

LABETTE HEALTH

**MEDICAL STAFF
RULES AND REGULATIONS**

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**LABETTE HEALTH
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**ARTICLE I
MEDICAL STAFF RULES AND REGULATIONS
MEDICAL STAFF STRUCTURE**

Capitalized Terms used in these Rules and Regulations shall have the same meaning as such terms in Labette Health’s Medical Staff Bylaws.

1.1. Meetings.

1.1.1. *Medical Staff.*

A. Time.

- (1) The meetings of the Medical Staff shall be held at 12 o’clock (noon) on the fourth Tuesday of the month.
- (2) Meetings shall be held during the months of January, April, July, and October, or at the discretion of the Chief of Staff.

B. Content.

- (1) A summary of the Credentialing/Privileging Report as approved by the Credentials Committee and Medical Executive Committee concerning any changes to Medical Staff membership and quality improvement/utilization review activities, as available;
- (2) A report from the CEO (or a designee) concerning the finances and demographics of the Hospital; and
- (3) A report from the CEO (or a designee) concerning those Hospital plans and activities that are relevant to Medical Staff activity

1.2. Timeline.

1.2.1. *Odd-Numbered Years.*

A. January.

- (1) Previous Vice Chief of Staff automatically assumes the position of Chief of Staff.
- (2) Newly elected Vice Chief of Staff and Secretary-Treasurer assume their elected positions.

- (3) Two (2) newly elected “at large” Members of the Medical Executive Committee begin their membership.
- (4) The immediate past Chief of Staff assumes chairmanship of the Nominating Committee and remains a member of the Medical Executive Committee.
- (5) The new Vice Chief of Staff assumes chairmanship of the Physician Peer Review/Risk Management Committee.
- (6) The new Secretary-Treasurer assumes chairmanship of the Credentials Committee.
- (7) All appointed Chairs of all Committees assume their respective roles.
- (8) All assigned Committee Members begin their respective roles.
- (9) All Department Chairs begin their respective roles.
- (10) All assigned Physician Advisors assume their role.
- (11) A general Medical Staff meeting must be held.

1.2.2. Even-Numbered Years.

- A. January. All Medical Staff meetings and Department meetings follow the same schedule as the odd-numbered years.
- B. August.
 - (1) Nominating Committee presents slate of candidates for Vice Chief of Staff and Secretary-Treasurer to the Medical Executive Committee.
 - (2) The Vice Chief of Staff nominates two (2) at-large Members of the Medical Executive Committee for the following two (2) years.
 - (3) Elections are held at the October Medical Staff meeting for the above offices.
- C. December.
 - (1) The Vice Chief of Staff (soon to be Chief of Staff) selects Department Chairs for the following two (2) years.
 - (2) The Vice Chief of Staff (soon to be Chief of Staff) selects Chairs and Medical Staff Members for the Internal Medicine/Critical Care Committee and the Ethics/Physician Health Committee. The Vice

Chief of Staff (soon to be Chief of Staff) selects Physician Advisors for Hospital departments and committees for the following two (2) years.

1.3. Departments. The following shall be the Medical Staff Clinical Departments and the physician specialists that are included in each Medical Staff Clinical Department's membership:

1.3.1. *Medicine.*

- A. General practice physicians;
- B. Family practice specialists;
- C. Emergency room physicians;
- D. Dental Medical Staff Members;
- E. Internal Medicine specialists;
- F. Internal Medicine subspecialists;
- G. Hospitalists; and
- H. Radiology specialists.

1.3.2. *Obstetrics/Pediatrics.*

- A. Obstetrics specialists;
- B. Pediatric specialists;
- C. Physicians with an active obstetrical practice; and
- D. Physicians with an active pediatric practice.

1.3.3. *Surgery.*

- A. Surgical specialists;
- B. Surgical subspecialists;
- C. Anesthesia specialists; and
- D. Pathology specialists.

1.4. Physician Advisors. Physician Advisors will assure an appropriate level of Medical Staff involvement in Hospital Department activities and policies and procedures as required by the Medicare Conditions of Participation.

The following Hospital Departments and committees each shall have an assigned Physician Advisor:

- 1.4.1. Chaplaincy
- 1.4.2. Emergency Preparedness Committee
- 1.4.3. Employee Health
- 1.4.4. Food and Nutrition
- 1.4.5. Home Health
- 1.4.6. Infection Control
- 1.4.7. Intensive Care Unit
- 1.4.8. Health Information Management
- 1.4.9. Pharmacy & Therapeutics
- 1.4.10. Respiratory Therapy
- 1.4.11. Safety Committee/Quality Council Committee
- 1.4.12. Health Information Technology
- 1.4.13. TPIC and Trauma
- 1.4.14. Anesthesia
- 1.4.15. Utilization Review

Two (2) Physician Advisors shall be assigned to Utilization Review, and those two Members, along with the Director of Utilization Review, shall serve as the Utilization Review Committee as specified in the Medical Staff Bylaws and Hospital policy.

- 1.5. **Performance Improvement Teams.** The Medical Staff will be actively involved in performance improvement teams.

ARTICLE II CONDUCT OF PATIENT CARE

- 2.1. **Attendance.**

- 2.1.1. *Designation.*

For every patient admission, a Member of the Active Staff, Associate Staff, Contract Staff, or Dentists, under limited circumstances, or Hospitalist, must be designated as the patient's

Attending Physician. To the extent possible, the Attending Physician should be the Member of the Active or Associate Medical Staff identified as the patient's primary care physician or a Hospitalist. In the case of an inpatient admission or outpatient stay for a surgical procedure, the surgeon responsible for the procedure may be designated as the patient's Attending Physician.

If the patient does not have a primary care physician who is a Member of the Active or Associate Medical Staff, a Hospitalist can be assigned as the patient's Attending Physician. With respect to post-discharge care for such patient, the Active or Associate Medical Staff member other than the Hospitalist most actively involved in such individual's care in the course of the inpatient admission or outpatient stay shall be responsible for such care insofar as it relates to the condition for which the patient was treated at the Hospital. If no Active or Associate Medical Staff Member other than the Hospitalist was involved in such patient's care, the Member on call for emergency designated patients at the time of the patient's admission or outpatient stay can be recommended to the patient for such follow-up care and assistance with appointment as indicated.

2.1.2. *Substitution.*

- A. If a Member of the Active Medical Staff is unable to act as an Attending Physician, then that Member must designate a substitute who is qualified, willing, and available to act as an Attending Physician.
- B. The substitute must be notified of and agree to the change and shall be made aware of any known or potential medical problems which the Attending Physician or his/her designee is currently managing.
- C. Notification of substitution shall be entered into the patient record for admitted patients or outpatient stays, and the patient shall likewise be made notified of the change. The Emergency Department must also be notified of any substitution.

2.1.3. *Transference of Attendance.* Whether or not hospitalized, an outpatient or inpatient has a basic right to select or change to an Attending Physician of his or her choice. While Attending Physician changes are sometimes awkward for hospital patients, if such action is desired by the patient, it should be carried out as rapidly as possible. The newly selected Attending Physician must be agreeable to the transfer of attendance. The transfer of Attending Physician must then be entered into the patient record and such change will require the new Attending Physician to provide any new orders and/or review and confirm the patient's previous treatment orders.

2.1.4. *Responsibility.*

- A. It is the overall responsibility of Attending Physician to ensure the patient is provided the best possible medical care to the patient and proper informed consent is obtained. As identified in the Bylaws and herein, this shall include, as indicated, an initial examination and assessment of the patient,

daily follow-up visits, ordering tests and procedures, obtaining consultations, transferring the patient to another facility as necessary, and discharging the patient when medically appropriate.

- B. It is the Attending Physician's responsibility to make a complete medical record of the patient's condition and care as described in Article III of these *Rules and Regulations*.

2.2. Consultation.

2.2.1. Indications. Except in an emergency, consultations with another qualified Practitioner are strongly suggested for the following medical conditions:

- A. First Caesarian section, if high-risk, unless the attending is an obstetrician.
- B. Curettages or other procedures by which a known or suspected pregnancy may be interrupted.
- C. Cases in which, according to the judgment of the Attending Physician or his/her designated substitute:
 - (1) The patient is not a good risk for operation or treatment; or
 - (2) The diagnosis is obscure and there is doubt as to the best therapeutic measures to be utilized.
- D. Myelograms not ordered by a neurologist or an orthopedist.
- E. Angiograms not ordered by a vascular surgeon, excluding MRI and CT Angiography.

