

Rules and Regulations  
of the Medical Staff of  
Indiana University Health Blackford Hospital

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RULES & REGULATIONS FOR GUIDANCE AND CONTROL OF THE  
MEDICAL STAFF OF IU HEALTH BLACKFORD HOSPITAL

1. **MEETINGS**

The regular meetings of the Medical Staff shall be held at least once each month at the place and time determined by a vote of the staff.

2. **ADMISSIONS**

- a. Patients may be admitted to the Hospital only by members of the organized Medical Staff with admitting privileges.
- b. Except in emergency, no patient shall be admitted without a provisional diagnosis.
- c. The Elective Case - It is assumed that all surgical cases scheduled in advance are elective. Medical cases for study may be elective. A statement of the urgency shall be made when listing the accommodation.
- d. Pregnant Women - Unless birth is imminent, pregnant women in need of hospitalization for conditions related to the pregnancy shall be transferred to another facility. When birth is imminent and transfer is impossible, the Emergency Room doctor may contact physicians with OB/GYN background and attend to the patient's needs to the best of his/her ability.
- e. All room reservations shall be made with the understanding that a particular accommodation may not be available on the day of admission.
- f. Contagious Cases – IU Health Blackford Hospital practices universal precautions in the treatment of all diseases in order that all possible protection to personnel and other patients will be given.

3. **CONSULTATIONS**

In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the Hospital staff through its Chief of Staff to see that members of the staff do not fail in the matter of calling consultants as needed. The consultant must be well qualified to give an opinion in the field in which his opinion is sought. A satisfactory consultation note, except in emergency, shall be recorded prior to operation.

4. **AUTOPSIES**

Every member of the Medical Staff is expected to be actively interested in securing autopsies.

No autopsy shall be performed without written consent of a relative or legally authorized agent.

All autopsies shall be performed by the Hospital pathologist or by a physician to whom he may delegate the duty.

Autopsies shall be considered in accordance with guidelines listed in Appendix A.

The members of the Medical Staff are encouraged to discuss with patients and their families the options of organ donation. Procurement can be performed only with proper consent on accordance with state law.

5. **DISCHARGES**

Once admitted, the patient shall be discharged only on the written order of the attending physician.

6. **EMERGENCY SERVICES**

The Medical Staff will provide back-up physicians who will be available in the event that an emergency room patient needs admission or follow-up and does not have a local physician. This list will be maintained in the administration department; it will be published monthly and be kept in the emergency department so that it will be immediately available to the emergency room physician. In the event that a back-up physician cannot be available (such as vacation), it is up to him/her to schedule a replacement.

7. **MEDICAL STAFF ENCOURAGEMENT OF EDUCATION**

It shall be the duty of members of the Medical Staff to encourage and aid in the educational advancement of the various professional groups serving in the Hospital.

8. **FEE SPLITTING**

No member of the Medical Staff of this Hospital shall receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services rendered in this Hospital, unless the patient is fully informed and agreeable to such payment.

9. **LABORATORY SERVICES**

Laboratory services shall provide for all services required by the Medical Staff to care for the types of patients admitted and services rendered. Complete laboratory services must be provided either in the Hospital or by affiliation with a recognized outside laboratory. If surgical procedures which customarily require immediate pathological investigation are done, provisions shall be made for Frozen Section Examination.

10. **MEDICAL RECORD ADMINISTRATOR REPORT TO MEDICAL STAFF**

From time to time, but not less than annually, the medical records administrator shall submit to the Medical Staff a report of the professional work of the Hospital. This shall show patients discharged and the results, deaths, (the cause being stated as given by the attending physician), autopsies, consultations, and infections of all kinds. The discussion at the meeting shall be based on this report. The secretary of the Medical Staff shall transmit to the administrator of the Hospital such reports and recommendations as the Medical Staff may deem necessary to adequately inform him and through him the Governing Body as to the status of the professional care given by the Hospital.

11. **TISSUE STUDY REPORT**

A report of the study of the staff of all the tissue removed at operation shall be filed monthly with the administrator for consideration for the Board of Directors.

12. **MEDICAL RECORDS**

a. Records-Medical and Custodially Responsibility:

All records, including x-ray films and tissue slides, shall remain in the custody and control of the Hospital and shall not be taken away without permission. In case of the re-admission of a patient, all previous records shall be available for the use of the attending physician upon written consent of the patient. This shall apply whether the patient be private pay or otherwise, and whether he may be attended by the same physician or another.

b. Records to Accompany Patient to Surgery:

A complete history, physical examination record, and tentative diagnosis, in writing or dictated, shall accompany the patient to the operating room together with necessary laboratory findings, per physician order. An Operative Report and applicable special consent forms will also accompany the patient. This applies to all operations except emergency in which case the attending physician will be expected to furnish such data within 24 hours after admission.

c. Practitioners routine order, when applicable, to a given patient, shall be reproduced in detail on the patient's order sheet and dated and signed by the practitioner.

