

**RULES AND REGULATIONS OF THE MEDICAL STAFF
AND ALLIED HEALTH PROVIDERS OF
INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL**

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RULES AND REGULATIONS OF THE MEDICAL STAFF AND
ALLIED HEALTH CARE PROVIDERS OF INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL

ARTICLE I. PROFESSIONALISM

- 1.1 These rules and regulations are intended to provide comprehensive information to members of the IU Health Tipton Hospital Medical Staff and Allied Health Care Providers in order for them to fulfill their commitment and responsibility to provide quality and safe patient care. In addition, members of the Medical Staff and Allied Health Care Providers are obliged to carry themselves in a manner, which exemplifies the utmost respect and professionalism toward patients, families, visitors, staff and employees of IU Health Tipton Hospital.

ARTICLE II. DELINEATION OF PRIVILEGES

- 2.1 Categories of Privileges:
A complete listing of all Medical Staff Privileges approved by the Board of Directors will be maintained in the Medical Staff Services Policy Manual.
- 2.2 The required qualifications for the privilege to perform each procedure or to treat each condition shall be predetermined by members of the Credentials Committee, the physician advisors, and directors of hospital services.
- 2.3 Practitioners will be granted privileges when his/her credentials file contains data and supporting information demonstrating current clinical competency.
- 2.4 Only practitioners who have been duly appointed to membership by the Medical Staff by the IU Health Tipton Hospital Board of Directors or who have been granted temporary privileges, and are in good standing, are eligible to serve as the admitting/attending physician for patients within the hospital. When a medical staff member is granted privileges he/she will automatically be granted privileges to perform the following within the scope of his/her individual privileges:
- a. Admit patients.
 - b. Perform histories and physicals (dentists & podiatrist cannot perform H&Ps).
 - c. Order diagnostic and therapeutic services.
 - d. Chart in patient medical records.
 - e. Make referrals and request clinical consultations.
 - f. Provide consultations as requested.
 - g. Use all skills normally learned during medical school or residency except those specifically identified as privileges outside the scope of the privileges granted to him/her.
 - h. Render any care in a life-threatening emergency.
 - i. Discharge patients.

Note Exception: Affiliate staff members, Emergency department physicians, radiologists, anesthesiologists, pathologists, dentists, and podiatrists may not admit patients for inpatient service nor discharge them.

2.5 Reporting Requirements

In addition to reporting requirements at the time of initial application and reapplication to the IU Health Tipton Hospital Medical Staff, all members of the Medical staff are to immediately report to the Medical Staff President (or his/her designee when off premises) any circumstances involving the following:

- a. suspension or any action (censure, reprimand, and/or fine) regarding their professional license
- b. loss, suspension or other actions (excludes routine renewal) regarding state or federal prescribing of controlled substances
- c. loss, suspension or limitation (excludes routine non-renewal) of clinical privileges at another health care facility
- d. filing of notice of exclusion/debarment from any federal health care program including Medicare/Medicaid
- e. filing of any criminal charge by state or federal authorities (excludes minor motor vehicle accident)

2.6 When the Executive Committee determines that a physician must have a proctor, the following rules apply:

- a. Proctors will be voluntary and agreed to by at least two-thirds (2/3) vote of the members present at any Medical Executive Committee meeting.
- b. Proctors will not have a conflict of interest.
- c. The proctor will prospectively and concurrently review with the physician the types of cases he/she is admitting and how he/she is doing. Also, on a nonspecific basis, the proctor will caution the physician if he/she appears to be having cases beyond his/her ability.
- d. The proctor has no duty or responsibility to intervene in the care of the patient. If the attending physician has any questions regarding a particular case, he/she may consult with the proctor who may then refer the matter to the Medical Staff President Staff. The Medical Staff President may intervene in the case or request another qualified physician (including the proctor) to intervene.
- e. Proctors will retrospectively review all medical records of all cases involved after discharge of the patient and then discuss them with the physician being proctored.
- f. Retrospective review will be completed using a form determined by the Credentials Committee.
- g. The proctor will make a report to the Credentials Committee every three (3) months for a period of not less than six (6) months. The report will recommend one of the following:
 1. Recommend a three (3) month continuation for:

- a. Six (6) months of proctoring not completed, or
 - b. Inconclusive data demonstrating clinical competency; or
 - c. Failure to admit or otherwise provide services to a minimum of twenty-five (25) patients.
2. Recommend full privileges and status in the area being proctored.
 3. Recommend termination of privileges and/or status in the areas being proctored.
- 2.7 All initial appointments and privileges are probationary. All activity between initial appointment and first reappointment is subject to review by the Credentials Committee.

