ARTICLE I
DEFINITIONS

Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges at Pawnee Valley Community Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as Medical Staff and corporate bylaws documents.

The following definitions shall apply to terms used in these rules and regulations:

(1) "Administrator/Chief Executive Officer" means the individual, or designee, in charge of the operations of the hospital.

(2) "Allied health professional" means a person who is a licensed or certified health professional who is not a physician (M.D. or D.O.) or dentist (D.D.S. or D.M.D.).

(3) "Appointee" means any physician and dentist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

(4) "Board" means the Board of Directors of Pawnee Valley Community Hospital, which has the overall responsibility for the conduct of the hospital.

(5) "Chief Medical Officer" is the Chief Medical Officer of Hays Medical Center who shall serve as a member of the PVCH Board of Directors and medical staff committees, supporting the administrative and clinical functions of PVCH.

(6) "Clinical Privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff appointee or other independent practitioner to render specific patient care services in the hospital within defined limits.

(7) "Clinician" is defined as a licensed or certified patient care provider or diagnostic technician employed by the Hospital

and authorized by licensure/registration/certification and job description to perform assigned duties and responsibilities within a defined scope of practice. Words used in these rules and regulations shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these rules and regulations.

(8) "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").

(9) "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."

(10) "Good standing" means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this hospital and/or at any other health care facility or organization.

(11) "Hospital" means Pawnee Valley Community Hospital.

(12) "Medical Staff" means all physicians and dentists who are given privileges to treat patients at the hospital.

(13) "Physicians" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(14) "Practitioner" means an individual, entitled by training and experience, who may or may not be licensed by the state to practice a profession.

(15) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of a staff appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

(16) "Professional review activity" means a peer review activity of the hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have clinical privileges with respect to his/her appointment; (b) to determine the scope or conditions of those clinical privileges and appointment; and (c) to change or modify such privileges and/or appointment.

(17) "Professional review body" means the Board of the hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

(18) "Provider" means the hospital, healthcare professional, or group of healthcare professionals who provide a service to patients.

(19) "Resident physician" is defined as a physician in training in an accreditation council for graduate medical education (ACGME) accredited, or, American Osteopathic Association (AOA) approved residency program.

(20) "Unassigned patient" means any individual who comes to the hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the hospital.

(21) "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.

ARTICLE II

ADMISSION

Section 1. Who May be Admitted:

The hospital shall accept patients of all types for care and treatment; however, some patients may be transferred or referred to another health care facility if more appropriate care is available elsewhere and/or if the patient or family requests a transfer.

Section 2. Who May Admit Patients:

(a) A patient may be admitted to the hospital only by physicians, dentists, and authorized licensed practitioners who have been appointed to the Medical Staff and who have been granted privileges to admit patients.

(b) Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 3. Admitting Appointee's Responsibilities:

(a) Each patient shall be the responsibility of a designated appointee to the Medical Staff. In the case of a group practice, the appointee who admits the patient shall be considered the responsible, designated Medical Staff appointee. Such appointee shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring appointee and to relatives of the patient.

(b) The admitting appointee shall clearly order the patients admission status. Such orders should reflect one of the following:

(1) "Admit Inpatient"

(2) "Admit Outpatient"

(3) "Admit observation status"

(c) Whenever these responsibilities are transferred to another staff appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record, whereupon the appointee to whom the patient has been transferred shall acknowledge the transfer by initialing the chart and shall be responsible for the care of that patient until the patient is discharged from the hospital.

(d) The responsible practitioner shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

(e) Precautions shall be taken in the care of potentially suicidal and/or abusive patients, and shall include but not be limited to the following:

(1) Any patient known or suspected to be suicidal shall be admitted; or if there are no accommodations available, referred to another institution where suitable facilities are available, following treatment for whatever emergent conditions that may exist.

(2) When transfer is not possible, or if the patient's medical condition makes transfer not feasible, then the patient may be admitted to a general area of the hospital, with constant attendance of an adult family member or a qualified attendant paid for by the family, and psychological/psychiatric consultation. (If appointee feels constant attendance is needed).

(3) Any patient known or suspected to be suicidal must be offered consultation by a qualified member of the medical staff.

Section 4. Care of Unassigned Patients:

Any patient who presents at the hospital who has not been referred by or is not the patient of a specific Medical Staff appointee, and who does not express a desire for the medical services of a particular appointee, shall be assigned as per Emergency Department Rules and Regulations. Nothing in this provision shall interfere with the patient's right to request his or her own physician if such a choice is expressed.

Section 5. Dental Patients:

A patient admitted for dental surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending dentist and a physician appointee.

(a) Dentist's responsibilities shall include:

(1) a detailed dental history justifying hospital admission;

(2) a detailed description of the examination of the oral cavity and pre-operative diagnosis;

(3) a complete operative report, including the name of the primary surgeon and assistants, post operative diagnosis description of the findings and technique used, specimens removed and in cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

(4) progress notes pertinent to the oral condition;

(5) clinical summary or statement including final diagnosis; and

(6) a written discharge order and instructions.

(b) Physician's responsibilities shall include:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to and suitability for anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

Section 6. Podiatric Patients:

A patient admitted for podiatric surgery shall receive the same basic medical appraisal as patients admitted for other services, and shall be the dual responsibility of the attending podiatrist and a physician appointee.

(a) Podiatrist's responsibilities shall include:

(1) a detailed history justifying hospital admission;
(2) a detailed description of the examination of the foot and pre-operative diagnosis;
(3) a complete operative report, including the name of the primary surgeon and assistants, post operative diagnosis description of the findings and technique used. All tissue shall be sent to the pathologist for examination;
(4) pertinent progress notes; and
(5) clinical summary or statement, including a final diagnosis
(6) a written discharge order and instructions.

(b) Physician's responsibilities shall include:

(1) medical history pertinent to the patient's general health;
(2) a physical examination to determine the patient's condition prior to anesthesia and surgery;
(3) supervision of the patient's general health status while hospitalized; and

Section 7. Alternate Coverage:

(a) Each Medical Staff appointee shall provide professional care for his or her patients in the hospital by being available or having available an alternate Medical Staff appointee who has clinical privileges at the hospital sufficient to care for the patient, and with

whom prior arrangements have been made. Failure to meet the requirements concerning availability may result in loss of clinical privileges.

(b) An attending appointee who will be out of town for twenty four (24) hours shall indicate in writing on the order sheet of the chart of each patient, the name of the alternate appointee who will be assuming responsibility for the care of the patient during the attending appointee's absence.

(c) When a staff appointee who is part of a group practice is unavailable, coverage shall be indicated by the group's call schedule.

Section 8. Transfer of Patients:

(a) Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or the attending appointee, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

(b) If the patient is to be transferred to another health care facility, the responsible appointee shall enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

(c) Refer to the ED Rules and Regulations/EMTALA Policy for EMTALA transfers.

Section 9. Priorities for Admission:

(a) The admitting office shall admit patients on the basis of the following order of priorities:

(1) **Emergency Admissions** - includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger.

(2) **Urgent Admissions** - includes non-emergency patients whose admission is considered imperative by the attending appointee. Urgent admissions shall be given priority when beds become available over all other categories except emergency.

(3) **Pre-Operative Admissions** - includes patients already scheduled for surgery or medical care. If it is not possible to accommodate such admissions, then the hospital high census plan will be followed.

(4) **Routine Admissions** - includes elective admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the hospital's high census plan.

(b) All admissions will be reviewed according to the Utilization Review plan. Evidence of willful or continued misuse of admissions shall be brought to the attention of the Executive Committee for appropriate action.

(c) Before admitting a patient, the attending appointee or a designee shall contact the admitting office to ascertain whether there is an available bed. If there is any question or conflict concerning the admission of a patient, the Chairperson of the Utilization Management Committee or a designee shall determine the necessity and/or appropriateness of the admission.

(d) Each patient admitted to a specific service shall be admitted to the area(s) of the hospital previously designated as reserved for patients in that service, unless that area is filled to capacity, in which case the nursing supervisor and/or the pre-admissions office may place patients in other areas deemed appropriate.

Section 10. Transfer Priorities:

Transfer priorities shall be as follows:

(a) from Emergency Department to an appropriate patient care area;
(b) from general care area to special care unit;
(c) from special care unit to general care area;
(d) from psychiatric unit to general care area; and
(e) from temporary placement in a non-clinical area to an appropriate clinical service area sufficient to meet the patient's medical needs.

Section 11. Emergency Admissions:

(a) The history and physical examination must clearly justify an emergency admission and must be recorded on the patient's chart within twenty-four (24) hours after admission. In the case of a psychiatric admission, the initial work-up shall also include a mental status examination and proposed treatment plan.
(b) Emergency admission patients who do not have a personal physician with admitting privileges shall be assigned per Emergency Department Rules and Regulations.
(c) Failure of the assigned appointee to respond to an emergency call may result in a professional review action, unless that appointee presents, in writing, to the Chief of Staff and the Chief Executive Officer, an acceptable reason for not attending the patient. An unexcused failure to respond to an emergency call shall be reported immediately to the Chief of Staff.

Section 12. Continued Hospitalization:

(a) The attending appointee shall be required to routinely document the need for continued hospitalization. The attending appointee's documentation must contain:

(1) an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) plans for post-hospital care.

(b) Any patient remaining in the hospital for more than 30 days must have the stay reviewed and approved by the chairperson of the UR Committee or designee.

