RULES AND REGULATIONS
OF THE MEDICAL STAFF
OF
MINIMALLY INVASIVE SURGERY HOSPITAL

Last Revision approved by the Minimally Invasive Surgery Hospital Authority Board of Directors
July 23, 2021

DEFINITIONS

ADVANCED PRACTICE PROVIDER (APP): An Advanced Practice Registered Nurse or a Physician Assistant.

ADVANCED PRACTICE REGISTERED NURSE (APRN): An Advanced Practice Registered Nurse who is licensed by the Kansas State Board of Nursing, and specializes as Certified Nurse Midwife, a Nurse Practitioner, a Clinical Nurse Specialist or a Certified Nurse Anesthetist (CRNA), and have entered into a Collaborative Practice Agreement with a physician Member of the Medical Staff.

ALLIED HEALTH PROFESSIONALS (AHPs): Health care practitioners, other than APPs, physicians and dentists, who are, by academic and clinical training, qualified to exercise certain degrees of independent clinical judgment in the care and treatment of patients, whose professional disciplines are recognized by an appropriate licensing, certifying, registering, or other professional regulatory body in the State of Kansas or by the Authority, and whose disciplines have been approved for practice within the Hospital.

ATTENDING PHYSICIAN: The Member under whose name the patient is admitted to the Hospital or any Special Unit or to whom the patient's care has been permanently transferred.

AUTHORITY: The Minimally Invasive Surgery Hospital Authority.

DESIGNEE: A Licensed Independent Practitioner, a member of the House Staff, or an APP with appropriate privileges and consistent with scope of practice under Kansas law.

DO NOT ATTEMPT RESUSCITATION (DNAR) DIRECTIVE: An individual's pre-hospital request not to attempt to be resuscitated, executed and witnessed in accordance with Kansas law.

DO NOT ATTEMPT RESUSCITATION (DNAR) ORDER: The written order from a patient's Attending Physician not to attempt to resuscitate a patient who has been admitted to the Hospital, made in accordance with Kansas law and the Hospital's Policy on Advance Directives and Patient Rights.

HOSPITAL: The general inpatient acute care facility owned by the Minimally Invasive Surgery Hospital Authority and located at 10951 Lakeview Avenue, Lenexa, Kansas 66219.

HOSPITAL'S POLICIES AND PROCEDURES: Those written policies and procedures adopted by the Minimally Invasive Surgery Hospital Authority and pertaining to the operation of the Hospital, and its Special Units.

HOSPITAL PREMISES: The Hospital, and its Special Units, located at 10951 Lakeview Avenue, Lenexa, Kansas 66219.

LICENSED INDEPENDENT PRACTITIONER: Those practitioners permitted by the Hospital to provide care, treatment, and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical Privileges and category assignment include Doctors of Medicine, Osteopathy, Dentistry, as well as Psychologists.

MEDICAL RECORD: A Medical Record shall consist of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Medical Records Health Information Management Department.

MEDICAL-SURGICAL UNIT: Any inpatient care unit located on the Hospital Premises

MEMBER: Any member of the Hospital's medical staff who has been admitted to the Active, Provisional, or Associate categories of medical staff membership.

OUTSIDE THE HOSPITAL DO NOT RESUSCITATE (OHDNR) ORDER: The written order from a patient's Attending Physician effective when the patient has not been admitted to or is not being treated within the Hospital, made in accordance with Kansas law and the Hospital's Policy on Advance Directives and Patient Rights.

PHYSICIAN ASSISTANT: A Physician Assistant licensed by the Kansas State Board of Healing Arts, who performs delegated medical services through delegated authority or a written agreement with a physician Member of the medical staff.

TRANSPORTABLE PHYSICIAN ORDERS FOR PATIENT PREFERENCE (TPOPP): means out of Hospital orders for resuscitation status and/or level of intervention which remain in effect when the patient is not in an inpatient setting.

Note: Unless specifically defined in these Rules and Regulations, all capitalized terms shall have the same meaning as in the Bylaws of the Medical Staff of the Minimally Invasive Surgery Hospital, as revised.

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ARTICLE I: ADMISSION AND DISCHARGE OF PATIENTS

Section 1.1 Only those Members authorized in accordance with the Bylaws of the Medical Staff may admit patients to the Hospital. No patient will be admitted except on an order of a Staff Member. Whenever a patient applies for admission and has no attending Member, he will be assigned to the Member who is on call at that time.

Section 1.3 To facilitate the safe and efficient transfer of patients from outside facilities, Members must communicate with Chief Medical Officer when accepting patients in transfer from other hospitals

Section 1.4 The patient’s Attending Physician shall execute, or cause to be executed, all physician

responsibilities as to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admission and discharge of patients from the Hospital.