2.2.2. Procedure.

- A. Request for consultation must be made per Practitioner order.
- B. If the need for consultation is urgent, it is expected that the Attending Physician or designated Practitioner will personally contact the consultant to describe the nature of the problem and the type of help desired.
- C. The Attending Physician or designated Practitioner should indicate, in writing or verbally to the consultant, whether the consultation is for the purpose of gaining advice only or for the purpose of patient care management.
- D. The intent of a consult is to provide a medical professional with the opportunity to ask another physician or other qualified medical provider for his/her advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because the physician being

consulted has expertise in a specific clinical area beyond the requesting professional's knowledge. A consultant may initiate diagnostic services and treatment at the time of initial consultation or during a subsequent visit for the specific condition in question if he/she is properly credentialed to provide such patient care at Labette Health.

- E. A transfer of the patient's care occurs only when a physician or other qualified medical provider requests that another physician or qualified medical provider take over his/her responsibility for managing the patient's medical care or for managing any aspect of the patient's medical condition(s) during the hospitalization. When the patient's medical care is transferred to the consultant, it is not expected that the requesting physician will continue to treat or provide medical care for the patient. If the consultant is managing a specific condition(s), the requesting physician is not expected to continue to provide medical care or treatment for that aspect of the patient's medical care (Ch. 12, Sect 30.6.10(B)). Under these circumstances, the requesting physician or other qualified medical provider is not asking for an opinion or advice and transfer of patient or the management of the patient's medical care must be documented in the medical record.
- F. A patient shall be seen by a consultant only at the request of the Attending Physician or other designated Practitioner. If an additional consultation is desired by the consultant, such consultation shall be approved by the patient's Attending Physician or his/her designated substitute.

2.2.3. *Qualification.*

- A. The consultant must be a Member of the Active Medical Staff, Consulting Staff, or the Associate Medical Staff.
- B. The consultant must be qualified by virtue of experience and training to render the medical assistance requested.
- C. If a procedure is requested of a consultant, the consultant must be competent and appropriately credentialed to perform the procedure.

2.2.4. *Availability.*

- A. A solo practitioner shall be available for consultation as much as possible within the context of his/her practice pattern.
- B. If two (2) or more physicians are available for consultation in any specialty, they shall agree to a schedule of availability. If three (3) or more physicians are available for consultation in any specialty, at least one (1) consultant must be available at all times.

- C. Each consultant or consultant group shall post a schedule of availability which shall be maintained in the Emergency Department.
- D. The availability noted in this Section 2.2.4 refers to Active Medical Staff Members.

2.2.5. Responsibility.

- A. A consultant is responsible for responding to every request for consultation during the time the consultant has identified that he/she is available.
- B. An acceptable consultation includes examination of the patient and his/her medical record. A signed written opinion created by the consultant must be included in the patient's medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation.
- C. When a procedure(s) requiring patient consent are desired by the consultant, the consultant is responsible for educating and informing the patient concerning the procedure(s) to be performed and obtaining proper consent. The attending must also be notified of the request for such procedure(s).
- D. The Attending Physician or designated Practitioner is responsible for requesting consultation when indicated. It is the duty of the Medical Staff, through its Physician Peer Review/Risk Management Committee, to make certain that Members do not fail to request consultations when medically indicated.
- E. The patient's Attending Physician is responsible for evaluating the advice of the consultant. If the Attending Physician chooses to ignore or change the consultant's advice, his/her rationale should be well documented in the patient's medical record.

2.3. Admissions.

2.3.1. Definition. Every patient occupying a bed within the Hospital will be considered an inpatient admission unless specifically designated by the Attending Physician or his/her designated substitute as an outpatient admission or observation stay.

2.3.2. Prerogatives. A patient can only be admitted to the Hospital by a Member of the Active Medical Staff, Contractual Staff who have admitting privileges, or, in limited cases, by a Member of the Associate Medical Staff.

2.3.3. Procedure.

- A. Orders for admission shall be given or approved by the attending.

- B. Admitting orders shall be written in accordance with professional standards and Hospital policy and shall include, but not be limited to:
 - (1) Name of patient;
 - (2) Provisional diagnosis and reason for admission;
 - (3) Name of the attending;
 - (4) Nature of admission (*i.e.*, surgical, medical, obstetrical, or requiring intensive care);
 - (5) Patient status (*i.e.*, Inpatient, Outpatient, or Observation);
 - (6) Special requirements (*i.e.*, private room or isolation);
 - (7) Diet and activity; and
 - (8) Initial evaluation and treatment orders.
- C. A patient admitted to the Intensive Care Unit must be evaluated by the Attending Physician or a consultant, which includes an Emergency Department physician and Telemedicine, within two (2) hours if patient is considered critical.
- D. All other admissions must be evaluated by the Attending Physician or his/her designated substitute on the day of admission unless evaluated the same day in the attending's office or in the Hospital Emergency Department.

2.3.4. *Priorities for Admission.*

- A. Patients shall be admitted to Labette Health without regard to race, color, religion, sex, age, disability, or national origin.
- B. The admitting office shall admit patients to the facility in the order of priority based on the following criteria:
 - (1) *Emergency Admissions* – Includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger.
 - (2) *Urgent Admissions* – Includes non-emergency patients whose admission is considered imperative by the attending Member. Urgent admissions shall be given priority when beds become available over all other categories except emergency.

- (3) *Pre-Operative Admissions* – Includes patients already scheduled for surgery. If it is not possible to accommodate such admissions, then the Hospital high census process will be followed.
 - (4) *Routine Admissions* – Includes elective admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the Hospital's high census plan.
- C. All patient admissions will be reviewed in accordance with the Hospital's Utilization Review Plan. Evidence of continued abuse of the patient admission process and/or improper patient admissions by to the Hospital by a practitioner shall be brought to the attention of the Medical Executive Committee for appropriate intervention.
 - D. Before admitting a patient, the attending Member or his/her designated substitute shall confirm bed availability. If there is any issue with or conflict with admitting a patient, the Chief of Staff, or his/her designee, shall determine the necessity and/or appropriateness of the admission for the patient in question.
 - E. If at all possible, each patient admitted to a specific medical service shall be admitted to the area(s) of the Hospital previously designated as reserved for patients in that service. If such unit or area is unavailable, the nursing leadership/supervisor and/or the preadmissions office may place such patient(s) in other areas deemed appropriate.

2.4. Hospital Stays.

2.4.1. Types. All patient admissions to the Hospital will be designated as one of the following: (1) observation stay; (2) inpatient acute care stay; (3) inpatient rehabilitation stay; (4) swing bed; or (5) outpatient.

2.4.2. Observation Stays.

- A. Observation stays include the use of a bed, periodic monitoring by nursing and other staff, and any other services that are reasonable and necessary to evaluate a patient's condition or to determine the need for a possible (inpatient) admission to the hospital.
- B. An observation stay is of shorter duration than an inpatient stay, usually no longer than twenty-four (24) hours. If additional care is needed, the patient should be admitted as an inpatient for an acute care stay.
- C. Records must be kept of the observation stay and, in accordance with professional standards and Hospital policy, include the following:
 - (1) Name of the patient and other identifying information;

- (2) Indication for the stay and physical findings (History & Physical Examination);
- (3) Diagnostic findings pertinent to those indications;
- (4) Practitioner orders; and
- (5) Instructions to be given to the patient at the time of release or discharge from the hospital setting.

2.4.3. *Acute Inpatient Care Stays.*

- A. All patients not qualifying as observation or inpatient rehabilitation stays shall be designated as acute inpatient care stays.
- B. All acute care inpatients are to be seen daily by the Attending Physician or his/her designated substitute.
- C. A daily record of the patient's condition shall be documented and maintained in accordance with Hospital policy.

2.4.4. *Inpatient Rehabilitation Stays.*

- A. A patient will be admitted as an inpatient rehabilitation stay only after he/she is appropriately screened and qualifies for such admission.
- B. Patients in the inpatient rehabilitation unit must be seen by the admitting physician or his/her designated substitute a minimum of three (3) times a week for rehabilitation management.
- C. A record of the patient's condition is to be documented with each physician visit.
- D. If the patient's condition should deteriorate to the point he/she can no longer be cared for satisfactorily, or if his/her condition fails to meet inpatient rehabilitation criteria, the patient must be discharged to the appropriate care setting.

2.4.5. *Swing Bed.*

- A. A patient will be admitted to or discharged from the a swing bed stay by a member of the Medical Staff who has admitting privileges and only when appropriately screened and qualified in accordance with guidelines approved by the Medical Staff for admission to the skilled level of care.
- B. At the time of admission to the Swing Bed Unit, the attending physician shall document the initial certification. All Swing Bed patients shall be seen by their attending physician at least weekly and more often if necessary.

