RULES & REGULATIONS OF THE MEDICAL AND DENTAL STAFF OF PRESBYTERIAN HEALTHCARE SERVICES SANTA FE, NEW MEXICO

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RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF OF PRESBYTERIAN HEALTHCARE SERVICES SANTA FE, NEW MEXICO

I. Medical and Dental Staff Credentialing Process by Criteria Based Tracking.

Applications for Medical Staff membership and clinical privileges as well as request for additional clinical privileges, reappointment, and reassignment of privileges are processed in accordance with the Credentialing and Privileging Policy.

II. Admission, Care & Discharge of Patients

A. The authority for admission of patients to a Presbyterian Healthcare Services inpatient facility (hereinafter "facility") has been vested in Presbyterian Healthcare Services Administrator by the Board of Trustees. Requests for admission are made by the Staff member but the final approval rests with the Administrator.

B. Presbyterian Healthcare Services shall accept patients with all types of diseases, including emotional disturbances and addictive diseases, providing that facilities are available for care of the patient and protection of personnel.

C. A patient may be admitted to a facility only by a member of the Medical Staff with admitting privileges or his/her designee. Patients may be admitted by an Advanced Practice Clinician (APC) who has been granted appropriate privileges. Should a patient leave a facility against advice, a notation of the incident shall be made in the record.

D. When, in the opinion of the attending physician, patient needs for care or safety could be better met in another facility, transfer shall be arranged in accordance with federal, state, and health plan regulations and the transferring physician shall contact the physician to whom referred. Pertinent patient care portions of the medical record shall be copied to accompany the patient.

E. The practitioner who admits a patient shall be responsible for the provision of medical care to the patient. Whenever a member transfers this responsibility it shall be entered in the medical record.

F. Each member of the Medical Staff who is not available for the care of his/her patients shall name
a member of the Medical Staff with equivalent privileges who is available and who will accept responsibility for continuing care of the Staff member's patients in the Hospital, including discharge or transfer to alternate facilities when medically indicated. In case of failure to name such an associate, the Chief of Staff, Chief of the Division/Section

concerned, or Medical Director shall have authority to call any member of the Active/Associate Staff to provide necessary medical care.

G. All hospitalized patients will be seen at least once daily by a privileged practitioner except in long-term care units which will establish their own policies in accordance with internal, state, or federal regulations.

H. Except in an emergency, no patient shall be admitted to a facility until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. In all cases, Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure protection of the patient from self- harm and to assure the protection of others.

I. A general consent form for diagnosis and treatment, signed by or on behalf of every patient admitted to a facility, shall be obtained at the time of admission.

J. Additional written, signed consents shall be obtained prior to diagnostic, therapeutic or operative procedures which have inherent risk. In the case of emergencies involving a minor or a patient who is unconscious or otherwise incompetent or when the patient's life is in jeopardy and suitable consent cannot be obtained, the circumstances shall be fully recorded in the medical record. In such instances, when time permits, a consultant's opinion is desirable.

K. Opinions requiring medical judgment, evaluation of the significance of medical histories and physical examinations, authentication of medical records and the prescribing of treatment shall be made only by members of the Medical Staff with clinical privileges.

L. All faxed and verbal diagnostic and therapeutic orders must be authenticated by the responsible practitioner within seventy-two (72) hours. For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.

M. Restraint orders must be reviewed and renewed every 4 hours for adults; every 2 hours for children (age 9-17); and every hour for children under the age of 9.

N. All pre-operative or pre-transfer orders for patient care shall be reviewed and authenticated with signature, time, and date by the attending physician at the time of surgery or on transfer to or from the designated critical care areas and the long- term care units.

O. Timely admission orders for non-critical care units including diagnosis, therapeutic orders, laboratory, diet and activity orders, and other ancillary studies will be submitted. Patients in critical care units will be seen and orders entered within two hours. When possible, emergency or urgent consultations will be personally requested by the attending practitioner.

P. Standing orders must be approved by the Medical Executive Committee upon the recommendation of the appropriate medical staff Division, section, or committee and the nursing and pharmacy departments All standing orders, order sets, and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

The Medical Executive Committee will confirm that all approved standing orders and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that such orders and protocols are reviewed periodically. The standing orders are to be followed insofar as proper treatment of the patient will allow and shall be signed, dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner responsible for the care of the patient

Q. The use of patient's own medications shall be reserved for only those circumstances where it would be difficult or impractical to dispense the medication from the pharmacy. If a patient's personal supply will be used, a written order must be placed in the chart. The medication will be stored on the unit unless self-administration is ordered by the physician. Orders for patient's own medications or for self-administration shall include the name of the drug, dosage to be given, and frequency of administration. The usage, storage and destruction of patient's own medication must comply with the medical staff's approved Patient Care Policy on *Patients' Own Medications.*

R. When orders are unclear, incomplete or illegible, the authorized employee receiving the order shall obtain clarification from the practitioner. The order will not be carried out until clarified. The clarified order will be written as a verbal order and authenticated as with other orders.