- d. A complete, legible medical record on every patient admitted to the Hospital is the sole responsibility of the attending physician. The history and physical examination shall be completed within 24 hours of admission.
- e. Progress notes shall be recorded with sufficient frequency to cover all events, complications in treatment, and to insure comprehensiveness for care.
- f. Operative Reports shall be written or dictated immediately after surgery and shall include all the findings made at surgery as well as the details of the procedure. When an Operative Report cannot be immediately transcribed, a Progress Note that details the finds at surgery and the details of the procedure shall be prepared.
- g. Symbols and abbreviations may be used in the medical record only when they have been approved by the organized Medical Staff. Each abbreviation shall have only one meaning. The list of approved symbols and abbreviations shall be updated annually and shall be appropriately distributed throughout the Hospital.
- h. The final diagnosis shall be recorded in full without symbols or abbreviations.
- i. Medical records shall be filed only when completed by the attending staff member or when ordered to be filed by the Medical Staff.
- j. An entry in the medical record shall be made by practitioners who have been credentialed by the Medical Staff, licensed and certified nursing personnel, respiratory therapists, paramedics, physical therapists, speech therapists, occupational therapists, social workers, chaplains, imaging technologists, dieticians, laboratory technicians/technologists, pharmacists, EMTs, and unit secretaries. Unit secretaries may only record entries relating to patient diet, activities, or level of care (acute, observation, or swing bed.)

### 13. **INCOMPLETE MEDICAL RECORDS**

All medical records should be complete following discharge of the patient from the Hospital including progress notes, final diagnosis, and clinical resume. If the record remains incomplete by the twenty second (22<sup>nd</sup>) day following discharge, the Medical Records Department shall issue "Notice of Incomplete Records" to the responsible practitioner. If a practitioner fails to complete any incomplete chart(s) within seven (7) days of the notice from the Medical Records Department, the Chief Executive Officer will notify the practitioner, in writing, that his/her privileges to admit patients and schedule surgery shall be automatically suspended until all delinquent charts are completed, pursuant to Section 3.1 of the Corrective Action/Fair Hearing Plan. This automatic suspension will not apply to patients admitted prior to the date of suspension, emergency admissions, or emergency surgery. In the event that records remain delinquent for 45 days or longer, the administrative suspension will then be expanded to apply to all admissions and all surgery patients, even emergency admissions and surgeries.

Physicians suspended due to medical record delinquencies may still attend patients admitted before the date of their suspension.

Twenty two days post discharge, the Medical Records Department distributes a “Notice of Incomplete Record(s)”.

Twenty nine days post discharge, the Chief Executive Officer (CEO) distributes a “Notice of Delinquent Records/Notice of Suspension”. Suspensions will not become effective until three (3) days following the distribution of the Notice of Delinquent Records/Notice of Suspension.

For practitioners notifying the Medical Records Department that they will be out of town and unavailable for five (5) or more consecutive days before distribution of a “Notice of Incomplete Records,” the days of absence will not be counted in the calculation of the 22 day period of time allowed for the completion of records.

Enforcement of the rules pertaining to the handling of incomplete Medical Records is the responsibility of the CEO, or in the absence of the CEO, the CEO's designee.

#### 14. **CONTENTS OF A MEDICAL RECORD**

##### A. **Inpatient Records:**

A complete medical record shall include information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medication and services. All medical records for inpatient hospitalized for more than forty-eight (48) hours must document the following, as appropriate:

Inpatient records - all patient records, except those in subsections, shall document and contain, but not be limited to, the following:

1. Identification data.
2. Appropriate general consents and informed consents.
3. The medical history and physical examination of the patient done within the time frames as described by the Medical Staff.
4. A statement of the diagnosis or impressions drawn from the admission history and physical examination.
5. Updated H&P.
6. Diagnostic and therapeutic orders.
7. Admission orders: Activity, diet, admission status, etc.
8. Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy and consistent with federal and State law.
9. Clinical observations, including results of therapy, documented in a timely manner.
10. Progress Notes.

11. Immediate post-op note if applicable.
12. Operative Note.
13. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
14. Nursing notes, patient education assessment including language and communication barriers, nursing plan of care, and entries by other health care providers that contain pertinent, meaningful observations and information.
15. Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures and their results.
16. Documentation of complications and unfavorable reactions to drugs and anesthesia.
17. A discharge summary, authenticated by the physician. The final progress note should include any instruction given to the patient and family.
18. Final diagnosis.
19. The medical record shall note when a patient receiving emergency, urgent, or immediate care left against medical advice.
20. The record of an inpatient with a length of stay less than 48 hours will not require a formal Discharge Summary. A final progress note shall suffice in place of a Discharge Summary.

