PARKVIEW
LOGANSPORT HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

Board of Directors Approval: 08/25/25

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ARTICLE 1 ADMISSION AND DISCHARGE OF PATIENTS:

1.1 ADMITTING/ATTENDING PROVIDER: A patient may be admitted to the hospital only by an Appointee of the Medical Staff with admitting privileges. All providers shall be governed by the official admitting policy of the hospital. The Hospitalist will be available to admit, evaluate, diagnose and provide treatment to patients including evaluation in the emergency department and Category III critical care medicine. The provider admitting the patient is the attending provider until changed by order in the patient's chart. The attending provider is defined as the provider who has principle responsibility for the patient's medical care and treatment during that admission.

1.1.1 When the Hospitalist is involved in the care of the patient of another member of the medical staff, the medical staff member shall designate the following:

- Consultation: Hospitalist shall only provide consultation to admitting/attending provider for a specific realm of the patient's care.
- Assume Management: Hospitalist shall assume primary responsibility for the patient and manage the further care of the patient through discharge to ensure a continuum of care.

1.1.2 When the surgeon is a podiatrist, and the anesthesia provider is a non-physician (CRNA):

- There shall be evidence in the medical record that a physician responsible for management of medical crisis has been notified of the case start and is immediately available to provide intervention (three to five minutes).
- The podiatrist is responsible for charting preoperatively which physician is responsible for the management of any medical crisis.

1.2 PATIENTS ADMITTING INFORMATION: Providers admitting patients shall be held responsible for giving the hospital such information to the extent known by the provider as may be necessary to assure the protection of other patients and the hospital's employees from those who are a source of danger from any cause whatever and to assure the protection of the patient from self-harm.

1.3 PROVIDERS RESPONSIBILITY: An Appointee of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, and for necessary special instructions.

1.4 ADMITTING DIAGNOSIS: No patient shall be admitted to the hospital until a diagnosis, provisional diagnosis or valid reason for admission has been recorded.

1.5 ADMISSION OF PATIENT FROM THE EMERGENCY DEPARTMENT: In the event a patient in the emergency department requires, in the opinion of the emergency department provider, admission to the hospital, then appropriate medical staff provider(s) shall evaluate and, when appropriate, admit such patients. The hospitalist shall be available for such consultation/admission. When the patient's problem so indicates, a member of the medical staff in the appropriate service shall be available, based on the on-call schedule.

1.6 INITIAL PATIENT EVALUATION: The admitting provider, or their authorized alternate, shall see each patient within twelve, (12) hours of admission. Thereafter, the attending provider, or their alternate, shall visit the patient at least daily and enter a progress note in the patient's chart.

1.7 DESIGNATING A SUBSTITUTE PHYSICIAN FOR COVERAGE: Any Appointee of the Medical Staff, who will be unavailable for contact or call by the hospital for any period of time, shall designate a qualified substitute from among appointees of the Medical Staff or a provider in the same specialty at a neighboring facility who will be available during their absence.

For providers in a group practice, this may be accomplished by use of a call schedule whereby one provider is always available. If the provider designated to be on-call by the call schedule will be unavailable for contact, then the provisions of this section apply. If the provider is not a member of such a call schedule, then the provisions of this section apply.

It shall be the duty of the absent provider to secure their substitute, and notify the switchboard operator when and how long they will be absent. The Emergency Physician may not be designated as a substitute. Prompt and adequate care of all patients is the goal of the Medical Staff. Failure of a provider to designate an approved substitute shall constitute grounds for the President to refer the facts in the case to the Chief of Staff for possible corrective action as stipulated in Article 2.3 of the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges.

1.8 ADMISSION PRIORITIES: The Medical Staff shall define categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. The categories shall be approved by the Medical Executive Committee. Registration will admit patients on the basis of the following order of priorities:

1.8.1 Emergency Admissions: Providers admitting emergency cases shall be prepared to justify to the Medical Executive Committee and Administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

1.8.2 Urgent Admissions: The category includes those so designated by the attending provider and shall be reviewed as necessary by the Medical Executive Committee to determine priority when all such admissions for a specific day are not possible.

1.8.3 Pre-Operative Admissions: The category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of Surgery may decide the urgency of any specific admission.

1.8.4 Routine Admissions: The category will include elective admissions involving all services.

All medical staff members having admitting privileges may register patients for admission to the Hospital without preference. The medical staff member who requests admission will be designated as the admitting physician. This medical staff member may either identify themselves as the attending physician, or may designate a different physician as the attending physician. This different physician may either be the hospitalist, with the agreement of the hospitalist, or may be an associate of the admitting physician. Care may also be transferred at a later time to an attending physician, upon agreement of both physicians, and documentation of such in the medical record.

Further information regarding admission criteria may be found in the Utilization Review Plan in Case Management.

1.9 EMTALA REGULATIONS: Under EMTALA, Parkview Logansport Hospital, which is a Medicare-participating hospital, will provide an appropriate medical screening examination to each person presenting for emergency services. The medical screening examination will be appropriate to their presenting signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This screening shall occur regardless of the patient's ability to pay and shall be conducted by the following individuals designated as "Qualified Medical Personnel" (QMPs) within the statutory definition:

- Physicians (MD, DO, DPM)
- Nurse Practitioners - Advanced Practice Registered Nurses
- Physician Assistants
- Labor and Delivery Nurses who have successfully completed Intermediate Fetal Monitoring, S.T.A.B.L.E, and Neonatal Resuscitation Program.

