MultiCare
Capital Medical Center

MEDICAL STAFF
RULES & REGULATIONS

Dates of Review/Revision	Reviewers/Approvals	Brief Synopsis of Revision(s) Made
Dec 2016	MEC, BOT, Voting Members	Complete Review & Revision
Jan 2018	MEC, BOT	On Call Requirements Completion of Medical Records- Discharge Summary
Jan 2021	SURG, MEC, BOT	Operative Reports- Post-Op Reports
Feb 2021	PERI, MEC, BOT	Nursery/Newborn Care
MEC- 08/04/21 BOT- 09/15/21	MEC, BOT	Emergency Screening, Discharge, Orders, Medical Records, Informed Consent, Pre-Op Studies, Residents/Fellows/Medical Students
MEC- 11/05/21 BOT- 11/17/21	MEC, BOT	Add detail to Orders, Post-Op Report, Informed Consent
MEC- 02/02/22 BOT- 02/16/22	MEC, BOT	Add Medical Escalation Path / Chain of Command

RULES AND REGULATIONS OF THE MEDICAL STAFF
OF CAPITAL MEDICAL CENTER

TABLE OF CONTENTS

TABLE OF CONTENTS continued

PREAMBLE

These Rules and Regulations are adopted pursuant to the Medical Staff Bylaws and are made a part thereof. They supersede, as of the date of adoption, all previous Rules and Regulations. Terms used herein shall have the same meaning given or applied to them in the Medical Staff Bylaws unless the context clearly indicates to the contrary. Whenever the term "he" appears in these Rules and Regulations, the term shall apply to either gender. The provisions of these Rules and Regulations shall apply equally to all Practitioners with privileges at the Hospital unless the context clearly indicates otherwise.

ARTICLE I
ON CALL REQUIREMENTS

1.1 CALL ROTATION

The Medical Staff is responsible for maintaining adequate emergency call coverage as determined by the Medical Executive Committee. The Medical Staff policies and procedures for providing on-call coverage shall be approved by the Board of Trustees. All members of the Active Medical Staff shall participate in the on-call rotation to the Emergency Department. Some exceptions to the call rotation schedule (e.g., Physician age) may apply. Physicians contracted to cover occasional shifts or weekend coverage for subspecialties (e.g., Pulmonary or Hospitalists) are not required to take On Call Rotation, regardless of the number of patient encounters. Refer to the Medical Staff On-Call Requirements Policy (Attachment A).

1.2 RESPONSE TO CALL

Physicians called are required to respond to the Emergency Department by telephone within ten (10) minutes. If requested to come in, they are required to do so within thirty (30) minutes after responding by telephone. Anesthesiologists and CRNAs are required to arrive within thirty (30) minutes of initial contact.

ARTICLE II
EMERGENCY SCREENING, TREATMENT, AND TRANSFER

The Medical Staff is responsible for maintaining adequate emergency call coverage as determined by the Medical Executive Committee. A formal Medical Staff On-Call Requirements Policy outlining the requirements for call coverage will be distributed to all medical staff members as well as any revisions (Attachment A).

2.1 INPATIENT EMERGENCY

In the event of an emergent health condition involving an inpatient in any patient care area, the Emergency Department (ED) Physician shall be paged via the Hospital Emergency Code procedure and will leave the Emergency Department to attend to the inpatient emergency as part of the Code Team. The Hospitalist Physician is also part of the Code Team and must respond to the Code. The ED Physician will not be required to respond to a Code call if he/she is already attending an emergent patient in the ED. In all cases, the inpatient's Attending Physician or assigned Hospitalist will be contacted immediately and is required to respond by telephone within ten (10) minutes to assume further care following the emergency. If requested, to come in to see the patient, the Attending or assigned Hospitalist is required to arrive within thirty (30) minutes of initial contact.

2.2 EMERGENCY DEPARTMENT SCREENING

Any individual who presents to the Emergency Department of this Hospital for care shall be provided with a medical screening examination to determine whether that individual is experiencing an emergency medical condition. Generally, an "emergency medical condition" is defined as active labor or as a condition manifesting such symptoms that the absence of immediate medical attention is likely to cause serious dysfunction or impairment to bodily organ or function, or serious jeopardy to the health of the individual or unborn child. Examination and treatment of emergency medical conditions shall not be delayed for determining the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.

All patients shall be examined by qualified medical personnel (QMP), which shall be defined as: (i) a hospital-privileged Physician trained in emergency and/or family practice medicine, who is deemed qualified through credentialing to provide patient care services in the hospital's emergency department; or (ii) a physician assistant (PA) or advanced registered nurse practitioner (ARNP), who is authorized through the hospital's credentialing process to provide patient care services in the hospital's emergency department, and who is supervised by a hospital-privileged physician providing services in the emergency department. In the case of a woman in labor, a registered nurse trained in obstetrical nursing, with documented initial and ongoing competency in assessment and treatment of labor and fetal monitoring, per Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) guidelines, and pursuant to Hospital policy, Medicare, and other applicable federal regulations, shall be considered QMP to evaluate patients for suspected labor. Services available to Emergency Department patients shall

include all ancillary services routinely available to the Emergency Department, even if not directly located in the department.

2.3 EMERGENCY DEPARTMENT TREATMENT AND STABILIZATION

2.3(a) Stabilization Prior to Transfer or Discharge

Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below. A patient is Stable for Discharge when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions; or the patient requires no further treatment, and the treating Physician has provided written documentation of his/her findings. A patient Stable for Transfer if the treating Physician has determined, within reasonable clinical confidence, that the patient is expected to leave the Hospital and be received at a second facility, with no material deterioration in his/her medical condition; and the treating Physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. The patient is considered Stable for Transfer when he/she is protected and prevented from injuring himself/herself or others.

2.3(b) Non-Stabilization Prior to Transfer or Discharge

A patient does not have to be stabilized when: the patient, after being informed of the risks of transfer and of the Hospital's treatment obligations, requests the transfer and signs a transfer request form; or based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a Physician signs a certification which includes a summary of risks and benefits to this effect. If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he/she has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by the Emergency Department supervisor.