**B. Observation, ambulatory care, and ambulatory surgery patients-** the content of the medical records for observation patients, ambulatory care patients, and ambulatory surgery patients shall document and contain, but not be limited to, the following:

1. Identification data.
2. Appropriate general consents and informed consents.
3. Medical history and description of the patient's condition and pertinent physical findings.
4. H&P update if H&P was completed prior to date of service.
5. Diagnostic and therapeutic orders.
6. Activity, diet, and admission status if observation.
7. Documentation of care based on identified standards of care and standards of practice, including nursing documentation such as initial assessments, educational assessment including language and communication barriers, and daily nursing notes.
8. Data necessary to support the diagnosis and treatment given, with reports of procedures, tests, and their results, clinical observations including the results of therapy, and anesthesia given, if applicable.
9. Immediate post-op note.
10. Operative note if applicable.
11. Final progress note including instructions to the patient and family with dismissal diagnosis and disposition of patient.
12. Authentication by the physician and other responsible personnel in attendance.

13. The medical record shall note when a patient receiving emergency, urgent, or immediate care left against medical advice.

**C. Outpatients** - outpatient records shall contain, but not be limited to:

1. Identification data.
2. Appropriate general consent and informed consent.
3. Diagnostic and therapeutic orders.
4. Description of treatment given, procedures performed, and documentation of patient responses to intervention, if applicable.
5. Results of diagnostic tests and examinations done, if applicable.
6. Initial assessment. (Nursing if applicable)
7. H&P for patients receiving sedation.
8. Educational assessment. (Nursing if applicable)
9. Nursing documentation and orders by other health care providers pertinent to care.
10. For patients receiving continuing ambulatory services the medical record contains a summary list noting:
  - known significant medical diagnosis and conditions
  - known significant operative and invasive procedures
  - known adverse and allergic drug reactions
  - medications known to be prescribed for or used by the patient
11. The medical record shall note when a patient receiving emergency, urgent, or immediate care left against medical advice.

**D. Emergency Service Records:**

1. Identification data.
2. Appropriate general consent and informed consent.
3. Time of arrival, means of arrival, time treatment was initiated, and time patient examined by physician, if applicable.
4. Admission orders, activity, diet, admission status, etc.
5. Pertinent history of illness or injury, description of the illness or injury, and examination including vital signs.
6. Diagnostic and therapeutic orders.
7. Description of treatment given or prescribed, clinical observation including the results of treatment, and the reports of procedures and test results, if applicable.
8. Authentication by the practitioner or licensed health professional who rendered treatment or prescribed for the patient in accordance with Hospital policy.
9. Instruction given to patient on release, prescribed follow-up care, signature of patient or responsible other, and name of person giving instructions.
10. Diagnostic impression and condition on discharge documented by the practitioner, disposition of the patient and time of dismissal.

11. Copy of transfer form, if patient is referred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.
12. The medical record shall note when a patient receiving emergency, immediate care left against medical advice.

15. **ORDERS**

Only licensed practitioners with appropriate clinical privileges shall have the authority to give orders for the care and treatment of inpatients. All orders must be entered in the patient's record, dated, and signed by the responsible practitioner.

Outpatient orders may be accepted from physicians and nurse practitioners who do not maintain Medical Staff membership/clinical privileges, provided, however, the Hospital is able to verify that the physician maintains a current Indiana license to practice medicine.

- a. All orders for treatment shall be in writing. A verbal order shall be accepted if dictated to a registered nurse, licensed practical nurse, and registered or certified therapist (may take orders pertaining to the therapy they are providing) by the responsible members of the staff. Such orders shall be entered on the order sheet, signed by the person to who dictated, and shall include the name of the member giving the order. The responsible member shall authenticate all such orders.
  1. Verbal orders, (either in person or via telephone) for all medications, treatments, or diagnostic testing will be accepted only under urgent circumstances when it is impractical for such orders to be given in a written manner by the responsible Licensed Independent Practitioner.
- b. Blanket orders of reinstatement of previous medications are not permitted.
- c. All medications brought to the Hospital by the patient shall be given to the nurse in charge. After proper identification by the pharmacist, they may be dispensed on order of the attending staff member specifying the name of the drug, dose, method of administration, and frequency of administration.
- d. Orders: Automatic Stop - All specific orders made by the physician to be given on a routine basis shall automatically be terminated after 72 hours for narcotics and 240 hours for antibiotics unless renewed by the attending physician, in writing. It shall be the duty of the attending nurse to check with the physician, at the end of the stop period, to determine if he wishes to renew the written order for an additional period.

16. **INFORMED CONSENT**

It is the policy of IU Health Blackford Hospital to obtain a signed "Consent for Treatment" at the time of admission and to obtain specific informed consent for the following:

- a. Any treatment or procedure which is non-routine or which presents significant risk;
- b. Operative and invasive procedures;
- c. Treatments or procedures for which written consent is required by law;
- d. Administration of anesthesia;
- e. Administration of blood and blood products;
- f. Any test to determine the presence of HIV antibodies.

Definitions:

- a. Informed consent means consent obtained from the patient (or someone authorized to give consent on the patient's behalf) after being provided a clear explanation of the proposed treatment or procedure.

The explanation includes:

- potential benefits and drawbacks
- potential problems related to recuperation
- the likelihood of success
- the possible results of non-treatment
- any significant alternatives.