(c) If it has been determined that the patient's continued hospitalization is inappropriate but the attending appointee refuses to discharge the patient, both the patient and the attending appointee shall be notified immediately and in writing by a designee of the UR Committee.

Section 13. Restraints:

1. A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Chemical restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

2. Restraint is used upon an individual order from a physician, APRN, or PA to ensure clinical justification of restraint use and identifying rationale for any variation in monitoring the patient and for release from restraint before the order expires. A Registered Nurse may initiate Violent/Self Destructive Behavior

restraint based on an appropriate assessment, in advance of a physician, APRN, or PA order in an emergency.

(a) Each order and renewal order shall be documented in the medical record using the restraint physician orders template.

(b) The order shall include the reason the restraint is required, the type of restraint to be used, and the beginning and ending time that the restraint is to be used.

3. Written orders for restraint are limited to:

(a) 24 hours for all patients in Non-Violent/Non-Self Destructive Behavior restraints;

(b) 4 hours for patients 18 years of age and older in Violent/Self Destructive Behavior restraint;

(c) 2 hours for patients 9 to 17 years of age in Violent/Self Destructive Behavior restraint; or

(d) 1 hour for patients 8 years of age or younger in Violent, Self-Destructive Behavior restraint.

4. The physician, APRN, or PA shall perform a face-to-face assessment of the patient in Non-Violent/Non-Self Destructive Behavior restraint within 24 hours of the initiation of the restraint, at which time the physician shall discontinue or write an order to continue restraint, and document the assessment in progress notes. The physician, APRN, or PA shall perform face-to-face assessments at least once every calendar day thereafter, at which time restraint shall be discontinued or re-ordered as indicated and the assessments documented..

5. The physician, APRN, or PA shall perform a face-to-face assessment of the patient's in Violent/Self Destructive Behavior restraint within one (1) hour of the initiation of restraint, even if restraint has been discontinued within the one (1) hour.

(a) If the physician, APRN, or PA is unavailable, the Registered Nurse shall obtain an order for Emergency Department physician consult for the use of restraint, and the Emergency Department

physician will do the initial one hour face-to-face assessment, if available.

(b) Documentation in the progress notes shall include the following:

- The patient's immediate situation;
- The patient's reaction to the intervention;
- The patient's medical and behavioral condition;
- The need to continue or terminate the restraint;

(c) The patient in Violent/Self Destructive Behavior restraint will be re-assessed by the physician, APRN, PA, or Registered Nurse, as follows:

- Every 1 hour or less for patients 8 years of age or younger;
- Every 2 hours for patients from nine to 17 years of age; or
- Every 4 hours for patients 18 years of age and older.

(d) Reassessments by the physician, APRN or PA shall be documented in progress notes.

(e) At the time of the reassessment, the physician, APRN, or PA will write a new time limited order if the restraint is going to be continued.

(f) If the Registered Nurse is performing the reassessment, the physician, APRN, or PA shall be contacted to assist the patient and Registered Nurse to identify ways in which the patients may gain control, revise the patient's treatment plan, as needed, and renew the order for restraint, as necessary.

6. Section 14, points 2 through 5 do not apply when:

(a) the restraint is used only when associated medical, dental, diagnostic, or surgical procedures and the related post-procedure care process;

(b) a restraint is used to meet the assessed needs of a patient who requires adaptive support.

(c) restraints used to protect the patient from falling out of bed which are removed at the patient's request;

(d) other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests;

(e) protective helmets;

(f) forensic and correction restrictions are used for security reasons; and,

(g) age or developmentally appropriate safety protective interventions used outside the healthcare setting to protect an infant, toddler, or preschool aged child.

7. The Registered Nurse responsible for the patient's nursing care may release the restraint when the patient's assessed behavior justifying the use of restraint no longer exists. If the same behavior reappears a new order for restraint is required.
8. The use of PRN restraint orders, whether for Non-Violent/Non-Self Destructive Behavior restraint or Violent/Self Destructive Behavior restraint, is not allowed.
9. Patients with Non-Violent/Non-Self Destructive Behavior restraints will be assessed by nursing every 1 hour and the assessment will be documented. Patients with Violent/Self Destructive Behavior restraints will be assessed by nursing every 15 minutes, and the assessment will be documented.

ARTICLE III

MEDICAL ORDERS

Section 1. General Requirements:

(a) Orders must be written clearly, legibly and completely. Orders which are illegible or improperly written shall not be carried out until they are clarified by the ordering appointee and are understood by the nurse or Clinician. (In some cases this may also be a therapist, etc.)

(b) The process for ordering home medications upon admission, resuming/continuing medications for patients who are post-op, transferred from other units, etc., is incorporated herein and referred to as **Appendix D**, Medication Reconciliation.

(c) All previous orders shall be canceled when patients go to surgery or are transferred in or out of a critical care area.

(d) Orders for "daily" tests shall state the number of days and shall be reviewed by the attending physician at the end of the expiration of said days unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format that it was originally recorded if it is to be continued.

(e) Orders for all medications and treatments for all patients shall be under the supervision of the attending appointee and shall be reviewed by the attending appointee in a timely manner to assure discontinuance when no longer needed.

(f) All orders must be completely reviewed when a patient is transferred from one service to another, as per the Medical Staff Policy on Medication Reconciliation, **Appendix D.**

(g) When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten. There will be automatic stop orders placed on all

medications unless another specific time limit is designated by the attending appointee.

(h) Medication Stop Orders Notice will be placed in patient charts for all medications in compliance with pharmacy regulatory requirements. A follow-up notice will again be placed in patient charts 24 hours before discontinuation.

(i) Only those abbreviations, signs and symbols authorized by the hospital shall be used in the medical record. It is encouraged abbreviations not be used when ordering medications or their strengths. However, no abbreviations, signs or symbols shall be used in recording the patient's final diagnosis or any unusual complications.

(j) The use of the summary (blanket) orders (e.g., "renew", "repeat", "resume", and "continue") to resume previous medication orders it <u>not</u> acceptable.

<u>Section 2. Who May Write Orders</u>:

(a) Medical Staff appointees and specifically designated Allied Health professionals shall have the authority to write orders only as permitted by their licenses and clinical privileges or by their scope of practice.

(b) All orders must be entered in the patient's record, dated, timed, and promptly signed by the ordering appointee.

(c) Resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the Medical Staff appointee responsible for the patient's care. Orders written by residents must be countersigned by the medical staff appointee responsible for the patient's care.

<u>Section 3. Verbal Orders</u>:

(a) A verbal order (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is

impractical for such order to be given in writing by the responsible appointee.

(b) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the medical record of the patient.

(c) A verbal order shall include the date, time, contain both frequency and duration as applicable and full signature of the person to whom the verbal order has been given. The ordering practitioner must date and time the order when he or she signs the order and must sign a verbal order as soon as possible, which is the earlier of the following: (i) the next time the prescribing practitioner provides care to the patient, assesses the patient, or documents information in the patient's medical record, or (ii) within seventy-two (72) hours of the patient's discharge or thirty (30) days, whichever occurs first. Verbal orders shall only be permitted for those diagnostic and therapeutic procedures/treatments specifically predefined by the Executive Committee after consultation with each clinical department chairperson. For verbal orders, the complete order shall be verified by having the person receiving the information record and "read-back" the complete order.

(d) Acceptance of a verbal order is limited to the following, with noted restrictions:

(1) a physician, physician assistant, APRN, dentist or podiatrist with clinical privileges at this hospital;

(2) a licensed registered nurse, LPN, or CRNA;

(3) a pharmacist who may transcribe a verbal order pertaining to drugs;

(4) a respiratory therapist, physical therapist, occupational therapist, speech therapist, who may transcribe a verbal order pertaining to appropriate therapeutic treatments;

(5) an imaging technician who may transcribe a verbal order pertaining to imaging tests and/or therapy treatments;
(6) a radiation therapist, medical physicist, or medical dosimetrist who may transcribe a verbal order pertaining to radiation therapy treatments.
(7) a dietitian who may transcribe a verbal order pertaining to a patient's diet;
(8) sleep and electroneurodiagnostic technologists who may transcribe a verbal order pertaining to their diagnostic service;
(9) laboratory personnel, including phlebotomists, as it relates to a laboratory test;
(10) social service personnel as it relates to social service;
(11) perfusionist personnel as it relates to perfusion services;
(12) licensed mental health professionals may transcribe a verbal order as it relates to mental health.

Section 4. Orders for Specific Procedures:

(a) All requests for radiological or other special examinations and services shall contain a documented pertinent clinical statement of signs, symptoms, or diagnosis indicating the reason for the examination. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series. This rule does not apply to orders written for patients in special care units.

(b) All orders for therapy and therapeutic diets shall be entered in the patient's record, dated and timed, and signed or countersigned by the ordering practitioner.

(c) All "NO CODE" orders shall be written physician orders pursuant to hospital Policy on Do Not Resuscitate (DNR) orders.

Section 5. Standing Orders, Order Sets and Clinical Protocols:

(a) For all order sets and clinical protocols, review and approval of the Medical Executive Committee, with input from nursing and the Hospital's pharmacy department. When appropriate, is required. Prior to approval, the Executive Committee shall confirm that the order set or clinical protocol is consistent with nationally recognized and evidence-based guidelines. The Executive Committee shall also take necessary steps to ensure that there is periodic and regular review of such order set and clinical protocols. All clinical protocols shall identify clinical scenarios for when the protocol is to be used.

