

PARKVIEW WABASH HOSPITAL, INC.

Wabash, Indiana

MEDICAL STAFF RULES AND REGULATIONS

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MEDICAL STAFF

RULES AND REGULATIONS

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**PARKVIEW WABASH HOSPITAL, INC.
MEDICAL STAFF RULES AND REGULATIONS**

The Medical Staff shall adopt such Rules and Regulations as may be necessary for the proper conduct of its work. These Rules and Regulations shall be subject to the approval of the Medical Staff Executive Committee and the Hospital Board of Directors and shall be attendant to the Bylaws. Said Rules and Regulations shall relate to the proper conduct of Medical Staff activities, and the level of practice that is to be required of each Practitioner in the Hospital. Applicants to and members of the Medical Staff shall be governed by these Rules and Regulations. The Active Medical Staff shall have the opportunity to review and make recommendations regarding any proposed revisions to the Rules and Regulations prior to any action being taken by the Medical Executive Committee. Any amendments to the Rules and Regulations passed by the Medical Executive Committee and approved by the Hospital Board of Directors must be communicated to the entire Medical Staff in a timely fashion.

ARTICLE I: ADMISSION AND DISCHARGE OF PATIENTS

Section 1. Admission of Patients

- A. No admission will be denied where the life or well-being of the patient might be in danger.
- B. Patients suffering from all types of diseases shall be admitted at the discretion of the Attending Physician and within the limitations of the Hospital to adequately provide care.
- C. Patients may be admitted to the Hospital only by members of the Medical Staff who have been granted Clinical Privileges by the Board of Directors to do so.
- D. Only Practitioners with the degree of M.D. or D.O. may admit patients. A physician member of the Medical Staff shall be responsible for the admission and for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization for any patient under the care of a podiatrist or dentist.
- E. Except in emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated by the admitting physician. In case of emergency, the provisional diagnosis shall be stated within 24 hours of admission.
- F. All admitted patients shall be assigned to the department or section concerned in the treatment of the diseases which necessitated admission.
- G. Patients requiring admission on an emergency basis, who have no Attending Physician or family doctor with Privileges at Parkview Wabash Hospital, shall be assigned to a member of the Staff as per the unattached call schedule.
- H. Physicians admitting patients shall be held responsible to give such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, and/or to assure protection of the patient from self- harm.
- I. Patients shall not be admitted to the Hospital without orders for treatment from a Medical Staff member.

Section 2. Discharge/Transfer of Patients

- A. Patients shall be discharged only on order of the Attending Physician.
- B. Should a patient leave the Hospital against the advice of the Attending Physician, or without proper discharge, a notation of the incident shall be made in the patient's Medical Record and the Release from Responsibility for Discharge Form shall be signed by the patient and be placed in the patient's chart. Should the patient refuse to sign this form, that refusal shall be noted in the record.
- C. Should a patient be transferred to another hospital for care, the Attending Physician shall arrange for the transfer by contacting a physician willing to accept the patient at the receiving facility and will ensure that the receiving facility has the capacity as well as the level of care required to care for his patient. The Attending Physician shall explain the risks and/or benefits of the transfer to the patient and/or family and shall complete the required transfer forms.

- D. When a patient is transferred to a Skilled Nursing Facility, it is the responsibility of the Attending Physician to complete the required transfer forms.
- E. In the event of a Hospital death, the deceased shall be pronounced dead by a physician Member of the Medical Staff (M.D. or D.O.) or 2 (two) Registered Nurses as per associated death policies.

Section 3. Observation Patients

Observation services are those services furnished on the Hospital's premises, including use of a bed with periodic monitoring by the Hospital nursing staff or other personnel, which are reasonable and necessary to evaluate an outpatient's condition to determine the need for a possible admission to the Hospital as an inpatient. Observation services usually do not exceed 24 hours. Documentation of the medical necessity of continued stay is required by the responsible physician.

ARTICLE II: CONSULTATIONS

Section 1: Required Consultations

In order to ensure the highest quality of care for our patients, consultation with another member of the Medical Staff shall be required in the following circumstances.

- A. Where the diagnosis is significantly obscure after ordinary diagnostic procedures have been completed.
- B. Where there is doubt as to the choice of therapeutic measures to be utilized.
- C. In any circumstance where specialized procedural skills of other practitioners are required.
- D. Whenever requested by the patient or his/her legally designated health care decision maker.

Section 2: Requesting Consultations

The Attending Physician shall be primarily responsible for requesting consultation when indicated. He/she shall be responsible for contacting the consultant, providing the consultant with the necessary history to assist him/her in his evaluation, and for authenticating the order requesting the consultation.

ARTICLE III: AUTOPSIES

All physicians are encouraged to obtain permission for an autopsy in cases of unusual deaths of medical, legal, or educational interest. Likewise, physicians shall request notification of the coroner whenever a death is of such a nature that he/she is required by Indiana law to do so. Findings from autopsies are used as a source of clinical information in quality assessment and improvement activities. No autopsy shall be performed without written consent of the family involved except in cases requiring coroner intervention. The

Attending Physician shall be notified by the nursing staff or pathologist when an autopsy is to be performed. All autopsies shall be performed by the Hospital pathologist or his/her designee. In cases referred to the coroner. The pathologist designated to perform the autopsy shall be at the coroner's discretion.

ARTICLE IV: THE MEDICAL RECORD

Section 1. Definitions

“Attending Physician” means that physician assigned the primary responsibility for the care or coordination of care of the patient. Generally, this will be the same as the Admitting Physician but at times may be a consultant.

“Authenticate” means to provide ownership by written signature, electronic signature, or identifiable initials.

“Invasive Procedure” means puncture or incision of the skin or insertion of an instrument or foreign material into the body including but not limited to, endoscopies, percutaneous aspirations, and catheterizations. This excludes venipuncture, arterial puncture, and IV therapy,

“Medical Record” means the documentation of a patient's care that serves as a communication tool for clinical information, support for financial claims, legal evidence, resource for research and statistical quality review, and an educational tool for clinicians.

“Need to Know” is a phrase used to help define who should access protected information. “Need to know” refers to information required to perform a job function and/or fulfill a responsibility.

“Principal Diagnosis” means the condition, after study, to be principally responsible for occasioning admission to the Hospital.

“Principal Procedure” means the procedure performed for definitive treatment rather than diagnostic or exploratory purposes or to take care of a complication.

Section 2. Responsibilities

- A. To promote continuity of care, a Medical Record will be created and maintained for each patient. Documentation will be complete, adequately support the diagnoses, justify the treatment rendered.
- B. Documentation: Unless otherwise indicated in the policy, all documentation concerning the patient must be entered into the Parkview Electronic Medical Record (EMR). References to “entries” may include dictating into the record. Hand-written entries are not acceptable. See specific exceptions as outlined in this document.
- C. Patient information must be kept confidential and secure. This includes the written word, the spoken word, as well as manual and electronic transmission of patient information. When patient information must be communicated to ensure continuity of care, access must be based on Need to Know criteria.
- D. All Medical staff members must comply with Computerized Physician Order Entry (CPOE) regulatory standards, and goals and requirements established by Parkview. Non-compliance may result in suspension of privileges and same consequences as

outlined in the Medical Records Completion Warning and Suspension Process set forth in this document.