If a person presents to the hospital with an emergency medical condition, including active labor, then the physician shall provide treatment to stabilize the medical condition or provide for an appropriate transfer of the patient to another facility. However, for purposes of these Rules and Regulations, that transfer shall not be deemed to be "appropriate" unless, prior to removing the patient from the hospital, arrangements have been made with another facility, sufficiently staffed and equipped to provide the type of care appropriate for the patient. Furthermore, such a transfer shall not be deemed to be appropriate if the process of transferring the patient to another facility threatens the well-being of the patient to a degree greater than the patient's well-being would be threatened if no transfer was made. If a transfer is made, arrangements shall be made so that copies of the patient's record shall be transferred with the patient.

Further information regarding EMTALA may be found in Policy #1034 "EMTALA" and Policy #1460 " Provision of On-Call Coverage for Emergency Medical Conditions".

1.10 PATIENT ADMISSIONS AND INTERUNIT TRANSFERS: Patients are admitted to particular rooms and particular units according to their identified needs. Factors considered and processes followed are explained in Nursing Policy #4001, "Admissions-Room Assignments-Room Assignment Change" which is reviewed and approved through a process that does involve medical staff.

1.11 UTILIZATION REVIEW: The attending provider is required to abide by the then current Utilization Review Plan as approved by the Medical Staff. This plan is defined in the Utilization Review Plan in Case Management.

1.12 INTENSIVE CARE ADMISSIONS: Admissions to the intensive care unit are governed by the specific policies of that unit. This is identified in Nursing Policy #4015, "ICU".

1.13 DISCHARGE ORDERS: Patients shall be discharged only on an order of the attending provider. Should a patient leave the hospital against the advice of the attending provider, or without proper discharge, or leaves without being seen, then Nursing Policy #4066, "AMA (Against Medical Advice) & LWBS (Left Without Being Seen)" shall be followed.

1.14 PATIENT DEATH: In the event of a hospital death, the deceased shall be pronounced dead by the attending provider or their designee within a reasonable time. Policies with respect to release of dead bodies shall conform to local law. This shall follow nursing policies #4023 “Deaths”, #4022 “DOA-Dead on Arrival”, and #4020 “Coroner’s Case-Unexpected Death”.

1.14.1 All patient deaths shall be reviewed and evaluated to determine that the patient received appropriate evaluation and care as part of the medical staff peer review process, and the Quality Council process.

1.15 AUTOPSIES: All Appointees of the Medical Staff are expected to be actively interested in securing autopsies. No autopsy shall be performed without the written consent of the next of kin or legally authorized agent. Performance of an autopsy may be appropriate in a variety of circumstances. Autopsies are of considerable value in contributing to the knowledge and understanding of the pathological processes that led to the death of the patient. Results from autopsies are used to identify opportunities to improve outcomes through performance improvement. Autopsies may be ordered through several different routes. The following criteria are to be used by the Medical Staff for identifying instances when an autopsy may be indicated:

An unanticipated death.
Death occurring while the patient is being treated under an experimental regimen.
Intraoperative or intraprocedural death.
Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
Death incident to pregnancy or following delivery.
Deaths where the cause is sufficiently obscure to delay completion of the death certificate.
Death occurring in infants or children with congenital malformations.

1.15.1 Coroner's Case: The list of circumstances outlined in nursing policy #4020 may be used by medical staff and nursing to identify cases which would be appropriate to refer to the coroner.

1.15.2 Family Request for an Autopsy: Families may make a request for an autopsy and postmortem examination. In this instance, nursing personnel are responsible for taking such request, discussing costs, obtaining consent, and making appropriate arrangements.

1.15.3 Physician Request for an Autopsy: In the event that a patient death occurs which is not appropriate to refer to the coroner, and in which the family does not request an autopsy, but the attending/covering physician believes that an autopsy would be appropriate/useful, then the physician, in cooperation with nursing, should talk to the appropriate family member/person to come to a decision about whether to order an autopsy. If a decision is made to proceed with autopsy, nursing personnel should obtain appropriate consent and make appropriate arrangements.

1.16 TRANSFUSION UTILIZATION REVIEW: The medical staff shall adopt blood and blood products administration practices based on current national guidelines, as per laboratory policy #7708LC-1 Logan, “Blood Products Guidelines”. A process is in place to review all transfusion activities, and report this thru the Blood Utilization Review Committee and the Quality Council.

ARTICLE 2 MEDICAL RECORDS:

2.1 MEDICAL RECORD CONTENT: The organization will have a Medical Record Service, which will maintain a medical record for every individual evaluated or treated in the hospital, including all areas, whether inpatient or outpatient. The Medical Record Service shall be organized per hospital administrative policies.

Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. All patient medical record entries must be legible, complete, detailed, timed and authenticated by the person responsible. The hospital shall have a procedure to ensure the confidentiality of each patient's medical record, and all members of the medical staff must follow hospital rules and regulations in regard to confidentiality, as well as any applicable federal privacy laws and/or HFAP standards.

The texting of medical orders is prohibited regardless of the platform utilized. The texting of patient information among members of the healthcare team is permissible if accomplished through a secure platform.

Entries in medical records are made only by individuals authorized to do so. The goal of the medical record, and the medical record management, is to obtain, manage and use information to enhance and improve individual and organizational performance in patient care, governance, management, and support processes.