2.4 TRANSFER

The Emergency Department Physician shall obtain the consent of the receiving Hospital facility before the transfer of an individual. The Physician shall also arrange for the patient transfer with the receiving Hospital. The condition of each transferred individual shall be documented in the medical records by the Physician responsible for providing the medical screening examination and stabilizing treatment. Upon transfer, the Emergency Department shall provide a copy of appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call Physician who has refused or failed to appear within a reasonable period of time to provide stabilizing treatment. All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient (or the patient's representative) of the risks and benefits of the proposed transfer.

ARTICLE III
ADMISSION AND DISCHARGE OF PATIENTS

3.1 ADMISSION

3.1(a) Admission Privileges and Procedure

A patient may be admitted to the Hospital only by a member of the Medical Staff who holds admitting privileges. The privilege to admit shall be delineated and is not automatic with Medical Staff membership. All Practitioners shall be governed by the Patient Admission Policy of the Hospital. The Admitting Physician shall be the designated Attending Physician for a patient until care is transferred to another Physician with appropriate privileges. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure protection of other patients or to assure protection of the patient from self harm.

3.1(b) Management and Coordination of Care

The management and coordination of each patient's care, treatment and services shall be the responsibility of a Physician with appropriate privileges. Each Medical Staff member shall be responsible for the medical care and treatment of each of his/her Hospitalized patients, for the prompt completeness and accuracy of the medical record, for necessary special instructions, for transmitting reports of the condition of the patient to any Referring

Practitioner and to relatives of the patient where appropriate. The patient shall be provided with pertinent information regarding outcomes of diagnostic tests, medical treatment, and surgical intervention. Whenever a Physician's responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records.

3.1(c) Emergency Management of Care

In an emergency and in the absence of the Attending Physician or his/her designee, any member of the Medical Staff with appropriate privileges may be called to attend the patient.

3.1(d) Admission Assessment and Re-Assessment

All patients admitted to the Hospital should be assessed by the Admitting or Attending Physician in a timely manner, depending on the patient's condition, but in all cases, in accordance with the Hospital Admitting Policy and with the requirements of these Rules and Regulations, including those pertaining to the "History and Physical" per Article 5.4. All patients in the Hospital shall be seen at least once each 24 hours by a Physician.

3.1(e) Priority for Beds

In the event of unavailability of Hospital beds, the decision on priority shall be made by the Chief of Staff or his/her designee, and per the Hospital Patient Flow Plan.

3.2 LENGTH OF STAY AND DISCHARGE

3.2(a) Documentation of Length of Stay

The Attending Physician is required to document the need for continued hospitalization prior to expiration of the designated length of stay. This documentation must contain:

(1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate

(2) Estimate of additional length of stay the patient will require; and

(3) Plans for discharge and post-hospital care.

3.2(b) Justification for Continued Hospitalization

If the Attending Physician indicates the necessity for patient's continued hospitalization longer than specified the attending Physician will agree to discuss justification of such with the Case Manager, including an estimate of the number of additional days of stay and the reason, therefore.

3.2(c) Provision of Information to Patient and Patient's Family

Pursuant to the Hospital's privacy policies and HIPAA regulations, and if the patient allows the sharing of his/her care and treatment information with family and/or responsible parties, the Attending Physician shall keep the patient and the patient's family informed concerning the patient's condition throughout the patient's term of treatment. The Attending Physician and Hospital staff shall ensure that the patient (or appropriate family member or legally designated representative) is provided with information that includes, but is not limited to, the following:

(1) Conditions that may result in the patient's transfer to another facility or level of care

(2) Alternatives to transfer if any

(3) The clinical basis for the discharge

(4) The anticipated need for continued care following discharge

(5) When indicated, educational information regarding how to obtain further care, treatment, and services to meet the patient's needs, which are arranged by or assisted by the Hospital; and

(6) Written discharge instructions in a form and manner that the patient or family member can understand.

3.2(d) Discharge

If a concern is raised about the Discharge plan, the Attending, Nurse, or Case Manager must:

(1) Hold the discharge until a resolution is reached supporting a safe discharge.

(2) If applicable, escalate the discharge plan to include a Physician Advisor who will collaborate with the discharging physician regarding the discharge plan.

(3) If applicable, escalate to the Physician Advisor Medical Director of Quality and/or the Chief Nursing Executive for concurrence on the discharge plan.

Patients shall be discharged only on order of the Attending Physician or his/her appropriately licensed and privileged designee. Should a patient leave the Hospital against the advice of the Attending Physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record. The appropriate form will be signed by the patient or a responsible family member whenever possible.

ARTICLE IV
ORDERS

All orders for treatment shall be in writing and will be signed, dated, and timed at the time of documentation. The hospital's electronic record applications cover these requirements.

When requested to sign/date/time any record that was missed, the practitioner must use the date of the actual signing rather than the date of the procedure or note. No backdating is allowed.

4.1 VERBAL ORDERS

Verbal orders must be used infrequently and only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order without delaying treatment. Verbal orders are discouraged except in emergency situations and must not be used for the convenience of the ordering Practitioner.

The content of telephone orders must be clearly communicated and requires verification by a "write down/read back" process of confirmation between issuer and receiver.

Verbal/telephone orders must only be accepted by a Licensed Caregiver who is authorized to accept verbal orders.

Verbal and telephone orders must be authenticated in the medical record within 48 hours by the practitioner who issued the order, or by a Licensed Independent Practitioner (LIP) who has assumed responsibility for the patient's care. Authentication means the LIP signs the order and includes the date and time the order was authenticated.

4.2 PRE-PRINTED ORDERS

Pre-printed orders completed by an individual Practitioner shall be made on the prescribed form and may be used only after the applicable committee has approved such pre-printed orders. To ensure continued appropriateness, practitioner-specific standing orders shall be reviewed as needed by the Practitioner and the appropriate committee(s). The pre-printed orders shall specify its initial adoption date (wherever possible) and last review date. Hospital staff may decline to utilize a pre-printed order that has not been reviewed in accordance with this Article.

4.3 TRANSFER ORDERS

Patient care orders must be rewritten anytime the patient is transferred between hospital inpatient units, the ED, or the OR.

4.4 RESUSCITATION ORDERS

Full CPR will be instituted unless orders specifically outline alternative resuscitation methods to be taken or an appropriate "Do Not Resuscitate" order appears in the patient's medical record.