- E. Dictated reports are encouraged for lengthy reports such as History and Physicals, Consultation Reports, Operative Reports, and Discharge Summaries. .
- F. The Attending Physician will document his/her involvement in the patient's care at the time of admission, on a daily basis, and at the time of discharge by way of an admitting History and Physical, daily Progress Notes, and a Discharge Summary.
- G. Unless otherwise specified, the Attending Physician will be responsible for the completion of the admitting History and Physical, the Discharge Summary, as well as the listing of final diagnoses and any procedures performed during the patient's stay.
- H. For complex cases with multiple physicians, the chart analyst will select the Attending Physician based on the definition stated above and the documentation in the Medical Record. Disagreements regarding this assignment will be resolved between members of the Medical Staff involved in the case.
- I. Care that is transferred from one member of the Medical Staff to another will be specifically documented in the Medical Record.
- J. Entries in the Medical Record are automatically timed, dated and authenticated.
- K. Electronic signatures are acceptable ONLY when the physician whose signature is represented has knowledge of the password and is the ONLY one who will use it. A signed statement to this effect must be on file in Medical Staff Services.
- L. Physicians who sign for one another assume full responsibility for the documentation for which they sign.
- M. The Physician Sponsor or their Medical Staff Member (MSM) designee will co-sign all H&P's, discharge summaries, operative reports, and anesthesia records authored by their Allied Health Practitioner. Orders written by a Nurse Practitioner or Physician Assistant do not require co-signature. Progress notes shall be co-signed whenever the MSM plans to use the note as evidence of his/her daily visit. Likewise, in order to document collaboration/oversight, a percentage of all progress notes shall be co-signed. That percentage shall be dependent upon the AHP's degree and experience as described in Indiana statutes.
- N. No abbreviations or symbols may be used to document the final diagnoses.
- O. Only those abbreviations approved by the Medical Staff are to be used in the Medical Record.
- P. Medical records will be completed within 10 days of discharge visit. (See incomplete records and suspension Section III of this Article). The Emergency Room Note will be completed within 24 hours of the end of the providers completed shift.
- Q. Records that are incomplete due to the death or relocation of a responsible physician shall be reviewed by the Community Hospital Chief Medical Officer (CMO). A statement to indicate that the record could not be completed will be permanently retained on the Medical Record and signed by the Community Hospital CMO.

- R. Original Medical Records are the property of the Hospital and may not be removed except by court order, subpoena, or approval of the Director of Health Information Management under the supervised delivery of an HIM professional.

Section 3. Incomplete Records and Suspension

- A. Physicians shall be provided adequate time to complete Medical Records after discharge/treatment.
 - 1. Warning notices will be sent on the first Tuesday of the month to Medical Staff members with delinquent records, i.e. incomplete records aged 21 days or more, inclusive of entries requiring attention by their physician extender (AHP).
 - 2. Automatic Suspension will be imposed on the third Tuesday of each month upon Medical Staff members with delinquent records aged 30 days or more, inclusive of entries requiring attention by their physician extender (AHP). A certified letter will be sent as notification of the Automatic Suspension. Automatic Suspension is fully explained in the Medical Staff Bylaws.
- B. Suspension of physician privileges will deny the treatment of new admissions, provision of consultation, acceptance of referrals, scheduling of elective admissions, and scheduling of elective surgeries. Contract physicians (Hospitalist, Emergency Medicine, Radiology, and Pathology) will exercise no privileges until their records are complete. In the interest of patient safety, emergency consultations, and emergency surgery will be exempt. Upon suspension of these privileges, the physician will be responsible for notifying his/her patients of the cancellation of their elective admission or procedure. Completing all delinquent records will reverse this Automatic Suspension.
- C. Physicians will not receive suspension notifications while on vacation or during an extended illness if the HIS HIM Department is notified in a timely manner of their absence.
- D. Physicians will not receive suspension notifications if they have made a good faith effort to complete their records but were unable to do so because of difficulties accessing those records, whether in paper or electronic form.
- E. Physicians who repeatedly receive suspension notices for failure to complete medical records timely will be referred to the Quality Resource Management Committee (QRM) for review as appropriate.

Section 4. The History and Physical

- A. A History and Physical (H&P) is required for all inpatient admissions, observation patients, outpatients undergoing invasive procedures, Newborns, and patients admitted to swing beds.
- B. The History and Physical must be completed within 24 hours after admission or readmission, and prior to any invasive procedure. (See the exception in C.)
- C. A History and Physical performed and documented up to 30 days prior to an admission, readmission, or procedure may be used for that admission, readmission, or procedure provided there is an examination and update performed within 24

hours after the admission or readmission, and prior to any procedure documenting any significant changes. If there are no significant changes, there must be a note stating this office prenatal record, signed by the physician, may be used as the History and Physical for an obstetrical patient. The most recent patient assessment must be within 24 hours of admission, or an update regarding any significant changes since the last entry must be documented. If there are no significant changes, there must be a notation to that effect.

- D. An H&P from another hospital may be used as long as the dictating physician is a member of a Parkview Health Medical Staff and the physician using the H&P indicates that the information has been reviewed and that he/she concurs with the findings. This must be documented in the chart.
- E. A current History and Physical must be on the chart prior to surgery or an invasive procedure. When transcription delays do not allow for the report to be transcribed prior to surgery, such as the case of an emergency surgery, the Attending Physician will document pertinent past history, vital signs, known allergies and any other information that should be known by other caregivers prior to surgery.
- F. A consult note may serve as the History & Physical provided all the elements of an H&P are present. It is the responsibility of the Attending Physician to clarify with the consultant who will be responsible for the H&P.
- G. Oral Surgeons and Podiatrists may be privileged to perform medical H & P's. Dentists, and Podiatrists are responsible for the H&P pertinent to their area of specialty.
- H. The complete History and Physical must be performed by those Medical Staff Members with Privileges to do so and shall include the following elements.
 - 1. History: current (home) medications per the medication reconciliation process, chief complaint; present illness; relevant past, social, and family history; allergies; review of pertinent systems.
 - 2. Examination: General appearance, vital signs and pertinent body systems.
 - 3. For pediatric patients developmental age and immunization status when pertinent to the medical condition.
 - 4. Diagnostic impression.
 - 5. Treatment plan.

Section 5. The Discharge Summary

- A. A Discharge Summary must be completed for all patients that are admitted to the hospital as inpatients or for observation (see exceptions in B).
- B. A discharge progress note can be used for normal newborns and for stays less than 48 (forty-eight) hours, as long as the documentation reflects the elements of a discharge summary.
- C. Medical Staff members in a given patient care area (e.g. physicians performing endoscopy or Obstetrics) may create predefined template summary forms to be used for uncomplicated hospitalizations provided all the elements of a Discharge

Summary are present.

- D. A dictated Discharge Summary is required for all complicated admissions, admissions with length of stay greater than 48 (forty-eight) hours, and all deaths regardless of length of stay. In the event of death, the discharge narrative must include the cause and time of death. When a physician is not present, the time of death shall be recorded by 2 (two) registered nurses.
- E. Documentation of the Discharge Summary will include the following:
 - 1. Patient Identification
 - 2. Dates of admission and discharge
 - 3. Reason for admission
 - 4. Discharge diagnoses including principal, secondary, and complications (Axis I-V for psychiatry)
 - 5. Operative or other procedures designating "principal" and "other"
 - 6. Significant findings to include diagnostic results relevant to management of patient's condition
 - 7. Hospital course and conclusions
 - 8. Condition on discharge
 - 9. Discharge instructions to include diet, medications, limitations for physical activity, and follow-up care.

Section 6. The Consultation Note

- A. Practitioners requesting consultations must ensure an order is on the chart delineating the name of the practitioner or group to be consulted.
- B. The record should reflect the reason for the consultation as well as the timeframe in which the consultation should occur if the request is urgent. If not otherwise specified routine consultation is to occur within 24 hours of the request for consultation.
- C. Consultation reports will include pertinent history and examination by the consultant, a professional opinion, and treatment advice.