The patient, and when appropriate the family, is also informed of:

- a. the name of the physician or other practitioner who has primary responsibility for the patient's care;
- b. the identity and professional status of individuals responsible for authorizing and performing procedures and treatments;
- c. any professional relationship to another health care provider or institution that might suggest a conflict of interest;
- d. their relationship to educational institutions involved in patient's care; and
- e. any business relationships between individuals treating the patient, or between the organization and any other health care, service, or educational institutions involved in the patient's care.

Emergency means a situation which presents an immediate threat to the life or a serious impairment to the health of the patient and any delay caused by an attempt to obtain consent could jeopardize the life or health of the patient.

Invasive procedure - 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 percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties,

and implantations and excluding routine venipuncture, intravenous therapy and routine physical examinations.

Except in an emergency, it is the responsibility of the licensed independent practitioner to obtain the informed consent of the patient to proposed treatments or procedures prior to initiation of the treatment or procedure.

1. The surgeon shall obtain the patient's informed consent to any surgical procedure undertaken by him/her or under his/her supervision, including ambulatory surgery.
2. The anesthesiologist shall obtain the patient's informed consent to the administration of anesthesia administered by him/her or under his/her supervision.
3. The Licensed Independent Practitioner who will perform the treatment or procedure shall obtain the patient's informed consent to the treatment or procedure.

Members of the Clinical Staff may not delegate the duty to obtain informed consent to Hospital staff members except in the following circumstances:

1. IU Health Blackford Hospital employees may obtain informed consent from the patient for the administration of blood and blood products.
2. In the event of an occupational bloodborne pathogen exposure to a "healthcare provider", Hospital employees may obtain informed consent from the source patient and/or the healthcare provider for any tests to determine the presence of HIV antibodies.

In all other circumstances, Hospital personnel may aid in procuring signed consent forms as a matter of courtesy to the members of the clinical staff. However, their role is ministerial in this regard. The responsibility of obtaining consent is the responsibility of members of the clinical staff. If the patient has questions concerning the treatment or procedure or is unsure of his/her decision, Hospital personnel shall refer the patient to the appropriate member of the clinical staff for additional explanation.

Except in an emergency, no treatment or procedure for which informed consent must be obtained will be performed unless a completed consent form is in the patient's chart. In an emergency, the nature of the emergency circumstances shall be fully explained in the patient's chart by the responsible practitioner.

Consents are to be signed and witnessed by an adult. An adult is defined as an individual eighteen (18) years of age or older. An individual not an adult is referred to as a "minor".

A minor may give consent for his/her healthcare if:

- a. He or she is emancipated;
- b. He or she is at least fourteen (14) years of age, is not dependent on a parent for support, is living apart from his parents or from an individual *in loco parentis* (in place of a parent) and is managing his or her affairs;
- c. He or she is or has been married;
- d. He or she is in the military service of the United States;
- e. He or she is authorized to consent to their own healthcare by any other statute (as in the case of treatment for venereal disease.)

If the minor is not authorized to consent to his or her healthcare, the consent may be given by:

- a. A judicially appointed guardian or judicially appointed health care representative;
- b. If there is no judicially appointed guardian or health care representative, then a parent or individual *in loco parentis*;
- c. If there is no judicially appointed guardian or health care representative or no parent or individual *in loco parentis*, then an adult sibling of the minor.

If an adult is incapable of giving consent and does not have an appointed health care representative or the health care representative is unavailable or declines to act, consent may be given by:

- a. A judicially appointed guardian or health care representative;
- b. If there is no judicially appointed guardian or health care representative, consent may be given by:
  - 1. Spouse
  - 2. Parent
  - 3. Adult child, or
  - 4. Adult sibling of the individual in that order.

The individual's religious superior if the individual is a member of a religious order. Telephone consents may be obtained if time does not permit obtaining a prior written consent. The telephone consent must be witnessed by two adults, either Hospital employees or physicians, and documented in the medical record. Telephone consents must be followed up with written consent from the individual giving consent.

Informed Consents for procedures shall contain the following elements: signature of patient or responsible party and date and time of signature; physician signature and date and time of signature; reference of risks of procedure; reference to benefits of procedure; alternatives to procedure (if any). No abbreviations are permitted.

## 17. **RULES AND REGULATIONS - COMPLIANCE**

All members of the Medical Staff shall comply with the rules and regulations adopted by the Governing Body, and any violation of the rules governing the Medical Staff such as

delinquency in keeping medical records, unethical practice of medicine or surgery, and addition to drugs of alcohol, shall be sufficient cause for the Board of Directors to invoke a summary suspension of the medical staff member pursuant to Section II of the Corrective Action/Fair Hearing Plan.

18. **SURGERY**

- a. Operation Surgical - Consent Form - No surgical operation shall be performed without the consent of the patient or his or her legal representative except in emergencies.
- b. Removal of Specimens - All specimens removed during a surgical procedure in the operating room, emergency room, or anywhere else in the Hospital shall be sent to the pathologist for evaluation with the exception of:
  - Cataracts
  - Orthopedic appliances
  - Portions of rib removed only to enhance operative exposure
  - Therapeutic radioactive sources
  - Foreign bodies given directly to law enforcement officers
  - Foreskin of newborn infants
  - Grossly normal placentas
  - Teeth, provided the number of the tooth or teeth, including fragments, are recorded in the medical record
  - Tissues or material not deemed necessary for pathological purposes
- c. Non-Resident Surgeons - Non-resident surgeons shall not operate on a patient unless they arrange to leave the case in the care of the local member of the staff and so notify the Chief Nursing Officer.