Section 1.5 At the time of the patient's admission to the Hospital, or as soon as possible thereafter, the patient's Attending Physician, or an Advanced Registered Nurse Practitioner (APRN) or Physician Assistant (PA), under the Attending Physician's supervision, shall record, either an Admitting Note or a History and Physical Examination in the patient's Medical Record. If an Admitting Note is recorded, the patient's Attending Physician, or APRN or PA with appropriate Privileges and consistent with scope of practice under Kansas law, and, shall, within twenty-four hours after the patient's admission, record an appropriate History and Physician Examination in the patient's Medical Record. Said History and Physical Examination shall be countersigned by the Attending Physician. APRNs and PAs must be approved as APPs and granted Privileges to perform Histories and Physical Examinations. All Admitting Notes and History and Physical examinations written by APPs must be signed or attested by the Attending Physician with in twenty-four (24) hours of completion.

1.5.1 A history and physical must be available in the medical record on all inpatients within 24 hours of admission and on all patients prior to surgery or procedure that requires anesthesia services.

1.5.2 The history and physical completed before admission is valid for 30 days only. It is acceptable to use up to a 30-day old history and physical as long as it is updated with any changes, or states that no changes have occurred.

1.5.3 The update can be written on the history and physical or in the progress notes. A history and physical greater than 30 days old cannot be updated, or referred to in a current history and physical. The patient must be assessed and a new history and physical documented.

1.5.4 On a computerized history and physical, the date of the actual assessment (not printing date) is the completion date of the history and physical and must be within 30 days of admission of the procedure.

1.5.5 A complete history and physical should contain the following: a) details of the present illness, including, when appropriate, assessment of the patient's emotional behavioral and social status, b) relevant past, social and family histories, appropriate to the age of the patient, c) significant past surgical history, d) any remarkable past medical history, e) relevant inventory of by body system, f) current physical assessment, h) a statement on the conclusions or impressions drawn from the admission history and/or physical examination, i) a statement of the course of action planned for the patient while in the hospital. In services as appropriate, for adolescents, the history and physical must include an evaluation of the patient's growth and development, immunization status, emotional, cognitive, social and daily activities as appropriative, and the family's and/or guardian's expectations for, and involvement in the assessment, treatment, and continuous care of the patient.

Section 1.6 Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body may perform the

medical history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s). Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry.

Section 1.7 For all patients who have been hospitalized in the Hospital, the patient's Attending Physician, or an APRN or PA with appropriate Privileges, shall dictate a complete Discharge Summary within forty-eight hours following the patient's discharge. The patient's Attending Physician shall sign or countersign the patient's Discharge Summary. All Discharge Summaries written by APPs must be countersigned or attested by the Attending Physician within seventy-two (72) hours of completion. A Discharge summary is dictated for stays greater than 2 mid-night stays.

Section 1.8 Admission Status Orders. ADMISSION STATUS definitions:

Inpatient Status – Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Generally, a Medicare patient who is expected to receive hospital services for at least two midnights; or a patient who stays less than two midnights when the physician's clinical judgment is clearly documented in the medical record and supports the rationale for an inpatient admission; or a patient who receives services listed on the Medicare's Inpatient-Only List, also known as Addendum E. Addendum E is available via the SharePoint portal.

Medicare's Inpatient-Only List (also known as Addendum E) – is a list of Surgical procedures represented by CPT codes listed in Addendum E to the yearly Outpatient Prospective Payment System (OPPS) Regulations that Medicare has defined as only being payable on an inpatient basis regardless if two night length of stay is not met.

Outpatient Status – Outpatient status occurs when a patient with a known diagnosis enters the hospital for a minor procedure or treatment that is expected to require a stay less than 24 hours regardless if a patient uses a bed.

Generally, outpatient status is a Medicare patient who is expected to receive a minor surgical procedure such as not to require a hospital stay or limited hospital services that will not result in a two midnight stay; NOT a patient who receives services on Medicare's Inpatient Only List, also known as Addendum E.

Outpatient Status includes outpatients receiving observation services.

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to plan, concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.

The physician's inpatient admission status order:

- Must be obtained at or before the time of the inpatient admission
- Must be supported by the physician admission and progress notes.
- Must be furnished by a physician or other practitioner who is: Licensed in the state of Kansas and Granted admitting privileges, and
- Knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission.

The documentation must include:

- Patient history and comorbidities; and/or
- Severity of signs and symptoms; and/or
- Current medical needs requiring inpatient care (e.g., frequent monitoring, IV medication requiring hospitalization, high risk of possible infection, etc.); and/or
- Risk of an adverse event should the patient be sent home or be treated as an outpatient.

Section 1.9 Age Limit. Hospital lower age admission limit is 16 years of age.

Section 1.10 Discharge. Patients will be discharged only on the written order of the attending Member, or upon receipt of a release signed by the patient, or the patient's authorized representative, or upon an order of a court. Insofar as possible, Members should write discharge orders and prescriptions for take-home medications the day before discharge on those patients who will be discharged the following day. Medication Reconciliation is part of every patient discharge and or transfer, member must take active participation in the medication reconciliation process. Discharge instructions will be reviewed with patient and or family whenever possible.

