RULES AND REGULATIONS OF THE PROFESSIONAL STAFF OF GRANDVIEW/SOUTHVIEW HOSPITAL

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1. Admissions

a. Provisional Admitting Diagnosis: No patient shall be admitted to the hospital until a provisional admitting diagnosis has been stated and the consent of a single admitting physician, or his/her alternate, secured. Every patient shall be under the care of a licensed Staff doctor of osteopathy or medicine with admitting privileges granted in accordance with these Bylaws. Only one active staff member may be designated as the attending physician responsible for patient care until the patient is transferred or discharged**.**

b. Patients: The hospital shall accept patients suffering from all types of diseases except those whose medical needs are beyond the scope of care provided at a facility of the hospital. Such patients presenting to a facility of the hospital for treatment will be stabilized and transferred to another appropriate facility.

c. Protection of Other Persons: Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatever or to assure the protection of the patient from self-harm. The hospital has the obligation of preventing hazards, and/or safeguarding all patients and personnel. Therefore, when any patient whose mental or physical condition causes him/her to be disturbing and/or unsafe to himself, other patients, and personnel of this hospital, the patient will be transferred to a private room, at his/her own expense. This transfer will be discussed with and approved by the attending physician. In case of disagreement, the appropriate clinical service chief will be contacted, and if a mutual decision with the attending physician

cannot be rendered, the Chief of Staff or his/her designee, shall be consulted and a final disposition made.

When transferred to a private room, the patient must have twenty-four (24) hour supervision, also at his/her own expense. If unable to afford the cost of special duty nursing, relatives or others, acceptable to the attending physician and the Vice President of Medical Affairs, must remain with the patient continuously. If the above procedures are not acceptable to the physician, patient, or his/her family, the physician will be obligated to transfer the patient from the hospital to an appropriate facility willing to accept the patient, or the patient and/or family may sign the patient out of the Hospital against medical advice, unless the physician deems the patient likely to harm himself or others**.**

d. Transfer of Service: Patient transfer from admitting physician's care to another physician is arranged by agreement of current attending physician and receiving physician whether the transfer is requested by the patient or patient's legal surrogate or by the attending physician.

To complete a patient transfer of service the attending physician must order a transfer of service with appropriate documentation of reasons for transfer in the physician progress notes as well as the receiving physician documenting acceptance of the patient transfer in the physician progress notes and order

e. Assignment of Cases:

(1) Uninsured or underinsured patients shall be attended by members of the Professional Staff and shall be assigned by the clinical service concerned in the treatment of the disease which necessitated admission.

(2) Private patients shall be attended by their own physician. In the case of the patient requiring admission who has no attending physician and does

not elect or is unable to choose one, he/she shall be referred to the appropriate clinical service on-call physician.

(3) Physicians to whom unattached patients are referred have a responsibility to provide care to the patient or secure referral to a proper available care provider.

f. All patients require daily patient visits by the attending physician or other qualified licensed individual in accordance with State law and Hospital policy that are documented in the progress notes as a part of usual care.

2. Restraints or Seclusion: Physical or drug restraints or seclusion use for medical and post surgical care or for emergent behavior management is limited to those situations with adequate and appropriate clinical justification (documented in the medical record) using the least-restrictive, safe and effective restraint or seclusion while protecting the patient's rights, dignity and well being. Restraints or seclusion may be used following a comprehensive individual assessment according to Professional Staff approved guiding protocols by individual authenticated verbal or written orders of a hospital credentialed licensed independent practitioner and are time limited and renewable according to the Hospital's Restraint and Seclusion Policy, consistent with federal and State guidelines and accrediting standards**.** Order for seclusion or restraint are never written as a standing order or on an as-needed basis.

3. Utilization

a. The history and physical and progress notes must document the patient's clinical course in sufficient detail to provide a reasonable understanding of the patient's evolving condition, diagnoses, treatment and plan of care. In addition, the note must provide sufficient information regarding the severity of illness and/or intensity of service that requires continued use of hospital resources.

b. Professional Staff members are required to provide appropriate written diagnoses or clinical indications to justify diagnostic tests and therapeutic intervention performed by hospital departments.

c. Admissions prior to the day of surgery will be permitted if the medical condition warrants. If prior approval for elective admission is required by the payor it must be obtained as specified by the payor prior to the admission.

d. If approval for performance of any procedures is required by the third party payor, such approval must be obtained prior to performance of that procedure.

e. Periodic review of the appropriateness of patient care may be made by the staff of the Quality Improvement Committee. Deviations will be referred to the Utilization Review Committee for initial review, and if appropriate to the applicable Professional Staff Chair or the Chief of Staff, or their designee for evaluation and recommendation, if any.

