RULES AND REGULATIONS

OF

THE MEDICAL STAFF

OF

INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL, INC.

Version Date: October 15, 2020

RULES AND REGULATIONS

INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL, INC.

ARTICLE 1

ADMISSION

PART A: WHO MAY ADMIT PATIENTS

Patients may be admitted to IU Health Ball Memorial Hospital only by physicians and dentists who have been appointed to the Medical Staff and have been granted specific privileges to admit patients or by House Staff physicians in accordance with relevant provisions of Graduate Medical Education. Patients may be admitted for the treatment of conditions and diseases for which the Hospital has facilities and personnel. However, patients shall not be admitted for the performance of an abortion unless the abortion is necessary to prevent a substantial impairment of the life or physical health of the pregnant woman. When the Hospital does not provide the services required by a patient or for any reason cannot be admitted to the Hospital, the Hospital or admitting physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

PART B: ADMITTING PHYSICIAN'S OR DENTIST'S RESPONSIBILITIES

Each patient shall be the responsibility of a physician or dentist appointed to the Medical Staff or a House Staff member. Such physician or dentist shall be responsible for the medical or dental care and treatment, for prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician or dentist and to relatives of the patient. The admitting physician or dentist shall be responsible for completing a medical history and performing an appropriate physical exam.

The admitting physician shall be primarily responsible for providing the Hospital with such information concerning the patient as may be necessary to protect the patient, Hospital personnel, or other patients from infection, disease or other harm, and to protect the patient from self-harm.

PART C: TIMELINESS OF INITIAL EVALUATION

Each patient admitted to the hospital shall be seen by a licensed independent practitioner (LIP) for initial assessment in a timely fashion and usually no later than twelve (12) hours after admission.

Patients with acute processes which compromise or threaten cardiopulmonary stability should be evaluated by a LIP generally no later than four (4) hours after admission. This would include, for example, patients admitted to the Intensive Care Unit.

PART D.: PODIATRIST'S RESPONSIBILITIES

(1) For patients admitted as an inpatient:

A podiatric physician (D.P.M.) who has clinical privileges may admit patients in conjunction with an allopathic/osteopathic physician (M.D./D.O.). The podiatrist is responsible for appropriate podiatric medical care and the co-admitting/consulting physician is responsible for the general medical care and concomitant health problems.

1. Podiatric Physician's Responsibilities:
   (a) A detailed podiatric history and physical justifying hospital admissions and/or surgical procedures;
   (b) Progress notes pertinent to the podiatic condition;
   (c) A complete dictated report of all procedures performed;
   (d) Discharge orders and dictated discharge summary when appropriate.
   (e) Podiatrists are to remain available for the ongoing care of the patient after the medical physician is co-admitting or consulting on the patient.

2. Co-admitting/Consulting Physician's Responsibilities:
   (a) A medical history and physical pertinent to the patient's general health and condition prior to anesthesia and surgery;
   (b) Supervision of patient's general health status while hospitalized.

(2) For outpatients:

Podiatric patients admitted for outpatient surgery should be seen prior to admission for appropriate medical history and physical. The podiatrist may be allowed to complete a medical history and physical examination for ASA Class 1 and 2 patients if they are deemed qualified to do so by the Credentials Committee and Executive Committee. For non-ASA Class 1 and 2 patients, the medical history and physical examination is to be completed by a physician who is an appointee to the Medical Staff, and the podiatrist shall be responsible for the podiatric history and podiatric physical examination. All appropriate pre-operative labs and testing should be ordered by the admitting podiatric physician or medical physician.

PART E: ALTERNATE COVERAGE.

Each appointee to the Medical Staff shall provide assurance of availability of adequate professional care for his or her patients in the Hospital by being available or having available an alternate practitioner with whom prior arrangements have been made and who has clinical privileges at the Hospital sufficient to care for the patient. Failure of the appointee to meet the above requirements is sufficient reason for an investigation by the Credentials Committee and further action according to the Medical Staff Bylaws.

PART F: ADMISSION OFFICE PROCEDURES

All patients admitted to the Hospital shall sign the consent to treatment form prior to admission or as soon thereafter as possible. The form shall be signed by a person authorized

to consent on the patient's behalf of the patient is unable to sign the form.

PART F: ADMISSION OFFICE PROCEDURES – Continued

At the time of admission or as soon as possible thereafter, each patient shall be fitted with the Hospital's means of patient identification.

PART G: PRIORITIES FOR ADMISSION

The physician or dentist shall first contact the Ball Admissions Center to ascertain whether there is an available bed. Except in an emergency, no patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon after admission as possible. The Admitting Office will admit patients on the basis of the following order of priorities:

(1) Emergency Admissions - This category includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permit harm and any delay in admitting the patient for treatment would add to that harm or danger. The physician or dentist can be required to furnish to the Medical Record/Utilization Review Committee, a signed, complete documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued inappropriate utilization of this category of admission, will be brought to the attention of the Executive Committee for appropriate action.

(2) Urgent Admissions - This category includes patients so designated by a physician or dentist and shall be reviewed as necessary by the Medical Record/Utilization Review Committee to determine priority when all such admissions for a specific day are not possible. This category of patient will be given first priority on available beds other than those needed for emergency patients and, in no case, will an urgent admission be delayed beyond 72 hours.

(3) Pre-operative Admissions - This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Medical Record/Utilization Review Committee may decide the urgency of any specific admission.

(4) Routine Admissions - This will include elective admissions involving all services.

If there is any question concerning the admission of a patient, the Chair of the Medical Record/Utilization Review Committee shall determine the necessity for, or deferment of, the admission.

PART H: EMERGENCY ADMISSIONS

The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart as soon as possible after admission or within twenty-four (24) hours.

PART H: EMERGENCY ADMISSIONS – Continued

In the case of emergency admissions, patients who do not already have a personal admitting physician or dentist and who have not requested the services of a specific physician who is reasonably available shall be assigned to an appointee to the Medical Staff or a member of the House Staff according to the appropriate clinical call schedule. The chair of each clinical department shall provide a call schedule for attendance to such patients.

PART I: PRE-ADMISSION AND POST-ADMISSION LABORATORY TESTS

The admitting physician shall authorize pre-admission testing for elective surgical patients.

PART J: CONTINUED HOSPITALIZATION

The attending physician is required to document the need for continued hospitalization daily.

Upon request of the Medical Record/Utilization Review Committee, the attending physician must provide written justification of the necessity for continued hospitalization of any patient within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for appropriate action.

PART K: ADVANCE PRACTICE PROVIDERS – OBSERVATION STATUS ASSIGNMENT

Assignment to Observation Status
Only physician/dentists or Advanced Health Practitioners (as defined in the Credentials Manual) who have been duly appointed to the Allied Health Staff, by the Board, to practice at the Hospital or who have been granted privileges, are in good standing, and have been granted observation assignment privileges are eligible to assign patients to Observation Status.

Orders
Initial admission, diagnostic, treatment and discharge orders may be written by the attending physician/dentist, resident, dentist or podiatrist, nurse practitioner, physician assistant – certified, or nurse midwife. The physician/dentist must write an admission status order (inpatient, observation, or outpatient in a bed) for each patient receiving services on a nursing unit provided, however, that an Advanced Health Practitioner with observation assignment privileges may write an assignment status order for Observation Status specific to patients placed in the areas declared to be an Observation Unit without the need for a separate order by a physician/dentist.

ARTICLE 2

MEDICAL ORDERS

PART A: GENERAL REQUIREMENTS

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 Part C Below) and signed by the prescribing practitioner. Orders, which are illegible, will not be carried out until they are rewritten and are understood.

Texted orders are prohibited.

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Only the abbreviations, signs, and symbols listed in Appendix A to these Rules and Regulations shall be used in the medical record.

