Policy Number: 0955

HUDSON HOSPITAL & CLINICS
MEDICAL STAFF RULES AND REGULATIONS
December 2011

Table of Contents

DEFINITIONS

The following definitions shall apply to terms used in these Rules and Regulations.

- Practitioner: An appropriately licensed medical physician, an osteopathic physician, an appropriatelyl licensed dentist or podiatrist, or Allied Health Licensed Independent Practiioner or Allied Health Advance Practice Nurse Prescriber.
- Allied Health Staff: Health care professionals other than physicians, podiatrists, and dentists who are licensed or certified by their respective licensing or certifying agency, and who provide needed services to hospital patients on the request of and under the supervision of or in collaboration with a physician staff member .
  - Allied Health Licensed Independent Practitioner: Licensed allied health professionals who can practice independently per state statutes (doctorate-level psychologists, advance practice social workers)
  - Allied Health Advance Practice Nurse Prescriber: An advanced practice nurse who has been granted a certificate to issue prescription orders under Wisconsin Statute (certified nurse midwife, CRNA, nurse practitioner).
  - Dependent Allied Health Professional: All other allied health professionals not otherwise defined above (physician assistants and other dependent professionals).

1.0 ADMISSION OF PATIENTS

Types of Patients

The hospital accepts all patients for care and treatment for which facilities, equipment, and trained staff are available. Within these guidelines, patients are admitted without regard to race, creed, age, gender, gender preference, national origin, disability, or economic status.

Admitting Prerogatives

A patient may be admitted to the hospital only by a member in good standing of the active or courtesy medical staff or a Certified Nurse Midwife. A podiatrist or dentist may, with the concurrence of a physician member of the medical staff, initiate the procedure for admitting a patient. The concurring member of the Medical Staff shall assume responsibility for the patient's overall care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for podiatric or dental care will receive the same basic medical assessment as patients admitted for other services.

Admitting Information

Except in an emergency, a patient shall not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the physician requesting admission. Extended outpatient status may be used for a limited number of hours (under 24) for those patients who do not meet the criteria for admission but require further monitoring prior to discharge.

The physician who admits, i.e. the attending, is responsible for providing the following information concerning a patient to be admitted:

- Any known source of communicable disease or significant infection;
- Behavioral characteristics that would endanger others; and/or
- Need for protecting the patient from self-harm.

Advance Directives

All patients age 18 years or older are queried as to whether or not they have an advance directive. If not, they are offered information at the time of hospital admission. Practitioners need to review patient advance directive status and ensure adherence to patient/patient designee wishes. If a surgery patient has an advanced directive and/or DNR, the surgeon and anesthesia provider will discuss with patient and document the issues related to the procedure and anesthesia to determine whether the DNR order will be maintained or partially or completely suspended.

Timely Visitation after the Patient is Admitted

The attending practitioner or his/her designee (i.e. another member of the staff in good standing with the requisite privileges to care for the patient) shall see the patient within the time frames provided below or within a shorter time frame if the patient's condition warrants it:

- Patients admitted to High Observation (Step-Up) beds within one (1) hour or less;
- Patients admitted via the Emergency Room to a general care unit within twelve (12) hours; and
- Elective admissions within twenty-four (24) hours.

2.0 RESPONSIBILITY FOR THE CONDUCT OF CARE

General

A member of the Medical Staff with appropriate privileges shall be responsible for the daily care and treatment of each patient in the hospital, planning for continuing care (as required), for prompt and timely response to pages and calls regarding his/her patients, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible, for necessary special instructions, for relaying reports of the condition of the patient to the other physician and nurse midwife (s) and staff involved in their care, and to, family members as appropriate. Primary physician responsibility for these matters belongs to the current attending physician. A designee of the physician may perform certain of these functions to the extent permitted by applicable laws, regulations, accreditation standards, the Medical Staff Bylaws and Hospital policies.

Attending Physician Designation – The physician who writes orders admitting the patient is the attending physician until care is transferred.

Transfer of Responsibility

When responsibility for a patient's care is transferred from the current attending physician to another medical staff member, verbal communication is expected to occur between the involved physicians, an order shall be written by the current attending physician to transfer care, indicating that the accepted physician has agreed to accept responsibility for that patient. In the case of a stable newborn, communication regarding the transfer of patient can be clinical assistant to clinical assistant.

Alternate Coverage: Responsibility for Continuous Care

Each physician and nurse midwife shall assure timely, adequate, and professional care for his/her patients in the hospital by being available and by designating a qualified alternate physician and nurse midwife with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient.

In the absence of such designation, the Chief of Staff, or his/her designee, has the authority to call any member of the staff with the requisite clinical privileges. The Chief of Staff or designee is ultimately responsible for the care of the patient, which may include, but not be limited to: (a) assigning another physician and nurse midwife , (b) calling a consultant, and (c) transferring the patient to another hospital.

Failure of any attending physician to accept such an assignment from the Chief of Staff may result in loss of staff membership or other disciplinary action as the Medical Staff deems appropriate, in accordance with the procedure outlined in the Bylaws.

On-Call Responsibilities

All active staff members are expected to participate in on-call schedules necessary to ensure continuity of care for patients, in a timely manner.

Anesthesia and Sedation Administration

Anesthetics and deep sedation may be administered by an anesthesiologist or a certified registered nurse anesthetist (CRNA) who is supervised by a surgeon or anesthesiologist. Moderate sedation may be administered by other practitioners demonstrating appropriate competency and meeting the guidelines in the Sedation Policy (#302).

Approved Locations for Use of Sedation (excluding minimal sedation)

Sedation may be utilized in any of the areas where all the requirements of the Sedation Policy are met.

3.0 PATIENT RIGHTS AND ETHICS

Expectations

- In keeping with the mission and vision of the hospital, medical staff members are expected to adhere to high ethical standards, applicable law, and regulation in all their professional activities. Identification and resolution of ethical issues in collaboration with families is the responsibility of each member.
- Consultation should be used as appropriate from professional colleagues, managers, directors, and other available resources.
- Decisions regarding admission, transfer and discharge are based first on the assessed health needs of the patient and our capability to provide those services. Other factors, such as potential payment, are considered only after patient safety has been assured. Patients are discharged only when they meet designated discharge criteria. Patients are transferred to another hospital only when their specific condition cannot be safely treated at Hudson Hospital & Clinics; or by their request following medical screening and stabilization. (Hospital Code of Business Ethics, Policy #021.)