4.5 PRONOUNCING ORDERS

4.5(a) Authority to Pronounce

Physicians will pronounce a patient's death, except that Registered Nurses (RN) may pronounce patient deaths in accordance with accepted Hospital policy and in accordance with Washington State Nursing Regulations. Upon a patient death, the House Supervisor will be notified.

4.5(b) Pronouncement Responsibility of Attending Physician

Prompt evaluation and pronouncement of death are the responsibility of the Attending Physician. If the Attending Physician is not in the Hospital, his/her designee will be notified promptly by Hospital personnel.

4.5(c) Transfer of Pronouncement Responsibility

If the Attending Physician is not immediately available to make the evaluation and pronouncement of death, he or she may transfer this responsibility to any staff Physician in the Hospital. If no other Physician is available, the Emergency Department Physician on duty may be asked to make the pronouncement. This course of action would be undertaken only after ensuring that the Emergency Department Physician can take time from his or her duties.

4.6 AUTOPSY ORDERS

Autopsies shall be secured by the Attending Physician as guided by Medical Staff approved criteria, and in accordance with the Hospital Autopsy policy and applicable state regulations governing the performance of autopsies by the Medical Examiner.

If an autopsy is indicated, the Attending Physician is responsible to request permission from the family or guardian for a complete or limited autopsy, unless the autopsy is required by law, in which event the Attending Physician shall

provide notice to the family or guardian. Efforts to obtain permission shall be documented in the medical record, and consents, if obtained, should be in writing signed by the family or guardian and placed in the medical record.

The Hospital Executive On-Call must approve all requests for autopsy performed at Hospital expense prior to the autopsy. Autopsies to be performed by the medical examiner shall be governed by applicable state law.

In all cases of unusual deaths and cases of medical, legal, and educational interest, the Hospital Administration will attempt to secure autopsies and will inform the Attending Physician of autopsies that the hospital intends to perform (MS.05.01.01, EPs 9 & 17).

4.7 CONSULTATION ORDERS

Consultations may be obtained whenever a Practitioner deems it to be appropriate but will be obtained in all cases where the Practitioner's privilege delineation for the clinical condition being treated requires consultation.

4.7(a) Circumstances Requiring Consultation

Consultation with the appropriate specialist must be obtained in the following circumstances:

(1) When a Practitioner's privilege delineation requires consultation
(2) Obstetrical consultation is required for high-risk obstetrical patients who are normally cared for by a Family Medicine Practitioner or Certified Nurse Midwife
(3) Obstetrical consultation is required for pregnant patients requiring non-obstetrical surgery per the Non-OB Surgery in Pregnant Patients Policy, and
(4) Pulmonary consultation is required for management of patients on ventilators for greater than 48 hours per the criteria requirements on the Physician's privilege list.

4.7(b) Other Circumstances When Consultation May Be Requested

Consultation may also be requested in, but not limited to, the following circumstances:

(1) When the diagnosis is obscure after ordinary diagnostic procedures have been completed
(2) When there is doubt as to the choice of therapeutic measures to be used
(3) For high-risk patients undergoing major operative procedures; and/or
(4) In situations where specific skills of other Physicians may be needed.

4.7(c) Procedure for Consultation

Requests for consultation should be made by Physician-to-Physician communication, especially in urgent situations. The order for a consultation, including the identity of the Physician who has agreed to provide a consultation, shall be documented in the medical record. Consultants who agree to a consultation request should evaluate the patient in a timely manner. In the event of a medical/surgical emergency, the appropriate specialist on call should respond within thirty (30) minutes.

4.8 PATIENT RESTRAINT ORDERS

A Practitioner with applicable clinical privileges shall be responsible for ensuring that written, patient-specific orders for restraint and/or seclusion are included in the relevant medical record; that patients are timely assessed and evaluated upon implementation of an order for restraint/seclusion, and for renewal of any such order; and that patient care plans are revised based upon the use of seclusion or restraint. Practitioners shall otherwise abide by federal law, Joint Commission standards, and all Hospital policies pertaining to restraints and seclusion.

ARTICLE V
MEDICAL RECORDS

5.1 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored, and maintained so that privacy and confidentiality are preserved. The Hospital and Practitioner is part of an Organized Health Care Arrangement (OHCA), which is defined as a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment, and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

5.2 PHYSICIAN RESPONSIBILITY

The Physician of primary responsibility is responsible for the completion of the patient's medical records. All medical records entries must be signed, dated, timed, and authenticated by the responsible Practitioner. The use of rubber stamp signatures in not permitted under any circumstances on any medical record.

5.3 DISCHARGE SUMMARY

Discharge Summaries are required on all patients who have been hospitalized over forty-eight (48) hours, or per the hospital policy, Discharge/Transition Planning PC 36.01. All deaths require a Discharge Summary regardless of length of admission. An adequate Discharge Summary shall contain, but not be limited to:

(1) A recapitulation of the reason for hospitalization
(2) The significant findings
(3) The procedures performed
(4) The care, treatments, and services rendered
(5) The condition and disposition of the patient on discharge (i.e., cognitive and functional status, and social supports needed)
(6) Any specific instructions given to the patient and/or family as pertinent; and
(7) Provisions for follow-up care

5.4 HISTORY AND PHYSICAL

Refer to the Medical Staff Bylaws for History and Physical Requirements

5.5 SYMBOLS AND ABBREVIATIONS

The use of symbols and abbreviations is limited to those which have been approved by the Medical Staff. Refer to the Hospital Medication Orders policy and the Plan for Medication Safety.

5.6 MEDICAL RECORDS JURISDICTION

Original medical records are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order or subpoena, or as otherwise required by law.

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied.

Any Physician on the Medical Staff may request a release of patient information providing that said patient is under his/her care and treatment. This does not allow the removal of the patient chart from the Hospital. Such releases, as a routine matter, will not require a Release of Information form to be signed by the patient. The intent of this Rule & Regulation is to address a Physician's need to have information available in his/her office to treat patients who may come to his/her office after having been seen, treated or tested at the Hospital.

