BEACON HEALTH SYSTEM

Community Hospital of Bremen

Rules and Regulations of the Medical Staff

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Approved: 12/29/2022, 02/23/2023

Signed and approved:

_____ _____
Algis Baliunas, MD Date
Medical Staff Chief of Staff

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Bill Davis, Chairman Date
Board of Directors

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David Bailey Date
Hospital President

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ARTICLE I ADMISSION AND DISCHARGE OF PATIENTS

1.1. The hospital shall allow admission of patients suffering from all types of diseases but shall not continue to offer services for patients requiring only prolonged rest or custodial care. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to the staff, or who have been granted temporary privileges. Specific privileges granted shall be based on previous training and experience and reviewed by the Medical Staff Committee of the Medical Staff.

1.2. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

1.3. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

1.4. All patients presenting to the hospital for care, without admitting orders from a member of the Active or Associate Medical Staff, shall be evaluated in the Emergency Department by the Emergency Department physician on duty.

1.5. Each member of the Medical Staff shall reside within a reasonable proximity of the hospital in order to provide for the needs of admitted patients. When a member is not available due to travel or illness, they shall name a member of the Medical Staff from the local area who may be called to attend his or her patients. A rotating call schedule can fill this purpose. In an emergency situation, the Administrator of the hospital, working with the appropriate Medical Staff leadership, shall have the authority to call any member of the Medical Staff to provide back-up if necessary.

1.6. All patients admitted to the hospital shall be seen in the hospital by their attending physician or designee within 24-hours of admission and daily thereafter for non-swing bed admissions. These guidelines do not apply for patients admitted for IV fluids, transfusion of blood or blood products, the administration of IV medications, or hospice care. Any critically ill patient or patient who becomes critically ill after admission shall be seen as soon as possible, unless the attending physician has anticipated such and has adequately provided for this in the patient care orders.

1.7. Hospital policies and procedures will be in place governing some activities of the Medical Staff in lieu of what has historically been called "standing orders". The use of order sets, protocols like ACLS, etc. allow a complex set of activities to be performed without the direct input of the provider on the specifics.

1.8. Physicians who are credentialed and have been granted clinical privileges as well as other hospital clinical personnel (e.g. RN's, Allied Health Professionals, physical therapy, respiratory therapy, social services, dietary, pharmacy, coding professionals (query forms only) physician assistant, and occupational therapy, etc.) may enter remarks as to the recommendations, progress, etc. of care for the patient. These notations shall be made preferentially into the hospital's electronic health record or through dictation. Documentation on paper is the least desirable method and should

be reserved for emergency situations only or when no appropriate means for electronic documentation is available.

1.9. All orders for treatment shall be entered into the electronic health record. Though direct order entry by the provider is preferred, it is not always practical. An order shall be considered acceptable if given verbally to a registered nurse or registered pharmacist which should be later processed in the electronic health record. Verbal orders are not the preferred method. In emergency situations, written orders are acceptable, but should be later processed into the electronic health record. The attending physician must electronically sign all orders before the chart is considered completed after discharge.

1.10. The attending physician or his or her designee is required to provide specific documentation regarding the need for ongoing hospitalization for each patient. The documentation must support the diagnosis, have justification and indication for all procedures or special treatments, and must describe thoroughly the patient's progress and response to medication and treatments. When possible, a statement about the presumptive timeline of care should be noted.

1.11. Patients shall be discharged only by order of the attending physician or designee. The attending physician shall see that the medical record is complete, state his or her final diagnosis and sign the record in a timely manner. Should a patient leave the hospital against medical advice or without proper discharge, a notation of the incident shall be recorded in the patient's medical record and, if possible, the proper form signed by the patient (discharge against medical advice).

1.12. In the event of a hospital death, the deceased shall be pronounced dead within a reasonable time and the body shall not be released until this is done. This may be done by an attending physician or his or her designee or this responsibility may be delegated to a registered nurse after proper information has been received from the attending physician.

ARTICLE II DOCUMENTATION GUIDELINES

2.1. The Medical Staff shall approve all changes in the components of the medical record listed below. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall be complete enough to facilitate the highest quality of patient care and allow any other similarly trained provider to assume care efficiently and safely should the need for a transfer of care happen. This documentation should include identification data; chief complaint; pertinent past medical history; pertinent family and social history; history of the present illness; physical exam; focused system review; special reports such as consultations; clinical laboratory data; x-ray reports, etc.; provisional diagnosis; medical and/or surgical treatment; operative diagnosis; pathological findings; progress notes; final diagnosis; condition on discharge; and summary or discharge note.

2.2. For all surgical and non-surgical patients, a complete history and physical shall be completed in accordance with the CHB Medical Staff Governance and Credentialing manual.