At the first reappointment following the probationary period, a report of all clinical activities (number, type and outcome) will be prepared for the Credentials Committee. The committee will evaluate the appointee's clinical competence and will render a written report of such to the Medical Executive Committee. The report may:

- a. Recommend:
 - Medical Staff: Awarding full medical staff status and granting privileges as requested until the next regularly scheduled time for evaluation of reapplication for privileges.
 - Allied Health Care Providers: Awarding full allied health care provider status and granting privileges as requested until the next regularly scheduled time for evaluation of reapplication for privileges.
 - b. Recommend:
 - Medical Staff: Termination of medical staff appointment and privileges.
 - Allied Health Care Providers: Termination of allied health care provider status and privileges.
 - c. Recommend a six (6) month continuation of probationary status for either:
 - Medical Staff: Failure to admit or otherwise provide services to a minimum of twenty-five (25) patients; or inconclusive data demonstrating clinical competence.
 - Allied Health Care Providers: Failure to provide services; or inconclusive data demonstrating clinical competence.
- 2.8 Focused Professional Practice Evaluations (FPPE) and Ongoing Professional Practice Evaluations (OPPE)
- Ongoing Professional Practice Evaluations will be performed regularly for Provisional, Active and Associate Medical Staff Members and Allied Health Care Providers. Please refer to Medical Staff Policy 769.143 regarding this process.

ARTICLE III. ADMISSIONS

3.1 Admission of Patients

Active, Associate, and Provisional Medical Staff members may register patients for admission to the hospitals. The physician who admits the patient will be designated as the attending physician and will provide a provisional clinical diagnosis. The admitting physician will be considered the attending physician unless an order is written to transfer care to another physician who has agreed to accept responsibility for the patient's care management. Such transfer of attending physician status is to occur only after physician to physician discussion of the patient's care and comprehensive discussion of the status of the patient's clinical needs.

3.2. Patients admitted to the hospital shall be the responsibility of the attending physician. Those patients admitted on an emergency basis and who have no preference for a physician shall be assigned to the Active Medical Staff member who is on call.

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

ARTICLE IV. Patient Care

4.1 Attending Physician Requirements

Patients admitted to the hospital must be seen within twenty-four (24) hours after admission by the attending physician. The attending physician is in charge of the patient's overall care management, including but not limited to review of orders, request of necessary consultations, determination of the patient's resuscitation status, planning for discharge, completion and signing of medical records documentation.

The attending physician shall be the primary physician during that hospitalization and shall be responsible for documentation (i.e., history and physical, orders, progress notes, and discharge summary). In the case of an elective surgery patient, the surgeon shall be the attending physician.

Inpatient and observation patients shall be seen daily by the attending physician or the attending physician will effectively delegate that responsibility to an associate/partner of the attending physician.

4.2 Patient/Family Complaint Procedures

Hospital patients shall be provided with appropriate channels to communicate dissatisfaction with medical care and treatment, safety and security, and be

provided a timely and appropriate response upon conclusion of the investigation into the concern. Members of the Medical Staff must fully cooperate in such investigations.

4.3 Consultations

To promote effective consultation among practitioners of various specialties involved in the treatment of patients, it is recommended that the attending physician, or his/her designee (nurse practitioner, physician assistant, other physician partner) directly discuss with a consultant practitioner the need to examine, discuss, or otherwise provide an opinion regarding a patient's care management.

Consultation should be considered:

- a. Where the diagnosis is obscure, or
- b. Where doubt exist as to the best therapeutic measures to be taken, including cases where the disorder or complications are not in the field of the attending physicians' practice, or
- c. Patient not responding to treatment as expected, or
- d. Patient or family requests clinical consultation or second opinion, or
- e. Other circumstances deemed necessary that are not listed.

Orders for consultation should include the reason for the consultation, extent and involvement in care expected from the consultant and notation that the consultant has been previously contacted by the ordering practitioner or his/her designee.

The consultation should be documented in the medical record and include discussion of background information and specific questions about the patient. The consultant must make and sign a report of findings, opinions and recommendations that reflects an actual examination of the patient and review of the patient's medical record. Consultation notes will be documented in the chart and a full typed or dictated consultation note should be created within 24 hours after seeing the patient. The consultant's report of findings will become part of the medical record.

4.4 Delegation of Practitioner Responsibilities

In order to insure quality health care to all patients, certain responsibilities must be performed by a physician and are not to be delegated to non-physicians without proper oversight. These responsibilities are as follows:

- a. Admission of patients to the hospitals – physician only.
- b. Physician must obtain and review the history of the present illness and perform the initial physical examination or review and countersign if performed by a credentialed physician assistant or nurse practitioner.
- c. Dictation of operative notes.
- d. Completion of discharge summary and/or death notes.