Medical information shall otherwise be released only with written consent of the patient, or his/her surrogate decision-maker or as otherwise permitted or required by applicable law. All Practitioners are expected to comply with Hospital policies pertaining to the privacy and security of medical information. The Hospital and the Physicians who hold clinical privileges are members of an organized health care arrangement, as that term is used in the Health Insurance Portability and Accountability Act of 1996 and the amendments and implementing regulations thereto.

5.7 OPERATIVE REPORTS

5.7(a) Pre-Operative Reports

The patient's physician or licensed independent practitioner (LIP) must document the provisional diagnosis and the history and physical in the medical record before an operative or other high-risk procedure is performed (TJC- RC.02.01.03, #2 & #3).

5.7(b) Post-Operative Reports

Immediately upon completion of the operative case or procedure, and before the patient is transferred from the perioperative setting (i.e., discharge from PACU/Recovery), CMS requires that the patient's Physician or LIP must complete a brief operative/procedural note or a full operative report for the medical record. The full operative report must be completed in the medical record within 24 hours after the procedure (TJC- RC.02.01.03, #5).

5.7(c) Required Contents (TJC- RC.02.01.03, #6 & #7)

Both the brief operative/procedural note and the complete operative report must contain the following elements:

(1) Name(s) of the primary surgeon(s) and any assistant(s)
(2) Anesthesiologist and type of anesthesia
(3) Preoperative diagnosis
(4) Procedure(s) performed
(5) Findings for each procedure performed

(6) Estimated blood loss
(7) Specimens removed
(8) Postoperative diagnosis

5.8 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, 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 treatment. Progress notes shall be written or dictated at least daily on all patients except on the day of admission. The written admission note shall serve as the progress note for the day of admission unless the patient's condition warrants further progress notes on that date.

5.9 COMPLETION OF MEDICAL RECORDS

a. The patient's medical record shall be complete at the time of discharge, including progress notes and final diagnosis.
b. The written or dictated discharge summary shall be completed within 72 hours of discharge.
c. When final laboratory or other essential reports are not received at the time of discharge, a notation shall be written or dictated that this information is pending.
d. Pathologic TNM Staging of newly diagnosed carcinoma per the American Joint Commission on Cancer (AJCC). The staging forms will be prepared by the Tumor Registrar and made available to the Physician. The clinical or pathologic staging will be completed by the managing Physician within fourteen (14) days from the listed data of availability in the electronic medical record (EMR).
e. Per the Delinquent Medical Records Policy (Attachment B), the Health Information Management (HIM) Department will provide each Physician with a list of his/her incomplete medical records every seven (7) days. At two (2) weeks, a letter of incomplete 'red' status will be sent to the Physician. At the twenty-first (21st) day for any incomplete medical records, a phone call is made warning the Physician that the record(s) will be delinquent at thirty (30) days and the Physician's privileges will be suspended if any records become delinquent.
f. Any chart which is not completed within thirty (30) days of discharge will trigger suspension of the responsible Physician's privileges. When a Physician is notified of suspension, the Physician may not provide any hands-on patient care, whether inpatient or outpatient. Surgeries scheduled for that day may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended Physician may not cover Emergency Room call, may not provide coverage for partners or other Physicians, nor admit under a partner's or other attending Physician's name.
g. Completion of all delinquent medical records and payment of a $100.00 administrative fee to the Medical Staff Fund will be required for the Physician's privileges to be reinstated.
h. Automatic Suspensions for delinquent medical records shall not entitle the Practitioner to any due process rights and shall not require a report to the National Practitioner Data Bank (NPDB).
i. Refer to the Hospital Delinquent Medical Records Policy for further information.

5.10 ALTERATIONS / CORRECTION OF MEDICAL RECORDS

Only the original author of a medical record entry is authorized to correct or amend an entry, with the exception that a Supervising Physician may correct or amend a medical record entry made by a Resident Physician during training rotation.

Any correction or amendment must be signed, dated, timed, and authenticated by the Physician making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out".

Patient requests for amendment or correction of the medical record shall be handled in accordance with applicable Hospital policy.

5.11 INFORMED CONSENT

The patient's medical record must contain evidence of the patient's written Informed Consent, or documentation of the reason written consent could not be obtained for any procedure and treatment for which it is appropriate. The authorized Informed Consent form must be used. Obtaining Informed Consent is the responsibility of the performing Physician and must be signed and dated by the performing Physician.

5.11(a) Signatures and Procedures

The Informed Consent shall be signed by the patient, or any authorized surrogate decision-maker only after the risks and benefits of the procedure, alternative treatment methods, current health status of the patient, plan of

care, and other information necessary to make a fully informed consent has been explained by the performing Physician.

In those emergencies involving a minor or unconscious patient where consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances is desirable before the emergency operative procedure is undertaken if time permits. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

5.11(b) Contents of Informed Consent

Consent forms must comply with the requirements of applicable state law and shall include, but not be limited to:

(1) The name of the Hospital
(2) The name of the specific procedure for which consent is being given
(3) The name of the responsible Practitioner who is performing the procedure
(4) A statement that the procedure, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative
(5) Laterality, when appropriate
(6) The name of the Practitioner obtaining consent.

5.11(c) Refusal of Consent

All refusals of consent to treatment by the patient, or one legally authorized to consent to treatment on the patient's behalf, must be documented in the patient's medical record.

ARTICLE VI
PATIENT MEDICATIONS AND INVESTIGATIONAL DRUGS / DEVICES

6.1 PATIENT'S OWN MEDICATIONS

Medications brought into the Hospital by patients shall not be administered unless the medications have been identified by the Attending Physician, another responsible Prescribing Practitioner, or a Hospital Pharmacist. There must be a written order from the responsible Practitioner to administer the medications (refer to the Hospital policy titled Administering Patient's Own Medications).

6.2 INVESTIGATIONAL DRUGS

All Investigational Drugs used at Capital Medical Center must have a licensed Institutional Review Board approved protocol and must be pre-approved through the Hospital's Pharmacy and Therapeutics Committee. The Drugs will be stored in the Pharmacy and will only be used under the direct supervision of the Ordering Physician, who is a member of the Medical Staff. It is the Ordering Physician's responsibility to secure an Informed Consent and place it in the patient's chart (refer to the Hospital policy titled Investigational Drugs).