S. Stop orders must comply with the medical staff approved Patient Care Policy on Medication Stop orders.

T. A facility formulary shall be maintained by the Pharmacy under the direction of the Pharmacy and Therapeutics Committee. The facility formulary permits a physician to order from drugs that are listed. When the brand of drug ordered is not listed in the formulary, the Pharmacy may dispense an equivalent drug of a different brand. However, it shall be within the discretion of the physician, at the time of prescribing, to disapprove substitution of a drug of a different proprietary brand than that ordered. All medications are administered by or under the supervision of appropriately licensed personnel in accordance with applicable law and regulation.

U. A Staff member who desires to use a drug that has not been approved for any purpose by the Food and Drug Administration shall follow procedures outlined by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee. In all cases where such a drug is used, the patient shall complete an informed consent form approved by the Institutional Review Board and the drug shall be dispensed from the Pharmacy on order of the physician. The procedures to follow shall be available at the Pharmacy.

V. Routine laboratory procedures for patients admitted for one (1) day or less for diagnostic procedures or for surgical procedures may be developed as indicated by the appropriate clinical service. Clinical Divisions/sections may establish needed pre-operative laboratory and ancillary studies prior to operative procedures.

W. Isolation of patients for certain infections and contagious diseases shall be required as specified by the Infection Control Committee.

X. Individual infection control reports shall be maintained in the Nurse Epidemiologist's office.

Y. In the event of a patient's death in a facility, the deceased shall be pronounced dead by the responsible physician or his/her designee. The body shall not be released until an entry has been made in the medical record by a member of the Medical Staff or his/her designee.

Z. Any member of the Medical may consider obtaining consultative support when one or more of the following elements arise during the course of care:

1. When a patient is seriously ill and the diagnosis is in doubt, improvement with therapy is not apparent (except in irreversible or terminal illness), or when specialized therapy or diagnostic procedures are to be used.
2. When the patient has an illness or problem requiring an unusual degree of expertise or competency in a subspecialty area acquired through subspecialty training.

AA. Members of the Medical Staff asked to provide consults for patients admitted to inpatient or observation status will personally assess the patient within 24 hours – unless explicitly specified otherwise. The consultant shall document that s/he personally has examined the patient and reviewed all pertinent medical records and lab findings. An appropriately credentialed APC f assisting the consultant may be designated to aid in accumulating information regarding the patient. Such APC may not perform the consultation in lieu of the consulting physician. The exception are those advanced practice professionals that work in the NICU who attend deliveries and provide low-level consultations.

BB. All pediatric patients less than 40 kilograms must have weight-based or age-based dosing of medications when available

CC. In accordance with the American Medical Association and the rules of the New Mexico Medical Board, it is the expectation of the Presbyterian Central Delivery System Medical & Dental Staff that Members of the Medical Staff or Providers holding privileges of any kind follow the guidelines detailed below when a family member, including significant other, is in need of medical care.

Physicians cannot act as a primary care provider or treating physician for chronic or significant medical conditions in family members or themselves. Physicians cannot perform surgery on, admit, or give/enter inpatient orders for family members. Physicians cannot prescribe controlled substances for themselves or family members. Physicians may provide routine care for short-term, acute, and self-limiting medical problems. This may include performing non-invasive exams and tests, issuing non-renewable prescriptions (not controlled substances), care of a minor injury, or treatment of an ailment until it can be reasonably evaluated and treated by a colleague.

Exceptions to these prohibitions listed above can be granted in emergency situations, and/or in the event that a provider is located in a remote location and no other immediate or necessary specialized treatment is available. In the event a Provider is faced with such an emergency or remote location dilemma requiring the treatment of themselves or an immediate family member, the Provider must notify the Chief Medical Officer, the President of the Medical Staff or the Administrator before or as soon as reasonably possible after rendering any treatment.

DD. In order to allow Physical Therapists and Occupational Therapists to accept self-referral/direct care patients, they shall be authorized to order applicable Physical Therapy/Occupational Therapy outpatient service. The therapist will act within their scope of practice and shall refer a patient to the patient's licensed health care provider according to their state practice act requirements.

III. Clinical Experiments and Research

Any experimental or research procedure or study involving patients, hospital facilities, or clinical records in a facility shall first be approved by the Institutional Review Board. Any reports resulting from such experimental or research procedures or study are reviewed by the Institutional Review Board.

IV. Treatment of Mass Casualties

Under conditions involving mass casualties, all Staff members may be assigned to posts in a facility, mobile casualty stations or areas of refuge, and it is their responsibility to report to their assigned stations. The implementation of the Office of Medical Staff Affairs internal and external disaster plan will be under the direction of the Office of Medical Staff Affairs. The review of policy and procedures utilized by the Office of Medical Staff Affairs will be under the direction and approval of the Medical Executive Committee.

V. Medical Records

An adequate medical record shall be maintained for every individual who is evaluated or treated at any Presbyterian Healthcare Services Hospital facility as an inpatient, outpatient, or emergency patient.

