PLATTE COUNTY MEMORIAL HOSPITAL

MEDICAL STAFF

GENERAL RULES AND REGULATIONS

DEFINITIONS

1. **Admitting Physician** The physician who admitted the patient and is responsible for the care of medical problems that may be present or arise during hospitalization.

2. **Attending Physician** The facility physician who had primary responsibility for the patient and includes the physician's cover or substitute.

3. **Consulting Physician** The physician who is consulting with the attending physician on the care of medical problems that may be present or arise during hospitalization.

GENERAL

These Rules & Regulations and related Hospital policies are designed to comply with standards of state and federal regulatory agencies, federal Medicare and Medicaid programs and the standards of The Joint Commission (TJC).

Quality Assessment and Quality Improvement

The Medical Staff Rules are an integral part of the Quality Improvement Program at the hospital. All Medical Staff members are expected to perform in good faith such duties as may be required to fulfill this obligation when requested by the Chief of Medical Staff and the facility CEO. The medical staff should assure a leadership role in the improvement of clinical processes that are dependent primarily on individuals with clinical privileges, such as surgery, physical examinations, and prescribing of medication. Select performance measures for processes that are known to jeopardize the safety of patients or are associated with sentinel events have select performance measures.

1. **Disaster**

    a. In the event of activation of the Facility Mass Casualty Plan, all practitioners shall respond immediately to the facility.

b. In the event a disaster declared pursuant to the Facility Disaster Plan requires evacuation of patients/ all staff members shall relinquish care of their patients in accordance with the Plan. The Rule overrides any rule to the contrary.

2. **Communicable Diseases**

Patients with communicable diseases, identifiable or suspect, shall be treated under proper isolation procedures for the protection of other patients and hospital staff using the Standard Precautions as identified by the Center for Disease Control.

ADMISSION POLICIES

1. **Who Can Admit**

Patients may be admitted to the facility only by practitioners who have been appointed to the Active or Courtesy categories of the Medical Staff and who hold admitting privileges or who have been accorded temporary admitting privileges. Expect in an emergency, as defined in the Medical Staff Bylaws, no treatment shall be rendered to a facility patient beyond the limits of the clinical privileges held by the provider at the facility. These privileges are on file in Administration and other appropriate departments.

2. **General Duties of the Admitting and Attending Physician**

a. The practitioner admitting the patient shall:

i. be responsible for the overall direction of the patient's care,

ii. be responsible to supply a timely, pertinent and complete medical record, appropriate orders within their privileges, including special instructions necessary to protect patients already in the hospital and staff from patients who are or may become a source of danger from any cause whatever, and

iii. transmit reports of the condition of the patients to any referring or collaborating practitioner and information and instructions to other caregivers, including family, as appropriate.

iv. Practitioners who cannot individually (a) meet Medicare, Medicaid and TJC requirements for management of all aspects of prospective patient's care; (b) perform and provide all required authentication of the full history and physical or (c) authenticate orders for reimbursement purposes, shall specify at the time of each admission the name of the specific physician who is on the Active Staff who has agreed to perform those functions in the individual case. A physician designated under this rule shall be the "Attending Physician" and shall have responsibility for the patient's care and documentation of the care to the extent that the care is outside the privileges of the admitting practitioner.

3. **Transfer of Responsibility**

Whenever responsibilities of the admitting practitioner or attending physician are transferred to another practitioner, a formal transfer order shall be entered on the order sheet of the medical

record by the original practitioner after they have made appropriate personal contact with the receiving practitioner to confirm acceptability of transfer and conveyed appropriate information concerning the patient

4. **Patient -Initiated Change of Practitioner**

In the event a patient discharges the attending physician or admitting practitioner without arranging for another who has relevant privileges, the Chief Nursing Officer (CNO) or designee will be notified. The CNO will contact the attending physician who shall arrange a transfer and give the appropriate order. In the event the attending physician fails to respond or is unable to arrange a timely transfer acceptable to the patient, a member of the Medical Executive Committee shall assign an appropriate practitioner, using the Emergency Room call list if feasible.

5. **Appropriateness of Admission**

The admitting practitioner shall provide sufficient information at the time of admission to establish that care can be provided to meet the needs of the patient. Appropriate care area will be identified based on patient status. (e.g. Medical Surgical, Swing Bed, Obstetrics).