- e. Performance of surgery, which the practitioner has agreed to perform.
- f. Signatures of reports, orders or other medical record entries.

4.5 Care Management

Care Management is a hospital-wide, interdisciplinary process that plans, organizes, and provides health care services in a timely, cost-effective manner while maintaining quality patient care consistent with the mission of IU Health Tipton Hospital. As an integral member of the team process, practitioners support effective and efficient utilization of hospital facilities and services through the following actions:

- a. Communicate with patient care coordinators and practitioner leaders to help improve inefficiencies in care and safely move the patients to a lower level of care when medically appropriate.
- b. Obtain specialty consultation early and frequently.
- c. Support evidence based medicine such as in the treatment of DVT, pneumonia, AMI and CHF patients.
- d. Review medicines and orders daily:
 - i. Discontinue interventions that are not medically necessary (examples: telemetry and Foley catheter)
 - ii. Change medicines from IV to oral when appropriate (examples: antibiotics and pain meds)
 - iii. Advance diet and activity when appropriate.
- e. Discuss daily with your patients (and families) those objectives that will need to be accomplished before discharge is possible.
- f. Keep your patient, the family and the interdisciplinary team informed of potential discharge plans and the expected date of discharge.
- g. When patient medically meets criteria for discharge and further testing is needed, discharge patient and finish workup as an outpatient
- h. Consider end of life issues where Palliative care, Hospice or Geriatric services may be appropriate for the patient.
- i. Compare your utilization, LOS and cost performance to your peers.
- j. Participate in communication between certification nurse and physician advisor if available to help resolve concurrent verbal denials for continued hospital stay.

The Medical Executive Committee and the IU Health Tipton Hospital Quality Council are responsible for the review of care including Utilization Management functions. Utilization Management issues will be reported at least quarterly or more frequently as deemed appropriate to these committees.

These committees may appoint practitioners outside of the committees to perform concurrent or retrospective chart reviews for Utilization Management. These practitioners will be available to assist and counsel personnel responsible for utilization functions and to consult with peers to resolve issues. Peer review protection applies in accordance with Indiana Peer Review Statue I.C. 34-4-

12.6.1.

4.6 Discharge of Patients

Patients are to be discharged only by order of the attending physician or his/her designee. Telephone orders for discharge may be utilized at the discretion of the attending physician or designee. The attending physician or designee is obligated to communicate to the referring practitioner all appropriate medical information. In the event that patient is being transferred to another agency or institution, the physician is to ensure the same information is documented on approved discharge/transfer forms and an immediate discharge summary is dictated.

Whenever possible, as part of the discharge process, the attending physician or designee is to identify the practitioner who will provide follow-up care after discharge from IU Health Tipton Hospital. Comprehensive communication to the practitioner conducting follow-up by the attending physician or designee is to include the patient's hospital course, medications upon discharge, and need for continuing care.

It is the responsibility of the attending physician or designee to ensure discharge of patients in a timely fashion. Discharge planning is multidisciplinary and practitioner designees are to engage nursing, case management, and other health care disciplines as needed in the process. Care conferences may be necessary to address challenging patient or family issues that could negatively affect discharge. Practitioner is to avail themselves to participate in such conferences or give input when needed.

4.7 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending physician or designee without proper discharge, the attending physician or designee will be notified and the patient will be requested to sign the appropriate release form, attested by the patient or legal representative of the patient and a competent third party. Such departure from the hospital is to be noted in the medical record by the attending physician or designee. Child Protective Services shall be contacted if parents or guardians of minors remove or threaten to remove a minor patient against medical advice.

ARTICLE V. CONSENT

5.1 Informed Consent Process

A separate Consent for Procedure form should be completed by the patient and his/her treating practitioner for proposed health care procedures, which involve medically significant risks or medically significant alternatives, for example:

- a. procedures using general anesthesia

- b. procedures performed in the operating room, treatment room, and endoscopy room
- c. procedures which involve such a risk or result that the patient would attach significance to the risks, or results when deciding whether or not to proceed with the proposed procedures, and
- d. blood product transfusion

Each clinical department may determine which procedures performed by department members require a Consent for Procedure Form. In addition to discussing the proposed procedures with the patient and completing the written Consent for Procedures form, the treating practitioner should include a note in the patient's medical record to the effect that the practitioner spoke with and advised the patient of the nature of the proposed care, treatment, services, medications, interventions, or procedures; potential benefits, risks, or side effects including potential problems related to recuperation; likelihood of achieving care, treatment and service goals; reasonable alternatives to the proposed care, treatment and service; relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations of the confidentiality of information learned from the patient. The attestation statement in the Consent for Procedure form may serve as the treating practitioner's written note.