A. Ownership

All patient medical records, radiographic films and studies, fetal heart monitoring tracings, pathology specimens, microscopic slides, photographs, videotapes, photographic slides, and any other documents resulting from the care provided are the property of the Hospital. Physicians and the individual departments are responsible for maintaining the integrity and confidentiality of the records. Under no circumstances may any of these originals be removed without express permission from the PHS HIM Department, or under court order. Copies may be obtained from the HIM Department in compliance with Federal and State regulations.

B. Access

Paper, Computer & Electronic Devices

Each member of the Medical Staff with access to the Hospital medical records agrees to comply with the information security policies of the Hospital including those set forth in the PHS *Electronic Information Security* policy, *Information Technology Acceptable Use* policy, and *Personal Computing Device* policy. Such policies include maintaining passwords and Personal Identification Number (PIN), which allow access to computer systems and equipment, in strictest confidence and not disclosing passwords and/or PIN to anyone, at any time, for any reason. Failure to comply with the information security policies of the Hospital may result in termination of access to computer systems, paper or other health information records, and in the initiation of corrective action as specified in the Bylaws. Loss, reduction or restriction of Medical Staff membership or clinical privileges for any reason may be grounds to terminate access to the system immediately and without prior notice to the Member .

Past Medical Records

Each Member of the Medical Staff shall have access to previous Hospital records of patients attended on an outpatient basis, when affiliation with the patient is evidenced by documentation of previous Hospital care. A requesting Member must obtain written patient consent when affiliation is not evidenced in previous health care records. At the time of readmission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible at the time of and for the duration of the readmission. Subject to the discretion of the Chief Medical Officer of Medical Staff Affairs, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital

Research and Committee Use
Access to all medical records of all patients shall be afforded to a Member of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. Access to all medical records of all patients shall be accorded to duly constituted committees of the Medical Staff for the purpose of medical care evaluation and review of utilization.

C. **Confidentiality & Release of Information**

Each Member of the Medical Staff understands that patient records are confidential and that access to such records is limited to those with a need-to-know in order to provide for the care of the patient. Unauthorized release of information from the Hospital records is prohibited. Unauthorized release includes printing of documents and re-release of these documents to others, whether or not they have appropriate access. Access to all medical records of all patients shall be accorded to duly constituted committees of the Medical Staff for the purpose of medical care evaluation and review of utilization

D. **Persons Authorized to Document in the Medical Record**

Entries in the medical record may be made by Members of the Medical Staff, APCs and by other persons specifically authorized by Presbyterian Healthcare Services Medical Staff. They may include:

Registered Nurses, licensed practical nurses, respiratory therapists, physical therapists, cath lab technicians, counselors, certified registered nurse anesthetists, registered dieticians, speech therapists, behavioral health therapists, polysomnography technicians, home health care coordinators, physician assistants, nurse practitioners, nurse specialists, certified nurse midwives, occupational therapists, pharmacists, radiology technicians and others as approved by the Medical Executive Committee.

E. **Medical Record Content & Documentation Requirements**

Accurate, appropriate, complete, legible, and timely documentation is the responsibility of all those that are authorized to make entries in the medical record. The definition of a complete medical record and detailed descriptions of the specific content of the constituent parts of the Medical Record are contained in Medical Staff Policy, *Medical Record Content & Documentation Requirements.* Requirements for timeframes of completion, who may document in a record as well as fines and/or suspensions from the Medical Staff based on failure to document or complete a medical record are based on the definitions contained in the *Medical Record Content & Documentation Requirements Policy.*

F. **Delegation of Medical Record Entries**

A physician (MD, DO, DDS/DMD, or DPM) may delegate all or part of the medical history and physical examination, discharge summaries, and operative reports to other practitioner provided the practitioner has the requisite privilege to perform the delegated task. Admission orders (including authentication of admission), H&P's and updates to H&P's may not be delegated to practitioners unless they have the specific privilege. A physician may also delegate to other practitioners progress note documentation, physician orders, and verbal orders without a co-signature requirement. Other practitioners include certified nurse practitioners, physician assistants, certified registered nurse anesthetists, certified nurse midwives, clinical nurse specialists. A physician (MD, DO, DDS/DMD or DPM) may delegate medical record entries to House Staff according to Medical Staff Policy governing residents.

G. **Incomplete/Delinquent Medical Records**

Federal law requires that records be completed, including all necessary signatures, in a timely fashion. Signature and content requirements for each component of the medical record are contained in the *Medical Record Content Policy.*

- Medical Records are incomplete if any component of the record, or any required signature/authorization of the record is missing.
- Medical records are delinquent if a record remains incomplete after the specified time frames noted in the Table of Completion Requirements.