6. **Admitting Information**

If the history-physical has been performed and dictated, but not transcribed and placed on the chart at the time of admission, the person responsible for its preparation shall put an interim note on the chart so stating. The interim note shall be in handwriting and will include:

a. the admitting diagnosis

b. statement of the patient's symptoms and general condition

c. other pertinent medical information and orders reasonable and necessary for the patient immediate care and to assure the protection and safety of the patient, other patients and staff.

7. **Timing of First Visit**

No practitioner shall admit a patient unless that practitioner is able to assume immediate, appropriate responsibility for the patient during the first twenty-four (24) hour period following admission. All inpatients and observation patients shall be seen by the admitting practitioner within twenty-four (24) hours and appropriate documentation of the visit recorded. The following categories of cases require a documented visit of the admitting practitioner no later that the indicated time (and earlier as required by the patient's condition)

a. AMI and/or thrombolytic intervention, within 30 minutes;

b. trauma, within 30 minutes;

c. upon request by the Emergency Room or other physician, within 30 minutes

d. obstetrics admissions in active labor, within 8 hours; and

e. ICU admissions within 4 hours.

8. **Potentially Suicidal Patients**

Any patient known or suspected to be suicidal shall be stabilized and transferred in accordance with the established emergency room policies and procedures. Any patient known or suspected to be suicidal shall have a consultation by a mental health professional within twenty-four (24) hours following admission or initial determination of suicidal risk.

CONSULTATION AND REFERRAL POLICIES

Consultation offers protection to the patient, to the physician and to the facility. In general, it is the duty of the attending physician to decide whether or not consultation is in order and whether or not to follow the recommendations of the consultant. If the patient outcome may be adversely affected by this decision, nursing or facility administration will ask the Chief of Staff or Vice Chief of Staff to evaluate the case.

1. Consultation should be considered under the following circumstances:

   a. the patient requires care beyond the expertise or clinical privileges of the practitioner

   b. when diagnosis remains in doubt after reasonable efforts

   c. the patient fails to respond to currently recommended/conventional treatment within an expected period of time

   d. there is a chance of major organ failure or loss of limb

   e. the patient or authorized designee requests consultation

2. When request for consultation is made, the attending physician is to indicate in writing on the physician order sheet the reason for the consult and the name of the requested consulting physician or physician group.

3. The attending physician and/or nursing staff will notify the consultant physician or physician group of the request.

4. The date and time of the consultation notification should be recorded on the order.

5. The consultant should examine the patient as well as the medical record then record or transcribe a consultation note to include pertinent findings, opinions, and recommendations.

6. When operative procedures are involved, the consultant shall record in the medical record prior the operation (except in an emergency).

INFORMED CONSENTS

1. **Informed Consent**

The facility 'Conditions of Admission' contains a general consent for routine diagnostic tests for patients. Specific written informed consent is required for any diagnostic testing, treatment or

procedure that is not routine in nature. Consent forms should be in writing and properly signed and witnessed. It is acceptable practice for someone other than a physician to obtain and witness a patient's signature on a consent form. Signed consent forms will be made a part of the patient's permanent medical record.

2. **Physician Responsibility**

It is the obligation of the practitioner performing the procedure or diagnostic test to make the initial determination of the patient's capability to give informed consent. Before initiating any procedure, the physician performing the diagnostic testing, treatment or procedure is responsible for informing the patient of (1) the nature of the condition for which the procedure is to be performed; (2) the nature and the probability of the reasonable foreseeable risks and benefits; and (3) alternative treatments. The physician must document this discussion with the patient. The Certified Registered Nurse Anesthetist (CRNA) must document the discussion leading to informed consent to anesthesia.

3. **Waiver of Informed Consent**

Informed consent may be waived if no legally authorized individual is available to give consent and the physician has determined that a medical/surgical emergency exists; that immediate care is needed to avoid serious or permanent injury to the patient; and that delay of treatment to secure express consent would materially increase the risk to the patient's life or health. The physician must document that an emergency existed and that immediate treatment was necessary.

4. **Capacity to Consent or Refuse Treatment**

An adult patient (18 or over) with decision-making capacity generally has the right to consent or refuse to consent to medical treatment. Spouses and other family members do not have the right to consent or refuse consent for competent patients. Where the patient is unable to make or communicate health care decisions, the patient's legal guardian, agent or surrogate may give or refuse consent. For unemancipated minors and wards, parents or guardians generally have the right to consent. (See Platte County Memorial Hospital policies on consent for further information).