Documentation of each visit's findings shall be made in the physician's progress notes at the time of the visit. An attending physician shall see certify continued stay at least every seven (7) days.

- C. Each week a meeting will be held to convene all disciplines that interact in patient care to discuss progress towards meeting treatment goals and to plot new goals.
- D. All treatments, medications, procedures, and ancillary tests must be ordered by a physician.
- E. All orders shall be documented, signed, dated, timed, and placed on the patient's medical record. Verbal and telephone orders will be authenticated by physician signature within 72 hours. The orders shall include (but are not limited to):
 - (1) Transfer information
 - (2) Medications
 - (3) Treatments
 - (4) Diet
 - (5) Activity
 - (6) Rehabilitation services required
 - (7) Specific follow-up orders
- F. All patients admitted to a Swing Bed will have the following addressed by the physician:
 - (1) Current medical findings
 - (2) Diagnosis
 - (3) History and physical examination within forty-eight (48) hours of admission or performed within the five (5) days prior to admission and updated upon admission
 - (4) Rehabilitative services required
 - (5) Rehabilitative potential (prognosis)
 - (6) Discharge summary of the patient's acute or other skilled care course

- G. Specialized rehabilitative services, as required, shall be provided under the written order of a physician and by qualified personnel.
- H. Dental care shall be available for all Swing Bed patients.
- I. Accurate, complete, and timely medical records shall be required and maintained on every person admitted to the Swing Bed Unit in accordance with Labette Health's medical record policies and procedures.
- J. A patient shall be transferred or discharged from a Swing Bed only on written order of the attending physician or his or her designee. The patient shall receive preparation and orientation to ensure safe and orderly transfer or discharge.
- K. A patient that is discharged from a Swing Bed shall be provided a discharge summary that includes:
 - (1) A recapitulation of the resident's stay;
 - (2) A final summary of the resident's status;
 - (3) A post-discharge plan of care that is developed with the participation of the patient and his or her family, which will assist the patient to adjust to his or her new living environment.
- L. If a patient leaves a Swing Bed against the advice of the attending physician or without proper discharge, a notation of the event shall be made on the patient's medical record. Whenever possible, the physician shall advise the patient of the adverse medical consequences to his or her leaving the Swing Bed and obtain from the patient a signed form documenting the release against medical advice which shall be made a part of the patient's record.
- M. The attending physician shall notify Swing Bed staff of a physician who will act as designee in his or her absence.
- N. The Chief of Staff shall appoint a Swing Bed Physician Advisor who shall be responsible for oversight of quality, safety, compliance with conditions of participation and conditions of payment, and development and implementation of policies and procedures for Swing Beds.

2.4.6. Outpatient. A patient who visits a hospital for a diagnostic, surgical, or therapeutic procedure not requiring inpatient or observation status.

2.5. Transfers to Other Facilities.

2.5.1. Indications. Transfers shall be initiated whenever it becomes clear that personnel or facilities in this Hospital are inadequate and there is a reasonable possibility that the patient could benefit from treatment available at another institution.

2.5.2. Procedure.

- A. Transfer shall be initiated only after appropriate informed consent is obtained.
- B. Transfer shall be initiated by the attending or his/her substitute.
- C. Transfer shall be in accordance with Hospital's Transfer Policy and Procedure and in accordance with all applicable legal standards.

2.6. Discharges.

2.6.1. Definition. A discharge shall occur whenever a patient admitted as an acute or observation stay leaves the physical confines of the Hospital, whether by release to home or transfer to another institution.

2.6.2. Prerogatives.

- A. A patient may be discharged only after receipt of an order from the Attending Physician or his/her substitute.
- B. In the event that the patient leaves the Hospital against the Attending Physician or other designated Practitioner's direction, he/she shall be asked to sign a release of responsibility form. If the patient refuses to sign, it shall be made clear in the medical record that the patient was advised that the Hospital and any medical providers are not responsible for any adverse effects of this decision.

2.6.3. Procedure.

- A. When discharged by transfer, the orders shall be written in accordance with professional standards and Hospital policy and shall include, but not be limited to:
 - (1) Name of the institution to which transfer is being made;
 - (2) Name of provider who will assume patient's care;
 - (3) Level of care to be provided;
 - (4) Mode of transportation (except transfer to an acute status within the Hospital); and
 - (5) Any medical treatment required until under the care of the new provider.
- B. For other discharges, the orders shall be written in accordance with professional standards and Hospital policy and include at a minimum:

- (1) Prescribed diet;
- (2) Activity instructions;
- (3) Medication and treatment instructions; and
- (4) Follow-up instructions.

2.7. Surgical Procedures.

2.7.1. Pre-Operative Care.

- A. A history and physical examination, together with any indicated pre-operative laboratory evaluation, must be completed prior to surgery. When a pre-operative diagnosis and a statement concerning the patient's general condition are not recorded before the stated time for operation, the operation shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

If the history and physical examination were performed and documented by a Practitioner other than the surgeon, the surgeon is expected to review the information that was completed prior to admission and conduct an assessment to determine whether there are any changes since the initial examination. If there are no changes, the surgeon is expected to prepare a medical record entry indicating the information was reviewed, the patient examined, and that the surgeon concurs with the findings of the history and physical completed on the specified date. This update must be attached to the original history and physical and documented within twenty-four (24) hours of admission and prior to any surgical procedure.

- B. A pre-anesthesia note must be made in the medical record by the physician or nurse anesthetist stating the choice of anesthesia for the procedure anticipated. This note shall include, but is not limited to:
- Medical, anesthetic, medication, allergy including anesthesia risk;
 - Physical exam (which, at a minimum, must include an airway assessment, pulmonary exam, including auscultation of lungs, cardiovascular exam, and such other standards set by the American Society of Anesthesiologists);
 - Review of diagnostic data;
 - Assignment of ASA status; and
 - Anesthesia plan discussed and agreed upon with patient or patient's legal representative.

- C. The duty to disclose the risks and benefits of, and alternatives to, a proposed surgical procedure rests with the Physician who is responsible for the performance of the procedure.
- D. An informed consent shall be obtained in accordance with Hospital policy and granted by the patient or responsible party before the surgical procedure is conducted. All surgical procedures require proper authorization and consent, except when there is a life-threatening emergency and the patient is unable to consent.
- E. When anesthesia is anticipated, the anesthesia provider is responsible for obtaining informed consent from the patient or responsible party in accordance with Hospital policy.

2.7.2. *Intra-Operative Care.*

- A. No surgical procedure shall be performed unless:
 - (1) The procedure has been authorized by the Surgery Department and the Medical Executive Committee;
 - (2) Appropriate and necessary equipment and supplies are available; and
 - (3) Surgical assistants and operating crew have received adequate training to adequately support the surgeon.
- B. Any substantive change in the method of doing a procedure shall also be approved by the Surgery Department and Medical Executive Committee prior to the procedure.
- C. All Medical Staff Members performing surgical procedures shall:
 - (1) Be Members of the Active, Associate, Contract or Consulting Medical Staff;
 - (2) Have appropriate training and experience for the procedure being provided; and
 - (3) Be approved by the Board of Trustees for the specific procedure being provided.
- D. When an operating team does not consist of a Physician, the Attending Physician must be present in surgery or arrange for another qualified medical provider to be present.
- E. The surgeon shall use such assistants at surgery as he/she deems appropriate, but such assistant(s) shall be properly trained and qualified. A

Medical Staff Member who is not a surgical specialist shall be properly credentialed for assisting in surgery. A surgical assistant who is not employed by the Hospital must apply for such privileges and be credentialed through the *Allied Health Professionals Policy*.

- F. Anesthesia is to be induced and maintained at a safe and required level for the procedure being performed. Continuous and appropriate monitoring of the patient shall be performed and recorded throughout the procedure. Any significant change shall be reported immediately to the surgeon. The intraoperative anesthesia note should be written in accordance with applicable professional standards and Hospital policy and shall include, but is not limited to:
- Patient re-evaluation immediately prior to initiation of anesthesia including a check of equipment drugs and gas supply;
 - Monitoring of the patient per ASA guidelines;
 - Amounts of drugs and agents used and time of administration;
 - Types and amounts of IV fluids used including blood and blood products and times of administration;
 - Estimated blood loss and urine output, if applicable;
 - Techniques used;
 - Unusual events; and
 - Status of the patient at the conclusion of anesthesia.