TABLE OF COMPLETION REQUIREMENTS – INPATIENT

Medical Record Component	**Content and Signature must be Completed by**
H&P (Admitted Patients)	• Completed within 30 days prior to inpatient admission, or • Within 24 hours of admission
Update to H&P (Surgical/Procedure Patients)	Whichever event occurs first: • Prior to surgery/procedure • No later than 24 hours after admission
Immediate Operative/Invasive Procedure Note	Immediately after procedure
Complete Operative & Invasive Procedure Reports	No later than 24 hours after procedure
All other portions of the Medical Record	No later than 21 days after the patient's discharge date

TABLE OF COMPLETION REQUIREMENTS – OUTPATIENT/AMBULATORY

Medical Record Component	**Must be Completed by**
Visit Note	No later than 21 days after Visit Date

H. **Notices and Suspensions**

The Health Information Management Department (HIM) of PH is delegated the task of monitoring all medical records for completeness and timeliness as well as issuing communications to providers who have not (i) not completed any required portion of a medical record and/or (ii) have not provided required signature/authorization for any required portion of the medical record. Providers will be given EHR notification as identified in the Table of Provider Delinquency Notices & Suspensions so that the provider has an opportunity to complete the record prior to further notice or a suspension being issued.

If a provider is suspended from the Medical Staff for a delinquent medical record, **the scope** of such suspension is as follows until all delinquent medical records assigned to the provider are completed:

- Suspended from admitting privileges
- Suspended from booking Operating Rooms
- Suspended from all surgical procedures
- Suspended from attending inpatients
- Suspended from outpatient visits

Suspended providers will still have access to the EHR so that they may complete delinquent records.

Failure to complete all delinquent medical records within ninety (90) days after a Suspension Notice is issued will be subject to an automatic voluntary resignation from Medical Staff membership and/or privileges. If, after an automatic voluntary resignation occurs pursuant to this process, any provider seeking to reinstate membership and/or privileges must meet all the requirements for reappointment and complete the reappointment process.

I. **Disputes Regarding Delinquency Notices and Suspensions**

If a provider disputes a delinquency notice or suspension and/or needs assistance in determining how to complete a delinquent record, they must first contact the HIM Department who will have personnel available 24/7 365 days a year to assist providers with delinquent and suspension issues. If, after seeking assistance from HIM personnel the provider still disputes the delinquency or suspension or otherwise has an emergency related to delinquent or suspended records, the provider may escalate the matter to the Chief Medical Officer (CMO) or their designee) on call. The CMO or their designee, in consultation with HIM personnel, will determine the resolution of the delinquency or suspension dispute and what steps, if any need to be taken with respect to immediate patient care issues.

Repeated suspensions for medical record delinquencies will be tracked as part of every provider's ongoing professional performance evaluation (OPPE) data. The Credentials Committee may make recommendations or take action as they deem necessary to address providers with repeated suspensions.

TABLE OF PROVIDER DELINQUENCY NOTICES AND SUSPENSIONS

Record Component	**First Notice**	**Second Notice**	**Suspension Notice**	**Automatic Voluntary Resignation from the Medical Staff**
H&P	X *Notice will be sent at time order is placed for patient to be admitted or placed in observation		Suspension occurs at 24 hours after patient admitted or placed in observation For SNF: Suspension occurs at 48 hours after admission **(added 5/15)**	After 90 days from suspension notice
Updated H&P	X *Notice will be completed/ scanned into system		OR or procedure staff will notify provider of failure to complete prior to surgery/ procedure. Provider's failure to respond to staff's request will be escalated to the CMO or designee on call	After 90 days from suspension notice
Immediate Operative/Invasive Procedure	X *Notice will be sent at time		Suspension occurs at time patient is	After 90 days from

	order is placed to be admitted or placed in observation		transferred or discharged from recovery phase of care	suspension notice
All other components of record	X *7 days after patient discharge or ambulatory visit	X *14 days after patient discharge or ambulatory visit	X *21 days after patient discharge or ambulatory visit	After 90 days from suspension notice

J. **Inability to Complete Medical Records**

No medical record shall be closed until it is complete and properly authenticated. In the event that a medical record remains incomplete by reasons of the death, resignation, or other inability or unavailability of the responsible practitioner to complete the record, the Chief Medical Officer or designee shall consider the circumstances and may enter such reasons in the record so that the record may be completed and closed.

VI. General Rules for Surgical Care

A. A surgical procedure shall be performed only with the informed consent of the patient or his/her legal representative. In an emergency, where a consent form cannot be completed in the usual manner, a statement by another staff member attesting to the existence of an emergency shall be obtained. The statement shall be made a part of the record.

B. Surgeons shall be in the Operating Room and ready to commence operation at the time scheduled.

C. The primary operating surgeon shall have a member of the Medical Staff or an appropriately privileged professional assist at operative procedures as determined by the appropriate surgical Division or section.

D. Patients scheduled for minor procedures shall be admitted at least two (2) hours before the procedure is scheduled. More time shall be allowed when laboratory studies are required.

