RULES AND REGULATIONS OF THE MEDICAL STAFF

FRANCISCAN ST. JAMES

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RULES AND REGULATIONS OF THE MEDICAL STAFF

PURPOSE

The following Rules and Regulations are established as the principal policies, procedures and protocols of the Medical Staff of Franciscan St. James Health. These guiding principles are created to insure the proper treatment and care of all patients. They constitute the rules by which all Medical Staff members will follow as standard operating procedures and will serve as the cornerstone for treating patients with compassionate and caring concern.

These Rules and Regulations are hereby adopted to standardize processes between facilities, protect patients, hospital personnel, and Medical Staff in the execution of their duties and responsibilities and to preserve the integrity of the institution and the patient/physician relationship.

Membership of the Medical Staff is conditioned upon signed agreement and adherence to the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops of the Roman Catholic Church or its successor, as the same may be amended or revised from time to time, and as interpreted by the local Bishop; and the Franciscan values and behavioral expectations of Franciscan St. James Health, as outlined in the Medical Staff Bylaws and Rules and Regulations.

ARTICLE I

GENERAL

Section 1. Definitions:

The following definitions shall apply to terms used in these Rules and Regulations and related policies and manuals:

(1) "ADMITTING PHYSICIAN" means the physician who authorized the patient's hospitalization.

(2) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than staff members who are authorized by law to provide patient care services, whose scope of practice is defined in the Allied Health Professionals Policy.

(3) "ATTENDING PHYSICIAN" means physician responsible for the care of the patient throughout their hospital stay.

(4) "BOARD" means the Regional Body of the Franciscan Alliance for the region in which the Hospital is located, which Regional Body acts as the governing body for the Hospital (or said Regional Body's designated committee).

(5) "CHIEF EXECUTIVE OFFICER" (OR "CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital. This definition also includes the CEO's designee.

(6) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(7) "CONSULTING PHYSICIAN" means a physician called in to consult on a patient's case.

(8) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(9) "DAYS" means calendar days.

(10) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(11) "EMERGENCY" (meaning that immediate treatment is necessary to prevent serious or permanent harm, to preserve life or to prevent the serious deterioration or aggravation of a condition), any member is authorized to do everything possible, within the authority of his license, to address the emergency. He may do

so irrespective of his Medical Staff status, department assignment or clinical privileges. He must summon help as soon as possible to arrange for follow-up care by an appropriately privileged member.

(12) "EMERGENCY MEDICAL CONDITION" (as described in the Emergency Medical Treatment and Active Labor Act, 41 U.S.C. 1395dd) is a condition manifesting symptoms (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) which, in the absence of immediate medical attention, is likely to cause serious dysfunction or impairment to a bodily organ or function or serious jeopardy to the health of the individual or unborn child. A pregnant woman who is having contractions is considered to be in an "emergency medical condition" if there is not enough time to safely transfer the woman prior to delivery or a transfer would pose a threat to the woman or her unborn child.

(13) "HOSPITAL" means Franciscan St. James Health.

(14) "HOUSE STAFF" means all physicians, dentists, oral surgeons and podiatrists who are assigned to the Hospital's graduate education and training program and will ordinarily carry the title of resident, intern or fellow.

(15) "MEC" means the Medical Executive Committee of the Medical Staff.

(16) "MEDICAL SCREENING" or "MEDICAL SCREENING EXAMINATION" means the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist. "Medical screening" means the appropriate process (examination and evaluation of the patient) consistently used by a qualified medical person, including ancillary services routinely available to the Emergency Department within the Hospital's capabilities (services and staff), to determine or diagnose whether or not the patient has an emergency medical condition. "Qualified medical person" means an emergency physician, on-call physician, obstetrician/gynecologist, house physician, resident, intern, emergency and OB department nurses, Physician Assistants and Advanced Practice Nurses. The assigned physician shall come to the Hospital as promptly as possible if requested by the emergency physician.

(17) "MEDICAL STAFF" means all physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board.

(18) "MEMBER" means any physician, dentist, oral surgeon, or podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(19) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital.

(20) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathic medicine (“D.O.s”).

(21) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).

(22) “PRIMARY CARE PHYSICIAN” means the physician responsible for coordinating the patient’s overall care.

(23) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending physician on the Medical Staff or who does not want the prior admitting physician to provide him/her care while a patient at the Hospital.

(24) “UNIVERSITY” means Midwestern University.

ARTICLE II

ADMISSION

Section 1. Who May Admit Patients:

(a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges.

(b) Except in an emergency, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

(c) When a physician with consulting staff status treats a patient in 23-hour observation and the patient requires full admission, it is the consultant's responsibility to secure the services of an attending as backup.

(d) When a patient has been admitted and is being held in the emergency department waiting for bed availability on the floor, it is the Emergency Department physician's responsibility to care for patient through the episode that created the emergency medical condition. At the time the patient is transferred to the patient care unit, the Attending physician accepts responsibility for the care of the patient unless a new emergent condition occurs, necessitating re-evaluation by the emergency physician if the patient is still in the emergency department.

Section 2. Attending Physician's Responsibilities:

(a) Each patient shall be the responsibility of the attending physician or his or her designee. The attending physician shall be responsible for the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care, the prompt and accurate completion of the portions of the medical record for which he or she is responsible, necessary patient instructions, and transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient.

(b) The attending physician (or designated office employee) shall notify the admitting office of each admission and shall provide all required information regarding the admission prior to sending the patient to the Hospital.

(c) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician, a note covering the transfer of responsibility shall be entered on the order sheet of

the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

(d) The attending physician shall 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.

Section 3. Care of Unassigned Patients:

In the case where a patient who is evaluated by the emergency physician requires Hospital admission and does not have an attending physician with clinical privileges at the Hospital, or has not requested that a specific physician on the Medical Staff with the appropriate clinical privileges assume his or her care, the patient shall be assigned to the appropriate on-call physician. Such on-call responsibilities are further described in the bylaws and policies of the Medical Staff and the Hospital, including the Policy on Emergency Medical Screening, Treatment, Transfer and On-Call Roster (the "EMTALA and On-Call Policy").

(a) The Medical Staff Office will prepare the Emergency Department Call Schedule for Unassigned Adult Patients for both the Chicago Heights and Olympia Fields campuses.

(b) The Emergency Department Call Schedule for Unassigned Adult Patients, specific to physician's primary campus, would adequately provide coverage for the Emergency Room on a rotational basis. The physicians included in this rotational schedule shall include Family Practitioners and General Internal Medicine practitioners, and those sub-specialists whose practice is not limited to the sub-specialty, but has a substantial practice in primary care.

(c) Members of the Active and Associate Staffs have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities. Removing a member from the on-call schedule, for any reason, does not trigger the hearing and appeals procedures in the Credentials Policy.

(d) When an unassigned patient presents with what would normally be managed by a primary care physician, those patients will be referred to the physician on the primary call list.

(e) The physicians on this list will be obligated to take call and adhere to the specified days of their call. If, however, a physician cannot take call on the assigned day, it is the obligation of the scheduled physician to find a physician who participates in the Emergency Department Call Schedule to replace him. This is not the responsibility of the Medical Staff Office. However, notification

to the Medical Staff office of the change in the schedule is required to allow for proper notification to the Emergency Room.

Section 4. ER Call Responsibilities:

(a) When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must:

(1) be immediately available, by telephone, to the Emergency Department; and

(2) respond in person, if so requested, within a reasonable time period. Generally, response is expected within 30 minutes. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient as soon as possible. The determination of the Emergency Department physician will be controlling and will be recorded in the medical record.

(b) An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including office follow-up related to that episode, when in fact, contact with the patient has been made and a physician/patient relationship has been established. The on-call physician has a responsibility to care for a patient if contact for follow-up care is made by the patient within five days of the episode that created the emergency medical condition. An on-call physician shall not, in the hospital or during an office follow-up visit, refuse to assume the responsibility of the care of the patient under the circumstances noted above for lack of insurance information or co-payment.

(c) A refusal or failure to timely respond shall be reported immediately to the Department Chairperson, or if unavailable, the Vice President of the Medical Staff, or the Vice President, Medical Affairs (VPMA), who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action.

(d) For those members of the Medical Staff whose department is solely located at one campus, ER call responsibilities will be required at the campus where the department resides, which is considered the primary campus; however in those rare instances when a patient cannot be moved to the campus where the department resides, it is the responsibility that the practitioner fulfill his duty of care to this patient by covering the emergency needs at the other campus.

(e) A continuous call schedule will be provided per Medical Staff policy, where it is reasonable for the hospital to provide given its resources, Medical Staff, location, and other local factors.

(f) Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.

(g) Hospital Medical Director/Director of Medical Affairs shall be dedicated to overseeing Medical Staff/administration relations with regard to ER call processes and will concentrate primarily on streamlining the on-call process, negotiating between the Medical Staff and administration to ensure that physicians understand their duties under these rules and regulations.

Section 5. On-Call Rotation Responsibilities:

(a) All specialists who are active and associate members of the Medical Staff will be required to take call at their primary campus per the Medical Staff Bylaws. In addition, all staff in good standing may also participate at both campuses, if one so desires.

(b) For those patients who present to the Emergency Department, whose condition requires outpatient follow-up and is better managed by a particular specialist, then the ER physician will refer those patients to the pertinent specialist directly via the specialty call list that will be generated from the Medical Staff Office.

(c) If a physician is not available to take his/her assignment, or if a physician decides that they do not wish to take assigned call on a permanent basis, it is the physician's responsibility to find a replacement staff member in good standing to cover the call on a regular basis. A permanent change to another covering physician would require a statement of acceptance signed by both physicians in order for this change to become effective.

Section 6. ER Call Responsibilities for Physicians Requesting LOA and Resignation:

(a) All leaves of absence must be first submitted in writing, reviewed and recommended for approval by the Credentials Committee, Medical Executive Committee and forwarded to the Board for final action. No leave of absence is considered immediate or granted until final board approval, unless an emergency medical condition exists as further stipulated in the Medical Staff bylaws.

(b) A physician may resign at any time by giving written notice to the Chief Executive Officer. This resignation must be first submitted by the individual physician, and not by a group, in order to be accepted. Any such resignation shall take effect upon receipt of such notice subject to completion of all outstanding medical records and the term of the ER call responsibilities. ER call responsibilities must be satisfied to the end of the term of the existing ER call

schedule or 30 days from the date of the letter of resignation, whichever comes first. In special circumstances, the CEO, in consultation with the President of the Medical Staff, may determine a release from ER call responsibilities sooner than 30 days if he deems appropriate. Unless as specified above, no acceptance of such resignation shall be necessary to make it effective.

Section 7. Stabilization and Treatment beyond the Capability of the Emergency Department:

(a) Except as set forth below, a patient experiencing an emergency medical condition must be stabilized prior to being discharged. A patient is considered to be stabilized when the treating physician has determined, with reasonable clinical confidence, that the patient's emergency medical condition has been resolved.

(b) An Emergency Department physician shall be responsible for the general care of all patients presenting to the Emergency Department until the patient's attending physician, or an on-call physician, assumes that responsibility or the patient is discharged or transferred.

(c) A patient may request that a particular physician be contacted to provide necessary stabilizing treatment. If the physician is on the hospital's Medical Staff, an attempt will be made to contact the physician.

(d) If (i) the patient does not request a specific physician or any member of a particular group, or (ii) a requested physician is unavailable to come to the hospital, or (iii) the requested physician does not respond within 30 minutes, the physician listed on the on-call rotation schedule shall be contacted to provide the necessary consultation or treatment for the patient.

Section 8. Dental and Podiatric Patients:

A patient admitted for dental or podiatric surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the dentist or podiatrist and the attending physician. The attending physician must provide the history and physical and medical care for the patient. However, dentists shall be responsible for that part of their patients' history and physical that relates to dentistry and podiatrists shall be responsible for that part of their patients' history and physical that relates to podiatry.

Section 9. Alternate Coverage:

(a) Each Medical Staff member shall provide professional care for his/her patients in the Hospital by being available or making arrangements with an alternate Medical Staff member who has appropriate clinical privileges at the Hospital to care for the patients.

(b) If an attending physician does not participate in an established call coverage schedule with known alternate coverage and is unavailable to care for a patient, or knows that he or she will be out of town, the attending physician will document on the order sheet of the chart the name of the alternate Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability.

