MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

Approved by the Board: October 5, 2021

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DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

ARTICLE II

ADMISSIONS,
TREATMENT, AND SERVICES

2.A. ADMISSIONS

(1) A patient may only be admitted to the Hospital, or designated as "observation status," by order of a Practitioner who is granted admitting Privileges.

(2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than ***24 hours*** after admission.

(3) Patients will be admitted based on the following order of priority:

(a) **Emergency** – includes patients in an emergency medical condition or in active labor who require hospitalization.

(b) **Urgent** – includes non-emergency patients whose admission is considered imperative by the Admitting Practitioner.

(c) **Routine Admissions** – includes scheduled elective admissions involving all services.

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

2.B. ADMISSIONS THROUGH THE EMERGENCY DEPARTMENT

If an Unassigned Patient is evaluated by the Emergency Department and requires admission, the patient will be assigned to the appropriate on-call Physician or admitted to the hospitalist service.

2.C. OBSERVATION STATUS

(1) Observation status is an outpatient status meant to be used as a period of diagnosis and/or treatment prior to or in lieu of an inpatient admission.

(2) All patients placed in observation status must be seen by the Admitting Practitioner or a Responsible Practitioner within the observation period and a history and physical examination completed.

2.D. RESPONSIBILITIES OF PRIMARY TREATING PHYSICIAN

(1) At all times during a patient's hospitalization, the identity of the patient's Primary Treating Physician (or his or her alternate or covering Physician) will be clearly documented in the medical record. Whenever the responsibilities of the Primary Treating Physician are transferred to another Physician outside of his or her established coverage arrangement, a note covering the transfer of responsibility will be entered in the patient's medical record. The Primary Treating Physician will be responsible for verifying the other Physician's acceptance of the transfer and updating the Primary Treating Physician screen in the electronic medical record ("EMR").

(2) If the Primary Treating Physician does not participate in an established coverage arrangement with known alternate coverage and will be unavailable to care for a patient for longer than 24 hours, the Primary Treating Physician will document in the medical record the name of the Medical Staff Member who will be assuming responsibility for the care of the patient during his or her unavailability. The Primary Treating Physician will be responsible for (i) verifying the other Physician's acceptance of the transfer, and (ii) notifying the Medical Staff Office and the Emergency Department, if applicable, of his or her absence and who will cover for him or her.

(3) If the Primary Treating Physician is unavailable and alternate coverage has not been arranged, the relevant Department Chair/Section Chief, the Chief of Staff, the CMO, the VPMA, or the administrator on call will have the authority to call on the on-call Physician in that specialty or any other Medical Staff Member to attend the patient. The Medical Staff Leaders will also confirm the Primary Treating Physician meets the eligibility criteria related to appropriate coverage, as outlined in the Medical Staff Credentials Policy.

2.E. CONTINUED HOSPITALIZATION

(1) The Primary Treating Physician will provide whatever information may be requested with respect to the continued hospitalization of a patient, including:

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

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

(c) plans for post-hospital care.

This response will be provided within 24 hours of the request. Failure to comply with this requirement will be reported to the Department Chair/Section Chief and/or the Chief of Staff for review and appropriate action.

(2) If a determination is made that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the Primary Treating Physician. If the matter cannot be appropriately resolved, the Leadership Council will be consulted.

ARTICLE III

MEDICAL RECORDS

3.A. GENERAL

A medical record will be prepared for every individual evaluated and treated at the Hospital. Each Practitioner who is involved in the care of a patient will be responsible for the timely and accurate completion of the portions of the medical record that pertain to the care he or she provides.

3.B. MEDICAL RECORD ENTRIES

3.B.1. Entries:

(a) The following individuals are authorized to document in the medical record:

(1) Admitting Practitioners, Consulting Physicians, and other Responsible Practitioners;

(2) nursing providers, including registered nurses ("RNs");

(3) other licensed or certified health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

(4) other health care providers who have access to the medical record pursuant to their job description (e.g., aides and assistants);

(5) volunteers, such as chaplains, functioning within their approved roles;

(6) residents and students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical and nursing students) if that documentation is reviewed and countersigned by the student's supervisor, who must also be authorized to document in the medical record; and

(7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

(b) Electronic entries will be entered through the EMR and/or Computerized Provider Order Entry ("CPOE") in accordance with Hospital policy.

(c) Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency

situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). Any such written or paper-based entries will be scanned and entered into the patient's EMR in accordance with Hospital policy.

(d) All entries, including handwritten entries, must be timed, dated and signed.

(e) Any entry in the medical record should be clear, concise, and objective. Practitioners should avoid editorializing in the medical record of a patient or entering extraneous comments or criticisms about a patient, a patient's family, or the care provided by other Practitioners or Hospital personnel.