E. All patients admitted to the Operating Suite for surgery who do not yet have a recorded history and physical examination on the chart shall have an admission note stating the reasons for admission, the essential findings, other pertinent information, and a provisional diagnosis before surgery is undertaken. When such requirements are not met, surgery shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

F. Where a choice of side/site for a surgical procedure exists, no patient shall leave the holding area for the operating room without having the side and site of surgery clearly marked. Surgery will be delayed, just as with the requirement for a history and physical in Paragraph E. above, until the surgeon completes the appropriate marking of the surgical side/site.

G. Immediately following any surgery or invasive procedure the surgeon must dictate or enter into the HER an Immediate Operative Note containing the components identified in the *Medical Record Content & Documentation Requirement Policy.* The Immediate Operative Note must be entered and signed by the surgeon before the patient completes the recovery phase of care.

H. In the cases of surgical procedures requiring Hospital stay of only a few hours, the medical record shall contain enough information to explain the reason for admission, the findings, the procedure, and the results.

I. In every case where an anesthetic is administered by an anesthesiologist or his/her authorized representative, a record shall be made of pre- and post-anesthetic examinations; and an anesthetic record shall be completed.

J. All specimens and tissues removed during a surgical procedure, except those exempted by the specific Division/Section, the Division of Pathology, and approved by the Medical Executive Committee shall be properly labeled and sent to the pathologist, who shall determine the extent of examination necessary for diagnosis.

VII. Clinical Sections

A. Emergency Medicine

1. Emergency Medicine shall be responsible for the oversight of quality of care provided in the Division of Emergency Medicine. It shall be the Emergency Medicine physician's responsibility to initiate emergency care when necessary, to screen all patients that come to the Division of Emergency Medicine, to see that appropriate care or referral is provided, and to provide care for patients as requested by the patient or the patient's physician. Emergency Medicine physicians may delegate any of these responsibilities, including the conducting of a Medical Screening Exam (MSE) to any APC who has been granted appropriate privileges. Pregnant patients with emergencies related to their pregnancy may be referred to OB triage. Certified Nurse Midwives and OB nurses with specific training may conduct MSE's for pregnant patients referred to OB triage, including the assessment of patients for active labor**.** All patients requiring extensive or involved treatment, or admission to the Hospital shall be referred to the physician of the patient's choice or to an appropriate member of the Medical Staff.

2. All qualified members of the Active and Associate Staff of the Hospital shall serve on the Division of Emergency Medicine Back-up Panel in the area in which they have sufficient privileges, except those who are over the age of 55 who request not to serve. Affiliate staff members shall be expected to participate if the applicable division or MEC determines a need. Each division or section will develop a policy that addresses the frequency of Emergency Call responsibilities that the members can perform. Such policy may be revised, and must be approved by the Medical Executive Committee, as necessary. The panel physician shall be available to the Division of Emergency Medicine on the days that he/she is scheduled. If he/she will not be available it will be his/her responsibility to obtain a substitute who has sufficient privileges in the field to be covered and who has agreed to accept the responsibility of coverage, and he/she shall notify the Division of Emergency Medicine of the substitution.

a. The Emergency Department may refer uninsured patients who do not have a physician to an appropriate panel physician for a follow-up visit. The patient shall be requested by the Emergency Department to call the referred physician's office within two working days for an appointment or consultation. The panel physician will provide at least one follow-up visit without concern about ability to pay when the Emergency Division refers a patient to them and when the patient has complied with the above directions. If after the initial visit, the panel physician does not wish to continue caring for the patient, the physician will make a reasonable effort to arrange for necessary continuing care for the patient with another physician.

b. The physician or APC practitioner providing service to a patient in the Division of Emergency Medicine shall be responsible for a medical record on each patient that contains a brief history, the essential findings, the treatment, disposition of the patient, and instructions given the patient when the patient is not admitted.

3. The Division of Emergency Medicine shall consist of a Chief, and Vice Chief elected by the members of the Division. The Division of Emergency Medicine shall meet monthly and shall submit minutes to the Medical Executive Committee. The Division of Emergency Medicine shall maintain written policies approved by the Medical Executive Committee to govern operation of the Division.

4. If consultation is necessary and no personal physician is listed, the patient will be asked if he has a preference of physician and the preference will be followed. If the patient has no preference, the appropriate physician on the back-up panel will be called. All inpatient admissions will be managed by a Hospitalist.

5. If a private physician requests that a patient be sent to his office, the patient must first be provide a MSE .

GENERAL RULES

1. The Emergency Division physician or APC will perform a MSE will provide diagnostic work-up and/or short-term definitive treatment and refer the patient for follow-up to an appropriate physician of the patient's choice or from the back-up panel.

2. All patients requiring extensive or involved treatment or admission will be referred to either a physician of the patient's choice , a Hospitalist or a back-up panelist.

3. The Emergency Division physician or APC shall render all emergent care necessary pending the arrival of the physician ultimately responsible for critically ill patients.

4. The Emergency Division physician or APC will not involve themselves in any treatment, not of a life saving nature, which requires prolonged time and may result in other Emergency patients having to wait an unreasonable length of time.