The medical record must contain complete information regarding evaluations, interventions, care provided, services, care plans, discharge plans and the patient's response to those activities. Patient medical information, such as but not limited to, laboratory results, test results, consultations, assessments, radiology reports and dictated notes, must be promptly filed in the patient's medical record in order to be available to the physician and other providers for use and making assessments of the patient's condition. The medical record must contain information to identify the patient, to justify admission, to justify continued hospitalization, to justify the care, treatment and services provided, to

support the diagnoses, and to describe the patient's course/progress, the response to medications and other care, services, interventions and treatments, to provide continuity of care among providers, and to support planning the patient's care.

The medical records department will have policies that address which parts of the medical record may be delegated to non-physician practitioners, and the requirements for co-signature/authentication for any such non-physician practitioners, including but not limited to nurse practitioners, certified registered nurse anesthetists and physician assistants. Medical staff members are responsible for following such policies. The parts of the medical record that are the responsibility of the physician must be authenticated by the physician.

Abbreviations and symbols are used sparingly, and only in accord with administrative policy #1413, "Abbreviation List".

2.2 CATEGORIES OF PATIENTS**:**

2.2.1 Inpatient Records: An inpatient medical record will contain all of the information as specified in 2.1. It will follow the guidelines listed in 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9 and 2.10.

2.2.2 Observation Patient Records: Observation history and physicals shall correspond to inpatient history and physical standards. For patient stays under 48 hours, the final progress note may serve as the discharge summary, but must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care.

2.2.3 Outpatient Infusion/Outpatient Treatment Records: In the case of a patient who requires medical services less than twelve, (12) hours to receive medical treatment such as antibiotics or other intravenous medications, or blood transfusion, the medical record shall contain the patient's demographics, the reason for intervention, the provider's order and evidence of informed consent for any procedure and/or treatment for which hospital policy requires consent. Nursing assessment as appropriate, discharge criteria, discharge instructions and related nursing information shall be per nursing/hospital policy.

2.2.4 Ambulatory Surgery Records and Outpatient Surgery Records: For all patients undergoing surgical procedures in the operating suite, the standards outlined in section 2.7 should be followed.

2.2.5 Outpatient Records:

2.2.5.1 When the hospital provides ongoing ambulatory care to a patient for the same problem(s), whether this be in the freestanding clinics, in the cancer center or in other areas, then the hospital shall by no later than the third visit formulate a multidisciplinary problem list including problems, needs, allergies and diagnoses.

2.2.5.2 Diagnostic testing/imaging shall be promptly interpreted, and entered into the medical record, per section 2.8. When outpatient procedures are performed on patients in the radiology suite, then a dictated radiology note describing the details of the procedure, as explained in 2.7.4, is appropriate. Evidence of informed consent, if appropriate, shall be recorded.

2.2.5.3 When patients are seen for ambulatory care as outpatients in the outpatient clinics, then appropriate documentation shall be promptly entered in the record by the appropriate provider, per policy as approved by the Medical Records Committee.

2.2.6 Emergency Department Records: All patients seen in the emergency department shall have a record promptly prepared. This shall include a history and physical examination appropriate to the patient's chief complaint; significant past medical history, allergies, and medications. It shall include evidence of informed consent for any procedures requiring informed consent, along with descriptions of any procedures performed. Results of pertinent laboratory or other testing shall be described. A tentative, presumptive or differential diagnosis, treatment plan, including follow-up care, and discharge instructions including medications shall be recorded.

2.2.6.1 Emergency room records shall be completed within 4 hours in the case of patient admission/observation, or within 24 hours of the patient's disposition from the emergency department.

2.2.7 Obstetric Records: Obstetric records should include all prenatal information. This can be transmitted electronically to the EMR, or a durably legible original or reproduction of the office or clinical prenatal record can be used. Forms approved by the Medical Records Committee of Parkview Logansport Hospital may be used.

The office prenatal record shall be available to the labor and delivery department. In the case where the labor and delivery department and the involved office are on the same EMR, such availability should be automatic. In the case where they are not, then the office prenatal record shall be forwarded to the labor and delivery department following the visit occurring nearest to the 34th week of pregnancy.

The prenatal record should include information regarding the findings from laboratory data, as outlined in the nursing policy #4046, "Obstetrics".

2.2.7.1 Obstetric H&P: An H&P is required for all obstetrical patients. This can include the initial OB Work-up H&P when accompanied by the Obstetrical Flowsheet documenting any subsequent changes that have occurred during the course of the pregnancy.

2.2.7.2 Cesarean Section H&P**:** An H&P for cesarean section must meet the requirements of section 2.7.1. If the H&P was previously documented within 30 days prior to the admission, as described in section 2.3, then an update shall be attached to document the events leading to the indications for cesarean section, a statement of the patients current physical status or any conditions adding to the surgical risk, a preoperative diagnosis and a surgical plan.

2.2.8 Newborn Care: A newborn record, which is separate from that of the mother, is initiated and maintained. This record reflects almost continuous observations during the first hours of transition, from in-utero, until thermal stabilization has occurred. Newborn assessment data begins at delivery with the recordings of 1 and 5-minute Apgar scores.

Initial data are recorded by nursing including legal identification processes.

Consolidated nursing and medical data sheets include infant cord management and any state-mandated ophthalmic prophylaxis.

All data points are considered to document that the newborn is "at", "small for", or "large for", their calculated gestational/developmental age.

A physician physical assessment is documented for normal newborns at the completion of the "transition" period or prior to discharge.

2.2.9 Pediatric/Adolescent Patients: The medical records of pediatric and adolescent patients shall include documentation of the achievement of age-appropriate physical, emotional and social developmental markers, as outlined in nursing policy #4008, "Assessment/Reassessment of Patient Needs".

