated and signed by the Chief of Staff, the Chief Executive Officer, and Chairperson of the Board of Trustees; or

8.3(b) Restating these Rules and Regulations, incorporating the approved amendments and all prior approved amendments which have been appended to these Rules and Regulations shall be dated and signed by the Chief of Staff, the Chief Executive Officer, and the Chairperson of the Board of Trustees.

Each member of the Medical Staff shall be given a copy of any amendments to these Rules and Regulations in a timely manner.

8.4 Suspension, Supplementation or Replacement

The Board reserves the right to suspend, override, supplement, or replace all of a portion of the Medical Rules and Regulations in the event of compelling circumstances affecting the operation of the hospital, welfare of its employees and staff, or provision of optimal care to patients.

MEDICAL STAFF RULES AND REGULATI0ONS
APPROVED AND ADOPTED:

Medical Staff:

By _____ _____
Chief of Staff Date

Board of Trustees:

By _____ _____
Chairman Date

SMMC:

By _____ _____
Chief Executive Officer Date