5. **Advance Directive**

The patient may execute Living Will/Advance Directive to either direct or guide their future health care decisions when they no longer have decision-making capacity. Risk Management should be consulted whenever a surrogate's decisions are known to conflict with the directives given by the patient in an Advance Directive. The physician must transfer care of the patient to another physician if the surrogate's decisions violate the physician's conscience. (See Platte County Memorial Hospital policies on Advance Directive for further information).

PHYSICIAN ORDERS

1. **General Information**

a. Admitting orders are provided by the responsible physician.

b. All physician orders are to be written in dark ink. Felt pens and pencils will not be accepted.

c. All physician orders will be dated and signed within the prescribed time frames.

d. Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be completely rewritten with the current date.

e. Nurses have the responsibility of questioning any order that they feel might harm the patient.

f. Orders which are not legible will be clarified with the responsible physician before they are carried out.

g. Orders written on another facilities transfer form are confirmed with the attending physician. Verification of appropriateness is written on the Platte County Memorial Hospital's physician order sheet. Transfer orders do not need to be re-written.

2. **Orders for Surgery/Invasive Procedures**

a. A physician order is needed to obtain consent for surgery or for any invasive procedure. The order will state the specific procedure to be performed. The procedure listed on a signed fax per-operative order form can serve as the surgical consent order. The physician is responsible for signing the orders and verifying that the correct surgical/invasive procedure has been indicated for telephone orders.

b. Anesthesia medication orders given by the CRNA doing the case will take precedence over other preanesthesia medication orders.

c. The surgeon should give all routine admission orders.

d. It is not necessary to write out detailed orders post-operatively, but the physician at their discretion may write on the physician order 'resume preoperative orders.'

e. For patients who have had a major surgical procedure, the attending surgeon will be in charge of the management of the patient's care. The surgeon will be responsible for designating which physicians will be participating in the patient's care.

3. **Orders for Outpatient Tests/Procedure**

a. A signed order must be received prior to performing outpatient procedures/tests

b. A statement of the reason for the test and/or diagnosis must be indicated on the order and it must also contain a physician signature and date.

c. The following facsimiles or original orders are accepted:

i. Outpatient scheduling form

ii. Prescription form

iii. Referral form

iv. Notation in patient's history and physical

v. Physician order sheet

vi. Physician office letterhead

4. **Preprinted(Standing) and Faxed Orders**

a. Preprinted orders may be used by the medical staff after review and approval of the appropriate Department and Medical Staff. These orders will be individualized for each patient by the ordering physician by drawing a line through the unwanted items and adding any additional orders as indicated. The physician must sign and date these orders.

b. If faxed orders are transmitted to our facility by the attending physician, the orders must be transmitted on the attending physician's letterhead or on our facility's physician order sheet. The order will be dated, signed and placed in the patient's medical record.

5. **Verbal and Telephone Orders**

Verbal and telephone orders may be dictated only to registered nurses, registered physical therapists, registered respiratory therapists, registered pharmacists, registered dietitians, licensed medical technologists, registered radiological technicians and registered physical, occupational and speech therapists acting within their scope of practice and privileges, but shall be immediately recorded on the order sheet by the recipient and read back to the prescriber to confirm the information. The date, time, and originator of the order must be recorded and the recipient shall sign his/her own name as the person receiving and recording the order. All verbal and telephone orders must be signed by their originator within twenty-four (24) hours after they are given. All orders for medications, diagnostics, or treatment shall be in writing.

6. **No Code Orders**

a. No code orders are entered in the patient's medical record and signed by the responsible physician. The progress note should contain the physician's medical reasons for the order and their discussion with the patient or where the patient lacks medical decision-making capacity, with the patient's agent or surrogate decision maker.

b. Telephone no code orders are discouraged. However, if no code orders must be placed by telephone, the RN taking the order will have a witness on the telephone to verify and document the no code status. Physicians will sign the no code order upon their next visit and document the reasons (as outlined in 'a.' above) even though the patient may have already expired. (See Platte County Memorial Hospital policies on no code orders for further information).