2.3 HISTORY AND PHYSICAL: A medical history and physical examination shall be completed and documented for all inpatients, observation patients, any patient undergoing conscious sedation, deep sedation/analgesia, general anesthesia and/or regional anesthesia, or any patient undergoing surgery except in the case of patients undergoing specific outpatient surgical or procedural services as defined below in 2.3.2. The History and Physical shall be documented in the electronic health record, per the EHR downtime policies, or legibly on an approved form and scanned into the EHR.

The purpose of a History and Physical is to determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment, such as but not limited to an allergy to a medication or comorbidity that requires certain additional intervention.

2.3.1 Although a History and Physical must be documented in the patient's record prior to any surgery or procedure requiring anesthesia, the complete History and Physical does not necessarily need to have been done by the provider who will be performing the surgery. If a different provider, such as the hospitalist, documents a complete History and Physical, then the provider who will be performing the surgery must complete and document in the record prior to the surgery a note, which, at a minimum, includes a history, review of pertinent clinical, laboratory and diagnostic data and physical examination sufficient to arrive at a preoperative diagnosis and plan, along with documentation of that diagnosis and plan.

2.3.1.1 Per ACHC Standard 03.01.07, more than one qualified practitioner can participate in performing, documenting, and authenticating an H&P for a single patient. Per national standards, and Section 2.3.3 of these Rules and Regulations, each chart must contain an assessment of the heart and lungs. In the case of a surgery patient, this will usually be documented by the surgeon. This may involve a different provider, such as the hospitalist, documenting a complete History and Physical, as described in the previous paragraph. This may also involve the surgeon documenting all needed content as described in 2.3.3 below, with the exception of assessment of the heart and lungs, which in that case is documented by the anesthesia provider and contained in the anesthesia preop note.

2.3.2 The History and Physical documentation must be in the patient's record within 24 hours of admission or registration, and prior to any surgery or procedures requiring anesthesia services, whichever is earlier.

If a History and Physical has been completed within thirty (30) days prior to admission or prior to surgery/procedure requiring anesthesia, or other similar procedure, then a copy of this report, with an appropriate addendum, may be used in the patient's medical record. An updated entry must be provided by the operating provider on the day of the procedure documenting that a history has been taken and an

examination has been performed to determine if there have been any changes in the patient's condition since the time that the patient's H&P was performed, that might be significant for the planned course of treatment.

If, upon examination, the provider finds no change in the patient's condition since the H&P was completed, they may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that no change has occurred in the patient's condition. If, upon examination, the provider finds that a change in the patient's condition has occurred, this should be documented and evaluated appropriately. If the provider finds that the H&P done before admission is incomplete, inaccurate or otherwise unacceptable, then the provider should document a new H&P.

The above described addenda and/or new H&P should be completed after but within 24 hours of the patient's admission/registration, but prior to surgery or any procedure requiring anesthesia.

2.3.3 Content of History and Physical: The medical history shall include the chief complaint, history of present illness, relevant past medical, past surgical, social and family history including emotional, behavioral and psychosocial issues, a list of current medications including dosages and schedules, a history of allergies and medication reactions, a review of body systems, and results of relevant diagnostic studies. Physical examination shall include an appropriate overall examination with particular attention to the body system involved in the chief complaint. Physical examination shall also include assessment of the heart and lungs. It shall include a diagnosis, presumptive diagnosis or differential diagnosis, as well as an initial plan.

2.3.3.1 Osteopathic Musculoskeletal Examination: An osteopathic musculoskeletal examination is indicated as an integral part of the H&P performed by osteopathic physicians unless contraindicated or not applicable. The reason for omitting the musculoskeletal examination is documented in those cases where this exam is contraindicated or not applicable.

2.3.3.2 Conscious Sedation/Moderate Sedation: If the patient is to undergo conscious sedation/moderate sedation without involvement of the anesthesia department, and the History and Physical is thus to serve as the pre-anesthesia assessment in addition to being the primary assessment, then the History and Physical must contain content as above, as well as including mental status, auscultation of heart and lungs, and visualization/assessment of oropharynx/airway.

2.3.3.3 Epidural Procedures or Facet Joint Interventions for Pain Management, Skin/Subcutaneous Procedures Under Local or No Anesthetic: Pursuant to Medical Staff standards, and to HFAP standards 30.00.10 and 10.01.09, and to the Code of Federal Regulations Part 482.22 (C) (5) (v), the Medical Staff has chosen to require an assessment of the patient in lieu of the above described comprehensive H&P, in the instance of patients receiving epidural procedures for pain management, facet joint interventions for pain management, and skin/subcutaneous procedures in the treatment room under local anesthetic or no anesthetic. These patients shall be 18 or older, receiving local anesthetic or no anesthetic, and be American Society of Anesthesiologists, “ASA” category 1 or category 2.

Applicable state and local health and safety laws shall be followed.

For pain management, assessment shall include at a minimum, consistent with recognized guidelines and published local coverage determination guidelines, a pre-procedure history sufficient to establish the indication for epidural steroid injection, “ESI” and to exclude contraindications and any other pertinent patient history, a pre-procedure physical examination which includes a basic musculoskeletal examination, focused neurologic examination and assessment of heart, lungs and airways sufficient to establish the indication for ESI and to exclude contraindications. Evaluation must be sufficient to determine ASA status, to determine concordance of assessment with radiologic/diagnostic testing, and to determine a comprehensive care plan.