The Treating Practitioner should attempt to complete the form at the time of the informed consent discussion with the patient or the patient's representative.

ARTICLE VI. Medical Records

6.1 Handwritten entries and Use of Abbreviations

All entries in the medical record must be legible and in black or blue ink. Pencil entries are not permitted. Entries are to be dated and timed. The date and time of the note will be the date and time of the entry, regardless of whether the content of the note relates to a previous date or time. Documentation throughout the medical record regarding medication orders must be written without the use of unsafe abbreviations.

In order to promote coordination of patient care, all practitioners contributing to care of a patient will be responsible for recording in the medical record: Diagnosis, observation, and patient instruction.

6.2 Authentication of entries

All entries in the medical record must be confirmed by written or electronic signature, identifying the credentials of the authro. Reports dictated and

transcribed through Health Information Management require physician and/or surgeon/procedural practitioner authentication or 3M's Electronic Signature Authentication.

- a. A Physician Assistant who is employed/supervised by Attending Physician and who is granted privileges per Medical Staff Bylaws may make appropriate entries in the patient's medical record. Such entries shall be countersigned by the Employing/Supervising attending physician within twenty-four (24) hours thereafter. Supervising physician must be physician physically present or immediately present for consultation at all times.
- b. A medical student (including Physician Assistant and Nurse Practitioner students) who has been cleared by Medical Staff Services may round with his or her supervising physician and make appropriate entries in the medical record under the supervision of said physician. These entries must be immediately countersigned by the supervising physician. Any orders that are not countersigned immediately should NOT be taken off the patient's chart without a verbal restatement of the order from the supervising physician.

6.3 Orders

All orders for treatment shall be in writing (electronic or on paper). Initial admission, diagnostic, treatment and discharge orders may be written by the attending physician, dentist or podiatrist (dentists and podiatrists cannot admit). The physician must write an admission status order (inpatient or observation) for each patient receiving services on a nursing unit. Admission orders are required no later than the patient arrival on the unit.

Orders occurring prior to a procedure will not be automatically resumed after the procedure. To ensure patient safety, orders must be rewritten after major procedures to ensure changes to the patient clinical status are taken into full consideration; however, a transfer order summary is available in Cerner which allows the physician/dentist to select orders for renewal. This should be placed on the patient chart by the unit secretary.

Verbal orders are to be reserved as much as possible for emergent situations.

- a. A verbal order shall be considered to be in writing if telephoned or dictated by the physician (or authorized member of the physician's office staff), dentist, podiatrist, or psychologist to the following authorized hospital staff:

Registered nurses	All orders
Licensed practical nurses	All orders
Laboratory technicians	Laboratory orders only
Radiology technicians	Radiology orders only
Respiratory therapy tech.	RT orders only
Physical therapist	PT orders only
Occupational therapist	OT orders only

Dietitian	Diet orders only
Registered pharmacists	Pharmacy orders
Specialty Care Center assistants	Outpatient tests and scheduling orders

- b. Authorized hospital staff members shall write such verbal orders in the medical record. The name of the ordering practitioner and/or authorized office staff member per his or her own name and title must be written in the order along with the name and title of the authorized staff member who received the order.
- c. The authorized hospital staff member who took the order shall repeat and verify the order with the ordering practitioner. The fact that the order was repeated and verified shall be documented on the order within the patient's medical record and appropriately signed and dated by the authorized staff member that took the order.
- d. All verbal orders not repeated and verified shall be signed and dated by the practitioner within forty-eight (48) hours. All verbal orders that were repeated and verified shall be signed and dated by the ordering practitioner within 30 days of discharge.
- e. Written verbal and telephone orders may be signed by another practitioner in the same call group if an Authentication Agreement is on file with Health Information Management.

Physicians who authorize personnel in their offices to communicate their orders must maintain a current list of those authorized individuals, and titles, with the hospital administration.

The medical staff may adopt and, from time to time change, standing orders where there is a specific diagnosis and only in specialized care areas such as Surgery and ICU. Such orders are to be signed by the practitioner who uses the orders. Standing orders must be reviewed and re-authenticated at least annually by the medical staff. Hospital administration shall be notified promptly of the adoption of the standing orders and changes therein and shall notify all personnel concerned.