Section 7. The Operative Report

- A. A report must be entered or written by the surgeon or responsible Practitioner immediately following invasive procedures.
- B. Documentation of the surgery/procedure will include the following:
 - 1. Date of the surgery/procedure
 - 2. Pre- and Post-operative diagnosis
 - 3. Names of surgeons and assistants
 - 4. Estimate of blood loss
 - 5. Findings
 - 6. Technical procedures used
 - 7. Specimens removed and noted if sent to Pathology
 - 8. Condition of patient

9. Complications

Section 8. The Anesthesia Record

- A. All patients undergoing anesthesia shall have an Anesthesia Record.
- B. Documentation in this record will include the following:
 - 1. A preoperative assessment
 - 2. An assessment immediately prior to induction
 - 3. An intra-operative note
 - 4. Postoperative documentation to include the following:
 - a. Respiratory function
 - i. Respiratory rate
 - ii. airway patency
 - iii. oxygen saturation
 - b. Cardiovascular function
 - I. HR
 - II. Blood pressure
 - III.
 - c. Mental status upon entering and leaving the unit
 - d. Temperature
 - e. Pain
 - f. N/V
 - g. Post-op Hydration
 - h. Medications including IVF
 - i. Blood and Blood components given (if any)
 - j. Any unusual event of postoperative complications including management of same.
 - k. Compliance with discharge criteria
 - l. Name of practitioner responsible for discharge

Section 9. Emergency Department Note

Documentation of the Emergency Department Note will include the following:

- 1. Chief complaint
- 2. HPI
- 3. Review of systems
- 4. Physical exam
- 5. Medical Decision Making
- 6. Diagnosis

Section 10. Clinical Reports

Reports of pathology, laboratory, radiology, and other diagnostic or therapeutic procedures will be documented in a timely manner.

Section 11. Progress Notes

- A. All hospitalized patients will be visited daily by their Attending Physician or another Medical Staff Member designated by the Attending Physician.
- B. The Attending Physician will document his/her involvement in the patient's care at the time of admission by way of an admitting History and Physical, on a daily basis by way of Progress Notes and at the time of discharge by way of a Discharge Summary.
- C. If the Discharge Summary is to be dictated at a later date, a Progress Note should be entered on the day of discharge. In some circumstances a discharge Progress Note may be used in lieu of a dictated discharge summary. (See Section 5 A-D)

Section 12. Autopsy Reports

Provisional anatomic diagnoses are recorded in the Medical Record within three days of autopsy completion. The complete report is included in the record within 60 (sixty) days. Exceptions to the policy may occur when the case has been referred to the coroner's office in which case documentation will be provided to the chart as appropriate under state law.

Section 13. Informed Consent

For all patients undergoing invasive procedures, anesthesia, or blood transfusion, the responsible physician or other healthcare provider will explain to the patient or his/her guardian the procedure to be performed and the risks, benefits, and alternatives for this procedure. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. To obtain informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity), the physician or other provider will: (1) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision. (2) Present relevant information accurately and sensitively, in language the patient can understand, in keeping with the patient's preferences for receiving medical information. (3) Include information about:

- The diagnosis (when known)
- The procedure name
- The nature and purpose of recommended interventions
- The burdens, risks, and expected benefits of all options, including forgoing treatment

The informed consent conversation and the patient's (or surrogate's) decision will be documented in the medical record. The consent form validating informed consent will be placed in the medical record. In emergencies, when a decision must be made urgently, prior informed consent is not needed. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

See also: Consent for Treatment policy

Section 14. Orders

Unless there is a valid admit order from the ED physician, the physician (MD, DO) listed as the Admitting Provider or covering partner is accountable to enter and, as necessary, co-sign the admission order. The admission order must be entered, signed and/or co-signed prior to discharge, with the expectation being within 24 hours of hospital admission. Verbal orders are for the convenience of the patient, rather than for convenience of the physician, and are to be used solely for the benefit of the patient.

- A. A responsible Medical Staff Member must be identified for all verbal, telephone and written orders. Written orders are defined as those orders that are transcribed to an approved order sheet from another physician signed document (i.e. the face sheet from another medical facility).
- B. Practitioners shall enter their own orders whenever possible to minimize the potential for error. Such orders must be complete. If orders are not complete, the physician shall be contacted for clarification.
- C. Whenever the Practitioner is not physically present or for reasons of patient safety is unable to write their own orders, verbal or telephone orders may be accepted according to the recipients' scope of practice by any of the following:
 - 1. Registered Nurse (RN)
 - 2. Registered Pharmacist
 - 3. Respiratory Care Practitioner (which includes Certified Respiratory Therapy Technicians and Registered Respiratory Therapists)
 - 4. Occupational Therapist (OTR)
 - 5. Physical Therapist (PT)
 - 6. Physician Assistant (PA)
 - 7. Speech Pathologist (SLP)
 - 8. Nuclear Medicine Technologist
 - 9. Ultrasound Technologist
 - 10. MRI Technologist
 - 11. Radiology Tech
 - 12. Medical Technologist
 - 13. Paramedics
 - 14. Licensed Practical Nurse
 - 15. Registered Dietician (RD)
- D. The professionals listed above may also accept Medical Staff Member orders transmitted by non-hospital employed physician office staff as authorized by their employing Medical Staff Member.
- E. When entered, verbal, written and telephone orders must include the following:
 - 1. the name of the Medical Staff Member issuing the order.
 - 2. the first initial, last name and credentials (if any) if the physician agent is transmitting the order.

3. the first initial, last name and credentials of the individual receiving the order.
 4. a notation that the order was a verbal order (v.o.), telephone order (t.o.) or written order (w.o.).
 5. a notation that the order was read back and verified (r/v) (if a verbal or telephone order).
- F. Unless otherwise authorized by the Medical Staff, the initial order for pre-printed protocols shall be obtained from the responsible practitioner prior to initiation of the protocol.
 - G. If authorized by the Medical Staff, some pre-approved protocols not requiring therapeutic selections may be initiated by those authorized in the protocol to do so.
 - H. Order changes that are directed by a protocol shall be written by those authorized by their scope of practice to do so, and those orders shall have the notation “as per _____ protocol”. The first initial, last name, and credentials of the individual entering the order shall also be documented.
 - I. All verbal orders, telephone orders, written orders, and orders per Protocol must be authenticated by the responsible Medical Staff member. Orders that have been read back and verified shall be authenticated within 30 (thirty) days of discharge. Verbal and Telephone orders that do not have a notation that they have been read back and verified must be authenticated within 48 (forty-eight) hours.

Section 15. Medication Orders

- A. All Medication orders must contain the name of the medication, the dose to be given, the route of administration, the frequency with which it is to be given, and the indication if the medication is to be given as needed (prn).
- B. An order to “resume home medications” or any order that does not specifically identify the medication that is being requested shall require verbal or written clarification of the exact medication ordered before the medication shall be given.

Section 16. Orders for Restraints

Only an authorized physician, clinical psychologist, or other licensed independent practitioner primarily responsible for the patient’s ongoing care, may order the use of restraint/seclusion in accordance with hospital policy, law and regulations. A physician’s order should precede the application of restraint. In unforeseen emergency situations, the application of the restraint/seclusion may precede obtaining a physician’s order. In such cases a Medical Staff member shall be notified immediately after the initiation of the restraint/seclusion and a telephone or verbal order for the restraint shall be obtained.