19. **VISITATION**

- a. Visitors in Operating Rooms - Visitors shall not be permitted in the operating room while an operation or delivery is in progress. An exception may be made by the attending physician.
- b. Visitors on Medical Surgical Services - Visitation will normally be permitted from 8:00 a.m. to 9:00 p.m. Patient condition, age, roommate status, and other factors will influence visitation times and/or restrictions.

20. **SEXUAL HARASSMENT**

IU Health Blackford Hospital and the Clinical Staff are committed to providing a work environment which is free from unlawful discrimination. In keeping with this commitment, no physician, dentist, medical assistant, or medical associate shall engage in unlawful discrimination, including sexual harassment.

- a. Sexual harassment includes, but is not limited to, unwelcome or unsolicited sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when:
  1. Submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment.
  2. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, i.e. hiring, firing, promotion, demotion, compensation, benefits, working conditions; or
  3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.
  
- b. Sexual harassment does not refer to occasional compliments of a socially acceptable nature. It refers to behavior that is not welcome, that is personally offensive, that debilitates morale, and therefore, interferes with work effectiveness. Examples of prohibited conduct include, but are not limited to:
  1. Demanding sexual favors in exchange for favorable reviews, assignments, promotions, continued employment or promises of the same;
  2. Continued or repeated sexual jokes, language, epithets, flirtation, advances or propositions;
  3. Verbal abuse of a sexual nature;
  4. Graphic verbal commentary about an individual's body, sexual prowess or sexual deficiencies, including social life;
  5. Sexual degrading or vulgar words to describe an individual;
  6. Leering, whistling, touching, pinching, brushing the body, assault, coerced sexual acts or suggestive, insulting or obscene comments or gestures;
  7. The display in the workplace of sexually suggestive objects, pictures, posters, or cartoons;
  8. Name calling, relating stories, gossip, comments or jokes that may be derogatory toward a particular sex;
  9. The display of sexually suggestive graffiti;

10. Retaliation against Hospital employees for complaining about such behavior;
  11. Asking questions about sexual conduct or sexual orientation or preferences; and
  12. Harassment consistently targeted at only one sex, even if the content of the verbal abuse is not sexual.
- c. Any Hospital employee or Medical Staff member who believes he or she has been unlawfully discriminated against, including sexual harassment, by a physician, dentist, medical assistant, or medical associate should promptly report the facts of the incident or incidents and the names of the persons involved directly to a supervisor or to the Chief Executive Officer. All claims will be investigated and appropriate corrective action will be taken. In the event a physician, dentist, medical assistant, or medical associate engages in unlawful discrimination, including sexual harassment which has been substantiated, corrective action will be taken which may include revocation of staff appointment.
- d. Retaliation is prohibited against Hospital employees and/or Medical Staff members who bring charges of unlawful discrimination, including sexual harassment, or those who assist in investigating charges.

## 21. CONTINUING MEDICAL EDUCATION

To be eligible for appointment or reappointment, the Clinical Staff candidate must show evidence to the Clinical Staff, through its offices, of earning fifty (50) hours of AMA approved Category I continuing medical education credits during the preceding two (2) years. Exceptions to this requirement are stipulated below:

### Board Certification/Re-certification

Practitioners who become Board certified or re-certified during a reappointment cycle will be considered to have met all CME requirements for that and the subsequent reappointment cycle.

### Residency/Fellowship

Practitioners who have completed an ACGME approved residency or a fellowship during a reappointment cycle will be considered to have met all CME requirements for that and the subsequent reappointment cycle.

### New Members

Practitioners who have joined the Clinical Staff within six (6) months of a reappointment date are exempted from the CME requirements for that appointment cycle.

For new clinical staff appointees who are appointed to the staff greater than six (6) months but less than two (2) years prior to reappointment, the CME requirement will be prorated to the duration of the appointment.

The Executive Committee may grant limited extensions on an individual basis for extenuating circumstances.

## 22. **CPR COMPETENCE**

All ER physicians, all physicians with privileges to admit patients, and all practitioners with Anesthesia privileges shall demonstrate ongoing competency to perform CPR. Competency to perform CPR may be demonstrated by current CPR and/or ACLS certification. CPR competency may also be documented through peer reference (at least two (2) references must be provided).

## 23. **IMPAIRED MEMBERS OF THE CLINICAL STAFF**

If a member of the Clinical Staff, Hospital personnel, patient, or patient's family has a reasonable concern that a member of the Clinical Staff is acutely impaired, then that concern must be communicated to the Administrator-On-Call to request that the Administrator come immediately to the Hospital. If the Administrator-On-Call finds that cause exists to believe that the member of the Clinical Staff is acutely impaired, then the Administrator shall contact a member of the Medical Staff Executive Committee (hereinafter "designated superior") and request that the designated superior come immediately to the Hospital. The following procedures will be followed:

For purposes of Part A, a member of the Clinical Staff is "acutely impaired" if the quality of his or her patient care is severely reduced from the usual and ordinary level of care.