ARTICLE II: GENERAL CONDUCT OF CARE

Section 2.1 Responsibility for Care and Treatment.

2.1.1 Each patient admitted to the Hospital shall be under the care and supervision of their Attending Physician. Each Attending Physician shall be responsible for everything in connection with the patient's hospitalization, including but not limited to the diagnosis and treatment of the patient's medical condition(s), the use of Consultants (as defined in Section 2.2.1), the appropriate communication with the patient, the referring practitioner, and the patient's relatives, the conveying of any necessary special instructions to the patent upon discharge, and the accuracy and prompt completion of the patient's Medical Record.

2.1.2 Whenever the responsibilities of the patient's Attending Physician are permanently transferred to another Service, the patient's outgoing Attending Physician or designee, shall clearly note the transfer of responsibility to the new Service in the patient's Medical Record.

Section 2.2 Consultations.

2.2.I Required Consultations. The following diagnoses/conditions, if not treated by the appropriate specialist, require a consultation by a physician who is credentialed in that field, or an APP, provided the APP has Privileges to perform a history and physical, and

Privileges to furnish the requested consultation ("Consultant"):

a) All patients with active suicidal ideation or who are exhibiting other severe: psychiatric symptoms require a psychiatric consultation or, transfer to an appropriate facility of care for a psychiatric evaluation.

2.2.2 Ordering Consultations. When ordering a consultation, the referring Member:

a) Must designate the consultation as either routine or emergent;
b) If emergent, the referring Member should directly contact the Consultant personally;
c) Should designate the consultation as: (i) opinion only; (ii) opinion with order-writing Privileges; or (iii) request for transfer to Consultant;

d) Must request a consultation as soon as indicated during a patient visit, and except in unusual circumstances, at least one day prior to discharge; and
e) Must countersign or attest all new consultations performed by APP Consultants within twenty-four (24) hours.

2.2.3 When Consulted. When consulted, the Consultant must:

a) For APP Consultants, ensure that the consultation request is within the APP Consultant's Privileges and obtain countersignatures as required;
b) Fulfill the consultation request as soon as possible for emergent consultations;
c) Fulfill the consultation request within 24 hours for routine consultations;
d) Conduct an appropriate history and physical examination;
e) Complete the consultation form; and
f) Communicate with the referring Attending Member.

2.2.4 A Consultant who agrees to assume any portion of a patient's care or treatment shall be responsible for that portion of the patient's care or treatment until the Consultant informs the Attending Physician that the Consultant is returning such responsibility to the Attending Physician and records a written notation of such in the patient's Medical Record.

Section 2.3 Patient Encounters. Each Attending Physician or designee, shall personally assess their patients at least once per day while admitted to the Hospital. At the time of each such assessment, or as soon as possible thereafter, the Attending Physician or designee shall record a Progress Note in the patient's Medical Record.

Section 2.4 Informed Consent. No care or treatment shall be rendered to any patient in the Hospital, without a written consent signed by the patient. In those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained, the Member proposing to render care or treatment to the patient shall follow the Hospital's Policies and Procedures and the Hospital's Ethics Handbook in either proceeding with treatment or obtaining consent from the appropriate surrogate decision maker or in obtaining administrative consent before proceeding with treatment. Written consents obtained more than six (6) months prior to the initiation of care or treatment will not be valid.

Section 2.5 Treatment Orders. Except as otherwise specifically provided herein, all orders for treatment shall be in writing, dated and timed, and signed by the issuing practitioner. Orders written by other than a Member of the House Staff must be cosigned by the supervising Member if and as provided herein. No Member's co-signature shall be required for the protocol-driven practice of APRNs so long as such APRNs are acting within their approved Privileges as permitted by K.S.A. 65-1130 and approved through the Hospital's credentialing process for Advanced Practice Practitioners. With respect to the practice and orders of PAs pursuant to delegated authority or medically approved protocols as permitted by K.S.A. 65-28a08, the supervising or responsible Member shall comply with all applicable supervision requirements of the State Board of Healing Arts,
K.A.R. 100-28a-10, and the Authority, including without limitation the following:

2.5.1 During the first thirty (30) days of the supervising physician-PA supervisory relationship, the supervising physician shall review and authenticate all medical records of each patient evaluated or treated by the PA within seven (7) days of the date the PA evaluated or treated the patient. The supervising physician shall authenticate each record by original signature or initials and shall record the date of the review. Electronically generated signatures shall be acceptable if reasonable measures have been taken to prevent unauthorized use of the electronically generated signature.

2.5.2 After the first thirty (30) days of the supervising physician-PA supervisory relationship, the supervising physician shall document the periodic review and evaluation of the PA's performance required by paragraph (a)(3), which may include the review of patient records. The supervising physician and the PA shall sign the written review and evaluation and maintain a copy at each practice location, which shall be made available to the Board upon request; and

2.5.3 If a patient has an emergency medical condition requiring immediate treatment that the PA has not been authorized to perform, the PA shall communicate with the supervising physician or substitute supervising physician concerning the patient's emergency medical condition as soon as is clinically feasible. The PA shall document that individual's communication with the supervising physician or substitute supervising physician in the patient's medical record.