Ethics Mechanism

Consultation on patient ethical concerns: for situations involving unresolved ethical issues, consultation is available from the ad hoc ethics group, which may be accessed by contacting Social Service, the Chief Nurse Officer, or the Nurse Manager of the involved area, who will work with the Medical Staff President to convene this group. Representatives from Quality/Risk Management, Health Information Management and/or other areas may be involved as needed. (Policy #035, Ethical Concerns)

Patient Choice

Members of the Medical Staff recognize the right of patients or their legal guardian/designee to determine their overall course of treatment, including the right to forego life-sustaining treatment. (Withholding or Withdrawing Medical Treatment, Policy #150)

Conflict of Interest

Should conflicts of interest exist in referral of patients to facilities or organizations, equipment or pharmaceuticals in which the member has a financial or personal interest, that conflict of interest is disclosed to the patient or family and alternatives are offered. (Policy #021)

Privacy/Confidentiality of Information

Specific patient care information is to be communicated with other caregivers only on a need-to-know basis. The patient's or family's status should not be discussed in locations in which they can be overheard, e.g. elevators, hallways. All members are expected to adhere to the hospital policy on confidentiality of information and to respect patient privacy.

Users of the hospital information system are expected to use those resources in an ethical, effective, efficient, and legal manner.

Interpretive Services

Arrangements are made through the hospital for interpretive services under the following circumstances: (a) when there is a language or cultural barrier, (b) when requested by the patient or family, (c) when communicating medical information, and (d) when obtaining informed consent. (Communication Services for Special Needs Patients, Policy #102)

Complaints/Concerns

Complaints/concerns from patient or families, hospital or medical staff members will be appropriately channeled through Medical Staff and/or Hospital channels. Patient grievances (unresolved complaints) will be handled expeditiously as described in the Hospital policy on Complaints and Grievances. (Policy #101)

Emergency Medical Screening and Stabilizing Treatment

When an individual on Hudson Hospital & Clinics (HH&C) requests examination or treatment for an emergency medical condition, or such request is made on his or her behalf, HH&C will, through a physician member of its medical staff or qualified provider (advance practice nurse, physician assistant qualified obstetrical registered nurse) provide an appropriate medical screening examination to determine whether or not the individual has an emergency medical condition. HH&C will not delay providing the medical screening examination in order to inquire the individual's method of payment or insurance status, HH&C will not refuse to provide the medical screening examination because the individual is an enrollee of a managed care plan and the plan refuses to authorize or pay for the medical screening examination.

A person is on HH&C property if he/she is in the emergency room, elsewhere in the hospital building, or in an HH&C parking lot, sidewalk, driveway or helipad. An individual is on HH&C property even if he/she is in an ambulance as long as the ambulance is on hospital property – even though the ambulance may have been instructed not to bring the person to HH&C.

A medical screening examination is the process required to determine, with reasonable clinical confidence, whether an emergency medical condition does or does not exist.

A person has an emergency medical condition if there are acute symptoms (such as severe pain, psychiatric disturbances, or symptoms of substance abuse) such that without immediate medical attention the person's health may be placed in immediate jeopardy or there may be serious impairment to bodily functions or serious dysfunction of any bodily organ or part. A pregnant woman who is having contractions has an emergency medical condition if there is inadequate time to safely transfer her to another hospital before delivery or if the transfer might pose a threat to the health or safety of the woman or her unborn child.

Qualified OB registered nurses are authorized to perform the medical screening exam on pregnant patients. Note: Emergency screening need not be provided in the Emergency Department. It may also be accomplished in the OB Department or other areas of the hospital, as appropriate.

Stabilizing Treatment for Emergency Medical Condition

Except in cases of refusal of treatment (see below) or appropriate transfer (see below), HH&C will provide to a person with an emergency medical condition all further medical examination and treatment required to stabilize the medical condition, within the capabilities of the staff and facilities available. Stabilizing treatment will be provided by medical staff and/or such other hospital healthcare professionals as may be appropriate for stabilization of the particular medical condition. HH&C will not delay providing this further medical examination and stabilizing treatment in order to inquire about the person's method of payment of insurance status, and HH&C will not refuse to provide further medical examination and stabilizing treatment because the individual is an enrollee of a managed care plan and the plan refuses to authorize or pay for the examination or stabilizing treatment.

A patient will be considered stabilized in any of several circumstances:

- The patient will be considered "stable for transfer" to another facility when the treating physician has determined, within reasonable clinical confidence, that the patient is expected to leave HH&C and be received at the second facility with no material deterioration in medical condition, and the treating physician reasonably believes that the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of the condition. In the case of a patient with a psychiatric condition, the patient must be protected and prevented from injuring him/herself or others.
- The patient will be considered "stable for discharge" when it is determined within reasonable clinical confidence that he/she has reached the point where continued care can be reasonably performed as an outpatient or later as an inpatient, and the patient has been given a plan for appropriate follow up care with discharge instructions. In the case of a patient with a psychiatric condition, a determination must be made that the patient is no longer considered to be a threat to him/herself or to others.
- A pregnant woman who is considered to have an emergency medical condition because she is in labor as described above will be considered to be stabilized when she has delivered the child and placenta.
- A patient will be considered stabilized when the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

Refusal to Consent to Treatment

A patient who has been determined to have an emergency medical condition (or a surrogate acting on behalf of an incompetent patient) may refuse stabilizing examination and treatment. The further examination and treatment must be offered to the patient or surrogate, and the risks and benefits must be explained to him/her. If the individual refuses to consent, the medical record will describe the further examination and treatment was offered and refused, the explanation of the risks and benefits of the offered examination and/or treatment that was provided, the reasons for the refusal of consent, and a written informed refusal signed by the patient or surrogate. If the individual refuses to sign a refusal of consent, the medical record must document the refusal to sign and the steps taken to try and obtain a signed refusal.

Pain Management

The patient's right to effective pain management is respected and supported. Ongoing assessment and reassessment to evaluate the changing nature of pain, as well as the effectiveness of treatment for pain, is essential. Adult and pediatric pain scales are available for use. Pain assessment should be included in chart documentation. (Policy #204)

4.0 CONSULTATIONS

Responsibility

The good conduct of medical practice includes the proper and timely use of consultation. The attending physician is primarily responsible for calling a consultation from a qualified physician or Allied Health Staff when indicated. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending physician. Consultations may be in person or by telephone.

Guidelines for Calling Consultations

Unless the attending physician's expertise is in the area of the patient's problem, consultation with a qualified physician is required in the following cases, except for (E) where a psychologist, social worker or chemical dependency counselor may be utilized.