(b) If the use of a standing order, order set or written protocol has been approved by the Executive Committee, the order or protocol shall be initiated for a patient only by an order from a practitioner responsible for or involved in the patient's care in the Hospital and acting within his or her scope of practice. Orders initialed by a practitioner responsible for the patient's care in the Hospital and acting within his or her scope of practice.

(c) When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

(d) Standing orders for clinically appropriate blood tests will be reviewed by the Medical Staff annually.

ARTICLE IV

MEDICAL RECORDS

Section 1. General Rules:

(a) A medical record shall be initiated and maintained for each patient who is evaluated or treated. The attending appointee shall be responsible for the preparation of a complete and legible medical record for each patient under his or her care. This responsibility cannot be delegated.

(b) The contents of the record shall be pertinent and current. It shall contain information sufficient to identify the patients, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care. A single attending appointee shall be identified in the medical record as being responsible for the patient at any given time.

(c) Only those abbreviations, signs and symbols authorized by the Executive Committee shall be used in the medical record. No abbreviations, signs or symbols shall be used to record a patient's final diagnoses or any unusual complications. An official record of approved abbreviations shall be kept on file in the hospital's Administrative policy and procedure manual and shall be available at each nursing station.

(d) An appointee's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and shall be dated, timed, and signed by the attending appointee.

(e) The following requirements shall be enforced by all clinical department chairpersons and chiefs:

(1) Histories and physicals may be completed by a physician or oral and maxillofacial surgeon who is a member of the medical staff and shall be completed and documented in the medical record no more than thirty (30) days before or

twenty-four (24) hours after an admission or registration, and prior to any high-risk procedure, surgery, procedure requiring anesthesia services, or other procedures requiring an H&P, and placed in the patient's medical record within 24 hours after admission.

(a) This time frame applies to weekend, holiday, and weekday admissions. The medical staff shall determine those non-inpatient services for which a patient must have a medical history taken and appropriate physical examination performed.

(b) A list of such determination will be kept in the Policy and Procedure repository and notification shall be given to the Medical Staff via postings in the physicians' lounge and one mailing to their offices.

(c) Histories and physicals may be performed by residents, PA's, and APRN's.

(d) Qualified oral and maxillofacial surgeons may perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure.

(e) Other licensed independent practitioners who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination, if granted such privileges.

(f) The findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified physician prior to major high-risk diagnostic or therapeutic interventions (high risk is defined by the Medical Staff).

(g) Dentists are responsible for the part of their patient's history and physical examination as it relates to Dentistry.

(h) Podiatrists are responsible for the part of their patient's history and physical examination as it relates to Podiatry.

(2) All consultations shall contain the date of the consultation and shall be documented in accordance with Article V, Section 7 of these rules and regulations.

(3) Progress notes shall be written at least daily on critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem. Progress notes for all other patients must be written as frequently as indicated by the patient's clinical condition, but at least every two days.

(4) All operations performed shall be fully described by the operating surgeon who shall record information immediately after the procedure consistent with that required in Section 6 of this Article.

(5) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, and the complete protocol shall be made part of the record within thirty (30) days, unless exceptions for special studies are authorized by the Executive Committee.

Section 2. Authentication:

Each and every medical record report and entry relating to services ordered, provided or evaluated by a Medical Staff appointee shall be authenticated, timed, and dated promptly by that appointee. A single signature on the face sheet of a record shall not be sufficient to authenticate the entire record. The appointee's authentication of a report

or entry shall indicate that he/she has verified the information contained therein and that the information is accurate. Authentication may be accomplished by the appointee's handwritten signature or computer key. If an appointee utilized a computer key to authenticate medical record reports and entries, the appointee must file an appropriate declaration in the office of the Chief Executive Officer of the hospital concerning restrictions on the use of such computer key. Failure to comply with the terms of such declaration shall subject a Medical Staff appointee to corrective action pursuant to the Policy on Medical Staff Appointment, Reappointment, and Clinical Privileges.

Section 3. Contents:

(a) A complete medical record shall include:

(1) the patient's name, address, date of birth, and the name of any legally authorized representative;

(2) the legal status of patients receiving mental health services;

(3) emergency care provided to the patient prior to arrival, if any;

(4) the record and findings of the patient's assessment;

(5) conclusions or impressions drawn from the medical history and physical examination;

(6) the diagnosis or diagnostic impression;

(7) the reasons for admission or treatment;

(8) the goals of treatment and the treatment plan;

(9) evidence of known advance directives;

(10) evidence of informed consent, when required by hospital policy;

(11) diagnostic and therapeutic orders, if any;

(12) all diagnostic and therapeutic procedures and test results;

(13) all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;

(14) progress notes made by the medical staff and other authorized individuals;

(15) all reassessments and any revisions of the treatment plan;

(16) clinical observations;

(17) the patient's response to care;

(18) consultation reports;

(19) every medication ordered or prescribed for an inpatient;

(20) every medication dispensed to an ambulatory patient or an inpatient on discharge;

(21) every dose of medication administered and any adverse drug reaction;

(22) all relevant diagnoses established during the course of care;

(23) any referrals and communications made to external or internal care providers and to community agencies;

(24) conclusions at termination of hospitalization;

(25) discharge instructions to the patient and family; and

(26) clinical resumes and discharge summaries, or a final progress note or transfer summary and necropsy reports when applicable

(b) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Forms Committee. All new forms proposed for use in the medical record shall be submitted to the Forms Committee for review. The Forms Committee shall approve (or

reject) all forms recommended for inclusion in the medical record. Approved changes shall not be made until the mechanics of standardization have been accomplished. Any disputes regarding forms may be referred to the Executive Committee for final consideration.

(c) The medical record should be maintained intact at all times. Once information has been filed in the record, it should not be removed for any reason.

***History and Physical – Refer to Medical Staff Bylaws – Art. VI**

Section 4. Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the hospital. Progress notes can be written by Medical Staff appointees and allied health professionals as permitted by their clinical privileges or scope of practice, and shall be legible, document the date and time of observation, and contain sufficient information to insure continuity of care at this hospital or other health care facility to which the patient might later be transferred. Where 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 treatments. Pertinent progress notes may also be made by residents. Progress Notes written by residents, PA's, and APRN's must be signed by the responsible appointee.

(b) Progress notes shall be written at least daily on critically ill patients, and on those where there is difficulty in diagnosis or management of the clinical problem. The frequency of recording progress notes shall be contingent on and consistent with the condition of the patient and the severity of the patient's illness, but in no case less frequent than every two (2) days.

(c) Progress note documentation shall include, but need not be limited to the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(2) any complications, new symptoms working diagnosis, or additional diagnoses for which the patient is to be evaluated or treated;

(3) plans for additional work-ups, consultations, or definitive treatment(s); and

(4) discharge planning.

(d) a simple reconfirmation of the patient's diagnosis is not sufficient

Section 5. Surgical Records:

(a) Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery, or the operation shall be canceled by the Chief Nursing Officer, after notifying the attending surgeon:

(1) verification of patient identity;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(4) provisional diagnosis;

(5) laboratory test results;

(6) consultation reports;

(7) consent form signed by the surgeon and the patient or the patient's legal representative, and an anesthesia consent form signed by the patient or the patient's legal representative and the attending anesthesiologist;

(8) x-ray reports, if applicable; and

(9) other ancillary reports, if applicable.

(b) Except in the case of an emergency, the patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received.

(c) In an emergency situation, the attending surgeon shall write at least a short but comprehensive note describing the patient's condition prior to the induction of anesthesia and the start of surgery. If the history and physical has been transcribed but not yet entered in the chart, an admission note and statement to that effect may be entered in the chart by the attending appointee.

Section 6. Operative Reports:

(a) A brief operative report shall be in the medical record immediately after surgery and shall contain:

(1) a description of the surgery, including its dates and times;
(2) the technical procedures used;
(3) the preoperative and postoperative diagnosis;
(4) any complications encountered;
(5) the names of the primary surgeon and any and all assistants;
(6) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;
(7) specimens removed, as appropriate;
(8) fluids, blood and blood components, as appropriate;
(9) estimated blood loss, as appropriate.
(10) prosthetic devices, graft, tissues, transplants, or devices implanted, if any; and

(11) description of specific significant surgical techniques that were conducted by practitioners other than the primary surgeon, if applicable.

(b) A detailed operative report shall be dictated within twenty-four (24) hours following surgery. The report shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and post-operative diagnosis.

Section 7. Anesthesia Note:

(a) A separate pre-anesthesia and post-anesthesia evaluation shall be documented in the medical record of all patients undergoing surgery and shall specifically include, but not be limited to, information relative to the choice of anesthesia for the procedure anticipated, any unusual risk possibilities or potential anesthetic problems, ASA rating, medical history, physical and necessary laboratory data pertaining to the anesthesia and the procedure to be performed and, where relevant, previous drug history and other anesthetic experiences. This evaluation shall be read by the individual administering the anesthesia prior to induction, such review shall be performed within 48 hours prior to surgery or a procedure requiring anesthesia services and documented in the patient's record. At least one post-anesthesia note shall describe the presence or absence of anesthesia-related complications. With respect to inpatients, a post-anesthesia evaluation must be completed and documented within 48 hours after surgery.

(b) The individual responsible for the anesthesia shall maintain a complete written anesthetic record for each patient and procedure performed.

(c) For more details, please see Appendix A – Operating Room Procedure, Section 4 – Anesthesia Rules and Records.

