MINISTRY SAINT MICHAEL'S HOSPITAL
STEVENS POINT, WISCONSIN
MEDICAL STAFF RULES AND REGULATIONS

TABLE OF CONTENTS

A. GENERAL PROVISIONS AND AUTHORITY 1
  1. Department Rules and Regulations 1
  2. Definitions 1

B. ADMISSION AND DISCHARGE OF PATIENTS 1
  1. Admitting Privileges 1
  2. Responsibility for Care 1
  3. Provisional Admitting Diagnosis 2
  4. Admission Priorities 2
  5. Need for Continuing Hospitalization 2
  6. EMTALA 3
  7. Certification of Death 3
  8. Discharge Orders 3

C. MEDICAL RECORDS 4
  1. Responsibility 4
  2. History and Physical Requirements 5
  3. Signatures 6
  4. Orders 6
  5. Countersignatures 7
  6. Symbols, Abbreviations and Acronyms 7
  7. Standing (Routine) Orders 7
  8. Legibility of Written Orders 8
  9. Corrections and Addenda to Medical Records 8
  10. Orders Rewritten After Anesthesia 8
  11. Radiology Orders 8
  12. Progress Notes 8
  13. Consultations 9
  14. Obstetrical and Newborn Records 10
  15. Completion of Medical Records: Disciplinary Action 11
  16. Emergency Department Records 12
  17. Release of Medical Information 12
  18. Access to Medical Information 13
  19. Removal of Medical Records from the Hospital 13
  20. Research Using Medical Records 13
  21. Operative and Procedure Reports 14
  22. Discharge Summary 14

D. GENERAL CONDUCT OF CARE 15
  1. Consent 15
  2. Drug Formulary 15
  3. Dangerous Patients 16

4. Suicidal Patients 16
5. Intensive Care Unit Admissions and Discharges 16
6. Autopsies 17
7. Restraint and Seclusion 18
8. Pre-anesthesia Evaluation 18
9. Examination of Tissue Specimens 18
10. Preventing Fetal Injury 19
11. Diagnostic Imaging Interpretations 19
12. Department Rules and Regulations 19
13. Verification of Critical Test Results 19

A. GENERAL PROVISIONS AND AUTHORITY

1. Department Rules and Regulations

   Each department shall adopt Rules and Regulations pertinent to the practice of medicine within their department, and these Rules and Regulations shall become effective when approved by the Medical Staff Executive Committee.

2. Definitions

   Terms used in these Rules and Regulations have the same meaning and definition as those terms are defined in the Medical Staff Bylaws.

B. ADMISSION AND DISCHARGE OF PATIENTS

1. Admitting Privileges

   A patient may be admitted to the Hospital only by an Active, Courtesy, Provisional Active or Provisional Courtesy Member of the Medical Staff with admitting privileges, except that consulting staff may admit patients for observation during a non-surgical treatment, or for chemotherapy, radiation therapy treatment or other procedures, as per Sections 4.7(b) and (e) of the Medical Staff Bylaws.

2. Responsibility for Care

   A physician member of the Medical Staff shall be responsible for the medical care of each patient admitted to the Hospital. The patient must be seen by the attending Practitioner, the responsible "on call" group Practitioner or, where appropriate, the attending psychologist, on a daily basis. The attending Practitioner is defined as the Practitioner who maintains primary responsibility for determining the patient's continued need for acute care and readiness for discharge, even when the Practitioner has consulted other Practitioners for specialized treatment. The Practitioner who has admitted the patient will be considered the attending Practitioner unless he formally transfers primary responsibility for treatment decisions, continued need for Hospital care and readiness for discharge to another Practitioner; or unless he is admitting the patient to a member of his clinic group or "on-call" group and clearly notes that on the admitting order sheet, in which case that member will be considered the attending Practitioner. When all of these responsibilities are transferred to another staff member, a note regarding the transfer of responsibility shall be entered in the medical record by the transferring Practitioner, after acceptance by the other Practitioner. However, temporary transfer of responsibility for care of the patient such as during nights and weekends to "on-call" Practitioners from the same clinic or

regular call group needs no formal note in the chart regarding such. A printed call schedule shall be available within the various Hospital departments and patient care floors so that Hospital and other personnel can readily determine which Practitioner is responsible for any given patient at any time.

3. Provisional Admitting Diagnosis

Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such a statement shall be recorded as soon as possible.

