Manual:	Medical Staff Corporate Policy and Procedure	Origination Date:	03/23/2022
		Approval Date	04/05/2022
Title:	Medical Staff Rules and Regulations	Next Periodic Review:	04/05/2025
		Owner:	Jodie Franzen
Duncan Regional Hospital, Inc., d/b/a DRH Health policies apply to Duncan Regional Hospital, Jefferson County Hospital and Rural Health Clinics, Solutions Specialty Clinics and Practice Management, and Advanced Medical Supply.			

Medical and AHP Staff Rules and Regulations DRH Health

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DEFINITIONS

1. **"Allied Health Practitioner"** or **"AHP"** shall mean an individual other than a licensed Physician, Dentist, or Podiatrist whose patient care activities require their authority to perform specified patient care services be processed through Medical Staff channels or with involvement of Medical Staff representatives. An AHP is not considered a member of the Medical Staff. An AHP is subject to the policies and procedures governing AHPs.

4. **"Appellate Review Body"** shall mean the group designated under the Fair Hearing Plan to hear a request for appellate review filed and pursued by an applicant or Medical Staff member.

5. **"Applicant"** shall mean any practitioner who has submitted a completed application for initial appointment to the Medical Staff.

6. **"Board Certified"** shall mean having successfully completed all requirements and be recognized as such by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or an equivalent organization in a country eligible for licensure through endorsement of current license by the Licensure Board.

8. **"Board of Directors" or "Governing Board"** shall mean the Board of Directors of Duncan Regional Hospital, Inc., d/b/a DRH Health.

9. **"Bylaws" or "Medical Staff Bylaws"** shall mean the Bylaws of the Medical Staff of DRH Health., and the following related manuals: (i) Medical Staff Fair Hearing Plan; and (iii) Medical Staff Rules and Regulations.

10. **"Chief of Staff"** shall mean the Chief of Staff of the Medical Staff.

11. **"Clinical Privileges" or "Privileges"** shall mean the permission granted by the Board to a Medical Staff Member to render specific diagnostic, therapeutic, medical, dental, or surgical services.

14. **"Credentials Committee"** shall mean the Credentials Committee of the Medical Staff.

16. **"Dentist"** shall mean an individual who has been awarded the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.) and who is licensed to practice dentistry in the state of Oklahoma.

24. **"Hospital"** shall mean Duncan Regional Hospital and Jefferson County Hospital and includes all inpatient and outpatient locations and services. Except as otherwise specified in the Bylaws, Medical Staff Rules or Medical Staff policies, references to "Hospital" shall be deemed to include all of the Hospital inpatient and outpatient facilities that are serviced by the Medical Staff.

25. **"Hospital Bylaws"** shall mean the Bylaws of the Hospital.

27. **"Licensure Board"** shall mean the Oklahoma State Board of Medical Licensure and Supervision for medical doctors; the State Board of Osteopathic Examiners for doctors of osteopathy; the Board of Governors of Registered Dentists of Oklahoma for Dentists, and the Oklahoma State Board of Podiatric Medical Examiners for Podiatrists.

28. **"Medical Executive Committee"** or "MEC" shall mean the Medical Executive Committee of the Medical Staff.

29. **"Medical Staff or "Staff"** shall mean the formally organized self-governing body consisting of those physicians, dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

30. **"Medical Staff Member" or "Member"** shall mean any practitioner who has been duly appointed to the Medical Staff and who is privileged to attend patients in the Hospital.

39. **"Physician"** shall mean an individual who has been awarded the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) and who is licensed to practice medicine in the state of Oklahoma.

40. **"Podiatrist"** shall mean an individual who has been awarded the degree of Doctor of Podiatric Medicine (D.P.M.) and who is licensed to practice podiatry in the state of Oklahoma.

41. **"Practitioner"** shall mean, unless otherwise expressly limited, any appropriately licensed physician, dentist, oral surgeon, podiatrist, or allied health practitioner.

43. **"President"** shall mean the individual appointed by the Board to serve as President, chief executive officer and administrator of the Hospital. Such individual shall have the authority and duties set forth in Section 4.5.3 of the Hospital Bylaws.

44. **"Professional Review Body"** shall mean as appropriate to the circumstances, the Board of Directors, the MEC, the Credentials Committee, the Investigative Committee, the JCH Medical Staff Committee, any investigation committee, any Hearing Committee, any Appellate Review Committee, the President of the Hospital, the Chief of Staff, and any other person, committee or entity having authority to make an adverse recommendation with respect to or to take or propose an action against any applicant or Medical Staff member when assisting the Board of Directors in a peer review process.

45. **"Rules and Regulations"** shall mean the rules and regulations adopted by the Medical Staff to establish a framework for self-governance of medical staff activity and accountability to the Board of Trustees.

I. General Rules and Regulations

A. The Medical Staff of DRH Health including both Duncan Regional Hospital (DRH) and Jefferson County Hospital (JCH) (the "Hospital"), shall meet as determined by the Medical Executive Committee with regular meetings held on the first Monday of the month at 6:00 p.m.

B. The order of business at a regular staff meeting shall be determined by the Chief of Staff. The agenda shall include at least:

1. Review and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

2. Administrative reports from the President, the Chief of Staff, governing board members, and committees;

3. The election of officers and of representatives to staff committees as required by the bylaws;

4. Reports by responsible officers and committees on the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients and on the utilization management activities of the staff and on the fulfillment of the other required staff functions;

5. Recommendations for improving patient care within the Hospital; and

6. New business.

C. It is recommended that each member of the active Medical Staff attend at least seventy-five percent (75%) of all staff meetings and at least seventy-five percent (75%) of all meetings of each committee of which they are a member.

D. It is the obligation of each member of the Medical and AHP Staff to adhere to the policies and procedures of each Hospital department as adopted by the Medical Staff and/or the Hospital.

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II. Admission and Discharge of Patients

A. A patient may be admitted to the Hospital only by a member of the Medical Staff or a psychologist or Allied Health Professional Staff admitting on behalf of their supervising physician.

B. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible. Except to the extent prohibited by the Emergency Medical Treatment and Labor Act, 42 U.S.C. §1395DD ("EMTALA") the Hospital reserves the right to limit or restrict admissions to the Hospital at any time if deemed in the best interests of the Hospital, and to the extent not inconsistent with the Hospital's tax-exempt status.

C. Each member of the Medical Staff shall be responsible for the medical care and treatment of each patient of such member in the Hospital, 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 practitioner and to relatives and/or power(s) of attorney of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered the medical record. Such note shall evidence acceptance of the patient by another qualified Medical Staff member.

D. Practitioners admitting patients shall be held responsible for giving such sufficient information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

E. Any active member of the Hospital's Medical Staff may admit patients to the ICU; however, members of the staff are limited to admission of patients in need of treatment within the scope of the medical and procedural privileges which they have been granted.

F. The attending physician or their physician representative is required to visit their patient(s) daily whom are acute care inpatients or observation outpatients. Exception is:

1. In the Comprehensive Rehab Unit (CRU), the attending physician will visit patients a minimum of three times per week.

2. In the Geriatric Psychiatric Unit (GPS), the attending physician (psychiatrist), will visit the patient(s) within 60 hours of admittance to GPS and a minimum of three times a week until discharge. A hospitalist or primary care physician, or their designee, , will visit patients within 24 hours of admission to complete the history and physical (H&P), and will see the patient a minimum of one time every seven (7) days, or more often as medically necessary.
3. For patients in Swing Bed Status, the attending physician will attend interdisciplinary care team meetings, at least every fourteen (14) days.

G. Patients will be discharged only on an order of the attending physician. An Allied Health Practitioner (AHP) may enter the discharge order on behalf of the attending physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Where possible, the attending physician will obtain the signature of the patient on a form to be provided by the Hospital that releases the Hospital and the physician of liability in this situation.

H. Pronouncement of Death.

1. Either the attending physician or their designee, who is a medical provider qualified to diagnose, will be present and pronounce the death of any patient. All pronouncements of death will take place within one (1) hour.