Section 8. Pathology Reports and Disposition of Surgical Specimens:

(a) All specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnosis.

(b) The pathologist shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within twenty-four (24) hours of completion, if possible.

(c) Foreign bodies and objects may be referred to the hospital pathologist at the option of the attending surgeon.

(d) The disposition of surgical specimens, whether discarded or submitted to pathology, shall be recorded in the operative record.

Section 9. Obstetrical Records:

The medical record requirements for obstetrical care shall include a complete prenatal record. The prenatal record may be a legible copy of the attending appointee's office record transferred to the hospital before admission, but an interval admission note that includes pertinent additions to the history and a current comprehensive physical exam must be documented in the record. A current history and physical examination must be recorded prior to any Cesarean Section.

Section 10. Special Requirements for Medical Records of Cancer Patients:

In all instances of the initial diagnosis of cancer, treatment plan, clinical and pathological staging shall be assigned at the time of diagnosis by the

appropriate physician. When appropriate, the AJCC (American Joint Committee on Cancer) method of staging shall be preferred.

Section 11. Medical Information To and From Other Hospitals or Health Care Facilities:

If a patient or physician requests that the patient's medical record information be transmitted to another hospital or other health care provider for purposes of treating the patient, the medical records department or clinic office staff shall transmit information to other hospitals or health care providers. Similarly, the medical records department or clinic office staff may request information for purposes of treating a patient, with or without written authorization of the patient, from other hospitals or health care facilities concerning the patient. Information received in response to said request shall be considered part of the patient's medical record at this hospital. Information requested and received for clinic records may become part of a patient's clinic record.

Section 12. Discharge Summaries:

(a) A clinical discharge summary shall be included in the medical records of all patients except those with minor problems who require less than a forty-eight (48) hour period of hospitalization, normal newborn infants, and uncomplicated obstetrical deliveries. A final progress note, which should include any instructions given to the patient or the patient's representative, may be substituted for the discharge summary of these patients.

(b) The discharge summary shall include:

(1) the reason for hospitalization or treatment;

(2) the significant findings;

(3) any complications;

(4) the procedures performed and treatment rendered;

(5) the final diagnosis, including relevant secondary diagnosis

(6) the condition of the patient on discharge; and

(7) any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care.

(8) discharge medication reconciliation.

(c) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

(d) When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate.

(e) The clinical discharge summary shall be completed within 48 hours post discharge of the patient.

Section 13. Delinquent Medical Records.

(a) A practitioner shall complete his/her records within 7 days after availability, and shall not exceed 30 days post discharge. Medical Records not completed timely will be monitored and reported to the Executive Chair, or designee. Physicians not in compliance will voluntarily relinquish their clinical privileges.

(b) History and Physical reports not documented within 24 hours of admission and operative reports not dictated within 24 hours of surgery shall be monitored and reported to the Executive Committee Chair or designee. Physicians not in compliance will voluntarily relinquish their clinical privileges.

(c) Relinquishment of privileges for failure to complete records more than three (3) times in any trailing 12-month period shall constitute a voluntarily relinquishment of all clinical privileges and a resignation from the Medical Staff. The practitioner may reapply.

Section 14. Possession, Access, Release and Retention:

(a) All medical records are the physical property of the hospital and shall not be taken from the confines of the hospital. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending appointee. Unauthorized removal of a medical record from the hospital by an appointee shall constitute grounds for a professional review action.

(b) No patient record shall be removed from the Health Information Management Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, appropriate review committee meetings, and/or as needed by the Chief Executive Officer or a designee.

(c) Upon written approval of the Chief Executive Officer, access to the medical records of all patients shall be afforded to Medical Staff appointees in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

(d) Subject to the discretion of the Chief Executive Officer, former Medical Staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Any publication of compiled data from the hospital's patient medical records is forbidden without written approval of the Chief Executive Officer.

(e) Written consent of the patient is required for release of medical information to those not otherwise authorized to receive information.

(f) It is the responsibility of Nurse Managers to assure any record taken out of the Health Information Management Department for the purpose of patient readmission shall be returned to the Health Information Management Department with the current record upon discharge of the patient.

(g) consistent with Hospital policy, the Hospital shall retain medical record in their originally or legally reproduced form for a period of at least ten (10) years after the date of last discharge of the patient, or one (1) year beyond the date that the minor patient reached the age of majority, whichever is longer.

Section 15. Filing of Medical Record:

A medical record shall not be permanently filed until it is completed by the attending appointee or is ordered filed by the Utilization Management Committee. Records with particularly sensitive information may be ordered sealed by the Hospital Risk Manager, his/her designee, or by the Director of the Health Information Management department. Psychiatric, drug and alcohol treatment, and HIV records shall be filed as part of the unit record, however, shall require specific patient authorization from the patient or legal guardian to release. The Health Information Management Department policy shall be followed for release of any Hospital patient health record information.

Section 16. Electronic Medical Record:

Hospital utilizes an electronic medical record system known as (hereinafter "EMR"). As such, Medical Staff and Allied Health Professional Staff Members ("Practitioners") must adhere to record keeping practices that support the electronic environment. Practitioners must utilize the EMR. Data will be created electronically; and only when

necessary, paper-based documentation will be timely scanned into the EMR. Records will be accessed by Practitioners and other users online, and the records will not be printed for internal use during inpatient stays. Access to patient information will be made available to Practitioners and their staff through secure online access. All access to the EMR will be tracked, and unauthorized access to the EMR will not be tolerated and could lead to disciplinary action.

(a) Electronic Medical Record Acknowledgement – A signed Declaration acknowledging that Applicant successfully completed Electronic Medical Record (EMR) training must be on file in the Medical Staff Office prior to exercising of clinical privileges at Hospital.

(b) Access - Access to the EMR by Practitioners, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, approved research, healthcare operations or other authorized activity. This requirement applies regardless of the form in which confidential medical records are maintained or stored and applies equally to information stored in hard copy form or electronically stored.

(c) Retention - The EMR is maintained and retained in accordance with state and federal laws, accreditation standards, regulatory guidelines and Hospital Policies.

(d) Confidentiality and Security of Medical Records - Medical records are the property of Hospital. The Pawnee Valley Community Hospital releases the information contained in the EMR only on proper written authorization, or as otherwise authorized by law and Hospital Policies. In addition, Hospital safeguards the EMR

against unauthorized disclosure and/or use, loss, defacement and tampering.

(e) Electronic Signature - Electronic signature authentication of medical records will be the standard practice. In order to maintain the integrity of the EMR as a legal document and assure that electronic signatures and/or computer generated signature codes are secure from unauthorized persons, all Practitioners must have on file with Hospital a signed statement that he/she is the only individual using and in possession of the confidential password. Each transcribed report will be individually authenticated by the responsible Practitioner. When multiple authors contribute to the same note electronically, the original author will complete his/her documentation and sign the entry prior to forwarding to the next author for addendum and co-signature.

(f) Mode of Entry – Records created after the patient is admitted shall preferentially be created utilizing Hospital systems, either through online entry or dictation to allow for patient information to be timely exchanged and shared electronically among caregivers. Hospital will accept prenatal information and History & Physicals from a physician office or from a previous admission provided the records meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations. All other records (including but not limited to: operative reports, consultations, discharge summaries, radiological images and reports, and progress notes) will be completed utilizing Hospital approved formats.

ARTICLE V
CONSULTATIONS

Section 1. General:

(a) The attending appointee shall be responsible for requesting consultation when indicated and for calling in a qualified consultant. Consultations may be performed by residents, PA's, and APRN's. Consultations by residents must be countersigned by the responsible appointee and will be considered pending until countersigned by the responsible appointee.

(b) Requests for a consultation shall be entered on an appropriate form in the patient's medical record. If the history and physical are not part of the patient's medical record it shall be the responsibility of the appointee requesting the consultation to provide this information to the consultant.

(c) If a provider responsible for a patient's care and employed by the hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that provider shall notify the appropriate appointee. If the issue is still unresolved, the professional provider will notify the Chief of Staff. If the issue is still unresolved the supervisor will notify the Chief of Staff or Chief Medical Officer for the clinical condition in question. Thereafter, the Chief of Staff or the Chief Medical Officer may request a consultation after discussion with the attending appointee.

(d) It is the duty of the Chief of Staff and the Chief Medical Officer to make certain that Medical Staff appointees request consultations when needed.

Section 2. Who May Give Consultations:

Any Medical Staff appointee or appropriate Allied Health Professional with clinical privileges or who has been given permission by the hospital

can be asked for a consultation within his or her area of expertise. Individuals who are requested to provide consultation are expected to respond in a reasonable period of time and appropriate manner. Consultation by appointees or other practitioners associated in the same office should be avoided insofar as possible. In circumstances of grave urgency or where consultation is required by these rules and regulations or imposed by the Executive Committee, the Board, the Chief Executive Officer, or the Chief of Staff shall at all times have the right to call in a consultant or consultants.

An Allied Health Professional with appropriate clinical privileges to see the patient, gather data, and/or order tests, such evaluation by an Allied Health Professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the Allied Health Professional is sufficient, and the Allied Health Professional reports and discusses the consultation with the consulting physician.

Section 3. Recommended Consultations:

(a) Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient's legal representative if the patient is incompetent.

(b) Consultations are required in all cases which, in the judgment of the attending appointee:

(1) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(2) there is doubt as to the best therapeutic measures to be used;

(3) unusually complicated situations are present that may require specific skills of other practitioners; or

(4) the patient exhibits severe symptoms of mental illness or psychosis.