MEDICAL STUDENTS AND RESIDENTS

1. **Residents**

   a. A Resident requesting authority to rotate with an attending physician at Platte County Memorial Hospital, must apply to the CEO, who has sole discretion to approve the rotation after consultation with the Chief of Staff.

   b. Residents in formal training programs may make entries into the patient's medical records under the following conditions:

      (a) History and physical examinations, operative notes, Emergency Room encounter forms and discharge summaries must be countersigned by the attending physician.

      (b) Consultation reports must be countersigned by the supervising consultant.

      (c) Progress notes need not be countersigned.

      (d) Orders written by the resident physician need not be countersigned.

      Medical students serving clerkships may enter the history and physical examination and orders into the patient's medical record, which must be countersigned by the attending physician. Progress notes need not be countersigned.

   a. Residents may write controlled substance orders for inpatients and outpatients provided that there is an agreement with the Home Program approving the rotation as an "approved rotation" and the Residents have a designated identifying number as required by Federal and State laws. Residents using the number of the Home Program must have their controlled substance orders written countersigned by an approved attending physician.

   b. Residents who are not credentialed to perform procedures must be supervised. When a Resident is involved in patient care, sufficient evidence is documented in the medical record to substantiate active participation and supervision of the patient care by the attending physician. All reports dictate by Residents are reviewed and signed by the responsible member of the attending staff. If the attending physician supervises a procedure (i.e. insertion of ART line, lumbar puncture, etc.), they should countersign the handwritten or dictated report.

   c. Orientation to facility and environment.

2. **Medical Students**

   a. Medical students may accompany the authorized physicians, but must wear proper identification and identify themselves properly to patients.

   b. Medical students will be processed through the Medical Staff office and must be on an official rotation or preceptorship. The student must receive prior approval by a medical staff member in good standing at the hospital. The level of participation protocols are outlined in the "Supervision of Medical Students" policy.

c. Orientation to facility and environment.

d. Other students not on an official clinical rotation will be processed through the Human Resource department.

3. **Removal**

a. Rotations of Students and Residents may be terminated by Platte County Memorial Hospital at any time, for cause or no cause. Students and Residents are not appointees to the Medical Staff and have no due process rights as set forth in the Medical Staff Bylaws or in the facility employee policies.

MEDICAL RECORDS

Platte County Memorial Hospital maintains medical records that are documented accurately, completed in a timely manner, readily accessible and permit prompt retrieval of information including statistical data. Medical records are the property of Platte County Memorial Hospital and shall not be removed except by court order statute or subpoena.

1. **Patient Access**

A patient may have access to information from their own medical record upon request, with reasonable advance notice, subject to any legal constraints (such as incompetence), unless the attending physician determines that access is contraindicated due to treatment of the patient for mental disorder, and notes this determination in the patient's medical record.

2. **Purpose**

An adequate medical record is compiled and maintained for each patient who has been treated or evaluated at our facility. The purposes of the medical records are:

a. To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment.

b. To furnish documentary evidence of the course of the patient's evaluation, treatment and change in condition.

c. To permit a consultant to render an opinion after an examination of the patient and review of the medical record.

d. To permit another practitioner to assume care of the patient at any time.

e. To document communication between the practitioner responsible for the patient and any other health care professional who contributes to the patient's care.

f. To assist in protecting the legal interest of the patient, facility and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, education and research.

3. **Information from Outside Sources**

Medical record information obtained on request from an outside source is placed in the medical record and is available to the professional staff concerned with the care and treatment of the patient. This information will contain the source name facility/address. Results of examination (lab and x-ray) performed prior to admission the patient to our facility are properly a part of the patient's medical record and should be recorded by the attending physician in his progress notes.

4. **Content**

All significant clinical information is incorporated into the patient's medical record in order to provide sufficient information to identify the patient, support the diagnosis, justify the treatment and document the results. Although the format and forms used to document in the medical record may vary, all medical records contain the following as appropriate:

a. Patient identification;

b. Health Care Directives, if provided by the patient or on the patient's behalf

c. Medical history;

d. Physical examination;

e. Diagnosis and therapeutic orders;

f. Medication orders;

g. Evidence of informed consent (documentation of the reason when consent is not obtainable);

h. Clinical observations;

i. Procedures, reports and test results;

j. Consultation reports, if consultation obtained;

k. A definitive principal (final) diagnosis;

l. Conclusions at the end of hospitalization, evaluation or treatment; and

m. Autopsy reports when necessary; and

n. Referrals, if any, to external or internal care providers or community agencies.