Blanket orders for reinstatement of previous medications are not permitted.

PART B: WHO MAY GIVE ORDERS

Only licensed independent practitioners and advanced dependent practitioners with appropriate Medical 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.

Notwithstanding the forgoing, a physical therapist may evaluate and treat an individual during a period not to exceed forty-two ***(42) 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 ***forty-two (42) 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.

PART C: VERBAL ORDERS

Verbal orders for chemotherapy agents shall not be accepted. 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 licensed independent 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 thirty (30) 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;

(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.

(12) Laboratory Technicians, who may transcribe verbal orders pertaining to laboratory orders.

PART D. OUTPATIENT ORDERS

All orders for tests/procedures that will be performed on an outpatient basis must include the following data elements in order for the test/procedure to be performed:

1. Name of the practitioner ordering the test/procedure;
2. Signature of the practitioner;
3. Address of the practitioner;

4. Phone number of the practitioner;
5. Date;
6. Patient name;
7. Test(s)/Procedure(s) ordered;
8. Diagnosis, sign, symptom, and/or ICD- 10 Code associated with the test(s)/procedure(s) being ordered.

Providing the above data elements is the responsibility of the ordering practitioner.

PART E. ORDERS FOR CHEMOTHERAPY AGENTS

All orders for chemotherapy agents will be entered or written by attending physicians. This includes all dosage forms of chemotherapy, (e.g., oral, intravenous, intramuscular, etc.) Attending physicians shall write all orders for intravenous chemotherapy on the hospital-approved "Chemotherapy Order Form." Orders for oral or intramuscular chemotherapy may be written on a standard order form. Verbal orders for chemotherapy agents will not be accepted.

PART F: (FAX) ORDERS

In order to facilitate patient care, the hospital agrees to accept orders through the use of fax transmission. Since such transmissions constitute part of the permanent medical record and proper receipt is critical to patient care, the following procedures should be followed:

The hospital requires that all orders transmitted by fax clearly state the following:

1. Name of the patient;
2. Name of the practitioner;
3. Patient's medical record number or patient's social security number and date of birth;
4. Name and telephone number of the individual who transmitted the order;
5. Number of pages transmitted;
6. Signature of the practitioner.

The ordering practitioner or the practitioner's staff shall be responsible for:

1. Documentation or proof that the faxed order was sent, such as a mechanically produced transmission log;
2. Ensuring that a fax cover sheet containing a confidentiality notice accompanies the faxed order.

Following receipt of faxed orders, hospital staff will:

1. Review orders for legibility and completeness;
2. Contact the practioner's office if the order requires clarification;
3. Place the order on the patient's chart or file the order in a secure area until the patient arrives for services.

ARTICLE 3

CONSULTATIONS

PART A: WHO MAY GIVE CONSULTATIONS

Any qualified practitioner with appropriate clinical privileges in this hospital can be asked for consultation within his or her area of expertise. Practitioners having privileges in the requested area shall perform mandated consultations. In circumstances of grave urgency, or where consultation is required by the rules of the Hospital, the hospital president or his/her designee and the Chair of the Executive committee or in his or her absence the appropriate department chair, acting together shall at all times have the right to call in a consultant or consultants.

PART B: REQUIRED AND RECOMMENDED CONSULTATIONS

Consultation shall be required in all cases in which, in the judgment of the attending licensed independent practitioner:

(1) The diagnosis is obscure after ordinary diagnostic procedures have been completed; or,

(2) There is doubt as to the best therapeutic measures to be used.

A reasonable effort to obtain consultation shall be made whenever the practitioner is requested to do so by the patient or by those responsible for the patient's care.

Consultation shall be recommended in all cases in which, in the judgment of the attending practitioner:

(1) Unusually complicated situations are present that may require specific skills of other practitioners;

(2) The patient exhibits severe symptoms of mental illness or psychosis.

The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant.

Each clinical department as required may establish additional requirements for consultation. It shall be the responsibility of the practitioner to obtain any required consultation through provider to provider contact. If the history and physical are not on the chart, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant. The consultant should enter orders for any diagnostics they want in order to expedite patient care and notify the referring physician of orders or changes in care in a timely manner.

If a nurse or other healthcare professional, after speaking to the attending practitioner has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of their superior who, in turn, shall refer the matter to the Chief Medical Officer (CMO). The

CMO shall bring the matter to the attention of the chair of the department in which the practitioner has clinical privileges. In all situations, which require it, the chair of the department may request a consultation after appropriate discussion with the attending practitioner.

If, in the opinion of the department chair, a practitioner has not requested consultations when needed, the Credentials Committee shall investigate the matter following receipt of a written request to do so. Failure of a practitioner to request consultations when needed is sufficient reason for an investigation by the Credentials Committee and further action according to the Medical Staff Bylaws.

PART C: CONTENTS OF CONSULTATION REPORT

As referenced in Article IX, Medical Records, Part G, each consultation report should contain a written opinion and recommendation by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement such as, "I concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

PART D: PATHOLOGY INTRAOPERATIVE CONSULTATIONS

At the time an operating surgeon requests intra-operative consultation, it shall be the responsibility of the assigned pathologists to obtain certain historical information concerning the patient or procedure in question. This will generally be accomplished at the time the pathologists pick up the tissue in the operating room suite. At this time, there should be a personal conversation between the operating room surgeon and the pathologist to include pertinent historical information and x-ray findings.
The subsequent examination (with or without frozen section) shall be done in a timely fashion.

Results shall be delivered personally by the pathologists to the operating room surgeon and will be confirmed by written documentation, which will immediately become part of the patient's medical record.

PART E: SECOND OPINION BEFORE THERAPY FOR PATIENTS WITH A CANCER DIAGNOSIS

1) A second opinion of pathologic interpretations will be obtained on non-emergent cases where major therapeutic interventions are planned based on a tissue or cytology diagnosis.
2) For those cases where the initial diagnosis was received from an outside source, a second opinion shall be rendered by a member of the IU Health Ball Memorial Hospital Medical Staff prior to therapy.
3) Issues of diagnosis disagreement will be resolved before therapy is instituted.

ARTICLE 4

SURGICAL CARE

PART A: SCHEDULING SURGERY

The presence of all members of the Operating Team is required at the scheduled time for surgery. In no case shall anesthesia be started until the operating surgeon is on the hospital campus, has notified the OR of their presence and is readily available.
Surgeons arriving in the operating room later than fifteen (15) minutes before scheduled start time (per the Surgical Services Scheduling Policy), without prior notification, will be addressed according to the Late Physician Policy below:

Guidelines:

(1) Surgeons who have scheduled operating room time and arrive greater than fifteen (15) minutes late, as defined by the Surgical Services Scheduling Policy, without notifying the OR Charge Nurse, will be given a written warning to be issued by the Chair of the Operating Room Committee (ORC).

(2) When a third written warning is issued within a calendar year, the issue will be referred to the ORC for determination of further course of action. The surgeon in violation will be invited to attend.

(3) When deemed appropriate by the ORC, the issue can be referred to the Executive Committee, along with a recommendation from the ORC as to the considerations to be made in each case.

Elective surgeries and urgent/emergent cases, as defined by the Surgical Services Scheduling Policy, shall be scheduled or cancelled according to the Surgical Services Scheduling Policy.
If a surgeon determines that an emergency case needs to bump a scheduled case, the Bump Policy shall be followed:

BUMP POLICY

If a surgeon determines that a case must be done as soon as possible, the bumping surgeon must notify the surgeon that is being bumped (surgeon to surgeon communication).

Guidelines:

- Bump own scheduled case;
- Bump first available room in order: Partner, Specialty;
- Time the bump so as to cause the least disruption to the OR schedule;
- The final decision on which case is bumped rests with the OR Charge Nurse and Anesthesiologist in charge;
- The bumping surgeon will follow with his/her scheduled case if it does not delay following surgeon's cases and/or there is an "open" available staffed OR suite.