- A. PRN
Orders for the use of restraint or seclusion must never be written as a standing order as needed (PRN).
- B. Pharmaceuticals: The purpose of a regular pharmaceutical regimen is to enable the patient to better interact with others or function more effectively. Pharmaceuticals are not considered restraints if:

1. The medications comprise the patient's regular pharmaceutical regimen (including PRN's).
 2. The medications are addressed in the patient's Plan of Care with documentation in the patient's chart.
- C. Calming / Least-Restrictive Measures: A comprehensive individualized patient assessment is used to initiate and evaluate the use of Calming / Least-Restrictive Measures during the episode of patient behavior.
- D. Discontinue: Once the unsafe period ends, the use of restraint-seclusion should be discontinued, and the patient's needs addressed using calming or least restrictive methods.
- E. Falls: The use of restraints for the prevention of falls should not be considered a routine part of a Falls prevention program. A history of falling without a current clinical basis for a restraint-seclusion intervention, does NOT support the need for restraint.
- F. Family: A request from a patient or family member for the application of a restraint, which they would consider to be beneficial, is NOT a sufficient basis for the initiation of restraint-seclusion.
- G. Use of restraint for medical/surgical care
1. Medical / surgical care restraint orders are valid for the duration of restraint / seclusion. A new order must be initiated if restraint / seclusion has been discontinued and then restarted.
 2. Restraint /seclusion orders can be initiated via telephone or verbal order but must be authenticated by the physician within 30 (thirty) days of discharge.
- H. Use of restraint or seclusion for behavioral management
1. A written, telephone, or verbal order must be authenticated in the Medical Record within 1 (one) hour of the initiation of restraint for behavioral reasons.
 2. The order must be time limited for no longer than:
 - a. 4 (four) hours for patients age 18 (eighteen) years and older;
 - b. 2 (two) hours for patients age 9 (nine) to 17 (seventeen) years old;
 - c. 1 (one) hour for patients ages 8 (eight) and under.
 3. Behavioral restraint/seclusion orders may be renewed according to the time limits for a maximum of 24 (twenty-four) consecutive hours. Every 24 (twenty-four) hours, a physician, clinical psychologist, or other licensed independent practitioner primarily responsible for the patient's ongoing care must see and evaluate the patient before writing a new order or restraint.
 4. In addition, a telemedicine link does not fulfill the in-person evaluation requirements and cannot be used for renewal or new orders.

Section 17. Orders for Outpatients

With a signed physician order, Parkview Wabash Hospital will provide outpatient services for Authorized Practitioners as described below:

“Authorized Practitioner” means a healthcare provider holding a current unrestricted State license whose scope of practice provides for ordering the specific test or procedure

in question. This provider requires the approval of Parkview Health and must supply the following information: full name, suffix, specialty or discipline, office address, telephone or fax number, health professional license number, and, if applicable, DEA, CSR and UPIN number. In addition to this information, mid-levels (NPs, PAs and Certified Midwives) must provide the name of their sponsoring or collaborating physician and the contact information for that sponsoring or collaborating physician. This information must be provided to Parkview Hospital Medical Staff Services (see bulletin board "Medical Staff"; form "Request Prac ID#"). License verification and Medicare/Medicaid sanction checks will be performed. Requested testing will be performed, but the diagnostic results withheld until the required information is provided. If the results reveal a critical lab value or test result, the results will not be withheld. The elements of a complete order would include: 1) Patient's full name; 2) Order date; 3) Diagnosis; 4) Services to be performed; 5) Signature.

Section 18. Outpatient Record Requirements

A. Simple Outpatient Testing (Risk level 0)

1. Risk level 0 procedures encompass simple and/or routine diagnostic testing performed on the order of a Medical Staff Member or other Authorized Practitioner usually not requiring the involvement of a Medical Staff Member to perform. The risk to the patient is believed to be negligible and such procedures can usually be performed on any patient without regard to underlying health conditions. Examples of Risk level 0 services include: phlebotomy, routine X-rays, mammograms, sonograms, EEGs, and pulmonary function tests.
2. Documentation requirements for risk level 0 include:
 - a. Registration form
 - b. Authorization to treat
 - c. Physician or Authorized Practitioner order with diagnosis
 - d. Test results

(Note: Screening mammography may be provided to patients without a physician order)

B. Outpatient Therapies, X-rays with Contrast, and Sleep Studies (Risk level 1)

1. Risk level 1 services encompass the evaluation and treatment rendered by the various rehabilitation therapists including physical therapists, occupational therapists, speech therapists, and those therapists involved with cardiac and pulmonary rehabilitation. X-ray studies requiring contrast (including Barium studies) are also included in this level. Risk level 1 procedures can be performed on the order of a Medical Staff Member or other Authorized Practitioner. The risk is considered minimal.
2. Documentation requirements for Risk level 1 Therapies include:
 - a. Registration form
 - b. Authorization to treat
 - c. "Physician or Authorized Practitioner order with diagnosis as required by state law."

- d. Initial therapist assessment and plan of care
 - e. Documented progress of therapy
 - f. Recertification if applicable
 - g. Discharge summary from therapist
3. Documentation requirements for Risk level 1 X-rays and sleep studies include:
- a. Registration form
 - b. Authorization to treat
 - c. Physician or Authorized Practitioner order with diagnosis
 - d. Consent for procedure (when applicable)
 - e. Test results

C. Outpatient Treatments, OB Testing, and EKGs (Risk level 2)

1. Risk level 2 services encompass primarily treatment of the patient rather than diagnostic testing (OB testing and EKGs excepted). These services do not typically require the presence of the ordering physician for their performance. Risk level 2 services may be ordered by an Authorized Practitioner. In the case of Obstetrics and EKGs, the likelihood of further emergency treatment and/or testing required merits the oversight of a Medical Staff Member. Examples of Risk level 2 services include: IV or IM medication injections, transfusions, respiratory aerosol treatments, OB non-stress and stress testing.
2. Documentation for Risk level 2 other than EKGs includes:
 - a. Registration form
 - b. Authorization to treat
 - c. Physician or Authorized Practitioner order with diagnosis
 - d. Clinical assessment
 - e. Test results (for OB testing)
 - f. Progress note (per physician or nurse)
 - g. Copy of prenatal H&P for OB testing
3. Documentation for EKGs includes
 - a. Registration form
 - b. Authorization to treat
 - c. Physician or Authorized Practitioner order with diagnosis
 - d. Test results

D. Outpatient Invasive Testing/Treatment and Treadmills (Risk level 3)

1. Risk level 3 services encompass those test and treatments that carry an increased risk of morbidity and are typically performed by a physician. These services may be ordered by a Medical Staff Member or an Authorized Practitioner but must be performed by a Medical Staff member who assumes

responsibility for the patient. Examples of Risk level 3 services include: nerve blocks, bone marrow aspiration/biopsy, procedures with local anesthesia, subcutaneous catheter placement, epidural steroid injection, blood patch, colposcopy, lumbar puncture, and exercise treadmills.

2. Documentation for Risk level 3 includes:
 - a. Registration form
 - b. Authorization to treat
 - c. Physician or Authorized Practitioner order with diagnosis
 - d. Physician assessment
 - e. Nursing (or other assistant) assessment
 - f. Operative report and anesthesia documentation (for invasive procedures)
 - g. Physician order including discharge orders and instructions (if any)
 - h. Test result (if applicable)

E. Emergency Room Visits, Observation Patients, Outpatient Surgeries, Endoscopy (Risk Level 4)

1. Risk level 4 services encompass those patient encounters that require a higher level of care and monitoring which may necessitate the need for hospitalization. Length of stay is expected to be brief but is unpredictable depending on presenting signs and symptoms. These services are generally both ordered and performed by a member of the Medical Staff. Examples include: needle biopsies, outpatient surgeries requiring general or monitored anesthesia care, endoscopies, bronchoscopies, myelograms, emergency department visits, procedures otherwise in a lower risk category but in special circumstances requiring sedation (MRI, CT scans), and patients being monitored for possible Hospital admission.
2. Documentation for Risk level 4 Emergency Department visits include:
 - a. Registration form
 - b. Authorization to treat
 - c. Physician assessment
 - d. Emergency department treatment record
 - e. Physician orders
 - f. Test results (if any)
 - g. Statement of disposition (including discharge instructions if appropriate)
3. Documentation for Observation Patients, Outpatient Surgeries, and Endoscopy include:
 - a. Registration form
 - b. Authorization to treat
 - c. History & Physical
 - d. Physician's orders

- e. Diagnostic test results
 - f. Physician progress note, as appropriate
 - g. Discharge note (to include diagnosis, condition, disposition, and instructions)
 - h. Nursing assessment
 - i. Nursing notes
 - j. Consent for surgery/procedure
 - k. Procedure note (if any)
 - l. Anesthesia record (if applicable)
4. If an observation patient remains in the hospital for more than 24 (twenty-four) hours, daily progress notes are required.