4. Orders

a. All inpatients must have orders upon admission.

b. Written/Verbal Orders: All orders (including orders for diagnostic procedures, treatment, medication, biologicals, progress notes, patient assessments, history and physicals, etc.) must be legible, complete, dated, timed and authenticated in written or electronic form by the prescribing physician or other licensed practitioner who is authorized to write orders by State law and Hospital policy, and who is responsible for the care of the patient even if the order did not originate with such practitioner. Verbal orders (including telephoned orders) shall be used infrequently and limited to those situations in which it is impossible or impractical to write the order or enter it into the computer, and shall not be accepted or carried out unless dictated to credentialed personnel within the scope

of their licensure consistent with federal and State law**.** All verbal orders received by telephone must be read back to the ordering practitioner for verification of accuracy. Verbal orders shall be reviewed for accuracy and authenticated as soon as possible and not later than 48 hours following the time the order was given by the responsible physician or another licensed practitioner who is responsible for the care of the patient and is authorized to write orders by Hospital policy in accordance with State law. Facsimile signatures are not permitted in authenticating verbal orders. Verbal orders for restraints must be reviewed and authenticated within 24 hours following the time the order was given.

c. Routine Orders: Routine orders may be formulated by a physician or a group to meet the needs of their patients. Routine orders may not replace or cancel those written orders for specific patients. Routine orders shall be signed by the attending physician or the consultant who wishes to institute them within the timeframe established by Staff policy and used only when a printed copy of such orders is affixed to the patient's record and each page of a preprinted order is signed, dated and timed by the ordering physician**.**

d. Stop-Orders: Stop-orders shall be applied to certain specified categories of drugs, and nursing service or pharmacy will notify attending physicians when such stop-orders have been applied.

e. Unusual Orders: When a nurse receives an order for a medication in unusual circumstances, or in dosage beyond that usually prescribed, or in excess of that listed in reference books or package inserts, he/she may verify the order with the hospital pharmacist. If the hospital pharmacist concurs with the physician's order, then the dosage ordered should be given. If the hospital pharmacist considers the order wrong in dosage, the attending physician is notified of this opinion by the

pharmacist. If the attending physician does not change the order, then the nurse shall consult with the appropriate Professional Staff Chair who will then consult with the attending physician, and a joint decision will be rendered. If necessary, the Chief of Staff shall be consulted and a final disposition made. If the nurse is unwilling to carry out the order for personal-professional-legal reasons, he/she shall refer the order to the appropriate Director of Nursing whereupon the order shall be carried out.

5. Records

Content, Review and Evaluation

a. **Content:** In general, a medical record must contain contemporaneously documented information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services. A complete inpatient medical record shall include identification data; complaints; history of present illness; relevant patient/family social-developmental history; relevant historical review of systems, relevant physical findings and examination; identification of problems and needs; provisional admitting diagnosis; medication history and current medications including intended purpose; allergies; medical or surgical treatment; operative report; pathological findings; progress notes; multidisciplinary notes and flow sheets; medication administration records; special reports such as consultations, clinical laboratory, x-ray and others; complications; hospital acquired infections; unfavorable reactions to drugs and anesthesia; final diagnosis; and a discharge summary, including a discharge diagnosis. Autopsy reports must be included in those cases in which an autopsy is performed. Physical examinations will include relevant body systems as indicated by the patient's medical histories including

chief complaint; present illness; past, social and family history; and review of systems. Newborn care initial assessments, intervention and reassessments are defined as approved by the Medical Staff in relevant clinical departments, including the Department of Obstetrics and Gynecology. Routine screening preventative physical examinations such as breast exams, pelvic exams, rectal exams, neurologic exams and fundoscopic eye exams are encouraged but not required for a completed medical record, unless indicated by the patient's history. Symbols and abbreviations may be used only when such have been approved by the Medical Executive Committee. An official current record of approved symbols and abbreviations will be kept on file in the Health Information Management Department. No medical record shall be stored until it is complete except by instruction of the Vice President of Medical Affairs.

b. **Non-Medical Comments:** Criticism, impertinent and inappropriate comments or language, or personal attacks against Staff members, hospital personnel or the hospital and its policies shall not appear in the medical record. Any questionable violation of this rule shall be referred to a committee consisting of the officers of the Professional Staff and the Vice President of Medical Affairs for interpretation, judgment, and action. If warranted, this committee shall refer the incident to the Staff Executive Committee for review and recommendation.

c. History and Physical: Each patient admitted for inpatient care shall have a complete medical history and physical examination (H&P) performed and documented no more than 30 days before or 24 hours after admission (but prior to any surgery or procedure requiring anesthesia) by the attending physician or other qualified licensed individual who has been granted such privileges by the Hospital in accordance with State law. Dentists, podiatrists and psychologists are

responsible for the part of their patient's H&P that relates to their respective specialty. An H&P performed within thirty (30) days prior to admission must be updated and documented within 24 hours after admission (but prior to any surgery or procedure requiring anesthesia). The update should include a physical assessment after admission to update any components of the medical status that may have changed since the H&P was completed, and should address any areas where more current data is needed, and shall be attached to the H&P**.** The H&P records, including update assessments and notes, are the responsibility of the attending physician, and if they are written by a member of the housestaff or other licensed professional who requires a co-signature under Hospital Policy in accordance with State law, they shall be verified, signed, timed, and dated by the attending physician in addition to being signed, timed, and dated by the individual preparing the record. In the event that the H&P have been completed by a remote practitioner who has not been granted privileges at this Hospital, then such H&P must be reviewed and updated by a licensed practitioner who is credentialed and privileged by the Hospital's Medical Staff to perform an H&P. An osteopathic musculoskeletal examination is required if the H&P is performed by osteopathic physicians unless such physician documents the reasons such is contraindicated**.**