6.3 INVESTIGATIONAL DEVICES

All protocols concerned with the use of investigational devices within the confines of the Hospital must be approved by a licensed Institutional Review Board (IRB). The procedure for approval of use of such devices within the Hospital will be found in the Criteria for New Treatments/Modalities policy.

ARTICLE VII
GENERAL RULES FOR SURGICAL CARE

7.1 PRE-OPERATIVE CLINIC

7.1(a) Patient Scheduling

The Pre-Operative Clinic is available at the Physician's discretion, no less than 24 hours prior to scheduled procedure

7.1(b) Pre-Operative Testing

If multiple testing is to be done, the patient shall be scheduled for such testing three (3) to seven (7) days prior to procedure to enable the surgeon and anesthesiologist to do an adequate pre-operative evaluation, whenever appropriate. All tests done at Capital Medical Center shall be completed no later than 48 hours prior to scheduled procedure. STAT orders for pre-operative tests should be avoided.

7.1(c) Receipt of Outside Testing Reports

Laboratory tests, EKGs, X-rays done by facilities other than Capital Medical Center shall be sent to the Pre-Operative Clinic no less than 48 hours prior to scheduled procedure, whenever possible.

7.1(d) Elective Procedures

All patients scheduled for an elective procedure shall have the following information available in the Pre-Operative Clinic no more than 24 hours prior to procedure:

(1) Admitting orders
(2) Signed and witnessed consent form
(3) Pre-operative prep requirements
(4) Request for special surgical equipment
(5) Relevant diagnostic tests
(6) Discharge orders/instructions (ambulatory only).

7.2 PRE-OPERATIVE HISTORY AND PHYSICAL

A complete History and Physical examination, as described in the Medical Staff Bylaws, shall be in the medical record prior to surgery.

7.3 PODIATRIC SURGERY

7.3(a) Podiatry History and Physical

A Podiatric Surgeon (DPM) may complete a History and Physical on patients provided that the DPM has been privileged to do so and, in the case of a surgical patient, that patient is an ASA Classification I or II.

(1) ASA Classification I or II

All patients considered for podiatric surgery that are deemed ASA Classification I or II may have a History and Physical written by the Podiatrist (DPM), provided that the anesthesiologist concurs with the ASA Classification I or II at the time of the pre-op evaluation.

(2) Other ASA Classification

For all other ASA patient classifications, a qualified CMC Medical Staff primary care Physician must provide the H&P for the patient before the surgery is scheduled.

7.3(b) Podiatric Care

The care of patients admitted for podiatric care is a dual responsibility of the Podiatrist and an MD or DO Physician.

(1) Podiatrist's (D.P.M) Responsibilities

i. A detailed History and Physical
ii. A detailed description of the examination of the feet, and pre-operative diagnosis
iii. A complete operative report describing the findings and techniques
iv. Progress notes
v. The care of the patient's feet
vi. Discharge Summary or summary statement
vii. The DPM must consult with a qualified MD or DO for patients admitted for any reason including observation or pain control, and not exceeding twenty-four (24) hours. If the patient's stay extends beyond twenty-four (24) hours, a qualified MD or DO must assume care of the patient.
viii. The DPM must round on the admitted patient.

(2) Physician's (MD or DO) Responsibilities

i. Medical History and Physical pertinent to the patient's general health to determine the patient's condition prior to anesthesia and surgery
ii. Supervision of the patient's general health status while hospitalized
iii. MD or DO Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.

7.4 DENTISTRY, ORAL, AND MAXILLOFACIAL SURGERY

7.4(a) Oral and Maxillofacial History and Physical

The DDS or DMD will provide a History and Physical exam for oral and maxillofacial surgery patients as it pertains to the oral or maxillofacial surgery. An MD or DO member of the Medical Staff will provide the remainder of the History and Physical prior to the procedure.

7.4(b) Dentistry, Oral, and Maxillofacial Care

The care of patients admitted for dental procedures including oral and maxillofacial surgery is a dual responsibility involving the dentist (DMD), oral surgeon (DDS), and Physician (MD or DO).

(1) DMD or DDS Responsibilities

i. A detailed History and Physical justifying Hospital admission

ii. A detailed description of the examination of the mouth and pre-operative diagnosis
iii. A complete operative report describing the findings and techniques
iv. Progress notes
v. The dentist is solely responsible for the care of the patient's mouth; and
vi. Discharge summary or summary statement.

(2) Physician (MD or DO) Responsibilities

i. Medical History and Physical pertinent to the patient's general health to determine the patient's condition prior to anesthesia and surgery; and
ii. Supervision of the patient's general health status while hospitalized
iii. Physicians are not responsible for any dentistry/oral/maxillofacial care or treatment of the mouth or consequences thereof.

7.5 PRE-OPERATIVE STUDIES

The Pre-Operative Assessment is important to allow for a more complete analysis of the patient condition and for improved patient care to be provided. Generally, the History and Physical will identify most problems and identify studies needed to delineate patient problems in more detail.

7.5(a) Studies Required Pre-Operatively

The History and Physical is the primary study required pre-operatively. Further consultations and studies needed pre-operatively should be based on the History and Physical. In addition, the patient or patient representative will complete a pre-admission questionnaire which seeks to identify diseases of various organ systems which might have a bearing on the conduct or course of surgery and anesthesia.

7.5(b) Acceptance of Previous Studies

Assuming no major changes in patient status, a normal chest x-ray within the last two (2) years; a normal electrocardiogram within six (6) months; and normal blood chemistry within the last 31 days (excluding pregnancy test and glucose measurement in diabetic patients) should be acceptable. The need for repeat of abnormal labs within the above time period should be individualized based on Physician judgment and patient assessment.

7.5(c) Special Situations

(1) Emergency Surgery: Individualized Physician judgment is required to determine whether emergency surgery should precede completion of some or all studies.
(2) Terminal Care: Lab requirements for terminal patients having minor palliative procedures will be individualized with the goal of only performing essential studies. For some cases, no new lab may be an appropriate decision.
(3) Spiritual/Religious Standards: Type & screen is not required if appropriate consent/waiver is obtained.

7.5(d) Records Required Pre-Operatively

Excluding emergencies, prior to any surgical procedure a History and Physical and other appropriate information, including the pre-operative diagnosis and appropriate laboratory tests, must be recorded on the patient's medical record. If not recorded, the operation shall be canceled. In all emergencies, the Practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of surgery.