2.7.3. Post-Operative Care.

- A. Operative reports shall be dictated or written as soon after surgery as possible, but must be completed the same day as the procedure. The operative report shall be written in accordance with professional standards and Hospital policy and shall include, but not be limited to:
- (1) Name and Hospital identification number of the patient;
 - (2) Date and times of the surgery;
 - (3) Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
 - (4) Pre-operative and post-operative diagnosis;
 - (5) Name of the specific surgical procedure(s) performed;

- (6) Type of anesthesia administered;
- (7) Complications, if any;
- (8) A description of techniques, findings, and tissues removed or altered;
- (9) Surgeon's or practitioner's name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- (10) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

B. Tissue or foreign body removed or excised in the operating room, treatment room, delivery room, or emergency treatment rooms will be submitted to the Pathology Department for examination by the pathologist. Exceptions that require no examination or identification are as follows:

- (1) Bone donated to the bone bank.
- (2) Bone segments or fragments removed as part of corrective or reconstructive orthopedic procedure.
- (3) Cataracts.
- (4) Dental appliances.
- (5) Fat removed by liposuction.
- (6) Foreign body such as bullets or other medical legal evidence given directly to law enforcement personnel.
- (7) Foreskin from circumcision of newborn.
- (8) Intrauterine contraceptive devices without attached soft tissue.
- (9) Medical devices such as catheters, gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to patient illness, injury, or death.
- (10) Orthopedic hardware and other radio-opaque mechanical devices provided there is documentation of their surgical removal.
- (11) Placentas, unless requested by physician.

- (12) Rib segments or other tissue removed only for purposes of gaining surgical access, provided that patient does not have a history of malignancy.
 - (13) Skin or other normal tissue removed during a cosmetic or reconstructive procedure, provided it is not contiguous with a lesion and the patient does not have a history of malignancy.
 - (14) Teeth when there is not attached soft tissue.
 - (15) Therapeutic radioactive resources.
 - (16) Normal toenails and fingernails that are incidentally removed.
- C. Specimens requiring only gross examination and identification are as follows (exceptions are at the pathologist's or clinician's discretion):
- (1) Accessory digits.
 - (2) Bunions and hammertoes.
 - (3) Nasal bone and cartilage from rhinoplasty or septoplasty.
 - (4) Prosthetic breast implants.
 - (5) Tonsils and adenoids from children (less than 18 years of age).
 - (6) Torn meniscus.
 - (7) Varicose veins.
 - (8) Traumatically amputated digits.
 - (9) Foreign bodies when documentation is needed.
- D. Orders for the post-operative care of the patient shall be given by the surgeon immediately following the surgery. Pre-operative orders will no longer be valid unless expressly continued or affirmed by the surgeon following surgery.
- E. An anesthesiologist or nurse anesthetist must complete and document a post-anesthesia follow-up report within forty-eight (48) hours of the completion of the surgery. This postoperative note shall be written in accordance with professional standards and Hospital policy and shall include, but is not limited to:
- Cardiopulmonary status;
 - Level of consciousness;

- Follow-up care including patient instructions; and
- Any complications.

2.8. Therapeutic and Diagnostic Procedures.

2.8.1. *Indications.* Indications for the performance of a therapeutic or diagnostic procedure must be clearly stated on the patient's medical record, including the expected benefits and the anticipated risks of the procedure.

2.8.2. *Consent.* In accordance with Hospital policy, informed consent for all procedures shall be obtained by the Medical Staff Member or qualified medical provider performing the procedure.

2.8.3. *Sedation.* Any sedation required shall be administered in accordance with Hospital's I.V. Conscious Sedation Policy and Procedure.

2.8.4. *Qualifications.*

- A. All therapeutic or diagnostic procedures shall be performed by a Member of the Active, Associate, Consulting, or Contract Medical Staff or other qualified medical provider.
- B. The Member or qualified medical provider performing the procedure shall be qualified by virtue of training and experience to perform such a procedure.
- C. The individual performing the procedure shall be approved for the performance of such procedure by the Board of Trustees, upon recommendation of the Medical Executive Committee.
- D. The introduction of a new therapeutic or diagnostic procedure shall be done only after:
 - (1) The proper equipment is available and tested;
 - (2) Those Hospital personnel involved are adequately trained;
 - (3) The procedure has been approved by the appropriate Clinical Department; and
 - (4) Final approval has been given by the Medical Executive Committee.

2.9. Special Situations.

2.9.1. *Mental Illness.* Patients who are emotionally ill, or become emotionally ill while in the Hospital, or who suffer the results of alcoholism or substance abuse, will be stabilized at Labette Health by the Emergency Department physician, the patient's Attending Physician, or other qualified medical provider. The patient shall also be

evaluated and screened by the appropriate mental health services provider. Upon recommendation from the appropriate mental health services provider, patients may be transferred to another facility so long as the patient is medically stable and no longer requires services from Labette Health or the patient may be treated as short-term inpatient with outpatient follow-up and treatment as deemed appropriate by the mental health services provider. Geriatric patients may be directly referred to a geriatric psychiatry unit without a mental health screen so long as the patient does not require inpatient services from the Hospital. A call roster for mental health services will be maintained in the Emergency Department and is accessible twenty-four (24) hours a day, seven (7) days per week.

2.9.2. Death.

- A. Impending Death. In the event of impending death, the Attending Physician shall be notified of the deterioration of the patient's condition. If the patient is known to be a terminal case, the provider or his/her designated substitute may wish to be present. On sudden and unexpected deaths, the presence of the Attending Physician or his/her designated substitute may be requested by the nursing personnel if needed for the sake of the family or for other pertinent concerns.
- B. Resuscitation. Resuscitation shall be attempted on all patients ceasing spontaneous heartbeat and respiration unless:
 - (1) There is an appropriately completed and signed "Do Not Resuscitate" order to the contrary made in accordance with the Hospital's policies and procedures; or
 - (2) Resuscitation is completely and undeniably futile.

2.9.3. Autopsy.

- A. Consent for Autopsy. Every Member of the Medical Staff is expected to be actively interested in securing autopsies, especially in cases of unusual deaths and cases where deaths are of medical-legal and/or educational interest. No autopsy shall be performed without proper written consent in accordance with Hospital policy. At the time of death, permission will be obtained from the legal next-of-kin to perform an autopsy on the deceased patient for the purpose of determining or attempting to determine cause of death and/or the extent of progress of disease or condition. The patient's physician or his/her designated substitute will discuss autopsy plans with the family.
- B. Criteria for Autopsy. All autopsies shall be performed by the Hospital pathologist or by a physician delegated this responsibility by the pathologist. Autopsy criteria includes, but is not limited to, the following:
 - (1) Unanticipated or unusual death;

- (2) Death occurring while the patient is being treated under a new therapeutic trial regime;
 - (3) Intra-operative or intra-procedural death;
 - (4) Death occurring within forty-eight (48) hours after surgery or an invasive therapeutic / diagnostic procedure;
 - (5) Death incident to pregnancy or within seven (7) days following delivery;
 - (6) All deaths of psychiatric patients;
 - (7) Death where the cause is sufficiently obscure to cause delay in the completion of the death certificate; or
 - (8) Deaths in infants/children with congenital malformations.
- C. Coroner's Case. If death falls under the jurisdiction of the coroner, written or verbal permission for release of the body must be obtained from the coroner and family consent is not necessary. The physician will discuss the death with the coroner. The coroner will be notified in accordance with Kansas law and Hospital policy.
- D. Medical Records. A complete autopsy report will be requested and become a part of the permanent patient medical record on all inpatient, non-coroner cases. Autopsy reports of coroner's cases shall be requested and, if received, shall become a part of the permanent patient record. However, autopsy reports of coroner cases may not be available for release to the Hospital for inclusion in the patient medical record.

ARTICLE III MEDICAL RECORDS

- 3.1. Definition.** The medical record is a permanent, comprehensive, unalterable compilation of data concerning the medical care of each patient cared for at Labette Health.
- 3.2. Ownership.** All medical records are the property of the Hospital and may be removed from the Hospital only by court order, subpoena, or statute. Any unauthorized removal of medical records by a Medical Staff Member may be grounds for suspension or revocation of Medical Staff membership.
- 3.3. Accessibility.** A Medical Staff Member shall have access to the medical records of those persons for whom the Member provides care and treatment for treatment, payment, and health care operations and as otherwise permitted by state and federal law as reflected in Hospital policies and procedures.