4. Admission Priorities

The patient will be admitted on the basis of the following priorities:

a. Elective -- The health of the patient is not in danger by delayed admission. Such patients are usually scheduled several days to several weeks before admission. In consideration of the patient, the Hospital will make every effort to accommodate the patient's desired date of admission. However, when circumstances dictate, admission of patients in this category can be deferred, as they are the lowest admitting priority.

b. Urgent -- Delay in admission beyond several hours might threaten the patient's life or well-being.

c. Emergent -- An immediate threat to the patient's life or well-being exists. This situation warrants the highest admitting priority.

In case of dispute, Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee and the administration of the Hospital that the emergency admission was a bona fide one. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's chart within a reasonable period of time. The same shall apply to scheduling emergency procedures.

5. Need for Continuing Hospitalization

The attending Practitioner is required to document the need for continued hospitalization of a patient. If questioned by Hospital utilization review personnel, the Quality Assurance Committee or the Executive Committee, the Practitioner must provide any necessary additional information. This report must be submitted by the attending Practitioner within twenty-four (24) hours and must contain a written justification of the need for

continued hospitalization, and an estimated period of time the patient will need to stay in the Hospital.

6. EMTALA

Consistent with the Hospital's EMTALA Policy, any individual who "comes to the emergency department," as that term is defined by law and Hospital policy, and requests or requires it, will receive an appropriate medical screening examination by qualified medical personnel to determine whether an emergency medical condition exists.

If the individual has an emergency medical condition, the individual will receive treatment within the capabilities and capacity of the Hospital until the condition is stabilized or an appropriate transfer to another facility is made. All such transfers shall occur in a manner consistent with applicable law and Hospital policy. Individuals without an emergency medical condition will receive or be referred for appropriate care.

Individuals who are designated as qualified medical personnel include physicians, physician assistants, advanced practice nurses, certified nurse midwives and obstetric registered nurses.

7. Certification of Death

In the event of a hospitalized patient's death, he shall be pronounced dead by the attending Physician or by his designee within a reasonable time. A hospice nurse may pronounce (but not certify the cause of) the death of a hospice patient who was under the care of a physician at the time of death and the death was anticipated. The body shall not be released until an entry has been made in the medical record of the deceased by a member of the medical staff or his designee, and by filling out the "Record of Death" form.

8. Discharge Orders

Patients shall be discharged only on the verbal or written order of the attending Practitioner or his designee. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge order, notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign a refusal of treatment form. If the patient refuses to sign, the refusal should be witnessed and documented in the medical record.

C. MEDICAL RECORDS

1. <u>Responsibility</u>

The attending Practitioner, substituting Practitioner or mid-level provider with clinical privileges to do so, shall be responsible for the preparation of a timely, accurate, legible and complete medical record for each patient. The medical record will include, as appropriate, the following:

a. Accurate patient identification data, including the patient's name, address, date of birth, sex, language and communication needs (including preferred language for discussing health care), and the name of any court appointed or otherwise authorized legal representative;

b. The reason(s) for admission for care, treatment and services, including a concise statement of complaints, including the chief complaint;

c. A health history, including pertinent personal and family history, and history of present illness and any conclusions drawn;

d. Any allergies to food or medications;

e. Results of a physical examination and any conclusions drawn;

f. All findings of assessments and reassessments;

g. Any observations and the patient's response to care, treatment and services;

h. Any emergency care, treatment and services provided to the patient before arrival at the Hospital;

i. Any medication ordered or prescribed, as well as any medications administered, including the strength, dose and route, and any medications dispensed or prescribed on discharge;

j. Any access site for medication, administration devised used and rate of administration;

k. Special reports, including consultation reports, and results of clinical laboratory and radiology services, as well as any other diagnostic or therapeutic reports or procedures;

l. Any adverse drug reactions;

m. All orders, including diagnostic and therapeutic orders;

n. Provisional diagnosis, including the patient's initial diagnosis, diagnostic impression(s) or condition(s);

o. Medical or surgical treatment;

p. Operative report, when applicable;

q. Pathological findings, when applicable;

r. Any advanced directives, when applicable;

s. Any informed consent, as required by Hospital policy;

t. Any patient-generated information, as well as any records of communication with the patient, as necessary;

u. Progress notes;

v. Any diagnoses or conditions established during the patient's course of care, treatment and services;

w. Treatment goals, plan of care and revisions to the plan of care;

x. Final (discharge) diagnosis;

y. Discharge plan and discharge planning evaluation;

z. Discharge summary or discharge note completed in accordance with Hospital policy;

aa. Autopsy report, when applicable; and

bb. Anatomical gift information.