(c) If an attending physician or his or her alternate is not available, the Chief Executive Officer or his or her designee will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

Section 10. Transfer of Patients:

(a) The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

(1) assessing the reason(s) for transfer;

(2) establishing the conditions under which transfer can occur;

(3) evaluating the mode of transfer/transport to assure the patient's safety; and

(4) ensuring that the organization receiving the patient assumes responsibility for the patient's care after arrival at that facility.

(b) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The attending physician will take the following steps as appropriate under the circumstances:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, Hospital staff, and family members participating in the patient's care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

(i) the reason for the transfer;

(ii) the risks and benefits of the transfer; and

(iii) available alternatives to the transfer.

(c) When patients are transferred, appropriate information will be provided to the accepting practitioner/facility, including:

(1) reason for transfer;

(2) significant findings;

(3) a summary of the procedures performed and care, treatment and services provided;

(4) condition at discharge;

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

(6) working diagnosis.

(d) When a patient requests a transfer to another facility, the attending physician will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (b) above.

(e) The transfer of a patient with an emergency medical condition from the Emergency Department to another facility will be made in accordance with the Hospital's applicable EMTALA policy.

(f) Transfers of patients from one campus of the Hospital to another are to occur only when (i) it is in the best interests of the patient and there is bed availability at the other campus facility, as determined by code purple as in the state of high census or interrupts the operation of the ER, or (ii) the physician has determined that the services needed by the patient are located at the other campus facility. A patient transfer between campuses is not to be done for the convenience of the physician. In such a situation, the physician is to either go over to the other campus, have a designated cover physician for him or her at the other campus, or turn the care of the patient over to the physician of the day at the other campus.

(g) When a patient presents whose specialty is located solely at the other campus (i.e., Pediatrics, OB), the patient would be transferred to the other campus for treatment and would require the necessary documentation for EMTALA compliance.

Section 11. Priorities for Admission:

The admitting office shall admit patients on the basis of the following order of priorities:

(a) **Emergency Admissions** – includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger.

(b) **Urgent Admissions** – includes non-emergency patients whose admission is considered imperative by the attending physician. Urgent admissions shall be given priority when beds become available over all other categories except emergency.

(c) **Pre-Operative Admissions** – includes patients already scheduled for surgery. If it is not possible to accommodate such admissions, the Operating Room Supervisor and the anesthesiologist may decide the priority of any specific admission after appropriate consultations with the physicians for the patients involved.

(d) **Routine Admissions** – includes elective admissions involving all clinical services.

Section 12. Continued Hospitalization:

(a) The attending physician or designee shall be required to document the need for hospitalization. The attending physician's documentation must contain:

(1) A daily entry by the attending physician (M.D. or D.O.) or his/her designee which includes a written or dictated record of the reason for hospitalization and the continued stay to include date, time and signature.

(2) plans for post-Hospital care.

(b) Upon request of the Hospital's Resource Management Chairperson/designee, the attending physician or designee, must provide written justification of the necessity for continued hospitalization. This documentation shall include the reason for continued stay, and plans for post-hospitalization care and will be completed within twenty-four (24) hours of the request. Failure to comply with this requirement shall be brought to the attention of the Medical Executive Committee for appropriate action.

(c) If the Resource Management Committee decides that continued hospitalization is not medically necessary, written notification must be given, no later than 24 hours after the determination, to the Hospital, the patient, or the patient's attending physician.

ARTICLE III

RESTRAINTS AND BEHAVIOR MANAGEMENT PROGRAMS

(a) Restraint use is minimal and "just-in-time" training will be provided when necessary.

(b) Restraints may be used only when clinically justified and when lesser restrictive alternatives would be ineffective. Restraint is defined as:

- any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or

- a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from falling out of bed or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(c) Restraints are never to be used as a means of coercion, discipline, convenience or retaliation. They may only be used to ensure the immediate physical safety of the patient, staff, or others. They must be discontinued at the earliest possible time, regardless of the length of time identified in the original order. Seclusion should not be used.

(d) Restraints may be used to support or promote healing and/or for the management of violent or self-destructive behavior to prevent harm to self or others.

(e) Restraints may be initiated only as follows:

(1) Pursuant to a physician order or order of another appropriately trained licensed independent practitioner ("LIP") who is responsible for the care of the patient, as permitted by state law.

(2) In an emergency application situation, where the physician or LIP responsible for the care of the patient is not available to provide an order, a registered (professional) nurse may initiate restraint because of a significant change in the patient's condition and shall contact a physician or LIP immediately to obtain a verbal or written order from the

practitioner. That order must be immediately recorded in the patient's record and the physician or treating LIP responsible for the care of the patient must physically examine the patient (face-to-face) within one hour after the restraint is initiated and, at that time, place a written order in the patient's record. This face-to-face examination must occur within one hour even if the restraints have been removed before he or she arrives. The physician or LIP:

(i) reviews the patient's physical and psychological status with the staff;

(ii) works with the patient and staff to identify ways to help the patient to regain control;

(iii) makes any necessary revisions to the patient's treatment plan; and

(iv) if necessary, provides a new written order.

(f) Physicians and LIPs shall take into consideration each patient's physical and psychological condition when writing orders for restraint. When possible, the method of restraint shall be selected so as to minimize any detrimental effect that the patient might experience, and the lowest level of restraint shall be implemented. All orders for restraint shall be implemented in accordance with safe and appropriate restraining techniques.

(g) When possible, at the time of the restraint, or as soon as possible thereafter, the physician or other LIP ordering the restraint shall inform the patient, and/or his or her family, of the need for the use of restraint, the method of restraint that was selected, and any other pertinent information related to the restraint. If the patient has objected to having his or her medical condition discussed with his or her family, there will be no discussion with the family. The attending physician must also be consulted as soon as possible whenever the order did not originate with him or her. This consultation can occur via telephone and does not need to be face-to-face.

(h) An assessment of a restrained patient's condition shall be made at least once every two hours, or more frequently if directed by the attending physician or indicated by the patient's condition. When restraints are applied for behavioral reasons, the patient must be monitored through continuous in-person observation and an assessment must be documented every 15 minutes. The assessment must be documented in the patient's record and shall address the following: injury associated with the restraint; nutrition and hydration; circulation and range of motion in the extremities; vital signs, as appropriate; hygiene and elimination; physical and psychological status and comfort; the possibility of downgrading to a less restrictive method of restraint; and readiness for discontinuation of restraint.

(i) An order, based on a face-to-face examination by the physician, must be written each calendar day. The order cannot be a standing order or on an as-needed basis (PRN). Restraints used for behavioral reasons shall be limited to emergency use and the patient should be transferred as soon as possible to an appropriate health care facility. The written order for restraint is limited to a maximum of:

- 4 hours – adults
- 2 hours – adolescents, ages 9 – 17
- 1 hour – children under age 9

When the original order expires, a verbal order from the physician or LIP must be obtained to continue the order for four hours for an adult, two hours for adolescents, and one hour for children. At the eighth hour for an adult, fourth hour for an adolescent and second hour for children under 9 years of age, the physician or LIP must conduct an in-person evaluation. The cycle for in-person evaluation will continue for as long as restraints are required.

(j) The following shall be documented in the patient's medical record:

(1) the one-hour face-to-face medical and behavioral evaluation if restraint is used to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others;

(2) a description of the patient's behavior and the intervention used;

(3) alternatives or other less restrictive interventions attempted (as applicable);

(4) the patient's condition or symptom(s) that warranted the use of the restraint; and

(5) the patient's response to the intervention(s), including the rationale for continued use of the intervention.

(k) Any death that occurs while a patient is restrained, within 24 hours after removal from restraint, and within one week after restraint where it is reasonable to assume that the use of restraints directly or indirectly contributed to a patient's death, will be reported to CMS.

(l) Reports of a patient's death must be made by phone to the CMS regional office by the close of the next business day. The date and time of the call must be documented in the medical record.

ARTICLE IV

MEDICAL ORDERS

Section 1. General Requirements:

(a) All medical orders must be legible, complete, dated, timed, and in writing and authenticated. “Orders” includes:

(1) orders both written and signed by a physician;

(2) verbal orders by a physician in accordance with Section 3 of this Article; and

(3) orders faxed by a physician, transcribed for inpatient only, and signed by authorized personnel and countersigned by the attending physician within 24 hours.

“Authorized personnel” as used in this subsection means a member of the Medical Staff, allied health professional, physical therapist, respiratory therapist, occupational therapist, speech therapist, registered radiology technician, registered nurse, intern, resident, fellow, dietitian, pharmacist or physician assistant, to the extent it is within the scope of his license. Under no circumstances may a student act in this capacity.

(b) Orders which are illegible or improperly written shall not be carried out until they are clarified by the ordering physician and are understood by the appropriate health care provider. In addition, if the physician’s written orders are found not to be legible (as determined by the Medical Executive Committee), that physician can be directed to write future orders in block printing (not script printing).

(c) All symbols and abbreviations in orders must be from the Hospital approved lists.

(d) Rules applicable to specific kinds of orders are:

(1) Treatment orders must include the treatment to be performed and the frequency it is to be performed.

(2) Orders for drugs and biologicals, with the exception of influenza and pneumococcal polysaccharide vaccines, must be documented and signed by a practitioner who is authorized by hospital policy to write orders and who is responsible for the care of the patient.

(3) Orders for influenza and pneumococcal polysaccharide vaccines may be administered per physician-approved hospital policy after an assessment of contraindications.

(4) Medication orders must include the patient name and location; time and date of order; drug name, strength (and dosage form, if necessary); directions for use (including route of administration, frequency and rate); prescriber's signature or that of his or her authorized agent. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols.

(5) Orders for "continue home meds" on admission or discharge or "resume previous orders" are not acceptable orders and shall be clarified by the physician.

(6) Orders for diagnostic and therapeutic services must direct the use of Hospital-based facilities when reasonably available, or, if not available, at another facility in accordance with Hospital policy and rules respecting use of outside laboratories.

(7) 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.

(8) Respiratory care services may only be provided on the order of an individual who is responsible for the care of the patient and who has been granted privileges to order the services by the Hospital.

(e) Standing orders may be formulated by Medical Departments and placed on file at the Hospital. These orders must be recorded on the patient's medical record and signed by the physician. Standing orders shall not, however, replace or cancel those written for the specific patient. Standing orders shall be reviewed at least annually by the Medical department and revised as necessary.

All standing orders, that include drugs, must be approved by the initiating Medical Department, Pharmacy and Therapeutics Committee, MEC and Forms Committee. Such orders shall be reviewed by the Pharmacy and Therapeutics and Medical Executive Committee on an annual basis, or as any changes are made to standing orders.

<u>Section 2. Who May Write Orders</u>:

(a) Medical Staff members, allied health professionals, interns, residents, fellows, nursing personnel, physician assistants, dieticians, physical therapists, respiratory therapists, occupational therapists, and pharmacists shall have the authority to write orders only as permitted by their licenses and, where applicable, as

permitted by the clinical privileges or scope of practice granted them by the Hospital.

(b) Hospital Policy will be followed in obtaining and validating non-staff physicians' license and NPI numbers so that their orders may be accepted for outpatient services.

(c) All orders must be entered in the patient's record, dated, timed, and signed by the responsible practitioner.

Section 3. Verbal Orders:

(a) A verbal order (via telephone or in person) for medication or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the responsible practitioner. Verbal orders are not accepted from interns or residents unless an emergency exists.

(b) All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated by the ordering physician or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy.

(c) Verbal orders will be verified via accepted "read-back" verification practices.

(d) All verbal orders will be countersigned/authenticated with date and time by the ordering physician, or a practitioner who is also involved in the patient's care in the Hospital, within 48 hours.

(e) The following are the personnel authorized to receive and record verbal orders:

(1) registered nurse;

(2) medical resident or fellow;

(3) intern;

(4) physician assistant;

(5) pharmacist;

(6) respiratory therapist;

(7) physical therapist;

(8) occupational therapist; and

(9) speech therapist.

(10) Radiology Technician

<u>Section 4. Electronic Signature Privileges</u>:

All Practitioners are required to enter into a Practitioner Electronic Signature Agreement with the Hospital. The Agreement confirms, among other things, (a) that the Practitioner's use of his or her electronic signature, whether arising out of the electronic health record maintained by the Hospital or the Practitioner, carries all of the legal and ethical obligations of a handwritten signature; and (b) that the Practitioner shall not delegate the use of his or her electronic signature to any other person.

<u>Section 5. Therapy Orders</u>:

The Medical Staff delegates to the therapist (Occupational, Physical, Speech-Language Pathologist), upon an order for therapy, to evaluate the ptients, develop a plan of treatment and initiate the plan of care prior to the physician siging off. The physician will sign the plan as soon as reasonably possible.