3.B.2. Entries by an Advanced Practice Professional:

(a) With the exception of Certified Nurse Midwives, the following entries by an Advanced Practice Professional must be countersigned by a Collaborating/Supervising Physician: the order to admit, history and physical examinations, consultations, discharge summaries, and procedure reports.

(b) A countersignature by a Collaborating/Supervising Physician indicates that the Collaborating/Supervising Physician has taken full responsibility for the entry that has been countersigned.

3.B.3. Authentication:

(a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or CPOE.

(b) The Practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.

(c) If a rubber-stamp signature or an electronic signature code is used to authenticate an order, the individual whose signature the stamp or electronic code represents is accountable for the use of the stamp or the electronic code.

3.B.4. Forms:

All printed forms and templates used for medical record documentation shall be approved by the Health Information Management ("HIM") Department. The EMR will be used for electronic documentation.

3.B.5. Symbols and Abbreviations:

(a) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used.

(b) The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

3.B.6. Clarity and Completeness:

All entries in the medical record shall be clear and complete so that other members of the health care team are able to understand the entry and the author's intentions.

3.B.7. Correction of Errors:

When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial entry. Any error made while entering an order in the CPOE should be corrected by entering another order.

3.B.8. Copying and Pasting:

Copying and pasting from a prior note in the EMR is only permissible when the posted note is properly updated in accordance with the standards outlined in the Professionalism Policy.

3.B.9. Permanent Filing of Medical Records:

A medical record will not be permanently filed until it is completed by the Responsible Practitioner, or it is ordered filed by the Medical Records Department under the direction of the MEC. Except in rare circumstances, and only when approved by the MEC, no Practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

3.C. OWNERSHIP, RETENTION, AND ACCESS TO RECORDS

3.C.1. Ownership of Records:

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

3.C.2. Retention of Records:

Hospital medical records will be retained in accordance with the Hospital's policy on the retention of patient records.

3.C.3. Access to Records:

(a) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and the Hospital's Health Insurance Portability and Accountability Act ("HIPAA") policies.

(b) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, pursuant to the Hospital's HIPAA policies.

(c) Access to all medical records of patients will be afforded to Medical Staff Members for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(d) Subject to the discretion of the Administrative Team, former Medical Staff Members may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

ARTICLE IV

CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

4.A. CONTENT OF MEDICAL RECORD

4.A.1. General Requirements:

All medical records for patients receiving an evaluation or treatment in the Hospital or at an Ambulatory Care Location will document the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, race, ethnicity, and name of authorized representative (if any);

(b) legal status of any patient receiving behavioral health services (i.e., voluntary or involuntary status);

(c) patient's language and communication needs, including preferred language for discussing health care;

(d) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or resuscitation orders (i.e., DNR or AND);

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

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

(g) admitting history (i.e., date, source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies and sensitivities;

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

(j) diagnosis, diagnostic impression, or symptoms;

(k) goals of the treatment and treatment plan;

(l) diagnostic and therapeutic orders, procedures, tests, and results;

(m) interval notes made by authorized individuals;

(n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, titration parameter, as applicable, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(o) consultation reports;

(p) operative procedure reports and/or notes;

(q) any applicable anesthesia evaluations;

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

(s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(t) reassessments and plan of care revisions;

(u) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments; and

(v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, medications dispensed or prescribed on discharge, and if the patient left against medical advice.

4.A.2. Emergency Care:

In addition to any of the applicable general requirements outlined in Section 4.A.1, the medical records of patients who have received emergency care will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative (if any);

(b) patient's language and communication needs, including preferred language for discussing health care;

(c) time and means of arrival;

(d) record of care prior to arrival;

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

(f) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his or her arrival at the Emergency Department;

(g) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;

(h) treatment given, if any;

(i) conclusions at termination of treatment, including final disposition, condition, instructions for follow-up care, and any changes in medications;

(j) if the patient left against medical advice; and

(k) a copy of any information provided to the health care provider or facility providing follow-up care, treatment, or services.

4.A.3. Interval Notes:

(a) Interval notes will be entered by the Primary Treating Physician or his or her covering Practitioner at least every ***calendar Day*** for all hospitalized patients and as needed to reflect changes in the status of a patient in an Ambulatory Care Location.

(b) Interval notes will be understandable, dated, timed, and authenticated. When appropriate, each of the patient's clinical problems should be clearly identified in the interval notes and correlated with specific orders as well as results of tests and treatments.

4.A.4. History and Physical:

The requirements for histories and physicals, including general documentation and timing requirements, are outlined in Appendix B of the Medical Staff Bylaws.