5. **Documentation in the Medical Record**

a. Abbreviations Only those abbreviations approved by the Medical Staff are to be used in the medical record. A list is posted on each nursing unit.

b. Entries All entries in medical records are dated, authenticated and a method is established to identify the authors of entries. Each practitioner authenticates the parts of the medical records that are their responsibility.

c. Error Correction To correct an error in the medical record, the practitioner must line through the incorrect information, write 'error', their name and date. Write in the correct information. The incorrect information should not be obliterated.

d. Patient Identification Each medical record will include patient identification (patient name, address, date of birth) which is shown on the registration sheet including a unique medical record number.

e. Authentication All authenticating signatures entered into a patient's medical record shall be by signature, initials, or electronic signature.

6. **History and Physical Examination**

a. Each history includes documentation of date of admission, identification data, chief complaint, allergies, history of present illness, pertinent past/social/family history, pertinent psychosocial needs, and a review of body systems. A physical exam must reflect a comprehensive physical assessment and be authenticated by an appropriately credentialed practitioner. A statement of the conclusion or impression (provisional diagnoses) drawn from the admission history/physical and a course of action planned for the patient must be documented.

b. A complete history and physical examination in all cases shall be recorded within 24 hours of admission. A history and physical performed greater than seven (7) days and less than thirty (30) days prior to admission is acceptable, provided such H&P has been updated and entered into the medical record within 24 hours of admission. An interval note for a readmission within 30 days of the previous stay (providing the admission is for the same condition) is also acceptable.

c. In addition to general requirements for medical record, Obstetrical records shall include:

i. Prenatal care record containing at least a serology test for syphilis, RH factor determination, past obstetrical history, physical examination and data concerning progress of present pregnancy;

ii. Labor and delivery record, including justification for any induction or operative procedure

iii. Records of anesthesia, analgesia and medications given in the course of labor.

d. In all surgical cases including same day surgery, and invasive procedures, a modified H&P examination must be on the record prior to the surgery or invasive procedure. A modified H&P can be performed which include documentation of date of admission, identification data, chief complaint, allergies, history of present illness, pertinent past/social/family history, pertinent psychosocial needs, and a review of at least cardiovascular, respiratory body system and any other system appropriate based on procedure and patient's medical condition.

e. When the H&P are not recorded before the time scheduled for surgery or invasive procedure, the operation or invasive procedure will be canceled, unless the primary operator/attending surgeon states in writing that such a delay would constitute a hazard to the patient. In such emergency situations, a note may be written by the primary operator/attending surgeon with date given, to include the preoperative diagnosis, description of any known drug allergies and other clinical findings pertinent to the safety of the patient during surgery or invasive procedure. Refer to the Minimal and Moderate Sedation Suggest under Surgical Cases.

7. **Progress Notes**

Progress notes will be completed by the attending physician and all other physicians actively participating in the course of treatment. Progress notes are to be documented by medical staff members who have been granted clinical privileges and allied health professionals within the approved scope of practice. Progress notes completed by allied health professional must be countersigned by the physician per the approved scope of practice. Progress notes give a pertinent chronological report of the patient's course in the hospital and reflect any changes in condition and the results of treatment. Progress notes will be completed following these timeframes:

a. For hospital patients, at least daily;

8. **Operative/Invasive Procedure Reports**

It is the responsibility of the operating physician to see that all operative/invasive procedures performed (including same day surgery) at this facility are fully dictated immediately after the procedure is completed. The procedure report and progress note will contain a description of the findings, technical procedures used, specimens removed, pre- and post-operative diagnosis, name of primary operator and assistants, any unusual events, post complications and management of such events.

9. **Procedures and Tests Performed**

Reports of all procedures and tests performed in diagnostic and therapeutic departments should be completed promptly and authenticated by the originator of the interpretation, with further reports of consultation prepared and signed within 24 hours of completion.

10. **Donor**

Medical record documentation will be consistent with the federal guidelines. (See Platte County Memorial Hospital policies on Organ Donation for further information).

11. **Nursing Documentation**

The medical record will contain pertinent, meaningful observations and information Nursing documentation requirements are developed by Nursing Service.