1. The Indiana State Medical Association (ISMA) has published a list of symptoms that may indicate impairment. The list is attached. No one symptom is singularly diagnostic of any one illness. A combination of these symptoms likely signifies an impaired physician.
2. The Clinical Staff member involved will be informed of these procedures by the member of the Clinical Staff or the Chief Executive Officer of the Hospital, whichever individual contacted the Administrator-On-Call. The Clinical Staff member will be informed that this is Hospital procedure. The Clinical Staff member will be requested to wait until the arrival of the Administrator-On-Call and designated superior, if the situation so requires. If the Administrator and designated superior determine that cause exists to believe that the Clinical Staff member in question may be acutely impaired, then a urine drug screen and blood alcohol level will be obtained. Chain of custody procedure will be followed in the collection of urine. If the Administrator and the designated superior do not agree that the Clinical Staff member may be impaired, then no testing shall occur. However, a Clinical Staff member may always request that such testing be done to demonstrate the absence of drugs or alcohol.

3. The refusal of a member of the Clinical Staff to wait as provided in Paragraph 3 above, or delay or refusal to provide a sample in response to a request for a urine drug screen and/or blood alcohol level are grounds for an immediate precautionary suspension of clinical privileges. The Clinical Staff member shall be requested to immediately cease patient care and the matter will be referred to the "Committee" authorized under the Clinical Staff Bylaws for consideration of a summary suspension of clinical privileges.
4. Consent of a member of the Clinical Staff to the release of urine or blood test results consistent with the execution of this policy and any other purposes required by the Clinical Staff Bylaws shall be presumed in any instance where testing is conducted in accordance with this policy. Should the urine screen and/or blood alcohol level be positive for a controlled substance or alcohol (defined as greater than .02 mg percent) or the designated superior determines the Clinical Staff member to be otherwise psychiatrically or physically impaired, Clinical Staff member in question will be required to cease patient care immediately. The designated superior shall arrange for immediate care of the clinician's patients.
5. If the urine and/or blood alcohol are positive, as defined in Paragraph 4 above, or the designated superior believes the Clinical Staff member is otherwise psychiatrically or physically impaired, the designated superior shall report that information to the Medical Staff Executive Committee to impose precautionary suspensions of clinical privileges. All information shall be provided to the Executive Committee for immediate review within two (2) business days after the results of the testing and other procedures are completed. The Clinical Staff member in question shall be apprized of this procedure. Within thirty (30) days after the referral of this matter to the Medical Staff Executive Committee, a decision whether the incident merits referral to the ISMA Physician Assistance Program (PAP), or provide a statement of the reasons why more time is needed, shall be made.
6. Nothing in this policy shall be construed to limit the Executive Committee in its application or administration of any other rule, regulation, or Bylaw of the Clinical Staff that may apply to the Clinical Staff member or the incident or concern that resulted in the original report.
7. If a referral is made by the Medical Staff Executive Committee to the ISMA PAP, the ISMA PAP will assist with the evaluation and investigation of the complaint. A course of action will be developed by the ISMA PAP and the Executive Committee. Options include, but are not limited to the following:
  - a. If an initial report lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be investigated.

- b. If reports prove substantial and the Clinical Staff member is recommended to undergo an appropriate evaluation by a facility or a physician Clinical Staff member approved by ISMA PAP, the Clinical Staff member must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendations is presumed by the Clinical Staff member into an evaluation contract with the ISMA PAP.
8. If treatment is recommended, the Clinical Staff member will sign a contractual agreement with the ISMA PAP. This agreement will be effective for at least five (5) years.
9. The contract will cover, but is not limited to the following areas:
  - a. Weekly random urine drug screens, if appropriate to the impairment;
  - b. Attendance at a weekly Alcoholics/Narcotics Anonymous meetings, if appropriate to the impairment;
  - c. Attendance at Caduceus meetings, a support group for physicians, if appropriate to the impairment;
  - d. Monthly meetings with an approved advocate;
  - e. Continued therapy, if recommended by the treating physician;
  - f. Other items appropriate to the impairment;
  - g. Approval to send regular reports to the appropriate Hospital personnel documenting contract compliance.
10. Failure to comply with requests for evaluation or the terms of the contract, including refusal to provide a blood or urine specimen if directed to do so, will result in a report to the Medical Staff Executive Committee and the Governing Board of the Hospital, and may result in a report to the Indiana Medical Licensing Board.
11. If any member of the Clinical Staff, Hospital personnel, patient, or the patient's family has a reasonable concern that a member of the Clinical Staff is impaired, the following procedures will be followed.
  - a. For purposes of Part B, the Clinical Staff member is "impaired" if the quality of his or her patient care is reduced from the usual and ordinary level of care.
  - b. The Indiana State Medical Association (ISMA) has published a list of symptoms that may indicate impairment. This list is attached. No one symptom is singularly diagnostic of any one illness. A combination of these symptoms likely signifies an impaired physician.
  - c. A written report of the specific concerns and behaviors shall be provided to the Medical Staff Executive Committee. The anonymity of the individual providing the report shall be maintained. The Medical Staff Executive Committee may invite the Clinical Staff member to discuss the

concerns and behaviors, but is not obligated to do so.

