COMMUNITY HOWARD REGIONAL HEALTH

RULES AND REGULATIONS OF THE MEDICAL AND ALLIED HEALTH PROFESSIONAL STAFF

Last approved by the Medical Executive Committee of Community Howard Regional Health on August 17, 2021, and Board of Directors of Community Howard Regional Health on August 26, 2021

COMMUNITY HOWARD REGIONAL HEALTH
GENERAL STAFF
RULES AND REGULATIONS

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RULES AND REGULATIONS OF
THE MEDICAL STAFF AND PROFESSIONAL STAFF OF COMMUNITY HOWARD REGIONAL HEALTH

A. Emergency Medical Screening Exams

1. Any individual who comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, then that individual must receive a medical screening examination performed by qualified medical personnel.

2. The following healthcare providers, besides all physician Members, are deemed "qualified medical personnel" by the Hospital to perform the medical screening exam:

   - emergency service physicians
   - primary care physicians
   - on-call specialist physicians
   - nurse practitioners
   - physician assistants
   - obstetric nurses
   - behavior health professionals
   - emergency services registered nurse
   - paramedics
   - emergency medical technicians

3. An appropriate medical screening examination will be within the capability of the hospital, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

4. If the qualified medical personnel concludes that a woman experiencing contractions may be in false labor, then a physician must confirm this diagnosis and complete the appropriate certification of such after a reasonable time of observation.

5. If the emergency service physician or other qualified medical personnel determine that the individual has an emergency medical condition, the hospital must provide for either (a) within the staff and facilities available at the hospital, such further medical examination and such treatment as may be required to stabilize the medical condition, or (b) for transfer of the individual to another medical facility in accordance with the Hospital's policy.

6. Off-campus departments will screen and provide stabilizing treatment to the best of their ability, and arrange for an appropriate transfer of individuals with a potential emergency medical condition.

B. Admissions

1. The Hospital will accept any patient needing care or treatment but shall not continue service for patients requiring only custodial care. Patients requiring facility, services or medical care not available at Community Howard Regional Health will be transferred to a facility where more appropriate care can be provided.

2. Patients with a contagious disease or with a provisional diagnosis of such disease shall be admitted for care only when appropriate isolation facilities are available.

3. Dentist and podiatric Members may co-admit with a physician Member of the Medical Staff, who shall assume those responsibilities as outlined below. Prior to the performance of dental or podiatric procedure, the Member is responsible for arranging for a physician Member of the Medical Staff to perform the initial history and physical examination and assessment of the patient's medical condition at the time of admission. If, in the medical judgment of this physician, medical conditions exist which preclude the administration of the proposed anesthesia or the proposed procedure, treatment will be suspended and the matter referred to the Chief of the Surgery Department. The chief of the Surgery Department may cancel the procedure, require additional consultation in making a decision, or request that the procedure be rescheduled at a later date after the medical condition has been controlled or corrected. These decisions are to be made solely on the basis of detrimental effect that the proposed procedure might have on the patient's overall medical status. If the above action is taken, this is in no way construed to mean that the proposed procedure in itself was inappropriate or unnecessary. The physician shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during the hospitalization, which are outside of the dental or podiatric Member's privileges and/or scope of licensed practice. The physician Member is not responsible for any dental or podiatric procedure.

4. Members requesting the admission of a patient must provide a provisional diagnosis for that patient. In case of an emergency, the provisional diagnosis shall be stated no later than twenty-four (24) hours following admission. This information is required to protect the patient, other patients, visitors, and hospital personnel.

5. The admitting physician/oral surgeon is responsible for obtaining approval from Medicare and/or third party payers for all diagnoses requiring pre-admission certification and forwarding such information to the Hospital.

6. Admissions through the emergency department. If the individual is determined to have an emergency medical condition needing further exam or treatment and the individual does not have a personal physician, the on call physician in the appropriate department will be called. The responsibility for any individual who presents through the emergency department and is assessed by the qualified medical personnel is passed to the admitting physician (or his designated covering physician) when the admitting physician (or his designated covering physician) has been informed of the patient and his physical status; and the patient has left the

Emergency Department. If the responsibility is to be transferred prior to this, it should be done by mutual consent of the emergency physician (or qualified medical personnel) and the admitting physician (or his designee).

7. It is the responsibility of the physician contacted for admitting orders to designate to the Hospital who shall be identified as admitting physician in the patient's hospital record.