Additional requirements for consultation may be established as recommended by the Executive Committee and approved by the Chief Executive Officer.

Section 4. Psychiatric Consultations:

Psychiatric evaluation and medical treatment by appropriate medical staff shall be requested for and offered to all patients who present self-destructive behavior, i.e., attempted suicide/ and or homicidal, chemical overdose, etc. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

Section 5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested for pre-op clearance, the practitioner requesting the consultation is ultimately responsible for ascertaining that an adequate notation of the consultation, including relevant findings and recommendations, appears in the patient's medical record in some readily retrievable form. Elective surgical procedures shall not proceed if the report is unavailable. When a surgical procedure is required urgently and the consultant's report is not readily available, it is the responsibility of the practitioner requesting the consultation to make the anesthesiologist and operating surgeon aware of the report status. Urgent surgical procedures may be allowed to proceed if in the judgment of the operating surgeon and anesthesiologist that a delay in surgery would not be in the patient's best interests.

Section 6. Mandatory Consultations:

(a) When a consultation requirement is imposed by the Executive Committee, pursuant to the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges, or by the Board, the

required consultation shall not be rendered by an provider or partner of the affected appointee.

(b) Failure to obtain required consultations may constitute grounds for a professional review action pursuant to the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges.

Section 7. Contents of Consultation Report:

(a) Each consultation report shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur" shall not constitute an acceptable consultation report. The consultation report shall be made on the progress notes in the medical record and shall be signed by the responsible appointee.

(b) Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the operation. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

ARTICLE VI

INFORMED CONSENT

Section 1. Responsibility for Obtaining Informed Consent:

(a) Patient consent (as distinguished from informed consent) is required for all medical treatments and procedures, and is obtained when the patient, and when appropriate, family and/or patient's representative signs the hospital's Conditions of Admission form at the time of admission. The admitting office shall notify the patient's provider whenever such consent has not been obtained.

(b) The patient's informed consent (as distinguished from consent) is not required for all medical treatments or procedures. It is required for a treatment or procedure that is not simple, commonly understood, or poses some risk to the patient. It is the responsibility of the provider to determine whether a treatment or procedure requires informed consent. With informed consent, the patient, and when appropriate, family and/or patient representative is provided with the information necessary to make an informed decision whether or not to undergo a recommended surgical, medical or diagnostic treatment or procedure.

It will be the responsibility of the provider to fully disclose/inform:

1. the diagnosis or suspected diagnosis;
2. nature and purpose of the treatment or procedure;
3. the name of the person performing the treatment or procedure;
4. the possible risks and side effects of the treatment or procedure;
5. the benefits and probability of success under the patient's particular circumstances;
6. any reasonable alternatives to the treatment or procedure and their risks and benefits;

7. the right to not consent to the treatment or procedure;
8. possible consequences if the provider's advice is not followed;

After hospital admission, it shall be the responsibility of the provider to obtain consent from the patient in the following circumstances:

(1) The provider performing the surgical procedure shall obtain the patient's informed consent to any surgical procedure to be undertaken, including ambulatory surgery. Surgical consent shall be considered valid for a period of thirty (30) days after the date of the signatures. If a significant change occurs in the patient's condition within those thirty (30) days, a new informed consent should be obtained.

(2) the provider performing a non-surgical procedure that is not simple, commonly understood, or poses some risk to the patient shall obtain the patient's consent to any such procedure. Such procedures may include, but not be limited to, diagnostic procedures such as arteriograms, venograms, myelograms, endoscopy exams, swanz ganz catheter insertions, lumbar punctures, central lines, arterial lines, umbilical catheters, blood transfusions, sedation, participation in research projects, etc.;

(3) the anesthesiologist, anesthetist, or provider shall obtain the patient's consent to the administration of anesthesia.

(c) Except in emergencies, a failure to include a completed consent form in the patient's medical record prior to the performance of a surgical or diagnostic procedure shall automatically cancel the surgery or procedure.

(d) Whenever the patient's condition prevents the obtaining of an informed consent, every effort shall be made and documented to obtain the consent of the patient's representative prior to the

procedure or surgery, and such effort shall be documented in the patient's medical record. Any emergencies involving a minor or otherwise incompetent patient in which consent for surgery cannot be immediately obtained from parents, legal guardian/representative, durable power of attorney, or appropriate next of kin, these circumstances should be fully explained on the patient's medical record. If possible, a consultation shall be obtained before any operative procedure is undertaken.

(e) Should a second operation be required during the patient's stay at the hospital, a second consent shall be obtained. If two (2) or more specific procedures are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

Section 2. Definitions:

The following definitions shall be applied when obtaining consent to treatment:

(a) Informed Consent – consent obtained from the patient or the patient's representative after being informed in a language or means of communication he/she understands by the provider of the diagnosis, the nature of proposed treatment, risks or side effects, the probability of success, the reasonable alternatives, and the possible consequences if the provider's advice is not followed.

(b) Emergency -- a situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent would further jeopardize the life, health or safety of the patient.

(c) Emancipated Minor – when a judge signs and files an order freeing parents from a duty to support, control, and supervise their minor. A minor who has been emancipated may consent to treatment.

Section 3. Who May Consent:

(a) A competent adult or emancipated minor may authorize any medical or surgical procedure to be performed upon his or her body, and the informed consent of no other person shall be required or shall be valid. Emancipated minors can consent on their own behalf and on behalf of their children.

(b) Informed consent shall be obtained from the parents or legal guardian of a non-emancipated minor before any surgical or medical procedure is performed on the minor, except in the following cases in which minors may consent for their own care:
   (1) emergencies;
   (2) unmarried, pregnant, and no parent immediately available, and seeking care related to her pregnancy;
   (3) sixteen (16) years of age or older, and no parent immediately available;
   (4) sixteen (16) years of age or older, married, or has been married;
   (5) seeking care for drug abuse, misuse, or addiction (alcohol or substance);
   (6) seeking care for treatment of venereal disease.

(c) Informed consent shall also be obtained in all non-emergency situations from the patient's legal representative of any incompetent adult before any surgical or medical procedure is performed.

Section 4. Incompetent Patients:

Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as

to treatment. When a patient has been declared incompetent by a court, a consent form signed by the court appointed legal guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the patient's legal representative shall be obtained.

Section 5. Unusual Cases:

(a) When questions arise regarding patient consent or when unusual circumstances occur not clearly covered by these rules and regulations, the provider shall promptly confer with hospital management concerning such matters. The hospital will make every effort to assist the provider in obtaining the required consent and to provide information relative to such matters. However, it is the ultimate responsibility of the provider to comply with the requirements contained in these rules and regulations.

(b) Telephone consent shall be permissible when a delay in obtaining consent on behalf of an incompetent individual or a minor would result in harm to the individual, or where it is impractical to obtain a written consent to convey the information necessary to make an informed consent in person.

(1) In such a case, the provider who will perform the procedure or provide the treatment shall, in the presence of at least one (1) witness who is on the line with the provider, convey the information via telephone at the same time It shall be noted on the consent form that the informed consent was obtained by phone, and the provider and witness shall sign the consent form.

(c) Clinical departments may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such forms shall become effective when approved by the Executive Committee.

Section 6. Surgical Procedure Resulting in Sterilization:

No request and/or informed consent other than from the patient will be accepted for a surgical procedure resulting in sterilization. Before consenting to a sterilization procedure, the patient must be informed and understand that the restoration of fertility is unlikely. In the case of an incompetent patient, appropriate legal informed consent shall be obtained.

Section 7. Refusal to Consent:

(a) A patient or, if incompetent, the patient's legal representative retains the right to refuse medical treatment, even in an emergency situation. If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, the refusal of care shall be documented in the chart by the provider.

(b) If a patient or, if incompetent, the patient's legal representative does not consent to any item on the consent form, the item(s) shall be noted in the "EXEMPTION" section of the consent form. If the provider is not the person completing the consent form, the health care Provider shall notify the provider of the exemptions prior to treatment or procedure.

(c) Any patient with psychiatric problems who refuses to consent to care may be held at the hospital in an appropriate observation or treatment area for a period not to exceed 72 hours if such psychiatric hold is determined to be in the best interest of the patient and meets applicable state law/regulation criteria for such detention.

Section 8. Documenting Informed Consent:

A standard consent form approved by the Hospital ‘s Forms Committee shall be completed by the provider to convey consent was obtained. The provider may obtain the patient’s informed consent, using the consent form, during an office visit. The completed consent form must be in the patient’s hospital medical record prior to surgery. It is the responsibility of the provider to ensure that the consent form is completed and available to be placed in the patient’s hospital medical record prior to surgery.

ARTICLE VII

PHARMACY

Section 1. General Rules:

(a) All drugs and medications administered to patients shall be:

(1) listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service," "A.M.A. Drug Evaluations," or "New and Non-official Drugs." Drugs for bona fide clinical investigations whose use is in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals," the regulations of the federal Food and Drug Administration, and approved by the Pharmacy and Therapeutics Committee and/or Institutional Review Committee shall be excepted;

(2) reviewed by the attending appointee daily to assure the discontinuance of all drugs no longer needed; all changes must be documented;

(3) canceled automatically when the patient goes to surgery and/or is transferred in or out of a critical care area; and

(4) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency or code situation.)

(b) All medication orders must clearly state the administration times or the time interval between doses. All PRN mediation orders should have an intent and duration of order.