12. **Non-physician Entries**

Non-physicians will record information on appropriately designated forms. Opinions requiring medical judgment must be written by medical staff and individuals who have been granted clinical privileges.

13. **Discharge Summary**

a. A discharge summary will be dictated by the attending physician at the time of discharge on all cases where the length of stay is longer than 48 hours. It shall recapitulate the reason for the hospitalization, significant findings, procedures or operations performed, treatment rendered, condition of the patient upon discharge and all specific instructions given to the patient or family. If recorded by a resident, 3rd or 4th year medical student or allied health professional, it shall be authenticated by the attending physician.

b. The following information shall be recorded:

i. Reason for admission;

ii. All pertinent laboratory, x-ray and physical findings;

iii. Any medical and/or surgical treatment;

iv. Physical condition of the patient when leaving the hospital;

v. Any recommendations and arrangements for future care (to include physical activity, medication, diet and follow-up care, equipment and how to obtain further treatment);

vi. The principal and additional or associated diagnoses; and

vii. All relevant diagnoses established as well as operative procedures performed.

c. A final progress note may be substituted for a dictated discharge summary for patients who require less than 48 hours of hospitalization.

14. **Incomplete Records**

a. The patient's medical record shall be completed within 30 days after discharge, including progress notes, final diagnosis and dictated discharge summary. Completion of the medical record is the responsibility of the admitting practitioner except to the extent a specific part of the record is the responsibility of another practitioner.

b. The Health Information Management department will track incomplete medical records monthly. The HIM manager shall notify the CEO and the responsible practitioner of delinquent records by mail. If the delinquent records are not completed within a seven (7) day grace period from the date of the notice the facility CEO will be notified

15. **Medication Use**

a. General Information All medication administered to patients at this facility will be supplied by the facility Pharmacy unless otherwise defined by policy or pharmacy approval. The Pharmacy maintains a formulary as authorized by the Medical Staff. The formulary is an established compendium of approved medications available at the hospital for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more that one brand of an approved individual medication. Medications ordered by trade may not necessarily be filled by that name unless the physician states 'do not substitute' on the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established by Pharmacy & Therapeutics and approved by Medical Staff.

b. Medication from the Outside Medications brought into the hospital by patients must be specifically ordered by the physician and identified according to approved policy before being administered by facility personnel. These medications will be kept in the pharmacy. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician and in accordance with facility policy. Medications brought in by the patient which cannot be identified will not be administered to the patient by facility personnel nor should they be taken by the patient. All outpatient prescriptions must be labeled by the Pharmacy, unless the prescribing physician indicates otherwise.

c. Medication Orders Medication Orders must be written clearly and accurately, including date and signature. All orders for medications must be complete including medication name, dosage form, dose, strength, route (if medications can be administered by more than one route), frequency, rate, method, and site of administration. Medications ordered as 'PRN' must specify frequency, and indication. The use of abbreviations should be minimized and only standard approved abbreviations can be used. Medication dosages should be expressed in the metric system and the use of unnecessary decimal points or zeros after a decimal point should be avoided. A zero should be placed in front of a leading decimal point.

d. Automatic Stop Orders Medication orders for controlled substances will be automatically stopped in accordance with the medical staff approved policy. Unless the medication

order indicates the exact number of doses to be administered or an exact period of time for the medication is specified the physician will be contacted regarding the need to reorder the medications.

e. Authorization to Order Medications Medical practitioners with clinical privileges and licensed by the State of Wyoming to prescribe medications may write orders for medications. Allied Health Professionals as defined in the Bylaws may write orders under the policies outlined in the Policy Guidelines for Allied Health personnel. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults.

f. Authorization to Administer Medications Only appropriately licensed personnel or approved personnel working under the direction of a licensed person may be allowed to administer medications and diagnostic contrast media. Refer to the Medication Administration policy. The following personnel may administer medications at this facility under the order of a qualified, licensed practitioner:

i. Physician, Resident and Physician Assistant

ii. Registered Nurse, Licensed Practical Nurse, Nurse Practitioner, Certified Registered Nurse Anesthetist

iii. Certified or Registered Respiratory Therapist (medication related to respiratory treatments only).

iv. Respiratory Technician (medication related to respiratory treatments only).

v. Radiology Technologist and Nuclear Medicine Technologist (medications related to radiology/nuclear procedures only).

vi. Physical Therapist (topical medication only).