d. **Outpatient Anesthesia:** Outpatients undergoing surgery or procedures which require anesthesia also require an H&P to be performed and documented prior to such surgery/procedure**,** with the exception of cases using only local anesthesia without any pre-operative medication, and except in the case of emergencies. In cases which use only local anesthesia, an H&P is not required, but a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary. Other pertinent positive findings, such as drug

allergies and serious pre-existing disease entities should also be noted. For obstetric patients where the office prenatal record is forwarded to the labor and delivery department, an update at the time of admission shall serve in lieu of a full H&P**.**

e. **Pre-Operative/Pre-procedure Record:** Emergencies excepted, patients shall not be taken to the operating room/or procedure room unless the medical record contains a signed and witnessed consent form, preoperative/or procedure attestation statement and/or anesthesia/or conscious sedation attestation statement, plan of care for the surgery/procedure and anesthesia, a current H&P, and a pre-anesthesia evaluation completed and documented within 48 hours prior to surgery/procedure by a licensed and qualified individual who is privileged to administer anesthesia under Hospital and State law. The pre-anesthesia evaluation shall include a notation of anesthesia risk, a history of anesthesia, drug allergies, potential anesthesia problems, and the patient's condition prior to induction of anesthesia**.** In emergency conditions, an acceptable H&P for preoperative purposes may be limited to major significant conditions requiring immediate surgery. Operating/procedure time may be forfeited on the authority of the operating/procedure room committee as outlined in the operating/procedure room policy, when the starting of the operation/procedure is delayed for more than fifteen (15) minutes.

f. **Pre-Operative Attestation:** To assist the patient in providing informed consent, the privileged Professional Staff individual performing surgery or procedures shall provide a plan of care for the patient including informing the patient and/or appropriate legal surrogates regarding the need for, benefits, alternative options, risks and potential complications associated with the operative procedure.

To assist the patient in providing informed consent, the responsible Professional Staff member shall inform the patient and/or appropriate legal surrogate(s) regarding the need for, benefits, alternative options, risks, and potential complications associated with blood transfusion when blood or blood components may be needed associated with an operative procedure.

To assist the patient in providing informed consent, the practitioner privileged to provide anesthesia or conscious sedation shall provide an anesthesia or conscious sedation plan of care including informing the patient and/or appropriate surrogate(s) of the need for, benefits, alternative options, risks, and potential complications associated with anesthesia or conscious sedation prior to administration of pre-operative medication.

These plans of care for surgery or procedures, anesthesia/conscious sedation and blood use, including the need for, benefits, alternative options, risk, and potential complications shall be attested to, dated and timed by the physician in the medical record, either on the consent form, history and physical, anesthesia record and/or in the physician progress notes except in an emergency situation where informed consent cannot be given. A properly executed Informed Consent Form must be in the patient's chart prior to any procedure (except in emergencies) in accordance with the hospital's Informed Consent Policy. Informed consents must include not only the name of the primary practitioner performing the procedure, but also the names of practitioners performing significant surgical tasks such as opening, closing, harvesting grafts, dissecting or removing or altering tissue, implanting devices, etc**.**

g. **Surgical Record:** All operations or procedures performed in the hospital shall be described in full, and shall include each practitioner's name, category and specific

surgical tasks performed**.** When a hard copy of the operative report is not placed in the medical record immediately after surgery or the procedure, a progress note of the operation or procedure is entered immediately. All tissues and foreign material surgically removed, unless specifically excluded by the Staff Executive Committee, shall be sent to the hospital pathologist who shall make such examination as he/she shall consider necessary to arrive at a pathological diagnosis and he/she shall issue a signed report which shall become a permanent part of the patient's record.

h. **Post-Anesthesia Evaluation**: Moderate and conscious sedation excepted, within 48 hours after surgery or a procedure requiring anesthesia services, a post-anesthesia evaluation must be completed and documented by a licensed individual who is qualified to administer anesthesia under State law and Hospital policy. The evaluation is required any time general, regional or monitored anesthesia has been administered to the patient. At a minimum, the post-anesthesia evaluation shall include monitoring/assessment of: respiratory function (including respiratory rate, airway patency and oxygen saturation); cardiovascular function (including pulse rate and blood pressure); mental status; temperature; pain; nausea and vomiting; and postoperative hydration. Depending on the surgery/procedure, additional types of monitoring and assessment that reflect current standards of anesthesia care may be necessary.

i. **Discharge Summary:**

(i) To facilitate continuity of care, a discharge summary containing at a minimum the reasons for hospitalization**;** significant findings~~,~~**;** procedures performed and treatments rendered; the resolution of the admitting diagnosis and chief complaint; course of the facility stay; interventions

and results; consultations; complications and their management; difficulties in establishing the diagnosis and treatment plan; the patient's final diagnosis and condition at discharge**;** and instructions to the patient and/or appropriate legal surrogate(s) regarding follow-up care and pain management will be included in a completed medical record. For normal newborns, uncomplicated deliveries, or patients whose admitted hospital stay is less than forty-eight (48) hours with uncomplicated care, a discharge progress note, which includes the condition at discharge, discharge instructions, and follow up care, may be substituted for a discharge summary. For patients with outpatient surgery or procedures and observation stay patients a progress note is required. In the event of death, in addition to the discharge summary, there shall be a final progress note covering end of life decisions, if any, pronouncement of death, potential harvesting of organs/tissues, a determination of the death not meeting criteria to be considered a coroner's case, and the disposition of the body.