5. In all cases of severe multiple trauma, a general surgeon will be called to act as team leader. The Emergency Division physician will be responsible for coordinating care until the general surgeon arrives. The Emergency Division physician will turn responsibility for case management over to the general surgeon on arrival.

6. Each physician called to the Emergency Division, whether she/he is a back-up panelist or patient's requested physician must be personally available within 40 minutes or the physician must discuss with the Emergency Division physician within 20 minutes plans for interim care unless more stringent policies are adopted by other sections. If a staff physician does not comply, the Emergency Division physician may call another staff physician of his choice. Noncompliance by a back-up panelist will be reported to the PHS Medical Director. The physician must respond in person when requested to do so by the Emergency Division physician.

7. Emergency Division personnel should attempt to contact physicians by all available routes and not rely solely on the call service. If such attempts are futile, the 20 minute rule will be observed.

8. If a Staff physician wishes another staff physician to see a patient, it shall be the Staff physician's obligation to obtain such a consultation.

9. All patients presenting to the Emergency Division will have a MSE performed by a physician or APC . Those patients who are "unstable" will be sent directly back to the Division. Those patients who are "stable" may be sent to registration before being seen by a physician as per triage protocols in place.

RULES GOVERNING PHYSICIANS ON EMERGENCY DIVISION BACK-UP PANELS

1. It is the responsibility of the Staff physician to answer his/her Emergency Division calls in person, when requested to do so, and determine disposition of patients. When the Emergency Division physician requests a back-up panelist or personal physician consult on a patient in the Emergency Division it shall be the responsibility of the Staff physician to see that patient and provide care or make arrangements for appropriate referral or transfer if he cannot assume the care of that particular patient.

2. The physician on Emergency Division back-up is responsible to any member of the Medical Staff requesting emergently necessary consultation for inpatients who have been admitted to the hospital. The determination of whether a consultation is "emergently necessary" is made by the requesting provider and any physician who is on Emergency Division back-up must respond to the requesting provider during their ED call shift, regardless of when the patient was admitted**.**

3. All eligible members of the Active and Associate Staff will rotate on back-up panels in their respective specialties. A policy for implementing the Emergency Room Call Schedule through the Office of Medical Staff Affairs shall be reviewed and approved by the Medical Executive Committee.

RULES GOVERNING EMERGENCY DIVISION PHYSICIANS

1. The Emergency Division physician will refer all patients to the physician of the patient's choice or the appropriate Back-up panelist. Certain circumstances may dictate referral back to the Emergency Division.

2. Emergency Division physicians will be assigned shifts in advance and the schedule posted in each Emergency Division. It is the scheduled physician's responsibility to see that the assigned shift is covered.

3. The Emergency Division physician must remain on duty until relieved by the next shift physician.

4 The Emergency Division physician is not expected to have expertise in all medical specialties, but must be able to recognize life threatening conditions and initiate emergency treatment for all patient types, and follow through with referral to appropriate specialists.

5. The Emergency Division physician shall respond to Code Blue calls within the hospital and coordinate ACLS until relieved by an attending physician qualified to continue care.

6. The Emergency Division physician may respond to requests from attending physicians for interim management of "crisis" situations of inpatients, if the ED physician is available and it is determined to be medically necessary.

7. The Division of Emergency Medicine shall be responsible for maintaining, testing and continuously evaluating policy and procedures for the management of internal and external disaster situations.

B. Medicine

1. The Division of Medicine is responsible for oversight of the quality of all adult medicine practiced in the Hospital and shall be organized and carry out duties as described in the Bylaws.

2. The Division of Medicine Executive Committee shall consist of the elected officers of the Division and the Chiefs of sections and such other members as necessary. The Committee shall conduct the business of the Division. A Division of Medicine Quality Management Committee, a Nominating Committee, and other committees, as needed, may be appointed to assist in carrying out the responsibilities of the Division. These committees shall meet as needed and report to the Chairperson of the Division of Medicine. The Chairperson of the Division of Medicine shall report to the Division of Medicine at their regular meeting.

B. Gastroenterology

1. The Division of Gastroenterology will be responsible for establishing criteria for the performance of procedures in the GI Laboratory and the utilization of GI Laboratory equipment.

2. Members must be readily available to all patients they have seen in consultation, both in-patients and out-patients, 24 hours a day, 365 days per year, either personally, or through agreement with a designated surrogate ("on-call") physician with comparable privileges and who is also a member of the Presbyterian Hospital Medical Staff. It is further required that should a patient already known to a member of the Division be admitted to the hospital by any service, and should that service require GI consultation, the GI physician

known to that patient (or his or her on-call designee) will provide GI consultative services, unless the patient actively requests otherwise.