ARTICLE V

MEDICAL RECORDS

Section 1. General Rules:

(a) A medical record shall be maintained for each patient who is evaluated or treated as an inpatient, outpatient, or emergency patient. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient under his/her care.

(b) The contents of the record shall be pertinent and current and will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. A single attending physician shall be identified in the medical record as being responsible for the patient at any given time.

(c) A patient must be seen by the attending physician/designee every calendar day and documented in the patient record. If the designee is an allied health professional, the supervising physician or his/her covering physician will see the patient at least once during the patient's stay.

(d) Only those abbreviations, signs, and symbols approved by the Medical Executive Committee shall be used in the medical record. No abbreviations, signs or symbols shall be used to record a patient's final diagnoses, any unusual complications, or discharge orders. An official record of approved abbreviations shall be kept on file in the Health Information Services Department.

(e) All routine medical orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and shall be dated, signed and timed by the ordering physician or other appropriate designee.

(f) The requirements outlined in these Rules and Regulations for the completion and documentation of H&Ps, operative reports, and autopsies shall be enforced by the Chairperson of the Resource Management Committee.

Section 2. Authentication:

(a) Authentication means to establish authorship by written signature or identifiable initials and may include written signatures, written initials, or computer entry using electronic signatures, but not rubber stamps.

(b) Orders, H&Ps, Consults and Discharge Summaries may be authenticated by ordering physician, dictating physician, partners, covering or other appropriate physician.

(c) There shall be no delegation to another individual of computer signature codes.

Section 3. Contents:

(a) A complete medical record shall include:

(1) identification data, including the patient's name, address, date of birth, next of kin, the name of any legally authorized representative, as well as a single unit number that identifies the patient and the patient's medical record;

(2) date of admission and discharge;

(3) medical history, including:

(i) the chief complaint,

(ii) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status, and history of present illness,

(iii) relevant past, social and family histories,

(iv) relevant menstrual and obstetrical history in females,

(v) an inventory by body systems, and

(vi) drug sensitivities/allergic history;

(4) provisional admitting diagnosis;

(5) report of a physical examination, including but not limited to vital signs, head, chest, abdomen and extremities, or a note as to the contra-indications for such an examination or valid reasons why the examination was not performed. In cases in which an osteopathic physician is the attending, an osteopathic musculoskeletal examination must be documented;

(6) a statement of the conclusions or impressions drawn from the admission history and physical examination;

(7) the goals of treatment and treatment plan;

(8) diagnostic and therapeutic orders;

(9) evidence of appropriate informed consent;

(10) clinical observations, progress notes, nursing notes, consultation reports;

(11) all reassessments and any revisions to the treatment plan;

(12) reports of procedures, tests and the results, including pre-operative and operative reports, pathological findings;

(13) diagnostic and therapeutic procedures and test results;

(14) consultation reports;

(15) documentation of any complications, Hospital acquired infections, and/or unfavorable reactions to drugs or anesthesia;

(16) conclusions at termination of hospitalization, including the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses, the condition at discharge, follow-up instructions including medications, diet or limitations of activities, the discharge summary or final progress note, and, when appropriate, the autopsy report; and

(17) the time and means of patient's arrival when emergent or urgent care is provided and whether the patient left against medical advice.

(b) For patients receiving continuing ambulatory care services, the medical record will contain an outpatient problems list, including the following information:

(1) known significant medical diagnoses and conditions;

(2) known significant operative and invasive procedures;

(3) known adverse and allergic drug reactions; and

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

(c) Medical records of patients who have received emergency care will contain the following information:

(1) date, time and means of arrival;

(2) name, sex, and age of the patient;

(3) nature of the complaint and results of the Medical Screening Examination, if any;

(4) name of the physician responsible for care;

(5) brief description of services provided;

(6) conclusions at termination of treatment, including final disposition, condition on discharge, and instructions for follow-up care;

(7) time of discharge; and

(8) whether the patient left against medical advice.

(d) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Medical Executive Committee. All new forms proposed for use in the medical record shall be submitted to the Resource Management Committee for review, following approval by the Forms Committee. The Resource Management Committee shall approve (or reject) all forms recommended for inclusion in the medical record and shall notify the Medical Executive Committee concerning such action. Approved changes shall not be made until the mechanics of standardization have been accomplished.

Section 4. History and Physical:

Details concerning the history and physical requirements are described in Article 11 History and Physical of the Medical Staff Bylaws document.

Section 5. Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the Hospital. Where 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.

(b) Progress note documentation shall include, but need not be limited to, the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(2) any complications, new symptoms or additional diagnoses for which the patient is to be evaluated or treated;

(3) plans for additional workups, consultations, or definitive treatment(s); and

(4) discharge planning.

If the patient's condition is stable and unchanged, a statement documenting that status shall be adequate.

(c) Progress notes can be written by Medical Staff members, housestaff, and allied health professionals as permitted by their clinical privileges or scope of practice.

(d) Progress notes shall be written at least daily, and at the time of a reassessment, for all patients who have been admitted to the Hospital. No faxing of progress notes is allowes. Reassessments will be documented whenever:

(1) a significant change occurs in the patient's condition or status;

(2) there is a significant response to a procedure/intervention; or

(3) at specified time intervals.

Section 6. Surgical Records:

(a) Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery.

(1) verification of patient identity;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(4) Pre-operative diagnosis;

(5) laboratory test results, if applicable (including those obtained from sources outside of the Hospital);

(6) consultation reports;

(7) consent form signed by the surgeon and the patient or the patient's legal representative;

(8) x-ray reports, if applicable (including those obtained from sources outside of the Hospital); and

(9) other ancillary reports, if applicable.

(b) Except in the case of an emergency, the patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report has been received.

(c) In an emergency situation, the attending surgeon shall write a note describing the patient's condition prior to the induction of anesthesia and the start of surgery. The attending surgeon shall write a note in the chart stating that the delay for recording the requirements in subsection (a) would constitute a danger to the health or safety of the patient. If the history and physical have been dictated and/or transcribed but not yet entered in the chart, an admission note and statement to that effect may be entered in the chart by the attending physician.

Section 7. Operative Notes and Reports:

(a) A pre-operative note which contains the patient's age, sex, pre-operative diagnosis and recommended surgery, discussion of risk and benefits of the surgery, the choice of anesthesia, a pertinent drug history and any allergies shall be documented in the medical record before the surgery is to be performed.

(b) Reports of pre-operative work-up appropriate to the patient's history and condition, as determined and documented by the attending physician, surgeon or anesthetist, shall be part of the medical record prior to the performance of any elective surgical procedure.

(c) A history and physical shall be performed for each patient and documented in the medical record prior to an elective surgical procedure, including any procedure to be performed as in-patient or any other procedure requiring sedation of any kind. In any emergency, the attending physician shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

(d) A brief operative note shall be handwritten in the medical record immediately after surgery and shall contain significant and pertinent findings.

(e) A detailed operative report shall be dictated immediately following surgery and shall contain:

(1) name and hospital identification number of the patient;

(2) date and times of the surgery;

(3) name of the surgeon and assistants or other practitioners who performed surgical tasks;

(4) preoperative and postoperative diagnosis;

(5) name of the specific surgical procedure performed;

(6) type of anesthesia administered;

(7) complications, if any;

(8) a description of techniques, findings, and tissues removed or altered;

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

(10) description of specific significant surgical techniques that were conducted by practitioners other than the primary surgeon, if applicable.

(f) A complete operative report shall be authenticated by the surgeon and filed in the patient's medical record as soon as possible thereafter.

(g) When a complete operative report is not placed in the medical record immediately after surgery, the appropriate portion of the peri-operative report (or a progress note that includes the following) shall be entered immediately:

(1) name of primary surgeon and assistants;

(2) findings;

(3) technical procedures used;

(4) anesthesia administered;

(5) complications, if any;

(6) specimens removed; and

(7) post-operative diagnosis.

Section 8. Anesthesia and Sedation Note:

(a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 24 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services. The evaluation will be recorded in the medical record and will include:

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

(2) an interview and examination of the patient;

(3) notation of any anesthesia risks;

(4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

(5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and

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

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 24-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 24 hours, but may be performed during or within 30 days prior to the 24-hour time period.

(b) 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 24 hours after the patient has been moved into the designated recovery area. The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(1) respiratory function;

(2) cardiovascular function;

(3) mental status;

(4) temperature;

(5) pain;

(6) nausea and vomiting; and

(7) post-operative hydrations.

Section 9. Pathology Reports and Disposition of Surgical Specimens:

(a) All specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as appropriate, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist, who shall 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.

(b) Pathology shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within twenty-four (24) hours of completion, if possible.

(c) All surgically removed specimens shall be referred to the Hospital Pathologist except those designated as exempt from Pathologist examination by Pathology, with Medical Executive Committee approval.

(d) The disposition of surgical specimens shall be recorded in the operative record.

Section 10. Medical Information from Other Hospitals or Health Care Facilities:

Upon written authorization of the patient, the Health Information Services Department shall transmit information to other hospitals or health care facilities requesting data concerning the patient's previous admissions, name, birth date, and dates of previous hospitalization. Similarly, the Medical Records Department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient.

Section 11. Discharge Summaries:

(a) A discharge summary shall be included in the medical records of all patients except:

(1) short stays/observation patients (those stays less than 48 hours);

(2) normal newborn infants; and

(3) uncomplicated obstetrical deliveries.

(b) For patient stays under 48 hours, the final progress note may serve as the discharge summary. Contents include discussion of:

(1) the resolution of the admission diagnosis and chief complaint;

(2) the course of the facility stay;

(3) interventions, procedures, operations, consultations, etc.;

(4) any complications arising and how these were managed;

(5) the progress made in regard to specific interventions; (i.e., physical therapy, respiratory care, etc.);

(6) difficulties in establishing the diagnosis and an effective treatment plan;

(7) condition on discharge; and

(8) instructions for follow-up care including nutrition, medication, activity, any referrals, and the next appointment if appropriate with the attending; and

(9) includes instruction for pain management post discharge.

(c) A concise discharge summary must be completed on each patient within 7 days of patient discharge. The discharge summary shall include:

(1) all diagnoses;

(2) the reason for hospitalization;

(3) the significant findings;

(4) any complications;

(5) the procedures performed and treatment rendered;

(6) the condition of the patient at discharge;

(7) discharge medication reconciliation; and

(8) any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care.

(d) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

(e) When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate and a copy of the preprinted instruction sheet used is available on the Hospital Intranet.

(f) All discharge summaries shall be authenticated by the attending physician, partner, covering or other appropriate physician.

Section 12. Delinquent Medical Records:

(a) It is the responsibility of each Medical Staff member 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 of the Hospital.

(b) Each medical record shall be completed within thirty (30) days of discharge. Outpatient records shall be complete within thirty (30) days of procedure.

(c) A staff member who has not completed his/her medical records within sixteen (16) days after discharge shall be notified, in writing, that there are incomplete records in his/her file. A deadline of one week shall be stated.

(d) A staff member who has not completed his/her History and Physical, Discharge Summary or Operative Report at the time of discharge will be notified immediately of delinquency and will not receive the customary sixteen (16) day completion period.

(e) All Discharge summaries must be dictated, handwritten discharge summaries will not be accepted for stays greater than 48 hours.

(f) If the record is delinquent for dictation of H&Ps, Op reports or Consults after 7 days, or if the record continues to be delinquent after 30 days from discharge, the following goes into effect:

   (1) All staff privileges shall be voluntarily relinquished until such time as all incomplete records have been completed.

   (2) This includes the staff member's admitting, consulting, and outpatient treatment privileges, as well as privileges to schedule or assist in surgery of any physician.

   (3) If surgery has been scheduled at the time of suspension, it may only take place with the express advance permission of the VP of Medical Affairs or his or her designee.

   (4) The suspension shall continue for as long as all incomplete medical records in question remain incomplete.

(g) Provisions for continued medical care of hospitalized patients as well as patients from scheduled ER coverage are the responsibility of the suspended physician.

(h) Physicians who are absent from hospital duties for three or more consecutive days and who notify the Medical Staff Office prior to their departure, will be given a seven (7) day window to complete their medical records upon their return.

Practitioners who notify the Medical Staff Office of their absence prior to departure will not be placed on the "No Admit List" during this time.

