

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
GOTTLIEB MEMORIAL HOSPITAL**

**MEDICAL STAFF
RULES AND REGULATIONS**

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ARTICLE I

DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in the Medical Staff Credentials Policy:

- (a) “Admitting Physician” means the physician who orders the admission of a given patient to the Hospital.
- (b) “Ambulatory Care” means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy.
- (c) “Ambulatory Care Location” means any department in the Hospital or provider-based site or facility where ambulatory care is provided.
- (d) “Attending Physician” means the patient’s primary treating physician or his or her designee(s) (e.g., the resident on the attending physician’s service or “on call” for that service or an appropriately privileged allied health professional), who will be responsible for directing and supervising the patient’s overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient’s status to the patient, the referring practitioner, if any, and the patient’s family.
- (e) “Consulting Physician” means a physician who examines a patient to render an opinion and/or advice to the attending physician (or his or her designee).
- (f) “Practitioner” means, unless otherwise expressly limited, any appropriately credentialed physician, resident, dentist, oral surgeon, podiatrist, or allied health professional, acting within his or her clinical privileges or scope of practice.

- (g) “Responsible Practitioner” means any practitioner who is actively involved in the care of a patient at any point during the patient’s treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and legible medical record entries related to the specific care/services he or she provides.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

2.1. Admissions:

- (a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges.
- (b) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.
- (c) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.
- (d) All patients admitted with a psychiatric diagnosis or significant psychiatric symptoms must be evaluated for a psychiatric consult. If a patient presents with or demonstrates suicidal ideations, an order for suicide precautions should be placed on the medical record and all appropriate guidelines to ensure patient safety followed. The attending physician retains final authority for medical clearance prior to the discharge of the patient or the transfer of the patient to a mental health facility.
- (e) If there are any questions as to the validity of an admission to, or discharge from, any special care unit (i.e., TCU, GBHU, ICU, OB), the decision to admit or discharge should be made in consultation with the Unit's Medical Director or the Department Chair.

2.2. Admissions from the ED:

There will be a consultation between the ED physician and the physician to whom the patient is being admitted (i.e., the patient's private physician, managing consultants, or the attending physician on call) on any admission from the ED. The ED physician may write admitting orders and/or write bridge orders in consultation with the physician to whom the patient is being admitted. The ED physician will document a report of the ED visit in the medical record. The attending physician (or his or her designee) is responsible for the history & physical and the admission order.

2.3. Active Surveillance Culture Screenings:

Admissions to the Intensive Care Unit will be screened according to current specific active surveillance culture screening criteria for the Intensive Care Unit.

2.4. Responsibilities of Attending Physician:

- (a) The attending physician will be responsible for the following while in the Hospital or an ambulatory care location:
 - (1) the medical care and treatment of the patient while in the Hospital or ambulatory care location, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);
 - (2) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;
 - (3) referring insurance or third-party payor inquiries for concurrent medical information to Utilization Management;
 - (4) communicating with the patient's third-party payor, if needed;

- (5) providing a physician certification of medical necessity of an inpatient admission;
 - (6) providing necessary patient instructions;
 - (7) responding to inquiries from Utilization Management regarding the plan of care in order to justify the need for continued hospitalization; and
 - (8) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate.
- (b) At all times during a patient’s hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient’s medical record. The new attending physician will be responsible for verifying his or her acceptance of the transfer and updating the attending physician screen in the electronic medical record (“EMR”) with his or her name.

2.5. Care of Unassigned Patients:

- (a) All unassigned patients will be assigned to the appropriate on-call practitioner or to the appropriate Hospital service.
- (b) An “unassigned patient” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

2.6. Availability and Alternate Coverage:

- (a) The attending physician will provide professional care for his or her patients in the Hospital or at an ambulatory care location by being personally available or by making

arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.

- (b) The attending physician or his or her designee (e.g., the resident on the attending physician's service or "on call" for that service or an appropriately privileged allied health professional) will comply with the following patient care guidelines regarding availability:
 - (1) Calls/texts from the Emergency Department ("ED") and/or a Patient Care Unit – must respond within 15 minutes, via phone, to an initial STAT contact from the Hospital and respond within 30 minutes, via phone, to all other initial contacts and, if requested, appear in person to attend to a patient as soon as possible but no later than 2 hours (or more quickly based upon (i) the acute nature of the patient's condition; or (ii) the Level II Trauma Center Designation Criteria (77 Ill. Admin. Code 515.2040); or (iii) as required for a particular specialty as recommended by the MEC and approved by the Board);
 - (2) All Inpatient Admissions– An attending physician or a credentialed allied health practitioner (unless a physician is specifically requested) must personally see the patient within 24 hours of admission;
 - (3) Patients Subject to Restraints or Seclusion – pursuant to Article XI of these Rules and Regulations; and
 - (4) Transitional Care Unit ("TCU") – must personally see the patient at a minimum of once every seven days or more frequently, as dictated by the patient's needs.
- (c) All physicians (or their appropriately credentialed designee) will be expected to comply with the following patient care guidelines regarding consultations:
 - (1) Critical Care Consults – must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner (all such requests for critical care consults – e.g., "stat," "urgent," "today," or similar terminology – must also include personal contact by the requesting individual to the consulting physician); and

- (2) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians.

- (d) If the attending physician does not participate in an established call coverage schedule with known alternate coverage and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability.