C. **Transfers**

1. Emergency department transfers. Transfers of any individual with an emergency medical condition to another healthcare facility shall be done in accordance with the Hospital's policies.

   a. If a unstabilized individual (or a legally-responsible person acting on the individual's behalf) requests a transfer after being informed of the Hospital's obligation under the Emergency Medical and Active Labor Act and of the risks of transfer, then the transfer to the other medical facility will be made pursuant to the Hospital's policies. The request must be made in writing, indicate the individual's reason for the request and that individual is aware of the risks and benefits of transfer, and be signed by the individual (or a legally-responsible person acting on the individual's behalf). This documentation shall become a part of the hospital's record and a copy is to accompany the transferred individual to the accepting facility.

   b. If the transfer is made based on the decision of a physician, that physician (and qualified medical personnel if applicable) must sign a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of the appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the women or unborn child from being transferred. This documentation shall become a part of the hospital's record and a copy is to accompany the transferred individual to the accepting facility.

2. Internal transfer of inpatients. The priorities shall be as follows:

   a. from the Emergency Department to appropriate patient bed;

   b. from obstetrical unit to general care unit when medically indicated;

   c. from intensive care unit to general care unit.

3. No patient will be transferred without notification of the attending physician.

D. **Physician Responsibility to Patient for Coverage**

1. A physician Member of the Medical Staff shall be responsible for the medical care and treatment of his patient in the Hospital. Whenever these responsibilities are transferred to another Staff Member, the hand off between physicians should consist of the attending physician communicating the patient status and condition with the covering physician and allowing an opportunity for the covering physician to ask questions regarding the patient's condition and problem. A note concerning the transfer of responsibility shall be entered on the order sheet of the medical record. From time to time, a covering physician may provide temporary coverage for a physician without officially transferring the case. The covering physician shall have privileges and credentials appropriate for the diagnosis and medical condition of the patient.

2. If a physician cannot fulfill his patient obligation, the physician needs to make arrangements with his covering physician and must notify nursing staff of the arrangements. Failure to provide for appropriate care as delineated elsewhere in the Medical Staff Bylaws, Rules and Regulations, and Policies shall be reported to the appropriate Department for consideration of disciplinary action.

3. Given the nature of cardiac conditions, all cardiologists must arrange with another cardiologist on the Medical Staff to provide coverage for cardiac conditions and consults when the Member is unavailable. Otherwise the covering physician shall have privileges and credentials appropriate for the diagnosis and medical condition. Failure to provide for appropriate coverage and care as delineated elsewhere in the Medical Staff Bylaws, Rules and Regulations, and Policies shall be reported to the appropriate Department for consideration of disciplinary action.

E. **Consultations**

1. Consultation should be requested when care needed is beyond the expertise or outside the scope of clinical privileges of the attending physician. Consultation is appropriate in major surgical cases in which the patient is not a good risk, in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized. Judgment as to the serious nature of the illness and question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient. Except in an emergency, consultation is required if requested by the patient or family. A psychiatric consultation is required for those patients who have attempted suicide or have taken an overdose of medications.

2. With the exception of psychiatric consults, which may be performed by a psychiatric nurse practitioner when a psychiatrist is not available, the consultant must be a physician who is appropriately-qualified to give an opinion in the field in which his/her opinion is sought. Consultation by physicians associated in the same office should be avoided insofar as possible. In cases in which consultation is required by these Rules and Policies of the Hospital, these services may be given without charge. In circumstances of grave urgency, or where consultation is required by Rules or other Hospital Rule, the Hospital President shall have the right

to call in a consultant or consultants after conference with the Chief of Staff, Vice Chief of Staff or the appropriate Department Chief.

3. A physician ordering a referral for any inpatient should also communicate directly with the consulting physician or psychiatric nurse practitioner in person or by telephone. In return, the consulting physician or psychiatric nurse practitioner should personally or by telephone relay findings and recommendations, if any, to the ordering physician.

4. If the consult request is accepted, the consultant's physical examination will occur within twenty-four (24) hours and the findings and recommendations communicated to the ordering/requesting physician should be performed within a reasonable period of time as warranted by the patient's condition unless specifically requested earlier, but no later than twenty-four (24) hours unless the ordering physician and accepting physician or psychiatric nurse practitioner mutually agree on a later time. The ordering physician will document this agreement.