(i) If a member of the Medical Staff is on the "No Admit List" fifty (50 consecutive or cumulative days in a twelve (12) month period, notification via certified mail will be sent from the President of the Medical Staff, on behalf o the Medical Executive Committee, notifying the member of the number of days he/she has accumulated and the consequences if the outstanding charts are not completed. If the member remains on suspension and consecutively or cumulatively accumulates twenty-five (25) more days, a fine of $250 for administrative cots will be imposed and must be collected by the Medical Staff office prior to resuming the member's membership/privileges. This money shall be deposited into the Medical Staff Fund account. Upon receipt of payment and completion of all medical records, the physician's privileges will be reinstated.

If the physician appears on the "No Admit List" after an additional 50 days during the same calendar year, a fine of $500 will be imposed and must be collected by the Medical Staff office prior to resuming the member's membership/privileges. Additionally, the physician must appear at MEC to explain the inability to complete medical records in a timely fashion. This money shall be deposited into the Medical Staff Fund account. Upon receipt of payment and completion of all medical records, the physician's privileges will be reinstated.

(j) When the privileges of a physician are suspended, this suspension applies to both the Chicago Heights and Olympia Fields campuses. A copy of suspended physicians will be posted on the intranet on the Medical Record Home Page.

(k) A copy shall also be attached to the quality file of the physician and such fact shall be considered in the reappointment of that staff member.

(l) Once a physician has completed all incomplete medical records, his/her privileges will be reinstated immediately.

Section 13. Possession, Access and Release:

(a) The Hospital will retain medical records in their original or legally reproduced form for a period of at least 10 years in accordance with Hospital policy.

(b) All medical records are the physical property of the Hospital and shall not be taken from the jurisdiction and safekeeping of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with federal and state law. Unauthorized removal of a medical record from the Hospital by a Medical Staff member may constitute grounds for a professional review action in accordance with the provisions set forth in the Credentials Policy.

(c) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Hospital policy.

(d) No patient record shall be removed from the Health Information Services Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the Chief Executive Officer or a designee.

(e) Upon written approval of the Internal Review Board, access to the medical records of all patients shall be afforded to Medical Staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

(f) The patient's written consent is required for release of medical information to those not otherwise authorized to receive information.

(g) Any record taken out of the Health Information Services Department for the purpose of patient readmission shall be returned with the current record upon discharge of the patient.

Section 14. Filing of Medical Record:

A medical record shall not be permanently filed until it is completed by the attending physician or is ordered filed by the VP of Medical Affairs or his or her designee.

(a) Any person not involved with direct patient care is not allowed to complete the patient chart.

(b) After 30 days from the date of a physician's resignation from the Medical Staff, any incomplete records are retired.

Section 15. Text Messaging:

Cell Phone Usage with Protected Health Information: To protect against unauthorized access or use of patient information, physicians and SSFHS personnel may not send or forward any patient information via text messaging. These messages are not transmitted or maintained on a secure site or network.

ARTICLE VI

CONSULTATIONS

Section 1. General:

(a) Any individual with clinical privileges at this Hospital may be requested to provide a consultation within his or her area of expertise.

(b) The attending Medical Staff member shall be responsible for requesting a consultation when indicated.

(c) Requests for a consultation shall be entered on an appropriate form in the patient's medical record by writing the word "consult," with consult by itself meaning "consult and participation as appropriate." The reason for the consult must be on the order. If the history and physical are not part of the patient's medical record and the consultation form has not been completed, it shall be the responsibility of the Medical Staff member requesting the consultation to provide this information to the consultant.

(d) If a nurse employed by the Hospital 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, that nurse shall notify the nursing supervisor who, in turn, may refer the matter to the Vice President of Patient Care Services or designee. The Vice President of Patient Care Services may bring the matter to the attention of the chief of the clinical department in which the member in question has clinical privileges. Thereafter, the chief of the department may request a consultation after discussion with the attending Medical Staff member.

(e) In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Medical Executive Committee, the Board, the Chief Executive Officer, the President of the Medical Staff, VP of Medical Affairs, or the appropriate department chair shall at all times have the right to call in a consultant or consultants.

(f) Consults should be completed within 24 hours of being notified.

Section 2. Required Consultations:

(a) Consultations are also required in all cases which, in the judgment of the attending Medical Staff member:

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

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

(3) unusually complicated situations are present that may require specific skills of other practitioners; or

(4) the patient exhibits severe symptoms of mental illness or psychosis.

Additional requirements for consultation may be established as outlined in Section 1 (e) above.

(b) Interns and residents or nursing must promptly notify an attending or consulting physician of significant changes in a patient's condition. If there is no response from the attending/consulting physician within 30 minutes, the interns and residents or nursing must contact the department chairperson. If the department chairperson is the attending, then the VP, Medical Affairs must be notified.

Section 3. Psychiatric Consultations:

Psychiatric consultation and treatment shall be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose). If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

Section 4. Mandatory Consultations:

(a) When, as a result of peer review activities, a consultation requirement is imposed by the Medical Executive Committee or the Board, pursuant to the Credentials Policy, the required consultation shall not be rendered by an associate or partner of the attending Medical Staff member.

(b) Failure to obtain required consultations may result in a further professional review action pursuant to the Credentials Policy.

Section 5. Contents of Consultation Report:

Each consultation report shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. The consultation report shall be made a part of the patient's medical record.

ARTICLE VII

INFORMED CONSENT

Section 1. Hospital Policy:

All patients are entitled to be advised by his physician of the following:

(a) the diagnosis, nature and purpose of the proposed course of treatment;

(b) the reasonably known risks and consequences of the treatment/procedure;

(c) the reasonable medical alternatives, if any; and

(d) the probable prognosis if the treatment/procedure is not administered.

The patient must be given enough information to be reasonably able to make a competent decision to consent to or refuse administration of the treatment or procedure.

Section 2. When Informed Consent Forms Are Required:

(a) A fully-completed informed consent form signed by the patient (or, as appropriate, by the patient's legal representative) must be obtained and countersigned by the physician or surgeon before performing any of the following procedures:

(1) any surgical procedure, whether major or minor;

(2) any procedure where anesthesia or conscious sedation is used, regardless of whether entry into the body is involved;

(3) procedures involving the use of radioactive material;

(4) diagnostic testing procedures;

(5) experimental procedures, devices and drugs; or

(6) any procedure determined by the Medical Staff to require specific informed explanation to the patient of the procedure contemplated and its risks and benefits.

(b) Doubts whether consent is necessary should be resolved in favor of obtaining consent.

(c) Should a second operation be required during the patient's stay at the Hospital, a second consent shall be obtained. If two (2) or more specific procedures or treatments are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

Section 3. How Consent Is Obtained:

Except as indicated below, consent must be obtained in advance of performing the suggested procedure or treatment.

(a) Consent is ordinarily obtained from the patient on a written consent form approved by the MEC and the Board for that purpose. A fully-completed informed consent form must contain at least the following:

(1) name of patient and responsible practitioner performing the procedure;

(2) name of the procedures and a statement that the procedures, including anticipated benefits, material risks, and alternative therapies, were explained to the patient or the patient's legal representative;

(3) alternative procedures and treatments;

(4) signature of the patient or the patient's legal representative;

(5) date and time the form was signed by the patient or patient's legal representative;

(6) signature and professional designation of the person witnessing the consent; and

(7) name and signature of person who explained the procedure to the patient or the patient's legal representative.

(b) Where written consent is not reasonably available, verbal consent should be obtained and the particulars recorded in the patient's progress notes.

(c) Prior to surgery, a Member in the Department of Anesthesiology must visit the patient or family and describe the plan of anesthesia. Consent must be recorded in the progress notes.

(d) Where the patient is unconscious, incompetent or under the influence of alcohol or drugs, consent should be obtained from the patient's next-of-kin or legal representative. Where the patient is a minor, consent should be obtained from at least one parent or guardian.

(e) When an incompetent patient has neither a legal guardian nor any known surrogate, consent to treatment or procedure shall not be required provided that two (2) or more physicians, after having consulted, indicate in writing that the treatment is necessary and that any attempt to secure consent from a court or to locate unknown relatives would result in delay of treatment or a procedure that would increase the risk to the incompetent patient's life or health.

(f) In an emergency, where consent cannot reasonably obtained from the patient, the physician should contact the Medical Director and the CEO as soon as possible.

(1) Consent by telephone from the patient's next-of-kin or legal representative should be obtained and such consent recorded in the patient's medical record;

(2) If immediate intervention is necessary, the physician must complete a brief progress note outlining the circumstances. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

(g) It is the responsibility of the Nursing Department to:

(1) provide the appropriate consent form;

(2) assure that the form has been properly completed prior to commencement of the treatment or procedure; and

(3) assure that the consent form is part of the patient's medical record and notify the physician if the form is not present.

Section 4. Special Rules for Minors:

Subject to the availability of resources, all minors may be treated for emergencies, even if consent cannot be reasonably obtained.

(a) The Hospital may not render non-emergent treatment to minors unaccompanied by a parent or guardian unless the minor:

(1) is pregnant;

(2) is emancipated and can present proof from a court of competent jurisdiction;

(3) is 12 years old or older and has been exposed to or is suffering from a sexually transmitted disease;

(4) has allegedly been raped or sexually assaulted or is seeking treatment for a sexually transmitted disease, regardless of reportability;

(5) is 12 years old and is a drug addict, an alcoholic, or an intoxicated person or who may have a family member who abuses drugs or alcohol; or

(6) is 16 years old and is seeking voluntary inpatient mental health treatment, or is 12 years old and is seeking outpatient psychological counseling.

(b) An unaccompanied minor may be treated under non-emergent circumstances if

(1) there is a valid Advance Consent form on file;

(2) the parent or guardian cannot be contacted by telephone; and

(3) the treating physician indicates that treatment may not be rescheduled without quality of care concerns.

(c) When a minor identified as a ward of the State or a foster child presents to the Hospital for treatment; the Hospital shall notify the Department of Children and Family Services.

(d) A minor may consent to the treatment of his or her child.

ARTICLE VIII

ON-GOING PROFESSIONAL PRACTICE EVALUATIONS (OPPE)
FOCUSED PROFESSIONAL PRACTICE EVALUATIONS (FPPE)

Section 1. Ongoing Professional Practice Evaluation

Ongoing Professional Practice Evaluations (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) and/or to revoke an existing privilege prior to or at the time of renewal. A process is established for the Medical Staff to monitor the competency of its members through an ongoing review of performance measurements in which negative trends are tracked and trended in a manner that will effect change. Prospective and real-time evaluation is performed to ensure the delivery of safe and competent care. The Medical Staff Ongoing Professional Practice Evaluation plan is applicable to all practitioners with privileges granted by the Board.

The information used in the Ongoing Professional Practice Evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and feedback from other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel.

Any individual (including patient/family, medical staff, allied health professional or hospital staff) may report concerns regarding the professional performance of practitioners. Reported concerns regarding privileged practitioner's professional performance will be uniformly investigated and addressed as defined by the organization and applicable law. Relevant information from the practitioner performance review process will be integrated into performance improvement initiatives. The activities of the Ongoing Professional Practice Evaluation are considered privileged and confidential.

Members of the medical staff will be involved in activities to measure, assess and improve performance on an organization-wide basis, including the Ongoing Professional Practice Evaluation through the Medical Staff Peer Review Committee. The review process involves monitoring, analyzing and understanding those special circumstances of practitioner performance that require further evaluation. When findings of this process are relevant to an individual's performance, the medical staff is responsible for determining their use in ongoing evaluation of a practitioner's competence, in accordance with HFAP standards on renewing or revising clinical privileges.

Specific performance improvement monitors will be incorporated into Ongoing Professional Practice Evaluation of practitioners. The indicators will be approved by the Medical Staff Executive Committee (MEC). The indicators will be reviewed by MEC as needed for revisions and at a minimum of every two years. The Medical Staff will determine data to be collected for the Allied Health Professionals that are relevant to their practice.