2. Nursing can examine the patient and report to the physician the cessation of vital signs. The physician can accept this and issue a telephone/verbal order of pronouncement of death and release of the body. The physician will then sign this telephone/verbal order as soon as possible.

3. Alternatively, the attending physician, if unable to be present, may ask the ER physician in a direct physician-to-physician communication, to assess the patient and, if appropriate, to pronounce the patient dead.

4. In the event the attending physician or physician designee has not been successfully contacted within 30 minutes following evidence of death, the ER physician will pronounce the patient dead.

I. Autopsy

Permission to obtain an autopsy should be sought in every inpatient death that occurs in the Hospital if one or more of the following criteria are met:

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

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

3. Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to provide reassurance to them regarding the same;

4. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures or therapies;

5. Death of patients who have participated in clinical trials (protocols) approved by institutional review boards;

6. Deaths resulting from high-risk infectious and contagious diseases;

7. All obstetrical deaths;

8. All neonatal and pediatric deaths;

9. Deaths of patients of any age where it is believed that autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs;

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

Except in circumstances in which an autopsy is required by law, no autopsy will be performed without the written consent of the duly appointed and acting personal representative (formerly referred to by law as the Executor/Executrix or Administrator/Administratrix) of the estate of the patient (as verified upon receipt of a certified copy of the Letters Testamentary or Letters of Administration for such individual) or a legally authorized agent or representative of the patient.

To facilitate use of autopsy findings in performance improvement activities, all autopsy reports will be reviewed by the Quality Improvement Committee for use in morbidity/mortality reviews and any other quality or performance improvement activity.

J. All patients presenting to the Hospital in active labor or with an emergency or a life-threatening condition, as determined following an appropriate medical screening examination, will be treated in compliance with EMTALA.

III. General Rules Regarding Medical Records

A. Observation and Inpatient Medical Records. The attending physician, or the AHP with appropriate privileges, shall complete a medical record for each patient admitted into the Hospital. This inpatient record shall include, at a minimum, the following information on the forms and in the manner required by the Hospital:

1. Medical history, including:
   a. Chief complaint
   b. History of present illness
   c. Past History
   d. Medications
   e. Allergies
   f. Social history
   g. Family history
   h. Review of systems.

2. Physical examination

3. Diagnosis

4. A plan of action;

5. Progress notes daily for acute care, three (3) times per week for Comprehensive Rehab Unit and Horizons Unit, and every seven (7) days for Swing Bed patients.

6. Consultation reports reflecting the opinion of any consultants, including their findings on physical examination of the patient;

7. Reports of operative and other invasive procedures, and administered anesthesia. The operative report shall include preoperative diagnoses, postoperative diagnoses, and a complete description of the surgical procedures and findings.

8. Reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatments;

9. Tissue reports, including a report of microscopic findings if Hospital regulations require that microscopic examination be done; otherwise, if only gross examination is warranted, a statement that the tissue has been received with a gross description by the laboratory;

10. Records of donation and receipt of transplants and/or implants;

11. Final diagnosis(es);

12. The discharge summary shall be documented for all patients with the following exceptions: a final progress note may be substituted for the discharge summary for those patients with conditions and interventions of a minor nature who require less than a 48-hour period of hospitalization and observation patients. The Physicians Record of Newborn may be used as the discharge summary for normal newborn records. The discharge summary shall include: reason for hospitalization, significant findings, and procedures performed and treatment rendered, condition of patient at discharge, and specific instructions given to the patient and/or family (disposition, diet, activity, medications, and follow-up).

13. Instructions to patient/family; and

14. Special clinical reports, including the following, as appropriate:

    a. For obstetrical patients, reports throughout labor, delivery and postpartum;
    b. For newborn patients, the infant's weight, length and other notes relative to physical examination;
    c. The prenatal record may be used as the History and Physical for obstetrical patients admitted for delivery. An interval note shall be completed prior to delivery. A history and physical shall be documented for patients not receiving prenatal care by an active DRH Health Medical Staff member.
    d. The Emergency Department provider's record may be used as the history and physical for patients having procedures involving anesthesia, including moderate sedation, in the Emergency Department.

B. Emergency Department Medical Records. The ER provider shall complete an ER medical record for each patient presenting in the ER who is seen and treated. The ER medical record will contain, at a minimum, the following information:

1. Patient identification;
2. Time and means of arrival;
3. History of disease or injury;
4. Physical findings;
5. Laboratory and x-ray reports, if any;
6. Diagnosis and therapeutic orders;
7. Record of treatment, including vital signs;
8. Disposition of the case;
9. Signature of a registered nurse;
10. Signature of the provider; and
11. Documentation if the patient left against medical advice.

C. Outpatient Medical Records. An outpatient medical record will be prepared and maintained for each individual receiving outpatient services at the Hospital. Information contained in any outpatient medical record shall be complete and sufficiently detailed relative to the patient's history, physical examination, laboratory and other diagnostic tests, diagnosis and treatment to facilitate continuity of care.

D. Promptness of Record Completion

All documents shall be completed within the timeframes defined below:

Documentation Requirement	**Timeframe**	**Exclusions**
Emergency Room Report	Completed and signed off at the completion of the provider's shift.	

History and Physical	Documented within 24 hours of admission or prior to surgery or any procedure requiring anesthesia. For H&P documented prior to admission, an interval note reflecting any changes in patient's condition may be used.	• Emergency surgery in which H&P cannot be documented prior. Medical record documentation should note the surgery or procedure was conducted on an emergency basis. • The prenatal record may be used as the History and Physical for obstetrical patients admitted for delivery. An interval note utilizing the "Physician's Updated Prenatal Assessment for Obstetrical Patient form shall be completed prior to delivery, a history and physical shall be documented for patients not receiving prenatal care by an active Medical Staff member.
Progress Note	Should be documented within 24 hours of the patient encounter.	
Consultation Report	Documented with 24 hours of consultation.	
Operative Report/Procedure Note	Should be documented immediately after surgery or delivery of a newborn.	When a postoperative progress note is utilized, a full, complete operative or procedure report must be documented within 24 hours after the procedure is completed.
Post-op Progress Note	Documented before the patient is transferred to the next level of care.	When a full operative report or procedure report is entered immediately into the patient's record a post-op progress note is not necessary.
Intraoperative and Post Anesthesia/Sedation Record	There will be a preanesthesia assessment performed not more than forty-eight (48) hours prior to surgery by the physician or CRNA. An anesthetic record of care should be completed at end of each procedure.	

	A post-anesthetic follow-up not more than forty-eight (48) hours after surgery.	
Discharge Summary	Must be completed within 7 days of discharge.	See description of Short Stay summary and Final Progress Note.
Short Stay Summary	For patients hospitalized for less than 24 hours, a short stay summary that includes the elements of the history and physical as well as the discharge summary may be used if completed within 24 hours of admission (to meet the history and physical requirements).	If not completed within 24 hour of admission, a history and physical should have been completed within the 24 hour time frame and a final progress note may be completed within 24 hours of the encounter. Otherwise, a discharge summary must be completed within 7 days.
Final Progress Note	For those patients with conditions and interventions of a minor nature who require less than a 48-hour period of hospitalization and observation patients may have a final progress note completed with 24 hours of the encounter.	A full discharge summary may be completed within 7 days instead.
Psychiatric Evaluation	Must be documented and signed within 60 hours of admission.	
Provider Coding Clarification	Ideally completed within 48 hours. Documented response no later than 7 days after provider notified.	

E. No medical record shall be filed until it is complete, except on order of the Quality Improvement Council.

F. All medical records are the property of the Hospital and shall not be removed from the Hospital except upon receipt of a valid court order, pursuant to an applicable statute, upon specific written authorization of the Hospital administration, or as otherwise provided by law. Medical records, as well as other protected health information must be obtained unless otherwise required or permitted pursuant to the Hospital privacy policies of by law.