5. A satisfactory consultation includes personal examination of the patient, unless privileged to provide telemedicine services, with a written record and opinion signed by the consultant which is made a permanent part of the record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

6. The Department Chiefs and Medical Executive Committee are responsible to oversee that Members or psychiatric nurse practitioners do not fail in the matter of calling for consultants as needed. Failure to obtain appropriate consults may result in disciplinary action.

F. **Physician's Orders**

1. All orders for treatment shall be entered into the patient record pursuant to hospital policy. Only those abbreviations and symbols approved by the Medical Audit and Review Committee and published as part of the Hospital's approved-abbreviation list may be used when documenting in the medical record. No orders shall be entered using any abbreviations deemed dangerous and unacceptable by the Hospital. Members, residents, and any practitioner privileged failing to follow this rule will be subject to disciplinary action.

2. Except for circumstances [in which the electronic medical record is unavailable] set forth below or that may arise from time to time, all orders must be entered through the Computerized Physician Order Entry (CPOE).

3. All orders must be entered clearly and completely. Orders which are improperly entered will not be carried out until clarified and re-entered.

4. Nursing administration may determine which licensed nurses may accept or implement verbal or written physician entered orders. The designated list, their qualifications, and criteria must be presented to and approved by the Medical Staff

Executive Committee. The entered orders shall be done in accordance with Hospital policy and shall include the name and title of each person involved. They may also give phone or verbal orders to other licensed, registered, or certified health professionals such as registered physical therapists, certified respiratory therapists, etc. so long as such orders are limited to the Department from which the service is requested (e.g. a physical therapist may accept only orders related to physical therapy) as set forth in the Hospital.

5. Offices may convey orders electronically or by faxing orders with date, time, and signature of Medical Staff Member or Allied Health Professional.

6. The entry of such orders shall be done in accordance with Hospital policy and shall include the name and title of each person involved. The individual accepting the order shall be responsible for entering in the medical record and the responsible Member or Allied Health Professional shall countersign such orders within forty-eight (48) hours.

7. All previous medication orders are suspended when the patient is taken to surgery. The Medication Reconciliation Form will be utilized when entering post-operative orders.

8. Members and Allied Health Professionals shall issue orders for seclusion and restraints pursuant to the Restraint and Seclusion Policy.

9. Residents may enter orders so long as the orders are co-signed by a physician or practitioner who is privileged.

G. **Order Sets**

1. Product line committees consisting of physician members from the medical staffs of the various Affiliated Hospitals of Community Health Network will establish electronic order sets for medications and procedures for the Affiliated Hospitals of the Network with nursing and pharmacy leadership. These product line committees will strive to ensure that such orders are consistent with nationally recognized and evidence-based guidelines and receive input from the Hospital's Medical Staff. These committees will conduct periodic and regular review of such orders and protocols and determine the continuing usefulness and safety of the orders and protocols with input from the Hospital's Medical Staff.

2. Order Sets will be initiated by the Hospital personnel only upon the specific order of the Member. Order Sets when applicable to a given patient shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the Member.

3. The Medical Audit and Review Committee will ensure that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient.

4. Any request for additions to electronic order sets must be submitted to the product line committees for approval.

5. Protocols will be approved and periodically reviewed by the appropriate medical staff committee of the hospital.

H. **Medical Records**

1. A medical record shall be completed for each patient in a manner which is consistent with state and federal laws and accreditation guidelines, and which provides adequate documentation for the protection of the patient, physician, and Hospital. If the patient is receiving hospice services, then the medical record may contain only those elements necessary under state and federal laws.

2. The attending physician/oral surgeon or podiatric surgeon shall have the responsibility for the preparation of the medical record for each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special records such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathologic findings; progress notes; final diagnosis; condition at the time of discharge; discharge summary or discharge notes, and an autopsy report when performed.

3. All entries entered by Documentation Assistant/approved scribe must be signed, timed and dated by the Documentation Assistant/approved scribe and the Members/Eligible Independent Practitioner must authenticate the entry by signing, timing and dating it. The Documentation Assistant/approved scribe may not enter the date and time for the Member/Eligible Independent Practitioner. The authentication must take place before the Member/Eligible Independent Practitioner and Documentation Assistant/approved scribe leave the patient care area.