Section 18. Authorization to Document in the Medical Record

The following health care providers are recognized by the Medical Staff as authorized to document in the Medical Record:

- Cardiopulmonary Specialist Respiratory (RRT)
- Certified Nursing Assistant (CNA)
- Certified Occupational Therapy Assistant (COTA)
- Certified Respiratory Therapist Technician (CRTT)
- Chaplain
- Child Developmental Specialist
- Clinical Dietician Specialist
- Critical Care Technician (C C T)
- Critical Care Therapist Respiratory (CCTT)
- Cytogenetic Technologist
- Dietician (RD Eligible)
- Doctor of Philosophy (PhD)
- Dietetic Technology Registered (DTR)
- EEG Tech
- EKG Tech I
- Endoscopy Tech
- Enterostomal Therapist
- Graduate Dietetic Student (Co-signed by RD)
- Graduate Speech Therapist (CFY-Co-signed by CCC/SP)
- Home Attendant (HA)
- Home Health Aide (HHA)
- Intravenous Therapist (IVT)
- Laboratory Tech Clerk
- Licensed Practical Nurse (LPN)
- Licensed Speech Pathologist
- Medical Laboratory Technician
- Medical Staff
- Medical Student
- Medical Technologist
- Microbiologist
- Nursing Assistant

Occupational Therapist (OTR)
Occupational Therapy Assistant (OTA) Co-signed by OTR
Occupational Therapy Student (with OTR signature)
Patient Care Technician
Pharmacist
RPh Pharmacy Student (Co-signed by RPh)
Phlebotomist
Physical Therapist (PT)
Physical Therapist Assistant (PTA Co-signed by PT)
Physical Therapist Assistant Student (Co-signed by PT)
Physician Extender
Psychiatric Technician
Psychologist (PSY)
Pulmonary Function Technologist Respiratory (PFT)
Radiation Therapist
Radiologic Technologist
Recreation Therapist
Registered Dietician (RD)
Registered Nurse (RN)
Registered Occupational Therapist
Respiratory Care Practitioner (RCP)
Registered Respiratory Therapist (RPT)
Respiratory Therapist (RT)
Social Worker (MSW)
Speech Pathologist (CCC.SP)
Speech Pathology Intern (Co-signed by CCC.SP)
Speech Therapy Student (Co-signed by CCC.SP)
Student Assistant
Technician I (Emergency Care Center)
Telemetry Monitor Technician (TMT) Unit Clerk
Unit Clerk

ARTICLE V: OBSTETRICS (FAMILY BIRTHING CENTER)

The Family Birthing Center provides the specialized personnel and equipment to care for both the complicated and uncomplicated course of the pregnant patient throughout her pregnancy and delivery. The unit also provides care for the newborn.

Section 1. Care of the Obstetric Patient

- A. A member of the Medical Staff with privileges in Obstetrics will be responsible for all patients presenting to the Family Birthing Center for treatment.
- B. Medical Staff with privileges in Obstetrics will care for unattached patients on a rotating basis
- C. Patients will be provided counseling on HIV during their prenatal course.
- D. Upon admission to labor and delivery, the mother's status of the following diseases (during the current pregnancy) is documented in the mother's medical record: Human Immunodeficiency Virus (HIV), Hepatitis B, Group B Streptococcus (GBS), and Syphilis. If the patient had no prenatal care or the disease status is unknown, the previous listed

testing will be performed, and results documented in the patient's medical record. If the mother tests positive for HIV, Hepatitis B, Group B Streptococcus (GBS), or Syphilis when tested in labor and delivery or during the current pregnancy, that information is also documented in the newborn's medical record after delivery.

- E. The office prenatal record should be on file in the OB Department when the patient is approximately 28 weeks' gestation and should include any laboratory results, as well as the results of any ultrasound examinations.
- F. The documentation requirements for Obstetric patients are listed in Article IV of these Bylaws.
- G. Except in cases where delivery is imminent, patients less than 35 (thirty-five) weeks gestation who are in active labor and are stable for transfer shall be transferred to a facility with neonatal intensive care capability prior to delivery.
- H. If inducing labor or performing an elective/repeat Cesarean section for patients less than 39 (thirty-nine) weeks gestation, adequate documentation of complications necessitating the induction/Cesarean section must be delineated in the Medical Record. Decisions should be based on a satisfactory determination of the estimated date of confinement (EDC) based on American College of Obstetrics and Gynecology (ACOG) standards.
- I. **Except in cases where upon presentation delivery is imminent, no Vaginal Births after prior Cesarean Section shall be performed.** The Attending Physician will request at least one other physician with privileges in Obstetrics and/or care of the newborn to be in attendance for all known multiple births.
- J. All patients presenting for delivery shall have a physician (with appropriate privileges) assigned to care for the newborn after delivery. Whenever possible, the physician who will care for the infant should be prearranged by the Obstetrician and/or patient to be delivered. In the event of an unattached patient, Medical Staff with privileges in care of newborns will be assigned to care for the infant on a rotating basis.
- K. Whenever possible, a determination of fetal position by ultrasound shall be obtained on admission to the OB unit when a patient presents for an elective Cesarean section to be performed with the sole indication of breech presentation. This ultrasound may be performed in the OB department and be limited to presentation only.

Section 2. Visitors

The recommended number of visitors in attendance at the time of delivery will be determined by the request of the patient and the discretion of the Attending Physician. (Maximum 2)

Section 3. Adoptions

Infants born in Hospital and relinquished by their parent(s) shall not be given out for adoption by either the Hospital or the physician without following proper procedures as per associated policies.

Section 4. Obstetric Anesthesia

- A. The anesthesiologist shall be responsible for the care of any patient receiving epidural, spinal, or general anesthesia during the course of labor and delivery (whether delivery is operative or non-operative)
- B. When treating patients with epidural analgesia, the anesthesiologist will:

1. Order all medications that are to be infused via the epidural catheter
2. Program all pump boluses and continuous rates
3. Initiate all continuous infusions and bolus doses
4. Perform any manipulation or repositioning of the epidural catheter
5. Be available throughout the time any patient is receiving epidural infusion
6. Assure removal of the epidural catheter

Section 5. Newborn Circumcision

No newborn circumcision shall be performed on an unstable patient or a patient less than 12 hours old.

ARTICLE VI: CONSTANT CARE UNIT

The Constant Care Unit is designed to meet the needs of the critically ill patient whose condition could potentially be reversed through intensive medical and nursing care. It provides a concentration of specialized personnel and equipment for the purpose of constant observation, monitoring, and intervention.

Section 1. Constant Care Unit Admitting Physicians/Orders

All patients admitted to the Constant Care Unit shall have a clearly delineated Attending Physician to co-ordinate their care. This may be the patients' primary care physician, or at times this may be delegated to a consultant who assumes care. Upon admission and discharge from the Constant Care Unit all previous orders will be cancelled and must be rewritten by the Attending Physician.

Section 2. Constant Care Unit Patients

Those patients who are candidates for admission to the Constant Care Unit include the following:

Patients with cardiac conditions including acute myocardial infarction (known or suspected), acute or severe congestive heart failure, cardiac arrhythmias, and unstable angina.