2.3. Patients seen in the Emergency Department will have proper documentation of their visit by the ED physician.

2.4. Pertinent progress notes shall be recorded sufficiently to permit continuity of care and transferability. Progress notes should be completed at least daily on all patients except those in swing bed. Progress notes give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment. A discharge summary shall be documented on all medical records of patients hospitalized. If the discharge summary is documented on the same day of discharge, no discharge progress note is required. If a discharge summary is not documented on the day of discharge, a progress note must be documented with the anticipation that a full discharge summary will be forthcoming at a later date. A final progress note summary may be substituted for a discharge summary of normal newborn infants and uncomplicated obstetric deliveries. The progress note summary must contain outcome of hospitalization, the case disposition, and any provisions for follow-up care. Patients admitted and discharged on the same day and seen only once by the attending physician may have a single document encompassing all elements of a H&P, progress note, and discharge summary. At the time of transition between hospital level of care to swing bed, an appropriate discharge summary and new admission note will be needed. At the time of transition between levels of hospital care (observation and acute inpatient for example) no such formal notation is needed as long as proper documentation is available to explain the transition. A patient in swing bed who transitions to a surgical procedure must be discharged and, if returning to the medical floor, re-admitted with brief, but appropriate, documentation of the need for this transition which may reference other documents such as a recent previous H&P.

2.5. All clinical entries in the record shall be accurately dated, timed and signed.

2.6. Symbols and abbreviations may be used only when approved by the Medical Staff. This list shall be available at nursing stations and in the Medical Records Department.

2.7. Authentic signatures/initials are required on all patient records where an e-signature is not available or feasible. Use of rubber stamps will not be permissible. A log of physician signatures/initials is kept in the Medical Records Department and is available upon request.

2.8. If the medical record is not complete at the time of discharge, the following action will be taken by the hospital:

a) If the record is not complete 23 days after patient discharge, the attending physician will be notified that he or she will be suspended from the Medical Staff on the 30th day unless documentation is completed.

b) When suspended from the Medical Staff, a physician may not see patients, including those previously scheduled for surgery, and may not attend patients in active labor. In unusual circumstances, patients may be admitted after consultation with the Medical Staff President, who will then notify the Hospital President or his or her designee.

c) The physician may regain membership on the staff only by completing all of his or her incomplete records.

d) If a member of the staff has been unable to take care of his or her charts because of illness or absence from the community, the Hospital President shall, when notified, delay the application of this regulation for a reasonable period of time.

e) The medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff President.

ARTICLE III USE OF MEDICAL RECORDS

3.1. All medical records are the property of the Hospital and may be removed only by a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient will be attended by the same physician or by another provider.

3.2. Free access to all medical records of patients shall be afforded to staff physicians for study and research subject to approval of the institutional research board or the appropriate committee, consistent with preserving the confidentiality of personal information concerning the individual patients.

3.3. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. No attorney or insurance representative may have access to the patient's chart while the patient is still confined to the hospital without expressed written permission of the patient.

3.4. With the availability of patient records electronically comes the responsibility of the proper use of that data when accessed remotely. Federal statute guides the use of patient-identified health information, and the hospital will hold anyone remotely accessing patient data to these standards.

ARTICLE IV CONSULTATIONS

4.1. The attending physician or his or her designee is responsible for ordering a consultation. Consultation requests not made directly from provider to provider must include adequate information transfer in order to express to the consultant the nature and urgency of the request.

a. Required Consultations

~~4.1.~~4.2. Consultants

a) A consultant must have privileges in the specialty field in which his or her opinion is sought.

b) A satisfactory consultation includes examination of the patient and the medical record within a timely manner. An opinion by the consultant must be included in the medical record which should indicate whether the consultant will continue to follow the patient daily or whether the consultation is considered complete. When operative procedures are involved, the consultation note, except in emergencies, shall be recorded prior to the

operation. As is requested of the physician ordering the consultation, the consultant physician is asked to provide feedback to the ordering physician to share information in ways that are best able to support the care of the patient.

~~4.2.~~4.3. Consultation and Transfer to Outside Entities

a) Any transfer of a patient to another facility is governed by federal law. This transfer consultation is required to be a verbal consultation between the transferring and receiving physician. Proper paperwork will be required and can be completed initially by our hospital staff.

ARTICLE V SURGERY

5.1. Unless it is an emergent situation, the surgeon shall be responsible for completion of the surgery consent form and it must be completed before the patient is taken to the operating suite.

5.2. History and physical examinations are to be completed as noted in the section on Admission and Discharge documentation above. If a history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be cancelled unless the attending surgeon states, in writing, that such delay would constitute a hazard to the patient.

5.3. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be documented within 24- hours following surgery and the report promptly signed by the surgeon and made a part of the patient's current medical record.

5.4. All specimens removed during surgery shall be submitted to pathology who shall make and submit a signed report of such examination(s) as may be necessary to arrive at a pathologic diagnosis. This shall be a part of the patient's record. Exceptions are as follows: specimens that do not permit fruitful examination or that rarely show pathological change such as cataracts, orthopedic appliances, foreign bodies, traumatically amputated members, foreskin, grossly normal placentas, teeth (number and fragments to be recorded in the medical record), hernia sack contents, scar tissue, toenails and fingernails, and the like. They shall be disposed of in accordance with hospital policy.