Only members of the Medical Staff or other professional personnel authorized by the Medical Staff shall record and authenticate entries in the medical record. Other professional personnel, include, but are not limited to ancillary departments, rehab, nutrition services, spiritual services, clinical students and Ministry Behavioral Health.

2. History and Physical Requirements

A complete history and physical examination shall be completed and documented no more than thirty (30) days prior to or within twenty-four (24) hours of admission or registration, but before surgery or a procedure requiring anesthesia services. The history and physical exam must be completed and documented by a member of the Active, Courtesy, Consulting or Limited Medical Staff (or provisional members in these categories), or by a mid-level provider granted privileges to do so. When

the history and physical examination is completed within the thirty (30) days prior to admission or registration, an updated examination of the patient must be documented in the medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

If a patient is readmitted within thirty (30) days for the same or a related condition, there shall be a reference to the previous history with an interval noted, and any pertinent changes in physical findings shall be recorded.

Additional rules and policies for specific conditions and procedures are set forth in Hospital policies.

3. Signatures

All clinical entries in the patient's medical record shall be legible, permanently recorded, timed, dated and authenticated with the name and title of the person making the entry. Another Practitioner may authenticate the order of a Practitioner, so long as the authenticating Practitioner is responsible for the patient's care, and assumes responsibility for the order as being complete, accurate and final.[1] All signatures are expected to be immediately completed and recorded in the medical record. Incomplete records may subject the Practitioner to corrective action as outlined in the Plan.

4. Orders

Orders for diagnosis and treatment may be given in writing or by spoken word by a Practitioner or other individual authorized by the Medical Staff within the scope of his practice (see Midlevel Provider Policy with Ordering and Countersignature Requirement grid). All outpatient orders must include the medical diagnosis or indication, the name and title of the ordering Practitioner or midlevel provider, and be dated, timed and authenticated by the ordering Practitioner or midlevel provider.

Verbal and telephone orders shall be used only in those circumstances where patient care requires them. All verbal and telephone orders shall be written in the orders section of the medical record and read back to the ordering Practitioner or midlevel provider by the appropriately authorized person to whom dictated, and then dated, timed and authenticated by the authorized person along with the name and title of the Practitioner or midlevel provider giving the order. Appropriately authorized person means a registered nurse, licensed pharmacist, physical or occupational therapist, dietician, respiratory therapist or social worker. Certain of these individuals may also be authorized by the Medical Staff to accept and

[1] Another Practitioner may only authenticate as described above until January 1, 2012.

implement orders generally, consistent with the individual's scope of practice and Hospital policy.

The responsible Practitioner or mid-level provider should time, date and authenticate verbal and telephone orders within twenty-four (24) hours, if at all possible, but no later than forty-eight (48) hours after entry into the patient's chart. Verbal orders should be limited to emergency situations, and be dated, timed and authenticated by the ordering Practitioner before he or she leaves the area.

With the exception of orders entered pursuant to the Hospital's electronic medical record system, orders must be permanently recorded in black or blue ink. Orders recorded in pencil or in any color ink than black or blue shall not be acceptable at any time.

5. Countersignatures

The attending Practitioner shall countersign the history and physical examination, all progress notes, and the discharge summary when they have been recorded by a physician assistant or advanced practice nurse in inpatient records. Requirements for countersignatures for lab, x-rays, electrocardiograms, physical therapy and drug orders are required for circumstances set forth in the Midlevel Provider Policy (see Ordering and Countersignature Requirements for Midlevel Providers grid).

Medical record documentation by non-Practitioners shall be performed consistent with Hospital policy, and the terms of any supervisory or collaborative relationship or other appropriate agreement. However, history and physical examinations must be countersigned within twenty-four (24) hours if possible, but no later than forty-eight (48) hours from the time of the entry into the patient's chart.

6. Symbols, Abbreviations and Acronyms

Only approved symbols, abbreviations and acronyms found in the Hospital's Dangerous Abbreviations Policy may be used in the medical record.

7. Standing (Routine) Orders

A Practitioner's routine, standing, or pre-written orders, when applicable to a given patient, shall be placed on the orders compartment of the patient's medical record, and dated, timed and authenticated by the Practitioner if used.

8. Legibility of Written Orders

A Practitioner's orders must be permanently recorded and written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten.