2.5.4 Each order must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or discrepancies are resolved by the nurse. The use of "Renew", "Repeat" and "Continue Orders" are not acceptable. All previous orders are canceled when the patient goes to surgery or ICU. A member shall be responsible and provide a completed order for inpatient, observation or outpatient service that is medically necessary, dated, timed and authenticated for all patient treatment, testing and/or procedures. Only pre-operative or admission orders maybe predated for elective surgical procedures or admissions.

Section 2.6 Verbal and Telephone Orders.

2.6.1 Verbal and telephone orders shall be used on a limited basis and issued only by a Member of the medical Staff. Such orders for medications and treatment may be accepted and transcribed by a duly authorized person functioning within his/her scope following hospital policy and procedure for verbal and telephonic orders.

2.6.2 Telephone orders shall be issued only if the circumstances are such that an immediate order is required and it would be impractical for the issuing prescriber authorized under Section 2.6.4 to do so electronically or for purposes of clarifying existing order. Telephone orders are not appropriate for routine orders.

2.6.3 All verbal and telephone orders shall be transcribed as a complete order and read back in their entirety, including patient identification information, to the ordering practitioner.

2.6.4 All telephonic reporting of critical test results shall be verified by having the person receiving the information record and read back the test results, including patient identification information.

2.6.5 All verbal and telephone orders must be authenticated, dated, and timed by the ordering Member

2.6.6 covering physician, or Attending Physician within seventy-two (72) hours of its issuance.

Section 2.7 DNAR, OHDNR and TPOPP.

2.7.1 It shall be the responsibility of a patient's Attending Physician or qualified designee to initiate DNAR Orders in accordance with applicable law and the Hospital's Policy on Advance Directives and Patient Rights.

2.7.2 Conflicts relating to a DNAR Order, a DNAR Directive, an OHDNR Order or a TPOPP shall be directed to the Hospital Ethics Committee.

2.7.3 Patients who present to the Minimally Invasive Surgery Hospital with an appropriately completed DNAR Directive, OHDNR order or TPOPP form will have those out of hospital orders reviewed and subsequently reflected in admitting orders as appropriate based on patient condition and discussion with the patient and/or their representative. If circumstances make review not possible, the information on the DNAR Directive, OHDNR or TPOPP form should be followed to the best of the provider's clinical judgment, utilizing all relevant information at hand regarding patient treatment goals. Appropriate completion is as follows:

2.7.3.1 A DNAR Directive must be executed by the patient or another person in the patient's presence and at the patient's express direction, a qualified witness, and the patient's physician in accordance with Kansas laws at K.S.A. §§ 65-4942, 4943, as such laws may be amended from time to time.

2.7.3.2 An OHDNR Order must be executed by the patient or surrogate and the patient's physician in accordance with Missouri law at Mo. Rev. Stat.§ 190.603, as such law may be amended from time to time.

2.7.3.3 A TPOPP must be signed by the patient or surrogate and the patient's physician.

Section 2.8 Drugs and Medications.

2.8.1 Except as otherwise specifically provided herein, all drugs and medications

administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Services,
A.M.A. Drug Evaluations, or the Minimally Invasive Surgery Hospital Formulary.

2.8.2 An order for medication must comply with the Hospital's Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted in, medication orders, both generally and for specific types of medications.

2.8.3 Hospital supply shall be used for medications administered to patients. Patients may use their own supply only under the following limited circumstances: (a) the medication is not on the Hospital Formulary and a reasonable therapeutic substitution is not available; (b) the Member, pharmacist and patient determine there is a medically necessary reason for the patient to use a personal supply to meet an individual patient need (and this is documented in the chart); or (c) the medication is an investigational medication provided under protocol as part of the patient's participation in an investigational study. In all of the foregoing circumstances, the medication must be contained in an original prescription container that allows Hospital staff to verify the content.

2.8.4 If a Member intends that a patient be permitted to use personal medications they bring into the Hospital, that Member shall write a complete order for that specific medication. Such order shall comply with Section 2.5 and contain the statement that the "patient may use their own supply" or another statement substantially similar thereto.

2.8.5 Patients of the Hospital shall not be permitted to self-administer own patient home medications. In addition, medications shall not be left at the patient's bedside to be taken unsupervised.

Section 2.9 Restraints and Seclusion.

2.9.1 General Standards for all Restraints and Seclusion.

2.9.1.1 A Member, of the Medical Staff, may order a physical restraint (or a drug to be used as a restraint) or seclusion and an APP with appropriate Privileges may order physical restraint for a patient only when appropriate alternatives have failed and the restraint or seclusion is necessary to protect the safety of the patient or others. Any physical restraint (or drug used as a restraint) employed shall be the least restrictive restraint necessary to achieve the desired level of safety.