3. The section agrees that in order to maintain hospital privileges and access to the Presbyterian GI Studies lab, each member, regardless of age, will take a 24 hour shift during which he or she is responsible for any and all consults requested for such patients ("Consult Call"). All members of the section will participate at a frequency proportional to the number of section members, up to 24 per year. This schedule will be made out 3 months or more in advance by and distributed through the Office of Medical Staff Affairs. Each shift begins and ends at 7 AM. Physicians may arrange Consult Call coverage by another agreeable GI Division member and call duties may be traded by mutual consent. It is understood that as a consequence of this Consult Call Arrangement, the member of the GI Division will not participate in the Internal Medicine Emergency Department backup Call pool. The GI specialist on consultative call is required to provide office follow-up when requested to do so by the ED physician for a patient seen in the ED according to the process described in these Rules and Regulations. and to provide GI intervention when appropriate for Esophageal Foreign Body.

C. Hospitalist

1. All inpatient care will be managed by Hospitalists, including physicians and advanced practice clinicians (APCs) who have been granted appropriate privileges.

2. Admit order must be signed by physician prior to discharge.

3. Hospitalists will work together as a team to provide continuity of care.

4. Hospitalists are responsible to notify the applicable primary care practitioner of a discharged patient requiring outpatient follow-up. Discharge orders and other pertinent information at the time of discharge will be provided to the practitioner's office. If it is the opinion of the Hospitalist that the condition of a patient requires a higher level of service the Hospitalist has the option of direct referral to an appropriate specialist. The Hospitalist should notify the primary care practitioner.

5. Hospitalists are responsible for significant points of transition such as transfer to another facility, referral to hospice or other outpatient services as applicable, with the assistance of charge nurses, social workers and case managers as appropriate.

C. Obstetrics & Gynecology

1. The Division of Obstetrics and Gynecology Committee shall consist of the elected Chairperson, Vice Chairperson and Secretary and such other members as may be necessary. An Obstetrical and Gynecological Care Evaluation Committee, Nominating Committee, and other committees as needed may be appointed to assist in carrying out the responsibilities of the Division. These committees shall report to the Chief of Obstetrics and Gynecology who, in turn, shall report monthly to the Division and to the Executive Committee.

2. Consultation

   a. Recommended for staff members with Class II privileges

      (1) All problems involving poor risk patients, doubt as to diagnosis, or doubt as to choice of time of therapeutic procedure.

      (2) All patients for whom radiation therapy is proposed.

      (3) All pregnant or puerperal patients with major medical, surgical or obstetrical complications.

   b. Required for staff members with Class I privileges

      (1) All the above.

      (2) For any complication, procedure or use of medication which causes patient to no longer be considered low risk.

      (3) For any postpartum complication which requires care beyond routine postpartum care.

      (4) Any obstetrical procedure other than the perineal phase of outlet forceps with or without episiotomy.

2. Medical Screening and Assessment of Active Labor in OB Triage

   Pregnant patients with emergencies related to their pregnancy may be referred to OB Triage. Certified Nurse Midwives and OB nurses with specific training may conduct MSE's for pregnant patients referred to OB Triage, including the assessment of patients for active labor.

D. Pathology

1. The Division of Pathology shall be responsible for oversight of the quality of Anatomic, Clinical and Radioisotopic Pathology practiced in the Hospital and shall be organized as described in Article XI of the Bylaws.

2. The Division of Pathology Committee shall consist of the Chairperson of the Division and other members as are necessary to review pathology practice in the Hospital and to conduct the business of the Division. The Committee shall review and make recommendations on credentials of all applicants and members of the Medical Staff requesting privileges in Pathology and continuously evaluate the quality of pathology practice in the Hospital and its allied institutions. The Committee shall meet quarterly and as needed; the Chairperson of the Division shall report to the Division and to the Executive Committee at regular intervals.

E. Radiology

1. The Division of Radiology shall be responsible for the oversight of quality of radiology practices at Presbyterian Healthcare Services.

2. The Division of Radiology Committee shall consist of the Chairperson of the Division and other members as are necessary to review radiological practice in the Hospital and to conduct the business of the Division. The Committee shall review and recommend on credentials of all applicants and members of the Medical Staff requesting radiologic privileges and continuously evaluate the quality of radiology practice in the Hospital and its allied institutions. The Committee shall meet quarterly and as needed; the Chairperson of the Division shall report to the Division and to the Executive Committee at regular intervals.

F. Surgery

1. The Section of General Surgery shall be responsible for the oversight of quality of general surgical care provided to patients in the hospital.

2. The Division of will include the sections set forth below. Each Division shall elect a Chief and Vice Chief. The Chief shall be a member of the Division of Surgery, Program Policy Committee or other special committees of the Division.

Orthopedic Surgery Section

(i). The Division of Orthopedic Surgery Committee shall be made up of the elected Chairperson, Vice Chairperson, Secretary and two (2) Members-at-Large and other members of the Division as designated by Chairperson. The committee shall conduct the business of the Division, review and make recommendations on credentials of all applicants and members of the Medical Staff requesting orthopedic privileges, and continuously evaluate the quality of orthopedics practiced in the Hospital. The

committee shall need monthly and as needed, and the Chairperson of Orthopedics shall report to the Division and to the Executive Committee at regular intervals.