(ii) The discharge summary is to include the future care of the patient, including nutrition, medication, activity, referrals, pain management, and other appointments as appropriate**.**

(iii) The attending physician shall be primarily responsible for completion of the medical record including the discharge summary, which entries must all be authenticated, dated and timed. If the discharge summary is written by other than the responsible physician, the physician responsible for the patient must co-authenticate and date the discharge summary to verify its content**.**

j. **Completion of Records - Requirements:**

1. History and physical, discharge summary, consultation and operative/procedure notes, orders, requisitions for tests and diagnostic reports shall be authenticated with a handwritten or electronic signature. Rubber stamp signatures are not acceptable for authentication.

   (i) Charts must be complete within thirty (30) days of discharge. Charts are complete only after dictated reports are signed; merely dictating before the deadline is not sufficient.

   (ii) The elective and emergency admitting privileges of a person holding a current Professional Staff appointment shall be automatically suspended upon written notification sent by registered mail for failure to complete medical records within thirty (30) days of discharge; provided that the Vice President of Medical Affairs or Chief of Staff, or their designee may excuse them if their medical records remain incomplete beyond the thirty (30) day period because of extenuating circumstances. Extenuating circumstances shall include, but not be limited to, illness, system or electronic failure.

   Suspension of admitting privileges does not in any way affect physicians' responsibilities for patients already under their care in the hospital.

   Any physician whose admitting privileges have been suspended because of incomplete or delinquent records, or portions thereof, may in the event of unusual or extenuating circumstances obtain authority to admit a specific patient from The Vice President of

Medical Affairs or the Chief of Staff, or their designee. The physician so authorized to approve a specific admission shall personally notify the admissions office of his/her decision prior to the admission of the patient.

(iii) A physician who has received two (2) temporary suspension letters during any one calendar year and who again has become delinquent will receive a suspension of privileges letter sent by registered mail from the Chief of Staff or the Vice President of Medical Affairs. Privileges will automatically be suspended and the physician will have to present himself/herself before the Staff Executive Committee at its next regularly scheduled meeting. When a physician's privileges are suspended, he/she will be unable to admit patients to the hospital or schedule surgery until the Staff Executive Committee lifts the suspension. Suspension of admitting privileges under this subsection does not in any way affect physicians' responsibilities for patients already under their care in the hospital. On an emergency basis the Vice President of Medical Affairs may temporarily restore the suspended physician’s privileges.

k. **Ownership:** All records, including original medical images, are the property of the hospital. The medical record may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending physician, whether the patient is being attended by the same physician or another.

l. **Access to Records:** Upon approval of the Hospital President, access to all medical records of all patients shall be afforded to Staff physicians in good standing for bona fide study and research consistent with preserving of confidentiality of personal health information concerning individual patients. Upon approval of the Hospital President, former members of the Professional Staff may be permitted access to information from the medical records of their patients covering all periods in which they attended such patients in the hospital. Review of medical records is limited to hospital professionals who are at that time responsible for and providing that care, or as assigned to that patient such as a student. Also, for peer review function, physicians may review any chart assigned for review. Physicians on the Professional Staff who have the permission of the attending physician and patient or patient's legal representative may review that patient's medical record. Physicians not on the Professional Staff, in the presence of the attending physician or his/her physician designee, and with permission of patient or patient's legal representative, may review that patient's medical record.

6. Medical Consultation

a. General - The responsibility for patient care rests with the attending physician but medical consultation is recommended when there is a reasonable doubt as to the diagnosis and/or treatment. Medical consultation is required when the patient needs care which is beyond the attending physician's scope of Professional Staff approved privileges. Except in emergencies, consultations are required on critically ill patients, patients who are poor surgical risks and those having diagnoses that are difficult or obscure. The patient’s medical record shall include

the reason the medical consultation was sought and provide sufficient information as is readily available to facilitate the consultation**.**

b. Professional Staff members are expected to respond to requests for medical consultations in a timely fashion that meets patient care demands and the need for appropriate utilization of services. Professional Staff member requesting medical consultation will be responsible to provide appropriate clinical information and time to respond expectations on the order sheet. Guidelines for time-to-respond expectations are as follows:

(1) Emergency medical consultations: The least amount of time as required by accrediting standards or State law, but not more than 30-60 minutes (e.g., emergency request from surgery, post-anesthesia recovery unit, ICU, emergency department). For the purpose of this section, an "emergency" medical condition is a condition manifesting itself by acute symptoms of sufficient severity which one could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

(2) Urgent medical consultations: 4 hours (observation unit, ICU). For the purposes of this section, an “urgent” medical condition is a condition which requires medical services to be furnished within twelve (12) hours in order to avoid the likely onset of an emergency medical condition.