- A. Patients in shock (of any origin)
- B. Patients requiring mechanical ventilation (including required sedation, if applicable)
- C. Patients requiring monitoring via arterial line or Swan Ganz catheter
- D. Any patient requiring IV drips of vasoactive medications including but not limited to Dopamine, Dobutamine, Nitroglycerin, Nipride, Cardizem, Lidocaine, Primacor, and Natrecor, Patients on these medications are not to be treated anywhere but the Constant Care Unit.
- E. Patients requiring intensive nursing care (e.g. diabetic ketoacidosis, hypertensive crisis)
- F. Patients requiring short-term intensive observation (e.g. post anesthesia recovery after surgery hours, drug overdose).

ARTICLE VII: EMERGENCY SERVICES

Section 1. Emergency Department Physician Coverage

- A. In order to assure the availability of adequate professional medical coverage in the Emergency Department, the Hospital contracts for 24 (twenty-four) hour physician coverage. These Contract Physicians are credentialed and granted Privileges in the same manner as all other members of the Medical Staff.
- B. Any member of the Medical Staff may assess and treat his/her patients in the Emergency Department within the scope of his/her privileges, however, all patients presenting to the Emergency Department for treatment shall be placed in the regular triage rotation and shall be seen by either their Attending physician or the Emergency Department physician whichever is more timely.
- C. Members of the Active Medical Staff shall participate in call coverage of the Emergency Department for unattached patients on a rotating basis.

Section 2. Emergency Department Physician Responsibilities

- A. All patients presenting to the Emergency Department shall receive a Medical Screening Exam.
- B. The Emergency Department physician will be available on the Hospital grounds while on duty and shall respond to all Hospital disasters including "Code Blues" and Rapid Responses
- C. Except in cases where any delay would jeopardize patient safety, the Emergency Department physician will contact the local primary care physician or his/her on call designee prior to transferring a patient to another hospital or obtaining consultation with another physician.
- D. Whenever a patient is determined by the Emergency Room physician to require admission, the Emergency Room physician shall notify a Medical Staff member with appropriate admitting privileges, prior to admitting the patient.
- E. Any physician caring for a patient in the Emergency Department shall complete the Medical Record as outlined in the Medical Record Rules and Regulations. (Article IV, Section 9)
- F. Whenever the transfer of a patient to another hospital is deemed necessary, the Emergency Department physician or other member of the Medical Staff directly caring for the patient will arrange for transfer in compliance with EMTALA guidelines.
- G. The Emergency Department physician is responsible for medical control for Emergency Medical Service (EMS) ambulance runs.

Section 3. Emergency Department Procedures

- A. Except in dire emergencies, no operative procedure shall be performed in the Emergency Department that would normally be done in the operating suite.
- B. The Emergency Room physician or Attending Physician shall see all patients prior

to ordering diagnostic tests. Exception to this shall be made when the physician is otherwise professionally engaged and a delay in testing may jeopardize patient safety or when a specific diagnostic protocol exists and is implemented (e.g. EKG immediately on all adult patients presenting with chest pain).

- C. Patients with conditions whose definitive care is beyond the capabilities of Parkview Wabash Hospital will be referred to the appropriate facility whenever the patients' condition permits such transfer.

Section 4. Emergency Mass Casualty Assignments

There shall be a plan for the care of mass casualties at the time of any major disaster based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. In the event of an emergency with mass casualties, all physicians shall be assigned to posts either in the Hospital or in casualty stations elsewhere. It is the physician's responsibility to report to such assigned stations. The Hospital President or designee, the house supervisor, and the Emergency Room Physician on duty will work as a team to coordinate activities and directions. All policies concerning patient care will be the joint responsibility of such persons and, in their absence, the persons next in line of authority respectively. All physicians on the Medical Staff specifically agree to relinquish direction of the professional care of their patients in cases of such emergency.

ARTICLE VIII: SURGERY

Section 1. Creating Policies, Procedures, Rules, and Regulations

Surgery Policies and Procedures, in addition to the Medical Staff Rules and Regulations, shall be established by the collaborative efforts of the operating room personnel, the Clinical Advisors for Surgery and Anesthesia, and other members of the Medical Staff as required. Such policies and rules shall address consents, scheduling, pre-operative assessments, who can visit, tissue examinations, and anesthesia services.

Section 2. Consents

For all surgeries, the physician will explain to the patient or his/her guardian the procedure to be performed and the risks, benefits, and alternatives for this procedure (including the use of blood and desire for resuscitation status). Subsequently, a written consent will be given to the patient or guardian to read and sign (see below). The surgeon shall also sign the consent and this form shall then be made a part of the patients' chart. In like fashion, a consent for anesthesia or sedation analgesia is required and must be signed by the patient or guardian and the anesthesiologist. All consent forms shall be dated and are valid for 30 (thirty) days. In the case of sterilization procedures for patients with Medicaid coverage, consent shall be signed at least 30 (thirty) days prior to the procedure, the patient must be at least 21 (twenty-one) years of age at the time the consent is signed, and a second consent must be signed prior to the actual surgery.

The following is a designation of who can sign the consent:

- A. The consent for a surgical procedure (including the use of blood) shall be signed by the patient or his legal representative in all surgical cases other than emergencies.

In an emergency, the patients' spouse or family member may sign the consent.

- B. If the patient is 18 years of age or older, and is deemed competent, he shall sign the written consent at least with an "X" and this shall be witnessed by at least one person.
- C. If the patient is under 18 years of age and not emancipated, or the patient has been declared mentally incompetent, the signature of a parent or legally appointed guardian is required.
- D. In cases where the patient is a minor or is unable to sign, and a family member or guardian is not present, a verbal consent by telephone will be permitted if monitored by two members of the Hospital staff who will then sign the consent.
- E. In the case of separated parents, the parent having legal custody must sign the consent. In this parents' absence, the parent with physical custody may sign.
- F. If the patient is a minor, and the parent is also a minor, the minor parent is considered by Indiana law to be competent to sign the consent for their child.
- G. An emancipated minor can give consent for his/her own treatment. An emancipated minor is a person under age 18 who lives away from his/her parents and is self-supporting, or who is married and living with his/her spouse, or who is in the armed services.

Section 3. Scheduling of Surgery

- A. The manager of surgery or his/her designee shall have full authority in the scheduling and rescheduling of surgery.
- B. The operative schedule will routinely begin at 0730. Exceptions to this start time may be made by the surgery manager or his/her designee.
- C. Scheduling elective surgical cases should be accomplished as far in advance as possible and should occur during the duty hours of the surgery manager.
- D. If the surgeon is delayed and wishes to change the scheduled surgery time, he/she or his representative shall notify the surgery manager and an attempt will be made to accommodate the change. In this instance, however, scheduled cases that are on time will have first priority.
- E. If the surgeon wishes to cancel a case, it is his/her responsibility to inform the surgery manager and all others involved.
- F. If the operating room availability is delayed, it is the responsibility of the surgery manager to notify the surgeon and to make arrangements to accommodate the surgeon if possible.
- G. It is the responsibility of the surgeon or his/her representative to notify the director of surgery or the house supervisor in emergency surgical cases.
- H. Emergency surgical cases always have priority when scheduling. Emergency surgery is defined as surgery which if delayed will compromise patient safety and could result either in, permanent disability, increased morbidity, or even death.
- I. To maintain a schedule of operation, the following requirements should be met:
 - 1. The patient should present to the hospital at least 2 (two) hours prior to

surgery if having a general anesthetic, and 1 (one) hour prior to surgery if having a local anesthetic. (Children under 5 (five) years or age may present 90 (ninety) minutes pre-operatively)

2. The patient should be in the operating room 15 (fifteen) minutes before the scheduled time of surgery. (This presumes that an operating room is available)
 3. The anesthesiologist should be in the Hospital 15 (fifteen) minutes before the scheduled time of surgery.
 4. The surgeon should be in the Hospital 15 (fifteen) minutes before the scheduled time of surgery (earlier if he/she wants to see the patient prior to surgery)
- J. Pertinent information to be given at the time of scheduling will include:
1. Patient's name, phone number, and birth date
 2. Operative procedure to be performed
 3. Exact site of the operation (right or left when applicable)
 4. Operative position
 5. Possibility of intra-operative X-ray or need for pathologist presence
 6. Probable length of case (particularly if different from the usually required)
 7. Specific anesthesiologist (if specific one requested)
 8. Whether patient will be an inpatient or outpatient
 9. Number of scrub persons needed
 10. Whether another physician will be assisting
 11. Insurance carrier (if any)
 12. Special equipment that may be required
- K. It is the responsibility of the surgeon to notify his assistant whenever surgical assistance is needed.
- L. The surgeon will inform the patient of the date and time of surgery and who will be assisting. (if any assistance is required)
- M. The surgeon will give the patient the pre-operative instructions and pre-admission information as required.
- N. The surgeon shall obtain consent for surgery. (preferably in his office for elective cases)
- O. The surgeon shall be responsible for completing the required Medical Records pre and post-operatively as per the Medical Records Rules and Regulations in Article III of this document.