In case of a dispute that cannot be resolved by the two surgeons, then the anesthesiologist

shall cast the deciding vote.

In the event that either of the two surgeons is dissatisfied with the anesthesiologist's decision, a request can be submitted for a bump-case review to be conducted at the next scheduled Operating Room Committee (ORC) / Surgery Clinical Effectiveness Team (CET) meeting.

PART B: SURGICAL RECORDS

Except in emergencies, the following data shall be recorded in the medical record prior to surgery:

(1) Verification of identity of patient.

(2) Medical history and supplemental information regarding drug sensitivities and other pertinent facts.

(3) General physical examination.

(4) Provisional diagnosis.

(5) Laboratory test results.

(6) Consultation reports, if applicable.

(7) Signed informed consent.

The patient shall not leave the holding area for the Operating Room until the chart is complete and contains the seven data elements outlined above. In an emergency situation, the attending surgeon shall write a note or post-operative note on the patient's condition, stating that delay for recording these requirements would constitute a danger to the health or safety of the patient and that he or she accepts responsibility for the patient's physical condition before the operation may begin.

Operative reports shall be dictated or written immediately after surgery. The report shall record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and the post-operative diagnosis. The completed operative report shall be dictated and authenticated by the surgeon in the electronic medical record as soon as possible after surgery. If it is not possible to dictate the report in the electronic medical record immediately after surgery – e.g., there is a transcription or filing delay – an operative progress note shall be entered in the medical record immediately after surgery to provide pertinent information for anyone required attending the patient.

PART C: ANESTHESIA RECORDS

Except in an emergency, there shall be an appropriate pre and post-operative patient evaluation by the Anesthesiologist with appropriate notation on the patient's chart.

PART D: RECOVERY AREA

The surgeon is to remain readily available until their patient is admitted to the appropriate recovery area. Post-operative orders must be written before the patient leaves the Surgery Department area. An anesthesiologist must participate in establishing policies for the discharge of patients from post-anesthetic care.

At least two registered nurses shall be on duty in the Recovery Room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

PART E: DENTAL PATIENTS

A patient without medical problems who is admitted for dental surgery by a qualified oral surgeon, who has clinical privileges to perform histories and physical examinations, is the responsibility of the qualified oral surgeon. A patient with medical problems under the care of a dentist, who is not a qualified oral surgeon with clinical privileges to perform histories and physical examinations, is the dual responsibility of the dentist and a physician with appropriate clinical privileges.

(1) Dentist's responsibilities:

(a) A detailed dental history justifying hospital admission;

(b) a detailed description of the examination of the oral cavity and pre-operative diagnosis;

(c) a complete operative report, describing the findings and techniques used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth, and fragments removed appropriate tissue shall be sent to the Pathologist for examination;

(d) Progress notes pertinent to the oral condition;

(e) Clinical summary of statement;

(f) Discharge order.

(g) Dentists are to remain available for the ongoing care of the patient after the medical physician is co-admitting or consulting on the patient.

(2) Physician's responsibilities;

(a) History pertinent to the patient's general health;

(b) Physical examination to determine the patient's condition prior to anesthesia and surgery;

(c) Supervision of the patient's general health status while hospitalized.

(3) If a patient without medical problems is admitted by a qualified oral surgeon who has clinical privileges to perform histories and physicals, that oral surgeon shall perform the responsibilities stated above; provided, in the event any medical problem arises, the oral surgeon shall promptly involve a physician with appropriate clinical privileges in the care of the patient.

PART F: OPERATING ROOM RECORDS

A roster of physicians and dentists with a delineation of the surgical privileges of each, shall be maintained in the surgical area and available to the Operating Room Nurse Manager.

An Operating Room log shall be maintained on a current basis.

PART G: ATTIRE

Anyone entering the operating room will comply with the surgical service dress code policy.

PART H: PATHOLOGY REPORT

All appropriate tissues or exudates removed during a surgical procedure shall be properly labeled and sent to the laboratory for examination. Certain specimens outlined in the Surgical Specimen Policy may be excluded from gross examination by the laboratory. The pathologist shall sign his or her report following examination which becomes a part of the patient medical record.

ARTICLE 5

INTENSIVE CARE UNIT

PART A: CRITERIA FOR REVIEW OF ADMISSIONS TO THE INTENSIVE CARE UNIT

The decision for admission or discharge of a patient to the Intensive Care Unit is made by the attending physician based on the admission and discharge review criteria for the multi-disciplinary Intensive Care Unit.

To be admitted to the Intensive Care Unit a patient must have a physician's order and must meet one or more of the following criteria:

(1) Respiratory compromise, defined as any one of the following:

(a) use/anticipated use of mechanical ventilation of artificial airway;

(b) unstable respiratory status requiring nursing assessment/intervention and/or pulmonary toilet every two hours or more frequently.

(2) Hemodynamically unstable, defined as any one of the following:

(a) unstable vital signs that require monitoring q2h or more frequently;

(b) anticipated use of vasoactive drugs requiring frequent titration and monitoring;

(c) unstable cardiac rhythm requiring frequent drug or mechanical intervention and/or at high risk for cardiac arrhythmia;

(d) use/anticipated use of invasive monitoring devices, i.e., pulmonary artery catheters, arterial lines.

(3) Neurologically unstable, defined as any one of the following:

(a) abnormal Glasgow Coma Scale requiring frequent neurological assessments;

(b) high risk for neurological deterioration;

(c) use or anticipated use of intracranial pressure monitoring.

(4) Metabolically unstable, requiring:

(a) intensive nursing assessment/intervention who are at significant risk for metabolic or hemodynamic deterioration;

(b) anticipated at risk for metabolic deterioration, i.e., toxic overdose, diabetic ketoacidosis, sepsis and endocrine emergencies and/or acute renal failure.

(5) Patients who fall outside the above diagnostic categories, i.e., CCU overflow admissions, may be admitted to the Intensive Care Unit. (See CCU Admission Review Criteria.)

(6) The Intensive Care Unit may accept telemetry admissions in the event that no telemetry monitors are available.

PART B: ADMISSIONS

All admissions to the Intensive Care Unit will be made at the request of a physician. In the event of a bed shortage, the chairman of the Critical Care Committee will resolve conflicting requests for admission.

(1) **Direct Admissions**: A patient may be admitted to this Unit directly from outside the hospital at the request of a physician. The physician requesting such admission will notify Admissions of the nature of the patient's illness and state that admission to the Intensive Care Unit is desired.

(2) **Emergency Room**: Need for admission to the Intensive Care Unit from the Emergency Room will be determined by the physician examining the patient. Admission to the Unit will be made directly from the Emergency Room with the

proper information being conveyed to Admissions and the Intensive Care Unit.

(3) In extenuating circumstances a patient may be admitted to the Unit without first being examined by a physician, per verbal phone order from a physician. A physician then will see the patient as soon as possible and within four hours.

PART C: TRANSFERS FROM SURGERY & DELIVERY

In the event that the surgeon or the anesthesiologist feels that because of some complicating factor a patient will require admission to the Intensive Care Unit, the Intensive Care Unit charge nurse in the Unit shall be advised that the patient will be admitted to the Unit as soon as he or she is discharged from or bypasses the Recovery Room.

In case the operation is being performed at an hour when the Recovery Room is not open, the Intensive Care Unit shall be informed that the patient will be admitted directly from the Operating Room.

It is anticipated that following certain major surgical procedures the patient will be admitted routinely to the Intensive Care Unit. At the time that the surgeon schedules such a case with the Operating Room, he shall indicate that such admission is desired. The Operating Room Supervisor will then inform the Intensive Care Unit and the Admitting Office that this particular patient will be transferred to the Unit after discharge from the Recovery Room.