- (e) If the attending physician is not available, the Chief Medical Officer or the President of the Medical Staff will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.7. Continued Hospitalization:

- (a) The attending physician will provide whatever information may be requested by Utilization Management with respect to the continued hospitalization of a patient, including:
 - (1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);
 - (2) the estimated period of time the patient will need to remain in the Hospital; and
 - (3) plans for post-hospital care.

This response will be provided to Utilization Management within 24 hours of the request. Failure to comply with this requirement will be addressed as outlined in the Utilization Management Policy.

- (b) If Utilization Management determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, it will be addressed as outlined in the Utilization Management Policy.

2.8. Infection Control:

- (a) As required by the Centers for Disease Control and Prevention (CDC) and other state and regulatory agencies, proper infection control practices are required. These include use of required standard and transmission-based precautions to reduce risks for and/or prevent health-care associated infections.

- (b) Every practitioner is required to comply with the Hospital's infection control practices, including proper hand hygiene techniques. Artificial nails and nail jewelry will not be worn by any practitioner who has direct patient contact.

ARTICLE III

MEDICAL RECORDS

3.1. General:

- (a) The following individuals are authorized to document in the medical record:
- (1) attending physicians and responsible practitioners;
 - (2) nursing providers, including registered nurses (“RNs”) and licensed practical nurses (“LPNs”);
 - (3) physicians responding to a request for consultation when the individual has clinical privileges or is an employee or member of the House Staff at the Hospital;
 - (4) other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;
 - (5) volunteers, such as volunteer chaplains, functioning within their approved roles;
 - (6) students in an approved professional education program who are involved in patient care as part of their education process if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record; and
 - (7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

- (b) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the EMR. Orders will be entered using Computerized Provider Order Entry (“CPOE”). Handwritten medical record entries will be legibly recorded in blue or preferably black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries must be timed, dated and signed.
- (c) Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.
- (d) All documentation, including handwritten entries, will be authenticated, dated and timed.
- (e) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the Unacceptable Abbreviation List, which will be periodically reviewed by the Medical Staff, may not be used.
- (f) Any error made while entering an order in the CPOE should be corrected in accordance with Hospital policy. If an error is made while making a handwritten recording in the record, the error should be crossed out and initialed.

3.2. Access and Retention of Record:

- (a) The Hospital will retain medical records in their original or legally reproduced form in accordance with the Hospital’s record retention policy and applicable law.
- (b) Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.
- (c) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Hospital policy.

- (d) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, upon presentation of an appropriately signed authorization form, unless the attending physician documents that such a release would have an adverse effect on the patient or another person.
- (e) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Loyola University Chicago Health Sciences Division (LUCHSD) Institutional Review Board (IRB).
- (f) Subject to the discretion of the Chief Executive Officer (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

3.3. Content of Record:

- (a) For every patient treated as a hospital inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services.
- (b) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's policies and procedures. Stamped signatures are not permitted in the medical record.
- (c) General Requirements. All medical records for patients receiving care in the hospital setting or at an ambulatory care location will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:
 - (1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

- (2) legal status of any patient receiving behavioral health services (i.e., voluntary or involuntary status);
- (3) patient's language and communication needs, including preferred language for discussing health care;
- (4) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or do not resuscitate ("DNR") orders;
- (5) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;
- (6) emergency care, treatment, and services provided to the patient before his or her arrival, if any;
- (7) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;
- (8) allergies to foods and medicines;
- (9) reason(s) for admission of care, treatment, and services;
- (10) diagnosis, diagnostic impression, or conditions;
- (11) goals of the treatment and treatment plan;
- (12) diagnostic and therapeutic orders, procedures, tests, and results; including both inpatient and outpatient services;
- (13) progress notes made by authorized individuals;

- (14) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
 - (15) consultation reports;
 - (16) operative procedure reports and/or notes (in accordance with Article 6 of these Rules and Regulations);
 - (17) any applicable anesthesia evaluations (in accordance with Article 7 of these Rules and Regulations);
 - (18) response to care, treatment, and services provided;
 - (19) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;
 - (20) reassessments and plan of care revisions;
 - (21) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
 - (22) discharge summary with outcome of hospitalization (in accordance with Article 13 of these Rules and Regulations), final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and
 - (23) medications dispensed or prescribed on discharge.
- (d) Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This

documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (1) known significant medical diagnoses and conditions;
- (2) known significant operative and invasive procedures;
- (3) known adverse and allergic drug reactions; and
- (4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

(e) Emergency Care.

(1) Patients Receiving Emergency Care In the Emergency Department. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

- (i) time and means of arrival;
- (ii) record of care prior to arrival;
- (iii) completion of History and Physical Examination;
- (iv) results of the Medical Screening Examination;
- (v) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;
- (vi) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

(vii) whether the patient left against medical advice or left without being seen; and

(viii) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

(2) Obstetrics Patients In the Emergency Department. Medical records of obstetrics patients receiving care in the Emergency Department will contain the information outlined in Article 9 of these Rules and Regulations.

(f) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(1) history of maternal health and prenatal course, including mother's HIV status, if known;

(2) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;

(3) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the designated room in the Emergency Department;

(4) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining hospital stay;

(5) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;

- (6) documentation of infant feeding: intake, content, and amount if by formula; and
- (7) clinical course during hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

3.4. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Appendix B of the Medical Staff Bylaws.