(3) Routine medical consultations: 24 hours (general medical-surgical floor)**.** Physician to physician contact is the preferred way of initiating these medical consultations.

c. Medical consultation with other members of the Active Staff, Active Affiliate Staff, Associate Active Staff, and the Consulting Staff shall be sought liberally and shall be required on behalf of all critically ill patients, all surgical cases in which the patient is less than a good risk, and for patients having a diagnosis that is difficult or obscure. In cases of financial hardship, consultation shall be furnished free of charge by the member of the Active Staff whenever such consultations are required solely to comply with rules, regulations, ordinances, or statutes.

d. Subsection b. notwithstanding, if circumstances are such as to render medical consultation undesirable or unnecessary, then medical consultation shall not be performed and the reasons thereof shall be entered in the progress notes of the clinical record.

e. Hospital patients with substance abuse medical problems requiring medical consultation may be referred to a Professional Staff member with substance abuse privileges or referred to an external community based substance abuse service.

f. If the attending physician and the consultant disagree on the management of a patient, then a second medical consultation shall be ordered**.**

g. Categories of consultant's involvement:

(1) Consultation only which leaves management to the attending physician and prohibits consultants from writing orders on the chart.

(2) Consultation and management of a specific entity or procedure in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending physician.

(3) Participation in management which permits the attending physician and the named physician to write orders, however, overall chart responsibility remains with the attending physician.

(4) Management is transferred to another named physician in which case patient care responsibilities in the hospital are transferred to the named physician and the admitting physician may no longer write orders.

h. Specifics:

(1) Sterilization for Patients of Majority Age (18)

May be performed at the request of the patient with a signed consent. When possible, the signed consent of the spouse is desirable but not required. No medical consultation is required.

(2) For Mentally Incompetent Patients and/or Minors

For mentally incompetent patients and/or minors, a sterilization procedure shall be performed only upon court order.

(3) Therapeutic Abortions

(a) Medical consultation shall be required for performing therapeutic abortions in any manner, whether induction of labor or entering the uterus in part or full as the method used. Such medical consultation shall consist of the committee whose chair shall be the Chair of the Department of Obstetrics, whose members shall consist of the Chair of Surgery and the Chair of the Department of Medicine. A medical consultation record shall be completed by the consultants who will indicate acceptable or unacceptable conditions for the procedure and these records shall be signed by the consultants and the attending physician. If the case is under

the care of any member of the various department heads, alternate medical consultation by another qualified member of that department shall be called by the Vice President of Medical Affairs to substitute on the medical consultation committee for that particular case. A unanimous vote of the consultants is required.

(i) A written medical consultation signed by the Chair of the Tumor Board of the hospital shall be considered adequate medical consultation where therapeutic abortion is to be done in conjunction with the treatment of carcinoma.

(b) When a patient is admitted in a condition of abortion she or her legal representative shall sign a statement certifying that neither any employee of the hospital or the attending physician was directly or indirectly responsible for its production. Cases of suspected criminal abortion shall be reported to the Vice President of Medical Affairs and the coroner**.**

(4) Reporting Suspected Abuse/Neglect

The Medical Staff shall comply with legal requirements to identify and report to the appropriate State agency and/or authority any suspected abuse or neglect in pediatric, elderly, adult (spousal/domestic violence), and vulnerable adult patients.

7. Discharge

Patients shall be discharged only on order of the attending physician or designated alternate.

8. Rape Examinations

Rape examinations will be performed by the emergency physician (unless the private physician prefers to do the exam on his/her patient). If there are complications which require more care, i.e., surgery, hospitalization, then the patient's attending physician, primary care preferred consulting physician, or the OB-GYN physician on-call will be responsible for that care.

9. Basic Rules for the Use of Hospital Facilities

a. A physician to be in charge of an area (director) shall be recommended by the Hospital President in consultation with the Chief of Staff, and report to the appropriate vice president.

b. The director (with committee approval and in conjunction with hospital administration) shall establish the necessary rules for scheduling and use of the facility.

c. Each physician requesting privileges or any current physician who may desire to perform these procedures shall demonstrate to the director his/her knowledge of the use of the hospital equipment and his/her understanding of the use of the facility. In the event that the director is not satisfied with applicant's knowledge and skills, he/she shall report these findings to the Chief of Staff and defer the use of the facility.

d. All privileges will be given on the understanding that failure to abide by the basic rules for the scheduling and use of the room or complications beyond those normally expected shall be cause for the loss of privileges. The physician director shall call these matters to the attention of the Chief of Staff who shall take such action as he/she feels necessary, including immediate suspension, if appropriate. The Staff Executive Committee will consider the action of the Chief of Staff at its next meeting and make recommendations in the established routine.

10. Autopsy

a. The attending physician should attempt to obtain permission for an autopsy in hospitalized cases where it is felt to be medically indicated or to satisfy family concerns, and in all cases of unusual deaths and of medical/legal and educational interest. Examples of deaths with medical/legal implication may include the following:

(1) dead on arrival to the emergency room or dying in the emergency room, without previous diagnosis or before definitive diagnosis could be made;

(2) trauma – internal;

(3) any case where there is medical/legal necessity;

(4) maternal deaths;

(5) cause of death not related to treatment;

(6) occult hemorrhage;

(7) pneumonia – no microbiological diagnosis;

(8) systemic infection – no microbiologic diagnosis;

(9) sudden infant death;

(10) pediatric deaths; and

(11) perinatal deaths.