SURGICAL CASES

1. Preoperative Preparation

Before surgery, an appropriate H&P, lab studies, imaging, and evaluation by the CRNA must be completed. The H&P, including the provisional diagnosis, must be recorded or stated in writing to have been dictated before the time stated for operation; otherwise, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. Anesthesia: Any patient for whom moderate or deep sedation or anesthesia is contemplated receives a pre-sedation or preanesthesia and post-anesthesia assessment provided by the practitioner providing the anesthesia care.

2. Pathology

a. Tissues and foreign bodies removed during a surgical procedure shall be sent to the hospital pathologist for evaluation. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operation room at the time of removal. Each specimen must be accompanied by postoperative

diagnoses. Receipt by the laboratory of surgically removed specimens for examination shall be documented, and identity of the specimens and patients shall be assured throughout the processing and storage.

b. Specimens sent to the lab shall be examined by the pathologist. The determination of which categories of specimens require only a gross description and diagnosis shall be make conjointly by the pathologist and the medical staff, and documentation in writing. Categories of specimens that are exempt from the requirement to be examined by a pathologist are the following:

i. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance;

ii. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

iii. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

iv. Specimens known to rarely, if ever, show pathological change and removal of which is highly visible postoperatively.

3. **Procedures Requiring an Assistant**

Refer to the Surgery Department policies and guidelines for specific procedures requiring an assistant. The qualifications of the assistant are at the discretion of the surgeon, taking into consideration the surgeon's opinion of the best interests of the patient, the wishes of the patient, and the opinion of the referring physician.

4. **Minimal and Moderate Sedation**

Sedation and/or analgesia are given for diagnostic, therapeutic, or invasive procedures. This allows the patient to tolerate unpleasant procedures while maintaining adequate cardio respiratory function and the ability to respond purposefully to verbal command and tactile stimulation.

Administration and/or monitoring moderate sedation may be performed by a qualified physician, certified registered nurse anesthetist (CRNA) or registered nurse trained in administering or monitoring moderate sedation.

The physician responsible for managing the patient receiving moderate sedation must be competent in the use of sedation/analgesic techniques and able to provide a level of monitoring that includes respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, and determining the patient's level of consciousness. The physician must also be able to manage complications that may be related to the administration of moderate sedation.

Refer to **GUIDELINES FOR MINIMAL AND MODERATE SEDATION POLICY**.

EMERGENCY CARE RESPONSE

When taking call practitioners must be able to respond appropriately within 30 minutes or less. Under some clinical circumstances, the term"appropriate" implies physical presence as soon as reasonably possible within 30 minutes. Requirements according to state and federal law, accreditation standards, or specific hospital and system policies are applicable.
Refer to the EMTALA Guideline: Qualified Medical Personnel Authorized to Perform Medical Screening Examinations policy.

USE OF PHYSICAL RESTRAINTS

The patient has a right to freedom from chemical or physical restraint.
Refer to Platte County Memorial Hospital Physical Restraint Policy.

AUTOPSY CRITERIA

The Medical Staff of Platte County Memorial Hospital recognize that for the advancement of medical knowledge and as a standard for accuracy, the following criteria will guide them in attempting to secure an autopsy in the following circumstances:

1. Sudden, unexpected, unattended death as required by the county coroner.
2. Suspected criminal behavior resulting in death, i.e. firearm fatalities
3. Carbon monoxide poisoning
4. Drowning
5. Drug-related, therapeutic or overdosage
6. Heart Disease
7. Hypothermia
8. Worker's Compensation Cases
9. Pre-natal death of fetus
10. Death of children aged 12 and under, including neonates
11. Deaths during invasive procedures
12. Deaths within twenty-four hours of blood or blood products transfusion
13. Post-operative deaths
14. Burn deaths

Unexpected autopsy findings shall be referred to the Medical Staff for review and classification:

Class A: Treatable major unexpected findings - Autopsy findings of a major diagnosis that, if diagnosed premortem, would probably have improved chances of patient survival.

Class B: Untreatable major unexpected findings - Autopsy findings of a major diagnosis that, if diagnosed premortem, would not have improved chances of patient survival.

Class C: Minor unexpected findings - Autopsy findings of a secondary diagnosis or unrelated diagnosis that were not an immediate or primary cause of death.