Criteria/Indicators will include triggers and fall generally into the following six areas of general competence:

a. **Patient care**
   Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, for the prevention of illness, for treatment of disease, and the end of life.

b. **Medical/clinical knowledge**
   Practitioners are expected to demonstrate knowledge and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and education of others.

c. **Practice-based learning and improvement**
   Practitioners are expected to be able to use the scientific evidence and methods to investigate, evaluate, and improved patient care.

d. **Interpersonal and communication skills**
   Practitioners are expected to demonstrate interpersonal and communication skills that enables them to establish and maintain professional relationships with patients, families, and other members of health care team.

e. **Professionalism**
   Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, a responsible attitude toward the patient, their profession and society.

f. **System-based practice**
   Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

Processes are established to ensure that the confidentiality and security of the Ongoing Professional Practice Evaluation data is maintained. The following staff may access and review the data:

(1) Respective Department Chair
(2) Credentials Committee
(3) Medical Executive Committee (MEC)
(4) Resource Management
(5) President of Medical Staff

(6) Chief Medical Officer/Vice President of Medical Affairs (CMO/VPMA)
(7) Personnel working in the Medical Staff Office, Quality Department or Medical Records Department.
(8) Physician Peer Review Committee
(9) Key leaders in the hospital as deemed appropriate by the CMO/VPMA

The Quality Department Analyst and/or designee will collect data to perform concurrent and retrospective review using medical staff approved screening criteria. Data will be collected on an ongoing basis and summarized at least three (3) times during each two-year appointment cycle.

Section 2. Focused Professional Practice Evaluation

The Medical Staff defines the circumstance requiring additional, focused monitoring and evaluation of a practitioner's professional performance. The focused professional practice evaluations (FPPE) process is designed to be a fair, balanced and educational approach to ensure the competency of the staff. To receive a focused review, the practitioner must meet or exceed the same FPPE triggers:

Administrative

1. Peer Review (Patient care):
    a. Definition: Any quality of care issue that is determined by the Physician Peer Review Committee to be a significant deviation from the standard of care that was avoidable and the occurrence was deemed to be moderately severe to severe.
    b. FPPE Trigger: 2 occurrences in one half a year.

2. CME Compliance (Medical Knowledge)
    a. Definition: Credentialing criteria per bylaws.
    b. FPPE Trigger: Noncompliance.

3. Query Response (Medical Knowledge)
    a. Definition: Response to documentation query generated by Documentation Specialists or Physician Advisors
    b. FPPE Trigger: Below 90% compliance for response to query after 9 days or three attempts.

4. CMS Non-Compliance (Practice based learning)
    a. Definition: Non-compliance with any quality metric reported to the Center for Medicare and Medicaid (CMS) by Franciscan St. James Hospital
    b. FPPE Trigger: 2 occurrences in one half year

5. Substantiated Complaints or Grievances (Interpersonal communication skills)
    a. Definition: Any complaint or grievance substantiated by the Physician Peer Review Committee after a formal investigation or is a validated violation of the Disruptive Medical Staff Members Policy.
    b. FPPE Trigger: 2 occurrences in one half year.

6. Not available while on call for ED/In Patient Calls (Professionalism)
    a. Definition: Incidents of non-availability while on call for the ED or inpatient units regarding patient care validated by Physician Peer Review Committee
    b. FPPE Trigger: 2 occurrences in one half year
7. Suspension List
    a. Definition: Any medical staff on the "No Admit List" fifty (50) consecutive or cumulative days in a twelve (12) month period
    b. FPPE Trigger: Fifty (50) consecutive or cumulative days in twelve (12) month period

Specialty Specific Quality - Anesthesia

1. Perioperative Assessment of Inpatient for Surgery completed
    a. FPPE Trigger: 2 occurrences of non-compliance one half year
2. Postoperative Assessment of Inpatient & Outpatient for Surgery completed
    a. FPPE Trigger: 2 occurrences of non-compliance in one half year
3. Adverse Events during Anesthesia
    a. FPPE Trigger: 2 occurrences in one half year

Specialty Specific Quality - Emergency Department

1. Unplanned Return to ED Within 24 Hours (in aggregate)
    a. FPPE Trigger: 2 Standard Deviations in one half year from National Benchmark
2. ACLS/PALS Certification
    a. FPPE Trigger: Noncompliance

Specialty Specific Quality - Family Medicine

1. Mortality Rate
    a. FPPE Trigger: Observed over expected > 1.3 in a six month period
2. Musculoskeletal Examinations (DOs)
    a. FPPE Trigger: 5% non-compliance in one half year
3. Length of Stay
    a. FPPE Trigger: 10% above geometric stay in one half year

Specialty Specific Quality – Internal Medicine

1. Mortality Rate
    a. FPPE Trigger: Observed over expected >1.3 in a six month period
2. Musculoskeletal Examinations (DOs)
    a. FPPE Trigger: 5% non-compliance in one half year
3. Cath Lab Complications (Cardiology)
    a. FPPE Trigger: 2 deviations below the Truven database Index for 1 year
4. Length of Stay
    a. FPPE Trigger: FPPE Trigger: 10% above geometric stay in one half year

Specialty Specific Quality - Pediatrics

1. Pediatric Transfers
   a. FPPE Trigger: 2 Standard Deviations in one half year from National Benchmark
2. Pediatric Readmissions
   a. FPPE Trigger: 2 standard deviations from Truven database benchmark

Specialty Specific Quality – Pathology

1. Frozen Section/Intraoperative Consultation-Final Diagnosis Agreement Consultation
   a. FPPE Trigger: ≤ 3% from benchmark for 1 year
2. Surgical Pathology Disagreement with Unsolicited Interdepartmental Review
   a. FPPE Trigger: ≤ 5% from benchmark for 1 year
3. Frozen Section/Intraoperative Consultation Diagnosis Turnaround Time
   a. FPPE Trigger: ≥90% from benchmark for 1 year
4. Cytology Turnaround Time
   a. FPPE Trigger: ≥90% from benchmark for 1 year
5. Surgical Pathology Turnaround Time
   a. FPPE Trigger: ≥90% from benchmark for 1 year

Specialty Specific Quality – Radiation Oncology

1. Pulmonary Toxicity
   a. FPPE Trigger: 2 standard deviations above national benchmark for one half year
2. Radiation Esophagitis
   a. FPPE Trigger: 2 standard deviations above national benchmark for one half year
3. Breast Skin Reaction
   a. FPPE Trigger: 2 standard deviations above national benchmark for one half year

Specialty Specific Quality – Radiology

1. Missed Interpretations- Critical Variance
   a. FPPE Trigger: 2 Standard Deviations in one half from the internal St. James Benchmark for one half year
2. ED Read Timeliness
   a. FPPE Trigger: ≥ 30 minutes 5% of the ED reads for one half year

Specialty Specific Quality – Surgery

1. Surgical Complications
   a. FPPE Trigger: 2 Standard Deviations in one half year from Truven database benchmark
2. Musculoskeletal Exam
   a. FPPE Trigger: 5% non-compliance in one half year
3. Surgical Mortality Related to Operative Procedure
   a. FPPE Trigger: 2 Standard Deviations in one half year from National database
4. Operative Report Completed per Medical Staff Bylaws
   a. FPPE Trigger: 2 occurrences in one half year

Specialty Specific Quality - Obstetrical/Gynecology

1. Surgical Complications
   a. FPPE Trigger: 2 Standard Deviations in one half year from Truven database benchmark
2. Operative Report Completed per Medical Staff Bylaws
   a. FPPE Trigger: 2 occurrences in one half year
3. Early Elective Delivery <36 weeks
   a. Trigger: 1 occurrence in one half year
4. Length of Stay
   a. FPPE Trigger: FPPE Trigger: 10% above geometric stay in one half year

Quality Evaluation of Low Volume Providers

1.The physician may be required to meet with the Credentialing Committee at the time of reappointment.

2. The physician must present appropriate information/datea to support privileges requested. (Ex.: PHO Quality data, or office/procedure logs for one (1) week per quarter with patient information de-identified).

3.The Credentialing Committee may interview the physician and discuss the quality of care they provide and evaluate if there is sufficient evidence that the physician should be re-credentialed taking the interview summation into consideration.

4.OPPE activity from another hospital the Physicians is on staff at may be accepted if approved by the Credentialing Committee

5.Failure of the Physician to attend the Credentialing Committee meeting when requested could lead to denial of re-credentialing by the Credentialing Committee.

Allied Health Professionals OPPE Administrative and Quality Speicfic OPPE/FPPE Metrics

For Allied Health Professionals (AHP) the following process will be followed:

1.The AHP will be asked to provide the Medical Staff office a log of their activity (Patient encounters, history and physicals and Treatment Plan/procedures) for a one week period once a quarter.

2.The AHP logs will be evaluated by the credentialing Committee at the time of re-appointment

3.Failure of the AHP to present the requested data could lead to denial of credentialing by the Credentialing Committee.

For the FPPE triggers for length of stay and response to query, the provider must have over 10 encounters in a reporting period to be put into a focused review. Criteria/indicators may be added or deleted only if agreed upon by the MEC. The applicable Medical Staff Department and the MEC will approve indicator criteria and trigger (threshold) parameters. The list of criteria/indicators will be reviewed on an ongoing basis with a minimum biannual review.

The Department Chair retains responsibility for practitioner performance within the Department. The President of the Medical Executive Committee is responsible for the performance of the Department Chairs. They may assign Peer Review Panels as appropriate. They will provide a summary report to the MEC on practitioner performance activities. They have the authority to send any questionable determination for further review and may request an external review upon Physician Peer Review recommendations. They will facilitate and provide oversight of any recommended actions/interventions. They can present case findings as appropriate at medical staff committee meetings as part of the performance improvement process. They will review the OPPE reports for their department and meet with individual practitioners when trends or suboptimal performance is identified. They may recommend an FPPE to the Credentials Committee or Peer Review as needed. They are responsible to determine the length of time a practitioner within their department should be under focused review. They can also request an extension of a focused review if warranted.

All newly credentialed physicians will undergo a focused professional practice evaluation upon initial credentialing. A report of the above administrative and specialty indicators will be run on any newly credentialed physicians for a 3 months period after initial credentialing. The Board will approve the period of continued focused professional practice evaluation (FPPE) for all new privileges granted either upon initial appointment or for requests for additional privileges if warranted.

Medical Staff will determine methods to resolve performance issues. The measure employed to resolve performance issues shall be consistently implemented and may include:

- Necessary education
- Proctoring/assisting for defined privilege
- Counseling
- Physician/practitioner assistance programs
- Suspension of specific privileges
- Revocation of specific privileges

The improvement plan must be documented and include the requirements, who is accountable, and how the improvement will be measured and documented. The outcome of FPPE will be documented and reviewed by the appropriate Department Chair in collaboration with the PEER Review Committee. Processes are developed to allow the practitioner to review findings and submit opinions.

The individual under review will receive written notification scorecards when trends exceed threshold parameters on established indicator criteria. The trend reports will be provided on the OPPE physician trend report. The Medical Staff Office will send OPPE and FPPE physician scorecards to physicians by Certified Mail, or other form of secured communication every reporting period. Each physician's Credentials File will contain updated OPPEs and any FPPE reviews. All actions/follow-up/requests for intervention will be in a written response and/or meeting with the involved practitioner. All correspondence will be confidential by Certified Mail. OPPE and/or FPPE results will be a part of the determination of any reappointment and privileging, and will always remain peer protected.

Once on a quarterly FPPE, physician may be trended for up to 4 quarters. However, physician privileges may be in jeopardy if there is no improvement in 2 quarters. Physicians may be removed from an FPPE trend and back on OPPE at any time if improvement is made and scores fall back into the OPPE parameters.

Cases meeting the criteria for reviewable circumstances will undergo review, conducted according to the defined process above. The conclusions reached during the review process are to be supported by rationale that specifically address the issues for which the review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines. Minority opinions and view of the individual under review are to be considered and recorded. The results of review activities are to become part of the practitioner's Credentialing File, and are to be considered for credentialing and privileging decisions and, as appropriate, in performance activities. The review conclusions are monitored for effectiveness by the Medical Executive Committee.

The President of Medical Staff leadership is responsible to submit recommendations to the Governing Body regarding a practitioner's need to continue FPPE and the continuation or limiting of privileges.

ARTICLE VIIII

PHARMACY

Section 1. Use of Drugs and Medications Within the Hospital:

(a) All drugs and medications administered to patients shall be:

(1) listed in the Corporate Master Formulary of Accepted Drugs, the American Hospital Formulary Service, or the United States Pharmacopeia (USP). Where possible, the physician will seek to prescribe drugs that have been reviewed by the Pharmacy and Therapeutics Committee and are included in the Hospital Master Formulary of Accepted Drugs.

(2) reviewed by the attending Medical Staff member at least weekly to assure the discontinuance of all drugs no longer needed;

(3) canceled automatically when the patient goes to surgery; and

(4) reviewed by a pharmacist before the initial dose is dispensed (except when a licensed independent practitioner with appropriate clinical privileges controls prescription ordering, preparation, and administration, as in endoscopy or cardiac catheterization laboratories, surgery, or during cardiorespiratory arrest, and for some emergency orders when time does not permit). This review shall include the patient's demographic information (e.g., age, weight, allergies, diagnosis) and drug therapy (current drug regimen). If the order is written when the pharmacy is "closed" or the pharmacist is otherwise unavailable, or the medication is removed from floor stock it should be reviewed by a pharmacist as soon thereafter as possible, preferably within 24 hours, but no more than 72 hours following preparation and dispensing.