Autopsies may be contracted to another hospital at the discretion of the Department of Pathology after consultation with the Vice President, Medical Affairs.

Certain cases fall under the jurisdiction of the coroner including: 1) deaths within twenty-four (24) hours of anesthesia, 2) deaths within twenty-four (24) hours of admission to the hospital, and 3) deaths under unusual circumstances (Also see Section 12 herein regarding Pronouncement of Death). If there is any question

whether or not the case falls within the coroner's jurisdiction, the coroner's office should be contacted for an opinion.

b. No autopsy will be performed without proper written authorization signed by the proper next of kin. Autopsies performed by the coroner do not require any type of authorization, written or otherwise. Documentation of the request for autopsy and response should be documented in the progress notes**.**

c. The Department of Pathology reserves the right to determine which infectious or presumptively infectious cases will have autopsies performed.

d. All outpatient autopsies will be performed at the discretion of the Department of Pathology. Consultation with the Department of Pathology is required on a case-by-case basis.

e. Most autopsies will be of the focused type. The area of focus will be determined by consultation with the referring and attending physician on the case. A focused autopsy means an autopsy restricted to the organ(s) or system(s) of most concern to the physicians involved in the patient's case, and will vary from case to case based upon the circumstances surrounding the case. The attending physician shall be notified by the Department of Pathology of when an autopsy is being performed.

f. When an autopsy is performed, the preliminary impression of the cause of death should be recorded in the medical record within three (3) days, with the final report to be completed and included in the medical record within sixty (60) days, except for valid delays due to forensic considerations. In the event the final diagnosis is not in accord with the final autopsy report, disagreement or correction of the final diagnosis shall be added to the progress report.

11. Guidelines for Determining Brain Death in Adults

a. Definition of Death

(1) Cardiorespiratory: Irreversible cessation of cardiac, circulatory, and respiratory function in the absence of artificial means of cardiopulmonary support.

(2) Brain Death: Irreversible cessation of all functions of the entire brain (cerebral hemispheres and brain stem) in the presence of artificial means of cardiopulmonary support.

b. Determination of whole brain death in patient with ventilator support and continuing cardiac function: 3 cardinal findings (must be present):

(1) Absence of cortical function

Deep coma and unresponsiveness: no motor response to the most intensely painful stimuli in all extremities (nailbed and supraorbital pressure). Peripheral nervous system activity and spinal cord reflexes may persist after death.

(2) Absence of brainstem reflexes

(a) Pupils

(i) No response to bright light

(ii) Size: midposition (4 mm) to dilated (9 mm)

(b) Ocular movement

(i) No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)

(ii) No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side)

(c) Facial sensation and facial motor response

(i) No corneal reflex to touch with a throat swab

(ii) No jaw reflex

(iii) No grimacing to deep pressure on nailbed, supraorbital ridge, or temporo-mandibular joint

(d) Pharyngeal and tracheal reflexes

(i) No response after stimulation of the posterior pharynx with tongue blade

(ii) No cough response to bronchial suctioning

(3) Apnea - testing performed as follows:

(a) Prerequisites

(i) Core temperature $\geq$36.5° C or 97° F

(ii) Systolic blood pressure $\geq$90 mm Hg

(iii) Euvolemia. Option: positive fluid balance in the previous 6 hours

(iv) Normal PCO_2 Option: arterial PCO_2 $\geq$40 mm Hg (check just before ventilator stopped)

(v) Normal PO_2 Option: preoxygenation to obtain arterial PO_2 $\geq$200 mm Hg

(b) Connect a pulse oximeter and disconnect the ventilator.

(c) Deliver 100% O_2, 6 1/min via E.T., into the trachea. Option: place a cannula at the level of the carina.

(d) Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).

(e) Measure arterial PO_2, PCO_2, and pH after approximately 8 minutes and reconnect the ventilator.

(f) If respiratory movements are absent and arterial PCO_2 is $\geq$60 mm Hg (option: 20 mm Hg increase in PCO_2 over a baseline normal PCO_2), the apnea test result is positive (i.e., it supports the diagnosis of brain death).

(g) If respiratory movements are observed, the apnea test results is negative (i.e., it does not support the clinical diagnosis of brain death) and the test should be repeated.

(h) Connect the ventilator if, during testing, the systolic blood pressure become $\geq$90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If PCO_2 is $\geq$60 mm Hg or PCO_2 increase is $\geq$20 mm Hg over baseline normal PCO_2, the apnea test result is positive (it supports the clinical diagnosis of brain death); if PCO_2 is <60 mm Hg or PCO_2 increase is $\leq$20 mm Hg over baseline normal PCO_2, the result is indeterminate, and an additional confirmatory test can be considered.

c. Irreversibility Determination

(1) Cause of coma is established clinically or by neuro-imaging and is sufficient to account for the irreversible loss of brain function.

(2) The possibility of recovery is excluded:

(a) No drug toxicity: no sedative, no anesthetic, or no neuromuscular blocking agents; no poisoning.