9. Corrections and Addenda to Medical Records

A charting error is corrected by drawing a single line through the incorrect portion so the error remains legible. "Delete" is written with the date and time of the correction and the author’s initials next to the error. The correct information is written as applicable. Corrections made in a limited space are lined out with "delete" written and an arrow drawn to the margin or closest available space to write the correct information. Scribbling out, write-overs, erasing or use of white-out or any other form that renders the original writing illegible are not acceptable for correcting medical record documentation. Only the author of the entry may correct any error.

Any addendum shall be denoted as such and timed and dated to reflect when the addendum was actually completed, with references, where appropriate, to the date or dates of the chart entries to which the addendum applies.

Electronic corrections shall be made in accordance with departmental procedures.

10. Orders Rewritten After Anesthesia

All orders shall be cancelled prior to and rewritten after general, spinal or epidural anesthesia.

11. Radiology Orders

An order for a radiology examination by the attending Practitioner or another individual with privileges to do so shall contain a concise statement of the reason for the examination, along with the name and title of the ordering Practitioner or other health care provider.

12. Progress Notes

Daily progress notes shall be recorded in sufficient detail to permit continuity of care and transferability by Practitioners and by other individuals who provide direct services to patients. Each of the patient's clinical problems should be clearly identified and discussed in the context of specific tests, treatments, and outcomes. Progress notes should be recorded not greater than twenty-four (24) hours following patient assessment.

13. Consultations

Consultation is encouraged when diagnostic studies fail to identify the nature of the patient's problem or when the results of a treatment plan deviate substantially from the range of anticipated results. Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise. The attending Practitioner or his designee must order the consultation and the reason for the consultation must be documented in the patient's chart.

The attending Practitioner or his designee is primarily responsible for requesting consultation when indicated, except in an emergency.

Consultation is required when requested by a mentally competent patient or by the legally responsible party for a patient who is incapacitated or not competent.

Consultation is required for each active medical problem or procedure for which the requesting practitioner does not hold clinical privileges.

If a nurse or other Hospital health care professional believes that appropriate consultation is needed and has not been obtained, he shall bring the matter in question to the attention of his immediate supervisor who shall then refer the question to the attending practitioner or his designee. If the matter remains unresolved, it may be referred to the chairperson of the department(s) wherein the Practitioner has clinical privileges. Where circumstances are such as to justify such action, the chairperson of the department may then himself request the consultation.

It is expected that notification of the consultant is to be provided by personal contact between the attending Practitioner and the consultant. At the time of such contact, the purpose and urgency of the consultation is to be communicated to the consultant. In addition to giving personal notification, the attending Practitioner or his designee shall record the time and date of the notice of such consultation and its purpose on the order section of the patient's medical record.

In instances in which the time of consultative evaluation is wholly elective in that its timing has no potential to adversely affect the safety, well-being or the future health of the patient, consultant notification may be given by the ward staff at the direction of the attending Practitioner or his designee. Hospital protocols specifically set up for these elective communicative purposes shall be followed.

Completion of a consultation shall occur with timeliness appropriate to the seriousness and urgency of the problem being addressed. In all cases,

consultation notes shall be dictated within twenty-four (24) hours of the time the consultation has been performed.

Depending on the urgency and severity of the patient's problems, preliminary findings and recommendations may be summarized in a written note on the medical record at the time the patient is seen and/or be communicated directly to the referring practitioner.

Consultation notes shall include patient identification data, requesting Practitioner, date and time of the consultation, pertinent items from the history of the present illness and past medical history, a directed physical examination if appropriate, pertinent Hospital study results, a statement of conclusions or impressions, and recommendations. When potentially hazardous or dangerous procedures are involved, the consultation note shall be written or dictated before any such procedure.

14. Obstetrical and Newborn Records

The prenatal record, or a legible copy thereof on the approved Hospital form, shall serve as the history and physical examination on patients having normal term deliveries. An interval admission note should be written that updates pertinent additions to the history and physical exam.

In addition to all other applicable medical record content requirements, the record of each obstetric patient shall include the following:

a. Prenatal history and findings, including complications, Rh determination, and other matters essential to adequate care;

b. Labor and delivery record, including anesthesia;

c. The practitioner's progress record;

d. The practitioner's order sheet;

e. A medicine and treatment sheet, including nurses notes;

f. Any laboratory or x-ray reports;

g. Any medical consultant's notes;

h. An estimate of blood loss.