3.4. Content.

3.4.1. Overview. While the format and forms in use in the medical record will vary, all medical records shall contain at least the following:

- A. Identification data;
- B. Admitting impression;
- C. The medical history of the patient;
- D. The report of a relevant physical examination;
- E. Diagnostic and therapeutic orders;
- F. Evidence of appropriate informed consent;
- G. Clinical observations, including results of therapy;
- H. Reports of procedures, tests, and the results;
- I. Final diagnosis at termination of hospitalization or evaluation/treatment;
- J. Final instructions at the termination of the patient's hospital stay; and
- K. A final summary of the patient's hospital stay.

3.4.2. Components.

A. Medical History and Physical Examination.

- (1) A complete medical history and physical examination for each patient shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services. When the history and examination were completed prior to admission, an update note must be added to the original history and physical and include any changes in the patient's condition. This note must be completed and documented in the medical record within twenty-four (24) hours following admission, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination and any update must be completed and documented by a physician or his/her appropriately designated substitute.
- (2) The history and physical for all laboring and C-Section obstetric patients will include the office prenatal record and a history and physical examination completed by the Attending Physician or other qualified medical provider on admission and always prior to a surgery/procedure requiring anesthesia.

- (3) Outpatient surgical history and physical examination requirements are the same as the inpatient requirements noted above in Item 3.4.2 (A)(1).
- (4) The medical history shall include the chief complaint; details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social, and family histories.
- (5) The physical examination shall include an evaluation of the organs of sense, the respiratory system, the cardiovascular system, the gastrointestinal system, and the skin and lymphatics. An examination of the genitourinary system shall be included unless prior, appropriate outpatient evaluation is documented and none of the patient's current symptoms in any way suggest involvement of the genitourinary organs. If such an exam is refused by the patient, or is not appropriate due to age, social, or physical factors, such reasons shall also be documented.

B. Diagnostic and Therapeutic Orders.

- (1) Orders for outpatient services may be made by any Practitioner who is:
 - (a) Responsible for the care of the patient;
 - (b) Licensed in, or holds a license recognized in, the jurisdiction where the Practitioner sees to the patient; and
 - (c) Acting within the Practitioner's scope of practice under State law.
 - (d) Notwithstanding the foregoing, Practitioners that are not credentialed at Labette Health may not order Milrinone Infusions (Primacor). A Practitioner's order is not required for the initiation of physical therapy, subject to and in accordance with K.S.A. 65-2921, as amended.
- (2) The order must include information sufficient for Labette Health to verify that the requirements in the preceding subsection are met. If information on or accompanying the order is insufficient, Labette Health shall obtain written or verbal verification that the requirements are met before any outpatient service may be provided.
- (3) Orders for inpatient care may be given only by an appropriately credentialed Practitioner.

- (4) CPOE or written orders will be used. All orders shall be authenticated, timed, and dated by the prescribing Practitioner. An order shall be considered to be in writing if dictated to an authorized Hospital employee and signed, dated and timed by the ordering Practitioner. An authorized person shall be considered a licensed or registered employee of the Hospital in the departments of nursing, radiology, pharmacy, respiratory therapy, laboratory, and physical therapy. All verbal orders or orders dictated over the telephone shall be signed by the person to whom the order was dictated with the name of the Practitioner providing the order by his/her own name. All verbal/phone orders shall be authenticated, timed, and dated by the prescribing Practitioner or another Practitioner responsible for the care of the patient within seventy-two (72) hours of the patient being discharged, or thirty (30) days, whichever comes first.
- (5) Orders which are illegible or improperly written shall immediately be brought to the attention of the person writing the order, and shall not be carried out until rewritten or appropriately clarified.
- (6) All prior orders shall be reviewed and confirmed or cancelled when a patient is transferred to surgery, into or out of the intensive care unit, into or out of the inpatient rehabilitation unit. Any new treatment orders should be appropriately documented in the patient's medical record.
- (7) Order protocols may be developed and must be approved by one of the Clinical Departments or by the Medical Staff Executive Committee. Orders to use such protocols must be written in accordance with the above guidelines. The protocol must then be included within the other orders, and must be dated, timed, entered into CPOE and signed by the ordering Practitioner. Any exceptions or deviation from the protocol must be clearly indicated and dated, timed, and signed.

C. Informed Consent.

- (1) Except in emergency, informed consent shall be obtained from the patient or the patient's representative prior to the performance of certain procedures and/or medical treatment in accordance with Hospital policy.
- (2) Responsibility for Obtaining Informed Consent.
 - (a) Hospital's admission consent form must be signed by the patient or the patient's representative at the time of admission. The admitting office shall notify the Attending

Physician or designated substitute whenever such consent has not been obtained.

- (b) After Hospital admission, it shall be the responsibility of the Practitioner to obtain written informed consent from the patient in the following circumstances:
 - (i) A surgeon shall obtain the patient's consent to any surgical procedure to be undertaken, including ambulatory surgery. Surgical consent shall be considered valid for a period of thirty (30) days after the date of the signatures;
 - (ii) The Practitioner performing a non-surgical procedure involving more than a slight risk of harm or a high-risk medical procedure shall obtain the patient's consent to any such procedure; and
 - (iii) The anesthesiologist or nurse anesthetist shall obtain the patient's consent to the administration of anesthesia.
- (c) Except in emergencies, the failure to include a completed consent form in the patient's medical record prior to the performance of a surgical or diagnostic procedure shall automatically cancel the surgery or procedure.
- (d) Whenever the patient's condition prevents obtaining consent, every effort shall be made and documented to obtain the consent of the patient's representative prior to the procedure or surgery, and such effort shall be documented in the patient's medical record. Any emergencies involving a minor or otherwise incompetent or incapacitated patient for which consent for surgery cannot be immediately obtained from parents, legal guardian/ representative, durable power of attorney, or appropriate next of kin should be fully explained on the patient's medical record. If possible, a consultation shall be obtained before any operative procedure is undertaken in such circumstances.
- (e) Should a second operation be required during the patient's stay at the Hospital, a second consent shall be obtained. If two (2) or more specific procedures are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

- (f) In event the patient or his/her legal representative decides to refuse medical treatment following appropriate discussions in accordance with Hospital policy, a properly executed refusal of medical treatment form should be obtained.
- (3) When questions arise regarding patient consent or unusual circumstances occur not clearly covered by the Medical Staff Bylaws, these Rules and Regulations or Hospital policy, the Practitioner shall promptly confer with Hospital management concerning such matters and Hospital management will take appropriate measures to assist the Practitioner in addressing such matter and obtaining the required consent.
- (4) Clinical Departments may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such form(s) shall become effective upon approval by the Medical Executive Committee.

D. Advance Health Care Directive.

- (1) *Patients' Rights.* Patients shall have the right to make decisions concerning their care, including, but not limited to, the right to accept or refuse medical/surgical treatment, and the right to formulate an Advanced Health Care Directive as permitted under Kansas law. Patients will be informed of their rights as stated in the Hospital's Advanced Health Care Directive Policy. No patient shall be discriminated against or will have care conditioned on whether or not an Advanced Health Care Directive has been executed.
- (2) *Practitioner Responsibilities.* With regard to Advanced Health Care Directives, a Practitioner's responsibilities shall include:
 - (a) Reviewing the patient's directive;
 - (b) Informing the patient or patient's representative of the acceptance or non-acceptance of the directive;
 - (c) Assisting in the validation of an Advanced Health Care Directive presented at a previous admission; and
 - (d) The Practitioner has the right to decline to participate in the limitation or withdrawal of the therapy. If this right is exercised, the physician must give adequate notice and take appropriate steps to transfer the care of the patient to another qualified medical care provider.

E. Clinical Observations.

- (1) Observations shall be reported in each patient's medical record which shall include, but not be limited to:
 - (a) Any improvement or deterioration in the patient's condition;
 - (b) Any sudden or unexpected changes;
 - (c) Any untoward reaction to any medication, treatment, or diagnostic procedure;
 - (d) Acknowledgment of any significant laboratory or diagnostic abnormality, together with a planned response;
 - (e) Acknowledgment of any consultant's recommendations together with a planned response;
 - (f) Response to medical therapy, as well as surgical or therapeutic procedures;
 - (g) An assessment of the patient's prognosis; and
 - (h) A summary of significant discussions held with the patient or patient's family.
- (2) Observations may be entered by writing or dictation. All entries shall be signed, timed, and dated by the Practitioner making the entry.
- (3) Frequency of clinical observations:
 - (a) Clinical observations shall be made at least daily on all patients admitted to the Hospital as an acute care stay.
 - (b) Critically ill patients may warrant more frequent entries.
 - (c) Clinical observations on patients admitted as an inpatient rehabilitation stay shall be made a minimum of three (3) times a week.
- (4) Entries may be made by Medical Staff Members or approved Allied Health Professional working under the direction of a Medical Staff Member, or those in training for a health professional if a student of an accredited allied health professional training program and if such student is personally supervised by a Medical Staff Member.