A. When the patient is not a good risk for an operative procedure
B. Where there are significant differences of opinion as to the best choice of therapy
C. In unusually complicated situations where specific skills of other practitioners may be helpful
D. When specifically requested by the patient or his/her family and with concurrence by the attending physician
E. For all patients who have attempted suicide or exhibit symptoms of acute psychiatric disorders, drug or alcohol abuse and cannot be transferred, appropriate consultations will be arranged as available and/or follow up referrals made.

Qualifications of the Consultant

A consultant must be a recognized specialist in the relevant area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. Any qualified practitioner may be called as a consultant, regardless of staff category assignment.

Consultant Request

When requesting consultation, the attending physician shall indicate in writing on the medical record the reason for the request and the extent of involvement in the care of the patient expected from the consultant, e.g. "for consultation and opinion only," "for consultation, orders, and follow-up re: a particular problem." If a surgical consultation is requested on an in-house patient and surgery is recommended, an order is required by the attending practitioner if he/she is transferring care to the consultant/surgeon.

Consultant's Report: For specific content, refer to Medical Records section.

Immediately after completing the consultation, the consultant shall make and sign a report of findings, opinions, and recommendations that reflect an actual examination of the patient. The report shall become part of the patient's medical record.

Attending Physician's Response to Consultant's Opinion

In cases of consultation, when the attending physician elects to not follow the advice of the consultant, he/she should document the rational for not doing so.

5.0 TRANSFER OF PATIENTS

Internal Transfer

When a bed is not available in the appropriate unit, an internal transfer may be necessary to accommodate an admission.

Internal transfer *priorities* are as follows:

A. Emergency patient to an available and appropriate patient bed
B. From obstetric patient care unit to general care unit
C. From special care unit to any general care room
D. From temporary placement in an appropriate clinical service area to the appropriate area for that patient
E. Or, as required by specific departmental policies

Transfers Between Acute and Transitional Care (Swing Bed)

A 'transfer' between these two areas is actually a discharge and an admission, with a new encounter being initiated

- Transfer arrangements into our Transitional Care Unit, whether the patient is internal or from an external facility, are coordinated through Social Service. The patient must meet admission criteria for that unit, as described in approved policy and procedure (#280). A discharge summary is required when patient is discharged from the Medical-Surgical area of this or another hospital: it serves as the admission history and physical for transitional care. For patients being admitted from another hospital, the history and

physical from that facility will also be required, and the patient must be accepted by a physician member of the Hudson Hospital & Clinics Medical Staff *prior to* the Hospital granting admission to the unit.

Transfer to External Medical Facility

A patient may be transferred to another medical care facility only:

A. Upon the order of the attending practitioner, after arrangements have been made for admission with the other facility
B. After receiving consent from the other facility to accept the patient
C. After the patient is considered sufficiently stable for transport
D. After the patient or his/her guardian/representative has consented to the transfer, except in life-threatening emergencies
E. With a completed transfer form, including all pertinent medical information necessary to insure continuity of care

Transfer of Emergency Patient to External Facility

Except as described below, HH&C will not transfer a patient with an emergency medical condition unless and until the emergency medical condition has been stabilized.

HH&C may only transfer a patient with an unstabilized emergency medical condition in one of the following circumstances:

- Transfer at Patient's request: A transfer may be made if the patient (or surrogate acting on behalf of an incompetent patient) has requested the transfer and all of the following conditions have been met:
  1. The patient (or surrogate) has been informed of HH&C's obligation under EMTALA and this policy to provide stabilizing medical treatment.
  2. The patient (or surrogate) has been informed of the risk of transfer.
  3. The patient (or surrogate) requests the transfer in writing, stating the reasons for the request and acknowledging the risks and benefits of the transfer.

- Physician Certification of Benefit: A transfer may be made if the physician has determined that the medical benefits of treatment at another facility outweigh the risk to the patient (or unborn child in the case of a woman in labor) resulting from the transfer. The determination must be documented in writing, must state the risks and benefits of the transfer, and must be signed by the physician.

- If the HH&C transfers a patient with an stable or unstabilized emergency medical condition upon the patient request or physician certification of benefit, it will first:
  (a) Provide medical treatment with in it's capacity to minimize the risks to the patient (and the unborn child in the case of the woman in labor);
  (b) Determine that the receiving facility has available space
  (c) Make sure that the receiving facility has agreed to accept transfer of the patient and to provide appropriate medical treatment, and document that agreement including the date, time and person agreeing to accept the transfer;
  (d) Obtain the written consent of the patient and surrogate
  (e) Send to the receiving facility all medical records related to the emergency medical condition including consent to transfer, the written request by the patient or surrogate for the transfer or the physician certification of benefit.
  (f) Make sure the transfer will be made using qualified personnel and transportation equipment and any necessary and medically appropriate life support measures.

Refusal to Consent to Transfer

A patient with an emergency medical condition (or surrogate acting on behalf of an incompetent patient) may refuse to consent to a transfer. The transfer must be offered to the patient or surrogate and the risks and benefits as determined by the physician must be explained to him or her. If the individual refuses to consent, the medical record will document the transfer that was offered, the risks and benefits of the transfer that were explained to the patient or surrogate, the reasons for the refusal to consent to the transfer, and a written informed refusal signed by the patient or surrogate. If the individual refuses to sign the refusal to consent, the medical record must document the refusal to sign and the steps taken to try and obtain a signed refusal.

6.0 SUSPECTED ABUSE OR NEGLECT; INFANT PROTECTION

It is the responsibility of all practitioners to report suspected abuse or neglect of a child or adult to the appropriate agency as required by law. This applies whether the suspected abuse or neglect is by a relative/significant other or staff member. Refer to Hospital policies #208, 209, and 210.

The hospital provides a safe setting for newborns up to the age of 72 hours who are at risk of abandonment, injury or death per Wisconsin statutes. Any hospital or medical staff member may accept a newborn infant into custody. The infant should be taken directly to the Emergency Department for immediate assessment and registration. (Policy # 207).

7.0 DISCHARGE OF PATIENTS

Discharge should occur in a timely manner once patient no longer requires acute care. Nursing, and Social Service when appropriate, should be alerted to potential discharges as soon as possible, to allow time for finalizing continuing care arrangements (if needed), transportation arrangements and discharge teaching. See Medical Record section for documentation requirements.

Leaving Against Medical Advice

If a patient requests to leave the hospital against the advice of the attending physician or without proper discharge, the attending physician shall be notified. The patient will be requested to sign the appropriate release form, witnessed by a competent third party. A notation shall be made in the patient's medical record regarding the patient leaving against medical advice.