G. Only recognized and approved abbreviations shall be used. No abbreviations shall be used in the final diagnosis(es).

H. Medical records should be finalized within 30 days of discharge**.** The following process shall apply regarding completion of medical records by providers:

1. Medical record deficiencies are entered or generated in Meditech for each provider. These deficiencies include needed signatures, dictation, and/or additional documentation. These deficiencies can be viewed by logging into Meditech.

   - Deficiencies should be completed within 14 days of assignment.
   - Deficiencies not completed within 14 days of assignment are considered delinquent.

2. A provider who will be unavailable should notify the Medical Staff (HIM) department prior to the departure date. The counting of days for medical record deficiencies will then be suspended during this period of time for that particular provider.

3. Every week a letter including the deficiencies to be completed by each practitioner will be generated. All deficiencies that have been signed out for 14 or more days are considered delinquent and are due by noon on the following Wednesday.

4. Medical Records (HIM) personnel will contact providers who had deficiencies that ere 14 days old the previous week. These providers will have until noon Wednesday to complete these deficiencies. If the deficiencies are not completed by noon on Wednesday, the Chief of Staff will be notified.

5. Each practitioner will have seven days after the initial notification to complete and sign delinquent deficiencies. If any deficiencies on this list are still incomplete at noon the following Wednesday, the Chief of Staff will be notified. The provider is eligible to have disciplinary action up to and including suspension of privileges.

   In the event a provider's privileges are suspended as indicated above, the provider will be notified of the suspension by the Chief of Staff. The Hospital administration, the Registration departments, the Surgery Department, the Emergency Department and the Medical Staff Coordinator shall be notified of such suspension.

Hospitalists will be responsible for completing their deficiencies prior to leaving shift.

6. Suspension of privileges shall prevent a provider from directly admitting patients to the hospital from the office, admitting patients from the Emergency Department, or scheduling surgeries. Providers with suspended privileges will be allowed to perform previously scheduled surgeries and complete hospital care of current inpatients. All such persons/departments also shall be promptly notified when the records are completed and such suspension is lifted. The Chief of Staff will notify the practitioner that their suspension has been lifted.

7. Providers with extraordinary circumstances may appeal this suspension to the Medical Executive Committee by notifying the Chief of Staff.

8. In the event a providers privileges are suspended for delinquent medical records three times within six months, such providers' Medical Staff membership and clinical privileges shall be automatically terminated pursuant to the Medical Staff Bylaws.

I. All Do Not Resuscitate (DNR) orders (formerly referred to as NO CODES or NO CPR orders) shall be documented in a patient's chart, but only after the attending physician has verified and documented in the medical record in the manner indicated that one or more of the following four circumstances exists:

1. The patient is capacitated and has advised the physician that the patient does not consent to CPR and either the physician has noted this in the patient's medical record or the patient has completed a Do Not Resuscitate form;

2. The patient is incapacitated but has a legally appointed representative (which may only include a court-appointed guardian, a health care proxy appointed by the patient in a valid advanced directive, an attorney-in-fact appointed in a durable power of attorney, and does not include a family member without any of the foregoing legal appointments) who has consented to a DNR order and/or has signed a DNR Form; provided, however, no decision may be made by such representative until (i) the representative has been instructed in writing by the patient's attending physician that the representative is deciding what the patient would have wanted if the patient could speak for himself or herself; (ii) the

attending physician has encouraged consultation among all reasonably available representatives, family members and persons close to the patient, to the extent feasible under the circumstances; and (iii) to the extent possible, the attending physician has explained to the representative and family members of the patient the nature and consequences of the decision to be made (with evidence of such explanation documented in the medical records of the patient). Further, the reason the representative, rather than the patient, has made a decision shall be documented in the medical record.

3. The patient is incapacitated, has been certified by two physicians as being terminally ill or persistently unconscious as defined under Oklahoma law, and has a valid advance directive directing that life-sustaining treatment not be performed in the event of cardiac or respiratory arrest;

4. The patient is incapacitated and without a legal representative but the attending physician has certified (by signing a Certificate of Physician) that the physician knows by "clear and convincing" evidence (which requires a firm belief or conviction as to the truth of the assertion, whether based on oral, written or other communications between the patient, when competent, and family members, health care providers and others involved in the care of the patient) that the patient, when competent and based on sufficient information to constitute informed consent, communicated that the patient would not consent to resuscitation under the circumstances present; or,

5. The patient is a minor child and the parent or legal guardian of the minor child, after consultation with the minor child's attending physician, has notified the minor child's attending physician that the parent or legal guardian does not consent to the administration of CPR in the event of the minor child's cardiac or respiratory arrest, and that the minor child, if capable of doing so and possessing sufficient understanding and appreciation of the nature and consequences of the treatment decision despite the minor child's chronological age, has not objected to the decision of the parent or legal guardian, and such notification has been entered in the chart of the minor child; provided medically indicated treatment may not be withheld from a disabled infant with life-threatening conditions to the extent that such medically indicated treatment is required by federal law or regulations as a condition for the receipt of federally funded grants to Oklahoma for child abuse, neglect and prevention treatment programs.

J. All orders in effect prior to transfer to or from ICU will be reviewed by the attending physician who shall order whether or not to continue such prior orders post-transfer.

K. Notwithstanding the foregoing, neither the attending physician, Hospital personnel nor any other health care provider is required to begin or continue the administration of CPR when, in the reasonable medical judgment of such health care provider, such action would not prevent the imminent death of the patient.

IV. General Conduct and Care

A. A general consent form, signed by every patient (or by an authorized legal representative on behalf of such patient) should be obtained for every registration. When possible, the patient should sign and initial the form. If the patient is incapacitated, a legal representative or next of kin may sign. If the patient's condition improves to a point where the form can be explained and the patient is able to provide a signature, another general consent form should be taken to the patient's location in the hospital and signature obtained. If the patient is a minor (a person not yet 18 years old), a parent or legal guardian should sign the general consent form. Parents may provide another adult with a written and signed authorization to consent to medical treatment for the minor child. Married and emancipated minors do not need parental consent. In an emergency, when it is evident that treatment is immediately necessary to save or preserve the life of a patient or prevent immediate and serious impairment of a patient's health, consent may not be required. Consent in such instances is implied. However, when the emergency has been resolved, reasonable effort should be made to obtain the appropriate consent.

B. All orders for treatment shall be documented. A verbal order shall be considered to be documented if indicated to a licensed or person functioning within their sphere of competence and countersigned by the responsible practitioner. All orders dictated over the telephone shall be signed by the licensed or person to whom dictated with the name of the practitioner per their own name. Health Unit Coordinators (HUCs) who have completed competency requirements shall be allowed to take telephone/verbal orders for diagnostic tests and diets. Medical Social Workers and HUCS may enter verbal orders for admission to be countersigned by the attending provider. Verbal/telephone orders for medications shall be given only to individuals so authorized by law and the Medical Staff and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal/telephone order and the signature of the individual receiving the order. The person

taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood. Signature stamps shall not be used as a substitute for the signature of the responsible practitioner. Failure to do so shall be brought to the attention of the Executive Committee for appropriate action.

C. Physicians who are members of the active Medical Staff may authenticate another physicians orders on inpatients or outpatients. Physicians who authenticate another physician's orders and the physician, whose orders are authenticated by another physician, understand and agree that the authentication by another physician indicates that both physicians understand that the covering and attending physician assume responsibility for the authentication that they provide their colleague. They also understand that the order is complete, accurate, appropriate and final.

D. A practitioner's written orders must be written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or clarified by the practitioner.

E. Standing orders shall be formulated by conference between the Medical Staff and the President. They can be changed by mutual consent of the Medical Staff and the President, and the latter shall notify all personnel concerned. The attending physician shall sign these orders.

F. Patients have the right to be free from chemical or physical restraint and/or seclusion unless such restraint is required to prevent injury to the patient or others. All restraints or seclusion shall be in compliance with 42 C.F.R. 482.13 and the Hospital restraint policy.