- F. Continued Hospitalization. The attending Member or his/her designated substitute shall be required to routinely document the need for continued hospitalization. This documentation must contain:
- (1) An adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);
 - (2) The estimated period of time the patient will need to remain in the Hospital; and
 - (3) Plans for post-Hospital care.
- G. Final Diagnoses.
- (1) A listing of the final conclusions regarding the patient's illness or disease shall be made at the time of the patient's release from an outpatient setting or discharge from an inpatient setting. The listing shall begin with that condition established after study, to be chiefly responsible for admission of the patient, to the hospital.
 - (2) The listing of the final diagnoses is to be made by the attending or by his/her designated substitute.
- H. Final Instructions.
- (1) There shall be documentation in the clinical record that the patient and/or family are given proper instructions upon the patient's release or discharge, with particular regard to physical activity limitations, medications, diet, and follow-up.
 - (2) Final instructions are also the responsibility of the attending or his/her designated substitute.
- I. Discharge Summary.
- (1) All medical records must contain a concise discharge summary. This discharge summary must discuss the outcome of hospitalization including a final diagnosis, the disposition of the patient, and the provisions of follow-up care. Follow-up care provisions include any post-hospital appointments, how post-hospital patient care needs are to be met, and any plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted living.
 - (2) For patient stays under forty-eight (48) hours, the final progress note(s) may serve as the discharge summary so long as it contains

the outcome of hospitalization, the case disposition, and the provisions for follow-up care.

- (3) For all other patient stays, the discharge summary shall either be a stand-alone entry in the medical record or part of the final summary documenting the patient's hospital stay and shall include language that identifies it as the discharge summary.
- (4) The responsibility for completion of the discharge summary rests with the patient's Admitting Physician or the physician responsible for the patient during his/her hospital stay.
- (5) The discharge summary, whether a stand-alone entry or part of the final summary, must be completed within seven (7) days of the patient's discharge from the hospital.

J. Final Summary.

- (1) Except as noted below, a final summary of the patient's hospital stay shall be made following the patient's discharge, or transfer, including patients who have expired.
- (2) The final summary shall include, but not be limited to:
 - (a) *Final diagnosis.* The listing shall begin with that condition established after study, to be chiefly responsible for admission of the patient, to the hospital.
 - (b) A synopsis of the patient's admission history and examination;
 - (c) A summary of significant laboratory and diagnostic evaluations;
 - (d) A summary of treatments rendered, including surgical and therapeutic procedures;
 - (e) An account of the patient's response to treatment;
 - (f) A statement of the patient's condition at the time of discharge; and
 - (g) A summary of discharge instructions given to the patient.
- (3) The final summary is the responsibility of the Attending Physician or his/her appropriately designated substitute.

- (4) A final summary is not required in those cases when the hospital stay has been so short that one document provides all the details of the condition and the care provided; such as those involving transfers, deaths within twenty-four (24) hours of admission, or outpatient stays for observation. A progress note summarizing the hospital treatment will suffice for medical record or chart completion in such cases.
- (5) The final summary and completion of any other unfinished aspects of the medical record, including physician signature, must be completed within fourteen (14) days of the patient's discharge from the Hospital or release from an outpatient stay.

3.5. Symbols and Abbreviations. Only symbols and abbreviations that have been approved by the Medical Staff and have an explanatory legend will be used in the medical record. A listing of approved abbreviations and symbols shall be compiled and made available for use by the Medical Staff and other qualified Practitioners.

3.6. Enforcement.

- 3.6.1.** In keeping with Section 3.4.2.I(5) above, on the seventh (7th) day after discharge, any Medical Staff Member or other qualified medical care provider with incomplete medical records based on the above requirements shall be notified immediately by the Hospital's Health Information Management Department. To meet the above fourteen (14)-day requirement, the incomplete portion of the record shall be completed within the next seven (7) days.
- 3.6.2.** Failure to complete the incomplete record by the fourteenth (14th) day following discharge shall result in notification of the Chief of Staff who will issue a letter of delinquency to the Member or other qualified Practitioner with a copy to the Hospital CEO.
- 3.6.3.** Failure to complete the delinquent record by the twenty-first (21st) day following discharge will result in an automatic termination of admitting or consulting privileges until the medical record is completed.
- 3.6.4.** An exception shall be made concerning the above requirements for final summary and completion of uncompleted elements of the chart when the Medical Staff Member or other qualified Practitioner is ill or out of town. Under those circumstances, the requirements for completion shall begin as soon as he or she returns to work. It is the Practitioner's duty to notify the Health Information Management Department of illness or being out of town.

**ARTICLE IV
HOSPITAL INTERACTIONS**

4.1. With Department of Nursing.

4.1.1. *Restraints and Seclusion.* A policy on the use of patient restraints and seclusion consistent with the Medicare Conditions of Participation addressing patient rights shall be developed in conjunction with the Nursing Department which shall be utilized by the Hospital and Medical Staff.

4.1.2. *Cardiopulmonary Arrest.*

- A. A plan of response to a situation of cardiopulmonary arrest shall be developed by the Critical Care Committee in conjunction with the Nursing Department and approved by the Medical Executive Committee.
- B. This plan shall include details on initiating an immediate Hospital-wide call for resuscitation (Code Blue Policy).
- C. Resuscitation shall be done according to basic and advanced cardiac life support standards of the American Heart Association until such time as an ACLS-trained Physician is available.
- D. The patient's attending shall be notified as soon as possible after resuscitation efforts have started.
- E. ACLS training is recommended for all Medical Staff Members, but all Hospitalists and Physicians credentialed for care of patients in the Emergency Department or in the Intensive/Coronary Care Unit must have completed or be actively engaged in completing ACLS training.
- F. Physicians and other Practitioners that provide for care of pediatric patients must have completed or be actively engaged in completing PALS training.
- G. All Physicians and other Practitioners that provide for care of infants and obstetrical patients must have completed or be actively engaged in completing NRP training.
- H. To the extent possible, a determination of each patient's desire for resuscitation shall be obtained from each patient or legal decision maker at the time of Hospital admission. Patients who have executed a Declaration under Kansas law or other equivalent legal document involving end-of-life decisions shall have those documents readily available at the time of Hospital admission.

4.2. With the Pharmacy Department.

4.2.1. Medications.

- A. All medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluation.
- B. Medication used for clinical investigation shall be in accordance with regulations of the Federal Drug Administration. Investigational medications shall be used only after approval of an ad hoc Institutional Review Committee and under the direct supervision of the principal investigator who shall be a Member of the Medical Staff and who shall assume the burden of securing the necessary consent.
- C. The Medical Staff, in consultation with the pharmacy service, establishes the formulary system and determines what medications are available for dispensing or administration. This criteria includes, at a minimum, the indication for use, effectiveness, risks (including propensity for medication errors, abuse potential, and sentinel events), and cost.

4.3. With the Laboratory Department.

4.3.1. Required Tests.

- A. For newborns, all testing required under state law shall be performed.
- B. For maternity cases, testing for RH incompatibility shall be documented.

4.4. With the Emergency Department.

4.4.1. Staffing and Supervision.

- A. The Emergency Department shall be staffed at all times by a qualified Medical Staff Member or other designated Practitioner who is credentialed for Emergency Department practice.
- B. An Active Medical Staff member shall serve as the Medical Director of each Emergency Department and will provide supervision of the Department and will be involved in the development and approval of Emergency Department policies and procedures.

4.4.2. Emergency Medical Treatment and Labor Act.

- A. Medical Screening Examinations. The Hospital shall provide for an appropriate medical screening examination within the capability of the Hospital's Emergency Department for any individual who comes to the Hospital's Emergency Department on whose behalf a request is made for

examination or treatment for a medical condition as required by the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd (“EMTALA”); 42 C.F.R. § 482.12, 489.20(l), (m), (q), and (r), and 489.24; CMS-Pub. 7, *State Operations Manual*, Appendix V; and applicable Hospital policies. A “medical screening examination” is the process required to determine, with reasonable clinical confidence, whether the patient has an emergency medical condition as defined under EMTALA and applicable Hospital policies.

B. Qualified Medical Personnel. All medical screening examinations shall be performed by qualified medical personnel in a manner consistent with Hospital policies. As determined by the Board of Trustees, “qualified medical personnel” shall include (i) Medical Staff Members acting within the scope of their privileges; (ii) Allied Health Professionals who have been approved to practice at the Hospital acting within the scope of their approval and (iii) for obstetrics patients, obstetrics registered nurses under the guidance of OB attending.