Discharge of Minor Patient

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 or guardian. If the parent or guardian directs that discharge be made otherwise, he/she shall so state in writing, and the statement shall be made part of the patient's medical record.

8.0 FORMULARY AND INVESTIGATIONAL DRUGS

The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary as approved by the Medical Staff. All drugs and medications administered to patients, with the exception of drugs for bona fide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia National Formulary, New and Non-Official Drugs, American Hospital Formulary Service, or AMA Drug Evaluations. Generic drugs may be substituted for trade names. (Policy #370, Medication Administration)

Use of investigational drugs shall be in full accordance with all Regulations of the Food and Drug Administration and authorized by the Pharmacy and Therapeutics Committee.

Sample Medications

Sample medications are not permitted in the hospital.

9.0 SIGNIFICANT ADVERSE DRUG REACTIONS

Significant adverse drug reactions (ADRs) are defined as unintended, undesirable, and unexpected effects of prescribed medications or of medication errors that require initial or prolonged hospitalization, result in disability, require treatment with a prescription medication, result in cognitive deterioration or impairment, are life-threatening, result in death, or result in congenital anomalies. All practitioners are responsible to report or have these ADRs and medication errors reported to Hospital Quality/Risk Offices. (Policy #372)

10.0 ORDERS

General Requirements

- All orders for treatment or diagnostic tests must be clear, legible, complete, and signed, timed and dated by the practitioner responsible for them, or his/her alternate. All diagnostic orders must also include a diagnosis, sign or symptom indicating the reason for the test. When a test report requires clinical interpretation, any relevant clinical information is provided with the request.
- All medication orders must include: medication name, dose, route, frequency, and other information as appropriate, such as start date and/or time and number of doses.
- Medications brought into the hospital by a patient may not be administered unless identified by the pharmacist, or practitioner, and there is a written order from the attending physician to administer the medication.
- The only medications for which self-administration by a patient is permitted are selected topical and metered dose inhalers. A specific written order by the authorized prescribing practitioner is required.
- Orders that are illegible or improperly written shall not be carried out until rewritten or clarified by the receiving health care professional.
- Orders for diagnostic tests that necessitate the administration of test substances or medications will be considered to include the order for this administration.
- Co-signatures must be obtained on medical records and orders generated by Physician Assistants:
    - Co-signatures can be obtained after treatment is given.
    - Drug orders must be co-signed within 72 hours after the origination time (this includes tests in which contrast is used)
    - All other orders (medical imaging, lab, etc.) must be co-signed within 2 weeks after the origination time.

Standing Orders and Protocols

All standing and pre-printed orders shall be written on an order sheet that shall be included in the patient's medical record. Standing and pre-printed orders shall be signed, dated and timed by the attending physician.

Standing and pre-printed orders shall be reviewed every year by the appropriate medical director and/or responsible committee. Major revisions and new standing orders and protocols are to be approved by the Medical Staff, unless they are for individuals/group practices.

Verbal/Telephone Orders

Verbal orders are discouraged for purposes of patient safety. When necessary, telephone and verbal orders may be taken by a licensed nurse. In addition, the following health care professionals may take orders within their respective areas of practice: registered pharmacist, respiratory therapist, physical therapist, speech therapist, psychologist, laboratory technician, radiology technician, dietician, occupational therapist, physician assistant, and social worker. Pharmacy technicians may take refill orders only (without any changes). Unit coordinators and LPNs may take diet, activity, consult and physician hand off orders. Telephone orders will be accepted from the responsible practitioner only when it is not practical for the order to be given in writing. (Policy #229, Clinical Order Processing) Read-back of orders and significant test results is expected for purposes of patient safety.

Documentation of Verbal, Telephone, and Standing Orders

All verbal and telephone orders shall be transcribed in the proper place in the medical record and shall include the date, time, name, signature of the person transcribing the order, and the name of the ordering provider. For electronic records, electronic signatures are date and timed stamped. Telephone/verbal orders must be co-signed

with date, time, and signature within 48 hours. It is permissible for a telephone/verbal order that has been transcribed by a nurse or other authorized individual to be authenticated by another practitioner when the originating practitioner is unavailable.

Automatic Cancellation of Orders

All previous orders are automatically discontinued, when the patient goes to surgery, is transferred to another unit, or to another level of service. New orders must be written.

Blood Transfusions and Intravenous Infusion Orders: Transfusions, except in emergencies, require documentation of informed consent. Blood transfusions and intravenous transfusions must be started by the attending physician, a CRNA, or by a registered nurse who has the requisite training to do so in the hospital. The physician's order must specifically state the rate of infusion.

Time-Limited Orders for Restraint & In-Person Evaluation by the Physician

Use of physical and chemical restraint should be minimized by making every effort to use the least restrictive means to help patients gain control. Nursing may initiate physical restraint based upon assessed patient need, but must receive a verbal or written order from the physician within the following time frames:

- 12 hours or less for medical-surgical restraint.
- 1 hour or less for threatening/aggressive behavioral restraint.

PRN orders are never acceptable. The physician must sign, date and time orders. In addition, the physician must conduct and document an initial face-to-face evaluation of the restrained patient within the time frames below:

- *within 24 hours for medical-surgical restraint*
- *within 1 hour of threatening/aggressive behavioral restraint.*

Physician re-evaluation (face-to-face) must occur and be documented:

- *daily (within 24 hours of last evaluation) for medical surgical restraint*
- *for threatening/aggressive behavioral restraint, every 8 hours for patients age 18 and up; and every 4 hours for those under 18.*

Reorders for restraint:

- *Medical-surgical reasons – every 24 hours*
- *Behavioral reasons – ages 18 and up – every 4 hours*
  ages 9-17 – every 2 hours
  ages under 9 – every 1 hour.

For more details, refer to the Hospital policy #301.

Orders to Withhold or Withdraw Treatment (Policy #150)

If a patient, guardian, or activated Living Will/Power of Attorney for Health Care agent documents the decision to limit resuscitative or life-sustaining treatments, an order specifying these limitations shall be written by the attending physician on the order sheet and supported by documentation in the progress notes. Consents and other procedures required shall be performed according to the hospital policy on withholding or withdrawing treatment.

11.0 MEDICAL RECORDS

Physicians, and other medical staff members and APNPs are responsible for their portion of a complete medical record, which shall be pertinent, accurate, legible, timely, and current. The records of all inpatients cared for by nurse practitioners and certified nurse midwives must be signed by a collaborating or supervising physician within 30 days of patient discharge. H&Ps and discharge summaries by Physician Assistants must be countersigned by the supervising physician within two weeks.