4.A.5. Consultation Reports:

(a) Consultation reports will be completed in a timely manner and documented in an EMR-generated note or, when the EMR is unavailable, a dictated or legible written note. The consultation report will contain the date and time of the consultation, opinions based on relevant findings and reasons, and recommendations by the Consulting Physician that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not

constitute an acceptable consultation report. The consultation report will be authenticated by the Consulting Physician and made a part of the patient's medical record.

(b) When non-emergency operative procedures are involved, the Consulting Physician's report will be recorded in the patient's medical record prior to the surgical procedure.

4.A.6. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

4.A.7. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

4.A.8. Operative Procedure Reports:

An operative procedure report must be dictated or written in accordance with Article 7 of these Rules and Regulations.

4.A.9. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient's medical record on appropriate paper or electronic forms in accordance with Article 8.

4.A.10. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

4.B. TIMELINESS OF DOCUMENTATION

(1) General Requirements. It is the responsibility of every Practitioner involved in the care of a patient in the Hospital to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies. A medical record is considered incomplete when:

(a) the H&P is not documented within ***24 hours*** after admission or registration (but in all cases prior to the procedure);

(b) the results of a medical screening examination are not documented within ***48 hours*** of the conclusion of an Emergency Department visit;

(c) an order, including a verbal order, is not signed within ***72 hours*** of the order;

(d) the full operative procedure report is not documented and entered into the medical record within ***72 hours***;

(e) the discharge summary is not completed within ***72 hours*** of the patient's discharge; or

(f) any other required patient reports are not entered, written, dictated and/or authenticated within ***30 Days*** of the patient's discharge.

(2) Notification. If a medical record is incomplete, the Practitioner will be notified, in writing, of the delinquency. The Notice will give the Practitioner seven Days to complete the medical record. In accordance with paragraphs (3) and (4) below, failure to complete the delinquent medical records within seven Days of the Notice will result in the Automatic Relinquishment of the Practitioner's Clinical Privileges.

(3) Enforcement. A Practitioner who automatically relinquishes his or her Clinical Privileges due to delinquent medical records will be subject to the following Progressive Steps whenever an Automatic Relinquishment occurs within a four-year rolling time frame:

(a) The **first time** that a Practitioner's Privileges are relinquished, the Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed.*

(b) The **second time** that a Practitioner's Privileges are relinquished will result in the matter being referred to the applicable Department Chair or Section Chief, who will offer assistance to the Practitioner in complying with this section of the Rules and Regulations. The Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed and the Practitioner has met with the Department Chair or Section Chief.*

(c) The **third time** that a Practitioner's Privileges are relinquished will result in a referral to the Leadership Council for review under the Medical Staff Professionalism Policy. The Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed and the individual has met with the Leadership Council to explain the reasons for the delinquencies.*

(d) A Practitioner who automatically relinquishes his or her Clinical Privileges a **fourth time** indicates his or her inability and/or unwillingness to meet the requirements in these Rules and Regulations. Accordingly, that Practitioner

will automatically resign his or her Medical Staff appointment (or Permission to Practice) and Clinical Privileges and must follow the steps outlined in (5) below if he or she wishes to rejoin the Medical Staff or renew his or her practice as a Licensed Independent Practitioner or an Advanced Practice Professional at the Hospital.

* The Practitioner will have 30 Days to complete each of these steps. Failure to do so will result in the Practitioner's automatic resignation from the Medical Staff (or Permission to Practice) and Clinical Privileges.

(4) Automatic Relinquishment Procedures. In the event that an Automatic Relinquishment occurs, the HIM Department will notify the Practitioner that his or her Clinical Privileges have been relinquished. The Chief of Staff, Emergency Department and nursing will also be notified. The Automatic Relinquishment will take effect immediately and the Practitioner will be responsible for cancelling any cases scheduled at the Hospital and for transferring the care of any patients in the Hospital to a Practitioner who has appropriate Clinical Privileges. However, the Practitioner must complete all scheduled emergency call obligations or arrange for appropriate coverage.

(5) Rejoining the Medical Staff or Renewing Practice as an Advanced Practice Professional After Resignation. Any Practitioner who resigns his or her appointment (or permission to practice) and Clinical Privileges as a result of medical record delinquencies may subsequently apply as an initial applicant, provided that all delinquent medical records have been completed. The individual may not be granted any temporary Privileges while the application is being processed until all records are completed.

(6) Former Practitioners. When a Practitioner no longer practices at the Hospital, and his or her medical records are filed as permanently incomplete, this will be recorded in the Practitioner's Confidential File and divulged in response to any future credentialing inquiry concerning the Practitioner.

(7) Exceptions. Any requests for special exceptions to the above requirements will be submitted by the Practitioner and considered by the MEC.

ARTICLE V

MEDICAL ORDERS

5.A. GENERAL

(1) Orders will be entered directly into the EMR by the ordering Practitioner utilizing the CPOE, except when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be transcribed or scanned into the patient's EMR as soon as possible, and no later than the time of discharge.