For skin/subcutaneous procedures, assessment shall include at a minimum, consistent with recognized guidelines, evaluation sufficient to determine ASA status, allergies, pertinent patient history, physical exam including heart, lungs, airways and area of procedure sufficient to determine a comprehensive care plan.

2.3.3.4 All records must document the admitting diagnosis.

2.3.3.5 The plan for evaluation and treatment shall be recorded.

2.4 DIAGNOSTIC AND THERAPEUTIC ORDERS: All orders for treatment shall be in writing or electronic, with electronic orders preferred and used when feasible. These shall be signed by the ordering provider, or their alternate as appropriate, and must be clear, legible and complete. Orders which do not meet these criteria will not be carried out until clarified. Texting of orders is not permitted. All orders shall be dated, timed and authenticated promptly.

A verbal order shall be considered to be in writing if dictated to a registered nurse, licensed practical nurse, registered pharmacist, registered x-ray technician, registered respiratory therapist, registered dietitian, registered occupational therapist or registered physical therapist functioning within his/her sphere of competence. All verbal orders must follow a "read back and verify" process to where the receiver of the order reads back the order to the ordering provider to verify for accuracy. All orders dictated over the telephone shall be signed promptly by the appropriately authorized person to whom dictated with the full name of the provider per his or her own name. The responsible provider shall date, time and authenticate repeated and verified orders as the provider completes the medical record within 48 hours. If the provider who gave the order is going to be off duty for an extended period of time, then another provider who is responsible for the patient's care may authenticate the order. A provider's routine orders, when applicable to a given patient, shall be reproduced in detail in the patient's record, and dated and signed by the provider. All previous orders are canceled when a patient goes to surgery or enters ICU, unless the attending provider specifically orders the previous orders to be continued.

2.4.1 Restraints: Orders for restraints shall be as stipulated in the Nursing Administrative Policy #4068, "Restraints".

2.4.2 Outpatient Orders: The stipulations of Administrative Policy #1481 "Outpatient Orders", shall be followed by all providers ordering outpatient services including but not limited to Laboratory, Radiology, PT, OT, and other services as described in said policy.

2.4.3 Preprinted Order Sets and Protocols: The stipulations of Pharmacy Policy #6710-021 "Routine Standing Orders" shall apply to all Providers.

2.5 PROGRESS NOTES: Progress notes should give a pertinent chronological report of the patient's course in the hospital and should reflect any changes in condition and the results of treatment.

Patients should undergo reassessments by providers responsible for their care whenever there is a significant change in the patient's condition or status, whenever there is a significant response, either desired or undesired, to a procedure or intervention, but in any case at least daily. These reassessments should be documented in the clinical record as progress notes.

2.5.1 Any patient that remains in the Emergency department for 12 hours or more shall have a progress note written at least every 12 hours, and more frequently if indicated for a change in the patient status. Providers are encouraged to include in their note at the end of their shift a statement of the current status of the patient, along with the fact that they have turned the patient over to another provider, and the name of that provider.

2.5.2 When a provider furnishes a consultation for a patient, that provider shall write daily progress notes as long as the provider continues to be involved in the care of the patient.

2.5.3 Multidisciplinary Plan of Care: Each patient will have a comprehensive, integrated, multidisciplinary plan of care, which shall be prepared in accordance with Nursing Policy #4038, "Interdisciplinary Care Planning/Plan of Care".

2.6 CONSULTATIONS: A consultation is a type of service provided by a Physician or other appropriate source whose opinion or advice regarding evaluation and/or management of a specific problem is requested. The request for a consultation must be documented in the patient's medical record. All patient records, both inpatient and outpatient, must document the results of all consultative evaluations of the patient and appropriate findings by the clinical staff involved in the care of the patient.

Any qualified provider with clinical privileges in the hospital can be called for consultation within their area of expertise.

Further regulations concerning the conduct of consultations can be found in Section 3.11 of these Rules and Regulations.

2.6.1 A written or dictated consultation report shall be placed into the patient's record as soon as possible after the consultation is performed.

2.6.2 A satisfactory consultation includes a history, examination of the patient and review of the medical record, and a written opinion, with recommendations and/or a plan, signed by the consultant, which shall be made a part of the patient's record.

2.7 REPORTS OF PROCEDURES, INCLUDING OPERATIVE PROCEDURES, AND OTHER INVASIVE PROCEDURES: All procedures should be recorded and authenticated in the medical record. This may also include any reports from facilities outside the hospital in which case the source facility shall be identified on the report.

2.7.1 Pre-Operative Evaluation: Surgery is performed only after an H&P or patient assessment, as explained in section 2.3, has been placed in the patient chart and authenticated. Even in an emergency situation, a brief

note including the preoperative diagnosis is recorded before surgery, unless such delay would be life-threatening to the patient. In the absence of appropriate preoperative evaluation, the surgery will be canceled.

2.7.2 Informed Consent: All records must document informed consent, as appropriate, for procedures and treatments. This shall follow Administrative Policy #1260, "General Consent/Informed Consent".

2.7.3 Operative Report: After any operation or other invasive procedure, a report shall immediately be placed into the patient's chart. Preferably, this report should be placed in the EHR, but if this is not possible, it shall be handwritten immediately in a legible fashion. This report includes, as applicable, at least, the name and hospital identification number of the patient; the date and time of the surgery/procedure; the name(s) of the surgeon(s) and assistants or other providers who performed surgical tasks, including, if applicable, a listing of any significant surgical tasks that were conducted by providers other than the primary surgeon/provider, including opening and closing, harvesting graft, dissecting tissue, removing tissue, implanting devices, and/or altering tissues; preoperative and postoperative diagnoses; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications (if any); a description of the techniques and findings; a description of the tissues removed or altered (if any); blood loss, and a listing of prosthetic devices, grafts, tissues, transplants or devices implanted (if any). This should also include a description of any unusual events or complications, including blood transfusion reactions, and the management of these events.