C. Call Panels.

(1) The Hospital shall maintain Call Panels to ensure the availability of on-call Medical Staff Members to provide further medical screening examinations and medical treatment necessary to stabilize patients with an emergency medical condition to fulfill the Hospital’s obligations under EMTALA. The Medical Executive Committee shall determine from time to time those specialties for which Call Panels shall be maintained.

(2) Each Active Medical Staff Member shall participate in a Call Panel as requested. Participation in a Call Panel shall be a duty and responsibility of all Active Medical Staff Members. Any Active Medical Staff Member who refuses to serve on a Call Panel shall be deemed to have voluntarily resigned his or her Medical Staff membership and clinical privileges, and shall not be entitled to the hearings and appeals processes set forth in the Medical Staff Bylaws. Participating in a Call Panel(s) is an option for the physician who has reach Emeritus status.

(3) The Chief of Staff or his/her designee shall be responsible for assigning appointees to Call Panels and creating written monthly on-call lists to ensure that the on-call rotation is adequately and fairly covered. The purpose of an “on-call” list is to ensure that the Emergency Department and other Clinical Departments are prospectively aware of the Active Medical Staff Members who are available (i) to examine and provide treatment necessary to stabilize a patient with an emergency medical condition, and (ii) to provide consultation services and other services for Hospital patients.

- (4) Service on a Call Panel is not a Clinical Privilege and is not a right of any Medical Staff Member. The Hospital may enter into exclusive or semi-exclusive contracts for Call Panel services in its sole discretion. The Chief of Staff may deny or terminate a Medical Staff Member's participation on a Call Panel. The Medical Staff Member shall be given a written statement of the reason(s) for the proposed denial or termination of Call Panel participation and an opportunity to appear before the Medical Executive Committee before such action becomes final. This opportunity to appear shall not constitute a hearing and shall not entitle the Medical Staff Member to any of the hearings and appeals rights set forth in the Medical Staff Bylaws. The Chief of Staff's decision shall become final if the Medical Staff Member does not request an opportunity to be heard by the Medical Executive Committee within ten (10) business days of the written statement or when approved by the Medical Executive Committee. Notwithstanding the foregoing, the Chief of Staff may suspend a Medical Staff Member's Call Panel participation at any time until the appointee has waived his or her opportunity to be heard or a final decision is reached by the Medical Executive Committee. The denial or termination of a Medical Staff Member's Call Panel shall not affect the Member's Medical Staff membership or Clinical Privileges, nor shall this decision be used as evidence in any corrective action. However, any relevant facts considered by the Chief of Staff and/or the Medical Executive Committee in reaching such decision may be used for any and all purposes, including any corrective action pursuant to the Medical Staff Bylaws.

D. Conduct of Call Panelists.

- (1) Each Call Panelist shall inform the designated individual at the Hospital how to reach him or her immediately and shall remain immediately available by telephone during his or her Coverage Period. Call Panelists shall remain available and in close proximity during his or her Coverage Period so as to be able to arrive at the Hospital within a reasonable time. A Call Panelist may schedule elective procedures and/or provide call coverage at another hospital during his or her Coverage Period.
- (2) Upon request from the Hospital's Emergency Department, the Call Panelist shall arrive at the Emergency Department within a reasonable time in view of the patient's clinical circumstances, (with the exception of the Radiologist), which generally shall not exceed thirty (30) minutes from the time of notification for immediate services for a patient with an emergency medical condition unless circumstances beyond the Call Panelist's control prevent him or her from doing so. The Radiologist shall be available by phone for

consultation generally within thirty (30) minutes from the time of notification and provide radiographic preliminary report readings within a reasonable time frame.

- (3) A Call Panelist who is unable to provide on-call coverage during his or her scheduled Coverage Period shall be responsible for arranging coverage by a Medical Staff Member who satisfies the criteria for Call Panel eligibility. The Call Panelist shall promptly communicate to the designated individual at the Hospital the name of the Medical Staff Member who will be substituting for the Call Panelist.
- (4) Each Call Panelist shall accept the care of all patients who are appropriately referred during his or her Coverage Period and shall provide all services in accordance with all appropriate Hospital policies. A patient may be admitted to the Hospital in the name of the Call Panelist by a physician in the Emergency Department if both parties concur, but if the physician in the Emergency Department so specifies, the Call Panelist must see the patient prior to the admission.
- (5) If a Call Panelist refuses or fails to respond to a call during his or her Coverage Period or is unable to respond due to circumstances beyond his or her control, the physician in the Emergency Department may attempt to contact other Medical Staff Members who participate in the same Call Panel or, if necessary, arrange for transfer of the patient to another health care facility. All Medical Staff Members shall cooperate to the fullest extent in order to provide screening and stabilizing treatment to patients seeking emergency care within the services and facilities available at the Hospital.
- (6) If a Call Panelist refuses or fails to respond by telephone or in person in a timely manner, the Director of Emergency Services shall report such matter pursuant to the Hospital's risk management plan. If a Call Panelist is unable to respond due to circumstances beyond his or her control, such matter shall be documented by the Director of Emergency Services, but no risk management report shall be made.

ARTICLE V PHYSICIAN HEALTH

- 5.1. Policy.** In recognition of the Medical Staff's and Hospital's obligation to protect patients from harm, the Medical Staff has developed a procedure to identify and manage issues of individual physician health. This procedure shall provide education about physician health; address prevention of physical, psychiatric, or emotional illness; and facilitate

confidential diagnosis, treatment, and rehabilitation of Physicians who suffer from a potentially impairing condition.

5.2. Purpose. The purpose of this process is to assist and rehabilitate, rather than discipline, and to aid Physicians in retaining or regaining optimal professional functioning, consistent with protection of patients. However, if at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Physician is unable to safely perform the Privileges he or she has been granted, the matter shall be forwarded to Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

5.3. Definitions.

5.3.1. Advocacy Agreement. A written agreement between the Physician and the Kansas Medical Advocacy Program, and/or the Ethics/Physician Health Committee, that provides for a five (5) year term of compulsory supervision consisting of a variety of requirements which may include, but not be limited to, treatment by (a) specified professional(s), random urine drug testing, attendance at twelve (12) step meetings and group psychotherapy, attendance at monthly monitoring meetings, taking medications only under supervision of a physician and adhering to any special aftercare arrangements required by the treatment program or treating psychiatrist.

5.3.2. Impairment. A Physician shall be considered “impaired” if the Physician’s ability to function competently has been affected by substance abuse or physical, psychiatric, or emotional illness.

5.3.3. Intervention. An organized confrontation of a potentially impaired Physician by a group of concerned, trained individuals for the purpose of motivating the Physician to accept evaluation and treatment for an impairment.

5.3.4. Kansas Medical Advocacy Program. A program developed by the Kansas Medical Society and sanctioned by the Kansas Board of Healing Arts for the purpose of initiating and monitoring the treatment of impaired physicians. The program will hereafter be referred to as “**KMAP**.”

5.3.5. Monitoring Plan. A written document prepared by the Ethics/Physician Health Committee and signed by the affected Physician that describes the Physician’s recommended treatment and supervision, establishes a schedule for reporting and monitoring meetings, and assigns monitoring responsibility to appropriate Committee member(s).

5.4. Procedure.

5.4.1. Education. The Medical Staff shall provide annual training for the Medical Staff and Hospital management (department-head level and above) regarding recognizing physician and/or provider illness and impairment and related matters. Written informational materials regarding illness and impairment are at all times to be available and/or accessible to Members of the Medical Staff and Hospital

personnel. This information may be in the form of informational brochures, informational posters, or information regarding other resources which have been reviewed and approved as appropriate by the Ethics/Physician Health Committee. Educational programs may be developed by the Ethics/Physician Health Committee, but should be done in cooperation with the Continuing Education Committee.