(c) The Pharmacy Department is responsible for preparing intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the patient's medical record noting date and time, and properly signed after the drugs have been administered.

(d) Self-medication by patients shall not be permitted, unless written in the orders by the attending appointee and witnessed by Nursing and recorded on the Medication Administration Record.

(e) The Pharmacy Department will dispense the generic equivalent drug which has an AB" rating by the FDA when a trade drug name is prescribed.

(f) All orders for antibiotics should state if they are being administered for therapeutic, prophylactic or empirical purposes.

(g) Non formulary medications requested by a Physician may have a substantial delay attached to the order, and the physician will be notified.

Section 2. Patient's Own Drugs or Devices:

If patients bring their own drugs, medicines or therapeutic devices to the hospital, such items shall be sent home or placed in a valuables envelope or locked in the hospital safe. Medications shall not be administered unless the attending appointee has written an order for their administration or use. This drug needs to be identified by the Pharmacy Department before use.

Section 3. Medication Errors; Adverse Reactions:

(a) Any medication error or apparent drug reaction shall be reported immediately to the appointee who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record.

(b) Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity, and to prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction,

shall be sent to the appointee and to the director of pharmaceutical services. Unexpected or significant adverse reactions shall also be reported promptly to the Food and Drug Administration (FDA) and to the drug manufacturer as required by the Pharmacy Department.

Section 4. Stop Orders:

A "STOP" order drug policy shall be in effect and shall apply, to all medications. Orders shall be automatically discontinued on all medications, which are not renewed. Inhalation therapy treatments shall automatically be discontinued after three (3) days, with notification.

Section 5. Storage and Access:

(a) In order to facilitate the delivery of safe care, medications and biologicals shall be controlled and distributed in accordance with Hospital policy and consistent with federal and state law.

1) All medications and biologicals shall be kept in a secure area and locked unless under the immediate control of authorized staff.
2) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be kept locked within a secure area.
3) Only authorized personnel may have access to locked or secure areas.

(b) Abuses and losses of controlled substances shall be promptly reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Chief Executive Officer.

ARTICLE VIII
INFECTION PREVENTION

(a) All nursing units shall follow the standard procedure for isolation as outlined in the Infection Prevention Plan which is based on the Center for Disease Control's Guidelines for Isolation Precautions in Hospitals (CDC Guidelines).

(b) Any patient with a known or suspected communicable disease or infection shall be isolated as required by the Infection Prevention Plan. The attending physician will be notified. The Chairperson of the Infection Prevention Committee shall be empowered to order appropriate isolation procedures or epidemiologic investigations as required.

(c) When a series of infections, including post-operative infections, occur, the Chairperson of the Infection Prevention Committee shall initiate procedures necessary to investigate and prevent further spread of infection.

(d) A culture should be taken when an incision and drainage is performed.

ARTICLE IX

ADVANCE HEALTH CARE DIRECTIVES

Section 1. Patients' Rights:

Patients shall have the right to make decisions concerning their care, including, but not limited to, the right to accept or refuse medical/surgical treatment, and the right to formulate an Advance Health Care Directive as permitted under state law. Patients will be informed of their rights as stated in the hospital's Advance Health Care Directive Policy. No patient shall be discriminated against or will have care conditioned on whether or not an Advance Health Care Directive has been executed.

Section 2. Physician Responsibilities:

With regard to Advance Health Care Directives, physicians' responsibilities shall include:

(a) reviewing the patient's directive;

(b) informing the patient or patient's representative of physician's acceptance or non-acceptance of the directive;

(c) assisting in the validation of an Advance Health Care Directive presented at a previous admission; and

(d) The physician has the right to decline to participate in the limitation or withdrawal of therapy. If this right is exercised the physician must give adequate notice and take appropriate steps to transfer the care of the patient to another qualified physician.

ARTICLE X

DISCHARGE

Section 1. Who May Discharge:

Patients shall be discharged only on a written/verbal order of the attending appointee or designee. Should a patient leave the hospital against the advice of the attending appointee, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the hospital's release form.

Section 2. Discharge Planning:

(a) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine no discharge planning is necessary in a particular case, that conclusion shall be noted on the medical record of the patient.

(b) Discharge planning shall include, but need not be limited to, the following:

(1) appropriate referral and transfer plans;
(2) methods to facilitate the provision of follow-up care; and
(3) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, and the amount of activity the patient should engage in; and any necessary medical regimens including drugs, diet, or other forms of therapy. Sources of additional help from other agencies and procedures to follow in case of

complications should also be part of the discharge plan. All such information should be provided by the attending appointee.

Section 3. Discharge of Minors and Incompetent Patients:

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

Section 4. Autopsies and Disposition of Bodies:

(a) The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician, and the event adequately documented in the patient's medical record within a reasonable period of time by the attending appointee or another designated Medical Staff appointee or resident.

(b) The body of a deceased patient can be subjected to disposition only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made and signed in the deceased patient's medical record by the attending physician or a designee. Completion of death certificates are the responsibility of the attending appointee.

(c) It shall be the duty of all Medical Staff appointees to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only with proper consent in accordance with state law and hospital policy. All autopsies shall be performed by the hospital pathologist or a designee. Consent for an autopsy

shall be effective only by inclusion of such notation on the appropriate hospital form signed by the appropriate legal representative of the patient. A copy of the autopsy report shall be forwarded to the patient's attending physician and included in the patient's medical record.

(d) Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol shall be made a part of the patient's medical record within sixty (60) days. If the attending physician desires to attend the autopsy, it is the responsibility of the attending physician, or the physician ordering the autopsy, to contact the pathologist concerning attending the autopsy.

Section 5. Coroner's Cases:

It is the responsibility of the attending appointee or an alternate to notify the coroner of any cases considered a coroner's case. The Kansas Child Death Review Act shall be followed for deaths of all children. Notification of the coroner is required in all deaths, except still births, for children under the age of 18.

ARTICLE XI
MISCELLANEOUS

Section 1. Disaster Plan:

(a) The hospital plan for the care of mass casualties shall be rehearsed twice a year by key hospital personnel, including Medical Staff appointees. Each appointee to the staff shall become familiar with the plan and shall be assigned and shall report to posts, either in the hospital or elsewhere.

(b) The Chief of Staff and the Chief Executive Officer shall work as a team to coordinate activities and shall give directions. In cases of evacuation of patients from one section of the hospital to another, or evacuation from the hospital premises, the Chief of Staff or the Chief Executive Officer, or their respective designees, shall authorize the movement of patients.

Section 2. Reports:

It shall be the responsibility of each appointee to the Medical Staff to report, in writing, to the Chief of Staff or the Chief Executive Officer, any conduct, acts or omissions by Medical Staff appointees, which are believed to be detrimental to the health or safety of patients or to the proper functioning of the hospital, or which violates professional ethics.

Section 3. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff appointees shall not discuss with any other individuals, the transacted business or discussions that occur within the confines of any official staff meetings or any meetings of its committees or departments.

(b) Medical Staff appointees shall not record or otherwise transcribe the proceedings of such meetings without the unanimous consent of all those in attendance.

(c) Written attendance records shall be maintained for all meetings of the Medical Staff, and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of meetings shall reflect the educational programs and clinical reviews conducted at each meeting.

Section 4. Orientation of New Medical Staff Appointees:

(a) Each new Medical Staff appointee shall be introduced to the various hospital departments by the Chief Executive Officer or a designee.

(b) The hospital Health Information Management Department and nursing service shall orient each new Medical Staff appointee as to their respective areas, detailing those activities and/or procedures that will help new staff appointees in the performance of their duties.

(c) The hospital Corporate Compliance Officer shall orient each new Medical Staff appointee as to the hospital's corporate compliance program including, but not limited to, the hospital's Code of Conduct.

Section 5. Harassment:

(a) Pawnee Valley Community Hospital ("Hospital"), Medical Staff, Allied Health Professional, or designee may safely decline to continue treating a stable patient based on the patient's harassing behavior so long as the Hospital complies with its Medicare discharge responsibilities and the patient is given notice and an opportunity to find another healthcare provider. The following procedures should be followed whenever a patient is going to be discharged due to harassment by a patient:

(1) Direct notification to the patient describing the harassing behavior and the need to cease and desist.

(2) If patient continues with the same harassing behavior after direct notification and education of the situation, the following procedure shall be followed:

a. The Hospital, Medical Staff, Allied Health Professional, or designee must not discharge patients that are unstable or have an emergency medical condition;

b. The Hospital, Medical Staff, Allied Health Professional, or designee must inform the patient that despite the discharge, the physician will still treat him or her for any emergency medical conditions;

c. The Hospital, Medical Staff, Allied Health Professional, or designee must comply with all the Conditions of Participation under Medicare related to discharge of patients; and

d. The Hospital, Medical Staff, Allied Health Professional, or designee must give the patient sufficient notice and opportunity to find the services of another physician so that he or she will not be harmed during the transition.

ARTICLE XIV
AMENDMENTS

(a) Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and regulations shall have the same force and effect as the Medical Staff Bylaws and the Policy on Medical Staff Appointment, Reappointment and Clinical Privileges.

(b) Particular rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee fourteen (14) days before being voted on, and further provided that all written comments on the proposed changes by individuals holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. Adoption of and changes to these rules and regulations shall become effective when approved by the Board.

(c) Rules and regulations may also be adopted, amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective when approved by the Board. Neither body shall unilaterally amend these rules and regulations.