3.5. Progress Notes:

- (a) Progress notes will be entered by the attending physician (or his or her covering practitioner) at least daily under normal circumstances for all hospitalized patients and as needed to reflect changes in the status of a patient in an ambulatory care location.
- (b) Progress notes will be legible, dated, and timed. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.
- (c) Progress notes may also be entered by allied health professionals as permitted by their clinical privileges or scope of practice.

3.6. Authentication:

- (a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE. Signature stamps are never an acceptable form of authentication for written orders/entries. All signatures or initials, whether written, electronic, or computer generated, shall include the initials of the signer's credentials (e.g., M.D., D.O., P.A., etc.).

- (b) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

3.8. Delinquent Medical Records:

- (a) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital including, but not limited to, Medical Staff Policy 18.08 "Delinquent Medical Records – Course of Action".
- (b) Medical records will be completed within 30 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete for more than seven days after notice of a deficiency has been provided, the practitioner's clinical privileges will be automatically relinquished in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the practitioner's records are no longer delinquent.
- (c) Interpretation of diagnostic and therapeutic orders, procedures and tests for both inpatient and outpatient services must be entered into the medical record within 7 days of the study being complete and ready for interpretation or they will be considered delinquent. If the record remains incomplete for more than 7 days after notice of a deficiency has been provided, the practitioner's clinical privileges will be automatically relinquished in accordance with the Credentials Policy. The relinquishment will remain in effect until all of the practitioner's records are no longer delinquent.
- (c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges three months from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

- (d) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner or it is ordered filed by the Health Information Management (“HIM”) Department. Except in rare circumstances, and only when approved by the HIM Department, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

- (e) When a practitioner is no longer a member of the Medical Staff or practicing as an Allied Health Professional and his or her medical records are filed as permanently inadequate, this will be recorded in the practitioner’s credentials file and divulged in response to any future credentialing inquiry concerning the practitioner.

- (f) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the HIM Department.

- (g) The chart completion requirements for ambulatory care will be the same as for other medical records.

ARTICLE IV

MEDICAL ORDERS

4.1. General:

- (a) Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the CPOE. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR via the CPOE in accordance with Hospital policy.

- (b) All orders must be:
 - (1) dated and timed when documented or initiated;

 - (2) authenticated by the ordering practitioner, with the exception of a telephone order which may be countersigned by another practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and

 - (3) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

- (c) Orders for tests and therapies will be accepted only from:
 - (1) members of the Medical Staff and House Staff; and

- (2) allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

- (d) The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.
- (e) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.
- (f) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.
- (g) All orders for medications administered to patients will be:
 - (1) reviewed by the attending physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;
 - (2) reconciled/compared to the list of the medication that the patient has been taking to avoid medication errors. This reconciliation must be done:
 - (i) upon admission,
 - (ii) when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization; and

- (iii) upon discharge; and

- (3) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is issued when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.

- (h) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All as necessary medication orders (also known as PRN) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

- (i) Allied health professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders issued by an allied health professional will be countersigned/authenticated by the Supervising Physician by the close of the medical record.

4.2. Verbal Orders:

- (a) Verbal orders are orders for medications, treatments, interventions or other patient care that are transmitted as oral, spoken communication between senders and receivers, delivered either face-to-face or via telephone. A verbal order transmitted via telephone is known as a telephone order.

- (b) A verbal order (via telephone or in person) for medication, biological, or other treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.

- (c) All verbal orders will include the date and time of entry into the medical record, and identify the names of the individuals who gave, received, and implemented the order. In person verbal orders must be authenticated with date and time by the ordering practitioner. A telephone order may be authenticated with date and time by another practitioner who is responsible for the care of the patient, as authorized by Hospital policy and state law, if it is impractical for the ordering practitioner to authenticate the telephone order.
- (d) Authentication of verbal orders will take place by the ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, and (ii) as soon as practicable, but no later than 72 hours after the order was given for telephone orders. All orders must be authenticated by the ordering practitioner except in circumstances of telephone orders which can be authenticated by a physician partner of the ordering physician with approval from the ordering physician.
- (e) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.
- (f) The following are the personnel authorized to receive and record verbal orders:
 - (1) an RN or LPN (TCU only) who may transcribe all verbal orders except DNR orders;
 - (2) a registered dietician who may make a recommendation pertaining to diet and nutrition;
 - (3) a registered medical technologist who may transcribe a verbal order pertaining to laboratory orders;
 - (4) a pharmacist who may transcribe a verbal order pertaining to medications;
 - (5) a registered physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

- (6) a registered occupational therapist who may transcribe a verbal order pertaining to occupational therapy treatments;
- (7) a registered speech therapist who may transcribe a verbal order pertaining to speech therapy;
- (8) a registered medical imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may transcribe a verbal order pertaining to diagnostic imaging;
- (9) a registered/certified respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments; and
- (10) a licensed social worker or licensed clinical social worker for discharge orders and discharge planning.

4.3. Standing Orders, Order Sets, and Protocols:

- (a) All standing orders, order sets, and protocols will be consistent with nationally recognized and evidence-based guidelines and will identify well-defined clinical scenarios for when the order or protocol is to be used.
- (b) Standing orders, order sets, and protocols are to be reviewed by the Medical Staff, nursing, and pharmacy leadership. This will be accomplished through the annual review of the Pharmacy and Therapeutics (“P&T”) Committee.
- (c) If the use of a standing order or protocol has been approved by the P&T Committee, the order or protocol will be initiated for a patient only by an order from a responsible practitioner acting within his or her scope of practice.
- (d) When used, standing orders and protocols must be dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or another responsible practitioner.