Required Content: Emergency Department Records

Adequate medical records to permit continuity of care after provision of emergency services shall be maintained on all patients. The emergency room patient record shall contain:

A. Patient identification information
B. Pre-hospital care provided, if any
C. History of disease or injury
D. Physical findings
E. Laboratory and x-ray reports, if any
F. Diagnosis
G. Record of treatment, including complete orders
H. Disposition of the case, including condition at discharge and instructions for follow-up care
I. Authentication by providers
J. Appropriate time notations, including time of patient arrival, time of physician notification, time of treatments, including administration of medications, and time of patient discharge or transfer. Contacts made with other hospitals, consultants, ambulances services, etc. must also be documented and timed.

Required Content: Inpatient Records

The record shall include:

A. Identification data (name, address, date of birth), name of any legally authorized representative if applicable, provisional diagnosis/chief complaint present upon admission, and personal and family medical histories
B. Description and history of present complaint and/or illness
C. Summary of the patient's psychosocial needs as appropriate to the age of the patient
D. Practitioner examination report
E. Diagnostic and therapeutic orders
F. Statement of the course of action and plan for the patient while in the hospital
G. Evidence of appropriate informed consent
H. Treatment provided
I. Clinical observations, including results of therapy, multidisciplinary progress notes
J. Reports of procedures, tests and their results, (such as clinical laboratory, radiology, EEG, EKG, pre and post anesthesia, operative and other diagnostic therapeutic procedures, etc.)
K. Documentation of complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia
L. Consultation reports
M. Pathological findings
N. Final diagnosis without the use of symbols or abbreviations
O. Conclusions at termination of hospitalization or evaluation of treatment
P. Condition on discharge, including instructions to patient and/or family on post-hospital care
Q. Autopsy report
R. Anatomical gift information, if applicable

Record Content Relative to Children and Adolescents

A. Evaluation of the patient's developmental age
B. Consideration of educational needs and daily activities as appropriate
C. The parent's report or other documentation of immunization status
D. The family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the patient

History and Physical Examination

A complete history and physical examination must be done for each patient by a physician, podiatrist, certified nurse midwife or, where appropriate, an oral maxillofacial surgeon, no more than 30 days before or 24 hours after admission for medical patients. A complete history and physical examination must be completed within

30 days of surgery and be present on the medical record prior to surgery. Surgical H&Ps must be reviewed and updated if indicated by the surgeon within 24 hours to the surgery. The surgeon documents his/her updated review on the pre-operative history and physical review form.

The history and physical examination report includes the following:

A. The chief complaint
B. Details of the present illness
C. All relevant past medical, social, and family histories (relevant to the age of the patient)
D. The patient's emotional, behavioral, and social status (when appropriate)
E. Review of systems
F. All pertinent findings resulting from a comprehensive, current physical assessment of all body systems
G. Impression
H. Plan

If unable to complete all elements of the history and physical, documentation needs to address the reason. If an element is "deferred," then that section must be completed and documented prior to discharge.

Short H&P: Patients having ambulatory procedures requiring moderate to deep sedation in the outpatient setting, will have a short H&P completed prior to the procedure. The short H&P must include a baseline health evaluation to include medications, allergies, relevant past medical history, adverse experiences with sedation or anesthesia, history pertinent to procedure, and a review of systems including vital signs, heart and lung assessment, height and weight and relevant diagnostic studies, as applicable.

- If the H&P content has been delegated to a privileged and qualified physician assistant, then that H&P must be endorsed (co-signed) by the responsible physician/surgeon prior to any surgical procedures, anesthesia, moderate or deep sedation.
- If the H&P is from a physician who is not a member of this medical staff, the responsible physician/surgeon must endorse (co-sign) the H&P.

Consultation Report Content

Consultations are to include the following:

A. Date and time consultation performed
B. Evidence of a review of the patient record
C. Evidence of examination of the patient
D. Pertinent findings of the examination
E. Consultant opinion, diagnosis, or impression
F. Outline of recommendations for treatment or actual orders planned
G. Signature and professional initials e.g. "M.D."

Preoperative Testing and Documentation

Pre-Operative Testing

- Urine Pregnancy test on all women able to bear children.
- K+ within 72 hours of surgery for all patients on diuretics.
- Finger stick glucose on all insulin dependent diabetics. *Recommended* for patients on oral hypoglycemics.

EKG: Must be completed on all patients age 50 and older within 6 months of surgery and be interpreted by a physician. Not required for patients having local anesthesia.

Additional diagnostic testing is left to the discretion of the surgeon, anesthesia and the attending practitioner. The results are to be available in the chart prior to the induction of anesthesia.

Pre-operative Surgical Consultation: A dictated or recorded in EMR surgeon's consultation report is required. This should include a notation about informed consent. Consult notes from the surgeon's office are acceptable.

Preoperative Anesthesia Evaluation

A. Preoperative anesthesia evaluation shall be performed and documented in the medical record within 48 hours prior to surgery, along with the anesthesia plan, which includes pertinent information relative to the choice of anesthesia and the procedure anticipated. Anesthetic plans developed by a CRNA require physician co-signature unless they are certified by the state and hospital as advance practice nurses with prescribing privileges or are recognized by the state as licensed independent practitioners. The CRNA or anesthesiologist shall conduct and document pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for preop medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medications have been administered.
B. An intra-operative anesthesia record documenting all pertinent events taking place during anesthesia shall be completed.
C. A post-anesthesia follow up report is written for each patient by the individual who administered the anesthesia within 48 hours after surgery.
D. Outpatients shall have a post anesthesia evaluation for proper anesthesia recovery in accordance with hospital policies and procedures.

Progress Notes

Pertinent progress notes must be recorded at the time of observation at least on a daily basis and must be sufficient to permit continuity of care and transferability of the patient.

Operative, Special Procedure, and Tissue Reports

Operative and Special Procedure Reports

Operative and special procedure reports shall contain, as applicable, a detailed account of the findings, the technical procedures used, the estimated blood loss, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. The complete report must be documented or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner.

If the report is dictated and not immediately transcribed in the record after the procedure, the practitioner must document an immediate post-operative progress note in the medical record to facilitate continuity of care. At a minimum, the progress note must include: primary surgeon and any assistant; findings; technical procedure; specimens removed; and post-operative diagnosis.

Tissue Examination and Reports

All tissues, foreign bodies, artifacts, and prostheses removed during a procedure, except those specifically excluded by policy shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen shall be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnosis. An authenticated report of a pathologist's examination shall be made a part of the medical record. See *Attachment A* for listing of exempt specimens.