4. History & Physicals:

   a. Admission. A complete history and physical examination shall be recorded within twenty-four (24) hours after admission. This history and physical report shall include all pertinent findings resulting from an assessment of all body systems. A prior history and physical examination performed within thirty (30) days of the admission may serve as the history and physical examination if transmitted to the hospital so long as, the physician updates any components of the patient's current medical status that may have changed or updates it with more current data. When a prior history and physical is used, the physician will enter an update note addressing the patient's current status and/or changes in patient's status regardless of whether there were any changes in patient's status within 24 hours of the admission. If the physician determines there have been no changes when updating history and physical, include statement such as "patient examined,

chart reviewed, and no changes." This rule does not apply to a hospice patient.

b. Surgery. A history and physical examination must be documented in the record before the commencement of any surgical procedure unless the surgeon documents in the medical record that such delay would be detrimental to the patient. If a history and physical is not present before a surgical procedure either inpatient or outpatient, the procedure shall be canceled. For outpatient podiatric surgeries and procedures, the podiatric surgeon may perform the history and physical examination.

c. The attending physician shall countersign the history and physical examination and preoperative note when they have been recorded by an intern, extern, or resident.

d. The history and physical will include the patient chief complaint, chronology of the present illness; past history (it is not acceptable to enter "see old chart"); medications; allergies; social and family history; vital signs; patient general condition; and a review of body systems to include CNS, HEENT, pulmonary, cardiac, GI, GU, and musculoskeletal (if not applicable, needs to be noted in the history and physical).

5. The surgeon will enter a postoperative progress note immediately following any surgical procedure using the form prescribed by the Hospital. In addition to the progress note, a comprehensive operative report must be entered or dictated by the surgeon immediately following the surgery. This operative report should contain a description of the findings, the technical procedures used, the specimens removed, the estimated blood loss, the postoperative diagnosis, and the name of the primary surgeon and any assistant surgeon.

6. The anesthesia record for inpatients and outpatients shall include evidence with date and time of a preoperative anesthesia evaluation of the patient by the anesthesiologist performed within forty eight (48) hours prior to surgery, a post-anesthesia evaluation no later than forty eight (48) hours after surgery, and the physician's order for discharge of the patient from the recovery area.

7. Progress Notes shall be entered daily at the time of observation, sufficient to permit the continuity of care and transferability whenever possible. Each of the patient's clinical problems should be clearly identified in the Progress Notes and correlated with special orders as well as results of tests and treatment. This rule does not apply to a hospice patient.

8. Radiology reports shall be recorded within twenty-four (24) hours of completion of the examination.

9. The Hospital's pathologist shall prepare for the approval of the Executive Committee a list of specimens which need not be submitted to the laboratory, as well as a list of those specimens which ordinarily require only a gross description

and record. The pathologist shall make such examination as considered necessary, to arrive at a tissue diagnosis. The authenticated report shall be made a part of the patient's medical record.

10. The obstetrical record shall include the prenatal record. The prenatal record may be a legible copy of the attending physician's office record, sent or transmitted to the hospital before admission; but an interval admission note must be entered which includes pertinent additions to the history and subsequent changes in the physical findings. When a physician is assessing and/or evaluating a patient during labor, the physician will enter the assessment/evaluation as follows:

    a. The physician will initial the fetal monitor strip when viewing it to demonstrate the physician's presence to assess/evaluate the patient; and

    b. The physician will enter a progress note in the patient's chart describing the observations of the patient.

    c. The physician shall enter or dictate a delivery note for any caesarian section, forceps or vacuum delivery.

11. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. All treatment orders and certification of diagnoses and procedures require authentication by electronic signature. Electronic signature of dictated and transcribed documents is allowed in keeping with hospital policy.

12. Final diagnoses shall be recorded in full without the use of symbols or abbreviations, dated, timed, and signed by the responsible physician or co-admitting health care provider at the time of discharge of the patient.

13. A discharge summary shall be entered (or dictated) in the medical record of all patients hospitalized as an inpatient except for vaginal obstetric deliveries and newborn infants; for these, a formal summation type progress note shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be signed by the responsible physicians.

14. Any access to the medical record by any privileged practitioner shall done in accordance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the policies and procedures of the Hospital. This means that access should only be for treatment purposes, including coordination of care. If issues arise as to the nature of the physician-patient relationship, CMS guidelines related to established patients will be considered in assessing record access.

15. When any inpatient or behavioral health patient requests to review his medical records, the attending physician shall be notified for approval prior to any access. The physician may enter an order that such release not be made to the patient if, in his/her opinion, release of the information to the patient would likely endanger the life or physical safety of the patient or another person. All such denials shall be

handled in accordance with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the policies and procedures of the Hospital.