2.9.1.2 An APRN may not order a drug to be used as a restraint (chemical restraint). An APRN may order a restraint in other settings only as consistent with Privileges and the collaborative practice agreement with a physician Member of the medical staff.

2.9.1.3 The Attending Physician must be consulted as soon as possible if the Attending Physician did not order the restraint or seclusion, and must co-sign the order.

2.9.1.4 A PA may not order drugs to be used as a restraint (chemical restraint). A PA may order restraint in other settings only as a delegated medical function consistent with the active practice request form entered into with a physician

Member of the medical staff, subject to appropriate physician supervision, and consistent with the PA's Privileges. The Attending Physician must be consulted as soon as possible if the Attending Physician did not order the restraint or seclusion, and must co-sign the order.

2.9.1.5 Chemical restraint is any medication used as a restriction to manage the patient's behavior or to restrict the patient's freedom of movement which is not standard treatment for the patient's medical or psychiatric condition.

2.9.1.6 All restraint and seclusion orders shall include the date and time limit of the order, type of restraint, clinical reason for the restraint and/or seclusion and restraint time frame (for violent/self- destructive behavior). PRN orders shall not be allowed.

2.9.1.7 There are different standards for the use of restraint and seclusion care which exist for violent/self-destructive behavior and for the use Of restraint for non-violent behavior. See the following sections for those specific standards.

2.9.1.8 Seclusion is not used on Hospital premises.

2.9.2 Restraint Use for Violent/ Self-Destructive Behavior and Violent and Self-Destructive Patient Restraints in Psychiatry:

2.9.2.1 Any Member of the Medical Staff who orders a physical restraint or seclusion for any patient hospitalized, shall ensure that the patient is examined and evaluated in a face to face manner by a Member, an APP with appropriate privileges or other qualified individuals as directed by hospital policy within one hour of the patient's placement in restraints or seclusion, regardless of the length of time the patient is in restraint or seclusion. If the Member who orders the restraint or seclusion is not the patient's Attending Physician, the Member shall notify the patient's Attending Physician of the restraint or seclusion as soon as possible.

2.9.2.2 No Member of the Medical Staff shall order a physical restraint or seclusion, for a violent and or self-destructive patient, to exceed 3 hours for adults, 2 hours for adolescents 9-17 years of age.

If at the end of the initial order (3 hours for ages 18 or older, 2 hours for ages 9 to 17, or I hour for children less than 9 years old), the registered

nurse assessment confirms the continued need for restraint/seclusion, the registered nurse may obtain a telephone order to renew restraint/seclusion for the time frames noted above as appropriate to the age of the patient.

2.9.2.3 After expiration of the renewal order, a new order may be issued as outlined in 2.9.1.1, if needed. The responsible Member or covering Member must personally perform a face to face evaluation of the patient at least once a day.

2.9.2.4 Monitoring of the violent and/or self-destructive patients, cared for with physical restraint or seclusion, occurs via constant observation of the patient.

2.9.3 Restraint Use for Non-Violent Behaviors:

2.9.3.1 Hospitalized patients whose non-violent behavior creates safety concerns, may require physical restraint. Any Member of the Medical Staff who is responsible for the care of the patient orders may order a physical restraint for any hospitalized patient exhibiting non-violent behavior. If the Member who orders the restraint or seclusion is not the patient's Attending Physician, the Member shall notify the patient's Attending Physician of the restraint or seclusion as soon as possible.

2.9.3.2 If a restraint is initiated by a registered nurse in an emergency situation, a telephone order must be obtained as soon as possible, not to exceed 4 hours from restraint initiation. If the restraint order is initiated via telephone, a Member responsible for the care of the patient will examine the patient and evaluate the need for restraint within 24 hours of restraint initiation.

2.9.3.3 The restraint for non-violent behavior must be renewed daily. The physician is to conduct a face-to-face reassessment to determine the continued need for restraint before writing a renewal restraint order. Monitoring and care shall be ensured and occurs by: assessment of the, patient at least every two hours for adequacy of restraint, presence of any potential injury, adequacy of circulation, desire to eat, drink, or use the toilet; and release and range of motion at least every four hours.

2.9.3.4 When restraints are discontinued prior to the expiration of the order, and then reapplied based on patient behavior a new order must be obtained. This does not include limb release, release for bathing, or short periods during which the registered nurse remains in the room, or when therapy is provided by PT.

Section 2.10 Constant Observation.

2.10.1 A Member of the medical Staff, may order constant observation for any patient when the patient is actively suicidal, actively homicidal, or when the patient is psychotic. In cases of severe agitation with combative behavior and risk to self and/or staff, a Member of the Medical Staff will work with Hospital administrative staff to determine if constant observation or police observation is most appropriate.

2.10.2 Any Member or duly licensed member of the House Staff who orders constant observation for a patient must document the reason for the order in the patient's medical record and reassess the patient and the need for constant observation at least once every 24 hours.