- (e) The attending physician must also acknowledge and authenticate the initiation of each standing order, order set, or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.

4.4. Orders for Drugs and Biologicals:

- (a) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.
- (b) All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations and other Hospital policies.

4.5. Orders for Outpatient Services:

- (a) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Medical Staff policy.
- (b) Orders for outpatient services must be submitted on a prescription pad, letterhead, or an electronic order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual; (iii) diagnosis; and (iv) the type, frequency, and duration of the service, as applicable.

ARTICLE V

CONSULTATIONS

5.1. Requesting Consultations:

- (a) The referring practitioner should request consultation in a timely manner.
- (b) The referring practitioner should document in the medical record the indications for the consultation and specific issues to be addressed by the consultant.
- (c) The referring practitioner is responsible for requesting a consultation. When clinically relevant, he or she should make reasonable attempts to contact the consultant directly to request the consultation and provide a summary of any information that may facilitate the consultant's evaluation and recommendations.

5.2. Responsibilities of the Referring Practitioner:

- (a) The referring practitioner should request consultation in a timely manner, whenever possible before an emergency arises. A good working relationship between the referring practitioner and the consultant requires shared concern for the patient's needs and a commitment to timely and clear-cut communication.
- (b) The referring practitioner is responsible for preparing the patient with an explanation of the reasons for consultation, the steps involved, and the names of qualified consultants.
- (c) The referring practitioner should provide a summary of the history, results of the physical examination, laboratory findings, and any other information that may facilitate the consultant's evaluation and recommendations.
- (d) Whenever possible, the referring practitioner should document in the medical record the indications for the consultation and specific issues to be addressed by the consultant.

- (e) The referring practitioner should discuss the consultant's report with the patient and give his or her own recommendation based on all available data in order to serve the best interest of the patient.
- (f) A complex clinical situation may call for multiple consultations. Unless authority has been transferred elsewhere, the responsibility for the patient's care rests with the referring practitioner. This practitioner should remain in charge of communication with the patient and coordinate the overall care on the basis of information derived from the consultants. This will ensure a coordinated effort that remains in the patient's best interest.

5.3. Responding to Consultation Requests:

- (a) Any individual with clinical privileges can be asked for consultation within his or her area of expertise.
- (b) The consultant should provide the consultation in a timely manner, but no later than 24 hours after notification.
- (c) The practitioner who is asked to provide the consultation may ask an Allied Health Professional with appropriate clinical privileges or a member of the House Staff to see the patient, gather data, and order tests. However, such evaluation by an Allied Health Professional or member of the House Staff will not relieve the consulting practitioner of his or her obligation to personally see the patient within the appropriate time frame, unless the practitioner requesting the consultation agrees that the evaluation by the Allied Health Professional or member of the House Staff is sufficient.
- (d) A summary of the consultation should be included in the medical record.
- (e) The consultant should verbally communicate findings and recommendations to the referring practitioner at the earliest opportunity when clinically relevant and appropriate.
- (f) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the Professional Practice Evaluation Policy or other applicable policy, unless one of the following exceptions applies to the practitioner asked to provide a consultation:

- (i) the practitioner has a valid justification for his or her unavailability (e.g., out of town);
- (ii) the patient has previously been discharged from the practice of the practitioner;
- (iii) the practitioner has previously been dismissed by the patient;
- (iv) the patient indicates a preference for another consultant; or
- (v) other factors indicate that there is a conflict between the practitioner and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

The requested practitioner must promptly notify the practitioner requesting a consult if he or she is unable to provide a consultation. To the extent possible, if the requested practitioner is unable to provide a consultation based on the aforementioned criteria (paragraphs (i) – (v)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the Chief Medical Officer, the President of the Medical Staff, or other appropriate clinical Department Chair can appoint an alternate consultant.

5.4. Responsibilities of the Consultant:

- (a) Consultants should recognize their individual boundaries of expertise and provide only those medically accepted services and technical procedures for which they are qualified by education, training, and experience.
- (b) When asked to provide consultation, the consultant should do so in a timely manner.
- (c) The consultant should effectively communicate findings, procedures performed, and recommendations to the referring practitioner at the earliest opportunity. The consultant's recommendations should be definitive, prioritized, and precise.
- (d) A summary of the consultation should be included in the medical record. However, direct verbal communication with the requesting physician is preferable to communicating via the chart, when appropriate.

- (e) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.
- (f) When the consultant does not have primary clinical responsibility for the patient, he or she should obtain concurrence for major procedures or additional consultants from the referring practitioner.
- (g) In all that is done, the consultant must respect the relationship between the patient and the referring practitioner, being careful not to diminish inappropriately the patient's confidence in other caregivers.

5.5. Psychiatric Consultations:

A psychiatric consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

5.6. Surgical Consultations:

Surgical consultations must be completed, communicated to the appropriate practitioners, and documented in the medical record prior to any surgery and anesthesia, unless the consultant determines that an emergency situation exists.

5.7. Obstetrical Consultations:

Obstetrical consultations will be obtained in accordance with the guidelines outlined in Article IX.