(2) All orders (including verbal/telephone orders) must be:

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering Practitioner, with the exception of a verbal order which may be countersigned by another Practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication*; and

(c) documented clearly and completely. Orders which are improperly entered will not be carried out until they are clarified by the ordering Practitioner and are understood by the appropriate health care provider.

* Orders entered into the EMR are electronically authenticated, dated, and timed.

5.B. ORDERS FOR TESTS AND THERAPIES

(1) Orders for tests and therapies will be accepted, to the extent permitted by their license and Clinical Privileges, only from:

(a) Medical Staff Members;

(b) Advanced Practice Professionals; and

(c) Other Healthcare Professionals.

(2) Orders for "daily" tests will state the number of Days, except as otherwise specified by protocol, and will be reviewed by the ordering Practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order

that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(3) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may also be ordered by Practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

5.C. ORDERS FOR MEDICATIONS

(1) All medication orders will clearly state the administration times or the time interval between doses and the indications for use when appropriate. Each dose of medication shall be recorded in the medical record of the patient after the medication has been administered. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations.

(2) All orders for medications administered to patients will be:

(a) periodically reviewed by the prescriber to assure appropriateness;

(b) reviewed when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

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

(3) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(4) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use. Multiple PRNs for the same indication are prohibited.

(5) Advanced Practice Professionals may be authorized to issue medication orders as specifically delineated in their Clinical Privileges. If required by the Advanced Practice Professional's written supervision/collaboration agreement, any such order will be countersigned in accordance with Section 3.B.2 of these Rules and Regulations.

5.D. VERBAL ORDERS

A verbal order for medications or treatment will be accepted in accordance with Hospital policy. The ordering Practitioner, or another Practitioner who is responsible for the patient's care in the Hospital, will countersign the verbal order within ***72 hours*** after the order was given.

5.E. STANDING ORDERS AND ORDER SETS

(1) The MEC and the Hospital's nursing and pharmacy departments must review and approve any standing orders and order sets (collectively, "standing orders") that permit treatment to be initiated by an individual (for example, a nurse) without a prior specific order from a Physician. All standing orders will identify well-defined clinical scenarios for when the order is to be used.

(2) The MEC will confirm that all approved standing orders are consistent with nationally recognized and evidence-based guidelines. The MEC will also ensure that such standing orders are reviewed at least annually.

(3) If the use of a standing order has been approved by the MEC, treatment may be initiated (i) by a nurse or other authorized individual acting within his or her scope of practice who activates the order; or (ii) when a nurse enters documentation into the medical record that triggers the standing order.

(4) When used, standing orders must be dated, timed, and authenticated promptly in the patient's medical record by the individual who activates the order or by another Responsible Practitioner.

(5) A Physician must authenticate the initiation of each standing order after the fact, with the exception of those for influenza vaccines, which may be administered per Hospital policy after an assessment for contraindications.

5.F. SELF-ADMINISTRATION OF MEDICATIONS

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

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

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

(c) in the case of a patient's own medications, the medications are visually evaluated in accordance with Section 9.B of these Rules and Regulations; and

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

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

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

(4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be maintained in accordance with Section 9.B of these Rules and Regulations.

5.G. STOP ORDERS

(1) The medication stop order policy shall apply to those medications defined by the Pharmacy and Therapeutics Committee, except for those orders which have:

(a) a specified number of total doses to be administered; or

(b) a specified time period for doses to be administered.

(2) The ordering Practitioner shall be notified in advance of the impending expiration of an order through the patient's medical record.

(3) Drug orders shall not be stopped until there is documented evidence that the ordering Practitioner has been contacted, is aware of the impending expiration of the order, and has had an opportunity to determine if administration of the drug is to be stopped, continued, or altered. Orders may be renewed by telephone.

5.H. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

(1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted Privileges to order the services by the Hospital or in accordance with the Hospital's policy on accepting orders for outpatient services from Practitioners who are not otherwise affiliated with the Hospital.

(2) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the imaging service.

5.I. ORDERS FOR RESPIRATORY CARE SERVICES

(1) Respiratory care services may be ordered by a qualified and licensed Practitioner who is responsible for the care of the patient, either independently or working in conjunction with a Medical Staff Member.

(2) Orders for respiratory care services must include: (i) the patient's name; (ii) the name and electronic or written signature of the ordering individual; (iii) the type, frequency, and, if applicable, duration of treatment; (iv) the type and dosage of medication and diluents; and (v) the oxygen concentration or oxygen liter flow and method of administration.

5.J. RESUSCITATION ORDERS

(1) Resuscitation orders (e.g., DNR) shall be documented in the patient's medical record by the patient's Responsible Practitioner.