Obstetrical Record

The current obstetrical record shall include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be documented that includes pertinent additions to the history and any subsequent changes in the physical findings. An exception to the prenatal record requirement involves those patients who deliver here, but have not had prenatal care at an area clinic. Other records required are: multidisciplinary progress notes, physician order sheet, medication and treatment sheet, lab and x-ray reports, and physician's estimate of blood loss. *All obstetrical patients undergoing surgery must have a history and physical examination recorded.*

Newborn Record

Newborn record shall include the following: A record of pertinent maternal data, type of labor and delivery and the condition of the infant at birth, physical exam, progress notes, medications and treatment sheet, weights, feedings, temperatures, and notes of any medical consultant. *In cases of fetal death, the weight and length of the fetus shall be recorded on the delivery record.*

Entries by Practitioner at the Conclusion of Hospitalization

The principal diagnosis, any secondary diagnoses, comorbidities, complications, principal procedure, and any additional procedures must be recorded in full and must be dated and signed by the attending practitioner.

The following definitions are applicable to the terms used on the diagnosis sheet:

A. Principal Diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
B. Secondary Diagnosis: A diagnosis, other than the principal diagnosis, that describes a condition for which a patient received treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
C. Comorbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis and is thought to increase the length of stay be at least one day (for about 75% of the patients).
D. Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness of the medical care required and is thought to increase the length of stay at least one day.
E. Principal Procedure: The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
F. Additional Procedures: Any other procedures, other than principal procedure, pertinent to the individual stay.

Discharge Summary and Final Progress Note

The discharge summary concisely recapitulates:

A. The reason for hospitalization
B. The significant findings
C. The procedures performed and treatment rendered
D. The condition of the patient on discharge
E. Specific instructions given to the patient and/or family relating to physical activity, medication, diet, and follow-up care

The condition of the patient at discharge is stated in terms that permit a specific measurable comparison with the condition on admission.

Patients with problems of a minor nature who require hospitalization of 48 hours or less, normal newborns, and uncomplicated obstetrics deliveries: a final Discharge Progress Note may be substituted for the discharge summary and daily progress note, provided that it contains:

A. Final diagnosis
B. Reason for hospitalization
C. Significant findings
D. Procedures performed
E. Condition of the patient on discharge/outcome of hospitalization
F. Any specific instructions given to the patient and/or family including follow-up care

In the event of death, the final progress note or discharge summary must also include the events leading to the death.

Incomplete/Delinquent Records

All patient medical records must be completed within 30 days of discharge. Records exceeding 30 days are considered to be delinquent. It is recommended that the patient's medical record be complete at the time of discharge, including progress notes, final diagnosis, and (dictated) discharge summary. Where this is

not possible because pathology or other essential reports have not been received at the time of discharge, the patient's chart will be available in the Health Information Department. A review of these records shall be done on a weekly basis, and notices provided to physicians regarding charts awaiting completion. Practitioners will receive notification of charts needing completion a minimum of three times prior to delinquency and suspension.

If a record is not completed within 30 days of discharge, it is delinquent and notification will be sent to the practitioner to complete the record(s) within 48 hours, or his/her admitting privileges may be suspended. If the records are not completed within the 48 hours, a letter signed by the Chief of Staff or his/her designee may be sent to the practitioner stating that suspension will start upon his/her receipt of the notification. This suspension will remain in place until the records are completed. The Admitting Office, surgery scheduling, nursing units, and other relevant areas will be notified of the action. The practitioner will be permitted to continue seeing and treating any patients that are in the hospital at the time of suspension. Three such suspensions of admitting privileges within any 12 month period will result in referral to the Credentials Committee. Suspension records will be a consideration in the reappointment/privileging process.

Use of Symbols and Abbreviations

Abbreviations are not to be used on operative reports or face sheets, but approved abbreviations may be used elsewhere in the chart, with the exception of those on the "Unapproved Abbreviations" list. Stedman's Abbreviation book has been approved by Medical Staff as the hospital's official abbreviation book. Each patient care area shall have a copy Stedman's and the "Unapproved Abbreviations" list for reference.

Authentication

All clinical entries in the patient's record must be legible, and individually signed, timed and dated. Authentication means to establish authorship by written signature, identifiable initials, or computer entry of an author who has reviewed and approved the entry. Rubber stamps shall not be used on the medical record in place of a signature. If a practitioner wishes to use electronic signature, he or she must sign a statement that he or she alone will use it. When authenticating an entry with an electronic signature, the author must be the sole user of his/her computer code/password/signature. Although it is permissible for a second practitioner to sign verbal orders issued previously by another practitioner, this does not apply to other documents such as history and physicals, operative reports and so on.

Filing an Incomplete Medical Record

A medical record will be filed only after it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation, or other inability or unavailability of the responsible practitioner to complete the record, the Medical Records/UR Committee or the Medical Executive Committee shall consider the circumstances and may enter such reasons in the record and order it filed.

Ownership and Removal of Records

All original patient medical records, including x-ray films, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the administrator. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record of any such portion thereof from the hospital is grounds for disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the Medical Staff and Board.

Access to Records

Patient Access

Patients have a right to access and amend their medical record information in all but a limited number of situations. Specifics are defined in Hospital policy #607.

For Statistical Purposes and Required Activities

Patient medical records shall also be made available to authorized hospital personnel, medical staff members, or others with an official, hospital-approved interest. The hospital may use the medical record information for these

purposes without the express authorization of the individual patient to whom it pertains; however, all individual patient identification will be excluded from the report of such findings and recommendations.

On Readmission

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner.

To Former Medical Staff Members

Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.

Other Circumstances

Written consent of the patient or his/her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section, the Bylaws or Hospital Policy.

12.0 INFORMED CONSENT

Informed Consent

Informed consent involves a discussion between the practitioner and the patient or his/her legal representative that describes the proposed procedure, the benefits, risks (including potential complications), alternative treatments, and consequences of not having the procedure. For procedures, the name(s) of the practitioner who will be performing the procedure must be provided. Presence of any vendor representatives or students must also be disclosed. The practitioner is responsible for providing the patient with information necessary to give informed consent prior to the start of any procedure and/or treatment. Practitioners document on the "Pre-Op H&P Review and Informed Consent Verification" form prior to surgery, and also dictate/document an informed consent note in the chart A patient does have the right to refuse medical treatment. The signature of a patient or his/her legal representative is required for the following procedures:

A. Anesthesia*
B. Surgical and other invasive and special procedures*
C. Use of experimental drugs
D. Organ donation*
E. Chemotherapy
F. Autopsy*
G. Photography*
H. Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form
I. Transfusion*
J. HIV lab test*
K. VBAC
L. Waterbirth

*Hospital specific forms are available on the shared drive.