2.10.3 Any Member of the Medical Staff who believes that a patient requires constant observation for more than 48 hours shall make arrangements for transfer to an appropriate facility for psychiatric consultation.

Section 2.11 Diagnostic Procedures. When ordering diagnostic procedures, including but not limited to radiology, lab/pathology, EKG, GI/Endoscopy, echocardiography, and EEG, Members shall include in the written requisition form the appropriate diagnostic code, other appropriate

information about the patient's diagnosis, or the sign or symptom providing the indication for the diagnostic procedure.

Section 2.12 Quality Improvement. Each Member shall participate if requested in the Hospital's quality improvement activities, including but not limited to the following:

a) responding to reasonable inquiries by a quality improvement or peer review committee of either the Hospital or the Medical Staff regarding the Member's care and treatment of any patient;
b) participating in root cause analysis; and
c) completing any mandatory educational activity approved by the Executive Committee of the Medical Staff.

Section 2.13 Advanced Practice Providers and Allied Health Professionals.

2.13.1 Each Member who agrees to supervise the care rendered by an Advanced Practice Provider or Allied Health Professional within the Hospital must oversee and direct the work of the Advanced Practice Provider or Allied Health Professional and annually evaluate the work of the Advanced Practice Provider or Allied Health Professional; must accept responsibility for all patient care services provided by the Advanced Practice Provider or Allied Health Professional; and must possess Clinical Privileges which permit the Member to perform the same patient care services performed by the Advanced Practice Provider or Allied Health Professional.

2.13.2 For Advanced Practice Providers who are APRNs, the Department Chairs or their designee shall serve as the "responsible physician" for the APRNs

practicing within their respective areas as long as the Privileges for the APRN remain the same. If working with another physician would require a change in the APRN's Privileges, this option would not apply and complete paperwork would be required to be on file. Responsibility in this regard shall include authorizing all written protocols for those APRNs who are delegated the responsibility of prescribing drugs. The foregoing notwithstanding, whenever an APRN provides care to a patient, the patient's Attending Physician shall be deemed to be the sponsoring physician of record in regard to services provided by the APRN, and that physician shall oversee and direct the work of the APRN.

2.13.3 No Member shall supervise the care rendered by an Advanced Practice Provider or Allied Health Professional within the Hospital unless the APP or AHP has been and remains duly credentialed and approved by the Hospital within the approved Privileges or scope of practice, as applicable, to perform the patient care services they seek to perform.

Section 2.14 Meeting Requirements. Medical Staff Members assigned to the Active Category are required to attend 50% of the General Medical Staff meetings per year.

ARTICLE III: RULES PERTAINING TO SPECIFIC SPECIALTIES

SURGERY AND PROCEDURAL SPECIALTIES

Section 3.1 Pre-surgical Documentation.

3.1.1 With the exception of emergency surgeries, no Member shall perform a major surgical operation on any patient until a written History and Physical Examination and the results of appropriate studies, as indicated by the patient's illness or condition, are completed and made a part of the patient's Medical Record.

3.1.2 If a complete history and physical examination has been performed within thirty (30) days prior to the patient's admission, a durable, legible copy of a report of such history and physical examination will fulfill this Section's requirement of a written History and Physical Examination provided any changes, or no changes noted, subsequent to the date the history and physical examination were obtained and/or performed have been recorded in the patient's Medical Record prior to performing the surgery. A history and physical greater than 30 days old cannot be updated, or referred to in a current admission document.

The history and physical is good for the entire hospital stay. Any changes in a patient's condition prior to surgery should be documented in the progress notes. Therefore, the admission history and physical is acceptable to use as the history and physical prior to surgery even if the patient has been in-house for greater than 30 days. Any changes would be documented in the progress notes.

3.1.3 With the exception of emergency surgeries, if a Consultant is to perform a surgery, the Consultant shall enter either a Consultation Report or a Pre- operative Note in the patient's Medical Record prior to performing the surgery.

3.1.4 With the exception of emergency surgeries, no Member shall perform any major surgical operation on any patient until an anesthesiologist or other qualified anesthetist has performed a pre-anesthesia evaluation of the patient and documented such evaluation in the patient's Medical Record.

3.1.5 In addition to the completed history and physical examination described above, prior to operation, all patients requiring anesthesia services, must have recorded on their chart the results of a pre-anesthesia assessment performed and signed by the Anesthesiologist and/or CRNA. The assessment may be focused to assess peri-operative risk and management. The same time frames as described above for a H&P also apply to a pre-anesthesia assessment.

The Anesthesia provider shall maintain a complete anesthesia OR record during a case.

3.1.6 In cases where respiratory therapy, physical therapy, or occupational therapy services are used, the Member ordering the treatment will justify the need in the progress notes of the patient's medical record. Documentation of respiratory services in the patient's medical record must include the specifications of the prescription and the effects of therapy, including any adverse reactions. In all cases, the responsible Member must place in the patient's medical record the timely, pertinent clinical evaluation of the results of respiratory therapy.