In addition to all other applicable medical record content requirements, the record of each newborn infant shall include the following:

a. Record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth;

b. A record of physical examinations;

c. A progress sheet recording medicines and treatments, weights, feedings and temperatures;

d. The notes of any medical consultant.

In the case of fetal death, the weight and length of the fetus shall be recorded on the delivery record.

The discharge data summary form may serve as the discharge summary in the case of normal newborn infants and uncomplicated obstetrical deliveries, but that summary form must meet the content requirements of a discharge summary.

15. Completion of Medical Records: Disciplinary Action

The medical record department will remind practitioners of an incomplete record on or about fifteen (15) days after discharge or death and specify the date thirty (30) days after discharge when the record would become delinquent. One week before the impending delinquency, the Medical Staff President will send via special notice a letter with his signature notifying the Practitioner that failing to complete the medical record(s) by the specified date will result in automatic limited suspension under Section 1.3 of the Plan. Suspension will take place at 5:00 pm on the date specified and shall be in effect until completion of the records. The suspension shall take the form of withdrawal of the Practitioner's clinical privileges, except the suspension will not affect the privileges to administer to patients already in the Hospital under the care of that Practitioner at the time of the automatic suspension. Three such suspensions of privileges within any twelve (12) month period may be sufficient cause for permanent suspension of the Practitioner's clinical privileges or other corrective action.

Failure to meet the standards for medical record completion established by rules, regulations or Hospital policy will be trended by the medical records department and monitored by the Executive Committee on a weekly basis. Habitual noncompliance may be a basis for corrective action under the Plan.

The medical record shall not be permanently closed until it is completed by the responsible Practitioner or is ordered closed and filed by the Quality Assurance Committee.

16. Emergency Department Records

In addition to all other applicable medical record content requirements, the Emergency Department medical record shall be sure to include the following:

a. Adequate patient identification;

b. Information concerning the time and means of the patient's arrival, including who transported the patient;

c. Pertinent history of the injury or illness and physical findings, including vital signs, details relative to first aid or emergency care given the patient prior to the patient's arrival at the Hospital and history of allergies;

d. Description of significant clinical, laboratory and radiologic findings;

e. Diagnosis, including condition of patient;

f. Treatment given and plans for management;

g. Final disposition, including instructions given to the patient and/or family as those instructions relate to necessary follow-up care, or the patient's condition on discharge or transfer;

h. Clinical observations, including results of treatment;

i. If the patient left the Hospital against medical advice, documentation regarding the incident as required by Hospital policy;

j. A copy of any information made available to the practitioner or organization providing follow-up care; and

k. Appropriate time notations, including the time of any physician notifications, administration of medications or and other treatments, and the time of discharge or transfer to a floor or unit of the Hospital or to another facility.

17. Release of Medical Information

No individual may view or have access to a patient's record unless the performance of their professional duties requires access. The patient's medical record shall be kept confidential and shall be used or disclosed only as authorized by the patient, or as specifically permitted or required by applicable federal and state privacy laws. The patient, his personal representative, or any legally authorized person shall have access to the

patient's medical record in accordance with applicable laws. Written authorization of the patient or his personal representative is required for release of medical information to persons not otherwise authorized to receive this information. Accessing patient health care information in violation of this rule is a violation of professional ethics.

18. Access to Medical Information

Practitioners and other health care professionals will sign a confidentiality statement before being given on-line access to patient health information. Practitioners and other health care professionals will be assigned unique passwords and access menus. Passwords are confidential and shall not be disclosed or shared with other users. Practitioners and other health care professionals are permitted to access records only in accordance with applicable legal and ethical standards. Computers are not to be left unattended after entry of the password until proper computer terminal sign-off procedures have been followed. When a Practitioner loses or resigns clinical privileges or Medical Staff membership (or is suspended), password and access codes will be immediately deactivated. In the same manner, when other health care professionals resign their position, their password and access codes will also be immediately deactivated.

19. Removal of Medical Records from the Hospital

Medical records may be removed from the Hospital's possession only in accordance with a court order, statute, or by permission of the Designated Administrative Officer.