G. Consultations:

1. Definitions:

a. <u>Consultations</u>: A consultation shall consist of any evaluation of the patient and any recommendations for treatment by the consultant. The attending physician shall remain in full charge of the care and the consultant's responsibility is limited to the implementation of written recommendations.

b. <u>Consult and follow (with or without orders)</u>: The consultant shall give a consult as above and continue to follow the patient with the attending

physician who shall remain in sole charge of the patient's care. Orders may be given by the consulting physician. If a conflict results concerning orders, the attending physician must be contacted for resolution.

c. Referral: The attending physician has transferred full responsibility for the care of the patient to the consulting physician and it shall be documented on the chart that the patient consented to the referral, to whom the patient was referred (e.g., "Referred by Dr. _____") and documentation that the consulting physician accepted responsibility for the patient.

2. Required Consultations: Except in an emergency, consultations with another qualified physician are required in:

a. Cases in which, according to the judgment of the physician:

i) The patient is not a good risk for operation;
ii) The diagnosis is obscure; or,
iii) There is doubt as to the best therapeutic measures to be utilized.

b. The patient's physician is responsible for requesting consultations when indicated.

3. Consultations:

a. A consultant must be well qualified to give an opinion in the field in which their opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of an individual's training, experience, and competence.

b. Essentials of the consultation: A satisfactory consultation includes examination of the patient and the record. A dictated opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation notes, except in emergency, shall be recorded prior to the operation.

c. A physician who is requesting a consult by another physician must personally contact the consulting physician. An order on the patient's chart for nurses to contact the consulting physician is not permissible.

d. Patients must be seen within a reasonable time which is commensurate with the patient's condition. This should be communicated between physicians at the time of the consult request.

H. Medications:

1. Medications prescribed shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-official Drugs, with the exception of medications for bona fide clinical investigations. Any exceptions to this rule must be approved by the committee responsible for the Pharmacy and Therapeutics function.

2. Approved formulary medications are listed in the Hospital formulary.

3. The committee responsible for the Pharmacy and Therapeutics function must review the literature and approve the use of all experimental medications which are not approved by the Food & Drug Administration ("FDA"), including medications approved by the FDA for use in adults but being administered to a pediatric patient, before they can be administered to a patient. Prior to administration of any experimental medication, the patient shall consent, in writing, to the administration of the experimental medication. The attending physician must administer the drug and the physician must provide the nursing staff with appropriate literature regarding the medication (including indications, contraindications, signs, symptoms, etc.).

4. Electronic renewal reminders will be sent beginning on day 9 for narcotics and antibiotics. If the renewal is not addressed by the physician renewal reminders continue to appear daily, until addressed.

I. Patients may leave the Hospital on pass privileges only on written order of the attending physician. The order must specify the period of time the patient may be out of the Hospital and the period of time must not exceed six hours. Pass privileges will not be allowed on the evening prior to surgery.

J. Mass Casualty Assignments shall be in accordance with the Hospital's Mass Casualty Disaster Plan.

K. Prior to endotracheal extubation, if the attending physician is not present, the nursing staff will check to see if an anesthetist is available. If an anesthetist is not available, the attending physician must remain in the building and be "available" for possible emergency reintubation. "Available" is defined as meaning a physician is able to respond immediately in an emergency.

L. Patients with arterial lines, Swan-Ganz catheters or transvenous temporary pacemakers, may only be admitted to the ICU.

M. All credentialed providers at DRH Health should maintain updated contact information with the Medical Staff Office, and should be available during and after business hours to receive and respond to critical results of outpatient tests they have ordered for their patient(s). The provider is responsible for securing coverage when they are unavailable for contact. The DRH page operator should be notified of the dates and times that a provider will be unavailable and the name of the individual, or call group who has agreed to cover in their absence.

V. General Rules Regarding Operative and Invasive Care

The following guidelines will be followed for operative and other invasive procedures.

An **operative procedure** is defined as a surgical or other procedure that put the patient at risk of death or disability.
An **Invasive procedure** is defined as a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to surgeries, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations and excluding venipuncture and intravenous therapy.

A. Appropriate Procedures. The appropriateness of operative and other invasive procedures will be based, in part, on a review of the patient's history, physical status, diagnostic data, the risks and benefits of procedures and the need to administer blood and blood products.

B. Anesthesia. Anesthesia services are administered in areas including but not limited to the operating room, emergency department, critical care areas, obstetrics, radiology, outpatient

surgery, and special procedure areas. Anesthesia may be provided by independent practitioners (i.e. CRNAs, MDs, DOs) who have privileges to perform anesthesia. CRNAs shall be credentialed per the Medical Staff Allied Health Practitioner Guidelines. The CRNA must collaborate with the physician or dentist performing the procedure or directly involved with the procedure. This collaboration involves the joint formulation, discussion and agreement of the anesthesia plan by both parties, and the physician or dentist performing the procedure or directly involved with the procedure must remain available for timely onsite consultation during the delivery of anesthesia (OK Nurse Practice Act, Section 567.3a(10)(a-b)).

1. Anesthesia services will include General, Spinal, Regional Blocks, Epidural, and Monitored Anesthesia Care.

2. It is the physician's responsibility to inform the patient of the type of anesthesia they are to receive and to obtain the consent of the patient.

    a. There will be a preanesthesia assessment of each patient for whom anesthesia is planned. The assessment will be performed not more than forty-eight (48) hours prior to surgery by the physician or CRNA and will include evidence of the following:

        i) A review of the objective diagnostic data, an interview with the patient or significant other to discuss the patient's medical, anesthetic and drug history;
        ii) A review of the patient's physical status;

    b. An anesthetic record on an approved Hospital form; and

    c. A post-anesthetic follow-up, with findings recorded, by the person responsible for administering the anesthesia to the patient not more than forty-eight (48) hours after surgery.

    d. Plan of anesthesia. Prior to the administration of anesthesia, there will be a determination that the patient is an appropriate candidate to undergo the planned anesthesia. This determination will be made by a CRNA with appropriate clinical privileges, in collaboration with the physician or

dentist performing the procedure, and will be based on the results of the preanesthesia evaluation. .

e. Moderate sedation may be administered by a physician or by a registered nurse under the orders of a physician with moderate sedation privileges per the Moderate Sedation policy.

f. Each provider with moderate sedation privileges must maintain certification in ACLS. Emergency Department physicians who maintain board certification in Emergency Medicine are exempt from this requirement.

C. Credentialing Required. Physicians shall perform only those procedures for which they have been granted privileges by the Hospital Board of Directors. Lists of privileges will be available on the DRH portal page.

D. Chair of Surgery Committee. The appointed Chairman of the Surgery Committee shall be the Medical Director of the Surgery Department and must be a MD or DO surgical specialist. The Chairman of the Surgery Committee also serves as the Medical Director for Surgery/Anesthesia Services and is responsible for planning, directing, supervising, and evaluating the quality of the anesthesia services throughout the organization. (CMS, COP 482.52)

E. History & Physical.

1. A preoperative history and physical shall be documented in the medical record prior to taking the patient to the room where the procedure is to be performed. A history and physical completed within 30 days before admission or readmission may be used provided an interval note is made reflecting any changes in the patient's condition. The interval note shall be documented immediately prior to taking the patient to the room where the procedure is to be performed. In an emergency situation, the history and physical should be documented as soon as possible and the record should indicate that the surgery or procedure was conducted on an emergency basis.

2. For outpatient operative and invasive procedures, a Short H&P Invasive Procedure Form, clinic documentation, or the Emergency Department provider's record may be used and must be completed prior to taking the patient to the room where the procedure

is to be performed, except in emergency situations. Timeframes in the above paragraph are applicable. For outpatients, the physician should reassess the patient and update the H&P the day of surgery prior to the start of the surgery or procedure.