Documentation Required

The informed consent shall be documented in the patient's medical records prior to the procedure/surgery and shall include at least the following information:

A. Nature of the contemplated treatment (described in lay terms)
B. Risks involved with the procedure
C. Prospects for success
D. Possible complications
E. Alternatives to treatment
F. Results likely if the patient remains untreated
G. Date and time of signature

Emergency Consent

In an emergency situation requiring immediate treatment, if the person legally authorized to give consent for treatment is not present or is unable to be contacted or located, treatment and/or surgery may be initiated if it is determined by the practitioner that failure to proceed may threaten the patient's life, safety, health or permanent well-being. Patient status, the emergency situation and attempts to contact the legally authorized person are to be documented in the medical record.

13.0 HOSPITAL DEATHS AND AUTOPSIES

Hospital Deaths: Pronouncement

In the event of a hospital death, the deceased shall be pronounced dead by a physician within a reasonable period of time.

Reportable Deaths

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law. See Hospital policy #299, Deaths and Autopsy, which includes criteria for Medical Examiner Referral.

Death Certificate

The death certificate shall be signed by the attending physician, unless the death is a Medical Examiner's case.

Organ Donation

The designated organ procurement organization (OPO) shall be contacted regarding each death by the nursing staff or the practitioner. The OPO shall make the determination as to whether or not the deceased is a potential donor. If deceased has been determined by the OPO to be a donor candidate, the family of the deceased shall be offered the option of organ donation by either the OPO, physician or hospital staff. Contact with the OPO, their determination, the approach to the family, and their response is to be documented in the medical record by the practitioner and/or nursing staff.

Release of the Body

A body may not be released without an order from a physician. In Medical Examiner cases, the body may not be released to anyone other than the Medical Examiner personnel except by order of the Medical Examiner.

Autopsies

It is the responsibility of members of the medical staff to discuss possible autopsies with families on all cases that meet established criteria which have been approved by the medical staff as listed below:

A. Unexpected death
B. Intra-operative or post-op death
C. Death incidental to pregnancy
D. Death within 48 hours of a surgical or an invasive or high-risk treatment or procedure, including radiology procedures
E. Death associated with an averse patient occurrence while undergoing treatment

This discussion should be documented in the medical record.

A consent for autopsy is obtained in accordance with applicable state and federal laws. All autopsies shall be performed by a pathologist. (Autopsy costs for patients meeting the above-listed criteria are absorbed by the hospital. (Hospital Policy #299)

Autopsy Reports

The provisional anatomical diagnosis shall be recorded in the medical record within 72 hours, and the complete protocol shall be a part of the medical record within 60 days.

14.0 SAFETY, HEALTH CARE ACCIDENTS, SENTINEL EVENTS, AND NEAR MISSES

Smoking

Effective January 1, 2005, the Hudson Hospital & Clinics will be a tobacco-free facility and grounds. Practitionerss cannot write orders to allow patients the use of tobacco while hospitalized at Hudson Hospital & Clinics.

(Policy #811)

Hudson Hospital & Clinics Emergency Code Information

All practitioners working on the Hudson Hospital & Clinics Health Campus are expected to know the following emergency codes and participate in drills and actual emergencies. The following are the current codes and definitions are as follows:

Code Blue	Adult Medical Emergency
Code White	Pediatric Medical Emergency
Code Pink	Infant/child is missing-secure building
Code Green	Severe weather advisory-follow plan
Code Gray	Combative Person
Code Silver	Person with Hostage or Weapon
Code Yellow	Bomb threat or Telephone Threat
Code Triage	Disaster
Code Red	Fire alarm notice-RACE & PASS
RACE	Rescue, Alarm, Contain, Extinguish
PASS	Pull pin, Aim, Squeeze, Sweep side to side

Health Care Accident; Care or Service Concern

A *health care accident*, sometimes called an 'occurrence,' is defined as an unintended act in the system of care which can be shown to have resulted in actual or potential negative consequences to the patient. Accidents are to be reported via the Event Report or Comment Line (531-6020) after steps have been taken to ensure patient safety. In addition, significant concerns; those that are unresolved after communication with the individual and/or department manager (for hospital staff or department issues); and recurring issues involving care, service, equipment, or practice are to be reported in the same manner. Such reports will be addressed through hospital and/or medical staff channels, as appropriate. (Policy #35, Concerns About Care or Service and #36, Occurrence/Even Reporting.)

Medical Device Injuries: Anyone becoming aware of any information suggesting that a medical device has or may have caused or contributed to the death, serious injury or illness of a patient and/or medical personnel is responsible to ensure removal from service immediately and notification to Quality/Risk, either by use of the Comment Line (531-6020) or written Event Report. (Policy #036)

A sentinel event is a subset of serious health care accidents that involves death, serious physical or psychological injury, which includes: an unanticipated death or major permanent loss of function which is unrelated to the natural course of the patient's illness or underlying condition.

All sentinel events will be evaluated to identify the causal factors so that actions may be taken to prevent or minimize the probability of future occurrences/accidents. Practitioners and other hospital staff members involved in such occurrences are strongly encouraged to participate in this analysis, which must be completed within 45 days of becoming aware of the event. (See Policy #38, Sentinel Events and Near Misses)

Sharing Care Outcomes with Patients, Including Unanticipated Events

Outcomes of care are shared with patients, and when appropriate, their family, as part of the normal patient care and education processes.

Significant Unanticipated Outcomes. Whenever treatment or procedure outcomes differ *significantly* from anticipated outcomes, the responsible practitioner and/or appropriate hospital staff explain the outcome to the patient, and, when appropriate, the family[1].

[1] This does NOT apply to errors or health care accidents that do *not* significantly affect outcomes or to sub-optimal outcomes that were anticipated and discussed with the patient before treatment, as part of the informed consent process.

At a minimum, this is done when:

- the patient (or family) must be knowledgeable about the outcome in order to participate in current and future decisions affecting the patient's care; and/or
- a sentinel event, as defined in section 14.4, has occurred.

A procedure has been developed to support the practitioners and staff in disclosing significant unanticipated outcomes, and it is described in policy #037, Disclosure of Care Outcomes to Patients, Including Unanticipated Outcomes.

