Rules and Regulations

of the Medical Staff of

Indiana University Health Blackford Hospital, Inc.

Revised: November, 1998
April, 2001
June, 2002
August, 2002
August, 2003
May, 2004
April, 2006
May 2008
December 2009
November 2011
November 29, 2012
May 19, 2016
September 17, 2020

TABLE OF CONTENTS

Rules & Regulations of the Medical Staff

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 generally be held on a monthly basis. It is anticipated that at least eight (8) monthly meetings shall be held each year.

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 should be transferred to another facility following the medical screening exam.

e. Room assignments – Room assignments shall be made with the understanding that a particular accommodation may not be available on the day of admission.

f. Infectious Disease – IU Health Blackford Hospital practices standard 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 Medical staff through its President 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

The remains of any deceased patient shall not be subjected to disposition until death has been officially pronounced by a member of the Medical Staff. Disposition shall be arranged in accordance with current Indiana law with the consent of the authorized representative, as applicable.

Medical Staff members should inform patients and their authorized representative of autopsies in accordance with guidelines listed in Appendix A, including informing of the transfer to another facility to conduct the autopsy, and secure autopsy consent, unless otherwise provided by law such as a Coroner's case.

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 Indiana law.

5. DISCHARGES

Once the patient has been admitted an order from the physician is required to discharge from the Hospital.

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.

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 RECORDS

a. Medical Records:

The Hospital initiates and maintains a medical record for every individual assessed or treated. All medical records shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course of treatment and results and promote continuity of care among the health care team. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient under his/her care. Its contents shall be pertinent and current. The medical record shall be completed within fourteen (14) days of the patient's discharge. A single attending practitioner shall be identified in the medical record as being responsible for the patient at any given time.

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:

The abbreviations listed in the IU Health Blackford Hospital Dangerous Abbreviations List will not be used in medical/health records of patients at IU Health Blackford Hospital.

Orders: If an unacceptable abbreviation is used in an order, the order will be considered invalid and will not be processed. The physician will be contacted for clarification. Clarification orders will be in writing in the medical record.

If, in the judgment of the registered nurse or pharmacist, the order is clear and complete and delay to obtain confirmation from the prescriber prior to execution of the order would place the patient at greater risk, then the order should be carried out and the confirmation obtained as soon as possible.

h. The final diagnosis shall be recorded in full without symbols or abbreviations.

i. 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.)

j. All entries in the medical record shall be dated, timed, and authenticated by the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry must be individually authenticated. Authentication is the signing of an entry or report after review. The author of each entry must authenticate his or her entry. Original signature, faxed signature, or computer key may accomplish authentication. Computer key and electronic signature is the authentication of an entry utilizing a confidential code that represents or affixes the author's signature.

11. INCOMPLETE MEDICAL RECORDS

(1) Definitions:

(a) Deficient: Any medical record that contains a deficiency that is in the date range of zero to fourteen (0-14) days post-discharge.

(b) Delinquent: Any medical record that contains a delinquency that is fifteen (15) days or greater post-discharge.

(2) Medical Records Procedure: The practitioner shall be responsible for completing all charts fourteen (14) days post-discharge.

1) Fifteen (15) days post-discharge – an electronic notification (email or fax) will be sent to all members whose charts are delinquent. The purpose of notification is to formally advise the member that their clinical privileges shall be administratively suspended in accordance with the Corrective Action/Fair Hearing Plan of the Medical Staff Bylaws if the member does not complete the delinquent records within six (6) days after receipt of the email.

2) On the 7th day after email notification, if the charts remain delinquent, the practitioner will be notified electronically (email or fax) that his/her clinical privileges will be suspended effective at 7am the next day and that the suspension will remain in effect for a minimum of 24 hours. The practitioner will be responsible for ensuring the transfer of on-going care for any patients he/she may have in the facility to another member of the medical staff with appropriate privileges until his/her privileges are reinstated.

12. 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.

13. ORDERS

Orders must include date and time and be entered electronically or be written clearly, legibly, and completely. An order shall be considered to be in writing if dictated to an authorized person (see verbal order below) and signed by the prescribing practitioner. Orders, which are illegible, will not be carried out until they are rewritten and are understood.

Only licensed independent practitioners and advanced dependent practitioners with appropriate Medical Staff or Allied Health Staff 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 appropriate licensed independent practitioner or advanced dependent practitioner.

Only licensed independent practitioners and advanced dependent practitioners who are authorized under Indiana law and their respective professional licensing statute to order outpatient tests and procedures shall have the authority to give orders for outpatient tests and procedures. Practitioners who wish to order outpatient tests/procedures are not required to obtain and/or maintain Medical Staff privileges, provided, however, the Hospital is able to verify that the practitioner maintains a current Indiana license.