(b) All medication orders must clearly state the administration times or the time interval between doses.

(c) All orders for insulin and heparin must be designated in units (mg. or ml are not permitted).

(d) Self-administration of drugs is permitted only upon the specific order of an authorized responsible prescribing practitioner. Upon receipt of the order, the pharmacy will note "Self-Administered" in the computer system and on the patient's MAR. Drugs shall not be left at a patient's bedside or in a patient's room (accessible to the patient) unless specifically authorized by the responsible practitioner. Unauthorized drugs shall be returned to the pharmacy.

Self-administered drugs shall be limited to drugs as approved by the Pharmacy that can be self-administered with little risk to the patient.

(e) To provide for optimal pharmaceutical care, renally excreted and metabolized medications will be reviewed by the Department of Pharmacy and dose adjusted in patients with reduced renal function. To improve the quality of care to these patients the Department of Pharmacy Services has been authorized, by the Pharmacy and Therapeutics and the Medical Executive Committees, to adjust dosages of renally excreted and/or metabolized drugs in accordance with the drug manufacturers recommendations and that of current literature in patients with impaired renal function.

(f) The Pharmacy shall encourage the Medical Staff to prescribe drugs in the hospital formulary or appropriate generic or therapeutic substitutions. Where possible, physicians are encouraged to prescribe drugs that have been approved by the Corporate Pharmacy Review Committee and the Pharmacy and Therapeutics Committee for inclusion into the Hospital Master Formulary. If an ordered drug is not in the Hospital Master Formulary, the pharmacist should:

(1) review the drug for potential generic substitutions. The pharmacist should note the equivalence of a trade name with the generic product upon order entry into the computer system (which will also be printed on the MAR). Generic substitution does not require any notification of the physician;

(2) review the drug for potential therapeutic substitution. The pharmacist will need to contact the physician and recommend a therapeutic alternative. If accepted by the physician, a new order must be written to clarify the change. This may be taken as a telephone order by the pharmacist, reduced to writing on a physician's order form, and sent to the patient's chart for inclusion with all other orders. The pharmacist should note the therapeutic equivalence upon order entry into the computer system (which will also be printed on the MAR);

(3) review the drug for an automatic therapeutic substitution. There are several classes of drugs, which have been pre-approved by the Pharmacy and Therapeutics and the Medical Executive Committee for automatic therapeutic substitution. This pre-approved therapeutic substitution does not require any notification of the physician. The pharmacist should note the therapeutic equivalence upon order entry into the computer system (which will also be printed on the MAR);

(4) review the drug for automatic conversion of drug route or dosage form. Several drugs have been pre-approved by the Pharmacy and Therapeutics Committee for an automatic dose form or route change. Examples of pre-approval include conversion from IV to oral for H2-blockers; and

(5) review the drug for recommended changes in drug route or dosage form. For patients that can tolerate oral drugs, the pharmacist will recommend converting from IV to oral medications where an equivalency of therapy can be demonstrated. If the recommendation is accepted by the physician, a new order must be written to clarify the change. This may be taken as a telephone order by the pharmacist, reduced to writing on a physician's order form, and sent to the patient's chart for inclusion with all other orders. The pharmacist should note the therapeutic equivalence upon order entry into the computer system (which will also be printed on the MAR).

(g) The Medical Staff, pharmacy, nursing service, administration, and other appropriate staffs, shall develop and maintain a formulary system to assure the availability of quality pharmaceuticals at reasonable costs. The formulary system shall include a formulary or list of legend and non-legend drugs accepted for use by the Corporate Pharmacy Review Committee and the Medical Staff and available at all times for prescribing/ordering. Drugs included in the hospital formulary shall be selected on the basis of:

(1) need in relation to the diseases and conditions treated by the hospital and the patient populations served;

(2) effectiveness, including:

- Efficacy (alone and in comparison to other products)
- Toxicity (alone and in comparison to other products)
- Pharmacokinetic properties
- Bioequivalence (if applicable)
- Pharmaceutical equivalence (if applicable)
- Therapeutic equivalence (if applicable);

(3) risks, including:

- Known incidence of adverse reactions
- Potential for error in prescribing or ordering, preparation, dispensing, and administration of drugs;

(4) acquisition costs and cost impact on the hospital (However, drugs shall be selected primarily on the basis of patient need and safety, not solely on costs and economics);

(5) any prescriber may propose additions or deletions to the Corporate Master Formulary. Non-formulary drug requests shall be reviewed and approved by the Pharmacy & Therapeutics and the Medical Executive Committee for possible additions to the hospital master formulary. The Medical Staff shall be informed of hospital formulary additions, deletions, and changes; and

(6) if an alternative drug is not acceptable to the prescriber, the prescriber will complete the non-formulary request form and_the pharmacy shall obtain the non-formulary drug from another hospital, community pharmacy, or other approved source. Obtaining non-formulary drugs may take from 24 to 72 hours. The Corporate Pharmacy Review Committee will review all non-formulary use of each facility.

(h) There shall be an automatic cancellation of temporary stoppage of orders on specified toxic and dangerous drugs as established by the pharmacy and therapeutics committee of the Medical Staff.

The Automatic Stop Order (ASO) policy applies to the following drugs and drug classes:

Albumin	48 hours
Anti-Infective orals	5 days
Anti-infective IV/IM	3 days (unless written otherwise)
Controlled Drugs (Schedule II)	3 days
Controlled Drugs (Schedule III-V)	7 days
Anticoagulants IV	7 days
Anticoagulants SQ	7 days (unless written otherwise)
Anticoagulants oral	7 days (unless written otherwise)
Cytotoxics (Antineoplastics)	All considered as one time orders
TPN fluids	1 day
Ketorolac (Toradol) injectable	5 days
Neseritide (Natrecor)	24 hours
Nebulizer (Medicated) Treatments	96 hours

All orders for drugs NOT listed above shall be automatically discontinue after 30 days.

(i) A medication reconciliation comparing a patient's medication orders to all the medications the patient has been taking will be completed at every transition of care in which new medications are ordered or existing orders are rewritten.

Section 2. Drugs and Medications Brought into the Hospital:

(a) All medications brought into the Hospital by a patient must be sent to the Pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the practitioner has prescribed or permitted. Any such medications shall be administered as directed by the attending physician.

(b) A patient's personal drugs shall not be administered to the patient unless specifically authorized by the prescribing practitioner responsible for the patient.

(1) Retention of Personal Drugs in the Hospital. Unless administration of a patient's personal drugs is authorized by the responsible prescribing practitioner, these drugs shall be sent home with the family or others. If the drugs cannot be sent home then they will be stored with the other patient's belongings through the Public Safety Department (Security).

(2) Identification of Patients' Personal Drugs. Drugs brought into the hospital by patients shall not be administered unless the drugs have been absolutely identified, their quality and integrity is not questionable, and there is a written order from the responsible prescribing practitioner to administer the drugs.

Identification of a patient's personal drugs should be completed by a pharmacist, using available references. The prescription may contain the name of the drug, however, confirmation of the contents is needed to insure that the drug inside is equal to the container label.

(3) Use of Personal Drugs in the Hospital. Where possible every effort will be made to use drugs on the hospital formulary, a generic equivalent, or a therapeutic equivalent. In those instances where no alternatives are available, the patient's drugs may be used at no charge to the patient. The pharmacy will indicate "POM" (Patient's own Medicine) in the computer system and on the MAR. Drug administration should be charted per normal policies on the MAR.

Section 3. Medication Errors and Adverse Reactions:

(a) Any medication error or apparent drug reaction shall be reported immediately to the Medical Staff member who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record. An occurrence report should also be filed.

(b) Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity, and to prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the Medical Staff member and to the Pharmacy. Unexpected or significant adverse reactions shall also be reported promptly to the Food and Drug Administration (FDA) and to the drug manufacturer, as required.

An ADR is defined as any unexpected, unintended, undesired or excessive response to a drug that occurs at doses used in human beings for prophylaxis, diagnosis or therapy for modification of physiological function and results in a patient outcome that is death, life threatening, hospitalization, disability, congenital anomaly or required intervention to prevent permanent impairment or damage.

Examples: Allergic reactions, anaphylaxis, arrhythmias, convulsions, hallucinations, hypotension, hypertension, shortness of breath.

Section 4. Drug Samples:

(a) The use of sample medications for inpatient use is strictly prohibited. Sample medications prescribed for patients in the ambulatory clinics, must be in full compliance with the hospital policies including maintenance of detailed records of receipt, issuance and recalls.

(b) The storage and use of drug samples is prohibited within the inpatient hospital. Some clinic and off-site physician practices may utilize samples.

(1) All hospital clinic samples received from drug companies and provided to patients are properly controlled, under lock, in the clinics. Only the Medical Staff and designated nurses have access to the drug samples. It is preferred that company vouchers be used instead of a drug sample to avoid compliance issues with State and Federal regulations.

(2) If sample medications are dispensed, complete and accurate records are retained of drugs received. Recording requirements include the drug name, dose, form, quantity, lot #, vendor and the date received.

(3) If sample medications are dispensed, complete and accurate records of drug samples provided to patients are maintained and available for inspection at any time. These records would include the patient's name, drug name, dose, form, quantity, lot #, manufacturer, date provided, physician's signature, notification if proper counseling was provided and

the date of providing drugs. Medications must also be labeled in accordance with State regulations as a Pharmacy.

Section 5. Storage and Access:

(a) 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.

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

(2) 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.

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

(b) 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 Chief Executive Officer.

ARTICLE X

CRITICAL CARE UNIT PROCEDURES

Section 1. Who May Be Admitted:

Patient admission to a Critical Care Unit ("CCU") shall be in accordance with Critical Care Admission Eligibility criteria established and reviewed annually by the Resource Management Committee after input from the Critical Care Committee.

Section 2. Admissions:

(a) Arrangements for admissions to a CCU shall be made at the request of the attending physician. An Intensive Care Managing Physician must be identified per policy. Written orders shall accompany the patient, or, in an emergency, the attending physician may telephone orders to the nurse of the CCU. In the event of a bed shortage, conflicting requests for admission shall be resolved by the director of a CCU.

(1) Direct Admissions: Patients may be admitted to the unit directly from their homes at the request of the attending physician. If the patient was seen by the physician within 12 hours prior to admission, otherwise the patient should be directed to the Emergency Department for initial assessment. The physician requesting such admission shall notify the critical care charge nurse of the patient to be admitted to the unit; and the Critical Care charge nurse notifies the admitting office of the admission.

(2) Emergency Room: The need for admission to the CCU from the emergency room shall be determined by the physician examining the patient in the emergency room in concurrence with the attending physician.

(b) The severity of a patient's condition shall be the primary criteria for admission to a CCU and fulfillment of the admission criteria as defined by the Resource Management and Critical Care Committees.

(c) A patient admitted to a Critical Care Unit should be seen within a time period that is appropriate to the illness, but in no case longer than twenty-four (24) hours, provided that the patient has been seen by a physician prior to transfer to the hospital or by the Emergency Room physician. If the patient has not been seen, the patient must be seen on an urgent basis by his personal physician or designee. Admitting orders shall be written for all patients. If agreed upon by the admitting physicians and the Emergency room physician, the Emergency Room physician may write the initial orders for the patient, but the admitting physician shall assume responsibility once the patient is in the Critical Care Unit.

Section 3. Transfer from Surgery and Delivery:

(a) If the operating surgeon or the anesthesiologist feels that a patient will require admission to a CCU and bypass the recovery room, the charge nurse in the unit will be so advised and the patient will be admitted to the unit immediately upon discharge from surgery. All other scenarios go through admitting.

(b) If an operation is being performed at an hour when the recovery room is not open, the CCU shall be informed that the patient will be admitted directly from the operating room and will be cared for by CCU personnel depending on staffing circumstances.

(c) During periods of high census, the on-call team for the Recovery Room will be called in to recover/care for the patient.

(d) It is anticipated that patients will be admitted routinely to a CCU following certain major surgical procedures. When such an operation is scheduled with the operating room, the surgeon shall indicate that CCU admission is desired. Thereafter, the operating room supervisor shall then inform the CCU and the admitting office.