In the event that it becomes necessary to admit a patient to the Intensive Care Unit following delivery, the obstetrician shall inform the Intensive Care Unit that such admission is indicated and the Delivery Room nurse shall inform the Admitting Office.

PART D: RECOVERY ROOM SERVICE

During the hours that the Recovery Room is closed, the Intensive Care Unit will provide Recovery Room service as deemed necessary by the surgeon and anesthesiologist. The charge nurse in the Operating Room shall inform the nurse in the Unit of this admission to the Unit as soon as the case is scheduled in the Operating Room.

PART E: TRANSFERS FROM GENERAL & SURGICAL

In case such transfer becomes necessary, the charge nurse in the Intensive Care Unit shall be advised of the pending transfer and given necessary information regarding diagnosis, treatment, and immediate measured that will be necessary upon transfer to the Unit. The charge nurse in the department shall then inform the Admitting Officer of the transfer. Such transfer shall be made only on an emergency basis necessitated by a sudden complication or worsening of the patient's condition.

PART F: CRITERIA FOR REVIEW OF DISCHARGES FROM THE INTENSIVE CARE UNIT

Patients shall be considered appropriate for discharge when their conditions are no longer life-threatening, they no longer require advanced technological and/or pharmacological treatment modalities, and/or they will no longer benefit from intensive medical/nursing care.

(1) Generally, patients shall be considered eligible for discharge from the Intensive Care Unit when the following criteria are achieved:

(a) Respiratory stability as defined by:

1. Does not require mechanical ventilation (exception may be made for chronic ventilator dependent patient);

2. Stable after extubation;

3. Arterial blood gases optimal for patient;

4. Requires pulmonary toilet no more frequently than q2h.

(b) Hemodynamic stability as defined by:

1. Stable vital signs;

2. Does not require titrated vasoactive drugs;

3. Stable cardiac rhythm (optimal for this patient);

4. Absence of invasive monitoring catheters/devices.

(c) Neurological stability as defined as:

1. No longer requires frequent neurological assessment/interventions;

2. Absence of intracranial pressure monitoring devices.

(2) Patients admitted for procedures, treatments or monitoring available only in the Intensive Care Unit shall be eligible for discharge upon their completion.

(3) Patients may not be discharged from the Intensive Care Unit with arterial and/or pulmonary artery catheters in place.

(4) Patients who experience further deterioration of a condition with no apparent hope of recovery and/or who are not to be resuscitated shall be appropriate candidates for discharge from the Intensive Care Unit.

(5) If, at any time, a bed is needed for a more critically ill patient, the physician, at his discretion, may transfer his patient without meeting the discharge criteria.

(6) If the unit is filled to capacity, the medical director of the Intensive Care Unit and/or designee has the authority and responsibility to ask the attending physician of the less critically ill patient to transfer his patient to provide for the critical one. Normally, the

charge nurse of the Intensive Care Unit will act on the director's behalf. If no decision can be reached, the charge nurse shall contact the medical director of Intensive Care Unit and his decision shall be final.

(7) In general, patients are not discharged to home from the Intensive Care Unit.

(a) Discharge to home requires a physician's order.

(b) Anyone going home against medical advice will be reviewed according to AMA (Against Medical Advice) policy.

(8) All patient discharges will be subject to the following screens for appropriate patient care under the review of the Critical Care Committee.

(a) Acute Respiratory Insufficiency

1. Stable Arterial Blood Gases x 24 hours (optimal for this patient)

2. No acute respiratory distress x 24 hours

3. Mechanical ventilatory support not needed

4. Pulmonary toilet required no more than q4h

5. Patient is extubated unless required for pulmonary toilet
6. Chest x-ray indicates no deterioration of disease process

(b) Acute Pulmonary Embolism

1. Absence of pain or controlled by oral medication x 24 hours

2. Stable Arterial Blood Gases x 24 hours

3. No acute respiratory distress x 24 hours

4. No acute bleeding as a result of anticoagulation therapy

(c) Shock secondary to any cause

1. Hemodynamic stability without IV medication requiring titration x 24 hours

2. Urinary output > 20cc/hours (if no history of renal failure)

3. Etiology of shock identified and controlled

(d) Hypertensive crisis

1. Blood pressure stability has been demonstrated x 24 hours

2. No continuous IV infusion antihypertensive medication x 12 hours

3. Urinary output > 20cc/hr (if no history of renal failure)

4. No deterioration of neurologic status x 24 hours

(e) Cerebrovascular Accident/Acute Coma states (including cerebral hemorrhages, drug intoxication)

1. No respiratory distress x 24 hours

2. If intubated for airway patency, pulmonary toilet is required no more than q4h

3. Mechanical ventilation is no longer required or can be appropriately maintained on general Medical/Surgical unit per hospital policy

4. Seizure activity controlled: or if not controlled, neurosurgical or neurologist consultation has been obtained and has deemed transfer appropriate.

5. No further deterioration of neurological status x 24 hours

(f) Acute fluid and electrolyte imbalances

1. Absence of life-threatening arrhythmias x 24-48 hours

2. Mechanical ventilation is not required or can be appropriately maintained on a general Medical/Surgical Unit

3. Blood pressure stability has been demonstrated x 24 hours

4. Urinary output > 20cc/hr.

5. No life threatening metabolic abnormalities present

6. No deterioration of sensorium level x 24 hours

(g) Gastrointestinal Bleeding

1. No evidence of active bleeding x 24 hours

2. Hemoglobin and hematocrit stable x 24 hours

3. Hemodynamically stable as defined above

(h) Post-operative surgical patient

1. No evidence of active bleeding

2. Adequate fluid volume as documented by hemodynamic parameters

3. Mechanical ventilation no longer required (unless chronic ventilator dependent)

4. If intubated for airway patency (or fresh tracheostomy), pulmonary toilet is required no more than q4h.

5. No evidence of uncontrolled or unidentified infection, likely to cause significant deterioration

6. Absence of life-threatening arrhythmias x 24 hours

7. Drainage tubes than can be appropriately managed on general Medical/Surgical Unit

ARTICLE 6

CORONARY CARE UNIT

PART A: CRITERIA FOR REVIEW OF ADMISSIONS TO CORONARY CARE UNIT

(1) The Coronary Care Unit is specifically designed for patients with cardiac disorders. The following diagnostic categories are within the CCU scope of care and serve as guidelines for appropriate patient placement. They also serve as quality screens for Critical Care Committee review.

(a) Acute Myocardial Infarction

1. Chest discomfort compatible with acute coronary insufficiency

2. ECG changes of either transmural or nontransmural acute M.I.

3. Elevated cardiac enzymes

(b) Impending or Suspected Myocardial Infarction

1. Chest discomfort suspicious of acute coronary insufficiency

2. ECG suggestive of acute ischemic changes

(c) Unstable Angina

1. Chest pain not controlled by standard dosage of NTG
2. Angina at rest or nocturnal angina
3. Increasing frequency, duration, and/or intensity of angina

(d) Cardiopulmonary Arrest

1. Ventricular asystole
2. Ventricular fibrillation
3. Symptomatic ventricular tachycardia
4. EMD (Electromechanical Dissociation)

(e) Acute Pulmonary Edema

1. Severe respiratory compromise requiring frequent nursing assessment/intervention
2. Acute onset of diffuse, moist rales with significant tachypnea, tachycardia, and/or acute diaphoresis
3. Anticipated need for assisted ventilation, hemodynamic monitoring and/or continuous IV medication therapy

(f) Severe Congestive Heart Failure (Associated with Malignant Arrhythmia or Acute Respiratory Distress)

1. Severe respiratory compromise requiring frequent nursing assessment/intervention
2. Continuous IV medication therapy
3. Hemodynamic monitoring

(g) Arrhythmias

1. Nonsustained VT
2. Multifocal PVC's or "R-on-T" phenomenon
3. Symptomatic 2nd degree block, Mobitz type II, 3rd degree block or bradycardia
4. Syncope

5. Rapid atrial fibrillation or atrial tachycardia with an uncontrolled ventricular response

6. Anticipated continuous IV medication or mechanical intervention

(h) Post Angioplasty/Stent/Rotoblation

1. Venous/arterial sheaths in place

2. Frequent nursing assessment/intervention

(i) Post Cardiac Catheterization

1. Venous/arterial sheaths in place

2. Unstable rhythm

3. Chest pain not controlled by SL NTG

4. Hemodynamically unstable

(2) In the event of a direct admission without orders, all patients will have the following:

(a) ECG monitoring

(b) IV to keep vein open

(c) Oxygen

Further orders are to be obtained as soon as possible.