Notwithstanding the forgoing, a physical therapist may evaluate and treat an individual during a period not to exceed ***twenty-four (24) calendar days*** beginning with the date of initiation of treatment without a referral from an authorized provider*; however, if the individual needs additional treatment from the physical therapist after ***twenty-four (24) calendar days,*** the physical therapist shall obtain a referral from the individual's authorized provider (i.e. physician, podiatrist, psychologist, chiropractor, dentist, nurse practitioner or physician assistant holding an unlimited license to practice) in accordance with the above two paragraphs. *Provided, however, (1) a physical therapist may ***not*** perform spinal manipulation of the spinal column or the vertebral column ***unless*** the physical therapist has received an order or referral from a physician or a chiropractor and the referring physician or chiropractor has examined the patient before issuing the order or referral; and (2) a physical therapist may ***not*** perform sharp debridement ***unless*** the physical therapist has received an order or referral from a physician or podiatrist.

Verbal orders (either in person or via telephone) for all other medications or treatments shall be accepted only under urgent circumstances when it is impractical for such orders to be given electronically or in a written manner by the responsible practitioner. Only qualified personnel listed below may accept a verbal order. All verbal orders must be immediately read back to verify accuracy. The individual taking the order shall transcribe the orders in the proper place in the medical record. The order shall include the date, time, signature and title of the person taking the order. Verbal medication orders shall include the name of the patient, the bed number, if appropriate, name and strength of the medication, dose, route of administration, directions for use and the name of the prescribing practitioner. The practitioner who issued the order shall countersign the verbal order within fourteen (14) days of the patient's discharge from the hospital. Acceptance of a verbal order is limited to the following personnel, with noted restrictions: (1) Physician or dentist or nurse practitioner or physician assistant; (2) Registered nurse; (3) Pharmacist who may transcribe verbal orders pertaining to drugs; (4) Physical therapist who may transcribe verbal orders pertaining to rehabilitation services; (5) Respiratory therapist who may transcribe verbal orders pertaining to respiratory therapy treatments; (6) Registered dietician who may transcribe verbal orders pertaining to nutritional care; (7) Occupational therapist who may transcribe verbal orders pertaining to rehabilitation services; (8) A physician's assistant, who may transcribe verbal orders from his or her supervising physician or from a physician designated by the supervising physician as an agent in accordance with the conditions established by the Board of Directors of the hospital regarding the scope of practice permitted for physicians' assistants at the hospital; (9) Radiology Technologists, who may transcribe verbal orders pertaining to radiology services (ie. CT, MRI, ultrasound, nuclear medicine); (10) Social workers who may transcribe verbal orders pertaining to social work services; (11) Speech-Language Pathologists who may transcribe verbal orders pertaining to rehabilitation services; and (12) Laboratory Technicians, who may transcribe verbal orders pertaining to laboratory orders.

Blanket orders of reinstatement of previous medications are not permitted.

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.

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.

14. INFORMED CONSENT

It is the policy of IU Health Blackford Hospital to obtain a signed "Consent for Treatment" at the time of treatment 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; and
e. Administration of blood and blood products.

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 informed consent explanation includes:

1. The general nature of the patient's condition;
2. The proposed treatment, procedure, examination or test;
3. The expected outcome and benefits of the treatment, procedure, examination or test;
4. The material risks of the treatment, procedure, examination or test; and
5. The reasonable alternatives to the treatment, procedure, examination test.

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

a. the name of the physician or other treating 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 treating practitioner to have the informed consent discussion and 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 or treating practitioner shall obtain the patient's informed consent to the administration of anesthesia administered by him/her or under his/her supervision.

3. The treating practitioner who will perform the treatment or procedure shall obtain the patient's informed consent to the treatment or procedure.

Members of the Medical Staff and Allied Health Staff may not delegate the duty to obtain informed consent to Hospital staff members.

Hospital personnel may aid in procuring signed consent forms as a matter of courtesy to the members of the Medical staff. However, their role is ministerial in this regard. The responsibility of obtaining informed consent is the responsibility of members of the Medical 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 Medical 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".

MINORS:

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

a. He or she is emancipated;
b. He or she is as 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); or

f. meets the requirements of a pregnant, in labor or postpartum minor described below.

PREGNANT, IN LABOR & POSTPARTUM CARE – MINOR

A ***minor*** patient (under the age of 18) is authorized to consent to her own health care with respect to the pregnancy, delivery and postpartum care ***if the minor***:

1. is at least 16 years of age; and
2. is: (A) pregnant; (B) in labor; or (C) postpartum for a sixty (60) day period after the birth.