Section 4. Pre-operative Laboratory Requirements and Medical Clearance for Surgery

Parkview Wabash Hospital does not require specific laboratory testing before surgery, therefore the surgeon and/or anesthesiologist will be responsible for ordering any

laboratory or radiology testing they feel warranted. This will be done on an individual basis according to the patients' age, gender, and medical condition(s). Similarly, the surgeon and/or anesthesiologist shall be responsible for arranging any pre-operative medical clearance felt to be warranted.

Section 5. Visitors

- A. To be present in the operating room, any visitor must first have permission from the surgeon, anesthesiologist, surgery manager, and the patient. (See exception in 5D)
- B. No one shall be permitted in the operating room unless properly dressed with caps that cover hair, masks, Hospital scrubs, and shoe covers (for shoes worn outside the Hospital)
- C. The father or significant other (one maximum) may be permitted to observe Cesarean sections at the discretion of those listed above in Section 5A. Any other visitor must be a Physician, RN, LPN, OR tech, Physician Assistant, Paramedic, Student in Medical School or Nursing School, or a salesperson assisting in the evaluation of surgical supplies/equipment. In rare circumstances, an exception may be granted upon approval of those listed under Section 5A.
- D. Those individuals directly involved in surveying the Hospital for purposes of licensure and/or accreditation may enter the operating room with only the consent of the patient. Such consent may be obtained by the surveyor or the Hospital staff at the surveyor's discretion.

Section 6. Tissue

All tissues removed at the time of surgery, except those listed on the tissue exempt list, shall be sent to the Hospital pathologist who will make examinations as he/she may consider necessary to establish a pathological diagnosis or histological identification and he/she shall sign the report. The approved list of tissues or objects removed that do not require submission will be published by pathology. The guideline for pathologic examination for placentas will be published by pathology.

Section 7. Enforcement of Surgery Rules and Regulations

The surgery manager has the responsibility and authority to enforce these rules which have the approval the Medical Executive Committee and the Board of Directors of Parkview Wabash Hospital.

ARTICLE IX: ANESTHESIA

Section 1. Responsibilities

- A. The Clinical Advisor for Anesthesia Services shall have overall administrative responsibility for the services provided and the quality of anesthesia care rendered by the anesthesia providers anywhere in the Hospital. He/she shall be responsible for the development of policies relative to the functioning of the anesthesia providers in the various units. He/she shall report to the various

- Medical Staff Committees including the Clinical Committee, QRM Committee, Administrative Committee, and the Medical Executive Committee.
- B. Only those clinicians who have had specialized training and/or experience and have been properly Privileged by the Hospital Board may administer/direct anesthesia.
 - C. Only a physician with Anesthesia privileges whose privileges have been approved by the Medical Staff may administer anesthesia.
 - D. Every surgical patient shall be seen by an anesthesia provider for a pre-anesthetic evaluation. This shall be documented in the Medical Record.
 - E. Consents for anesthesia shall be obtained as described in Section 2 of this Article.
 - F. An Anesthesia Record is required for every patient undergoing anesthesia and shall contain the elements listed in Article III Section 8 of this document.
 - G. Documentation of pertinent information relative to the anticipated choice of anesthesia for the surgical or obstetrical procedure planned shall be done by the anesthesia provider pre-operatively (except in the case of an emergency precluding this).
 - H. The A.S.A. patient classification and Mallampati score shall be part of the pre-operative documentation.
 - I. The anesthesia provider, after consulting with the surgeon, shall have the final decision concerning the type of anesthesia to be administered.
 - J. Immediately prior to induction of anesthesia, the anesthesia provider shall reassess the patients' condition and document his findings on the anesthesia record.
 - K. The anesthesia provider shall monitor and care for the patient at all times during the surgical procedure unless relieved by another Practitioner.
 - L. The anesthesia record maintained during the procedure shall reflect the ongoing assessment and care of the patient.
 - M. Post-operatively, the anesthesia provider shall accompany the patient to the appropriate post-anesthesia care unit (POST-ANESTHESIA RECOVERY or CONSTANT CARE UNIT) and shall advise the responsible personnel of specific problems presented by the patients' condition.
 - N. The anesthesia provider shall remain with the patient in the post anesthesia care unit for as long as is medically necessary to ensure patient safety.
 - O. Standards for release from the PAR to any care area other than the CONSTANT CARE UNIT are as follows:
 - 1. Patients must be fully awake
 - 2. Vital signs must be stable
 - 3. The patient should have a score of 8 (eight) or higher on the Aldrete scale and if this is not the case, this must be explained either in the nurses notes or physician progress notes.
 - 4. The endotracheal tube must be removed (with rare exception and reason for exception documented by the physician)

- P. If the patients' condition does not meet these criteria, the patient should remain in PAR or be transferred to the CONSTANT CARE UNIT.
- Q. If the patient is an outpatient and requires more than the expected 4 to 6 hours recovery time post-operatively the patient may be placed in observation status or admitted. Documentation of the medical necessity of the continued stay is required and is the responsibility of the surgeon or Anesthesia provider.
- R. Documentation of a post anesthesia follow-up visit noting the presence or absence of anesthesia related complications shall be made on all inpatients within 48 (forty-eight) hours post-operatively.

Section 2. Anesthesia Equipment and Monitoring Requirements

- A. Anesthesia machines are to be used only in the operating rooms.
- B. All anesthesia machines shall have the following safety devices available for use: oxygen analyzer, pressure and disconnect alarm, pin index safety systems, gas scavenging system, and oxygen pressure interlock system.
- C. Anesthesia equipment, apparatus, and machines shall be inspected and tested by the anesthesiologist before use and any defect reported.
- D. There shall be no flammable gases used in the operating room. (except oxygen)
- E. All anesthesia equipment shall have regular inspections by the Hospital Bio-medical Department.
- F. A pulse oximeter, anesthesia gas monitor, blood pressure monitor, cardiac monitor, and temperature monitor shall be available for all patients having general anesthesia.
- G. Patients receiving conscious sedation shall be monitored with at least a blood pressure monitor, cardiac monitor, and pulse oximeter. If the conscious sedation is administered by the surgeon, a nurse shall be assigned to monitor the patient.
- H. Blood pressure will be monitored on all patients receiving local anesthesia.
 - I. Resuscitation equipment including a defibrillator, ambu bag, and medication for use per ACLS protocols shall be readily available in the surgical department.
- J. A fully stocked cart shall be available with a detailed written protocol for the treatment of Malignant Hyperthermia shall be readily available in the surgical department.
- K. Equipment for the prevention of hypothermia including warmers for IV solutions, hypothermia blankets, and patient warm air units shall be readily available

ARTICLE X: PHARMACY

Section 1. Standards

All medications used at Parkview Wabash Hospital shall meet the standards of the United States Pharmacopoeia and National Formulary, with the exception of those used for legitimate clinical trials which have been so documented.