5.8. Concerns:

- (a) If a consultation is required for a patient in accordance with this Article or is otherwise determined to be in patient's best interest, the Chief Medical Officer, the President of the Medical Staff, or the appropriate clinical Department Chair will have the right to call in a consultant.

- (b) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending practitioner, that nurse will notify his or her nursing supervisor who, in turn, will contact the attending practitioner. If a consultation is not thereafter ordered by the attending practitioner, the nursing supervisor may then bring the matter to the attention of the Department Chair in which the member in question has clinical privileges. Thereafter, the Department Chair or Chief Medical Officer may request a consultation after discussion with the attending practitioner.

- (c) A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the applicable Department Chair, the President of the Medical Staff, or the Chief Medical Officer.

ARTICLE VI

SURGICAL SERVICES

6.1. General:

- (a) Surgery will be performed by practitioners according to the privileges granted to them by the Board, as recorded on the clinical privilege form.
- (b) The primary surgeon will determine if a first assistant is needed during a major surgical case and will arrange for this assistant.
- (c) No visitors are allowed in the operating room or the Post Anesthesia Care Unit (PACU) without the permission of the Director of Surgical Services or the Chairperson of the Department of Surgery. If surgery is to be observed, then the patient's permission will also be obtained.

6.2. Pre-Procedure Protocol:

- (a) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent in accordance with the Hospital's Informed Consent Policy; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.
- (b) The anesthesiologist may postpone a surgical case when any pre-procedure assessment/evaluation is determined to be incomplete or if a patient's laboratory data is deemed incomplete.
- (c) Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

- (1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
 - (2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;
 - (3) the attending physician (i.e., surgeon) is in the Hospital; and
 - (4) the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.
- (d) Patients posted for elective surgery will not be brought to the operating room without proper consultations, operative permits, current H & P, and required lab work in the medical record or a statement confirming that pre-surgical requirements have been met.

6.3. Post-Procedure Protocol:

- (a) If the full operative report cannot be entered into the medical record immediately after the operation or procedure, for example due to transcription or filing delay, then a brief post-op note must be dictated or entered by a physician (attending physician or resident only) in the EMR immediately after the procedure to provide pertinent information for anyone required to attend to the patient. The brief post-op note will include:
- (1) the names of the physician(s) responsible for the patient’s care and physician assistants;
 - (2) the name and description of the procedure(s) performed;
 - (3) findings, where appropriate, given the nature of the procedure;

- (4) estimated blood loss as well as no blood loss, when applicable or significant;
 - (5) specimens removed as well as no blood loss;
 - (6) post-operative diagnosis; and
 - (7) the signature of the physician along with the date and time.
- (b) The full operative procedure report must be documented and entered into the EMR within 24 hours under normal circumstances. The full operative procedure report will include:
- (1) the patient's name and hospital identification number;
 - (2) pre- and post-operative diagnoses;
 - (3) date and time of the procedure;
 - (4) the name of the attending physician(s) and assistant surgeon(s) responsible for the patient's operation;
 - (5) procedure(s) performed and description of the procedure(s);
 - (6) description of the specific surgical tasks that were conducted by practitioners other than the attending physician;
 - (7) findings, where appropriate, given the nature of the procedure;
 - (8) estimated blood loss as well as no blood loss;

- (9) any unusual events or any complications, including blood transfusion reactions and the management of those events;
- (10) the level of anesthesia/sedation used;
- (11) specimen(s) removed as well as no specimens removed;
- (12) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and
- (13) the signature of the attending physician along with the date and time.

6.4. Specimens:

It is the responsibility of the operating surgeon to see that all specimens removed during surgery in the operating room are sent, accompanied by the pre-operative and post-operative diagnoses, to the pathologist for such examination as considered necessary to arrive at a pathological diagnosis.

ARTICLE VII

ANESTHESIA SERVICES

7.1. General:

- (a) Anesthesia may only be administered by the following qualified practitioners:
 - (1) an anesthesiologist;
 - (2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;
 - (3) a dentist, oral surgeon or podiatrist, in accordance with state law;
 - (4) a CRNA, acting within the scope of his or her license, as long as the CRNA is medically directed/supervised by a physician, to the extent required by state law; or
 - (5) an anesthesiologist's assistant under the supervision of an anesthesiologist who is immediately available, if needed.

- (b) A medically directing/supervising physician is immediately available if he or she is in physical proximity that allows the physician to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the Department of Anesthesiology.

- (c) "Anesthesia" means general and/or regional anesthesia, and/or monitored anesthesia care (which includes the continuum from minimal to deep sedation under the direct care of anesthesiology providers). "Anesthesia" does not include topical or local anesthesia, minimal, moderate or deep sedation provided by non-anesthesiologists.

- (d) Because it is not always possible to predict how an individual patient will respond to minimal or moderate sedation, a qualified practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.
- (e) General anesthesia for obstetric and/or emergency surgical services will normally be available within 30 minutes from the time that anesthesia is deemed necessary.
- (f) General anesthesia is not permitted in the ED unless the surgical and anesthetic procedures are considered of a life-saving nature and are performed by an anesthesiologist or CRNA on staff.