Additional requirements for Health Care Providers treating Pregnant, In Labor or Postpartum Minors at least 16 Years of Age:

1. **Before** a treating practitioner may provide care to the minor, the treating practitioner shall make a ***reasonable effort*** to ***contact*** the minor's ***parent or guardian for consent*** to provide the treatment and ***document in writing*** each such attempt. If after making a reasonable attempt to contact the minor's parent or guardian, and either the treating practitioner is (A) unable to make contact; or (B) the parent or guardian refuses to provide consent for treatment, then the ***treating practitioner shall act*** in the ***manner*** that is in the ***best interests*** of the ***minor and the fetus***.
2. If, after the initial appointment or treatment, the treating practitioner determines that ***additional care*** is in the best interest of the minor and the fetus, the treating practitioner shall ***make one (1) additional attempt to contact*** the ***parent or guardian for consent*** before: (A) the provision of prenatal care; (B) the delivery of the baby; and (C) the provision of postpartum care.

Further, a minor who is capable of consenting to the minor's *own* health care (meets criteria listed above) may, in a writing singed by the minor, *disqualify* an individual from having health care consent authority over the minor, and under such circumstance, a treating practitioner may not accept health care consent from a *disqualified* individual.

If the ***minor*** is ***not authorized*** to consent for the minor's health care, then health care consent for a ***minor*** may be given, in the following ***order of priority*** (unless otherwise disqualified or as provided below), by:

1. a judicially appointed guardian or judicially appointed health care representative;
2. if there is no judicially appointed guardian or judicially appointed health care representative, then a parent or individual in loco parentis;
3. if there is no judicially appointed guardian or judicially appointed health care representative or no parent or individual in loco parentis (*after reasonable effort*s are made by the health care provider to determine whether the minor has a parent or individual in loco parentis), then an adult sibling of the minor; or

4. if there is no judicially appointed guardian or judicially appointed health care representative or no parent, no individual in loco parentis and no adult sibling (*after reasonable efforts* are made by the health care provider to determine whether the minor has a parent, individual in loco parentis or adult sibling), then a grandparent of the minor.

Consensus/Disagree-Majority Controls: If there are ***multiple*** individuals in the ***same level of priority*** (e.g. 3 adult siblings of the minor), then those individuals shall make a ***reasonable effort*** to reach a ***consensus*** as to the health care decision. If the individuals in the same level of priority ***disagree*** as to the health care decision, then a ***majority*** of the available individuals at the same priority level ***controls***.

ADULT:

If in the opinion of the patient's attending physician, the ***adult*** patient 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, then health care consent for an ***adult*** may be given, in the following ***order of priority*** (unless otherwise disqualified or as provided below), by:

1. A judicially appointed guardian or judicially appointed health care representative
2. A spouse
3. An adult child
4. A parent
5. An adult sibling
6. A grandparent
7. An adult grandchild
8. The nearest other adult relative in the next degree of kinship who is not listed in subdivisions 2. through 7. above
9. A friend who:
    - Is an adult
    - Has maintained regular contact with the individual; and
    - Is familiar with the individual's activities, health, and religious or moral beliefs
10. The individual's religious superior, if the individual is a member of a religious order.

Consensus/Disagree-Majority Controls: If there are ***multiple*** individuals in the ***same level of priority*** (e.g. 3 adult children of the adult), then those individuals shall make a ***reasonable effort*** to reach a ***consensus*** as to the health care decision. If the individuals in the same level of priority ***disagree*** as to the health care decision, then a ***majority*** of the available individuals at the same priority level ***controls***.

Not Able to Render Health Care Consent for an Adult: Notwithstanding being listed as able to consent to health care for an ***adult*** in 1. – 10. above, the following individuals

may not provide health care consent: (1) A Spouse who: (a) is legally separated; or (b) has a petition for dissolution, legal separation or annulment of marriage pending in a Court; (2) Individual who is subject to a Protective Order or other Court Order that directs that Individual to avoid contact with the incapable adult; or (3) Individual who is subject to a pending criminal charge in which the incapable adult was the alleged victim. Further, an adult capable of consenting to the adult's *own* health care may, in a writing singed by the adult, *disqualify* an individual from having health care consent authority over the adult, and under such circumstance, a Health Care Provider may not accept health care consent from a *disqualified* individual.