(2) All resuscitation orders should be accompanied by an interval note justifying the appropriateness of such order and documenting discussions with the patient and/or his or her family resulting in this decision.

5.K. DISCHARGE ORDER

Patients shall be discharged in accordance with Article 11.

ARTICLE VI

INPATIENT CONSULTATIONS

6.A. GENERAL

This section of the Medical Staff Rules and Regulations applies to requests for inpatient consultations. Requests for consultations in the Hospital Emergency Department will be governed by the On-Call Physician Responsibilities Policy.

6.B. REQUESTING INPATIENT CONSULTATIONS

(1) Requests for inpatient consultations shall be ordered in the EMR by a Requesting Practitioner and in accordance with the following communication guidelines:

- **Emergent Consults** – For emergent consults (e.g., "stat" or similar terminology), the Requesting Practitioner must be a Physician who personally speaks with the Consulting Physician (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the emergent consultation.

- **Urgent Consults** – For urgent consults (e.g., "urgent," "today," or similar terminology), the Requesting Practitioner must be a Physician who personally speaks with the Consulting Physician (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the urgent consultation.

- **Routine Consults** – In addition to entering the reasons for the consultation request in the EMR, the Requesting Practitioner (who may be any member of the requesting care team) will make reasonable attempts to personally contact the Consulting Physician to discuss all routine consultation requests.

(2) Failure by a Requesting Practitioner to follow the communication guidelines described in this Section may be reviewed through the appropriate Medical Staff policy.

6.C. RESPONDING TO CONSULTATION REQUESTS

(1) Any Medical Staff Member can be asked to provide an inpatient consultation within his or her area of expertise. If the Medical Staff Member is reasonably available and accepts the inpatient consultation, he or she will respond to the request either in person or via telephone or technology-enabled direct communication and evaluation (i.e., text or other EMR communication) as allowed by Hospital policy. In either case, a Medical Staff Member who has accepted a consult (i.e., the

Consulting Physician) is expected to respond in accordance with the following patient care guidelines:

(a) **Emergent Consults** – will respond within ***twenty (20) minutes*** of request via telephone or technology-enabled direct communication and otherwise evaluate patient within ***one hour*** of the request, unless the patient's condition requires that the Consulting Physician complete the consultation sooner;

(b) **Urgent Consults** – will respond within ***four hours*** of the request, unless the patient's condition requires that the Consulting Physician complete the consultation sooner;

(c) **Routine Consults** – will respond within ***24 hours*** of the request or within a time frame as agreed upon by the Requesting Practitioner and the Consulting Physician.

If a requested Medical Staff Member is unavailable or otherwise unable to respond to a request for a consultation within the timelines provided above, then the request for a consultation shall be referred to the relevant On-Call Physician under the On-Call Physician Responsibilities Policy, which shall guide emergency consultation requests for both Emergency Department patients as well as hospitalized patients.

(2) The Consulting Physician may ask an Advanced Practice Professional with appropriate Clinical Privileges to see the patient, gather data, order tests, and develop an assessment plan. However, an evaluation by an Advanced Practice Professional will not relieve the Consulting Physician of his or her obligation to personally see the patient within these time frames unless agreed to by the Requesting Practitioner. The Collaborating/ Supervising Physician must still personally see the patient and render an opinion.

(3) When providing an inpatient consult, the Consulting Physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the Consulting Physician will be directly communicated to the Requesting Practitioner through a note in the EMR or by a phone call or text message.

(4) Failure to reasonably respond to a request for an inpatient consultation in a timely and appropriate manner may be referred for review under the appropriate Medical Staff policy (e.g., the Medical Staff Professionalism Policy).

(5) Once the Consulting Physician is involved in the care of the patient, the Requesting Practitioner and Consulting Physician are expected to review the patient's medical record on a regular basis to assure continuity of care until such time as the Consulting Physician has signed off on the case or the patient is discharged.

6.D. RECOMMENDED CONSULTATIONS

(1) Consultations are recommended in all cases in which, in the judgment of the Primary Treating Physician:

(a) there is doubt as to the best therapeutic measures to be used;

(b) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) complications are present that may require specific skills of other Practitioners; or

(d) they are indicated for the clinical specialty in admission to special care units.

(2) The Chief of Staff, the CMO, the VPMA, and the appropriate Department Chair/Section Chief shall each also have the right to call in a Consulting Physician where a consultation is determined to be in the patient's best interest.

6.E. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide) or who are determined to be a potential danger to themselves or others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

6.F. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the Consulting Physician, including relevant findings and reasons, must appear in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the surgeon states in writing that an emergency situation exists.