7.2. Pre-Anesthesia Procedures:

- (a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.
- (b) The evaluation will be recorded in the medical record and will include:
 - (1) a review of the medical history, including anesthesia, drug and allergy history;
 - (2) an interview, if possible, pre-procedural education, and examination of the patient;
 - (3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
 - (4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

- (5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and
- (6) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

- (c) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

- (a) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.
- (b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:
 - (1) the name and Hospital identification number of the patient;
 - (2) the name of the practitioner who administered anesthesia and, as applicable, any supervising physician;
 - (3) the name, dosage, route time, and duration of all anesthetic agents;

- (4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;
- (5) the name and amounts of IV fluids, including blood or blood products, if applicable;
- (6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and
- (7) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations:

- (a) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.
- (b) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).
- (c) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:
 - (1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;
 - (2) cardiovascular function, including pulse rate and blood pressure;

- (3) mental status;
 - (4) temperature;
 - (5) pain;
 - (6) nausea and vomiting; and
 - (7) post-operative hydrations.
- (d) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists (“ASA”), using a modified Aldrete Recovery Score or similar post-anesthesia recovery scoring system. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.
- (e) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.
- (f) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

7.5. Minimal, Moderate or Deep Sedation:

All patients receiving minimal, moderate or deep sedation will be monitored and evaluated before, during, and after the procedure by a trained practitioner. However, no pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations are required.

7.6. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE VIII
RADIOLOGY SERVICES

8.1. General:

- (a) The Radiology service will be under the full-time direction of a qualified board certified radiologist who supervises radiology services.
- (b) All radiologists will be granted clinical privileges in accordance with the processes set forth in the Medical Staff Credentials Policy.
- (c) Radioactive materials are to be used in the Hospital only under the direct supervision of a member of Radiology .
- (d) Teleradiology services are provided by physician members of Radiology and/or contracted services.

8.2. Orders for Radiology Services:

- (a) Radiology services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state and federal law, other practitioners authorized by the Medical Staff and Board to order services.
- (b) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

8.3. Radiology Services Responsibilities:

Professional services for which a radiologist will be responsible include, but may not be limited to, such services as the following:

- (a) determination of the problem, including interviewing the patient, obtaining history and making appropriate physical examination to decide on the method of performing the radiologic procedure (when necessary);
- (b) performance or direction of the procedure, including instructions to the technologists or other assistants, and prescribing of radiation exposure factors and variations in a diagnostic procedure;
- (c) checking of preliminary films as necessary;
- (d) study and evaluation of evidence provided by diagnostic procedures;
- (e) provision of written consultative reports; and
- (f) personal consultation with referring physicians regarding the results of the procedure, when appropriate.

ARTICLE IX

PROCEDURES FOR OBSTETRICAL CARE

9.1. Emergency Department Encounter:

In the event a pregnant patient arrived in the Emergency Department, a consultation is required consistent with the Pregnant Individuals Presenting to the Gottlieb Memorial Hospital Emergency Department Policy.

9.2. Consultation with and Referral to Maternal-Fetal Medicine Specialists:

Maternal-fetal consults should be obtained as required by the IDPH Perinatal Rules and Regulations consistent with the Pregnant Individuals Presenting to the Gottlieb Memorial Hospital Emergency Department Policy.

9.3. Required Laboratory Procedures:

A standard OB panel, including HIV, should be performed during the obstetrical patient's Emergency Department encounter and recorded as part of the prenatal documentation in the Emergency Department record. Cord bloods will be sent to the laboratory for all deliveries to determine potential incompatibility when indicated based on maternal blood type.

9.4. Medical Record and Birth Certificate:

- (a) An obstetrical patient's Emergency Department medical record will include prenatal documentation consistent with Section 5, Appendix B, of the Medical Staff Bylaws, and will include the medical and obstetrical history, observations and proceedings during labor, delivery and postpartum period, and laboratory and x-ray findings, to the extent applicable.
- (b) Birth certificates are the joint responsibility of the Hospital and the delivering physician (or other member of the health care team), who must provide the medical information required by the certificate within 72 hours after the birth occurs.

9.5. Identification:

The Hospital means of patient identification will be attached to the mother and newborn infant before they are removed from the delivery room, or operating room in the case of a caesarean section.

9.6. Post Delivery:

The physician will remain in the operating room area or such other designated room in the Emergency Department until the patient is stable and transferred to the appropriate facility consistent with the Pregnant Individuals Presenting to the Gottlieb Memorial Hospital Emergency Department Policy.

9.7. Attire:

Anyone entering the operating room or such other designated room in the Emergency Department must be properly attired in the approved suit and footwear. Hair, nose and mouth will be properly covered at all times with caps and masks provided in the scrub areas of each such room.

9.8. Obstetrics On-Call Roster:

A current roster of Medical Staff members with obstetrical privileges will be maintained and made available to nursing personnel. An on-call schedule will be established and maintained to provide for obstetrical coverage at all times.

ARTICLE X

PHARMACY

10.1. General Rules:

- (a) Orders for drugs and biologicals are addressed in the Medical Orders Article.
- (b) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.
- (c) Adverse medication reactions, transfusion reactions, and errors in administration of medications will be immediately documented in the incident reporting system and reported to the attending physician. The incident reporting system reports are analyzed by the Hospital's quality assessment and performance improvement program.
- (d) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.
- (e) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, the American Hospital Formulary Service, or FDA approved.
- (f) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the Institutional Review Board.
- (g) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

10.2. Storage and Access:

- (a) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.
 - (1) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.
 - (2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.
 - (3) Only authorized personnel may have access to locked or secure areas.
- (b) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

ARTICLE XI

RESTRAINTS, SECLUSION, AND BEHAVIOR MANAGEMENT PROGRAMS

Restraints, seclusion, and behavior management programs will be governed by the Hospital Policy addressing restraints, seclusion, and behavior management.