The completed operative report should be filed and authenticated as soon as possible after surgery so that the care of the patient is transferable if the surgeon is unable to attend to the immediate needs of the patient.

2.7.3.1 Additionally, if an operative report is not immediately available (i.e. dictated and not yet typed), an immediate post-op note should be documented in the medical record immediately after surgery (within 30 minutes) to provide pertinent information for any individual required to attend to the patient while the comprehensive report is being prepared. This immediate post-operative progress report should be documented for any procedure in the OR, or any other invasive procedure done elsewhere in the hospital that in the opinion of the treating physician, places the patient at significant risk. It should contain the name of the primary surgeon and any assistants, findings, technical procedures used, specimens removed, postoperative diagnosis, and complications.

2.7.4 Interventional Procedures Performed Outside the Surgery Suite: For minor procedures (such as insertion of central venous catheter or other similar procedures) a note in the progress notes describing the procedure, along with any complications from the procedure, is indicated. For procedures in the radiology suite, a dictated radiology note is appropriate. For more detailed procedures (such as endoscopy), a dictated operative note meeting the criteria in section 2.7.3 should be recorded.

2.7.5 Pre-Anesthesia Evaluation and Anesthesia Record: There shall be a pre-anesthesia evaluation completed and documented prior to but within 48 hours of any procedure requiring anesthesia. This includes evidence of a patient interview verifying past and present medical history, including anesthesia, drug and allergy history and previous anesthetic experience, evidence of a patient physical status assessment (such as the American Society of Anesthesiologists' Physical Status Classification System), results of relevant diagnostic studies, and choice of anesthesia. Before anesthesia there is a determination that the patient is an appropriate candidate to undergo the planned anesthesia. This determination is made by a provider or practitioner with appropriate clinical privileges and is based on the results of the pre-anesthesia assessment, and such assessment and determination are recorded and authenticated in the medical record. Immediately prior to the induction of anesthesia, the patient is re-evaluated. During anesthesia, an appropriate anesthetic record is maintained. The patient's post-operative status is assessed on admission to and discharge from the post-anesthesia recovery area. Post-operative documentation includes at least a record of the vital signs and level of consciousness, medications (including intravenous fluids) and blood and blood components administered, and documentation of the patient's readiness for discharge from the post-anesthetic care unit by the responsible Licensed Independent Practitioner or by the use of relevant discharge criteria. The recording of post-anesthetic visits, including at least one note describing the presence or absence of anesthesia related complications should be documented in the medical record.

2.8 REPORTS OF TESTS: Tests such as but not limited to clinical laboratory examinations, pathology, radiology, ultrasound, nuclear medicine, other imaging services, other diagnostic testing and any other diagnostic procedures shall be completed promptly and filed in the electronic record within twenty-four, (24) hours of completion, whenever possible. Clinical laboratory results should be filed in the electronic record as quickly as possible, in agreement with current laboratory policy #CF-140713 "Turnaround Times". If the electronic medical record is down, downtime procedures shall be followed.

2.9 DOCUMENTATION OF COMPLICATIONS: All records, both inpatient and outpatient, shall document, as appropriate, any complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia.

2.10 CONCLUSIONS AT TERMINATION OF HOSPITALIZATION: The Medical Record must document a discharge summary with the reason for hospitalization, the discharge diagnoses and outcome of hospitalization, any procedures/operations performed, disposition of the case and provisions for follow up care. For patient stays under 48 hours, the final progress note may serve as the discharge summary, but must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. Newborns who are transferred shortly after birth are considered short stay infants, and documentation requirements include one transfer note which contains all history, physical examination, progress and discharge/transfer information.

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.

2.10.1 For all inpatients, and all complicated patients, a formal discharge summary shall be dictated by the responsible physician or other qualified provider who is responsible for the patient's care during hospitalization. This shall be completed, filed and authenticated within 7 days of patient discharge. Other providers who are knowledgeable about the patient's condition, the patient's care during the hospitalization, and the patient's discharge plans may write the discharge summary at the request of the responsible provider.

2.10.2 The discharge summary requirements also include outpatient records, such as but not limited to outpatient surgery patients or an emergency department patient. These records do not require a separate discharge summary, but the overall record should contain information about the outcome of the surgery/patient visit, the disposition of the case and the provisions for follow-up care.

2.10.3 In the event of a patient death, the final documentation/discharge summary should indicate the presenting diagnosis, the findings and course in the hospital, and the events leading to death. If any information is available regarding coroner's case/autopsy, it may be included.

2.10.4 The patient discharge instructions should include information regarding medications, diet, physical activity and follow-up care. The patient must be presented with medication instructions at discharge in lay terminology, including dosage, route, and frequency of administration. When preprinted discharge instructions are given to the patient and/or family, the record should so indicate.

2.11 RELEASE OF MEDICAL INFORMATION: Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information, as stipulated in Administrative Policy #1420, “Release of Medical Record/Patient Information”.

2.12 REMOVAL OF RECORDS FROM HOSPITAL: Records may be removed from the hospital’s jurisdiction and safekeeping only in accordance with court order, subpoena duces tecum or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the ~~CEO~~ President. In case of readmission of a patient, all previous records shall be available for the use of the attending provider. This shall apply whether the patient is attended by the same provider or by another. Unauthorized removal of records from the hospital is grounds for suspension of the provider for a period to be determined by the Medical Executive Committee. These regulations are designed to ensure information confidentiality, security, and integrity.