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

5.6. If the attending physician is not assisting in the surgery, then the history and physical should be done by the surgeon. For podiatry cases, a H&P with risk stratification of the patient for surgery must be filed by a member of the Active Medical Staff within seven (7) days prior to surgery.

5.7. Except in cases of emergency, patients admitted for surgery shall be scheduled for admission by the surgical scheduler.

5.8. All required lab work shall have been done before admission and reports available at the time of outpatient surgery. If the surgeon is unreasonably late (30 minutes) or delayed in reaching the operative suite at the hour a given procedure is scheduled, it shall be the prerogative of the supervisor of surgery to proceed with the next scheduled case.

5.9. All previous orders are cancelled when patients go to surgery. Medication reconciliation and pre-op order reconciliation may facilitate the return of the patient to the Medical Unit.

5.10. All dental patients shall be admitted under the names of both a physician and a dentist. The physician shall be responsible for the history and physical examination and the overall medical care of the patient, including surveillance of orders written by the dentist. The dentist shall be responsible for the dental surgery and the pre-and-post operative orders pertaining to the dental procedure.

ARTICLE VI OBSTETRICS

6.1. Under no circumstances is the termination of a normal pregnancy permissible in this hospital. Any circumstance in which interruption of an abnormal pregnancy is considered requires consult with colleagues prior to proceeding. A D&C for incomplete abortion is permitted when a procedure is warranted.

6.2. Prenatal laboratory work is to be consistent with guidelines set forth by the AAFP and/or the ACOG and should be available on the OB unit between the 36th and 38th week gestation. The hospital reserves the right to collect any specimens required to meet this requirement if a woman presents in labor and for whom these results are unavailable.

ARTICLE VII EMERGENCY DEPARTMENT

7.1. The basic operation of the Emergency Department, as well as performance of each member in the department, will be monitored. The Emergency Department shall review and evaluate, on a regular basis, the quality of medical care given in the department.

7.2. An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's hospital record. The record shall include:

a) adequate patient identifying information;

b) information concerning the time of the patient's arrival, means of arrival, and by whom transported pertinent history of the injury or illness including details;

c) relative to first aid or emergency care given the patient prior to his or her arrival at the hospital, allergic condition and tetanus status when indicated;

d) description of significant clinical and laboratory findings;

e) diagnosis;

f) treatments rendered;

g) condition of patient on discharge or transfer;

h) instruction to patient/family.

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

7.4. There shall be an ER Committee of the Medical Staff that meets regularly and includes attending physicians who are not working in the Emergency Department.

ARTICLE VIII PHARMACY

8.1. All drugs and medications administered to patients shall be those listed in the latest edition of the U.S. Pharmacopia, National Formulary, American Hospital Formulary Service and AMA Drug Evaluations. Experimental drugs shall be used in full accordance with "statement of principles involved in the use of investigational drugs in hospitals" AMA publications and all regulations.

8.2. Orders for IV antibiotics shall automatically expire after 72 hours. Orders for antibiotics shall automatically expire after seven (7) days, and IV anticoagulants after 24-hours unless otherwise specified and in the original order. These stop orders shall be automatically extended until the following day when the attending physician has had an opportunity to see the patient.

ARTICLE IX INFECTION CONTROL

9.1. Patients shall be placed in appropriate isolation for the effective management of various infectious diseases. This may be done initially without a physician order to facilitate its timely application to support public health with proper follow-up communication with the attending physician.

ARTICLE X PODIATRY

10.1. All podiatric surgery patients are to have their H&P performed by a primary care physician in a timeframe that allows for adequate assessment of operative risk.

10.2. At the time that a patient is scheduled for podiatric surgery, his or her primary care physician will be notified by the Surgery Department. If necessary, a request for a H&P can be made and the proper timing for said evaluation can be relayed to the physician.

10.3. Podiatrists who are determined to qualify for (by and through additional training and experience) and receive Clinical Privileges to perform the medical portion of the history and physical, a medical history and physical examination will be made and recorded by a Practitioner who maintains appropriate Clinical Privileges to do so. That Practitioner, and/or another designated Practitioner with appropriate Clinical Privileges, shall be responsible for the care of any medical

problem that may be present at the time of admission or that may arise during hospitalization and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The Podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and physical examination. Podiatrists may issue orders within their licensed scope of practice and granted Clinical Privileges, and consistent with applicable Bylaws, Policies, and Procedures.

ARTICLE XI MISCELLANEOUS

11.1. As per the Hospital Disaster Plan, available physicians shall be assigned disaster duties in the hospital, and it is their responsibility to report to their assigned stations. In cases of disaster, all physicians on the Medical Staff agree to relinquish direction of the professional care of their patients to the physicians available at the hospital during the disaster.

11.2. If a nurse has reason to question the care of a patient, he or she shall bring this to the attention of the attending physician as well as the nursing supervisor. If the question is unresolved, he or she can discuss it with the Executive Director of Patient Care Services, who can bring it to the attention of the Medical Staff President, if warranted.

11.3. Each Committee Chairman should send a representative from their group to attend Medical Staff Committee meetings and each Committee Chair should ensure attendance of at least sixty-six percent (66%).