A verbal or written time-limited order with specific start and stop times is required for each use of restraint or seclusion. The type of restraint must be included in this order. Physician must consider and reject all other alternative treatments as a reason for restraint. The use of PRN orders for restraints or seclusion is prohibited.

- 6.4 History and Physical
Requirements for History & Physical Examinations can be found in the Appendix of the IU Health Tipton Hospital Medical Staff Bylaws.

6.5 Progress Notes

Progress notes shall give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, the results of treatment, and discharge planning.

Progress notes must be recorded at the time of observation and be sufficient to permit continuity of care and transferability of the patient. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

Progress notes must be typed daily, dated and timed, and be authenticated by the practitioner making the note.

The attending physician may make prior arrangements with another member physician for daily rounds, progress notes and management of care in their absence.

A Physician Assistant who is employed/supervised by Attending Physician and who is granted privileges per Medical Staff Bylaws may round on behalf of the Employing/Supervising attending physician and is required to make appropriate entries including progress notes in the patient's medical record. Such entries shall be countersigned by the Employing/Supervising attending physician within twenty-four (24) hours thereafter. Supervising physician must be physician physically present or immediately present for consultation at all times.

A medical student (including Physician Assistant and Nurse Practitioner students) who has been cleared by Medical Staff Services may round with his or her supervising physician and make appropriate entries including progress notes and orders in the medical record under the supervision of said physician. These entries must be immediately countersigned by the supervising physician.

6.6 Operative/Procedure Notes

Operative reports must be dictated immediately following any surgical or invasive procedure. The operative report must be dictated within 24 hours using the hospital's dictation system or the responsible physician/surgeon can provide the completed typed operative report to the facility within 48 hours of the procedure. The reports must contain the preoperative diagnosis, the postoperative diagnosis, name of the primary surgeon and any assistants, detail the technical procedures used, the description of findings, blood loss, specimens removed, and the condition of the patient at the conclusion of the procedure

The practitioner must enter an operative progress note in the medical record immediately after the procedure, providing sufficient and pertinent information for any practitioner required to attend to the patient until the operative report is

available.

6.7 Tissue and Examinations Reports

Tissue removal procedures are directed through the Medical Staff Policy on Tissue/Surgical Case Review. All surgery pathology reports prepared by the Pathology Department shall have a code inserted by the pathologist to convey one of the following:

1. **Code 0:** Insufficient clinical information concerning pre-operative diagnosis for coding purposes.
2. **Code 1:** Tissue removed for diagnostic purposes.
3. **Code 2:** Tissue removed for therapeutic purposes with no major discrepancy between the pre-operative (clinical) and post-operative (pathological) diagnosis.
4. **Code 3:** A major discrepancy exists between the pre-operative (clinical) and the post-operative (pathological) diagnosis.
5. **Code 4:** Referral or consultation case originating at another institution.

Through audit efforts of the Tissue Review Committee, cases of concern will be channeled for peer review.

6.8 Cancer Staging

AJCC (American Joint Committee on Cancer) Staging is assigned by the managing physician based on primary site, histology, and clinical and pathologic staging criteria for all eligible analytic cases. The managing physician includes the surgeon(s), hematology/oncologist, radiation oncologist, or other specialist(s) involved in diagnosing or treating the cancer patient. The AJCC TNM (Tumor-Nodes-Metastasis) staging classification system is a tool for physicians to stage different types of cancer based on anatomic location and specific standard criteria.

Staging allows for determination of appropriate treatment, and serves as a prognostic indicator. Physician staging of cancer provides a means of comparison of internal experience with national data, and is a recognized benchmark of quality in cancer patient care. Refer to the Oncology Policy/Procedure Manual staging policy, ONC - 01 for complete details and definitions.

6.9 Discharge Summary

The discharge summary is the responsibility of the attending physician. The discharge summary must be completed upon discharge of the patient from the hospital. The discharge summary must include documentation of the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses established by the time of discharge, significant findings, procedures performed and treatment rendered, condition of the patient on discharge, and specific instructions given to the patient and/or family (especially relating to

physical activity, diet, medications, and follow-up care). A final progress note may be used for patients staying less than 48 hours (inpatient or observation) if it includes data necessary to support the diagnosis and the treatment given, with reports of procedures and tests, and their results, clinical observations, including the results of therapy, and anesthesia given, if applicable. A discharge summary is required for a deceased patient whose stay was less than 48 hours.

6.10 Autopsy

Every member of the Medical Staff is expected to attempt to secure autopsies in all deaths that meet the criteria adopted by the medical staff. 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 delegated this responsibility. The attending physician shall be notified when an autopsy is being performed.