ARTICLE XII

EMERGENCY SERVICES

12.1. General:

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

12.2. Responsibilities of the ED Physician:

- (a) An ED physician will be present in the ED 24 hours a day. The ED physician will remain on duty at all times and provide medical supervision of all patients treated in the ED.
- (b) ED physicians are responsible for the coordination of medical care related to the traumatically injured patient as defined by the Region Eight Trauma Policy.
- (c) ED physicians will not be expected to perform surgery in the operating room.
- (d) The ED physician will evaluate any patient with an orthopedic problem, immobilize the site of any possible fracture, order and read any x-rays, and consult with the applicable on-call physician, as needed.
- (e) The ED physician is responsible for treating any injury sustained by a rape victim.
- (f) Placing a history and physical in the chart within 24 hours.
- (g) Notifying the physician or specialist responsible for the continuation of care prior to admission.

12.3. Medical Screening Examinations:

Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

(a) Emergency Department:

- (1) members of the Medical Staff with clinical privileges in Emergency Medicine;
- (2) other Active Staff members; and
- (3) appropriately credentialed allied health professionals.

(b) Labor and Delivery:

- (1) members of the Medical Staff with OB/GYN privileges;
- (2) Residents;
- (3) Certified Nurse Midwives with OB privileges; and
- (4) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

12.4. On-Call Responsibilities:

It is the responsibility of the scheduled on-call physician to respond to calls from the ED in accordance with Hospital policies and procedures.

ARTICLE XIII

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

13.1. Who May Discharge:

- (a) Patients will be discharged only upon the order of the attending physician.
- (b) At the time of discharge, the discharging practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.
- (c) If a patient insists on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient's medical record.

13.2. Identification of Patients in Need of Discharge Planning:

- (a) All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual's status.
- (b) Criteria to be used in making this evaluation include:
 - (1) functional status;
 - (2) cognitive ability of the patient; and
 - (3) family support.

13.3. Discharge Planning:

- (a) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The responsible practitioner is expected to participate in the discharge planning process.

- (b) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

13.4. Discharge Summary:

- (a) A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed as soon as possible after discharge, but no later than 7 days from the date of discharge or transfer:
 - (1) reason for hospitalization;

 - (2) significant findings;

 - (3) procedures performed and care, treatment, and services provided;

 - (4) condition and disposition at discharge;

 - (5) information provided to the patient and family, as appropriate;

 - (6) provisions for follow-up care; and

 - (7) discharge medication reconciliation.

- (b) A discharge progress note may be used to document the discharge summary for normal obstetrical deliveries, normal newborn infants, ambulatory care patients, and stays less than 48 hours.
- (c) When a patient is discharged from an acute care setting and is admitted to the TCU and then discharged, two separate discharge summaries are reported.
- (d) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

13.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual will so state in writing and the statement will become a part of the permanent medical record of the patient.

13.6. Discharge Instructions:

- (a) Upon discharge, the responsible practitioner, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.
- (b) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.
- (c) The responsible practitioner, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

- (d) When the Hospital determines the patient's transfer or discharge needs, the responsible practitioner, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.

- (e) When continuing care is needed after discharge, the responsible practitioner, along with the Hospital staff, will provide appropriate information to the other health care providers, including:
 - (1) the reason for discharge;

 - (2) the patient's physical and psychosocial status;

 - (3) a summary of care provided and progress toward goals;

 - (4) community resources or referrals provided to the patient; and

 - (5) discharge medications.

ARTICLE XIV

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

14.1. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

- (a) assessing the reason(s) for transfer;
- (b) establishing the conditions under which transfer can occur;
- (c) evaluating the mode of transfer/transport to assure the patient's safety; and
- (d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

14.2. Procedures:

- (a) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner will take the following steps as appropriate under the circumstances:
 - (1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;
 - (2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

- (3) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and
 - (4) provide the following information to the patient whenever the patient is transferred:
 - (i) the reason for the transfer;
 - (ii) the risks and benefits of the transfer; and
 - (iii) available alternatives to the transfer.
- (b) When patients are transferred, the responsible practitioner will provide appropriate information to the accepting practitioner/facility, including:
- (1) reason for transfer;
 - (2) significant findings;
 - (3) a summary of the procedures performed and care, treatment and services provided;
 - (4) condition at discharge;
 - (5) information provided to the patient and family, as appropriate; and
 - (6) working diagnosis.
- (c) When a patient requests a transfer to another facility, the responsible practitioner will:

- (1) explain to the patient his or her medical condition;
- (2) inform the patient of the benefits of additional medical examination and treatment;
- (3) inform the patient of the reasonable risks of transfer;
- (4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and
- (5) provide the receiving facility with the same information outlined in paragraph (b) above.

14.3. EMTALA Transfers:

The transfer of a patient with an emergency medical condition from the ED to another hospital will be made in accordance with the Hospital's applicable EMTALA policy, the Pregnant Individuals Presenting to the Gottlieb Memorial Hospital Emergency Department, and any other applicable policies.