G. Anesthesiology

1. The Anesthesiology Section Division shall be responsible for the oversight of quality of anesthesia care provided to surgical and obstetrical patients in the Hospital**.** An anesthesiologist who is a member of the Medical Staff and a member of, or eligible for, membership in the Division of Anesthesiology shall be appointed Director of Anesthesiology and shall have overall administrative responsibility for anesthesia services, although the responsibility may be shared with the Chief of the Division. The Director may or may not be the Chief of the Division.

2. The anesthesiologist is responsible for appropriate preoperative and pre-induction evaluation of the patient and the patient record. The anesthesiologist is responsible for the choice of anesthesia and the anesthetic agent or technique with the concurrence of the surgeon. The anesthesiologist is primarily responsible for the care of the patient in the Recovery Room and is responsible for pre- and post-anesthesia evaluation and for appropriate anesthesia records.

H. Allied Health Personnel

1. Allied Health Personnel, employed by members of the Active or Associate Staff may provide services to patients within the limit of their skills and the scope of lawful practice upon recommendations of the Medical Executive Committee and approval of the Board of Directors of Presbyterian Healthcare Services. The assigned permit is not a contractual or property right and can be terminated at any time for substandard performance or conduct. The wearing of an identification name tag shall be required by all Allied Health Personnel while functioning within the Hospital.

2. For the purposes of this section, Allied Health Personnel shall include Technicians who perform selected skills or assist with specified procedures under the direction and supervision of a member of the Active or Associate Staff and audiologists/speech pathologists.

3. Processing of applications will be conducted as described in the AHP Policy.

3. Conditions of Practice for AHPs

a. AHPs are not permitted to function independently. As a condition of being granted permission to practice, all AHPs specifically agree to abide by the conditions of practice set forth in this Section and all applicable policies. In addition, as a condition of being permitted to utilize the services of AHPs, all Medical Staff members who serve as Supervising Physicians specifically agree to abide by the conditions set forth in this Section and all applicable policies. Physicians who wish to utilize the services of an AHP in their clinical practice must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately granted a scope of practice in accordance with applicable Policy before the AHP performs services or engages in any kind of activity in the Medical Center.

b. The following conditions of practice apply to the functioning of AHPs:

1. Admitting Privileges. AHP s are not granted inpatient admitting privileges and therefore may not admit patients.

2. Consultations. AHP s may not independently provide patient consultations.

3. Emergency On-Call Coverage. AHPs may not independently participate in the emergency on-call roster.

4. Daily Inpatient Rounds. An AHP may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate if the Supervising Physician is present.

4. Oversight by Supervising Physician:

a. AHP s may function only so long as they have a Supervising Physician.

b. Any activities permitted to be performed at the Medical Center by an AHP will be performed only under the oversight of the Supervising Physician.

c. If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the AHP fails, for any reason, to maintain an appropriate relationship with a Supervising Physician, the AHP 's scope of practice will be automatically relinquished, unless he or she has another Supervising Physician who has been approved by the Medical Executive Committee.

4. Questions Regarding the Authority of an AHP :

a. Should any member of the Medical Staff, or any employee of the Medical Center who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an AHP to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate at the time the instructions of the AHP . Any act or instruction of the AHP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.

b. Any question regarding the conduct of an AHP will be reported to the Chief Medical Officer.

VII. Temporary Suspension of Rules & Regulations

The Medical and Dental Staff of Presbyterian Hospital, through the authority delegated to it from the Bylaws of the Medical and Dental Staff and the Bylaws of the Governing Board, promulgate Rules & Regulations in order to ensure patient safety, continuity of care and compliance with federal and state laws. From time to time and only under extraordinary circumstances, the Medical Executive Committee (MEC) may need to temporarily suspend or otherwise temporarily modify a Rule & Regulation. The Chief Medical Officer, the President or President Elect of the Medical Executive Committee or the Facility Administrator may request a temporary suspension of a Rule or Regulation be instituted by the MEC under the following conditions and in the following manner:

a. Unexpected failure or malfunction of a facility structure, technology, equipment or supply resulting in extraordinary circumstances;
b. Unanticipated critical personnel shortage arising from extraordinary circumstances.
c. Other extraordinary circumstances resulting in a critical and unexpected issue that has an immediate, negative impact on the ability to deliver care to patients

Under such circumstances, the requesting party shall present to the MEC the (i) nature of the issue, (ii) the extraordinary circumstances giving rise the issue, (iii) the specific rule or regulation that requires temporary suspension or modification, (iv) the anticipated time frame for the suspension or modification of the rule, (v) means of notification plan to Medical Staff regarding the issue and rule in question and (vi) alternative methods for addressing any patient safety issues or state and federal laws the rule is intended to address. Temporary Rules suspensions will only be granted by the MEC in extraordinary circumstances for the shortest possible timeframe. The President of the MEC shall inform the Chair of the Governing Board as soon as possible in the event such a temporary suspension of a rule or regulation is granted.