(3) Patients who fall outside the above diagnostic categories, i.e., ICU overflow admissions, may be admitted to the CCU if they are hemodynamically unstable or exhibit signs of respiratory, neurologic or metabolic instability. (See ICU Admission Criteria for definitions.)

(4) The CCU may accept telemetry admissions in the event that no telemetry monitors are available.

PART B: ADMISSIONS

All admissions to the Coronary Care Unit will be made at the request of a physician. In the event of a bed shortage, the Chair of the Cardiology Section will resolve conflicting requests for admission. If the Chair of the Cardiology Section is not available, the Critical Care Committee Chair may act in his/her behalf.

(1) Direct Admissions: A patient may be admitted to the Coronary Care Unit directly from outside the hospital at the request of a physician. The physician will notify the

Admissions Department of the nature of the patient's illness and state that admission to the Coronary Care Unit is desired.

(2) Emergency Room: Need for the physician examining the patient will determine admission to the Coronary Care Unit from the Emergency Room. Admission to the Unit will be made directly from the Emergency Room with the proper information being conveyed to the Coronary Care Unit (and subsequently the Admissions Department).

(3) In extenuating circumstances, a patient may be admitted to the Coronary Care Unit without first being examined by a physician.

PART C: TRANSFERS FROM OTHER AREAS OF THE HOSPITAL

In the event the physician feels that a patient has sufficient cardiac complications to require admission to the Coronary Care Unit, the charge nurse in the Unit shall be advised of the pending transfer and given necessary information regarding diagnosis, treatment, and immediate measures that will be necessary upon transfer. The charge nurse at the site of the patient's origin shall then inform the Admissions Department of the transfer.

PART D: CRITERIA FOR REVIEW OF DISCHARGES FROM CORONARY CARE UNIT

(1) In general, patients are eligible for transfer from the Coronary Care Unit when vital signs are stable, no life-threatening abnormal lab values are present and there is no evidence of acute hemodynamic or respiratory compromise x 12 hours.

(a) Stable vital signs

Tolerates minimal activity with:

1. No > 30 beat/minute increase in heart rate
2. No > 10 respirations/minute increase
3. No > 30 mm Hg variance in SBP
4. DBP < 100 mm Hg

(b) Hemodynamic stability

1. Does not require titrated vasoactive drugs
2. Absence of invasive monitoring devices
3. Absence of Intra Aortic Balloon Pump
4. Life threatening arrhythmias absent or controlled x 24 hours

(c) Respiratory stability

1. Does not require mechanical ventilation (exception may be made for chronic ventilator dependent patient)

2. Stable after extubation x 12 hours

3. Arterial blood gases optimal for patient

4. Requires pulmonary toilet no > q2h

(2) More specifically, all patient discharges will be subject to the following screens for appropriate patient care under Critical Care Committee review.
(a) Acute Myocardial Infarction

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours

2. Resolving ECG changes

3. Decreasing cardiac enzyme levels

4. Absence of life-threatening arrhythmias or arrhythmia controlled by medication x 24 hours

5. No evidence of acute Congestive Heart Failure.

(b) Impending or Suspected Myocardial Infarction

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours

2. Resolution of ischemic ECG changes

3. No evidence of acute MI after 24 hours.

(c) Unstable Angina

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours

2. No evidence of acute MI after 24 hours of observation.

(d) Acute Pulmonary Edema

1. Mechanical ventilation not required

2. Resolution of tachypnea, tachycardia.

(e) Congestive Heart Failure (Associated with Malignant Arrhythmia or Acute Respiratory Distress)

1. Arrhythmias controlled x 24 hours.

(f) Arrhythmias

1. Arrhythmias controlled x 24 hours (Controlled by oral medication x 4 hours when transfer to telemetry bed.)

(g) Post Angioplasty/Stent/Rotoblation

1. Absence of chest pain

2. Removal of venous/arterial sheaths

3. No evidence active bleeding or arrhythmia.

(h) Post Cardiac Catheterization

1. Removal of venous/arterial sheaths

2. Absence of chest pain

3. Arrhythmias controlled x 24 hours

(3) Patients who experience further deterioration of a condition with no apparent hope of recovery and/or who are not to be resuscitated shall be appropriate candidates for discharge from the Coronary Care Unit.

(4) Patients admitted for procedures, treatments or monitoring available only in the Coronary Care Unit shall be eligible for discharge upon their completion.

(5) Patients may not be discharged from the Coronary Care Unit with arterial and/or pulmonary artery catheters in place.

(6) If, at any time, a bed is needed for a more critically ill patient, the physician, at his discretion, may transfer his patient without meeting the discharge criteria.

(7) If the unit is filled to capacity, the Chairman of the Cardiology Section or his designee has the authority and responsibility to ask the attending physician of the less critically ill patient to transfer his patient to provide for the critical one. Normally, the charge nurse of the Coronary Care Unit will act on the Chairman's behalf. If no decision can be reached, the charge nurse shall contact the director and his decision shall be final.

(8) In general, patients are not discharged to home from the CCU

(a) Discharge to home requires a physician's order

(b) Anyone going home against medical advice will be reviewed according to AMA (Against Medical Advice) policy.

(9) In the event that a patient may require services not provided by BMH, arrangements will be made to transfer patient to another institution upon order of the attending physician. A Coronary Care Unit registered nurse may accompany patient during transport at the request of the attending physician.

ARTICLE 7

DELIVERY ROOM

PART A: ADMISSION

Obstetrical patients may be admitted on a twenty-four (24) hour basis via the Emergency Room or Admission Office. Nursing personnel shall notify the attending physician when the patient is admitted.

PART B: LABOR AND DELIVERY CARE

(1) The physician must be named when a case is scheduled and is responsible for the care of the patient.

(2) When the physician has been informed that a patient is in active labor, it is his responsibility to be present for the delivery.

PART C: MEDICAL RECORDS

Appropriate medical records must be completed in the electronic medical record so that they are available in the Operating Room. Where not feasible, a note of the emergency situation shall be written and signed by the physician. If a C-Section delivery/surgical procedure is performed, the medical record documenting the C-Section delivery/procedure must comply with the Surgical Record requirements stipulated in these Rules and Regulations.

PART D: IDENTIFICATION

Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the Labor & Delivery/Operating Room.

PART E: ATTIRE

Anyone entering the Labor & Delivery/Operating Room must be properly attired. Hair, nose, and mouth shall be properly covered at all times with caps and masks provided by the hospital.

PART F: DELIVERY ROOM ROSTER

A current roster of physicians with a delineation of their obstetrical/gynecological privileges shall be maintained and made available to nursing personnel. An on-call roster shall be established and maintained to ensure that a physician with obstetrical/gynecological privileges is readily available at all times.