2.13 ACCESS TO RECORDS BY MEDICAL STAFF: Free access to all medical records of all patients shall be offered to appointees of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee before records can be studied. Subject to the discretion of the President~~,~~ former Appointees of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all patients during which they attended such patients in the hospital.

2.14 FILING OF MEDICAL RECORDS: A medical record shall not be permanently filed until it is completed by the responsible provider or it is ordered filed by the Medical Record Committee. If records remain incomplete due to the absence or death of the provider, a notice will be placed in the record by the Chairman of the Medical Records Committee to indicate the reason for the incompleteness, as per the Medical Records Policy #8710-129, “Administrative Closure of Medical Records”.

2.15 INCOMPLETE MEDICAL RECORDS: Providers with delinquent medical records shall be subject to the sanctions specified in the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges.

2.16 SIGNATURE RESPONSIBILITY: The parts of the medical record that are the responsibility of the medical provider must be dated and signed by them, or their alternate or consultant as appropriate within 30 days of discharge. All entries made by non-medical staff personnel are counter-signed by the appropriate attending medical staff appointee. Authentication may be by written signature or electronic/computer signature, (as per the Medical Records Policies).

2.16.1 Electronic/Computer Signature: An electronic/computer signature is acceptable under the conditions stipulated in Medical Records Policy #8710-111, "Physician Signature File".

2.16.1.1 The Practitioner whose signature the unique identifier, such as a number or computer key represents is the only one who uses it.

2.17 PRESCRIPTION WRITING FOR NON-PATIENTS: The hospital and medical staff acknowledge AMA opinion 1.2.1, whereby a provider treating oneself or their family is discouraged from doing so. The hospital and medical staff also acknowledge that writing a prescription for such persons is legal in the state of Indiana. In the event that a Provider at LMH chooses to write a prescription for themselves, their family, friends, coworkers, or anyone with whom they do not have an active, official, documented patient/provider relationship, then the prescribing provider must document the care provided in the EMR. This may be accomplished by hand writing a note describing the condition treated/diagnosis, and the medication prescribed, and having office personnel scan that note into Cerner. The note describing the condition treated/diagnosed, and the medication prescribed, may also be entered by the prescribing provider directly into Cerner, under communicate/message. If the prescribing provider enters Cerner to document such a note, they should be aware that under HIPAA, their interactions with the chart will be tracked, and any action whereby they look anywhere else in the chart will be treated as per the HIPAA guidelines. To protect themselves, it is suggested that the provider notify either their office manager or the HIPAA Privacy Officer that they have or intend to enter the restricted chart. If the patient for whom the prescription is written is not a Cerner patient, then the handwritten note shall be sent to pharmacy for filing.

ARTICLE 3 GENERAL CONDUCT OF CARE

3.1 GENERAL CONSENT: A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. Hospital personnel will obtain the patient's signature on the general consent form. This shall be as stipulated in Administration Policy #1260, "General Consent/Informed Consent".

3.2 INFORMED CONSENT: A policy of informed consent shall be developed by hospital administration and shall be consistent with any legal requirement and appropriate forms for such consents will be adopted with the advice of legal counsel, (see Administrative Policy # 1260, "General Consent/Informed Consent"). The provider ordering and/or providing specialized care shall be responsible for obtaining and signing the informed consent form, following hospital policy.

3.3 DRUG APPROVAL: All drugs and medications administered to patients shall be those approved by the Federal Drug Administration, or those authorized under Emergency Use Authorization by the FDA and/or listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations.

3.4 MEDICATION ORDERING AND DISTRIBUTION: The ordering and distribution of medications will be done in strict accordance with all federal and state laws and regulations as per the current pharmacy policies.

3.4.1 Medications are ordered and dispensed as stipulated in Pharmacy Policy #6710-015 "Drug Distribution".

3.4.2 Narcotics are ordered and distributed as stipulated in Pharmacy Policy #6710-024 "Medication Distribution – Controlled Substances". Use of narcotics will also be guided by Policy #8770-219 "Prescribing of Opioid Controlled Substances for Chronic Pain Management", Policy #8910-010 "INSPECT Reports", and Policy #8910-011 Prescribing of Controlled Substances".

3.4.3 High risk medications are ordered and distributed as stipulated in Pharmacy Policy #6710-020 "High Risk / High Alert Medications".

3.5 PATIENT PHARMACEUTICALS BROUGHT TO THE HOSPITAL: Drugs brought into the hospital by patients may be used as stipulated in the Pharmacy Policy #6710-023 "Patient's Own Medications".

3.6 INFECTION PREVENTION: All providers shall abide by the Hospital Infection Prevention Policies as outlined in the policy manual.

3.6.1 Cultures are initiated by order of the attending provider, except in the event of purulent drainage from or inflammation at a vascular access site with the presence of systemic symptoms such as an elevated temperature, in which case the vascular catheter, will be cultured per hospital procedure.

3.6.2 The Infection Prevention Committee has the authority through its chairman or designee to institute any appropriate control measures or studies when there is considered to be a danger to any patient or personnel.