16. In case of readmission, all previous records shall be available for use of the attending physician; this shall apply whether the patient shall be attended by the same physician or another physician. Copies of the previous record shall be made available to the attending physician upon request.

17. Unauthorized removal of any charts or medical record from the Hospital is grounds for suspension of the Member or Allied Health Professional for a period to be determined by the Medical Executive Committee of the Medical Staff.

18. Access to all medical records of all patients shall be afforded to Members of the Medical Staff for bona fide study and research, only if an authorization is obtained from the affected patients or the requirement for such an authorization is waived or modified by an Institutional Review Board or a Privacy Board in compliance with the Privacy Regulations (45 CFR Parts 160 and 164) pursuant to HIPAA including, but not limited to, 45 CFR § 164.512(i). Any such project must be approved by the Executive Committee of the Medical Staff before being undertaken. Former members of the Medical Staff shall be permitted access to information from the medical records concerning their patients, covering all periods in which they attended such patients in the hospital, but only in compliance with the HIPAA Privacy Regulations.

19. No medical record shall be permanently filed until it is completed by the responsible Member or Allied Health Professional or is ordered filed by the Medical Audit and Review Committee.

20. The Member or Allied Health Professional shall strive to have the patient's medical record complete at the time of discharge, including progress notes, final diagnosis and (dictated) clinical resume. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's record will be available for completion.

21. Incomplete medical records:

    a. In order to facilitate continuity of care, better quality review, and timely billing, physicians are required to record the patient’s discharge diagnosis at the time of discharge. Any information necessary to complete the coding process must be provided within seven (7) days of request or will be considered delinquent, and failure to complete will operate as an automatic suspension of the ability to exercise privileges during any new patient encounter which includes any new admission, consult, or order. However, the physician will be allowed to continue to exercise privileges to complete any inpatient care started or consults requested prior to the suspension.

    b. Completion of those components of the medical record required to be entered and finalized in a defined period of time as set forth in the Bylaws,

Rules and Regulations and Policies will be monitored. When warranted, members who have a pattern of not complying with those specific time frames will be referred to the Medical Executive Committee.

c. The entire medical record will be completed (entered and signed) within fourteen (14) days of the patient's discharge. The attending physician failing to complete the record within fourteen (14) days of the patient's discharge will be put on notice that he has a delinquent medical record that requires immediate completion and that failure to complete the delinquent record within three (3) days will operate as an automatic suspension of the ability to exercise privileges during any new patient encounter which includes any new admission, consult, or order. However, the physician will be allowed to continue to exercise privileges to complete any inpatient care started or consults requested prior to the suspension.

d. The suspension will be lifted once all delinquent records are complete. Such suspension does not give rise to fair hearing or appeal rights.

e. Physicians repeatedly suspended for delinquent medical records or on prolonged medical record suspension will be reported to the Medical Executive Committee by the Credentials Committee or the Medical Audit & Review Committee. The Medical Executive Committee shall recommend corrective action to the Board of Directors and the Board will take final action.

f. The Medical Executive Committee will establish a reasonable benchmark for medical record suspensions which each member will be expected to stay within. At reappointment, the applicant's medical record suspension history will be reviewed. Those members who received more medical record suspensions than acceptable during the current appointment term will need to submit a written plan of action to address the timely completion of medical record to the Credentials Committee. If the plan is approved by the Credentials Committee, the applicant will be eligible for a reappointment term of one (1) year. If during the time of that reappointment term, the member does not demonstrate improvement in medical record completion, the Medical Executive Committee will take corrective action, which may include a suspension of 31 days. Such a recommendation will give rise to hearing or appeal rights.

22. The timeframes set forth in these Rules and the Medical Staff Bylaws apply to those exercising locum tenens privileges. However, all entries must be completed and authenticated prior to the departure of the locum tenens practitioner after hospital-based shift work. Failure to do so may lead to the automatic suspension of the locum tenens privileges and preclude the practitioner from seeking privileges at the Hospital for a period of five years.

23. Addendum to the medical record may be entered pursuant to hospital policy.

I. **Drugs and Medications**

1. Drugs and medications administered to patients shall be Federal Drug Administration ("FDA") approved. The Pharmacy and Therapeutics Committee may review any order or proposed order of an FDA approved drug for a non-FDA approved purpose. Except in emergencies, use of drugs which have not been approved by the FDA is prohibited within the hospital without prior written consent of the hospital Pharmacy and Therapeutics Committee.

2. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the statement of principals involved in the use of investigative drugs in hospitals and all FDA regulations. Expedited approval for the use of an investigational drug for a single patient may be obtained from the physician chairman of the Pharmacy and Therapeutics Committee as specified in the policies of that committee.

3. The Hospital's formulary system, approved by the medical staff, shall govern the procuring, prescribing, dispensing and administering of drugs by either their generic or trade name.

4. The Hospital pharmacist shall be authorized to dispense and administer another brand of a generically equivalent product identical in dosage, form and content of active therapeutic ingredients and/or medication approved by the Pharmacy and Therapeutics Committee and placed on the formulary that is therapeutically as effective unless otherwise indicated.

J. **Critical Care Unit**

The Critical Care Committee will develop policies and procedures for the critical care unit. When questions of admission or discharge arise, the chairman of the Critical Care Committee will have final authority.

K. **Utilization Review**

1. The attending Member is required to document the justification of the need for continued hospitalization after specific periods of stay as requested by the Director of Case Management or the Medical Audit and Review Committee. This entry must include:

   a. an adequate documentation of medical necessity for continued hospitalization;

   b. the estimated period of time the patient will need to remain in the hospital; and

   c. plans for post hospital care.

2. Upon request of the Director of Case Management or the Medical Audit and Review Committee, the Member must provide written justification of the necessity for continued hospitalization, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

L. **Release of Information**

1. Written consent of the patient shall be obtained from the patient for release of medical information to insurance carriers or to persons otherwise not authorized to receive this information.

2. Medical records may be removed from the Hospital only in accordance with court order or subpoena.

M. **Medical Staff Disaster Assignments**

1. Members shall be assigned to posts either in the Hospital, in the auxiliary Hospital, or in mobile casualty stations, and it is their responsibility to report to their assigned duty areas. The Chiefs of the Medical and Surgical Departments in the Hospital and the Hospital President will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital premises, the Department Chiefs, in coordination with the Hospital President, will authorize and coordinate such movement.

2. All policies concerning patient care will be the joint responsibility of the Department Chiefs and the Hospital President. In their absence, the assistant Department Chiefs and the administrator designated to act in the absence of the Hospital President shall assume such responsibility. All Members specifically agree to relinquish direction of the professional care of their patients, service and private, to the Chief of the Medical and Surgical Department in case of such an emergency.

N. **Consents**

1. It is the sole responsibility of the Member, who admits or schedules a procedure, to communicate with the patient or the authorized consenting representative to obtain consent. This communication to and securing the consent of the patient is the sole obligation of the Member. The discussion should include the general nature of the patient's condition, the proposed treatment or procedure, the expected outcome, the material risks of the treatment or procedure, and the reasonable alternatives.

2. Members agree to provide copies of their office charts or other documents evidencing this communication when requested by the Hospital for internal purposes including state and federal surveys. Members may document in a progress note the extent of such discussion concerning the recommended procedure or

course of treatment and the patient's agreement wherever, in the judgment of the treating Member, such an entry is appropriate.

3. Except in emergency situations, when the patient arrives at the Hospital, the patient or authorized representative will be asked to complete and sign a general Verification of Consent form. If the patient has questions about the procedure or is in any way unsure of the nature of the procedure, the alternatives, or the risks, the attending/submitting Member will be immediately notified as it is the sole duty of the Member to answer the patient's questions concerning the physician's recommended treatment.

   Similarly, the attending/admitting Member will be immediately notified if there is any question of the patient's mental competency to complete and sign the Verification of Consent. The Member must obtain the patient's signature and document in the medical record the Member's judgment that the patient is competent to give consent.

4. Members may request that special verification of consent forms be used by the hospital for particular procedures. Such requests shall be reviewed and approved by the Medical Audit and Review Committee.

5. When a situation exists which requires immediate action to preserve the life of the patient or to prevent a possible impairment of the patient's health, and it is impossible to obtain the patient's consent the required procedure may be performed without consent. There must be sufficient documentation in the medical record for the necessity for proceeding with treatment without consent.

6. As a general principle, any competent adult may consent to or refuse any and all recommended medical treatment even when such refusal may result in death. Neither the Hospital nor any physician is empowered to impose medical treatment on a competent adult who refuses such treatment absent a court order to the contrary.