7.6 ELECTROCARDIOGRAM

When an electrocardiogram (EKG) is required, both the EKG tracing and its interpretation shall be on the chart at the time of surgery. EKG tracings and interpretations from outside the Hospital shall be submitted to the Pre-Operative Clinic at least 48 hours prior to surgery. If the EKG is not read within 24 hours prior to surgery, the EKG will be processed as a STAT EKG per medical policy.

7.7 CONSULTATION

A written report of all medically indicated pre-operative consultations must be in the patient's chart at the time of surgery. If the dictated consultation is not yet available in the chart, pertinent positive findings will be recorded in the patient's chart prior to surgery.

7.8 TISSUE SPECIMENS

All tissues removed from a patient within the Hospital shall be sent to the Pathology Department for analysis by a Medical Staff Pathologist. A gross description of the tissue specimens received will be dictated by a Medical Staff

Pathologist, and appropriate sections taken for microscopic analysis if, in the opinion of the Pathologist, these would be of assistance in providing information which would help immediately or in the future with care of the patient.

The following tissues may be exceptions from the pathology analysis, and their disposal must be documented in the operative note:

(1) Cataract
(2) Orthopedic appliances
(3) Foreign bodies and incidental tissue with no medical/legal significance
(4) Foreign bodies with medical/legal significance which are given directly in claim of custody to a law enforcement officer
(5) Foreskin from newborn circumcision
(6) Grossly normal placenta, removed from operative and non-operative obstetrical patients
(7) Teeth, provided the number is recorded in the operative medical record
(8) Nasal septa
(9) Vaginal mucosa from Anterior-Posterior repair
(10) Bunions and hammertoe specimens
(11) Debridement from trauma
(12) Bone chip fragments
(13) Excised surgical scars
(14) Urinary Stones
(15) Tonsils and Adenoids
(16) Hernia sac
(17) Hydrocele
(18) Tissues removed during body contouring or cosmetic surgical procedures such as abdominal soft tissue from abdominoplasty, lipoaspirate from liposuction, scar tissue from around breast implants, eyelid skin from blepharoplasty, and ear skin from otoplasty
(19) Breast implants when removed from cosmetic surgery patients unless (a) needed for medicolegal purposes or (b) implants have contributed to patient illness or injury

7.9 SURGICAL ASSISTANTS

Second and third assistants at major operations, and first assistants at lesser operations, may be nurses or technicians. The operating surgeon is responsible for obtaining qualified assistants when assistants are required. Hospital staff will assist in obtaining an assistant for after-hours cases only upon direct request of the surgeon.

ARTICLE VIII
ANESTHESIA

Anesthesia services include a range of services, including topical or local anesthesia, minimal sedation, moderate sedation, monitored anesthesia care (including deep sedation), regional anesthesia, and general anesthesia. For purposes of this Article, these services are defined in the same manner as in the Centers for Medicare and Medicaid Services Revised Hospital Anesthesia Services Interpretive Guidelines.

8.1 ANESTHESIA SERVICE AND QUALIFICATIONS

Anesthesia services throughout the hospital shall be organized into one anesthesia service under the direction of a qualified physician. The Medical Staff will establish criteria for the qualifications for the Medical Director of Anesthesia Services in accordance with state law and acceptable standards of practice. Responsibility for the management of anesthesia services for an individual patient lies with the physician or licensed independent practitioner who provided the anesthesia services. Only credentialed and qualified individuals as defined in the policies and procedures of the hospital may provide anesthesia services. The Credentials Committee shall approve credentialing guidelines consistent with federal regulations and Joint Commission standards for individuals providing anesthesia services. Specific privileges to provide anesthesia services shall be granted in accordance with the procedures of the Medical Staff Bylaws and must be approved by the Board of Trustees.

8.2 CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

Certified Registered Nurse Anesthetists (CRNAs) may administer anesthesia services subject to such supervision requirements as appear in these Rules & Regulations and the policies and procedures of the Hospital. CRNAs administering general anesthesia, regional anesthesia, and monitored anesthesia care must be supervised either by the Operating Physician who is performing the procedure, or by an Anesthesiologist who is immediately available. An Anesthesiologist is considered “immediately available” only if he/she is physically located within the same area as the CRNA and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

When supervision of CRNA-administered anesthesia services by a Practitioner other than an Anesthesiologist is required, a doctor of medicine or osteopathy with clinical privileges to perform invasive procedures may supervise the qualified CRNA in the administration of general anesthesia, regional anesthesia, and monitored anesthesia care. Dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law may supervise the qualified CRNA in the administration of regional anesthesia and monitored anesthesia care.

The Anesthetist or Anesthesiologist shall maintain a complete anesthesia services record, the required contents of which shall be set forth in the appropriate policies and procedures of the hospital. For each patient who receives general anesthesia, regional anesthesia, or monitored anesthesia care, this record shall include a pre-anesthesia evaluation, an intra-operative record, and a post-anesthesia evaluation.

8.3 PRE- AND POST- ANESTHESIA EVALUATION

Where required, a pre-anesthesia evaluation must be performed by an individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital. The pre-anesthesia evaluation must be performed within forty-eight (48) hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. In addition, the Anesthetist or Anesthesiologist will reevaluate and document the patient's condition immediately before administering moderate or deep sedation, or anesthesia, as such terms are defined by The Joint Commission. For inpatients, the individual who administered the patient's anesthesia, or another individual credentialed and qualified to provide anesthesia as defined in the policies and procedures of the hospital, must perform a post-anesthesia evaluation of the patient, and document the results of the evaluation within forty-eight (48) hours of the patient's surgery or procedure requiring anesthesia services. For outpatients, the post-anesthesia evaluation must be completed prior to the patient's discharge. In no event shall the post-anesthesia evaluation begin until the patient is sufficiently recovered from the administration of anesthesia to participate in the evaluation.

8.4 INFORMED CONSENT FOR ANESTHESIA

The Anesthetist or Anesthesiologist will be responsible to obtain and document Informed Consent for anesthesia in the medical record. To ascertain the patient's wishes as they relate to the continuance of Advanced Directives, said Advanced Directives and DNR orders will be discussed with the patient by the Anesthetist or Anesthesiologist, or the Attending Physician, prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives. The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary.