A signed autopsy authorization permit shall be obtained before any postmortem examination will be performed. Individuals authorized to give consent for a postmortem examination include the county coroner and the nearest living kin of the deceased. The signed consent and identity of the person giving the consent shall be filed and kept with the patient's medical record.

The pathologist performing the autopsy shall report the findings of the postmortem examination as follows:

- For hospital cases:
    - The attending physician will be notified of the time and location of the autopsy so that the physician may attend if so desired. This notification will be documented in the autopsy report.
    - A phone call will be made to the attending physician upon completion of the gross examination.
    - A written final autopsy report will be issued within 30 days of performing the postmortem examination. The preliminary and final written autopsy reports shall be kept in the medical record.

- For coroner's cases:
    - A phone call will be made to the coroner upon completion of the gross examination.
    - A written final autopsy report will be issued within 30 days of performing the postmortem examination.
    - Further dissemination of the autopsy report will be at the discretion of the coroner and may become part of the medical record if appropriate.

QUALITY RESOURCE MANAGEMENT

1. In the management of any admission, it is the attending physician's responsibility to utilize medical resources efficiently, including to:

    a. Obtain pre-admission or pre-procedure certification if necessary.

    b. Admit patients on the day of their elective surgery or procedure or provide documented reasons of medical necessity for earlier admission.

    c. Initiate timely discharge planning.

    d. Facilitate, when possible, the appropriate pre-admission testing and medical clearance for elective surgical admissions.

e. Cooperate with physician advisors when issues or questions arise regarding necessity for admission or continued stay.

f. Participate in appeal of outside denials if the denial is felt to be unjustified.

2. Where an insurance plan has prospectively denied hospitalization, the physician should not order discharge until it is medically justifiable; should immediately appeal with the plan for reevaluation of medical necessity; and inform the patient of the denial to permit the patient to appeal and/or to authorize medical services at their own expense.

ADOPTION AND AMENDMENT

MEDICAL EXECUTIVE COMMITTEE AUTHORITY AND RESPONSIBILITY

The Medical executive Committee shall be responsible for the development, adoption, and periodic review of the General Rules and Regulations which must be consistent with the policies and applicable laws. The Rules and Regulations of the Medical Staff are adopted by the Medical Executive Committee and approved by the Board prior to becoming effective.

ADOPTION AND AMENDMENT

Policy Review: The Medical Executive Committee will review this policy periodically and as needed, based on revisions in regulations and practices.

Amendment: The policy may be adopted, amended, or repealed, in whole or in part, upon recommendation by the Medical Executive Committee and approved by the Governing Board.

Adoption: The policy will be adopted by approval of the Medical Executive Committee and the Governing Board.

TECHNICAL AND EDITORIAL AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Rules and Regulations as are technical or legal modifications or clarifications, reorganization or renumbering of the Rules and Regulations, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression. Such amendments shall be effective immediately upon Board approval.

Adoptions and Revisions to Rules and Regulations

Adopted by the Medical Staff	August 28, 1989
Approved by the Lutheran Hospital & Homes Board	October 20, 1989
Revision by the Medical Staff	March 31, 1997
Approved by the Luther Health Systems Board	April 30, 1997
Revision by the Medical Staff	May 28, 1998
Approved by the Lutheran Health Systems Board	July 23, 1998
Revision by the Medical Staff	May 28, 1998
Approved by the Lutheran Health Systems Board	December 2, 1998
Revision by the Medical Staff	January 25, 1999
Approved by the Lutheran Health Systems Board	March 1, 1999
Revision by Medical Staff	March 27, 2000
Approved by Banner Health System Board	April 20, 2000
Revision by Medical Staff	May 22, 2000
Approved by Banner Health System Board	June 12, 2000
Revision by Medical Staff	March 31, 2003
Revision by Medical Staff	November 27, 2006
Approved by Banner Health Board	December 21, 2006
Revision by Medical Staff	November 26, 2007
Approved by Banner Health Board	December 20, 2007
Revision by Medical Staff	February 24, 2009
Approved by Banner Health Board	March 11, 2009
Revisions by Medical Staff	March 31, 2009
Approved by Banner Health Board	April 9, 2009
Revision by the Medical Staff	October 27, 2009
Approved by the Banner Health Board	November 12, 2009
Revision by the Medical Staff	November 3, 2011
Approved by the Banner Health Board	December 8, 2011