Section 3.2 Tissue Disposition. All tissues relevant to the surgical procedure removed at surgery or during any procedure, except those tissues specified in advance as defined by hospital policy or approved research consent or exempted or designated for disposal only at the time of surgery in accordance with the "Specimen Handling for Perioperative and Procedural Departments" policy, shall be sent to the Department of Pathology for examination by the department.

Section 3.3 Post-Surgical Documentation.

3.3.1 Any Member who performs surgery or a procedure on any patient shall prepare or dictate an Operative Report following such surgery or procedure, whether the surgery or procedure was performed on an inpatient or outpatient basis. When the Operative Report is not placed in the record immediately after the surgery or procedure, the Member who performed the surgery or procedure shall record a Brief Operative Note or Immediate Post Procedure Note in the patient's Medical Record immediately following the surgery or procedure. In all cases, an Operative Report shall be completed in accordance with medical records policy.

3.3.2 The anesthesiologist or qualified anesthetist who managed the patient's anesthesia during surgery shall document a post anesthesia evaluation within 48 hours of the surgery or procedure, whether the surgery or procedure was performed on an inpatient or outpatient basis.

3.3.2.1 The post-anesthesia evaluation is conducted when the patient is sufficiently recovered from the effects of anesthesia, allowing the patient to participate in the evaluation. If the patient cannot participate, the anesthesiologist or qualified anesthetist will document the reason the patient is unable to participate, as well as the, expectations for recovery time.

3.3.2.2 The post-anesthesia evaluation will include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function including pulse and blood pressure; mental status; temperature; pain; nausea and vomiting; and post-operative hydration.

3.3.3 Notwithstanding the requirement of Section 3.3.1, the documentation or dictation of Operative Reports, Procedure Notes, Progress Notes, and anesthesia records required by this Section may be delegated to a member of the House Staff only if they were physically present during the surgery or procedure.

Section 3.4 SITE MARKING / TIME-OUT – UNIVERSAL PROTOCOL

Advise the patient or surrogate decision maker or significant other of the required procedure and identify the body part directly involved. The Surgical Consent form must be signed by the patient (or the individual legally entitled to consent on behalf of the patient) and must state the procedure being performed, including laterality and level if applicable. This information will be clearly recorded in the patient's medical record.

Review the following data prior to marking for the procedure:

– X-rays and other radiologic images if appropriate
– Medical devices or special equipment supply

- History and physical (H&P) and other clinically relevant material (i.e., consults, progress notes, laboratory values, etc.) in the patient's medical record.

Prior to the patient entering the Operating/Procedure Room, the surgeon/LIP performing the procedure must mark the correct site, side and location (level) of the procedure with approved marking method on paper and/or the body where the patient understands the procedure will take place.

The surgeon will actively participate during the Time-Out procedure to ensure the correct procedure is being performed on the correct patient, side and site prior to the start of the procedure.

ARTICLE IV: MEDICAL RECORDS

Section 4.1 General.

4.1.1 All Medical Records, and any copies or other reproductions thereof (unless provided directly to the patient), are the property of the Hospital and shall not be removed from the Hospital Premises for any reason except as specifically authorized by an appropriate representative of the Authority.

Protected health information (PHI) shall not be stored on personal or portable devices. Viewing of PHI offsite shall follow security practices in accordance: with Medical Records Ownership & Accessibility Policy.

4.1.2 All Medical Records, the information contained therein, and any other patient- specific information shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information and shall be released only in accordance with the Hospital’s Policies and Procedures governing medical records.

4.1.3 Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient’s Medical Record shall be as stated in the Hospital's Policies and Procedures governing medical records.

4.1.4 Standardized symbols and abbreviations may be used when they have been through the approval process. Those approved are listed in the Hospital Formulary.

4.1.5 All Members shall record their entries in a patient's Medical Record legibly. All physicians will be required to participate in the use of the Electronic Medical Record when available.

4.1.6 The patient's Attending Physician shall be responsible for the timely preparation and completion of the patient's Medical Record. The Medical Record will be completed timely, as close to the event as possible, not to exceed 30 days following discharge of the patient.

4.1.7 Any Consultant who is consulted as to any patient shall be responsible for the timely

preparation and addition to the patient's Medical Record of a Consultation Report and any other notes, orders and other written entries describing the Consultant's examination and impressions of the patient, any diagnosis made by the Consultant, any recommended testing and/or course of treatment for the patient, and any testing and/or treatment of the patient undertaken directly by the Consultant.

4.1.8 When recording a History and Physical Examination, Consultation Report, or Progress Note in a patient's medical record, a Member may reference elements of properly recorded APP or Licensed Independent Practitioners.

4.1.9 All clinical entries in the patient's Medical Record shall be accurately dated and authenticated by the individual making the entry. The method of acceptable authentication used shall be either:

a) A handwritten signature; or

b) An electronic signature, but only if the Member, or Licensed Independent Practitioner (as applicable) has signed a Hospital "CONFIDENTIALITY AGREEMENT / SIGNATURE ATTESTATION" form agreeing that the user log on and password will not be shared with anyone.