ARTICLE VII

SURGICAL SERVICES

7.A. PRE-PROCEDURAL PROCEDURES

Except in a documented emergency situation, the following will occur before an operative procedure or the administration of anesthesia occurs:

(1) the Operating Physician is in the Hospital;

(2) the Operating Physician will thoroughly document in the medical record:

(a) the provisional diagnosis and the results of any relevant diagnostic tests;

(b) the consent of the patient or his/her legal representative; and

(c) a complete and appropriately updated history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room;

(3) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(4) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(5) a pre-anesthesia evaluation is performed in accordance with Section 8.B of these Rules and Regulations; and

(6) the procedure site is marked and a "time out" is conducted, as described in the Operative Procedure Site Verification and Time Out Protocol.

7.B. POST-PROCEDURAL PROCEDURES

(1) Post-Operative Interval Note. A brief, post-operative interval note must be entered in the medical record ***immediately*** after an operative procedure and before the patient is transferred to the next level of care by the Operating Physician. The post-operative interval note will include:

(a) the names of the Physician(s) responsible for the patient's care and physician assistants;

(b) the name and description/technique of the procedure(s) performed;

(c) findings, where appropriate, given the nature of the procedure;

(d) estimated blood loss, when applicable or significant;

(e) specimens removed; and

(f) post-operative diagnosis.

A full operative note may substitute for the brief, post-operative note if it is completed and signed immediately following the procedure.

(2) Full Operative Report. The full operative procedure report must be dictated or entered ***within 72 hours*** after an operative procedure. The full operative procedure report shall include:

(a) the patient's name and hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) the name of the Operating Physician(s) and assistant surgeon(s) responsible for the patient's operation;

(e) procedure(s) performed and description/technique of the procedure(s);

(f) description of the specific surgical tasks that were conducted by Practitioners other than the Operating Physician;

(g) findings, where appropriate, given the nature of the procedure;

(h) estimated blood loss, where applicable;

(i) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(j) the type of anesthesia/sedation used;

(k) specimen(s) removed, if any;

(l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(m) the signature of the Operating Physician.

7.C. PATHOLOGY REPORTS AND DISPOSITION OF SURGICAL SPECIMENS

(1) All significant surgical specimens removed during an operative procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the Hospital pathologist, who will determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnoses.

(2) The pathologist will document the receipt of all surgically removed specimens and sign the pathology report, which shall become part of the patient's medical record. The pathology report will be filed in the medical record within ***24 hours*** of completion of the pathology work-up.

(3) The disposition of surgical specimens, whether discarded or submitted to pathology, will be recorded in the operative record.

ARTICLE VIII

ANESTHESIA SERVICES

8.A. GENERAL

(1) Anesthesia may only be administered by the following qualified Practitioners:

(a) an anesthesiologist;

(b) an M.D. or D.O. who has been granted Clinical Privileges to administer certain types of anesthesia in a specific patient care area or for a specific procedures; or

(c) a CRNA who is under the direct supervision of an Anesthesia.

(2) "Anesthesia" includes general or regional anesthesia, monitored anesthesia care or deep sedation, including epidurals/spinals and other nerve blocks. "Anesthesia" does not include topical or local anesthesia or minimal or moderate ("conscious") sedation.

(3) Because it is not always possible to predict how an individual patient will respond to minimal or conscious sedation, a qualified Practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

8.B. PRE-ANESTHESIA PROCEDURES

(1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia.

(2) The following elements of the pre-anesthesia evaluation must be performed within the ***48 hours*** immediately prior to an inpatient or outpatient surgery or procedure requiring anesthesia services:

(a) a review of the medical history, including anesthesia, drug and allergy history; and

(b) an interview, if possible, preprocedural education, and examination of the patient.

(3) The following additional elements of the pre-anesthesia evaluation may be performed up to 30 Days prior to an inpatient or outpatient surgery or procedure

requiring anesthesia services, but must be reviewed and updated as necessary within ***48 hours*** of the surgery or procedure:

(a) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(b) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway as identified through an airway examination, any ongoing infections, limited intravascular access (e.g., Mallampati scoring));

(c) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(d) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

Per the Centers for Medicare & Medicaid Services Conditions of Participation, under no circumstances may these elements be performed more than 30 Days prior to surgery or a procedure requiring anesthesia services.

(4) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

8.C. MONITORING DURING PROCEDURE

(1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor the patient per current ASA standards.

(2) All relevant events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented in an intraoperative anesthesia record, including at least the following:

(a) the name and Hospital identification number of the patient;

(b) the name of the Practitioner who administered anesthesia and, as applicable, any supervising Practitioner;

(c) the name, dosage, route, time, and duration of all anesthetic agents;

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

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

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

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

8.D. POST-ANESTHESIA EVALUATIONS

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

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

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

(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(b) cardiovascular function, including pulse rate and blood pressure;

(c) mental status;

(d) temperature;

(e) pain;

(f) nausea and vomiting; and

(g) post-operative hydration status.