3. The history and physical for an outpatient procedure requiring anesthesia must be submitted prior to admission or registration by a physician or qualified licensed individual who may or may not be member of the medical or AHP Staff, or who does not have admitting privileges at the Hospital, but is acting within his/her scope of practice under State law or regulations. Generally, this occurs when the H&P is completed in advance by the patient's primary care practitioner. The update to this H&P just prior to the surgery or procedure will be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform an H&P.

F. Diagnostic Testing. Diagnostic testing relevant to the patient's condition as requested by the physician will be performed and documented on the patient's medical record. Additional studies may be requested by the CRNA per approval of the surgeon.

G. Informed Consent Requirements.

1. Anesthesia shall be administered, and surgery and invasive procedures shall be performed, only upon consent of the patient or his/her legal representative, except in case of a life-threatening emergency. All invasive procedures to be performed shall be fully described to the patient by the physician performing the procedure.

2. There will be evidence in the medical record that the practitioner performing the procedure has appropriately informed the patient and/or legal representative of information necessary to make an informed decision for care and treatment. Informed consent discussion includes a description of the proposed procedure including anesthesia to be used (if applicable), the indications for the procedure, potential risks, and benefits, potential complications, treatment alternatives and their risk and benefit, probable consequences of declining, recommended or alternative therapies, and whether other personnel will be performing important tasks (e.g. opening, closing, dissecting tissue, administering anesthesia, placing invasive lines, etc.) related to the procedure.

H. Operative Report. An operative report or procedure report shall be documented upon completion of the operation or procedure and before the patient is transferred to the next level of care. If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next level of care, the full report may be dictated or created in the new unit or area of care.

When a full operative report or procedure report cannot be entered immediately into the patient's record, a progress note may be documented before the patient is transferred to the next level of care and includes the following:

1. Name(s) of primary surgeon(s)
2. Name(s) of assistant(s)
3. Procedure performed
4. Type of anesthesia
5. Description of significant findings
6. Estimated blood loss
7. Specimen Removed
8. Post-operative diagnosis

When a postoperative progress note is utilized, a full, complete operative or procedure report must be documented within 24 hours after the procedure is completed.

I. Scheduling of Surgical Procedures.

1. Surgical procedures are scheduled through Central Scheduling Department Monday through Friday. To add a procedure to the current day's schedule, contact the OR Charge Nurse.

2. Hours of elective surgery are 7:00 a.m. to 3:00 p.m., with elective cases to be completed by 5:00 p.m.

3. Information which must be provided when scheduling a case consists of the patient's name, date of birth, procedure, type of anesthesia, a phone number to contact the patient, and type of admission (e.g. outpatient, day of surgery admission, inpatient).

4. Surgical procedures are scheduled on a "first come, first served" basis with room(s) reserved for "block" scheduling on designated days. Blocks are approved by the

Surgery Committee and reviewed for usage. The start time is considered the time at which the patient enters the operating room. Start time is routinely scheduled for 0730 unless otherwise specified by the surgeon with subsequent cases scheduled as to follow.

a. Block Scheduling: A surgeon should fill their block prior to scheduling elective cases outside of the block. Unused block will automatically be released at 12:00 noon the day. The physician with the next scheduled case by time will be given opportunity to move to the earlier available time. Surgeons should notify scheduling ideally one week in advance to release a block when the surgeon is not available to use it (e.g. vacation).

   Cases scheduled to begin later than 0800 will start at the scheduled time providing that earlier cases are completed in a timely manner. In the event a case needs to be added ahead of a later scheduled case, the surgeon adding the case should contact the scheduled surgeon to discuss the need to bump the scheduled case time back.

b. "Emergency" cases added at the beginning of the day will "bump" the most recently scheduled case. The type/length of surgery and the condition of the patient and the involvement of the pathologist or the physician assistant, as well as the surgeon's previously bumped cases will be taken into consideration. The final decision will be made by the Director of Surgery or designee. An emergency case occurring during the regular scheduled day will bump the first available room.

   The physician adding the emergency case will contact the other physician if time allows. Cases added to the schedule throughout the day will be scheduled to follow the next available room, as resources (e.g. staff/equipment) are available.

c. As resources permit, a "flip-flop" crew will be made available for regularly scheduled procedures between 7:30 A.M. and 3:00 P.M. Priority will be given to the physician working within their block day, the physician with the longest time scheduled for that day, and/or the physician that the additional surgery team could make the greatest benefit to efficiency.

5. Surgeons should arrive early enough to complete the pre-operative patient visit and still meet the scheduled start time. On time start is defined as the patient entering the operating room no later than 5 minutes past the scheduled start time. The surgeon's monthly on time start percentage will be reported at Surgery Committee. Reasons for late start will be documented by the circulating nurse and tracked by the OR Director.

6. Unexpected delays and disruptions may occur during the course of the scheduled day. If a surgeon has planned delays or disruptions during their scheduled time (e.g., business meeting, personal business, etc.), the surgeon should notify scheduling or the OR charge nurse of the expected length of the delay so patient arrival times and OR/Anesthesia resource utilization can be planned accordingly.

J. Staffing for Surgical Cases. Staffing for Surgical Cases will be per OR Staffing Plan, Surgery Policies and Procedures.

K. Tissue Removed.

All tissues removed at operation, with the exceptions outlined below, shall be sent to a pathologist with appropriate privileges at the Hospital, who shall make such examination as they may consider necessary to arrive at a pathological diagnosis. They shall submit a signed report.

Categories of specimens that may be exempt from this requirement are:

1. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure.

2. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

3. Traumatically injured body parts that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.

4. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

5. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant.

6. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics.

7. Teeth, provided the number, including fragments, are recorded in the medical record.

8. Specimens from ptosis repair (levator aponeurosis) and specimen from eye muscle surgery for strabismus.

L. Frozen Sections.

1. Frozen sections will be scheduled through the Hospital's designated provider at the surgeon's request through scheduling clerk.

   a. In the event pathology services cannot be scheduled, the physician will determine if the procedure should be rescheduled.
   b. Tissue submitted for examination by frozen section shall be taken directly to pathologist, as appropriate.
   c. Communication between the pathologist and surgeon shall be by phone, or in person.
   d. The pathologist documents a preliminary report for the medical record.
   e. In the event that surgery is underway and an emergency frozen section is indicated, arrangements for pathology services should be made with the closest available pathology service provider.

M. Counts.

1. Instrument, sponge, and sharp counts will be performed per Surgery Policy and Procedures.

N. Post Anesthesia Care.

1. Patient's receiving general anesthesia, regional blocks and monitored anesthesia care will routinely be recovered per PACU Standards of Care unless physician

specifies differently. "After hour" care will be provided by an appropriately credentialed nurse.

2. Patients receiving moderate sedation will be appropriately monitored per the Hospital's Moderate Sedation Policy until discharge criteria are met.

3. Patients will be discharged upon order of the physician or when discharge criteria are met.

4. All discharge criteria will be approved by the Medical Staff.

VI. General Rules Regarding Obstetrical and Newborn Care

A. Obstetrical records shall include a complete prenatal record which is a legible copy of the attending physician's office record transferred to the Hospital 14 to 28 days before the estimated date of confinement.

B. The attending physician for any patient undergoing labor augmentation or induction with medication must be able to be physically present in the hospital within 30 minutes of receiving notification by phone, pager, or other accepted method of communication.

C. No lay person, husband or otherwise, will be allowed to observe any delivery of a newborn performed under general anesthesia.

D. All obstetrical patients will be delivered by traditionally accepted obstetrical practices. Any deviation is subject to be reviewed by the OB Committee.

E. In the event the attending physician approves the early dismissal of an obstetrical patient (such as 2 to 4 hours postpartum) they must enter a statement in the record certifying the physician has discussed any possible ramifications of the early dismissal of the OB patient and infant.

F. All OB patients shall be evaluated by an OB physician prior to transfer. All transfers must be in compliance with EMTALA.