The use of rubber stamp signatures is strictly prohibited.

4.1.10 Unless otherwise stated in these Rules and Regulations, all Medical Record entries required of any Member may be documented or dictated when appropriate by a member of the medical Staff or Licensed Independent Practitioner under the Member's direct supervision.

4.1.11 Each member of the Medical Staff, as well as every Practitioner or Allied Health Professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to as the "Provider" in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital which is defined in 45 C.F.R. 164.501, (which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.

4.1.12 Prohibited activities regarding patient medical records, include but are not limited to:

1. Using software without authorization;
2. Attempting to use or obtain another user's password, user i.d., token, or biometric information;
3. Allowing another individual to use a user id, password, token, or biometric information which is not his or her own;

4. Obtaining access to patient information without authorization; or
5. Disclosing or distributing patient information without authorization.

Section 4.2 Content of Entry

4.2.1 Admitting Notes. If utilized, Admitting Notes shall contain, at a minimum, the admitting diagnosis, the reason or reasons for admission to the Hospital, pertinent findings, and the course of treatment contemplated.

4.2.2 Progress Notes. Progress Notes shall include, at a minimum, a description of the patient's status, including any changes since the last Progress Note, an assessment of the patient's disease process or injury and its response to treatment, and any changes in the diagnosis and/or treatment plan.

4.2.3 Operative Reports and Procedure Notes.

All operative reports and immediate post-procedure notes shall indicate the primary physician and assistants involved, the name of the procedure performed, and include a detailed account of the findings during the surgery or procedure, the details of the surgical or procedural technique used, any specimens obtained, estimated blood loss (unless none or negligible, no notion is required), and the pre and post-operative diagnosis. A Brief Operative Note or Immediate Post Procedure Note must also be completed, to be available prior to the patient going to the next level of care, unless the complete operative/procedure report is completed by this time and available in the medical record.

4.2.4 Pre-Operative Notes. Pre-Operative Notes shall contain the patient's diagnosis and a general statement of the planned surgical procedure.

4.2.5 Post-Operative Notes. Post-Operative Notes shall record the patient's vital signs and level of consciousness, medications, blood and blood components used post-operatively, any unusual post-operative events or complications, and the management of such events or complications.

4.2.6 Consultation Reports. Consultation Reports shall show evidence of a review of the patient's record by the Consultant, pertinent findings on the Consultant's examination of the patient, and the Consultant's opinions and recommendations. If the Consultation Report contains a recommendation that the patient undergo surgery or other invasive procedure, the Consultation Report shall contain a statement of the indications for the surgery or procedure and a general description of the planned surgery or procedure.

Section 4.3 Standing Order.

4.3.1 Any Member may utilize preprinted standing orders provided such standing orders, and any revisions thereto, have been approved in advance by the Medical Records Committee and the Executive Committee of the Medical Staff.

4.3.2 Any Member wishing to utilize preprinted standing orders approved in accordance

with this Section must, on a case-by-case basis, specifically order that such standing orders be applied.

Section 4.4 Discharge Summaries. All Discharge Summaries shall identify the patient, and contain sufficient information to support the diagnosis, justify the treatment, document the course and results of the treatment, and permit adequate continuity of care among health care providers. Discharge Summaries shall also contain instructions given to the patient relating to physical activity, medication, diet and follow-up care.

A discharge summary containing at a minimum the outcome of the hospitalization, disposition of the case, and provisions for follow-up care must be dictated for hospital stays longer than 48 hrs (or 2 midnight stays). For inpatient hospital stays shorter than 48 hrs (2 or less midnight stays) with at least an overnight stay, a written discharge note containing the outcome of hospitalization, disposition of the case, and provisions for follow-up care is placed in the medical record by the discharging physician.

ARTICLE V: AUTOPSIES

Section 5.1 Unless otherwise required by the County Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. All Medical Staff Members shall request and secure written consents for autopsies whenever possible.

Section 5.2 Deaths in which an autopsy should be especially encouraged are:

a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
b) All deaths in which the cause of death is not known with certainty on clinical grounds.
c) Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
d) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
e) Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
f) Natural death; which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at the hospital, (b) deaths occurring in the hospital within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
g) Deaths resulting from high-risk infectious and contagious diseases.
h) Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients or transplant organs.
I) Deaths known or suspected to have resulted from environmental or occupational hazards.

Section 5.3 All autopsies shall be directed by the County coroner's office.

ARTICLE VI: AMENDMENTS

These Rules and Regulations may be amended by a majority vote of the Executive Committee. Any such amendment shall become effective upon approval of the Board.

Approved:

_______________________________________ _______________________________________

Paramjeet Sabharwal, MD, CEO	Wanda Kaniewski, MD, CMO
MISH Hospital Governing Authority	MISH Hospital Medical Staff Authority