5.4.2. *Ethics/Physician Health Committee.*

- A. Formation. An Ethics/Physician Health Committee shall be formed by the Medical Staff in accordance with the Medical Staff Bylaws. The appointment and membership shall be as designated in Section VII of the Medical Staff Bylaws.
- B. Referrals to the Committee. A Physician may self-refer, or be referred by a Medical Staff Member or other Hospital personnel, to the Ethics/Physician Health Committee for assistance. Referrals to the Ethics/Physician Health Committee shall be in writing, addressed to the Chairman of the Committee, and shall, to the extent possible, identify the health issue (whether physical, psychiatric, or emotional) and/or the symptoms or behaviors evidencing that health issue. Individuals wishing to make a referral to the Ethics/Physician Health Committee are encouraged to contact any member of the Committee for assistance in completing the written referral request.
- C. Evaluation. Upon receipt of a written referral, the Ethics/Physician Health Committee shall appoint one of its members to investigate and evaluate the credibility of the complaint, allegation, or concern evidenced by the referral. The investigation may include an interview of the Physician in question and/or other Medical Staff Members or Hospital personnel as well as review of any relevant documentation (including, but not limited to, quality improvement or utilization review information, risk management information, and relevant medical records). The investigation may also include interviews or other information obtained from sources outside the Hospital including, but not limited to, the Physician's family members and colleagues in other practice settings.
- D. Assistance. If the Ethics/Physician Health Committee's evaluation of a particular referral indicates that the Physician is likely suffering from physical, psychiatric, or emotional illness, the Ethics/Physician Health Committee shall: (1) make a recommendation to the Physician that he or she seek professional assistance from KMAP or an appropriate professional for diagnosis and treatment of the condition or concern, or (2) the Committee may, in its discretion, request that KMAP conduct an intervention and any necessary evaluation and treatment. The Committee's recommendation or request shall be made in writing. The Committee may assist the Physician by identifying specific professionals or programs that the Physician may contact to seek assistance. The Committee itself shall

not provide treatment or supervision of clinical practice for a Physician. The Committee shall refer the Physician to appropriate resources for evaluation and/or treatment. The Physician shall be responsible for all costs of treatment, monitoring, and follow-up.

E. Monitoring. It shall be the responsibility of the Ethics/Physician Health Committee to monitor the progress of Medical Staff Members who are under treatment or subject to supervision of clinical practice due to substance abuse or physical, psychiatric, or emotional illness. For all such Physicians, the Ethics/Physician Health Committee shall establish a Monitoring Plan and shall obtain (or prepare, as appropriate) an Advocacy or Monitoring Agreement.

(1) *Referrals from Kansas Medical Advocacy Program.* If a Physician enters KMAP without involvement of the Committee, the Committee shall receive and monitor all information provided to the Hospital by KMAP and/or the Board of Healing Arts.

(2) *Referrals Directly to Committee.* If a Physician is referred directly to the Committee and the Committee's evaluation indicates that the Physician is likely impaired, the Committee shall, unless otherwise indicated, refer the Physician to KMAP. The Physician shall provide the Committee with a copy of the Advocacy or Monitoring Agreement entered into between the Physician and KMAP. The Physician shall authorize KMAP to report to the Committee regarding the Physician's progress under the Advocacy or Monitoring Agreement. The Committee shall receive and evaluate such progress reports. The Committee, or its designee, shall meet with the Physician on a regular basis (with such frequency as determined in the Committee's discretion) during the term of the Advocacy or Monitoring Agreement to assess and evaluate the Physician's continuing compliance with the Agreement.

F. Proctoring or Leave of Absence. If the Committee's investigation of a Physician indicates that the Physician's clinical skills may be affected by his or her impairment, the Committee shall appoint a proctor to monitor the Physician's clinical performance and review records of the impaired Physician to assure patient safety. If the Committee determines that proctoring would not provide sufficient assurance of patient safety, the Committee shall so advise the Physician in writing and the Physician may request a medical leave of absence until such time as his or her impairment is under sufficient control as to not present a risk to patient safety. If the Committee determines that proctoring would be insufficient to assure patient safety, and the Physician, after receipt of written notice of the same, fails to request a leave of absence, the Committee shall refer the matter to the Medical Executive Committee for summary suspension or other appropriate action.

- G. Failure to Comply. If at any time a Physician (1) fails to comply with the Committee's referral to KMAP or other professional assistance, (2) fails to comply with an Advocacy or Monitoring Agreement with KMAP or the Committee, or (3) fails to comply with any other request or directive of the Committee, the Committee shall immediately refer the matter to the Medical Executive Committee for appropriate action.
- H. Freedom From Discipline. So long as the Committee, in cooperation with KMAP and any treating professionals, determines there is not a risk to patient safety and the Physician is in compliance with an Advocacy Agreement, the Monitoring Plan, the provisions of these Rules and Regulations, and any requests or directives of the Committee, the Physician shall not be subject to disciplinary action as a result of his or her physical, psychiatric, or emotional condition.
- I. Record Keeping and Reporting. With respect to each Physician who is under an Advocacy Agreement or Monitoring Plan, whether with KMAP or the Committee, the Committee shall maintain a record. Such record shall be separate from the Physician's credentials or personnel file. The record shall include, but not be limited to, the following: any referral requests or recommendations, the Monitoring Plan, a copy of the signed Advocacy Agreement, and any written reports or records assessing the Physician's compliance with such Agreement or status and recovery. The Committee shall maintain the confidentiality of such record to the fullest extent permitted by law. The record shall be maintained in a separate, locked file which shall be accessible only by members of the Ethics/Physician Health Committee. The record shall be maintained in accordance with the Hospital's record retention policies and procedures. The Committee shall report periodically to the Medical Executive Committee and the Governing Board regarding the number, but not the identity, of Physicians under the Committee's care.
- J. Confidentiality. All proceedings, deliberations, and records of the Ethics/Physician Health Committee shall be confidential. At no time shall the identity of the Physician or the nature of his or her impairment be released to anyone other than the Committee, KMAP, healthcare providers evaluating or treating the Physician, or, if required pursuant to paragraphs F or G above, the Medical Executive Committee. Except as otherwise provided herein, disclosure of this information outside of the Ethics/Physician Health Committee shall be made only to another Medical Staff peer review committee as reasonably necessary to assist that committee with its peer review activities and at the written request of the Physician or with the advice of legal counsel.
- K. Peer Review Status. In recognition of the responsibility of the Ethics/Physician Health Committee to evaluate Members referred to the Committee, and to thereby improve the quality of care provided by the

Medical Staff, the Ethics/Physician Health Committee shall function as a peer review committee in accordance with K.S.A. 65-4915 and 65-4923, as amended.

ARTICLE VI MISCELLANEOUS

6.1. Disaster Plan.

6.1.1. The Hospital Disaster Plan shall comply with the Medicare Conditions of Participation (“CoPs”), including the CoP for Emergency Preparedness, 42 C.F.R. 482.15, as amended.

6.1.2. The Chief of Staff and Hospital CEO shall work as a team to coordinate activities and shall give directions. In cases of evacuation of patients from one section of the Hospital to another, or evacuation from the Hospital premises, the Chief of Staff or Hospital CEO, or their respective designees, shall authorize the movement of patients.

6.2. Reports.

6.2.1. It shall be the responsibility of each Medical Staff Member and/or other qualified Practitioners to report, in writing, to the Chief of Staff or Hospital CEO any conduct, acts, or omissions by Medical Staff Members or other qualified Practitioners which are believed to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

6.3. General Rules Regarding Medical Staff Affairs.

6.3.1. Medical Staff Members shall not discuss with any other individual the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of its committees or departments. No Medical Staff Member shall discuss with any person outside the confines of any official Medical Staff committee, or department meeting as provided for herein any confidential information relating to any Hospital patient, any Medical Staff member, any Hospital employee, the Medical Staff’s operations, or the Hospital’s operations including, but not limited to, credentialing and personnel decisions, disciplinary action, matters before the Ethics/Physician Health Committee, and peer review, risk management, quality improvement, and utilization review activities.

6.3.2. Medical Staff Members shall not record or otherwise transcribe the proceedings of such meetings without the unanimous consent of all those in attendance.

6.4. Orientation of New Medical Staff Practitioners.

6.4.1. Each new Medical Staff Practitioner shall be introduced to the various Hospital Departments by the Hospital CEO or a designee.

- 6.4.2.** The Health Information Management Department and Nursing Service shall orient each new Medical Staff Practitioner as to their respective areas, detailing those activities and/or procedures that will help new staff appointees in the performance of their duties.
- 6.4.3.** Each new Medical Staff Practitioner shall be oriented concerning the applicable provisions of the Hospital's Code of Conduct and the Hospital's Corporate Compliance Program.

These Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, and, henceforth, all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges in the Hospital shall be taken under and pursuant to the requirements of these Bylaws.

The present Rules and Regulations of the Medical Staff are hereby readopted and placed into effect insofar as they are consistent with these Bylaws until such time as they are amended in accordance with the terms of these Bylaws.

ADOPTED by the Medical Staff on

April 25, 2023



Chief of Staff


Medical Staff Secretary / Treasurer

APPROVED by the Board of Trustees on

May 4, 2023


Board President
Board Secretary
President / CEO