G. First or second trimester elective termination of pregnancy is permitted only if a condition is present that is critical or life-threatening to the pregnant woman, only after approval consisting of two members of the Medical Staff OB/GYN Committee. The members of the OB/GYN Committee shall document in the medical record their concurrence with the attending physician that the patient met those criteria requiring abortion.

H. The physician will be required to document a delivery note for all deliveries.

I. Medical Staff members who attend newborns must maintain certification in neonatal resuscitation (Neonatal Resuscitation Program - NRP.

VII. General Rules Regarding Dental Services

A. A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the Medical Staff.

1. Dentists' Responsibilities:

   a. A detailed dental history justifying Hospital admission.

   b. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

   c. A complete operative report, describing the findings and consult technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

   d. Progress notes, as they are pertinent to the oral condition.

2. Physicians' Responsibilities:

   a. Medical history pertinent to the patient's general health.
   b. A physical examination to determine the patient’s condition prior to anesthesia and surgery.
   c. Supervision of the patient’s general health status while hospitalized.
   d. The attending physician must be in the building during a dental procedure when general anesthesia is being administered.
   e. Discharge or short stay summary.

3. The discharge of the patient shall be upon the order of the attending physician member of the Medical Staff.

4. Qualified Oral Surgeons and Periodontists may perform the history and physical examination without the attending physician. These specialists may also perform surgery without an attending physician present.

VIII. General Rules Regarding Emergency Services

A. Emergency Services

1. At DRH, the Emergency Department (ED) service is under the supervision of the Medical Staff Patient Care Committee with the Emergency Services Medical Director working in concert with the Chair of the Patient Care Committee to oversee and assure the quality of services. At JCH, the ED service is under the supervision of the JCH Committee with the Emergency Services Medical Director working in concert with the Medical Director of the JCH Committee. The Medical Staff assigned to Emergency Department coverage must be adequately trained to handle the diversified patients that present themselves for care and be familiar with the Hospital policies and procedures regarding ED services. The ED practitioner will use their judgment in calling for assistance from other staff members and specialists located in near facilities.

2. Each staff physician will be on call to admit their own patients and shall be responsible for their care unless another staff physician has agreed to cover their practice. In the event that the attending physician or covering physician is unavailable, the Hospitalist shall be contacted for admission. The staff physician must notify the Hospital operator of coverage in their absence.

3. On call specialist physicians will have arranged coverage when they are on call, but unavailable.

4. If an on-call specialist is not available or cannot respond due to circumstances beyond the physician's control, another staff physician in that specialty may be contacted to determine availability to respond, or transfer of the patient to another facility may be initiated.

5. If a regular staff physician wishes to be considered for Emergency Department duty in the event that vacancies exist they should notify the Emergency Department Director and formally submit to the Credentials Committee a request for Emergency Department Privileges.

6. When a staff physician has another staff physician covering their practice, the covering physician also takes any ED admissions unless other prior arrangements have been made.

B. Emergency Unassigned Patient Call

1. The Medical Executive Committee will recommend for approval by the Medical Staff which of the specialties represented on the medical staff will be placed on the published monthly unassigned patient call schedule. Qualified active staff physicians will be required to serve on the emergency call rotation in the capacity of specialty call or adult primary care. At DRH rotational call lists will be maintained for Adult Medicine (Family and Internal Medicine), Pediatrics (Family and Pediatrics), General Surgery, Orthopedics, Obstetrics (OB/GYN and Family with OB privileges), and other specialties as determined by the Medical Staff and/or as required by law. At JCH rotational call lists will be maintained for Acute Inpatient Care (also serves as follow-up referral for patients in the ED) and Inpatient Swing. Compensation is at the sole discretion of the Hospital Board. No specialist physician whose specialty is on the emergency call rotation will be required to take more than 1/3 of the total calls for that specialty. All physicians in any one specialty on the emergency call schedule will equally share weekdays, weekends and holiday emergency call for that specialty on a rotational basis that is fair to all physicians involved, unless such providers otherwise agree. The cooperative written call schedule for each specialty will be provided to the medical staff coordinator at a minimum of 30 days in advance of each month. Exemption from emergency call may be granted to an active staff physician at age 62 years or by a majority vote at any regular staff meeting. Requests for exemption must be made in writing.

2. The Unassigned On-Call Physician is obligated to one follow-up clinic appointment within a reasonable period of time, if requested by the patient, regardless of the patient's ability to pay, for patients without a regular physician who are seen in the ED or hospitalized by a hospitalist physician. The Unassigned On-Call Physician responsible for each such patient will be determined by using the day of admission to either the hospital or the ED as the appropriate call schedule day to assign the responsible physician for the follow-up appointment. If the responsible physician feels there is a conflict in seeing a particular patient, the physician will be responsible for finding an alternate physician.

C. All on-call time is a 24-hour tour of duty from 7:00 a.m. to 7:00 a.m.

D. Admission of patients without a primary care physician (PCP) or if the PCP is unavailable:

1. At DRH the Hospitalist will admit emergency patients to their service if the patient's regular physician does not have admitting privileges, is checked out to the Hospitalist for admissions, or cannot be contacted or if the patient has no regular physician. If the Hospitalist or ED physician believes the illness requiring admission to be outside their area of practice, they may request the patient to select an appropriate physician from the active staff or is responsible for arranging transfer of care. The Hospitalist or ED physician will care for the patient until transfer to another service is accepted by the receiving physician. At JCH the physician on-call for Acute Inpatient Care will admit emergency patients to their service if the patient's regular physician does not have admitting privileges, is checked out, or cannot be contacted or if the patient has no regular physician. If the Acute Inpatient on-call physician believes the illness requiring admission to be outside of their area of practice, they may request the ED provider arrange an appropriate transfer to another facility for admission. The ED provider will care for the patient until transferred.

2. The Hospitalist or the Acute Inpatient physician on-call at JCH shall remain responsible for a patient whom they admit until such time as one of the following circumstances occurs:

   a. The patient's regular physician sees the patient;

   b. The patient's regular physician is advised of the patient's admission and accepts the responsibility for the patient;

   c. The patient is referred to another physician who accepts the patient.

   When any of the above conditions has been met, the former physician is automatically discharged from the case. They will, at this time, be freed from all further ethical or legal responsibility to see or prescribe for the patient, or to carry out or evaluate diagnostic procedures.

F. Transfer. Transfer of a patient from the Hospital Emergency Department to another facility shall be at the discretion of the ED practitioner. No transfer will take place until the patient

has received a medically appropriate initial screening examination that meets the criteria for transfer set forth in EMTALA. The transfer certification must contain a summary of the benefits and the risks of transfer. Prior to transfer, the transferring practitioner or their designee shall establish contact with the receiving facility and the receiving physician to verify acceptance of the transfer. The transferring practitioner will determine the clinically appropriate method of transfer and will coordinate with Hospital personnel to make arrangements for the transfer. All relevant records, including a transfer/discharge summary stating the condition of the patient at the time of transfer and any other facts relevant to the ongoing care for the patient, will be transferred with the patient.

IX. Emergency Department Physicians and Emergency Services

A. Duty Time: It is the responsibility of the Emergency Department Medical Director to provide adequate emergency coverage 24 hours a day, 7 days a week.

B. Requirements for Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), and Pediatric Advanced Life Support (PALS) Certification:

1. ACLS, PALS, and ATLS are required of all physicians and AHP's with privileges in the Emergency Department with the following exceptions:
   a. Physicians who have completed residency training in Emergency Medicine and maintain board certification in Emergency Medicine;
   b. Physicians who have recently completed Emergency Medicine training and are planning to take their boards within 12 months, and;
   c. Physicians without Emergency Medicine training but who have taken these courses in the past and completed and maintain Emergency Medicine board certification.

2. For residents to work in the Emergency Department as a primary ED physician, it is required that they have current ACLS, ATLS, and PALS certification regardless of their status in their training program.