When one or more of the following criteria are present the medical staff will make a concerted effort to secure autopsy permission:

- a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications of the attending physician.
- b. All deaths in which the cause of death or major diagnosis is not known with certainty on clinical grounds.
- c. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same.
- d. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical procedure and/or therapies.
- e. All obstetric deaths.
- f. All neonatal and pediatric deaths.

The following deaths must also be reported to the coroner; however, a coroner's forensic autopsy will not necessarily be performed:

- a. Violent deaths whether apparent homicide, suicide or accident, including but not limited to deaths due to thermal, chemical, electrical, or ionizing radiation injury; and deaths due to illegal abortion, whether apparently self-induced or not.
- b. Deaths from suspicious, unusual or unnatural circumstances.
- c. Deaths in patients not recently seen by a physician.
- d. Deaths related to disease that might constitute a threat to public health such as hepatitis, AIDS, or other communicable diseases. This category overlaps the duties of the County Health Officer requiring the cooperation between the Coroner and Health Officer.
- e. Deaths that occur in the course of a therapeutic or diagnostic procedure.
- f. Deaths related to disease resulting from employment or to an accident while employed; including disease related to injury.
- g. Deaths of transplant surgery donors that are the result of trauma.

- h. Sudden or unexpected death of child, including sudden infant death syndrome.
 - i. Deaths of poisoning/overdoses.
- 6.11 The inpatient record shall include identification data, report of the medical history and relevant physical examination, diagnostic and therapeutic orders, evidence that the physician has discussed with the patient the proposed surgery or other treatment, the risks and alternatives, and that a written informed consent has been secured, clinical observations, including results of therapy, reports of procedures, tests and results, a summary of the termination of hospitalization, including plans for follow-up, discharge medications, diet, and instructions to the patient in regard to physical activity limitations, and a provisional and final diagnosis.
- 6.12 The emergency department records shall include patient identification, time and means of arrival, pertinent history of the illness or the injury and physical findings, including vital signs, emergency care given to the patient prior to arrival, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedures and tests, diagnostic impression, final disposition of the patient condition on discharge or transfer, instructions given to the patient (or other responsible person) for follow up care, and signed consent for treatment.
- 6.13 The ambulatory care record shall include patient identification, relevant history of illness or injury and physical findings, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedures, tests and results, diagnostic impression, patient disposition and any pertinent instructions given to the patient (or other responsible person) for follow up care, and signed consent for treatment.
- 6.14 The outpatient surgery record shall include patient identification, appropriate history, physical examination, and any required laboratory and x-ray examination, preoperative diagnosis established prior to surgery, reports of procedures, tests and results, postoperative diagnosis, dismissal order by physician releasing patient from the hospital, postoperative care including patient care guidelines for post-anesthesia recovery, disposition of the patient and written instructions for follow up care for the patient (or other responsible person), directions for obtaining an appropriate physician for postoperative problems, and signed consent for treatment.

ARTICLE VII: On-Call Responsibilities

- 7.1 All primary care physician (i.e., general practitioners, family practitioners, and internists) members of the Active Medical staff practicing in this hospital will

participate in the emergency call service with the exception of the following:
(Approved Board of Trustees 4/11/88).

- a. All specialists.
 - b. Individual cases subject to consent of the medical staff.
- 7.2 The staff physician will be assigned based on the group's call schedule. Responsibility begins at 6:00 a.m. each day and ends at 6:00 a.m. the following day unless an exception is noted on the call schedule.
- 7.3 The scheduled physician must be available on his scheduled days or be responsible for contacting another to act as his substitute. In case of substitution, the originally scheduled physician is responsible for notifying the hospital switchboard of the substitution.
- 7.4 When covering on-call services at the hospital, the physician on call is required to respond promptly to all pages or phone calls. The physician on-call must be physically within a reasonable distance from the hospital in order to promptly report to the hospital when needed.
- 7.5 The physician scheduled for the day will be called when:
 - a. The ED physician determines that an ED patient should be admitted for inpatient service or needs outpatient follow up and the patient has no area physician or his attending physician or the physician covering his practice cannot be reached.
- 7.6 No patients will be admitted from the ED for inpatient services until the staff physician who will treat the patient is notified.
- 7.7 Associate staff physicians will be responsible for the care of their patient admitted to the hospital unless they have made prior arrangements with an Active staff member.