ARTICLE 8

NURSERY AND CARE OF NEWBORN

PART A: ON-CALL ROSTER

A physician on-call schedule shall be posted in the nursery to provide that a physician is available at all times to come to the Hospital and deal with emergency situations.

PART B: EXAMINATIONS

All newborn infants shall have a complete physical examination by a physician within 24 hours after admission to the Nursery, and the results of the examination shall be recorded in the infant's medical record. A physician shall examine any infant who displays abnormal signs and symptoms at any time as soon as possible or when a physician is requested by a nurse. A physician shall examine every newborn infant on the day before or the day of discharge, and the findings shall be recorded in the infant's medical record.

PART C: HIGH-RISK INFANTS

The physician to be in charge of the infant and the nurse in charge of the Nursery shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants and especially for high-risk infants is to be initiated in the delivery area, with constant observation of newborns for distress.

The physician responsible for the care of the infant shall be informed of any instance of:

(1) AN APGAR score of less than 5 points at five minutes or an infant requiring admission to the Neonatal Intensive Care Unit (NICU). .

(2) Respiratory distress or atelectasis:

(3) Generalized cyanosis;

(4) Significant jaundice;

(5) Blood dyscrasia or anemia;

(6) Persistent vomiting;

(7) Persistent diarrhea;

(8) Delay in voiding or passage of meconium;

(9) Neurological abnormalities of any type;

(10) Congenital heart disease;

(11) Any congenital defects that interfere with function or that are disfiguring;

(12) Whenever the diagnosis is obscure;

(13) Staphylococcal infections or other infections;

(14) Dermatitis of any type except for erythema neonatorum toxicum.

PART D: IDENTIFICATION

The identification of each infant and his mother shall be checked again at the time of discharge from the hospital. Infants discharged or transferred to another nursery or hospital shall be identified.

PART E: TRANSPORTATION OF INFANTS

Care in the protection of the infant shall be taken when transporting the newborn to the Nursery from Labor & Delivery. Transfer of distressed infants to the Nursery shall be done in such a manner as to minimize heat loss and to ensure adequate oxygenation.

PART F: MEDICAL RECORDS

Every newborn shall be examined at the time of delivery and the following noted on his medical record:

(1) Condition at birth including APGAR score.

(2) Time of sustained respirations.

(3) Any physical abnormalities or pathological states.

(4) Any evidence of distress.

The record of the newborn infant shall accompany the infant from the place of delivery to the Nursery and be immediately available to Nursery personnel. In addition to the information listed above, this record shall also include information concerning prenatal history, course of labor, delivery, drug administration to mother and infant, relevant conditions of the mother, procedures performed on the infant in the LDR/Operating Room, complications of any type, and other facts and observations.

A complete medical record for every newborn should include the following information:

(1) Obstetrical history of mother's previous pregnancies.

(2) Description of complications of pregnancy or delivery.

(3) List of complicating maternal disease.

(4) Drugs taken by the mother during pregnancy, labor, and delivery.

(5) Duration of ruptured membranes.

(6) Maternal antenatal blood serology, rubella titer, blood typing, Rh factors, and, where indicated, a Coombs test for maternal antibodies.

(7) Description of progress of labor including reasons for induction and operative procedures, if any, signed by the attending physician or his authorized delegate.

(8) Anesthesia, analgesia and medications given to mother and infant.

(9) Condition of infant at birth, including the one- and five-minute APGAR Score or its equivalent, resuscitation, time of sustained respirations, details of physical abnormalities, pathological states observed and treatments given before transfer to the Nursery.

(10) Any abnormalities of the placenta and cord vessels.

(11) Date and hour of birth, birth weight and length, and period of gestation.

(12) A written verification of eye prophylaxis.

(13) Report of initial physical examination, including any abnormalities signed by the attending physician or his authorized delegate.

(14) Discharge physical examination, including head circumference and body length, unless previously done; recommendations; and signature of attending physician or his delegate.

(15) A listing of all diagnoses since birth, including discharge diagnosis.

(16) Specific follow-up plans for call of infant.

PART G: NURSING NOTES

Upon admission to a Nursery, nurses shall initiate and maintain records on all infants as to weight, type and volume of feedings; time of first voiding; time of passage of first stool; number, color, and consistency of stools; and temperature. If abnormalities are suspected or recognized, nurses shall also make notations on respiratory rate, dyspnea, color, cyanosis, jaundice, pallor, lethargy, twitching, motor activity, skin and buttocks, vomiting, condition of the eyes and umbilical cord, and other relevant factors as indicated and warranted by the condition of the infant. Treatments, medication and special procedures ordered by a physician should also be recorded with time, date, and the time and title of the individual who administers them.

ARTICLE 9

MEDICAL RECORDS

PART A: GENERAL RULES

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 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. Only symbols and abbreviations listed in Appendix A may be used in the medical record.

PART B: MEDICAL RECORD ENTRIES/AUTHENTICATION

Medical Record Entries. An entry in the medical record is any documentation (handwritten or dictated) that is made by any healthcare provider during the patient's continuum of care. An entry in the medical record shall be made by licensed independent practitioners who have been credentialed by the Medical Staff, licensed and certified nursing personnel, respiratory therapists, physical therapists, speech therapists, occupational therapists, social workers, chaplains, imaging technologists, dieticians, laboratory technicians/technologists, pharmacists, and clinical secretaries.

Authentication. All entries in the 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.

Author Identification. Author identification may be verified by reviewing employee signatures contained in the employee's personnel records in Human Resources or physician signatures contained in the Physician Signature Manual in Information Systems for First Perspective Imaging System.

PART C: COUNTERSIGNATURES OF HOUSESTAFF

All dictation in the record, concerning diagnosis, history and physical, and discharge summary, made by Housestaff shall be reviewed and countersigned as follows:

(1) If the patient has been treated solely by Housestaff, first year Residents shall be reviewed and countersigned by a second or third year Resident.

(2) If a member of the Medical Staff is the attending physician and coverage has been

provided by Housestaff, the records shall be reviewed and countersigned by the attending physician.

(3) If a Resident is on rotation with a member of the Medical Staff for a specialty and dictates a consultation, the record shall be reviewed and countersigned by the member of the Medical Staff.

PART D: CONTENTS

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 medications and services. All medical records for inpatients hospitalized for more than forty-eight (48) hours must document the following, as appropriate:

(1) Identification Data;
(2) Evidence of a physical examination, including a health history, performed no more than seven (7) days prior to admission or within twenty-four 24 hours after admission;
(3) Admitting diagnosis;
(4) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;
(5) Documentation of clinical observations, including results of therapy, complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia;
(6) Properly executed informed consent forms for procedures and treatments specified by the Medical Staff or by Federal or State law if applicable, to require written patient consent;
(7) All practitioners' orders, nursing notes, nursing plan of care, reports of treatment, medication records, radiology and laboratory reports, vital signs and other entries by health care providers that contain information necessary to monitor the patient's condition;
(8) Progress notes;
(9) Operative note;
(10) Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatments, anesthesia records and any other diagnostic or therapeutic procedures and their results;
(11) Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. The physician must authenticate the discharge summary. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instructions given to the patient and family;
(12) Final diagnosis with completion of medical records within fourteen (14) days following discharge.

Outpatient records shall include, but not be limited to the following information:

(1) Identification data;
(2) Diagnostic and therapeutic orders;
(3) Description of treatment given, procedures performed and documentation of patient

responses to intervention, if applicable;
(4) Results of diagnostic tests and examinations done, if applicable.

For patients receiving continuing ambulatory care services, the medical record contains a summary list noting known significant medical diagnoses and conditions, known significant operative and invasive procedures, know adverse and allergic drug reactions; and medications known to be prescribed for or used by the patient.
The summary list is initiated for each patient by the third visit and maintained thereafter.