20. Research Using Medical Records

Consistent with Hospital policy, if waiver of individual patient authorization has been approved by the applicable institutional review board or a privacy board in accord with federal privacy regulations and the researcher has made the representations required under the privacy regulations, access to medical records may be afforded to members of the Medical Staff for a bona fide research study consistent with preserving the confidentiality of personal information concerning the individual patients, unless the patient has filed a written objection with the Hospital. All such projects shall be approved by the Executive Committee before records can be studied. Subject to the discretion of the Designated Administrative Officer and the conditions specified above for current members of the Medical Staff, former members of the Medical Staff may also be permitted access to information from the medical records of their patients for bona fide research study.

21. <u>Operative and Procedure Reports</u>

Operative or procedure reports should be dictated immediately after an operation or other potentially hazardous procedure. This report shall contain documentation of the patient's informed consent, the title or name of the procedure, the names of the Practitioner who performed the procedure and any assistants, the indications or preoperative diagnosis, the findings of the procedure, postoperative diagnosis, a detailed account of what was done, what biopsies or specimens were taken or removed, complications, estimated blood loss, patient's condition and the disposition of the patient.

If the report is not placed in the medical record immediately after the operation or procedure due to transcription or filing delay, then an operative progress note should be entered in the medical record immediately after the procedure to provide pertinent information for anyone required to attend to the patient. This operative progress note should contain, at a minimum, the following: name of primary surgeon and assistants, procedure performed and a description of each procedure, finding, specimens removed and postoperative diagnosis as well as estimated blood loss.

Immediately after the operation or procedure is defined as "upon completion of the operation or procedure, before the patient is transferred to the next level of care." This is to ensure that pertinent information is available to the next caregiver.

22. <u>Discharge Summary</u>

A discharge summary should be dictated at the time of discharge on all Hospital inpatients except for uncomplicated obstetrical deliveries and normal newborn infants. This summary shall include the following:

a. Final diagnosis;

b. Reason for hospitalization;

c. Significant findings, including the care, treatment and services provided;

d. Procedures performed, if applicable,

e. Condition of the patient upon discharge;

f. Any specific instructions given to the patient and/or the patient's family, including any necessary information related to follow-up care;

g. Discharge medications;

h. Diet; and

i. Activity.

Discharge summaries must be completed and signed within seven (7) days of discharge or death, after which time they will become delinquent. Discharge summaries on deaths where an autopsy was performed shall be completed within seven (7) days of availability of the final autopsy report.

All discharge summaries shall be dictated by the attending Practitioner or another licensed health care provider privileged to do so. A countersignature on the discharge summary is required if the person completing the discharge summary is not a member of the Active or Courtesy Staff (or provisional members in these categories).

For outpatient stays under forty-eight (48) hours, the final progress notes may serve as the discharge summary and must contain the following: discharge instructions, patient's condition at discharge, final diagnosis, the outcome of hospitalization, the disposition of patient and any provisions for follow-up care.

All discharge summaries shall be completed (dictated and signed) within seven (7) days of discharge and must include a final diagnosis.

D. GENERAL CONDUCT OF CARE

1. <u>Consent</u>

A general consent form signed by or on behalf of every patient admitted to the Hospital must be obtained at the time of admission except in an emergency. The admitting personnel should notify the attending Practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

In addition, except in emergencies, a surgical procedure may only be performed with the consent of the patient or the patient's legally authorized representative. The circumstances surrounding such an emergency must be documented in the patient's medical record.

2. <u>Drug Formulary</u>

All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia or American

Hospital Formulary Service and approved by the Pharmacy and Therapeutics Committee. Investigational drugs must have a protocol approved by the Federal Drug Administration. Controlled drugs, antibiotics, anticoagulants and corticosteroids ordered without a time limit will be subjected to a stop date approved by the Pharmacy and Therapeutics Committee. Drugs shall not be stopped without notifying the attending Practitioner.

3. <u>Dangerous Patients</u>

The admitting Practitioner shall be held responsible for giving such known information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever he reasonably believes the patients might be a source of danger from any cause whatsoever.

4. <u>Suicidal Patients</u>

a. Any patient considered suicidal on admission shall have a consultation by a member of the psychiatric staff or their designee(s) within twenty-four (24) hours of admission.

b. If a patient is discovered to be suicidal in ideation after admission, the psychiatric consultation shall be done within 24 hours of that time.

Any patient known or suspected to be suicidal shall be placed under the Hospital's established protocols by attending practitioner order, no matter where in the Hospital the patient is placed.