APPENDICES

APPENDIX A
OPERATING ROOM PROCEDURES

Section 1. General:

(a) Enforcement of the rules and regulations pertaining to the operating room procedures shall be the responsibility of the Chief Nursing Officer and the Chief of Staff. The Chief Nursing Officer shall have the responsibility of administrative supervision of the operating room and shall have the authority to plan and execute the daily operative schedule.

(b) The operating room schedule shall begin promptly each day. The time scheduled for each operation shall be defined as the time the anesthetist clears the patient for initiation of the procedure... When local anesthesia is used, the scheduled time shall be defined as the designated operating time appearing on that day's schedule.

(c) The Chief Nursing Officer shall have the responsibility for designing a schedule based on the maximum efficient use of the operating room and the anesthesia personnel.

(d) When a sponge, sharps, instrument or needle count is incorrect, an x-ray shall be taken before the patient leaves the operating room.

(e) Any personnel with an open infection shall not be permitted to enter the operating suite.

Section 2. Scheduling Surgery:

(a) The presence of all members of the operating team in scrub suits and the patient in the operating room is required at the scheduled time for surgery. The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during and after the operation. If the operating surgeon is more than fifteen (15) minutes late for any scheduled case without contacting the Chief Nursing Officer, that case shall be canceled and the patient returned to his or her room by the

operating room staff. Or if the operating surgeon is late for more than three (3) times in a ninety (90) day period loses the privilege to have 8:00 a.m. starts. This decision will be made by the OR committee. In no case shall anesthesia be started until the operating surgeon is present in the building. Operating time shall be released promptly when a case is canceled or the patient and surgical team are not available on schedule.

(b) Specific, contemplated procedures must be designated on the schedule, with the name of the patient, age, diagnosis, and surgical procedure. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case will be done as originally posted or rescheduled. Cases requiring frozen sections should be posted as such at the time the case is scheduled.

(c) Infectious or contaminated cases should be posted at the end of the operating room schedule or as otherwise authorized by the Chief Nursing Officer or a designee. It shall be the obligation of the operating practitioner to inform the Chief Nursing Officer that a given case is contaminated.

(d) An emergency case shall take precedence over an elective surgical case not in progress. Schedules for Saturdays, Sundays and holidays shall be limited to emergencies and urgent cases, or in order to resolve hospital utilization problems.

(e) In the event of a scheduling conflict which cannot be resolved by the Chief Nursing Officer, the Chairperson of the Department of Surgery shall be notified and shall, after consultation with the surgeons involved, render a final scheduling decision.

Section 3. Surgical Procedures:

Surgery shall be performed by a surgeon-appointee according to the surgical privileges granted by the Board. If a surgeon attempts to schedule an operative procedure for which no privileges have been

granted, the Chief Nursing Officer shall inform that surgeon of the lack of such privileges and immediately notify the Chief of Staff and the Chief Executive Officer of the matter.

Section 4. Anesthesia Rules and Records:

(a) Anesthesia care shall be provided by anesthesiologists, other qualified physicians, dental anesthetists and/or certified registered nurse anesthetists ("CRNA").

(b) The surgeon shall identify the patient prior to administration of the anesthetic and shall remain in the operating suite in operating attire prior to and during induction. The surgeon may be asked to assist or supervise the position of the patient on the operating table and must be available in the event of an emergency.

(c) The anesthesiologist or anesthetist shall verify that a pre-anesthesia evaluation of the patient has been conducted. The pre-anesthesia evaluation must include the gathering of information necessary to determine the readiness and the capacity of the patient to undergo anesthesia and to formulate an anesthesia plan. This evaluation must include a review of objective diagnostic data, an interview with the patient regarding medical, anesthetic and drug history, and a review of the patient's physical status. The findings of the pre-anesthesia evaluation by an anesthesiologist or an anesthetist shall be recorded prior to surgery.

(d) The anesthesiologist or anesthetist shall review and document the patient's condition immediately prior to induction of anesthesia and shall check the readiness, availability, cleanliness, sterility when required, and working condition of all equipment to be used in the administration of anesthetics, and check the drugs and gas supply. If there is concern during anesthesia for the patient's condition, it shall be conveyed to the surgeon by the anesthesiologist or the anesthetist.

(e) A record shall be maintained of all events taking place during the induction of, maintenance of and emergence from anesthesia, including:

(1) the dosage and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(4) unusual events during the anesthesia period; and

(5) the status of the patient at the conclusion of anesthesia.

(f) Post-anesthesia evaluation and follow-up shall be conducted upon admission to and discharge from the recovery area, and shall be documented in the patient's chart by an anesthesiologist or an anesthetist within twenty-four (24) hours after surgery. The post-anesthesia evaluation note shall be found on the Post Anesthetic Care Unit and/or anesthesia record and include:

(1) a record of vital signs;

(2) level of consciousness;

(3) intravenous fluids administered, including blood and blood products;

(4) all drugs administered;

(5) post-anesthesia visits by the anesthesiologist or anesthetist; and

(6) any unusual events or post-operative complications and the management of those events.

(g) The number of post-anesthesia visits shall be determined by the status of the patient in relation to the procedure performed and anesthesia administered. The anesthesiologist or anesthetist shall examine the patient early in the post-operative period and once after complete recovery from anesthesia. Complete recovery shall be determined by the clinical judgment of the discharging surgeon, the anesthesiologist or designated anesthetist.

(h) When surgical or anesthesia services are performed on an ambulatory basis, the patient shall be provided with written

instructions for follow-up care that includes information about how to obtain assistance in the event of post-operative problems. The instructions shall be reviewed with the patient or the patient's representative.

(i) The administration of anesthesia shall be limited to areas where it can be given safely. General anesthesia for surgical procedures shall not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

(j) A qualified CRNA may write pre-operative orders pursuant to a verbal order of the attending physician/surgeon, who must countersign such order.

Section 5. Recovery Room:

(a) All patients receiving general or regional anesthesia or who experience complications during a local anesthetic will be placed in the recovery room or admitted directly to ICU at the discretion of the surgeon or anesthesiologist. The surgeon and/or the anesthesiologist or the anesthetist shall convey pertinent information to the recovery room personnel regarding the patient's condition and required care.

(b) The surgeon shall remain in the vicinity of the operating room area until the patient is considered ready to be transferred to PACU or the ICU. Post-operative orders must be written by the surgeon or a qualified designee before the patient leaves the PACU. The attending surgeon or anesthesiologist shall be responsible for the decision to discharge the patient from the recovery room. When the surgeon is not personally present to make the decision to discharge the patient or does not sign the discharge order, the name of the practitioner responsible for the discharge shall be recorded in the patient's medical record and the discharge criteria applied to determine the readiness of the patient for discharge. A

patient who does not meet a score of 8, 9 or 10 must be discharged by the attending surgeon. (Unless pre-op score was less than 8)

(c) At least one (1) registered nurse shall be on duty in the recovery room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

Section 6. Operating Room Records:

(a) A roster of appointees currently possessing surgical privileges, with a delineation of the surgical privileges of each, shall be maintained in the surgical suite and be available to the Chief Nursing Officer. There shall be an on-call schedule of surgeons established and posted at each patient unit or other area where surgical patients are admitted, or at the communications center of the hospital to ensure that there is twenty-four (24) hour emergency care or post-operative follow-up care, or both, available.

(b) An operating room register shall be provided and maintained on a current basis. The operating room log or register shall contain:

(1) the date of each operation;

(2) name and hospital number;

(3) names of surgeons and surgical assistants;

(4) names of anesthetists and type of anesthesia given;

(5) pre- and post-operative diagnosis;

(6) type of surgical procedure; and

(c) The Chief Nursing Officer shall be responsible for and authorized to carry out all orders, which will ensure optimal technical procedures. Disputed matters shall be referred to the Chief of Staff.

Section 7. Safety Checks in Operating Suite:

The appropriate check for safety hazards (electrical and radiation) shall be performed at frequent intervals and it will be the responsibility of the Chief Nursing Officer and the Chief of Staff to assure that such checks are being performed and that the results of those checks are satisfactory.

APPENDIX B

PROCEDURES FOR MEDICAL SCREENING EXAMINATIONS IN THE EMERGENCY DEPARTMENT

a) In accordance with Medicare Regulations hospitals must formally determine who is qualified to perform the initial medical screening examination. Pawnee Valley Community Hospital defines qualified persons as Doctors of Medicine or Doctors of Osteopathy.

b) Psychiatric Registered Nurses and Licensed Mental Health practitioners, with Allied Health Professional privileges at PVCH, including Licensed Specialist Clinical Social Worker (LSCSW), Licensed Masters Level Psychologist (LML), Ph.D. psychologist and Licensed Master Social Worker (LMSW) may perform a screening exam as outlined in the crisis screening policy.

c) A medical screening examination may be performed by an Emergency Department physician, another physician, or a non-physician practitioner who is qualified and credentialed to conduct such examination ("qualified medical personnel").