12. If the report clearly suggests impairment, the Medical Staff Executive Committee will evaluate and investigate the complaint. A course of action will be developed by the ISMA PAP and the Medical Staff Executive Committee. Options include, but are not limited to the following:
  - a. If an initial report lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be investigated.
  - b. If the reports prove substantial and the Clinical Staff member is recommended to undergo an appropriate evaluation by a facility or physician approved by the ISMA PAP, the Clinical Staff member must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendation is presumed by the Clinical Staff member entering into an evaluation contract with the ISMA PAP.
13. If treatment is recommended, the Clinical Staff member will sign a contractual agreement with the ISMA PAP. The contractual agreement will be effective for at least five (5) years. The contract will cover, but is not limited to the following:
  - a. Weekly random urine drug screens, if appropriate to the impairment;
  - b. Attendance at a weekly Alcoholics/Narcotics Anonymous meetings, if appropriate to the impairment;
  - c. Attendance at Caduceus meetings, a support group for physicians, if appropriate to the impairment;
  - d. Monthly meetings with an approved advocate;
  - e. Continued therapy, if recommended by the treating physician;
  - f. Other items appropriate to the impairment;
  - g. Approval to send regular reports to the appropriate Hospital personnel documenting contract compliance.
14. Failure to comply with requests for evaluation of the terms of the contract will result in a report to the Medical Staff Executive Committee and the Governing Board of the Hospital and may result in a report to the Indiana Medical Licensing Board.

For purposes of this section of the Rules and Regulations, the Medical Staff Executive Committee will not function as a Committee of the Whole. In this section of the Rules and Regulations, the term “designated superior” means any member of the Medical Staff Executive Committee.

## 24. **DISRUPTIVE PHYSICIANS**

It is the policy of IU Health Blackford Hospital that all Clinical Staff members are to exhibit the highest professional ethics and to conduct themselves in a manner which is in keeping with those ethics as well as with the Bylaws and policies of the Hospital and the Bylaws, Rules and Regulations of the Clinical Staff. Clinical Staff members are further expected to work harmoniously with others to preserve the orderly operation of the Hospital and the Clinical Staff organization. All conflicts caused by the failure to abide by such expectations shall be resolved in the following manner:

1. First Level Resolution: When possible, conflicts shall be settled to the satisfaction of complainant and involved physician on a interpersonal basis. Supervisory personnel and/or other physicians may assist at this level through informal mediation.
2. Second Level Resolution: When interpersonal resolution is not possible, the Medical Staff President shall be notified. The Medical Staff President shall then attempt to settle the dispute to the satisfaction of the complainant and the involved physician through informal mediation. The incident may be brought to the attention of the Medical Staff President by supervisory personnel, directly by the affected individual, or by witnesses.
3. Third Level Resolution: An incident that cannot be resolved informally shall come to the Medical Staff Executive Committee for action. The Executive Committee shall conduct an investigation and make all appropriate recommendations in accordance with the Corrective Action/Fair Hearing Plan for the Medical Staff of IU Health Blackford Hospital.

Second Level and Third Level Resolutions shall be reported to the Medical Staff Executive Committee. The Executive Committee, at its discretion, may track these incidents and may order that a copy of the dispute and its resolution be placed in the involved physician's credentials file.

A physician with adverse behavior actions in their physician file may, after five (5) years of good behavior, request that the Executive Committee review the file, and at the discretion of the Medical Staff Executive Committee, purge said reports of actions.

## 25. **PROHIBITION OF SMOKING MATERIALS**

- A. The Medical Staff shall support the ban on smoking materials within the Hospital building. Exceptions to the prohibitions must be authorized by a physician's order and must be based on the following medical criteria:
  1. Terminal stage illness
  2. Anxiety exhibited by significant changes in vital signs

26. **USE OF RESTRAINTS**

The use of restraints must be authorized by a physician's order. Time limits for obtaining the order and length will be in accordance with existing Hospital policies and procedures. Seclusion will not be used.

27. **GENERAL CONDUCT OF CARE**

If a nurse or any other professional person has reason to doubt the appropriateness of care provided to any patient, the matter shall be reported to the Chief Nursing Officer. The Chief Nursing Officer shall consult with the attending physician and, if a misunderstanding still exists, the director shall report to the Chief of Staff or the Chief Executive Officer.

28. **TEMPORARY CREDENTIALING OF PRACTITIONERS IN THE EVENT OF EMERGENCY OPERATIONS PLAN ACTIVATION**

To provide a mechanism for temporarily credentialing and privileging practitioners who are not members of the Medical Staff, but volunteer their services in the event the Emergency Operations Plan is activated. See Medical Staff Bylaws Article VI.