7. Consent for a minor patient (a person under the age of 18) must be obtained from a parent, court-appointed guardian, or Child Protective Services if a child is in CPS custody. In the case of divorced parents, authority to consent for the treatment of a minor generally lies with the parent having legal custody. When any other person presents a minor to the Hospital and requests treatment, the Member should contact the Hospital administration immediately to obtain legal advice but should bear in mind the general principle that emergency presumes consent as set forth above. Exceptions to the general rule that minors cannot consent are as follows:

   a. a minor, by law, may consent to diagnosis and treatment for venereal disease without any parent authorization;

   b. a minor may seek diagnosis and treatment for drug/alcohol abuse without authorization of parent or other adult;

c. a minor who is at least seventeen (17) years of age may consent to donate blood;

d. any married minor or minor who has been married;

e. a minor, who is the parent of a child, may consent for treatment of their child.

8. Some restrictions on the power of parents to consent on behalf of their minor children exist and include:

a. a parent may not refuse medical treatment which is advisable in the judgment of the treating Member and refusal of which could threaten the child's life or health;

b. a parent may refuse medical treatment for a child when the attending Member agrees the treatment may not be appropriate or advisable. Such a refusal of treatment may include orders not to resuscitate, the termination of life support systems, and orders that artificial hydration and nutrition be withdrawn;

c. a parent who wishes to discharge a child from the Hospital against medical advice may not be allowed to do so and must be advised that such conduct would be reported by the Hospital to CPS for investigation as possible child abuse.

9. The consent by a parent or court-appointed guardian of a minor may be obtained by telephone if documented and witnessed by two (2) persons to the conversation.

10. Living Wills and Advance Directives:

a. A competent adult may execute a document known as "living will" specifying conditions under which he/she requests his/her physician to terminate treatment, including termination of life support systems. Similarly, a competent adult may execute a document known as "life support measures declaration" which sets forth his/her request for life support measures to be continued as long as possible. Such documents are set out in the Indiana Living Will Statute, and any patient presenting such a document should be referred to the medical social services department to check on the form of document and to advise the attending physician of the procedures required for honoring such a document.

b. Any physician considering termination of life support systems for a terminally ill patient who has not executed a living will may consult the hospital administration for legal advice.

c. A physician must comply with Living Wills and other types of advance directives to the fullest extent possible, consistent with reasonable medical

practice. If unwilling to comply, the physician must notify the patient when the declaration is delivered or as soon thereafter as possible, and must document such notification in the patient's medical record. If the physician fails to notify the patient of unwillingness to comply and the patient later becomes incompetent, the physician must promptly take all reasonable steps to transfer care of the patient to a physician who is willing to comply.

11. Indiana law requires the Hospital and physicians to notify next of kin of potential organ donors of the availability of the organ donor programs. Any person who has signed an organ donor card (frequently found on the back of driver's licenses) has authorized donation of his/her body parts. Any physician who has a patient who may be a potential organ donor should contact the medical social services department to discuss his/her duties to discuss organ donor programs with the patient's family.

O. Do Not Resuscitate Orders

1. "Do Not Resuscitate" means in the event of an acute cardiac or respiratory arrest no cardiopulmonary resuscitative measures will be initiated.

2. A comprehensive evaluation of the patient's medical condition is necessary before consideration of the do not resuscitate ("DNR") order. The attending physician shall determine the appropriateness of the DNR order for an individual patient. The attending physician's DNR order need not be confirmed by a second physician or an ethics committee. However, if the attending physician has any substantial doubt about the order, then they are advised to obtain the opinion of another physician. DNR orders are compatible with maximal therapeutic care. The patient may be receiving vigorous medical support and yet, justifiably, be considered for the DNR order. When the patient is competent, the DNR decision will be reached consensually by the patient and the physician. When the patient is incompetent, this decision will be reached consensually by the appropriate family members (spouse, adult children, parents), and the physician. If a competent patient disagrees or in the case of an incompetent patient, the family members disagree, a DNR order will not be implemented.

3. Once the do-not-resuscitate decision has been made, a “Patient Wishes and Rights Statement with Physician Orders” section of the record will be completed. A progress note should be entered which includes the physician’s opinion of the patient’s competence, physician’s opinion that the patient meets the medical criteria for DNR order, and the nature of the discussion with the patient, family, or guardian. The DNR order may be rescinded at any time at the request of the patient or, if the patient is not able to make the decision, by the family responsible for health care decision-making. Such rescission shall be recorded in the physician’s orders and authenticated with signature, time, and date.