APPENDIX C

SWING BED SERVICES

Section 1. Criteria for Admission:

a) All patients in need of swing bed services will be pre-screened to assure that the services can provide for the needs of the patients and that the patients are appropriate candidates for the program. General Admission criteria includes:
   - Patient must have had a medically necessary acute stay of at least 3 consecutive calendar days.
   - Or patient must have started receiving swing bed services within 30 days after discharge from a qualifying acute stay and must be treated for the condition that was previously treated during the acute stay.
   - Patient is in need of physician visits/order changes.
   - Patient is in need of complex care such as:
     - Physical, speech or occupational therapy.
     - IV therapy such as IV antibiotics, IV fluids, IV pain medications and total parental feedings.
     - Complex clinical needs such as suctioning, respiratory therapy, oxygen, tracheostomy care, wound ulcer, surgical wound care, open lesions, tube feeding, weight loss, pain control, diabetes mellitus with injections and with physician order changes.
     - Cognitive impairment in decision making, recall and short-term memory.
   - Discharge goal is to a lesser level of care.
   - Patient's pre-morbid condition indicates potential for improvement.
   - Patient's prognosis indicates a progressively improving medical condition or possibility of functional improvement.
   - Patient does not require mechanical ventilation.
   - Other criteria as required by third party payers.

b) Any staff physician may admit and follow patients on the swing bed services.
c) Out-of-town patients may be admitted by any staff physician. They will be responsible for the medical care of the patient throughout the period of hospitalization to assist with the assessment of the patient's continued medical stability.
d) Patients who meet the admission criteria for swing bed services will be evaluated upon admission to determine an appropriate treatment plan and length of stay. Continued stay shall be based upon each patient's skilled needs.
e) Certification for swing bed services must be completed by the physician on admission, on day 14, on day 44 and on day 74.

Section 2. Discharge Planning:

Team conferences shall be held at least weekly by the interdisciplinary team (e.g. physician, nurse, social worker, therapists, etc.) to: assess the patient's progress on problems impeding progress; consider possible resolutions to such problems; and assess the validity of the skilled goals initially established. Decisions regarding discharge planning and the adjustment of goals shall be documented in the clinical record.

APPENDIX D

MEDICATION RECONCILLATION

Purpose:

The Medication Reconciliation and Order Form will be used to identify patients' current medications, dosages, routes, frequencies and last doses. This will allow the physician to review the information and order the appropriate medications and dosages for patients upon admission to, after procedures in, change of admission status within, and discharge from Pawnee Valley Community Hospital. Medication reconciliation will be an interdisciplinary process between patients, medical staff, pharmacy and nursing. Designed to decrease adverse drug events or potential adverse drug events, improve the safety of using medications, and provide the most therapeutic outcome.

Scope:

Patients, Medical Staff, Pharmacy, Nursing, Health Unit Coordinators

Procedure: **Placement in the Chart**

The Medication Reconciliation and Order Form will printed utilizing Forms on Demand and placed within the "Physician Orders" tab in the paper medical record.

Guidelines for Completion

I. Obtaining a Complete Medication History

A. A RN, physician, APRN, PA, or pharmacist shall obtain a thorough medication history from the patient and/or family members present at the time of entry into Pawnee Valley Community Hospital (PVCH) whenever possible. Medication name, dose, route, frequency, and last time dose taken will be documented on the Inpatient Medication Reconciliation and Order Form.

B. In cases when the patient and family are not considered to be a reliable source of information, consultation with an alternative source(s) may be necessary to generate the most accurate home medication list. The following sources may be utilized: doctor offices, pharmacies, transfer documentation, or recent admissions. The sources used to obtain the patient's current medication list shall be documented on the Inpatient Medication Reconciliation and Order Form.

C. The RN, physician, APRN, PA, or pharmacist shall confirm the history with the patient.

D. The medication history shall be completed within 2 hours of entry to the organization.

II. On Admission

A. A PVCH or Hays Medical Center (HMC) Pharmacist will review the Inpatient Medication Reconciliation and Order Form after it is scanned to the pharmacy and make needed corrections or revisions to the home medication list and write clarification orders in physician orders.

B. Upon inpatient or outpatient admission, the physician, APRN or PA responsible for the patient shall review and reconcile each medication on the Inpatient Medication Reconciliation and Order Form and decide whether to continue or discontinue each medication during the patient's hospitalization by circling the " ;Y" for YES and "N" for NO under the CONT. ON ADMISSION column.

C. The physician, APRN or PA must sign, date, and time the Inpatient Medication Reconciliation and Order Form in the MEDICATIONS ORDERED BY box. Once signed, dated, and timed, the medications are treated as orders. The form should be scanned to pharmacy and filed within the "Physician Orders" tab in the paper medical record. The Health Unit Coordinator (HUC) or nurse who scans the orders shall document their initials along with the date and time he/she scanned the orders to pharmacy in the SCANNED TO PHARMACY box.

D. If additional medication history is made available after the Inpatient Medication Reconciliation and Order Form has already been scanned to pharmacy, the medication history shall be updated by editing the Medication Reconciliation and Order Form and writing a clarification orders in physician orders.

E. If additional medication history is made available before the Inpatient Medication Reconciliation and Order Form has been scanned to pharmacy, the medication history shall be updated by editing or updating the current Medication Reconciliation and Order Form and writing a clarification orders in physician orders.

F. Admission orders shall indicate "See Medication Reconciliation and Order Form".

G. New medications shall be ordered with the admission orders.

H. For medications that require a dosage change, the medications shall be discontinued on the Medication Reconciliation and Order Form, and the new doses included with the admission orders.

I. For medications which there exists a hospital therapeutic substitution, the medication shall be discontinued on the Inpatient Medication Reconciliation and Order Form, and the new medication to be substituted shall be ordered with the admission orders. If a medication which has a hospital therapeutic substitution is marked to continue, pharmacy will generate an Auto Substitution Form to facilitate ordering the hospital therapeutic medication.

J. If the Inpatient Medication Reconciliation and Order Form are not completed by the physician, APRN, or PA at the time the admission orders are written, home medications listed on the Medication Reconciliation and Order Form shall be reconciled with the admission medication orders by the RN or Pharmacist. Discrepancies shall be brought to the attention of the physician, APRN, or PA for clarification. Once contacting the physician, APRN, or PA, the RN or pharmacist will order the home medications on the Medication Reconciliation and Order Form by circling the "Y" for YES and " N" for NO under the CONT. ON ADMISSION column and sign the orders as a telephone order per the physician, APRN, or PA in the MEDICATIONS ORDERED BY box.

III. At Discharge or Transfer to Another Facility (Includes transfer to Skilled Care level of service)

A. The physician, APRN or PA responsible for the patient shall review, reconcile, and decide whether to continue or discontinue each medication after the patient leaves the hospital or transfer to another facility, including Pawnee Valley Community Hospital' Skilled Care level of service, by circling the "Y" for YES or "N" for NO under the CONT. ON DISCHARGE column of the Inpatient Medication Reconciliation and Order Form.

B. The physician, APRN, or PA must sign, date, and time the Inpatient Medication Reconciliation and Order form in the MEDICATIONS ORDERED BY box. Once signed, dated and timed, the medications are treated as orders. The form should be scanned to pharmacy and returned to the "Physician Orders" tab in the paper medical record. The Health Unit Coordinator (HUC) or nurse who scans the orders shall document their initials along with the date and time he/she scanned the orders to pharmacy in the SCANNED TO PHARMACY box.

C. If the Inpatient Medication Reconciliation and Order Form is not completed by the physician, APRN, or PA at the time the discharge or transfer to another facility orders are written, the medications on the Medication Reconciliation and Order Form shall be reconciled by the RN or Pharmacist. Discrepancies shall be brought to the attention of

the physician, APRN, or PA for clarification. Once the physician, APRN, or PA has been contacted, the RN or pharmacist will order each medication on the Medication Reconciliation and Order Form by circling the "Y" for YES and "N" for NO under the CONT. ON DISCHARGE column and sign the orders as a telephone order per the physician in the MEDICATIONS ORDERED BY box.

D. All discharge medications and instructions shall be included on the home instruction sheets. The discharge medication list shall be faxed to the next provider of care.

IV. Applicable Settings and Services for Medication Reconciliation

A. Medication reconciliation applies to all inpatients and the following outpatient settings and services:

- Where a practitioner who can review and modify the patient's medications is a part of the outpatient service.

V. Outpatient Services Home Medication Reconciliation and Order Form

A. An Outpatient Services Home Medication Reconciliation and Order Form shall be printed by utilizing Forms on Demand. B. The home medication list shall be reconciled with the current medications by the physician, APRN, or PA responsible for the patient at the time of discharge from Pawnee Valley Community Hospital.

B. The physician, APRN, or PA responsible for the patient shall decide whether any home medication list changes are needed upon discharge by circling the "YES" or "NO" on the Outpatient Services Home Medication Reconciliation and Order Form. If "YES", the needed home medication list changes are documented under the HOME MEDICATION LIST CHANGES DUE TO SURGERY / PROCEDURE / EXAM box of the Outpatient Services Home Medication Reconciliation and Order Form.

C. The physician, APRN, or PA must sign, date, and time the Outpatient Services Home Medication Reconciliation and Order Form in the PHYSICIAN SIGNATURE box. Once the form is signed, dated, and timed, the changes are treated as orders and included on the home instruction sheet.

D. All discharge medications and instructions shall be included on the home instruction sheets. The discharge medication list shall be faxed to the next provider of care if there are changes to the home medication list.

Please refer to Forms on Demand for the correct forms.

Approved by Executive Committee: 6/23/10; 9/15/10; 1/18/11; 1/13; 1/14/14; 4/15/14; 10/14/14; 1/12/16; 4/12/16; 4/17/18
Adopted by Board of Directors: 6/28/10; 9/28/10; 1/31/11; 1/28/13; 1/27/14; 4/28/14; 10/27/14; 1/27/16; 4/27/16; 4/30/18