5. <u>Intensive Care Unit Admissions and Discharges</u>

a. A patient may be admitted or transferred to the intensive care unit by any member of the Medical Staff with the privileges to do so. Specific ICU admitting privileges are not required; however, when the patient requires care beyond the scope of practice or privileges of the admitting or transferring physician, the responsibility for care must be transferred to another member of the Medical Staff qualified and privileged to provide the care required, or the physician must request that such a member consult on and follow the patient while in the ICU.

b. Questions as to the advisability of admission or transfer to the intensive care unit or the discharge therefrom shall be resolved through discussions between the attending Practitioner and the chair of the intensive care unit committee. Should the chair of the intensive care unit be absent, any qualified physician in the hospitalist program may replace him in that function.

c. Should the intensive care unit be full, priorities for admission, transfer or discharge of patients shall be resolved by discussions between the attending Practitioner and the chair of the intensive care unit. Should the chair of the intensive care unit be absent, any qualified physician in the hospitalist program may replace him in that function.

6. Autopsies

Consistent with Hospital policy, the Medical Staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. It is recommended that autopsies be sought if any one of the following circumstances exists:

a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

b. All deaths in which the cause of death is not known with certainty on clinical grounds.

c. Cases in which autopsy may help allay concerns of the family and/or the public regarding a death, and provide reassurance to them regarding same.

d. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.

e. Death of a patient who has participated in clinical trials (protocols) approved by an institutional review board.

f. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

g. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as: persons dead on arrival (DOA) at hospitals; deaths occurring in hospitals within twenty-four (24) hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.

h. Deaths resulting from high-risk infectious and contagious diseases.

i. All obstetric deaths.

j. All neonatal and pediatric deaths.

k. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.

l. Deaths known or suspected to have resulted from environmental or occupational hazards.

m. Any other cause of medical-legal and educational interest.

7. Restraint and Seclusion

Consistent with Hospital policy, patients have a right to be free from restraint and seclusion that is not medically necessary. Restraint or seclusion may be used when clinically indicated to improve the patient's well being or when warranted to prevent a patient from injury to himself or others and when less restrictive interventions are ineffective or inadequate.

A Practitioner's order is necessary for restraint or seclusion initiation by Hospital personnel, and the order may not be made on a standing or PRN basis. Orders for restraints will contain specific time limits for use of the restraints in compliance with Joint Commission standards, federal law and Hospital policy. Patient's rights, dignity and well being are protected during use of restraint and seclusion. The least restrictive safe and efficient restraint method is employed.

8. Pre-anesthesia Evaluation

Every surgical patient shall have a pre-anesthetic evaluation by a person qualified to administer anesthesia, with findings recorded within forty-eight (48) hours before surgery, a pre-anesthetic visit by the person administering the anesthesia, and an anesthetic record and post anesthetic follow-up examination, with findings recorded within forty-eight (48) hours after the procedure by the individual who administered the anesthesia.

9. Examination of Tissue Specimens

All tissues removed at any procedure shall be sent to the Hospital pathologists, except those specimens listed as exempt by the Medical Staff and department of pathology . The pathologists shall make such examinations as they consider necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

The Medical Staff and the pathology department together shall determine which tissue specimens require macroscopic examination and which require both macroscopic and microscopic examination.

10. Preventing Fetal Injury

Female patients of child-bearing age shall be evaluated for possible pregnancy before the administration of any drugs or before the performance of any tests, procedures or treatments which might be potentially harmful to the fetus.

11. Diagnostic Imaging Interpretations

Interpretations of x-rays and other diagnostic imaging studies shall be written or dictated and shall be done and signed by a qualified Practitioner authorized by the Medical Staff to interpret diagnostic imaging studies.

12. Department Rules and Regulations

Rules and Regulations, and policies for each clinical department or section are included by reference only and are determined by those departments and sections individually.

All individual clinical department or section Rules and Regulations and policies, along with any proposed changes or revisions thereto, shall be reviewed by the bylaws committee for recommendation for adoption to the Executive Committee, then adopted or rejected by the Executive Committee.

13. Verification of Critical Test Results

When critical test results are relayed orally to the ordering or attending Practitioner, the person receiving the results must record the results and read back the results so recorded to the person who relayed the results.

ADOPTED by the Executive Committee of the Medical Staff of Ministry Saint Michael's Hospital of Stevens Point, Inc.

Andrew J. Braun, MD
Medical Staff, President

Date March 22, 2011

APPROVED by the governing body of Ministry Saint Michael's Hospital of Stevens Point, Inc.

Mr. James Schuh
Secretary of the Board

Date March 29, 2011