C. Responsibilities:

1. Emergency Medical Screening Exam:

As required by law, the Hospital will provide for an appropriate medical screening examination to individuals presenting to the Emergency Department, the Labor and Delivery Department and other areas of the Hospital in which the Hospital is required to provide such examination.

The Board of Directors of the Hospital requires that a medical screening examination for the purpose of determining the existence of an emergency medical condition be performed only by a qualified physician or a qualified allied health professional. A medical screening examination of a presenting labor patient may also be done by a qualified labor Registered Nurse who completes a nursing assessment. The results of this nursing assessment will then be communicated to a physician or allied health professional, either in person, or by telephone consultation. The physician or allied health professional will then determine whether or not an emergency medical condition exists.

All physicians and allied health professional at DRH Health are deemed qualified to perform the medical screening exams on the basis of core privileges.

2. Admissions from the Emergency Department:

The Emergency Department practitioner will notify and obtain permission from the patient's regular physician or their designee to admit the patient at the time of admission. If the regular physician or their designee does not have admitting privileges, is checked out to the Hospitalist for admissions, or cannot be contacted or if the patient has no regular physician, the Hospitalist or Acute Inpatient physician on-call shall be contacted.

The Emergency Department practitioner will complete a set of transition orders when a patient is admitted from the ED. The admitting physician is responsible for the patient after accepting responsibility for the patient’s admission. However, the ED practitioner is responsible until the patient is admitted to the floor.

If the patient is admitted in the evening, the admitting physician is required to see the patient the following morning. In the event that the admitting physician is checked out to a covering physician, the admitting physician must inform the covering physician of the admission. The covering physician must see the patient by the next morning after admission.

3. Patients seen in the Emergency Department may require consultation and/or care by a specialist. The Emergency Department practitioner will contact the regular physician or their designee, or if unavailable, the Hospitalist or Acute Inpatient physician on-call, who will then make the disposition.

4. Documentation must be made by the Emergency Department practitioner as to which physician is taking responsibility of each new admission and/or referrals, and further, this must be entered on the chart by the Emergency Department practitioner.

5. On-call specialist physicians on the active Medical Staff of the Hospital are expected to respond within a reasonable amount of time from initial contact attempt or time notified (CMS 489.24(j): EMTALA Interpretive Guidelines; OSDH Hospital Standards 310:667-59-9).
Guidelines for emergency response times:

Pediatrics	30 minutes
Obstetrics	30 minutes
General Surgery	30 minutes
Orthopedics	60 minutes
Internal Medicine	30 minutes

F. Other:

1. New Emergency Department practitioners will be oriented by the Emergency Department Medical Director, or designee, upon beginning Emergency Department coverage.

2. The Emergency Department Medical Director, or designee, will review any formal complaint concerning any Emergency Department practitioner. This review should be conducted within 7 days. Copies of any complaints are submitted to the Hospital's Chief of Staff or peer review committee as applicable. Other complaints may also be recorded and reviewed.

3. If an Emergency Department practitioner is not available for any reason, the Emergency Department Medical Director, or designee, is fully responsible for covering the Emergency Department.

X. General Rules Regarding Podiatrists

A. Clinical privileges granted to podiatrists are based on their training, experience and demonstrated competence and judgment.

B. Podiatrists applying for Hospital privileges in the Hospital, who complete their undergraduate training after June 30, 1975, shall be licensed by the State of Oklahoma.

C. The scope and extent of surgical procedures that each podiatrist may perform are specifically defined and recommended in the same manner as all other surgical procedures. A prerequisite to any such surgical privileges shall require completion of a residency program in podiatric surgery approved by the Council of Education of the American Podiatric Association, such training to be certified by the director of the program, plus one year documented Hospital experience.

D. A podiatrist with clinical privileges may order medications within the limits of their license to practice in the state.

E. A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the Active Medical Staff, initiate the procedure for admitting a patient to the Hospital.

F. The podiatric patient must receive the same basic medical appraisal as a patient admitted for other services, and the medical history and physical examination shall be performed by the podiatrist.

G. The podiatrist has the obligation of requesting consultation with the patient’s medical physician when a medical problem arises during hospitalization of their patient.

H. If a medical problem is evident upon admission or any arises during hospitalization of the podiatric patient, the attending physician not only should follow the patient, but they and the podiatrist should jointly discharge the patient when the patient's condition justifies dismissal.

I. The podiatrist's responsibilities shall include:

1. A detailed history justifying Hospital admission;

2. A detailed description of the physical examination and a preoperative diagnosis;

3. A complete operative report, describing the findings and techniques; all tissue, including bone fragments, shall be sent to the pathologist for examination;

4. Progress notes as are pertinent to the podiatric condition;

5. Order for discharge of patient;

6. A clinical resume (discharge summary) including postoperative instructions given to the patient by the podiatrist and the medical instructions by the attending physician if they join in discharging the patient.

XI. General Rules for Participants in Professional Graduate Education Programs

A. **Responsibilities:**

All medical students, residents and other participants in professional graduate education ("PGE") programs must:

1. Maintain harmonious and effective relations with peers and staff;
2. Manage interpersonal relations with patients and families;
3. Assure behavior and appearance are consistently professionally appropriate;
4. Accurately complete medical records in a timely and appropriate manner;
5. Keep attending physician informed of significant patient care issues and therapies in a timely manner; and
6. Be aware of and follow appropriate Hospital policies and procedures.

B. **Permissible Patient Care Activities**

1. Medical Students – Medical students are present in a clinical capacity by virtue of an institutional affiliation agreement. Medical students are responsible clinically to a member of the active Medical Staff of the Hospital and have their clinical activities defined and supervised by such Medical Staff member (referred herein as the "preceptor"). They may participate in responses to patient care emergencies under the supervision of a member of the Medical Staff when no member of the Medical Staff has assumed direction of the emergency situation.

2. Entry Level (1st Year) Resident – These are graduate physicians who are licensed or in the process of obtaining a license by a process defined by the appropriate licensure board and are enrolled in the initial year of their resident training program. If resident is a member of a residency program with which the Hospital has a formal agreement, activity will follow the established guidelines of that agreement. Resident will be required to submit completed application and other supporting documentation (i.e., references, insurance requirements, and licensure) to Medical Staff Office prior to any activity. They function closely with and under the direct supervision of the preceptor. Their responsibilities include the performance of a complete history and physical examination and the evaluation and development of treatment plans under the direct supervision of the attending physician. They may make chart entries and enter orders for evaluation and treatment of patients to the extent permitted by their license, and may be involved in the ongoing care of patients with careful monitoring and review by the attending physician. They may perform simple diagnostic and invasive procedures under the close supervision of the attending physician. Residency program will maintain liability insurance as required (limits and type) by the Hospital Board of Directors.

3. Mid-Level Resident – These are fully licensed physicians with authority to dispense narcotics, who may be assigned greater levels of responsibility than entry level trainees. They may be involved in assessment, treatment plan development, chart entry and order entry, providing care to a wide range of patients under the overall supervision of the attending physician. They may perform basic and moderately complex procedures with senior residents or faculty available for assistance, if needed.

4. Senior/Chief Resident (4th or greater year depending upon the training program). These are fully licensed physicians nearing the completion of their residency training program. They may have responsibility for and direct involvement in an expanded range of diagnostic and therapeutic processes and procedures under the supervision of the attending physician, but with significant independence for simple and mid-level complexity activities.

   A PGE program preceptor and the director of a participant's PGE program will develop and implement a system for (i) reviewing the participant's progress and (ii) determining the appropriate level of independence/supervision for such participant. Such system may include (i) maintaining specific progress notes on the participant and (ii) participating in periodic meetings to discuss the progress of the participant.

C. **Chart and Order Entries**

Medical students: Third and Fourth year medical students may enter discharge summaries, history and physicals, and progress notes in patient charts with the co-signature of their preceptor. The attending physician must validate orders written by third and fourth year medical students prior to their implementation. At any time, the physician may alter a student's notation in the chart if the alteration is also initialed by the physician. Attending countersignature of the treatment plan, procedure and operative notes, history and physicals, and the discharge summary is required.