3.7 RESUSCITATION OF A PATIENT: In the event that resuscitation of a patient becomes necessary, the hospital shall expend all efforts to resuscitate said patient, following generally accepted medical standards, including but not limited to American Heart Association BLS/ACLS protocols. In some cases, resuscitation may be inappropriate, or not desired, and a DNR/No Code order may be appropriate. In that situation, the attending physician should play the

major role. Medical Staff documentation requirements for writing DNR/No Code Orders are specified in Nursing Policy #4079, "Writing DNR/No Code Orders". Perioperative care of patients with Do Not Resuscitate (DNR) orders shall follow Nursing Policy #6300- 246, "Perioperative Care of Patients with Do Not Resuscitate (DNR) Orders".

3.8 RESTRAINT OF A PATIENT: In the event that restraint of a patient becomes necessary, the Medical Staff shall abide by the Nursing Administrative Policy #4068, "Restraints".

3.9 FIRST ASSISTANTS IN SURGERY: The Medical Staff hereby defines that no cases eligible to be performed at this facility are considered "hazardous" procedures which would require the presence of a physician first assistant to be scrubbed. Furthermore, decisions regarding what type of assistant is indicated for any specific case is up to the operating surgeon. The Medical Staff defines that no cases eligible to be performed at this facility specifically require a non-physician first assistant, just as none require a physician first assistant. If a non-physician first assistant is used in a particular case, that person must meet appropriate qualification standards. For dependent practitioners, that would be defined by the Policy on Allied Health Professionals and Dependent Practitioners, and the associated credentialing process. For non-physician hospital employees not covered under that policy, the qualification process shall be handled via Human Resources, with specific criteria approved by the Chairperson of the Surgery Section.

3.10 Anesthesia Providers: The Medical Staff designates that general anesthesia, regional anesthesia (including spinal or epidural anesthesia) more extensive than digital blocks and ankle blocks, and monitored anesthesia care, may only be administered by a qualified anesthesiologist or certified registered nurse anesthetist (CRNA). Planned deep sedation/analgesia may only be administered by qualified anesthesiologists or certified registered anesthetists, or by qualified physicians credentialed and privileged in the emergency department, and working in the emergency department. Digital blocks, field blocks, ankle blocks, and topical or local anesthetics may be administered by provider/practitioners who have appropriate training and education. Moderate sedation may be administered by members of the medical staff, Allied health professionals and dependent practitioners who have been granted appropriate privileges to do so.

3.10.1 CRNAs must be supervised by a physician, in concordance with state law. This is further discussed in the CRNA clinical privilege application form. Such nonphysician providers do remain accountable to the organized medical staff. CRNA's may be supervised by an anesthesiologist, or by another physician, including the operating physician. Physicians may supervise a CRNA who is providing anesthesia for a procedure of the general type and complexity that the physician generally performs. This does not specifically mean that any given physician need to be granted specific privileges for a specific type of procedure in order to supervise a CRNA providing care for that procedure.

3.10.2 Further information regarding administration of minimal sedation and moderate sedation by members of the Medical Staff, Allied Health Professionals and Dependent Practitioners who are nonanesthesia providers may be found in policy #4019.

3.11 CONSULTATIONS: A consultation is a type of service provided by a Physician or other appropriate source whose opinion or advice regarding evaluation and/or management of a specific problem is requested. The request for a consultation must be documented in the patient's medical record. All patient records, both inpatient and outpatient, must document the results of all consultative evaluations of the patient and appropriate findings by the clinical staff involved in the care of the patient.

Any qualified provider with clinical privileges in the hospital can be called for consultation within their area of expertise.

Regulations regarding the Medical Record aspects of consultations can be found in Section 2.6 of these Rules and Regulations.

3.11.1 When a member of the medical staff requests a consultation from another member of the medical staff, then such consultation must be performed. If the need for consultation is urgent, then such consultation should be performed as soon as possible. For all other consultations, any consultation called by 3 PM should be seen the same day, and any consultation called after 3 PM shall be seen no later than 10 AM the following day.

3.11.2 Requests for consultation, as well as requests for diagnostic testing which require professional interpretation, such as but not limited to imaging or pathology, should include sufficient detail to facilitate the interpreters review. The reason why a consultation is sought should be clear. The professional staff that provide patient assessment consultations and/or evaluate diagnostic tests should logically come to their own conclusions; however, these professionals should be provided sufficient information and data to facilitate such requested consultations and evaluations.

3.11.3 For all patients who are in psychiatric crisis, have attempted suicide or have taken a chemical overdose with suicidal intent a mental health evaluation will be done by the Parkview Logansport Hospital nursing staff and the provider caring for the patient, (refer to Nursing Administrative Policy #4043, "Management of Patients in Psychological, Emotional, or Substance Abuse Crisis in the Emergency Department").

3.11.4 Consultation may be required for certain medications as specified by the Pharmacy and Therapeutics Committee, and approved by the Medical Executive Committee.

3.11.5 Anytime the scope of care exceeds the scope of privileges granted to the provider, a consult with the appropriate specialist will be required. This includes patients in the ICU/critical care patients, whose care provider does not have appropriate critical care privileges, and who therefore require consultation with an appropriately privileged specialist.

ARTICLE 4 AMENDMENTS TO THE MEDICAL STAFF RULES AND REGULATIONS:

The Medical Staff Rules and Regulations may be amended or repealed following the procedure cited in the Medical Staff Bylaws Article 10. Such changes become effective when approved by the Board.

ARTICLE 5 ADOPTION:

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Rules and Regulations.

Amended by the **Medical Executive Committee** on August 14, 2025.

Olusina Akande, MD
Chief of Staff

Approved by the **Board of Directors** on August 25, 2025

Jessica McClintock Glover, M.D.
Chairman, Board of Directors