ARTICLE VIII. AVAILABILITY

- 8.1 Physicians should be readily available to respond to calls from the hospital. It is the responsibility of all members of the Medical Staff who provide patient care at IU Health Tipton Hospital to quickly and accurately resolve immediate and urgent clinical concerns.
- 8.2 The following criteria are applicable to calls from the hospital:
 - a. During office hours, the physician's office should be called initially.
 - b. STAT pages or phone messages should be answered or returned within 10 minutes. **They will be coded as a "1" on numerical pagers or "STAT" on text pagers when the physician is paged.**
 - c. STAT pages or calls also should be utilized when nursing personnel deem

- an emergency situation exists regarding patient care.
- d. All other pages or calls shall be answered within 30 minutes.
 - e. If a physician does not answer within the above time frame, a repeat page should be undertaken and an additional number be called (i.e., home phone).
 - f. If a physician does not respond to a second page or call, an alternate physician should be contacted, as delineated below. This physician should be contacted if the second page or call is not answered within 5 minutes for a STAT page or 15 minutes for a routine call.

ALTERNATIVE PHYSICIANS (in order of calling sequence, depending on availability):

- 1. ON CALL PHYSICIAN
 - 2. OTHER MEMBERS OF CALL GROUP
 - 3. MEDICAL STAFF PRESIDENT
 - 4. MEDICAL STAFF VICE PRESIDENT
- g. Summary of steps will be followed when pages or calls are not promptly answered:

<i>STAT</i>	<i>ROUTINE</i>
<i>No answer in 10 min. - repeat call.</i>	<i>No answer in 30 minutes. - repeat call.</i>
<i>No answer in 5 min. - call alternate physician at this point.</i>	<i>No answer in 15 minutes.</i>

- h. Lack of availability may result in disciplinary action.

ARTICLE IX. QUALITY/PATIENT SAFETY

9.1 Quality Measurement and Improvement

Medical Staff Members and Allied Health Providers are expected to participate in quality activities for the clinical service in which the practitioner practices. Trending of aggregate data on clinical processes and outcomes, professionalism, administrative and utilization data is shared with the practitioner. Practitioner is expected to examine their individual performance as compared to peers among their service in order to identify opportunities for improvement in their clinical practice.

Practitioner will at intervals be asked to participate on performance improvement teams.

9.2 Peer Review Activities

Assessment of individual episodes of patient care management is triggered through various mechanisms, such as routine quality reviews, care management, medical staff committee activities and risk management activities. Peer review

will be conducted as part of quality improvement efforts. Practitioner is to respond promptly to queries from peer practitioners regarding interventions for individual episodes of care.

- 9.3 Root Cause Analysis (RCA) and Risk Management Activities
Practitioner may be requested to participate in at intervals in activities to promote patient safety and reduce risk to patients and improve processes throughout IU Health Tipton Hospital. Root causes analysis (RCA) sessions will be conducted on any sentinel event, serious event with the systems implication of a sentinel event, or a near miss event. The Risk Management Department, or in some cases, the Quality Department, will contact the practitioner to determine a meeting time to conduct a systems review. Practitioners are asked to make attendance at such meetings a priority.

Additionally, Practitioners are to promptly report patient errors or other patient-related safety issues to the Risk Management Department by completing an incident report or by contacting the Risk Management Director.

ARTICLE X. MEDICAL STAFF MEETINGS

- 10.1 The regular meetings of the Medical Staff shall be held on the second Monday of every other month at 12:00 noon and shall be conducted in accordance with the bylaws.
- 10.2 Medical Executive Committee (MEC) will meet on the second Monday of every month and shall be conducted in accordance with the bylaws. MEC will meet immediately following each Medical Staff Meeting. On the months that full Medical Staff does not meet, MEC will meet at 12:00 noon.
- 10.3. The Annual Medical Staff meeting shall be the November regular Medical Staff meeting.

ARTICLE XI. GENERAL RULES/EXPECTATIONS

- 11.1 Confidentiality
In keeping with state and federal laws as well as IU Health Tipton Hospital policy, all medical records, patient-specific information, peer review materials, risk management materials, credentialing records and files, minutes of relevant Medical Staff and hospital meetings, are the property of IU Health Tipton Hospital.

Access to confidential materials by Medical Staff is permissible only when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, credentialing or other authorized activity. This requirement applies to information in electronically stored or hard copy format.