(b) No hypothermia below 32.2° C (90°)

(c) No shock

(d) No severe electrolyte, acid-base or endocrine disturbances.

(3) Persistent cessation of all brain function for a period of at least 12 hours.

d. Confirmatory laboratory tests which may be used:

(1) Repeat clinical examination in 6 hours.

(2) EEG: One EEG recording showing electrocerebral silence done in accordance with the standards of the American EEG Society Guidelines at least 12 hours after persistence of the clinical criteria outlined above.

(3) Conventional 4 vessel angiography: no intracerebral filling at carotid bifurcation or circle of Willis (external carotid circulation is patent).

(4) Somatosensory evoked potentials of median nerve: absent N20-P23.

(5) Brain stem auditory evoked potentials: absent except for wave I.

(6) Isotope angiography with Tc-99m HMPAO: no brain uptake.

(7) Transcranial doppler ultrasonography: very high vascular resistance associated with increased intracranial pressure, produces early small systolic peaks without diastolic flow or reverberating flow.

e. Medical record documentation:

(1) Etiology and irreversibility of condition

(2) Absence of brain stem reflexes

(3) Absence of motor responses to pain

(4) Absence of respiration with apnea test

(5) Confirmatory test justification and results

(6) Repeat neurologic exam 6 hours after first diagnosis of brain death.

12. Pronouncement of Death

Only licensed physicians may pronounce a patient dead. Temporary certificate holders, as some of the residents on-call sometimes are, are not duly licensed physicians. The physician need not personally examine the body. A resident, nurse, or other competent observer may report findings on the telephone and the physician make the death pronouncement. The physician pronouncing the patient is responsible for completing the Death/Autopsy form on all deaths. The death certificate must be signed by the attending, fully-licensed physician or coroner. The following deaths require reporting to the coroner: accidental deaths - falls, blunt force, cuttings/stabbings, explosions, firearms, asphyxiation, vehicular accidents, weather-related deaths, drug overdose, burns, electrocutions, stillborn or newborn infant death with a recent or past trauma; homicides; suicides; sudden deaths; occupational deaths; confinement deaths (jail or custody); therapeutic deaths: anesthesia induction or post-anesthesia; during or following diagnostic or therapeutic procedures, due to administration of drug, vaccine or other substance; deaths involving allegations of "medical malpractice"; abortion-related death; delayed death (past traffic or industrial accidents with debilitating injuries, etc.)**;** death about which there is doubt/question suspicion; any unattended death at home or in a public or outdoor place.

13. Access to Personal File

Members of the Professional Staff may inspect and obtain a copy of their own personal file maintained by the hospital in the presence of a Professional Staff officer, the Vice President of Medical Affairs, the Professional Staff coordinator, or the administrative assistant to the Vice President of Medical Affairs.

14. Conduct

Unprofessional and unethical conduct and the violation of these Rules and Regulations, or those of the hospital shall constitute cause for summary suspension of privileges in this hospital.

15. Disruptive Physician Three-Step Policy

Disruptive Physician Three-Step Policy.

1. On the first alleged offense regarding a physician's disruptive behavior as outlined in the hospital bylaws, the Vice President of Medical Affairs and Chief of Staff will be informed of the allegations. A conference will occur between the Vice President of Medical Affairs and the Chief of Staff at which time a decision will be made as to whether a) the case warrants investigation or b) the case should be dismissed. Should both the Vice President of Medical Affairs and the Chief of Staff agree the allegation merits investigation, the Vice President of Medical Affairs shall obtain from the parties directly involved a written synopsis of the disruptive behavior to substantiate the claim outlining when, where, and under what circumstances this event occurred. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the physician involved will be requested to attend a meeting held by the Vice President of Medical Affairs, Chief of Staff, and Department Chairman at which point these allegations will be

brought to the physician's attention. Upon conclusion of this meeting the Vice President of Medical Affairs, Chief of Staff, Department Chairman and the physician involved will decide if a 28-day observation period to include a follow-up meeting with the Vice President of Medical Affairs and Chief of Staff to monitor and discuss the physician's behavior, and a formal letter outlining the offense should be placed in their administrative file. The matter can then be considered resolved upon satisfactory completion of the observation period. If the physician involved feels this resolution to be unsatisfactory, this individual can request a hearing at the next Medical Executive Committee meeting and present the case where the Medical Executive Committee will be the final determining body. Should the Medical Executive Committee at that point feel that the problem warrants a 28-day observation period and a formal letter placed in their file, this will be undertaken. If they feel it is undeserving, no action will be taken and the matter will be considered resolved.

2. Should a second disruptive offense occur by the same physician during a three-year period, the Vice President of Medical Affairs and Chief of Staff will be informed of the allegations. A written synopsis shall again be obtained from the parties directly involved with the disruptive behavior. Only unsolicited information from the primary source of the complaint or those directly observing the incident will be accepted. Upon receipt of this information, the physician involved will be requested to attend a meeting held by the Vice President of Medical Affairs, Chief of Staff, and Department Chairman at which point these allegations will be brought to the physician's attention. Upon conclusion of this meeting the Vice President of Medical Affairs, Chief of Staff, Department Chairman and the physician involved will decide if a 28-day observation period to

include a follow-up meeting with the Vice President of Medical Affairs and Chief of Staff to monitor and discuss the physician's behavior, and a second formal letter outlining the offense should be placed in their administrative file. If the physician involved feels this resolution to be unsatisfactory, this individual can request a hearing at the next Medical Executive Committee meeting and present the case where the Medical Executive Committee will be the final determining body. Should the Medical Executive Committee at that point feel that the problem warrants a 28-day observation period and a second formal letter placed in their file, this will be undertaken. If they feel it is undeserving, no action will be taken and the matter will be considered resolved.