ARTICLE IX
ORGAN & TISSUE DONATION

The Attending Physician shall notify the family of each potential organ donor of the potential to donate, or decline to donate, organs, tissues, or eyes. The patient's medical record shall reflect the results of this notification.

The Hospital shall review all inpatient deaths, emergency room deaths and dead-on-arrival cases (term birth to age 75) and refer as appropriate to the designated organ procurement agency and/or tissue and eye donor agency to determine donor suitability and shall comply with all CMS conditions of participation for organ, tissue and eye procurement.

No Physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

ARTICLE X
RECORDS OF MEDICAL STAFF FUNCTIONS

10.1 CONFIDENTIALITY AND MAINTENANCE

All Medical Staff committee minutes, files, and records will be maintained in the Medical Staff Services office or in the Physician Advisor Medical Director of Quality office per the confidentiality standards outlined in the Medical Staff Bylaws. The credentials files will be maintained per Joint Commission, state, and federal regulations; and are to be used to document the Practitioner's training and certifications and for ongoing review of practice and reappointment.

10.2 COMMITTEE DOCUMENTS

Official permanent records of all Medical Staff committee meetings will be maintained by the Medical Staff Services Director or the Physician Advisor Medical Director of Quality. All such records are confidential and will be distributed to Medical Staff and Hospital personnel on a need-to-know basis only and per Hospital policy and Medical Staff bylaws.

10.3 QUALITY ASSURANCE DOCUMENTS

Working documents of all committees involved in quality assurance functions (not limited to the Quality Improvement Council itself) will be maintained in confidential files in the Medical Staff Office and/or the office of the Physician Advisor Medical Director of Quality.

Results of quality assurance reviews which reflect on the professional performance, judgment, and clinical/technical

skills of the members are maintained for review by the Credentials Committee and/or the Medical Executive Committee at the time of reappointment and/or the renewal or revisions of clinical privileges.

ARTICLE XI
MEDICAL STAFF DISASTER PLAN

The Medical Staff members will cooperate with the provisions and requirements of the Emergency Disaster Plan developed by the Hospital and approved by the Medical Executive Committee (see Credentials Manual Article 2.7).

ARTICLE XII
OBSTETRICAL CARE

Obstetrical Privileges may be granted or modified at any time as cited in the Medical Staff Bylaws.

12.1 PRENATAL HISTORY AND PHYSICAL

The following information is considered standard for prenatal histories and should be supplied by the Admitting Physician prior to admission for childbirth:

(1) Last Menstrual Period/Estimated Date of Confinement
(2) Medical History
(3) History of previous pregnancies
(4) Physical Examination with pelvic exam
(5) Lab evaluations. Hgb or HCT, Rubella, ABO, HBSAg, VDRL, UA, diabetes screen, antibody screen; Recommend Pap smear, HIV screening, Chlamydia, GC, and B strep culture.
(6) Flow sheet graphic of progress, including weight, Blood Pressure, fetal heart tones, urinalysis, growth.

12.2 OBSTETRICAL TRANSFER AND DISCHARGE

A Physician's order is required for all intra-facility transfers and discharges.

12.3 CESAREAN SECTION PHYSICIAN TEAM

All high-risk cesarean sections will be performed by a qualified team consisting of a Surgeon, an Assistant, an Anesthesiologist, and a qualified Practitioner in attendance to care for the infant. The Anesthesiologist will not be responsible for care of the infant. Low risk, scheduled, repeat cesarean sections may be attended by a nurse who is qualified to provide newborn resuscitation. The Obstetrician is responsible for providing appropriate assistance.

12.4 OBSTETRICAL PATHOLOGY EVALUATION

Normal placenta from either vaginal or cesarean deliveries will not be submitted for pathologic exam unless requested by the Physician. The placenta and umbilical cord will be referred for pathologic evaluation in the following circumstances:

(1) Maternal diabetes mellitus (excluding diet-controlled gestational diabetes);
(2) Pre-term delivery (<36 weeks)
(3) Unexplained maternal fever
(4) Unusual intrauterine procedure
(5) Stillborn or newborn death
(6) Multiple pregnancy
(7) Intrauterine growth retardation
(8) Ominous fetal heart tracing
(9) Thick meconium
(10) Low Apgar score
(11) Abruptio placenta
(12) Placental infarction
(13) Abnormal cord

12.5 MEDICAL SCREENING FOR LABOR

In the event that an obstetrics patient comes to the Labor and Delivery Unit in suspected labor, Registered Nurses or ARNPs on the Labor and Delivery Unit that have been given specialized training in obstetrical nursing with documented initial and ongoing competency in assessment and treatment of labor and fetal monitoring, per Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN) guidelines, shall be allowed to perform the appropriate medical screening necessary to evaluate patients for suspected labor, and to provide the information to the physician via phone consultation in order to make an appropriate decision.

The Nurse/ARNP must discuss each case with the patient's Physician or the Physician on call (phone consultation is acceptable) before making the determination for labor, and the Physician will determine at that consultation if there is a medical need to appear and examine the patient. The Physician must certify any diagnosis of false labor.

The consultation and evaluation must be recorded in the chart notes by the Nurse/ARNP with date, time, and signature; and verified by date, time, and signature by the consulted Physician within 48 hours.

12.6 OBSTETRICAL CALL

Obstetrical Call policies and procedures will be determined by the Medical Executive Committee and approved by the Board of Trustees in keeping with the Medical Staff Bylaws and the Hospital On Call Policy (Attachment A).

12.6(a) Unassigned Obstetrical Patients

(1) OB/GYN Specialists; and Family Medicine Physicians, Nurse Practitioners, and Certified Nurse Midwives with obstetrical privileges; who are privileged through the Medical Staff Office at CMC will participate in the Call Schedule for unassigned obstetrical/gynecologic patients.

(2) It is the responsibility of the On Call OB/GYN Physician to consult on all emergent cases in the ED or after admission to the hospital, as requested.