Near Miss Events

Near miss events are events that could have resulted in a health care accident or sentinel event, but were intercepted before actually reaching the patient, and therefore did not affect the outcome of care.

Health Program for Licensed Independent Practitioner(LIP) Members

The medical staff maintains a process to identify and manage matters of individual health and/or disruptive behavior that is separate from the medical staff disciplinary function. The purpose is assistance and rehabilitation to aid the physician or other privileged LIP in retaining or regaining optimal professional functioning, consistent with protection of patients. Self-referrals are encouraged, and any medical staff member or hospital staff member may make a referral to the program. Refer to the Licensed Independent Practitioner Health policy #953 for details.

15.0 MEDICAL DIRECTOR'S RESPONSIBILITIES

The Medical Staff is not departmentalized; therefore, the Medical Staff as a whole is responsible for the quality of the medical care provided in the hospital. However, administrative medical directors are utilized to facilitate close coordination and communication between the hospital departments and medical staff.

Responsibilities of the Medical Director

The responsibilities of the Hospital Medical Directors generally include:

A. Chairing meetings of the Clinical area and/or related Medical Staff Committees and collaborating with the Hospital Department director/manager in setting agendas
B. Providing consultation to the manager of the area on clinical activities, as required
C. Providing input into the administration of the functional area as appropriate:
    1. Personnel resources needed; qualification and competency of patient care providers
    2. Space, equipment, and other resources
    3. Integration of the area with other functions of the hospital
    4. Reviewing and participating in the revision of area-specific clinical policies, procedures, and standing orders at least every other year or more frequently, as necessary.
    5. Collaborating with the area manager in maintaining quality controls and performance improvement activities, as appropriate
    6. Assessing and recommending off-site sources of patient care services.
D. Participating in orientation and continuing education of all persons in the department, as appropriate.
E. Participating in the evaluation of practitioners providing services within their clinical area.

16.0 INFECTION PREVENTION AND CONTROL: GENERAL AUTHORITY

The Infection Prevention and Control Committee, and the Infection Control Nurse has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

17.0 SAFETY OFFICER: GENERAL AUTHORITY

The Safety Officer has the authority to initiate and carry out any activities necessary to ensure a safe and secure environment within the Hospital and its property.

18.0 POINT OF CARE (WAIVED) TESTING

Point of care test results are used as a screening tool in patient assessment and definitively for monitoring. They are not used for diagnostic determination.

19.0 TELEMEDICINE SERVICES

Digital imaging may be utilized for preliminary and/or final diagnostic readings in the Medical Imaging and diagnostic cardiac areas.

Sleep study readings may be provided via telemedicine. Refer to Medical Staff policy on Telemedicine, Credentialing of Practitioners.

20.0 CLINICAL PRACTICE GUIDELINES

Evidence-based clinical practice guidelines and protocols are considered for use in improving care processes. Protocols are considered to be predetermined care plans, which are sometimes in the form of an algorithm. Guidelines are viewed as decision-support tools containing general strategies for patient management which may or may not be applicable to a given patient. Both may be developed internally or may be adopted from authoritative external sources and modified for local use. The selection/development process needs to involve the impacted disciplines and be approved by the appropriate committee and/or full medical staff. When utilized, measures need to be in place to identify opportunities to improve. Variances are not viewed negatively, but as potential opportunities. (Policy 022, Performance and Safety Improvement Plan)

Guidelines may form the basis for standing orders (with the flexibility to individualize for specific patients) for specific diagnoses, procedures or medications. Such orders are reviewed and updated periodically so that they remain current. See Section 10.3. At times, it may be appropriate to utilize a combination of a guideline, protocol and/or set of standing orders to facilitate the care process.

21.0 COMPARABLE LEVEL OF CARE

Patients are entitled to receive a comparable level of care for the same condition, regardless of the provider discipline or the setting (inpatient or outpatient). This comparability is evaluated through the performance improvement process and the privileging process.

22.0 AMENDMENT

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by a resolution of the Medical Staff recommended to and adopted by the Board of Directors. Neither the Medical Staff nor the Board of Directors may unilaterally amend these Rules and Regulations.

23.0 ADOPTION BY THE MEDICAL STAFF

These General Rules and Regulations were adopted by the Medical Staff on December 13, 2011.

24.0 ADOPTION BY THE GOVERNING BOARD

These General Rules and Regulations were approved and adopted on behalf of the governing body by resolution of the Board of Directors on December 13, 2011.

_____

Chairperson, Board of Directors

_____

President, Medical Staff

_____

President and CEO

Attachment A

Specimens Which Are Exempt from Pathology Examination

- Foreign bodies
- Cataract and lens
- Hardware
- Insects
- Sutures and wires
- Traumatic amputation of digits
- Nail (finger and toe)
- Teeth
- Bladder Stones (calculi)
- IUD
- Surgical scars and excess normal skin
- Arthroscopic shavings
- Bone fragments
- Norplant capsules
- Pessary
- Tonsils
- Hernia Sacs
- Varicose Veins
- Hemorrhoids
- Sebaceous Cysts
- Gall Stones

Attachment B

Listing of Hospital Policies Referenced in the Bylaws, Rules and Regulations

Policy Number	**Policy Title**
021	Hospital Code of Business Ethics
022	Performance and Safety Improvement Plan
035	Ethical Concerns
037	Disclosure of Unanticipated Events
038	Sentinel Events and Potential Sentinel Events
101	Complaints and Patient Grievances
102	Communication Services for Special Needs Patients
117	Consent to Interview, Photograph and Videotape…
118	Consent Policy*
124	Organ, Tissue and Eye Donation*
150	Withholding or Withdrawing Treatment
204	Pain Management
207	Infant Protection
208	Child Abuse/Neglect, Suspected
209	Adult Abuse/Neglect, Suspected
210	Domestic Abuse, Suspected
229	Order Processing
280	Admission to Hudson Hospital & Clinics
281	Hospital Admission from Hudson Physicians Clinic
299	Deaths and Autopsy
300	Use of Deep Sedation
301	Restraint Use
302	Use of Moderate Sedation and Analgesia
370	Medication Administration
372	Adverse Drug Reaction
373	Medication Errors
509	Occurrence/Event Reporting
607	Patient Request for Amendment to Their Medical Record
761	Complaint Resolution Procedure
811	Alcohol and Tobacco Free Campus
949	Telemedicine Credentialing
951	Fast Track Appointments
952	Fast Track Reappointments
953	Independent Licensed Practitioner Health Program

Access to these policies:

- Hard copies are available in Administration and Inpatient Departments.
- Policies are also available in electronic format on the Hospital's shared drive.