3. Should a third disruptive offense by the same physician during a three-year period be brought to the attention of the Vice President of Medical Affairs and/or the Chief of Staff, the physician involved will be asked to report directly to the next Medical Executive Committee meeting for a presentation of the facts from the written synopsis of all three events with the physician involved relating his/her account of the events. A decision will then be made by the Medical Executive Committee as to whether a) any action is warranted, or b) if the action warranted should be educational in nature, involve counseling or suspension of privileges. If the physician involved successfully completes the program as outlined by the Medical Executive Committee per the Chairman, the matter will be considered resolved. If they do not complete this to the satisfaction of the Medical Executive Committee per the Chairman, a continuation of education, counseling and/or suspension can proceed. Lastly, it should be noted that at the end of three years, if there has been no action or complaints regarding the physician, their administrative file is to be purged.

16. Medical Staff Disaster Assignments

In the event of a disaster, physicians should report to the command post at the hospital. The physician in charge, according to the hospital's disaster plan, will make appropriate assignments. In case of a major disaster involving multiple hospitals, the physician should report, as assigned, to the command post of a hospital at which he/she has privileges.

17. Professional Liability Action

Each individual with clinical privileges at the hospital will notify medical staff services within thirty (30) days of a final settlement or judgment of a professional liability action. It is recommended that individuals with clinical privileges notify the risk management office of the hospital if they are aware that a professional liability action involving the hospital has been filed or is likely to be filed.

18. Residents, Interns and Medical Students

Residents, interns and medical students will be supervised for all clinical activities by a physician with privileges at the hospital, according to hospital policies (including the Hospital's Housestaff Policy Manual) and applicable state law.

19. Sources of Patient Care Provided Outside the Hospital

Staff Executive Committee will approve sources of patient care provided outside the hospital either through referral, consultation, or contractual arrangements. A written agreement defining the nature and scope of patient care will include providing care in a timely fashion and consistent performance of patient care processes according to appropriate accreditation standards.

20. Use of Investigational/Experimental Drugs or Devices

Physician must obtain Institutional Review Board ("IRB") approval prior to using any investigational/experimental drugs or devices for research studies or emergency use.

Investigational/experimental drugs or devices are defined as any non-FDA approved drug/device or a drug/device used in a research study. IRB approval is for protection of patient's rights and does not imply credentials beyond those approved by the medical staff. Investigational procedures may need to be processed through the usual credentialing process. The granting of Professional Staff privileges for new procedures that are necessary to use these investigational/experimental devices will follow the process set forth in Article II, Part C, Subsection (E) of the Professional Staff Bylaws.

Research Studies: To obtain approval of investigational/experimental drugs or devices for use in an ongoing research study, submit a protocol and consent form in the normal method to the IRB Office for approval at the next scheduled IRB meeting. Investigational procedures may need to be processed through the usual credentialing process as well.

Emergency Use: Emergency use is defined as the use of an investigational/experimental drug or device on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval for its use. A written request, usually in letter form, that includes the risks, benefits, and consent, signed by the requesting physician, stating the life-threatening situation or one-time need and, the absence of standard acceptable treatment, is submitted to the IRB Office. The IRB Chair or designee will review the request and approve or disapprove its use. In accordance with FDA Regulation 21 CFR 50.23 and CFR 56.104, the protocol and consent form are reviewed and approved by the IRB Committee within five (5) working days of initial approval. The standard guidelines for obtaining informed consent apply.

Patients currently on research protocols from the hospital or other institutions who are admitted, must follow Pharmacy Department Policy covering investigational drug procedures.

When the IRB receives a request from a physician for an emergency use of an investigational/experimental drug or device, the IRB must examine each case to assure itself and the institution that the emergency use was justified.

21. Cancer Staging

All newly diagnosed cancers will be staged by the managing physician (defined as the treating physician, usually the surgeon, medical oncologist, or radiation oncologist) using the American Joint Commission on Cancer-TMN staging format. The staging format will be entered on a form adopted by the Tumor Board Committee and the completion of the staging will be required to complete the medical record on the patient. Cases that cannot be staged will be so indicated on the staging form with a reason why it cannot be staged. In addition, each case of cancer shall be reported to the Ohio Department of Health on a form provided by the department or on computer tape or diskette.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on November 23, 1999

Revisions adopted by the Medical Executive Committee on October 19, 2010

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Chief of Staff

Originally approved by the Board of Trustees on December 8, 1999, after receipt of a recommendation by the Medical Executive Committee. Revisions approved by the Board of Trustees on November 9, 2010, after receipt of a recommendation by the Medical Executive Committee.

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Hospital President

Revised November 2010

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