P. Abortions

Abortions may be performed at the Hospital on a patient's request, or upon a physician's recommendation; however, no physician shall be required to perform, nor shall a patient be forced to accept an abortion. Abortion is an operative procedure and shall be performed only by a physician who has clinical privileges for the care of obstetric/gynecologic patients or the operative procedures involved in an abortion.

Q. Continuing Education

All Members of the Medical Staff and Professional Staff shall participate in continuing education activities that relate to the privileges granted. Each Member shall document accrued continuing medical education activities biennially (each two years) in conjunction with reapplication and re-credentialing. Physician Members of the Medical Staff are required to accrue fifty (50) hours of Category I continuing medical education in the two preceding years. Maintenance of Certification (MOC) by the American Board of Medical Specialties or Osteopathic Continuous Certification (OCC) by the American Osteopathic Association will be considered equivalent to the CME Requirement for reappointment. Providers not participating in such certification programs must provide a total of fifty (50) hours of Category I Continuing Medical Education that relate to the area of practice during each reappointment cycle. Oral surgery Members are required to have continuing education units that satisfies their Indiana licensing requirements. Members of the Professional Staff are required to have continuing educational units that satisfy their respective licensing or certification requirements.

Failure to document compliance will result in limiting reappointment to one (1) year on probation. If the requirement (e.g. 50 hours accrued in the preceding two years for physicians) is not met by the end of the probationary year, the Medical Staff Member or Professional Staff will be considered to have resigned. This automatic termination will not give rise to hearing rights.

R. Notification Requirements

All Members of the Medical Staff and Professional Staff shall promptly notify the Medical Staff Services Office of the following:

(1) Any formal complaint filed, voluntary restrictions, or disciplinary action taken against a Member by the State Medical Licensing Board or Dental Board;

(2) Any disciplinary action proposed or taken by a hospital or other healthcare entity or organization (other than Community Howard Regional Health);

(3) Any filing of any lawsuit against a Member/Professional alleging medical malpractice or involving a patient;

(4) Any arrest, indictment, guilty or no contest plea, or judicial finding of guilt involving a felony or misdemeanor;

(5) Any "quality letter" from a Healthcare Excel or any other peer review organization. A copy of the "quality letter" shall within 24 hours of receipt by the Member/Professional be submitted with a letter of notification;

(6) Any clinical trials that the member intends to participate and the name of the institutional review board overseeing the process;

(7) Any action or proposed action taken by a federally-funded program including the suspension of payments; and

(8) Any voluntary surrender or restriction of the controlled substance registration of the Member/Professional.

The information shall be forwarded to the Chief of Staff for whatever action is deemed appropriate. This information shall only be used in the Hospital as part of the peer review, utilization review, and quality assurance process and shall not be released to third parties unless required by law or authorized by the Member/Professional. Failure to comply with this Rule and Regulation may result in corrective action.

S. **Regulatory Requirements**

As a condition for obtaining or continuing privileges, all Members and Allied Health Professionals agree to perform any and all services in conformance with all applicable state and federal laws and regulations and accreditation standards. Members or other privileged practitioners are required to immediately report concerns of noncompliance to the hospital's compliance officer. Additionally, the Member or eligible Independent Practitioner agrees to comply with Hospital efforts to improve performance on quality measures such as those established by the Centers for Medicare and Medicaid Services (CMS), any other governmental agency, payer, or Accreditation Body.

T. **Identification Badges**

The Hospital shall provide identification badges displaying the name of the Medical Staff Member and Allied Health Professional. Anyone not displaying a proper identification badge may be approached, requested to show identification, and may be denied access to patient care areas, patients, and medical records until satisfactorily identified.

U. Primary Communications Emails

The primary means of regular communications between the medical staff to members and privileged practitioners will be through electronic mail. It is the duty of all members and privileged practitioners to provide the medical staff office an electronic mail address and notify the medical staff office of any changes to the address. It is also the responsibility of all members and privileged practitioners to read emails from the medical staff upon receipt.

RULES AND REGULATIONS

OF

THE MEDICAL STAFF OF COMMUNITY HOWARD REGIONAL HEALTH

Reviewed, Revised, and Approved by Medical Executive Committee on August 17, 2021.

Approved by Board of Directors on August 26, 2021

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Jennifer Labrie-Deem, MD
Chief of Staff

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Lynette Hazelbaker, MD
Chair, Board of Directors