Residents: Members of the Medical Staff to whom Residents are assigned will continue to make orders and notations in the chart, as they deem appropriate and may alter a Resident's notation in the chart if the physician also initials the alteration. Attending countersignature of the initial history and physical, orders and treatment plan, procedure and operative notes and the discharge summary is required.

1. If a residency program does not have a formal agreement with the Hospital, the resident must be granted specific privileges (job description) to perform the following:

   a. Give orders (All orders must be countersigned by the responsible physician within 24 hours.)

   b. Perform history and physical examinations. All history and physicals must

be authenticated by the responsible M.D. or D.O., within 24 hours of admission.

c. Document history and physical. All such reports must be authenticated by the responsible M.D. or D.O., within 24 hours.

d. Document Discharge Summaries and other reports in the medical records. All such reports must be authenticated by the responsible M.D. or D.O.

e. Act as first assistant in surgery.

f. Invasive procedures.

2. Hospital shall have the right to limit or terminate any privileges granted to a resident in accordance with the formal agreement between the Hospital and any applicable residency program or, in the absence of such an agreement, to the extent deemed necessary and advisable by the Hospital. Procedures set forth in the Medical Staff Bylaws and Fair Hearing Procedure shall not be applicable to residents.

D. **PA Students**

1. The preceptor will retain full responsibility for the care of patients and will maintain administrative and professional supervision of the student.
2. The student shall have no primary responsibility for patients, except when under the supervision of the preceptor.
3. The student shall follow additional preceptor and/or facility rules concerning their participation in patient care.
4. All history and physical exams, brief work-ups, and progress notes must be countersigned by the preceptor.
5. The student will introduce himself/herself to the patients as a Physician Assistant student. When appropriate, the student should explain their role as a P.A. student to the patient.
6. The student is expected to complete administrative work required by the facility and/or preceptor in a timely manner.
7. The student, under responsible supervision of a licensed physician and program approved preceptor, will be expected to:

a. Collect and record a complete database, (detailed histories and complete physical examinations) on all patients, both inpatients and outpatients.

b. Draw blood specimens, start intravenous therapy, insert and remove NG tubes, insert and remove urinary catheters, and take 12 lead EKGs.

c. Assist the physician in the performance of procedures such as thoracentesis, paracentesis, lumbar puncture, venous cut-down, joint aspiration/injection, bone marrow aspiration/biopsy, and endotracheal intubation. The student may perform these procedures only under the direct supervision of the preceptor.

d. Assist the physician in major and minor surgery.

e. Suture lacerations with no major vessel, nerve or tendon involvement.

f. Write orders for medications and indicated therapy modalities as directed by the physician, the physician's plan or the Hospital service protocol for the patient's problem.

g. Make daily rounds to observe and record the patient's progress in the Hospital record.

h. Instruct the patient and their family in preventive health care, in understanding medical and surgical problems, and in the use of prescribed treatment according to the physician's plan.

i. Initiate supportive therapy for a patient with an emergent condition until the physician arrives.

8. The student will NOT be permitted to:

a. Initiate patient care which is not outlined and or supervised by the preceptor for that problem.

b. See, treat, or dismiss a patient without review and discussion of the patient's problem with the physician.

c. Dispense or write prescriptions for any medications without the approval of the responsible preceptor and their signature on the prescription.

d. Take the initiative to tell the patient about the patient's physical findings or about conclusions drawn from the historical information without prior discussion with the responsible physician.

e. Enter orders on the patient's chart.

f. Initiate treatment for a patient they have not seen and examined.

g. The student shall not be required to participate in treatment or diagnostic procedures, if in their opinion the activity requested is beyond their training or level of competence. The student shall communicate this refusal to the preceptor and the program. Such actions shall not necessarily constitute insubordination nor require discipline.

h. The student may refuse to see any individual patient. However, such refusal shall be communicated to the preceptor and the program. Such actions shall not necessarily constitute insubordination nor require discipline.

XII: General Rules for Infection Control and Communicable Diseases

Each member of the Medical and AHP Staff has a personal responsibility to prevent the development and transmission of infection in patients and team members of DRH Health. Infection control practices are an integral part of this process and must be practiced by everyone. Specific infection control practices are outline in the Infection Control and Team Member Health policies and procedures of DRH Health.

A. Standard precautions are practiced at all times. Standard precautions includes hand hygiene before and after each patient contact, surface disinfection of all patient equipment between patient uses and appropriate use of personal protective equipment (PPE).

B. Patients with symptoms of communicable infection shall be placed in the appropriate transmission-based precautions. The appropriate transmission-based precautions are practiced at all times by the Medical and AHP Staff.

C. Practitioners with a known infection, or symptoms of an infection, should not have direct contact with patients or team members at DRH Health unless the infection is deemed noncontagious. Incidents of known contagious infections should be reported to the Team Member Health Nurse as soon as possible for contact tracing. The Team Member Health Nurse can be consulted as needed by any member of the Medical or AHP Staff.

D. Communicable disease exposure incidents should be reported to the DRH Health Team Member Health Nurse for follow-up. This includes, but is not limited to, blood borne pathogens, TB, meningitis, measles, rubella and mumps, COVID-19.

E. Patients with legally reportable communicable diseases and conditions must be reported to the Oklahoma State Department of Health (OSDH) per OAC 310:515-1-3.

F. The Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standards shall be followed (e.g., correct disposal of sharps, correct handling of blood and body fluids, and correct handling of sharps in a surgery setting).

G. Upon initial appointment and annually, evidence of immunity to specific diseases is required for all Medical and AHP Staff working in patient care areas of DRH Health, unless the practitioner documents an acceptable medical or religious contraindication. The same immunity requirements of DRH Health team members are applicable to the Medical and AHP Staff members. These include, the diseases listed in the Team Member Health policy, Mandatory Influenza Vaccination policy and other applicable team member health policies. Patient care privileges are automatically suspended if evidence of immunity or immunization are not documented within 30 days of initial appointment or by the deadlines listed in the policy for annual immunizations. Distant site practitioners with telemedicine-only privileges are excluded from immunization requirements.

H. Proper respirator use is essential for healthcare workers who interact with patients with infectious respiratory diseases. OSHA requires respiratory fit testing for Medical and AHP Staff that may care for these patients prior to patient contact, annually, with any changes in physical condition that could affect respirator fit, and or when a new model

or type of respirator is used (OSHA Standard 1910.134). All applicable Medical and AHP Staff are required to be fit tested for respirator use prior to initial patient contact and annually thereafter. Patient care privileges are automatically suspended if fit testing is not completed within 30 days of initial appointment or annual due date.

XIII: ADOPTON AND AMENDMENT OF RULES AND REGULATIONS

A. **Medical Staff Responsibility and Authority:**
The Medical Staff shall have the initial responsibility and authority to formulate and recommend to the Board these Rules and Regulations and amendments thereto which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized professional level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the community of the Medical Staff as needed, but not less often than every three (3) years for the purpose of revising the Bylaws as necessary to reflect current practice with respect to Medical Staff and its functions.

B. Methodology:
These Rules and Regulations are adopted, amended, or repealed by the following combined action:

1. **Medical Staff:**
The affirmative vote of a majority of the Medical Staff Members eligible to vote on this matter at a meeting, at which a quorum is present, provided a copy of the proposed Rules and Regulations and/or alterations accompanied the meeting notice and was presented at the preceding regular meeting.

2. **Board:**
The affirmative vote of a majority of the Board.

C. **Dissemination of Information:**
If significant changes are made in the Rules and Regulations, members of the Medical Staff and other individuals who have delineated Clinical Privileges will be provided a copy of these revisions at the time of reappointment, or earlier if deemed necessary by the MEC.

D. **Compliance and Compatibility**
The Medical Staff Bylaws, Rules and Regulations, and Policies, the Governing Board

Bylaws, and the hospital Policies shall be compatible with each other and shall be compliant with law and regulation.