(4) Patients will be discharged from the recovery area by a qualified Practitioner according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a post-anesthesia recovery scoring system. Post-operative

documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

(6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

8.E. MINIMAL OR CONSCIOUS SEDATION

All patients receiving minimal or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained Practitioner in accordance with applicable Hospital policies. However, such procedures are not subject to the requirements regarding pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations described in this Article.

8.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction the Department Chair, who satisfies the Eligibility Criteria as defined in section 3.B of the Bylaws, and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE IX

PHARMACY

9.A. GENERAL RULES

(1) Orders for medications are addressed in the Medical Orders Article.

(2) Adverse medication reactions and errors in administration of medications will be documented in the patient's medical record and reported to the Primary Treating Physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name medication when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.

(4) All medications will be administered in accordance with the Policies and Procedures of the Pharmacy and Therapeutics Committee. A Hospital Formulary shall be developed by the Pharmacy and Therapeutics Committee. All investigational drugs must be reviewed and approved in accordance with the Policies and Procedures of the Institutional Review Committee and shall only be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

(5) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to Medical Staff Members, Advanced Practice Professionals, and other Hospital personnel.

9.B. PATIENT'S OWN MEDICATION

If a patient brings his or her own medications to the Hospital, these medications shall not be administered unless the Primary Treating Physician or the Hospital pharmacy has inspected the medications and labelled it for use in the Hospital. Otherwise, the medications shall be (1) sent home with the patient's personal representative or other person identified by the patient on admission or (2) kept in a secure area such as the Hospital pharmacy for up to 30 Days after the patient's discharge, at which time such medications will be returned to the patient or given to the patient's legal representative. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall be returned to the patient on discharge unless the Primary Treating Physician states otherwise.

9.C. STORAGE AND ACCESS

(1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.

(a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(c) Only authorized personnel may have access to locked or secure areas.

(2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the CEO.

ARTICLE X

EMERGENCY SERVICES

10.A. GENERAL

Emergency services and care will be provided to any person who comes to the emergency department, as that term is defined in the EMTALA regulations, whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's insurance status, economic status, or ability to pay for medical services.

10.B. MEDICAL SCREENING EXAMINATIONS

(1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel ("QMP") who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

(a) Emergency Department:

(i) Medical Staff Members with Clinical Privileges in Emergency Medicine;

(ii) other Active Staff members; and

(iii) appropriately credentialed Advanced Practice Professionals.

(b) Labor and Delivery:

(i) Medical Staff Members with OB/GYN Privileges;

(ii) Certified Registered Nurse Midwives with OB Privileges; and

(iii) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

(2) The results of the medical screening examination must be dictated within ***48 hours*** of the conclusion of an Emergency Department visit.

10.C. EMERGENCY CARE

(1) Any person presenting at the Emergency Department who has not been referred by or is not the patient of a specific Medical Staff Member, and who does not express a desire for the medical services of a particular member, shall be assigned to the hospitalist service or the appropriate Physician on call for Unassigned Patients.

(2) Nothing in this provision shall interfere with the patient's right to request his or her own Physician if such a choice is expressed.

(3) A roster of Medical Staff Members who are on call for primary coverage and specialty consultations will be maintained in accordance with the Medical Staff's Emergency Department On-Call Policy.

10.D. MEDICAL RECORDS FOR PATIENTS RECEIVING EMERGENCY SERVICES

In accordance with Section 4.A.2 of these Medical Staff Rules and Regulations, a medical record will be maintained for patients who have received emergency care at the Hospital.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.A. WHO MAY DISCHARGE

(1) Patients will be discharged only upon the order of the Primary Treating Physician or another Practitioner acting as his or her designee.

(2) At the time of discharge, the discharging Practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(3) Practitioners should follow the Hospital's policy on Patients Leaving Against Medical Advice or Refusing Treatment whenever confronted with a situation in which a patient leaves against medical advice.

11.B. DISCHARGE PLANNING

(1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The Responsible Practitioner is expected to participate and collaborate in the discharge planning process, which includes documentation/updates of the expected discharge date in the EMR throughout the patient's stay.

(2) Discharge planning will include determining the need for continuing care in an acute care setting, treatment, services after discharge or transfer, and services which can be obtained in an outpatient vs. inpatient setting.

11.C. DISCHARGE SUMMARY

(1) A concise discharge summary will be prepared for every patient who is admitted to, or placed in observation at, the Hospital by the Practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another Practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed as soon as possible and no later than ***72 hours*** after discharge:

(a) reason for hospitalization;

(b) significant findings;

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

(d) final diagnosis and the patient's condition and disposition at discharge;

(e) information provided to the patient and family, as appropriate;

(f) provisions for follow-up care;

(g) discharge medication reconciliation; and

(h) updated problem list.