ARTICLE XV

GRADUATE MEDICAL EDUCATION

15.1. House Staff:

- (a) House Staff refers to a physician who has graduated from an accredited allopathic or osteopathic medical school or accredited school of podiatric medicine, and who has been conferred the degree of Doctor of Medicine, Doctor of Osteopathy or Doctor of Podiatry, and possesses licensure or temporary licensure in the State of Illinois, and who is serving as a medical resident or fellow in a residency rotation at the Hospital.
- (b) The House Staff will consist of residents and fellows appointed to participate in graduate medical education rotations at the Hospital. Its members will be under the supervision of members of the Medical Staff to whom they are assigned and will have privileges to perform history and physical examinations, treat patients and write patient care orders.

15.2. Supervision:

- (a) The Medical Executive Committee requires each graduate medical education rotation to develop and maintain an explicit written description of supervisory lines of responsibility for the care of patients. Such description will include a delineation of trainee clinical responsibilities by post-graduate year (PGY) level, including operative and invasive procedures that may be performed independently.
- (b) Delineation of resident clinical responsibilities by PGY level is available to the Medical Staff through the intranet.

15.3. Evaluation:

The Medical Executive Committee requires that at the conclusion of each graduate medical education rotation an evaluation be completed on each resident or fellow participating on the rotation.

15.4. Oversight and Communication:

- (a) Oversight of graduate medical education is provided by the Medical Executive Committee.
- (b) The Chair of the Medical Executive Committee is responsible for communicating with the Medical Staff and the Board about the safety and quality of patient care, treatment and services provided by, and the related educational and supervisory needs of, the participants of the graduate medical education programs. This is accomplished through reports to the Board at least annually.

15.5. Adherence to Policies:

All House Staff participating in a graduate medical education rotation at the Hospital must abide by these Medical Staff Rules and Regulations and Hospital policies and procedures.

ARTICLE XVI

HOSPITAL DEATHS AND AUTOPSIES

16.1. Death and Death Certificates:

- (a) In the event of a patient death in the Hospital, the deceased will be pronounced dead by a physician (e.g., the attending physician or the ED physician) within a reasonable time frame.
- (b) The medical certification of the cause of death within the death certificate will be completed by the attending physician (or his or her designee) within 24 hours of when the certificate is made available.

16.2. Release of the Body:

- (a) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the attending physician (or his or her designee) or other designated member of the Medical Staff.
- (b) It is the responsibility of the attending physician (or his or her designee) to notify the coroner/medical examiner of any cases considered by law a coroner/medical examiner's case.

16.3. Organ and Tissue Procurement:

All suitable organ or tissue donors will routinely be afforded the opportunity to consent to donation in accordance with Hospital policy.

16.4. Autopsies:

- (a) It will be the duty of all Medical Staff members to secure autopsies whenever possible as provided in Illinois State law. A Medical Staff member's attempt to secure permission

for an autopsy must be evidenced by the completion of an inpatient death note in the patient's medical record. The following criteria determine when an autopsy is recommended:

- (1) a neonatal or pediatric death;
- (2) an obstetric death;
- (3) death in which an autopsy may help explain unknown and unanticipated medical complications to the attending physician;
- (4) death in which the cause of death, of a major diagnosis, is not known with certainty on clinical grounds;
- (5) cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or the public regarding the death;
- (6) unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedure(s) and/or therapy(ies) (after the coroner has been notified and released the body);
- (7) death in which the patient has participated in clinical trials (protocols);
- (8) death resulting from high-risk infections and contagious diseases, when there are unexplained findings;
- (9) death in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs; and
- (10) cases in which autopsy may help to address medical legal and educational interest.

- (b) An autopsy may be performed only upon written consent signed in accordance with Illinois State law. All autopsies will be performed by the Hospital pathologist or by a pathologist delegated this responsibility. The complete report should be made a part of the medical record within 60 days. A written preliminary report must be in the medical record within 48 hours.

- (c) Any request for an autopsy by the family of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the Hospital pathologist. The payment for such autopsies is the responsibility of the patient's family or legal guardian. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer and/or the Chief Medical Officer.

- (d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

16.5. Do Not Resuscitate ("DNR") Policy:

The Medical Staff will administer care in accordance with Hospital policy, for those competent adult patients or the parent of an infant, neonate or minor child who knowingly chooses to forgo treatment.

ARTICLE XVII

MISCELLANEOUS

17.1. Self-Treatment and Treatment of Family Members:

- (a) Members of the Medical Staff are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

- (b) A member of the Medical Staff should not admit or perform an invasive procedure on a member of his or her immediate family, including spouse, parent, child, or sibling, except in the following circumstances:
 - (1) no viable alternative treatment is available, as confirmed through discussions with the President of the Medical Staff or the Chief Executive Officer;

 - (2) the patient's disease is so rare or exceptional and the physician is considered an expert in the field;

 - (3) in the ED where the Medical Staff member is the attending physician or is on call; or

 - (4) in an emergency where no other Medical Staff member is readily available to care for the family member.

This prohibition is not applicable to in-laws or other relatives.

17.2. HIPAA Requirements:

All members of the Medical Staff will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information. Failure to comply with HIPAA requirements can result in civil and criminal penalties.

ARTICLE XVIII

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XIX

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee on: December 22, 2014

Approved by the Board on: December 23, 2014