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. In place of the patient's or patient's authorized representative signature on the form, the treating practitioner should write a statement indicating that the patient or patient's authorized representative was not physically able or available to sign the consent form and describing the method used to obtain consent (i.e. telephone conversation with the patient's authorized representative, etc.).

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.

15. 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.

16. 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 tooths, 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.

17. SEXUAL HARASSMENT

IU Health Blackford Hospital and the Medical 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 factors 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 member of the Medical Staff 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.

18. 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.

19. IMPAIRED MEMBERS OF THE MEDICAL STAFF AND ALLIED HEALTH STAFF

PART A: RESPONSIBILITY TO IDENTIFY & REPORT SUSPECTED IMPAIRMENT

To support quality and safe patient care, it is important to identify impaired Medical Staff members and Allied Health Professionals (both referred to as "Provider"), and facilitate treatment and rehabilitation. Impairment means a physical, mental or substance-related condition (including abuse and dependency of drugs and alcohol) that interferes with a Provider's ability to perform services in a safe and professionally acceptable manner.

We all share the responsibility of ensuring a safe and effective environment for our patients, colleagues, team members, visitors and volunteers, including the responsibility to immediately report any suspicions of impairment concerning a Provider.

Impairment can be difficult to identify. The observations set forth on **Appendix C** may indicate suspected impairment.

PART B: SELF-REPORTING

When a Provider wishes to self-report his/her impairment, they may refer themselves to the Provider Health & Well-Being Committee for assistance (or, if an employee within IU Health, they may also contact the Employee Assistance Program).

PART C: PROCEDURES TO FOLLOW FOR SUSPICION OF IMPAIRMENT

1. If a member of Medical Staff or an Allied Health Professional has reason to suspect that another Provider is rendering patient care or professional activities while impaired, they shall immediately contact the Administrator On-Call to request that the Administrator On-Call immediately come into the facility.

2. If an employee, team member, volunteer, patient or patient's family member reasonably believes or expresses a reasonable concern that a Provider appears impaired while rendering patient care or professional activities, the employee, team member or volunteer shall immediately contact their supervisor, manager or department director. Upon receipt of the report, the supervisor, manager or department director shall immediately contact the Administrator On-Call to request that the Administrator On-Call immediately come into the facility.

3. The Administrator On-Call shall make arrangements for a physician member of the Medical Staff Executive Committee, a Medical Director, a Department Chair or the Chief

Medical Officer ("Medical Staff Leader") to also immediately come into the facility.

4. The Provider suspected of impairment will be removed from patient care, escorted to a private area (e.g. conference room, office) by individuals who have witnessed (or received reports) of the suspected impairment and will be instructed to wait until the arrival of the Administrative Director On-Call and Medical Staff Leader. Other leadership and security may be consulted to assist in this process.

5. The Provider will be informed of these procedures by the Administrative Director On-Call or Medical Staff Leader. If the Administrative Director On-Call *or* Medical Staff Leader determines that testing of the Provider is appropriate, then STAT drug testing will be utilized for suspected impairment from drugs or alcohol (urine and/or blood) along with confirmatory send-out testing. During business hours, the testing will be conducted in the lab. If the situation arises after hours, then the Administrator On-Call will call Nursing Services to coordinate testing in the lab under the oversight of the House Officer/AA. Chain of custody procedures will be followed, and the Provider shall sign all requested consent forms for the release of the test results as provided herein. If the Administrative Director On-Call *and* Medical Staff Leader determine that the Provider is not exhibiting behaviors associated with suspected impairment, then no testing shall occur.

6. The refusal of a Provider to wait as provided in Section 4. above, or delay or refusal to provide a sample in response to a request for testing, urine and/or drug, or refusal to sign consents for the release of the test results are each grounds for immediate precautionary suspension of the Provider's clinical privileges.

7. The Provider will be directed to contact family or other appropriate person for transportation home. If family or other significant others are not available, the Administrator On-Call will secure a taxi to transport the Provider home.

8. Test results will be communicated to the appropriate Medical Staff Leader, Committee or designee. If the STAT test results are negative, the Provider may be allowed to return to patient care activities as determined by the Medical Staff Leader. A record will be kept of allegations proved to be negative through testing to assess at intervals for trends which might indicate need for focused education on signs of impairment.

9. If the STAT test results or send-out confirmatory test results are positive or the Provider refused to be tested and/or sign consents, the appropriate Medical Staff Committee or Medical Staff Leader will immediately suspend the Provider from patient care activities and notify the respective Medical Staff Department Chair to ensure patient care responsibilities can be immediately reassigned.

10. The Medical Staff Leader arriving on site to participate in above procedures will promptly make a full report of such incident to the Medical Staff Executive Committee regardless of whether or not the testing was positive.