Emergency Service records shall include, but not be limited to the following information:

(1) Identification data;
(2) Time of arrival, means of arrival, time treatment was initiated, and time examined by physician, if applicable;
(3) Pertinent history of illness or injury, description of the illness or injury, and examination, including vital signs;
(4) Diagnostic and therapeutic orders;
(5) Description of treatment given or prescribed clinical observations including the results of treatment and the reports of procedures and test results, if applicable;
(6) Authentication by the practitioner or licensed health professional who rendered treatment or prescribed for the patient in accordance with hospital policy;
(7) Instruction given to patient on release, prescribed follow-up care, signature of patient or responsible individual and name of individual providing instructions;
(8) Diagnostic impression and condition on discharge documented by the practitioner, disposition of the patient and time of discharge;
(9) Copy of transfer form, if patient is transferred 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.
(10) The medical record shall note when a patient receiving emergency, urgent, or immediate care left against medical advice.

PART E: HISTORY AND PHYSICAL

A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by a physician appointee to the Medical Staff, a member of the House Staff, a nurse practitioner or a physician assistant with appropriate clinical privileges. Cases performed using topical/local anesthesia are exempt from this requirement (per CMS Interpretive Guidelines). This report shall reflect a current physical assessment. If the history and physical examination is performed by a nurse practitioner, the history and physical examination shall be co-signed by the admitting physician. If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record, provided that the patient has been reassessed by a physician appointee to the Medical Staff, a member of the House Staff, or a nurse practitioner with appropriate clinical privileges (co-signed by admitting physician) and the patient's clinical status is updated by documentation in the medical record within twenty-four (24) hours of the time of admission/registration but in all cases

prior to a surgery/invasive procedure if it occurs within the first twenty-four (24) hours. Any history and physical that is greater than 30 days old is invalid.

When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be cancelled unless the attending physician states in writing that an emergency situation exists.

PART F: PROGRESS NOTES

Progress notes made by practitioners should give a pertinent chronological report of the patient's course in the Hospital. Progress notes shall be legible, recorded at the time of observation, and shall contain sufficient content to ensure continuity of care if the patient is transferred. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be recorded by a credentialed provider at least daily on all inpatients.

Pertinent progress notes may also be made by other personnel specified by the Hospital.

PART G: CONSULTATION REPORTS

Each consultation report should contain a written opinion and recommendation by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement such as, "I concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

PART H: DISCHARGE SUMMARIES

All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate.

A clinical discharge summary and final progress note shall be included in the medical records of all patients except normal newborn infants and uncomplicated obstetrical deliveries. A final progress note may be substituted for the discharge summary for these patients, which should include condition at discharge, discharge instructions, and follow-up care.

The discharge summary shall be dictated and/or recorded by a physician appointee to the Medical Staff, a member of the House Staff or an advanced practice provider with appropriate clinical privileges. If the discharge summary is dictated and/or recorded by an advanced practice provider, the discharge summary shall be co-signed by a physician appointee to the Medical Staff. The discharge summary shall include the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient or family, as pertinent. The condition of the patient on discharge should be stated in terms that

permit a specific measurable comparison with the condition on admission. When preprinted instructions are given to the patient or family, the record should so indicate. All summaries shall be authenticated by the attending physician or dentist.

PART I: POSSESSION AND ACCESS

The legal medical record is considered to be the electronic medical record. All medical records are the property of the Hospital and shall not be taken from the premises of the Hospital by appointees to the Medical Staff. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from the Hospital is grounds for suspension from the Medical Staff and shall require that the matter be turned over to the Executive Committee for appropriate action. All medical records must be available for retrieval by the Health Information Management Department upon completion of services or discharge of the patient from the hospital.

Upon written approval of the Chief Executive Officer, or his designee, access to the medical records of all patients shall be afforded to appointees to the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the Chief Executive Officer, former staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patient's medical records is forbidden without written approval of the Chief Executive Officer.

Written consent of the patient or other person authorized by law to consent to the release of medical information is required for release of medical information to those not otherwise authorized to receive this information.

PART J: CHART COMPLETION POLICY

(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 Article 7D of the 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.

PART K: LEGIBLE HANDWRITING POLICY

For purposes of patient safety and quality care, each member of the Medical Staff shall use legible handwriting in the medical record. The Health Information Management Department will conduct random audits of handwriting legibility in the medical record and will forward to the Executive Committee of the Medical Staff handwriting samples which it deems illegible. The Executive Committee of the Medical Staff will then review the handwriting samples forwarded to it by the Health Information Department and make a determination, within its sole discretion, as to whether the handwriting in the medical record is legible or illegible.

If the Executive Committee of the Medical Staff determines the handwriting in the medical record to be illegible, then the Chair of the Executive Committee shall send a registered letter to all members whose handwriting in the medical record is deemed illegible notifying them that: i) if this is the member's ***first*** registered letter received under this policy or more than six (6) months have elapsed since the member received a registered letter under this policy, then the member will be advised that it is strongly suggested that he/she implement handwriting tool(s) recommended by the Health Information Department and that in the event the member should receive a second registered letter under this policy within a six (6) month time period that the member shall have fourteen (14) days from receipt of the second registered letter in which to provide proof of implementation of a handwriting tool(s) recommended by the Health Information Department to the Chair of the Executive Committee or such failure to do so will result in automatic relinquishment of their clinical privileges; or ii) if this is the member's ***second*** registered letter received under this policy within a six (6) month period, then the member will be advised that he/she shall have fourteen (14) days from receipt of the second registered letter in which to provide proof of implementation of a handwriting tool(s) recommended by the Health Information Management Department to the Chair of the Executive Committee or such failure to do so will result in automatic relinquishment of their clinical privileges effective immediately which relinquishment shall remain in effect until proof of implementation of a handwriting tool(s) recommended by the Health Information Management Department has been received by the Chair of Executive Committee. The Chair of Executive Committee shall notify the Credentials Office, Patient Access Department, Nursing Services and Surgical Services of the automatic relinquishment of the member's clinical privileges.

For purposes of this policy, the registered letter will be deemed to have been received by the member on the third day following its deposit in the mail addressed to the member.

ARTICLE 10

INFORMED CONSENT

PART A: TREATMENTS/PROCEDURES WHICH REQUIRE INFORMED CONSENT

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

(1) Any treatment or procedure which is non-routine or which presents significant risk;
(2) Operative and invasive procedures;
(3) Treatments or procedures for which written consent is required by law;
(4) Administration of anesthesia;
(5) Administration of blood and blood products;

DEFINITIONS

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

The explanation includes:

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

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

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

(2) 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.

(3) 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.

PART B: RESPONSIBILITY FOR OBTAINING INFORMED CONSENT

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

(1) The surgeon shall obtain the patient's informed consent to any surgical procedure undertaken by him/her or under his/her supervision, including ambulatory surgery.

(2) The anesthesiologist shall obtain the patient's informed consent to the administration of anesthesia administered by him/her or under his/her supervision.

(3) The licensed independent practitioner who will perform the treatment or procedure shall obtain the patient's informed consent to the treatment or procedure.

Members of the Medical Staff may not delegate the duty to obtain informed consent to BMH staff members.

BMH 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, BMH personnel shall refer the patient to the appropriate member of the Medical Staff for additional explanation.

PART C: WRITTEN CONSENT

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

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

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

- He or she is emancipated;
- He or she is at least fourteen (14) years of age, is not dependent on a parent for support, is living apart from his parents or from an individual *in loco parentis* (in place of a parent) and

is managing his or her affairs;
- He or she is or has been married;
- He or she is in the military service of the United States;
- He or she is authorized to consent to their own healthcare by any other statute (as in the case of treatment for venereal disease).
- 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 Healthcare Providers treating Pregnant, In Labor or Postpartum Minors at least 16 Years of Age:

1. **Before** a Provider may provide care to the minor, the Provider 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 Provider is (A) unable to make contact; or (B) the parent or guardian refuses to provide consent for treatment, then the ***Provider 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 Provider determines that ***additional care*** is in the best interest of the minor and the fetus, the Provider ***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.