Section 2. Stop Order Time Limitations

Orders for narcotics, sedatives, antibiotics, ketorolac injections, anti-coagulants, and stimulant medications shall be subject to automatic stop order time limitations as follows:

- A. Narcotics will automatically be discontinued 72 (seventy-two) hours after the initial order unless the physician rewrites the order.
- B. Sedatives, hypnotics, anti-coagulants, stimulants, and antibiotics will be discontinued 7 (seven) days after the initial order unless the physician rewrites the order.
- C. Keterolac injection will automatically be discontinued after 5 (five) days of therapy.

Medication shall not be discontinued without notifying the physician. If the order expires in the night, the medication will be continued until the following morning when it shall be brought to the physicians' attention.

Section 3. Hospital Formulary

The Hospital maintains a formulary, and each member of the Medical Staff shall follow this formulary unless in the judgment of the Practitioner it would jeopardize patient safety to do so. Pharmacy policies exist for the procurement of non-formulary medications.

Section 4. Investigational Drugs

Investigational medications will not usually be utilized in the Hospital. In the event that the use of such a medication is requested by anyone on the Medical Staff, an appropriate protocol for its use will be formulated by the pharmacist and the ordering Practitioner in consultation with the Clinical Committee Chair. Significant concerns on the part of the pharmacist and Clinical Committee Chair may preclude use of these medications in the Hospital.

Section 5. Placebos

While the use of placebos in the care of hospitalized patients is strongly discouraged, we recognize that unusual circumstances may warrant their administration. Any order for use of placebos shall be reviewed by the Quality & Resource Management Committee.

Section 6. Drug Security

Pharmaceuticals are to be locked in a secure area whenever a department is closed. Drug stocking levels are to be reviewed periodically by pharmacy and surgery personnel to insure appropriateness.

ARTICLE XI: PODIATRISTS AND DENTISTS

Podiatrists shall be responsible for a detailed podiatric history and examination on all

patients they attend in the Hospital and a surgical report shall likewise be created for any procedure they perform in the Hospital. In like manner, dentists shall be responsible for a detailed history and examination of the oral cavity on any patient they attend in the Hospital and they shall create a surgical report for any procedure they perform as well. As described in ARTICLE I Section 1 of these Rules and Regulations, however, a Medical Staff Member with an M.D. or D.O. degree must admit the patient for the podiatrist or dentist and must care for any other medical condition either pre-operatively or post-operatively.

ARTICLE XII: PHYSICIAN COVERAGE

Active Medical Staff Members shall either provide or arrange for the provision of continuous coverage for their patients in the Hospital and for those presenting to the Emergency Department. Affiliate Medical Staff Members shall provide or arrange for continuous coverage for their hospitalized patients whenever they are the Attending Physician.

Active Medical Staff Members practicing in a specialty area shall provide any service for which they are privileged to all patients requiring such services whenever they are on call. All Active Medical Staff Members shall take a "reasonable" amount of call to ensure continuous coverage for patients.

Active Medical Staff Members shall provide coverage for unattached patients. The Medical Staff Member responsible for this coverage on a given day will generally be determined by the utilization of an on-call schedule.

In the event patients presenting to the Hospital require the services of a physician who is scheduled to be unavailable, and there is no adequate on call back up, (i.e. when only one or two members of a specialty are on Active Staff), patients requiring this physician's services will be transferred to a facility with appropriate provider availability.

All physicians shall inform the Hospital Emergency Department of the method by which they can be contacted; and, whenever they will be unavailable, the Physician shall provide instructions regarding an alternate Medical Staff Member to contact.

ARTICLE XIII: RULES AND REGULATIONS FOR OTHER DEPARTMENTS

The Medical Staff may not make rules and regulations for other personnel in the Hospital.

**ADDENDUM A: Parkview Community Hospitals Tissue Exempt and Gross Only Lists
(PNH, PHH, PWB, PWH)**

A. TISSUE EXEMPT LIST

All tissues, foreign bodies, calculi, etc., removed during an operation shall be sent to the hospital pathologist, who will make such examination as he may consider necessary to arrive at a pathologic diagnosis, and record same on the patient record. The following are exceptions, and are not required to be sent for pathologic review:

Oral Surgery

- Teeth (caried and non-caried)
- Hardware and appliances

Urology

- Stents
- Penile implants
- Ribs for exposure, clinically noninvolved by infection or tumor

Cardiovascular

- Blood clots, clinically uninfected from AV fistulas

Neurosurgery

- Bone from craniotomy, clinically noninvolved tumor, infection or metabolic bone disease
- Bone and soft tissues from laminectomy not involved by tumor or infection
- Shunt equipment

Ophthalmology:

- Eye muscles
- Cataracts
- Skin removed for cosmetic purposes with no other pathology in area

Orthopaedics

- Orthopaedic hardware and appliances
- Toenails and fingernails
- Finely fragmented bone or meniscus

Otolaryngology

- Deciduous teeth in children
- Myringotomy tubes

General

- Epidermal scars - from trauma or recent burns, no past history of cancer in area
- Muscles, tendon, skin for debridement from acute trauma
- Hardware/Appliances
- Foreign bodies not chronic or considered to clinically have future legal implications
- Normal Placenta (see placental exemption list)

- Foreskin - neonatal

B. GROSS ONLY LIST

The following are specimens, which may not require a microscopic examination. In each case, the specimen should undergo careful gross examination by the pathologist/pathologist assistant, described and a final diagnosis dictated. Should a specimen on this list arouse the examiners suspicion regarding unusual or uncertain pathology, microscopic examination should be performed to delineate its etiology. Clinicians may also request microscopic examination.

- accessory digits
- bone – from non-pathologic fractures, bunion, hammer toe, incidental rib removals.
- cartilage – from knee, menisci-plica ligaments and tendons
- femoral heads removed for degenerative joint diseases, except for fracture
- foreign bodies – forensic or medical/legal specimens must follow strict chain of custody
- knee joint removed for degenerative joint disease
- nasal bone and cartilage – from septoplasty/rhinoplasty
- prostheses
- varicose veins
- umbilical hernia sacs in children

ADDENDUM B: Placental Guidelines for Pathologic Examination; for Parkview Community Hospitals (PNH, PLH, PHH, PWB, PWH)

The following is a guideline for pathologic examination for placentas. Since placentas are the products of normal pregnancy, normal placentas are listed on the exempted list.

In the following conditions, placentas shall be sent to pathology for examination:

- Fetal depression (5-minute APGAR <7, pH <7)
- Fetal distress with a bad outcome
- Hydrops fetalis or severe anemia (HCT <35)
- Intrauterine growth restriction (IUGR) / Small for gestational age (SGA) (< 5 lbs. at term)
- Major congenital anomalies (omphaloceles, chromosome abnormalities)
- Multiple gestations (twins, triplets)
- Neonatal neurological problems / seizures (not mother)
- Preterm Delivery (< or = 34-week gestation)
- Suspected fetal or maternal infection
- Fetal demise

In the following conditions, placentas may be sent to pathology for examination at the discretion of the attending physician, after consideration of the clinical situation:

- Abnormally large or small placenta
- Non reassuring fetal heart rate
- Maternal systemic disease with clinical concern for mother or baby (ex: Pre-eclampsia, diabetes, lupus anti-coagulant, etc.)
- Oligohydramnios or polyhydramnios
- PIH – Pregnancy induced hypertension
- Umbilical cord anomalies (abnormally short < 32, or long > 100 cm, 2 vessel, etc.); if not sent to pathology, document in medical record
- Vaginal bleeding in late pregnancy
- Heavy or thick meconium staining
- Placentas of non-prescribed or illegal drug users
- No prenatal care
- Babies 10 pounds and over
- Provider request or paternal/maternal request

PWB Rules and Regulations - Approved









4.15.2025

Final Audit Report

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