(e) In the event that it becomes necessary to admit a patient to a CCU following delivery, the obstetrician shall inform the delivery room nurse to notify the admitting office that such admission is indicated.

Section 4. Transfer from General Medicine:

If a transfer from general medicine becomes necessary, the attending physician will write the order and the physician or the nurse will notify admitting, giving necessary information regarding diagnosis, treatment, and any immediate measures that will be necessary upon transfer to the unit. Admitting will immediately notify the CCU charge nurse.

Section 5. Transfer to Other Areas of the Hospital:

According to transfer criteria, a CCU patient must be transferred to a Telemetry, general medicine or surgery unit. The attending physician shall write the order for the transfer, and the CCU shall thereafter notify the admitting office which shall be responsible for locating an appropriate bed for the patient.

Section 6. Discharge from a CCU:

According to discharge criteria, if a discharge is made directly from a CCU, it will be processed in the same manner as discharges from other Hospital units.

Section 7. Ventilator Patients:

All ventilator patients, including chronic, must be seen on a daily basis by a pulmonologist with the exception of post-surgical patients, who are under the care of an anesthesiologist; trauma patients under the care of trauma surgeon; and/or open heart patients under the care of the cardiovascular group.

ARTICLE XI

INFECTION PREVENTION

(a) Hand hygiene (either handwashing with soap and water or by using a waterless antiseptic hand rinse) must be done before and after patient contact and after removing gloves. Soap and water should be used for any patient with a suspected or confirmed case of Clostridium Difficile.

(b) Standard Precautions, as defined by the CDC and hospital policy, will be followed during all patient care.

(c) Patients with a known/suspected communicable disease or infection/colonization with multiple drug resistant organisms will be placed on the appropriate Isolation Precaution, as required in the Infection Control policies based on the CDC guideline. Physicians will comply with the requirements of these Precautions, including the use of barrier precautions (gloves, gowns, masks, etc.).

(d) The Chairperson of the Infection Control Committee shall have the authority to order appropriate isolation precautions if necessary.

(e) The Chairperson of the Infection Control Committee has the authority to investigate healthcare acquired infections, particularly those occurring in clusters. This includes the authority for obtaining microbiological cultures from patients and staff as indicated.

(f) Medical Staff members and other health care personnel known to be a source of a healthcare acquired outbreak shall not be permitted in the surgery suite, delivery room, nursery or obstetrics department until cleared.

(g) Medical Staff members are required to submit Tuberculosis testing results at least every two years.

ARTICLE XII

OPERATING ROOM PROCEDURES

Section 1. General:

(a) The operating room supervisor shall be responsible for the administrative supervision of the operating room and shall have the authority to plan and execute the daily operating room schedule in order to make maximum efficient use of the operating room and the anesthesia department.

(b) The operating room schedule shall begin at 7:30 a.m. promptly each day. The time scheduled for each operation shall be defined as the time of the induction of the anesthetic. When local anesthesia is used, the scheduled time shall be defined as the designated operating time appearing on that day's schedule.

(c) When a sponge, instrument, or needle count is incorrect, an x-ray shall be taken before the patient leaves the operating room.

(d) Any operating room personnel who have an infection or disease that could be potentially harmful for patients undergoing surgery shall not be permitted to enter the operating room suite.

Section 2. Scheduling Surgery:

(a) All surgical cases shall be scheduled through the surgery scheduler, operating room supervisor or designee.

(1) Elective procedures will be scheduled in accordance with issued block times for each specific surgeon. Surgeons who do not possess a block as well as add-on procedures will be issued time on a first-come, first-served basis.

(2) First priority shall be given to emergency cases. Second priority shall be given to urgent cases.

(b) The physician's office staff/secretary must give the following patient information when scheduling a surgical procedure:

(1) identification of patient (name, age, sex and phone number);

(2) pre-operative diagnosis;

(3) operation to be performed;

(4) name of surgeon, anesthetist and assistant, if different from attending physician;

(5) type of anesthesia;

(6) inpatient or outpatient; and

(7) other pertinent information necessary to perform the procedure.

(c) The operating surgeon must be named when the case is scheduled and shall be responsible for the surgical care of the patient before, during, and after the operation.

(d) If the operating surgeon is more than fifteen (15) minutes late for the first case without contacting the operating room supervisor, that case may be canceled and the patient returned to his/her room by the operating room staff. In no case shall anesthesia be started until the operating surgeon is present in the department. Operating time shall be released promptly when a case is canceled or the patient and surgical team are not available. Any surgeon who is scheduled for the first case of the day and is 15 minutes late more than two times in a month, will no longer be given the first surgical time slot.

(e) Specific contemplated procedures must be designated on the schedule, with the name of the patient, age, diagnosis, and surgical procedure. Unrelated elective procedures may not be added to a case after it has been posted if other cases are already posted to follow. The case will be done as originally posted or rescheduled.

(f) Cases requiring frozen sections should be posted as such at the time the case is scheduled. Infectious or contaminated cases must be posted at the end of the operating room schedule or as otherwise authorized by the operating room supervisor.

(g) All operative reports are to be dictated immediately following surgery and not to exceed 24 hours.

(h) An emergency case shall take precedence over an elective surgical case not in progress as outlined in the rules and regulations of the Department of Surgery.

Section 3. Surgical Procedures:

(a) The patient and presence of all members of the operating team in scrub suits and the patient in the operating room are required at the scheduled time for surgery.

(b) Surgery shall be performed in accordance with the surgical privileges granted by the Board. If a surgeon attempts to schedule an operative procedure for which no

privileges have been granted, the operating room supervisor shall inform that surgeon of the lack of such privileges and immediately notify the President of the Medical Staff and the Chief Executive Officer of the matter.

(c) The following will occur before a surgical procedure or the administration of moderate or deep sedation or anesthesia occurs:

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

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

(3) the attending physician is in the Hospital; and

(4) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, which includes verification of:

(i) the patient's identity;

(ii) correct site and side;

(iii) agreement on procedures;

(iv) availability of implants/special equipment/requirements; and

(v) required documentation for each element.

(d) Hazardous cases which require two physicians to be scrubbed are: Major Liver Resection; Scheduled AAA; and Suprarenal Aneurysm, and other such procedures as deemed necessary by the surgeon.

(e) Observers in surgery or for special procedures are limited to hospital affiliated students or Health Care Industry Reps (HCIRs) covered under the hospital HCIR policy.

Section 4. Anesthesia Rules and Records:

(a) The anesthesiologist's daily services will be assigned by a physician member of the anesthesia department or special arrangements may be made in advance by the surgeon.

(b) In all cases, except in an emergency, the following must occur prior to the administration of the anesthetic: (1) the surgeon shall identify the patient and shall remain in the operating room area, and (2) an H&P and informed consent must be completed and documented. The surgeon may be asked to assist or

supervise the position of the patient on the operating table and must be available in the event of an emergency.

(c) The anesthesiologist or anesthetist shall verify that a pre-anesthesia evaluation of the patient has been conducted in accordance with Article V, Section 8.

(d) If the planned anesthesia includes intravenous sedation, the anesthesiologist or anesthetist shall assess the patient's mental status, perform an examination specific to the proposed procedure and to any co-morbid conditions, and document the results of an auscultatory examination of the heart and lungs.

(e) If general, spinal, or epidural anesthesia is planned, the anesthesiologist or anesthetist shall assess the patient's mental status, perform an examination specific to the proposed procedure and any co-morbid conditions, document the results of an auscultatory examination of the heart and lungs, and assess the patient's general health.

(f) If topical or local anesthesia or a regional block is to be used, the anesthesiologist or anesthetist shall evaluate the patient's mental status and perform an examination specific to the proposed procedure and any co-morbid conditions.

(g) The anesthesiologist or anesthetist shall review the patient's condition immediately prior to induction of anesthesia to confirm that the patient remains able to proceed with care and treatment and shall check equipment, drugs and gas supply.

(h) A record shall be maintained of all events taking place during the induction and maintenance of, and the emergence from, anesthesia, including:

(1) the dosage and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(4) unusual events during the anesthesia period; and

(5) the status of the patient at the conclusion of anesthesia.

(i) The anesthesiologist or anesthetist will conduct a post-anesthesia evaluation of the patient in accordance with Article V, Section 8. 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 24-hour time frame and a notation documenting the

reasons for the patient's inability to participate will be made in the medical record.

(j) The number of post-anesthesia visits shall be determined by the status of the patient in relation to the procedure performed and anesthesia administered. The anesthesiologist or anesthetist shall examine the patient early in the post-operative period and once after complete recovery from anesthesia. Complete recovery shall be determined by the clinical judgment of the anesthesiologist or anesthetist, or the discharging surgeon.

(k) Patients will be discharged from the recovery area by a qualified practitioner or according to criteria approved by the clinical leaders. 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.

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

(m) General anesthesia for surgical procedures shall not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

Section 5. Recovery Room:

(a) The surgeon shall remain in the operating room area until the patient is admitted to the recovery room. Post-operative orders must be written by the surgeon or a qualified designee before the patient leaves the operating room suite. The anesthesiologist or anesthetist shall subsequently examine the patient and write orders to discharge the patient from the recovery room.

(b) The recovery room will be appropriately staffed in accordance with the ASPAN guidelines. Two (2) professional registered nurses are scheduled for on-call duty.

Section 6. Operating Room Records:

(a) A roster of members currently possessing surgical privileges, with a delineation of the surgical privileges of each, shall be maintained on the Hospital Intranet under the medical staff department. There shall be an on-call schedule of surgeons established and posted at each patient unit or other area where surgical patients are admitted, or at the communications center of the Hospital to ensure that there is twenty-four (24) hour emergency care or post-operative follow-up care, or both, available.

(b) An operating room register shall be provided and maintained on a current basis. The operating room log or register shall contain:

(1) the date of each operation;

(2) the name and number of the patient;

(3) the names of surgeons and surgical assistants;

(4) the name of the anesthesiologist/anesthetist and type of anesthesia given;

(5) the pre- and post-operative diagnoses;

(6) the type of surgical procedure; and

(7) the presence or absence of complications in surgery.

(c) The operating room supervisor shall be responsible for and authorized to carry out all orders which will ensure optimal technical procedures. Disputed matters shall be referred to the President of the Medical Staff.

ARTICLE XIII

PROCEDURES FOR OBSTETRICAL CARE

Section 1. General Information:

(a) A pregnancy test shall be routinely performed on all patients under the age of fifty (50) years prior to a diagnostic dilation and curettage procedure or a hysterectomy.

(b) An obstetrical patient's medical record shall contain complete medical, family, social and obstetrical histories; a complete physical examination record; and the complete prenatal record.

Section 2. Admission:

Obstetrical patients may be admitted via the emergency room or admitting office. Nursing personnel shall notify the attending physician when the patient arrives in the department. No obstetrical patient shall be denied a bed because of the presence of gynecological patients in the unit. If necessary, gynecological patients shall be transferred to other clinical units of the Hospital.

Section 3. Required Laboratory Procedures:

Hemoglobin, Hematocrit, RPR, Rh and Type, Hepatitis, GBS Status, HIV, Rubella laboratory procedures should be performed prior to admission of an obstetrical patient and recorded on the prenatal record. If not performed prior to admission, then such laboratory procedures must be performed upon admission in addition to a urinalysis. Cord bloods shall be sent to the laboratory for all deliveries to determine potential incompatibility.

Section 4. Delivery:

(a) The attending physician, i.e., obstetrician and pediatrician, must be named when the patient is admitted, and shall be responsible for the care of the patient and baby before, during, and after the delivery.

(b) When the attending physician has been informed that a patient is in active labor, that physician or a qualified designee shall assume responsibility and be present for the delivery.

Section 5. Oxytocic Drugs:

Oxytocic drugs shall only be used in the following manner:

(a) no more than three elective inductions may be scheduled at one time. Oxytocin Challenge tests will be counted as elective inductions. Elective inductions over 39 weeks may be scheduled by calling the labor and delivery charge R.N. Less than 39 weeks must fill out appropriate form documenting the reason for early induction;

(b) intravenous oxytocin orders may only be initiated by the Attending physician;

(c) the reason for the induction of labor shall be stated in the history or progress note;

(d) intravenous oxytocin for induction of labor shall be administered by the R.N. as per IDPH guidelines and Franciscan Alliance policy/procedure per physician order; and

(e) the attending physician must be readily available within 30 minutes_to the OB Department.

Section 6. Medical Record:

All procedures shall be fully dictated or written in the patient's chart by the Attending physician within twenty-four (24) hours after delivery.