12.6(b) Pregnancy-Induced Hypertension and Other High-Risk Conditions

(1) In cases where the patient presents without a primary care Practitioner and has the diagnosis of severe pregnancy-induced hypertension (PIH), or is in active labor with any of the following diagnoses, the OB/GYN Specialist on-call will be contacted first by the LDRP Nursing Staff to evaluate the patient:
   i. Previous C-section
   ii. Breech presentation
   iii. Prematurity (less than or equal to 36 weeks gestation)
   iv. Multiple gestation

(2) Severe PIH is defined as the presence of any one of the following criteria in patient with pregnancy-induced hypertension:
   i. Blood pressure more than 160 mm Hg systolic or more than 110 mm Hg diastolic on two occasions at least 6 hours apart and with the patient at bed rest
   ii. Proteinuria of more than 5 g per 24-hour urine collection or 3+ to 4+ on dipstick
   iii. Oliguria (less than 400 ml in 24 hours)
   iv. Cerebral or visual disturbances (blurred vision, photophobia, persistent occipital headache that does not respond to usual doses of analgesics)
   v. Thrombocytopenia with or without hepatocellular damage or hemolysis
   vi. Epigastric or right upper quadrant pain
   vii. Pulmonary edema or cyanosis

(3) In other cases where the patient presents with a condition which the Primary Care Practitioner determines to be beyond his/her capabilities to manage after having seen the patient, he/she will call the OB/GYN Specialist on call.

ARTICLE XIII
NURSERY/NEWBORN CARE

Nursery/Newborn Privileges may be granted or modified at any time as cited in the Medical Staff Bylaws. Completion of the Newborn Record shall constitute a medical history and physical assessment for newborns.

13.1 NORMAL NEWBORN CARE

(1) All healthy newborns will be examined by a Medical Practitioner with nursery privileges within 24-hours of birth. Subsequent visits will occur daily thereafter until discharge.

(2) Routine newborn orders are entered in the Electronic Medical Record, individually reviewed for each patient, and

amended or added to as necessary. Routine orders should be reviewed and updated yearly.

13.2 NURSERY CALL

(1) Nursery call policies and procedures will be determined by the Medical Executive Committee and approved by the Board of Trustees in keeping with the Medical Staff Bylaws and policies.

(2) The Nursery shall maintain a call schedule of Medical Practitioners privileged in newborn resuscitation to attend high-risk deliveries as required or requested by the Delivering Physician.

(3) Medical Practitioners of the Active Medical Staff with nursery privileges will participate in a rotating schedule to care for all newborn patients at this hospital.

13.3 HIGH-RISK DELIVERY TEAM

(1) All high-risk deliveries, vaginal or cesarean, shall be attended by a Medical Practitioner qualified to perform newborn resuscitation. The sole responsibility of this Practitioner shall be to manage care for the infant.

(2) Low-risk deliveries (such as routine elective cesarean sections) may be attended by a nurse who is qualified to perform newborn resuscitation (unless attendance by a Medical Practitioner is requested by the delivering Physician or family). The sole responsibility of this nurse shall be to care for the infant.

(3) Deliveries complicated by concern for fetal/neonatal compromise will require attendance by a Practitioner qualified for high-risk delivery. Such conditions may include but not be limited to, the following:

i. Severe preeclampsia
ii. Uncontrolled Insulin-dependent mother
iii. Discordant twins
iv. Known congenital anomaly with potential for infant compromise
v. Placental abruption or previa, or antepartum hemorrhage
vi. Vaginal breech
vii. Prolapsed cord
viii. Prolonged bradycardia
ix. Significant maternal hypotension
x. Premature delivery equal to or less than 36 weeks
xi. Abnormal fetal heart rate or rhythm (i.e., paroxysmal atrial tachycardia)
xii. Severe intrauterine growth retardation
xiii. Rh sensitization - zone 2 or greater
xiv. Fetal distress
xv. Fetal hydrops

(4) Conditions requiring immediate notification of the newborn's Attending Practitioner, but not necessarily attendance at birth, shall include the following:

i. Maternal diabetes
ii. Maternal intoxication (alcohol or other substance)
iii. Isoimmunization
iv. Rupture of membranes greater than 24 hours
v. Apgar score less than 5 at 5 minutes
vi. Maternal diagnosis of chorioamnionitis

ARTICLE XIV
MEDICAL ESCALATION PATH / MEC CHAIN OF COMMAND

14.1 Responsibility and Obligation

It is the responsibility and the obligation of the executive team to support staff members to speak up when they witness or have knowledge of actions which could adversely impact patient safety. The individual should convey his/her concern using an assertive stop-the-line CUS communication:

- Concerned: *I am concerned*
- Uncomfortable: *I am uncomfortable (succinctly explain the issue/problem)*
- Safety: *I feel this is a safety issue and we should (propose a solution in a clear and concise manner)*

The Chain of Command/Escalation is an administrative process, which is promoted by the Hospital executive team, and utilized to resolve clinical patient care issues. This ensures that:

- The appropriate people are aware of the situation
- Issues progress from the level closest to the event and move up as the situation warrants

- Further information can be obtained which may result in resolution of the issue, thus contact information of the reporting personnel is essential

Clinical Situations often involve judgment, which at times may differ among caregivers. However, caregivers have a duty to advocate for the patient through the organizational chain of command when they believe that a practitioner is unresponsive to concerns about the patient's condition or is making decisions that would be detrimental to the patient's well-being. Retaliation against anyone who invokes Chain of Command procedures is prohibited.

14.2 Escalation and Chain of Command

The Hospital Chain of Command is as follows:

1. The Charge Nurse or designated lead of the unit/department
2. The House Supervisor
3. The unit/department Manager/Director
4. The Chief Nursing Officer or designated Administrator-On-Call
5. The Hospital President and Chief Medical Officer

14.3 MEC Chain of Command

Medical Executive Committee (MEC) Chain of Command is as follows:

1. Service Line (Emergency, Medicine, Surgery) Chair
2. Chief Medical Officer or Medical Director of Quality
3. Vice Chief of Staff
4. Chief of Staff

The Medical Staff Office will ensure that the current listing of Medical Staff Officers and Department Chairs is available to all hospital employees and contracted staff.

ARTICLE XV
AMENDMENT AND APPROVAL OF RULES & REGULATIONS

These Rules & Regulations shall be developed, adopted, amended, and reviewed in accordance with the procedures outlined in the Medical Staff Bylaws related to development, implementation, amendment, and review of the Rules and Regulations.