PART D: SUSPENSION

If the Provider has been suspended, the procedures set forth in the Medical Staff Bylaws shall be followed.

PART E: REFERRAL

If the Medical Staff Executive Committee or other Medical Staff Committee makes a referral to the Indiana State Medical Association Physician Assistance Program ("ISMA PAP") at 1-800-257-4762 (each reference to ISMA PAP herein shall be deemed to include the applicable program if an Allied Health Professional), then the Provider shall cooperate with the Medical Staff designee and ISMA PAP, including signing all necessary consent forms for release of information. When an initial report lacks sufficient information to warrant further action, the report will be kept in a confidential file. If further information is received, the case will be reinvestigated. If the Provider is recommended to undergo an appropriate evaluation by a facility or physician through the ISMA PAP, the Provider must agree to undergo the evaluation and follow the recommendation of the evaluation. Consent to undergo evaluation and follow treatment recommendations are verified when the Provider enters into an evaluation contract with ISMA. If ISMA PAP recommends treatment, the Provider shall sign a monitoring contract with the ISMA PAP. Compliance with the contract will be shared with the Provider Health & Well Being Committee by the ISMA PAP. Failure of a Provider to cooperate and comply with requests or with the terms of an ISMA PAP contract will result in a report to the Medical Executive Committee and may result in a report to the Indiana Medical Licensing Board. In such instance, disciplinary proceedings may be initiated against the Provider.

20. 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.

21. 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.

22. 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.

23. EMERGENCY PRIVILEGES PROCEDURES – DISASTER/EMERGENCY

To provide a mechanism for documenting emergency privileges for practitioners who are not members of the Medical Staff, but volunteer their services in the event of a disaster or emergency. 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 should be approved by the President, (or his/her designee). The following procedures should be followed to the extent practical during the disaster/emergency:

1. The individual seeking to volunteer completes an 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 is documented on the emergency privileges form.

   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 the 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 emergency 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 y emergency privileges shall cease when the emergency situation no longer exists.

24. AMENDMENTS

Any proposed amendment to these Rules and Regulations shall be presented at a regular or special meeting for review by the Medical Staff. The amendments may be approved by a majority vote of those present at a meeting of the Medical Staff. Such amendments shall become effective when approved by the Governing Board.

APPENDIX A

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 of suspected deaths arising from environmental or occupational hazards.

*This list is not intended to be all inclusive.

ref: American College of Pathology

APPENDIX B

Indiana University Health Blackford Hospital, Inc.
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 (or designee) Date

APPENDIX C

Impairment can be difficult to identify. The following observations may indicate **suspected impairment.**

Job Performance Indicators

- Unexplained work errors
- Unexplained work related accidents or injuries
- Unexplained excessive absenteeism or tardiness especially if a pattern is evident
- Long lunch breaks
- Absence from work area

Physical Indicators

- Dilated pupils or pinpoint pupils
- Bloodshot eye
- Drowsiness/sleepiness
- Tremors
- Constant runny nose
- Frequent illness
- Personal grooming deterioration

Mental/Emotional Indicators

- Hyperactive or Euphoric
- Unusual mood swings over short period of time (aggressive or extreme anger, laughter or depression)
- Impaired short-term memory
- Depression
- Nervousness
- Difficulty understanding, following directions – Impaired logical thinking
- Difficulty in comprehending conversation or responding to direction - confusion
- Disorientation
- Difficulty in expressing themselves
- Unusually aggressive behavior

Speech Indicators

- Slurred
- Slow
- Rapid
- Incoherent
- Rambling

Motor Skills Indicators

- Lack of coordination when walking or performing tasks
- Difficulty standing without leaning
- Lack of manual dexterity
- Trouble sitting still, a change from the "normal"

Drug Addiction Indicators

- Patient's complaint of not being able to sleep after sleep medication was charted as been given
- Patient's pain level increase during team member's shift and then decreases during other shifts
- Errors in patient care
- Not having waste medications witnessed
- Deteriorating handwriting
- Pattern of drug discrepancies
- Drug administration habits that indicate theft or diversion

Physical Symptoms of Use or Withdrawal

- Runny nose
- Watery eyes
- Dilated or constricted pupils
- GI disturbance
- Anorexia
- Mood swings
- Odor of alcohol on breath

Enabling Symptoms of Department Staff

- Excuse nurse from full responsibility and/or exempt nurse from constructive criticism
- Fail to deal with inappropriate behavior
- Cover for the nurse – take on his/her duties
- Eventually feel responsibility or guilt themselves
- Agree to sign when waste was not witnessed