Section 7. Recovery Room:

The Attending physician shall examine the patient and write appropriate orders. In cases of caesarean section, the anesthesiologist or anesthetist is authorized to act on behalf of the Attending physician in writing orders to discharge the patient from the recovery room. If postpartum hemorrhage is observed during recovery, the Attending physician shall be notified immediately, and shall return to reexamine the patient and to determine the appropriate therapy.

Section 8. Attire:

Anyone entering the Surgical Suite must be properly attired in the approved suit and footwear. Hair, nose, and mouth shall be properly covered at all times with caps and masks provided in the scrub areas of each room.

Section 9. Delivery Room Roster:

A current roster of Medical Staff members (and other health professionals, if applicable) with obstetrical privileges shall be maintained and made available to nursing personnel.

An on-call schedule shall be established and maintained to provide for obstetrical coverage at all times.

ARTICLE XIV

PROCEDURES FOR THE NURSERY AND CARE OF NEWBORNS

Section 1. On-Call Schedule:

An on-call schedule shall be posted in the nursery.

Section 2. Examinations of Newborns:

Any newborn who displays abnormal signs and symptoms at any time shall be examined by a physician as soon as possible. Every newborn shall be examined by the Admitting physician within twenty-four (24) hours after birth, and the findings of the examination, including, but not limited to, the age of the newborn at the time of the examination, shall be recorded in the newborn's medical record.

Section 3. High-Risk Infants:

The Admitting physician on call shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants, especially for high-risk infants, shall be initiated in the delivery area, with observation for distress. The term "high-risk infant" means any infant, including a newborn, who, on the basis of socioeconomic, genetic, or patho-physiologic history prior to delivery, or on the basis of findings since birth, manifests or is likely to manifest persistent and significant signs of distress. These infants will be cared for in the intermediate or special care nursery.

Section 4. Identification:

The identification of each infant and its mother shall be carefully rechecked at the time of discharge from the Hospital. Infants discharged or transferred to another nursery or Hospital shall be carefully identified.

Section 5. Birth Certificates:

Birth certificates are the responsibility of the Admitting physician and must be completed within seventy-two (72) hours of the birth.

Section 6. Prophylactic Treatment of Newborns:

Ophthalmic prophylactic treatment shall be performed in compliance with AAP/ACOG/IDPH standards. Nursing personnel shall instill in each newborn's conjunctival sacs antibiotic solution or ointment within one hour after birth. Currently, acceptable solutions include, but may not be limited to, tetracycline ophthalmic ointment or solution, or erythromycin ophthalmic ointment or solution. If the parent or guardian of the newborn child objects on the ground that the prophylactic treatment conflicts with the

parent's religious beliefs or practices, prophylactic treatment shall be withheld. An entry in the child's Hospital record indicating the reason for withholding treatment shall be made and authenticated by the Admitting physician and the parent or guardian. Vitamin K is administered at birth per State guidelines.

Section 7. Testing for Phenylketonuria and Other Diseases:

Tests for phenylketonuria and other metabolic diseases of the newborn that may lead to mental retardation or physical defects shall be performed by the RN/OB Tech as required by law. The results of such tests shall be made part of the newborn's medical record.

Section 8. Consultations:

A consultation with a qualified neonatologist is recommended in any instance of admission to Special Care Nursery.

Section 9. Medical Record:

(a) Every newborn shall be examined by the Physician at the time of delivery and the following noted on his/her medical record:

(1) condition at birth, including APGAR score;

(2) any physical abnormalities or pathological states; and

(3) any evidence of distress.

(b) The medical record shall accompany the newborn from the place of delivery to the nursery as soon as possible. In addition to the information listed above, this record shall also include information concerning prenatal history, course of labor, delivery, drug administration to mother and newborn, relevant conditions of the mother, procedures performed on the newborn in the delivery room, complications of any type, and other facts and observations.

(c) A complete medical record for every newborn shall include the following information:

(1) obstetrical history of mother's previous pregnancies;

(2) description of complications of pregnancy or delivery;

(3) list of complicating maternal disease;

(4) drugs taken by the mother during pregnancy, labor and delivery;

(5) duration of ruptured membranes;

(6) maternal antenatal blood serology, rubella titer, blood typing, Rh factors, and, where indicated, a Coombs' test for maternal antibodies;

(7) complete description of progress of labor, including reasons for induction and operative procedures, if any, signed by the attending physician or an authorized delegate;

(8) condition of newborn at birth, including the one- and five-minute APGAR score, resuscitation, time of sustained respirations, details of physical abnormalities, pathological states observed and treatments given before transfer to the nursery;

(9) any abnormalities of the placenta and cord vessels;

(10) date and hour of birth, birth weight and length, and period of gestation;

(11) a written verification of eye prophylaxis;

(12) an initial physical examination, including any abnormalities will be done by the physician or RN;

(13) discharge physical examination, including head and chest circumference and body length and weight, unless previously done; recommendations, and signature of attending physician or an authorized designee;

(14) a listing of all diagnoses since birth, including discharge diagnosis; and

(15) specific follow-up plans for care of newborn.

Section 10. Obstetrical Care:

(a) The current obstetrical records shall include a complete prenatal record. All obstetrical medical records shall have complete prenatal histories, physical examinations and discharge summary. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital, shall be up-to-date and shall include findings since the time of the last visit.

(b) Patients having Cesarean sections shall have an updated history and physical examination. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.

(c) All previous orders are canceled after Cesarean section.

Section 11. Newborn Care:

(a) All newborn orders must be itemized, including orders for formula and care of the newborn, and signed by the physician.

(b) A physical examination shall be recorded in the medical record of all newborns within 24 hours of delivery.

(c) State of Illinois Metabolic Screening shall be done on all newborns prior to discharge home.

(d) Hearing screen shall be done on all newborns prior to discharge home.

ARTICLE XV

DISCHARGE

Section 1. Who May Discharge:

(a) Patients shall be discharged only upon an order of the attending physician or his/her designee. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Hospital's release (Against Medical Advice) form.

(b) Physicians shall use their best efforts to write discharge orders that will allow patients to be discharged from the hospital by 12:00 p.m. Noon on the day of discharge.

Section 2. Discharge Planning:

(a) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, which includes an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record.

(b) Discharge planning shall include, but need not be limited to, the following:

If applicable:

(1) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, and the amount of activity the patient should engage in; and any necessary medical regimens including drugs, diet, or other forms of therapy. Sources of additional help from other agencies and procedures to follow in case of complications should also be part of the discharge plan. The attending physician should provide all such information.

(2) The Medicare Discharge Notice, "An Important Message from Medicare about Your rights" will be given to patients as outlined in the Administrative Policy and Procedure Notification of Hospital Discharge Appeal Rights (Medicare).

(3) Patient will not be referred to any unlicensed, uncertified or unregistered extended care facility, hospice or assisted living environment.

(4) Methods to facilitate the provision of follow-up care; that is, when to follow-up with the physician and

(5) appropriate referral and transfer plans;

Section 3. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, responsible parties, or court order. If the parent or guardian or another responsible party directs that discharge be made otherwise, the statement shall become a part of the permanent medical record of the patient.

ARTICLE XVI

AUTOPSIES

Section 1. Autopsies and Disposition of Bodies:

(a) The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician, and the event adequately documented in the patient's medical record within a reasonable period of time by the attending physician or another designated Medical Staff member.

(b) The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by the attending physician or a designee. Death certificates are the responsibility of the attending physician and must be completed within twenty-four (24) hours of death (or birth in the case of fetal death).

(c) The College of American Pathologists' guidelines shall be used to identify those cases in which an autopsy is appropriate.

(d) It shall be the duty of all Medical Staff members to secure consent to meaningful autopsies whenever possible. An autopsy shall be performed only with proper consent in accordance with state law and Hospital policy. The Hospital pathologists reserve the right to refuse to perform an autopsy in cases in which a lack of appropriate facilities or equipment would present an unacceptable health hazard to the Hospital staff. All autopsies shall be performed by the Hospital pathologist or a designee. Consent for an autopsy shall be effective only by inclusion of such notation on the appropriate Hospital form signed by the appropriate legal representative of the patient. A copy of the autopsy report shall be forwarded to the patient's attending physician and included in the patient's medical record.

(e) Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours of autopsy and the complete protocol shall be made a part of the patient's medical record within thirty (30) days, except in unusual cases requiring special studies or expert consultation, in which case the protocol shall be made a part of the patient's medical record within sixty (60) days of autopsy.

Section 2. Medical Examiner's Cases:

It is the responsibility of the attending physician or an authorized designee to notify the medical examiner of any cases considered a medical examiner's case. The attending physician or a designee, indicating the investigator's name, identification number, and

action taken must place a record of this communication in the decedent's chart. Only decedents released by the medical examiner's office may be subject to postmortem examination by a Hospital pathologist.

ARTICLE XVII

MISCELLANEOUS

Section 1. Disaster Plan:

(a) The Hospital plan for the care of mass casualties shall be rehearsed twice a year by key Hospital personnel, including Medical Staff members. Each Medical Staff member shall become familiar with the plan and shall be assigned and report to designated posts, either in the Hospital or elsewhere.

(b) The President of the Medical Staff and the Chief Executive Officer shall work with the Incident Command Officer to coordinate activities. In cases of evacuation of patients from one section of the Hospital to another, or evacuation from the Hospital premises, the Chief Executive Officer, in consultation with the President of the Medical Staff and the Incident Command Officer, shall authorize the movement of patients.

(c) Refer to the Hospital's Disaster Plan for specific procedures.

Section 2. Reports:

It shall be the responsibility of each Medical Staff member to report, in writing and confidentially, to the Medical Director of Quality Improvement, President of the Medical Staff (and/or the Chief Executive Officer) any conduct, acts, or omissions by other Medical Staff members, which are believed to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

Section 3. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff members shall not discuss with any other individuals the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of Medical Staff committees or departments.

(b) Medical Staff members shall not record or otherwise transcribe the proceedings of such meetings without the unanimous consent of all those in attendance.

(c) Written attendance records shall be maintained for all meetings of the Medical Staff, departments, and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee.

Section 4. General Supervision of House Staff:

(a) Residents and interns must be supervised by the Director of Medical Education, or designee, during the course of their training programs. This supervision shall

be in accordance with the affiliation agreement between the Hospital and the University as well as the Basic Documents for Postdoctoral Training as published by the American Osteopathic Association.

(b) Residents and Interns will provide patient care under the direction of the attending physician within the framework of the mission and philosophy of the Sisters of St. Francis Health Services, Inc.

Section 5. Research Activities:

(a) Participation in research projects by Medical Staff members is encouraged and shall be in accordance with the Hospital's Institutional Review Board and research policy.

(b) The results of all research projects, clinical, statistical, or otherwise, and all publications written or provided by Medical Staff members using the name of this Hospital, must be submitted to the Chair of the Institutional Review Board for approval prior to any publication.

Section 6. Orientation of New Medical Staff Members:

(a) Each new Medical Staff member is mandated to attend an interview/orientation that will take place prior to the Medical Staff member being granted full privileges by the Board of Directors.

(b) This orientation process includes the Ethical and Religious Directives for Catholic Health Services, the Franciscan values and behaviors of the Sisters of St. Francis Health Services, along with key components such as instructional presentations by Information Services, Medical Records, Business Development and the Medical Staff Office detailing those activities and/or procedures that will help new staff members in the performance of their duties.

(c) In addition, this orientation will allow for introduction of key clinical department chairs and officers of the Medical Staff and an overview of the Hospital and its environment.

(d) The Corporate Compliance Officer shall orient each new Medical Staff member as to the Hospital's Corporate Compliance Program including, but not limited to, the Hospital's Code of Conduct.

Section 7. Definitions:

The definitions contained in Article I of the Medical Staff Bylaws are hereby incorporated by reference and shall apply to these rules and regulations as well.

ARTICLE XVIII

AMENDMENTS

(a) Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Medical Staff Bylaws and the other Medical Staff documents.

(b) Rules and regulations may be adopted, amended, repealed, or added by the Medical Staff provided that the procedure used in amending the Medical Staff Bylaws (Article 9 of the Medical Staff Bylaws) is followed. All such changes shall become effective when approved by the Board.

ARTICLE XIX

ADOPTION

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

Adopted by the Medical Staff:

By: ______________________________
Tonja Austin, M.D.
President/Medical Staff

____
(Date)

Approved by the Board:

By: ______________________________
Terry Brown
Chairman of the Board

____
(Date)