Any practitioner volunteering to provide patient care services during activation of the IU Health Blackford Hospital Emergency Management Disaster Plan must be granted privileges by the President, Chief Executive Officer (or his designee). The following information must be available in order to grant temporary emergency patient care privileges:

1. The individual credentialed in an emergency shall complete a temporary emergency privileges form (Appendix B) and sign a statement that the information given to the Hospital is accurate.
2. Information satisfying one of the following Paths must be available in order to be granted temporary emergency privileges.

**Path A:**

1. Valid professional license or certification to practice in the State of Indiana.
2. Photo identification (driver's license, photo ID from another hospital, passport)

Note: Depending on the severity of the emergency, out-of-state medical licensure may be accepted if so declared by the State of Indiana.

**Path B:**

1. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

**Path C:**

1. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.
3. To the extent feasible, the practitioner will be paired with a currently credentialed Medical Staff member of IU Health Blackford Hospital.
4. Conspicuous identification is to be worn by any practitioner practicing in this capacity.
5. The individual agrees to be bound by all Hospital policies and rules, as well as the Medical Staff Bylaws, and Rules and Regulations.
6. The Credentialing Office shall perform verifications of the above information as soon as feasible, but results of queries are not necessary to grant temporary emergency patient care privileges. Verifications shall include querying the National Practitioner Data Bank and Office of the Inspector General (OIG). Whenever possible, Hospital affiliations will be verified by telephone. Verification of malpractice insurance will be obtained from the most current hospital affiliation. A record of this information will be retained in the Credentialing Office.
7. Any information gathered that is not consistent with that provided by the practitioner will be referred to the Hospital Administrator who will determine any additional necessary action. A practitioner's emergency privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering patient care services in an emergency. Termination of the practitioner's privileges does not entitle the practitioner to request a hearing or other due process.
8. Credentials files are considered peer review and will be maintained as confidential to the full extent authorized by law.
9. The practitioner's privileges will be for the period needed during the duration of the emergency disaster only. The practitioner's temporary emergency patient care privileges and credentialing automatically terminate when the Emergency Operations Plan is officially deactivated.

29. **AMENDMENTS**

**Any proposed amendment to these Rules and Regulations shall be presented at a regular** or special meeting for review by the Medical Staff. A majority of the Active Staff is required for passage. Such amendments shall become effective when approved by the Governing Board.

IU HEALTH BLACKFORD HOSPITAL  
GUIDELINES FOR AUTOPSY\*

1. Deaths in which an autopsy would explain unknown or unanticipated medical complications.
2. All deaths in which the cause is not known with certainty on clinical grounds.
3. Deaths in which an autopsy would allay concerns of the public/family regarding death to provide reassurance to them regarding the same.
4. Any unexplained/unexpected deaths from any dental, medical, or surgical diagnostic procedures and/or therapies.
5. Natural deaths which are subject to or waived by a forensic medical jurisdiction such as:
  - a. Persons arriving DOA at a hospital;
  - b. Deaths occurring in the hospital within 24 hours of admission;
  - c. Deaths in which a patient sustained or apparently sustained injury while in the hospital.
6. Deaths resulting from high risk, infectious, and contagious diseases.
7. All obstetric deaths.
8. All neonatal and pediatric deaths.
9. Death at any age when an autopsy would disclose a known or suspected illness which also may have a bearing on survivors.
10. Known or suspected deaths arising from environmental or occupational hazards.

\*This list is not intended to be all inclusive.

ref: American College of Pathology

**IU Health Blackford Hospital, Inc.**  
**Temporary Emergency Privileges Form**

Date of Disaster/Emergency \_\_\_\_\_

**Information to be taken from License and Identification:**

Practitioner's Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Hospital(s) where Practitioner holds Active Staff membership & privileges:

\_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge, information and belief. I agree to abide by the Medical Staff Bylaws, Rules & Regulation, and any Hospital policies and directives.

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Date

**Documentation for Emergency Privileges**

Path A      1. License copied/verified

Path B      Individual is a member of a  
Disaster Medical Assistance  
Team (DMAT)

Internet: <https://extranet.in.gov/WebLookup/Search.aspx>

Path A      2. Photo ID verified (visual)

Path C      Identification indicating that  
the individual has been  
granted authority to render  
patient care in emergency  
circumstances, such authority  
granted by a federal, state, or  
municipal entity.

\_\_\_\_\_  
Verifications Completed By

\_\_\_\_\_  
Date

**Approval**

\_\_\_\_\_  
President, Chief Executive Officer

\_\_\_\_\_  
Date

ADOPTED by the Medical Staff and RECOMMENDED for approval to the Governing Body on November 29, 2012.

By: \_\_\_\_\_  
President of the Medical Staff

\_\_\_\_\_  
Secretary of the Medical Staff

APPROVED by the Governing Body on November 29, 2012.

By: \_\_\_\_\_  
Chairman of the Board of Directors

\_\_\_\_\_  
Assistant Secretary of the Board of Directors