(2) A discharge summary is required in any case in which the patient dies in the Hospital, regardless of length of admission. (See 11.D below).

(3) If the discharge summary is prepared by an Advanced Practice Professional, the Primary Treating Physician will authenticate and date the discharge summary to verify its content.

11.D. DEATH SUMMARIES

A death summary shall be completed in the event of an inpatient death, regardless of the length of the patient's stay in the Hospital. The death summary shall include date of admission, admitting and final diagnoses, reason for hospitalization, significant findings, course of treatment, events leading to death, and the date and exact time of death. If the death summary is prepared by an Advanced Practice Professional, the Primary Treating Physician will authenticate and date the death summary to verify its content.

11.E. DISCHARGE OF MINORS AND INCAPACITATED PATIENTS

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

ARTICLE XII

TRANSFERS TO AND FROM OTHER FACILITIES

Transfers to and from other hospitals will be carried out in accordance with the applicable Hospital policy (i.e., Emergency Medical Screen and Patient Transfers (EMTALA) and Patient Transfers to Other Hospitals or Healthcare Facilities).

ARTICLE XIII

HOSPITAL DEATHS AND AUTOPSIES

13.A. DEATH CERTIFICATES

(1) In the event of an inpatient death at the Hospital, the deceased will be pronounced dead by a Physician, a Certified Registered Nurse Practitioner, or a Physician Assistant within a reasonable time frame. Death certificates are the responsibility of a Responsible Practitioner and will be completed within ***24 hours*** of when the certificate is available to the Responsible Practitioner and in accordance with state law.

(2) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the Responsible Practitioner or other designated Medical Staff Member.

(3) A Responsible Practitioner will notify the coroner/medical examiner of any cases considered by law to be a coroner/medical examiner's case.

13.B. AUTOPSIES

(1) The Medical Staff should attempt to secure autopsies in accordance with state and local laws. No autopsy shall be performed without written consent of a relative or legally authorized agent. Such consent must be documented in the medical record.

(2) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. A Responsible Practitioner must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of a Physician, an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this must be documented in the medical record.

(3) The Primary Treating Physician must be notified when an autopsy is to be performed. All autopsies shall be performed by the Hospital pathologist or by a Practitioner delegated this responsibility by the Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within two working Days and the complete protocol should be made part of the record within 30 Days after the autopsy.

(4) The Medical Staff shall be actively involved in the assessment of the use of developed criteria for autopsies.

13.C. POTENTIAL ORGAN AND TISSUE DONORS

It is the policy of the Hospital to identify potential organ and tissue donors and to offer the relatives or legally authorized agents of every medically suitable deceased patient, the opportunity to donate. All Practitioners will cooperate fully in this effort.

ARTICLE XIV

MISCELLANEOUS

14.A. ORIENTATION

All new Practitioners will be provided an overview of the Hospital and its operations. As a part of this orientation, the Medical Records Department and nursing service will orient new Practitioners as to their respective areas, detailing those activities and/or procedures that will help new Practitioners in the performance of their duties.

14.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS, COLLEAGUES, AND CO-WORKERS

14.B.1. Self-Treatment:

(a) Practitioners are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) Practitioners should never write prescriptions for controlled substances for themselves.

14.B.2. Guidelines for Treatment of Immediate Family Members, Colleagues, and Co-Workers:

(a) Generally, Practitioners should refrain from the following activities in the Hospital:

(1) admitting or consulting on immediate family members (i.e., a parent, spouse, child, or anyone else residing in the same household); or

(2) being involved in the care of a family member with complex or potentially serious symptoms or diagnoses.

When considering these guidelines, factors such as the availability of other Practitioners to provide the needed care, patient acuity, and the patient's right to direct his/her own medical care should also be considered.

(b) Practitioners should never write prescriptions for controlled substances for family members.

(c) As it relates to colleagues and co-workers in the Hospital, Practitioners should refrain from:

(1) treating any individual without first performing an appropriate assessment and creating a proper medical record; or

(2) writing a prescription for any individual in the absence of a formal Practitioner-patient relationship.

14.C. INFECTION PRECAUTIONS

All Practitioners will abide by Hospital infection control policies.

14.D. HIPAA REQUIREMENTS

All Practitioners will:

(1) adhere to the security and privacy requirements of HIPAA and the Hospital's HIPAA policies, meaning that only a Responsible Practitioner may access, utilize, or disclose protected health information; and

(2) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.

ARTICLE XV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XVI

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all other bylaws, rules and regulations, policies, or manuals of the Medical Staff.

Adopted by the Medical Executive Committee on:

Date: _____

_____
Chief of Staff

Approved by the Board of Directors on:

Date: October 5, 2021

_____
Chair