- 11.2 Adherence to IU Health Tipton Hospital Policy and Procedures
All members of the Medical Staff are expected to adhere to established policies and procedures for IU Health Tipton Hospital. This includes adherence to all health care regulatory and accreditation requirements. Breach of policies, standards or regulations by individual practitioners will be handled through peer review mechanisms of the Medical Staff.
- 11.3 Drugs and Pharmacy
Physicians shall follow the Pharmacy and Therapeutics guidelines. Exceptions to the guidelines must have the approval of the Pharmacy and Therapeutics Committee chairman.
- 11.4 Emergency Care
Individuals who “come to the dedicated emergency department” (as defined within 42 CFR §489.24) will receive a medical screening examination appropriate to their presenting signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This screening shall occur regardless of the patient’s ability to pay and shall be conducted in whole or in part by the following individuals designated as “Qualified Medical Personnel” (QMPs) within the statutory definition:
- Credentialed Physicians or Dentists
 - Credentialed Allied Health Practitioners
 - Emergency Department Triage Nurses
 - Psychiatric Professionals/Assessment Team Members
 - Labor and Delivery Nurses

When non-Credentialed staff members assist with or perform the medical screening examination, their assessments are consistent with established policies and protocols or are in collaboration and consultation with appropriate Credentialed practitioners as necessary. The patient’s primary physician/dentist, if applicable, will be notified of the patient’s condition. If, based on the patient’s condition, the Emergency Department physician/dentist determines that consultation of a specialist is required; the Emergency Department physician/dentist will contact a specialist in accordance with the primary care physician/dentist’s normal referring pattern.

Patients received in the Emergency Department without referral by, or not under the care, of a private physician/dentist will be assigned to a physician/dentist on-call as deemed appropriate by the Emergency Medicine Physician/dentist. The Emergency Department physician/dentist will contact an appropriate primary/specialty care physician/dentist guided by the on-call schedule established by each section.

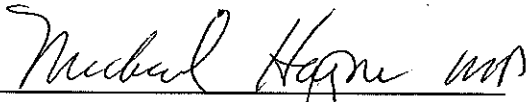
- 11.5 Each Medical Staff member and Allied Health Care Provider shall be familiar with the Internal/External Disaster Alert Policies and, should such an emergency occur, actively participate under the direction of the Medical Staff President and Incident Command.
- 11.6 Members of the medical staff are encouraged to attend medical education meetings on a local, state, and national level and report to the staff of the points of interest.
- 11.7 Appropriate psychiatric counseling will be offered to patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse. Restraints will be used in accordance with hospital policy as well as Medical Staff Rules and Regulations, Article VI, 6.3.
- 11.8 A member of the medical staff, having surgery privileges but who is not located closely enough to the hospital to provide continuous care to his/her surgical patients must, prior to any inpatient surgery he/she wishes to perform, make arrangements with a properly qualified member of the medical staff for coverage of the inpatient surgical patient from admission until the patient's discharge from the hospital. Such arrangement must be noted in the patient's chart and such notation shall be initialed by the surgeon and covering medical staff member.
- 11.9 The medical staff shall have input into developing and reviewing hospital policies and procedures related to patient care. Physician advisors and physician directors of hospital services shall review (and sign) hospital and nursing policies related to their respective service on a yearly basis. A summary, with particular note of significant change, will be reported.
- 11.10 All Medical Staff Members and Allied Health Care Providers shall be assessed dues. The dues shall be collected annually in January in the amount established annually by the Medical Staff.
- 11.11 In the event that the practitioner's patients' records become delinquent while he/she is out of town, on vacation, or ill (at least for a 5 day period), he/she shall have seven (7) days following his/her return to correct the delinquency.
- 11.12 All records, including x-ray films and tissue file and tissue slides, are the property of the hospital and shall not be removed without an appropriate court order, subpoena, or statutory authorization. In case of readmission of a patient all previous records shall be available for the use of the attending physician and/or practitioner.
- 11.13 Free access to all medical records of all patients shall be afforded to practitioners

in good standing for study and research as approved by the Executive Committee, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted free access to the information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

- 11.14 Every three years, these rules as a whole shall be reviewed and revised as necessary by the Medical Executive Committee. They shall be presented for adoption by the Medical Staff and shall be presented to the Board of Directors for their approval.
- 11.15 These rules may be amended and adopted at any regular meeting of the medical staff by a two-thirds (2/3) vote of those members of the Active Medical Staff present at the meeting, and such amendments shall become effective when approved by the governing board of the hospital.

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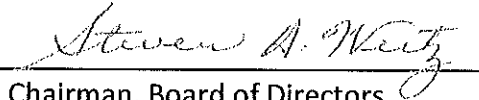
Approved at a regular meeting of the Executive Committee/Medical Staff on 1/9/2017.



Medical Staff President

1/9/17
Date

Approved by the Board of Directors on 1/26/17.



Chairman, Board of Directors

1/26/17
Date