If the minor is not authorized to consent to the minor's healthcare, then health care consent for a minor may be given, in the following ***order of priority*** (unless otherwise 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.

If an adult is incapable of giving consent and does not have an appointed health care representative or the health care representative is unavailable or declines to act, then health care consent may be given, in the following ***order of priority*** (unless otherwise 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 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***.

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.

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

ARTICLE 11

ABORTION

"Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

Abortions may not be performed at IU Health Ball Memorial Hospital unless the abortion is necessary to prevent a substantial impairment of the life or physical health of the pregnant woman.

A physician performing an abortion at IU Health Ball Memorial Hospital is responsible for assuring compliance with any and all legal requirements concerning abortions prior to performing the procedure.

ARTICLE 12

PHARMACY SERVICES

PART A: GENERAL RULES

All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia National Formulary," "American Hospital Formulary Service," or "AMA Drug Evaluations", with the exception of drugs for bona fide clinical investigations and approved alternative products (i.e. herbals) as approved by the P&T Committee. Investigational drugs may be used as part of a study previously approved by the Institutional Review Board (IRB). Investigational drug studies must be registered with the Department of Pharmacy Services and dispensed through the Department of Pharmacy Services. The entire protocol must be given to the Department of Pharmacy Services. The Department of Pharmacy Services shall not obtain, stock, or dispense non-FDA approved alternative products.

A pharmacist may prepare intravenous solutions with additives, dilute, dried, or concentrated injectables, or prepare unit dose medications for administration by an appropriately qualified individual. Each drug dose shall be recorded in the medical record of the patient and properly signed after the drugs have been administered.

PART B: SELF-ADMINISTRATION; PATIENT'S OWN DRUGS

Patients's personal medications from home may be used only if the medication is not stocked in the pharmacy and cannot be obtained in a timely manner. Under these circumstances, the practitioner who prescribed the medication must write a complete order for the administration of the patient's personal medication. Patient's personal IV Hyperalimentation bags or other IV admixtures may not be used during the patient's hospitalization. Medications brought to the hospital by patients shall be sent home or shall be stored in the pharmacy and returned to the patient upon discharge.

PART C: MEDICATION ERRORS; ADVERSE REACTIONS

Any significant medication errors and apparent adverse drug reactions shall be reported as soon as possible to the practitioner who ordered the drug. Any entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the medical record of the patient. Any adverse drug reaction shall be documented in the patient's chart. Notification of all drug sensitivities, including any apparent adverse reactions, shall be sent to the Department of Pharmacy Services. All medication errors and adverse drug reactions shall be documented through the appropriate reporting system.

PART D: HOSPITAL FORMULARY SYSTEM

The Hospital shall maintain a formulary system whereby the Medical Staff, working through the Pharmacy and Therapeutics Committee, evaluates, appraises, and selects those medical agents for use in patient care. The Hospital formulary shall be reviewed and revised by the Pharmacy and Therapeutics Committee to reflect current clinical judgment. With some exceptions, as determined by the Pharmacy & Therapeutics Committee, generically equivalent drug products will be substituted as necessary. The practitioner who prescribed the medication shall not be notified of the substitution.

PART E: AUTOMATIC THERAPEUTIC SUBSTITUTION

With the approval of the Pharmacy & Therapeutics Committee, the Pharmacy Services Department may substitute therapeutically equivalent products. Specific drug and dose substitutions will be reviewed by the P & T Committee. When a substitutable drug is Ordered, the pharmacist will write the order for the approved drug and dose and indicate that the substitution was made in accordance with P & T Committee guidelines.

PART F: MEDICATION ORDERS

Medication orders must be written completely with drug, dose, route of administration, frequency and duration (if applicable) noted on the order. Diagnosis/indication for use may be included but is not required. To avoid errors, leading decimals (e.g., .5 mg) and trailing zeros (e.g., 5.0 mg) should not be used when writing drug dosages. Illegible, unclear, or questionable drug orders will result in an intervention by a pharmacist.

ARTICLE 13

DISCHARGE

PART A: WHO MAY DISCHARGE

Patients shall be discharged only on a written order of the attending physician or dentist. Should a patient leave the Hospital against the advice of the attending physician or dentist, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient shall be asked to sign the Hospital's release form. The attending physician will be notified of patients leaving against medical advice.

PART B: DISCHARGE PLANNING

Discharge Planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge Planning shall include, but need not be limited to, the following:

- Appropriate referral and transfer plans.
- Methods to facilitate the provision of follow-up care.
- Information to be given to the patient or his family or other persons involved in caring for the patient on matters such as the patient's condition; his health care needs;

the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complications. This information should be provided by the attending physician, dentist or designated ancillary department.

Patients transferring from the hospital to a skilled nursing facility for the first time or after a stay at home with a readmission to the hospital, must be referred to the Social Work/Discharge Planning Department to facilitate compliance with state and federal pre-admission guidelines before transfer.

Patients requiring a referral to a home health agency for the first time or a re-referral after discontinuation of home health services must be referred to the Social Work/Discharge Planning Department to facilitate compliance with the federal statute requiring that all patients are advised of eligible home health providers before a referral is made.

PART C: TRANSFER OF PATIENTS

Patients shall be transferred to other medical facilities in accordance with the guidelines established in the Comprehensive Omnibus Reconciliation Act (COBRA). The transferring Medical Staff member shall document compliance with COBRA requirements and such documents shall become part of the medical record.

PART D: DISCHARGE OF MINORS & INCOMPETENT PATIENTS

A patient who is unable, by reason of his minority or other incompetency, to consent to his own care or treatment shall be discharged only to his parent, his guardian or another responsible party as determined by the Hospital, unless the Hospital is otherwise directed in writing by the parent, guardian or court order. If such direction is received by the Hospital, the writing or order shall be made a part of the permanent medical record of the patient.

PART E: AUTOPSIES: DISPOSITION OF BODY

The remains of any deceased patient including a fetal death or a neonatal death shall not be subjected to disposition until death has been officially pronounced by a Medical Staff appointee or House Staff member. Disposition shall be arranged in accordance with current Indiana law/statute with the consent of the parent, surviving spouse, legal guardian, or responsible person.

It shall be the duty of all Medical Staff appointees or House staff to secure consent to autopsies whenever possible. An autopsy may be performed only with proper consent in accordance with state law. All autopsies shall be performed by a pathologist or by his designee. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete protocol shall be made a part of the medical record within 30 days.

ARTICLE 14

GENERAL RULES REGARDING PRACTICE IN THE HOSPITAL

PART A: REPORTS

It shall be the responsibility of each physician or dentist to report to the Chairman of the Executive Committee any conduct, acts or omissions by appointees to the Medical Staff of which he is aware which he, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

PART B: DISASTER PLAN

Each appointee to the Medical Staff except Honorary and Courtesy Staff members shall be responsible for familiarizing him/herself with the Hospital's Mass Casualty Disaster Plan. The members of the Medical Staff shall participate as requested in periodic disaster "drills" to test the effectiveness of the Hospital and community's emergency preparedness plans.

PART C: CARE OF SERVICE (CHARITY) PATIENTS

(1) Patients may be referred to "Service" by any physician or dentist on the Medical Staff admitting such cases to the Hospital.

(2) The referring physician or dentist will write an admitting note on the patient's chart, which will include original orders for treatment and also will indicate that the patient is referred to the service physician for further treatment.

(3) The service physician or service physician team will remain actively involved with each service patient until the patient is discharged.

(4) Service assignments for departments will be made by the chairman or designee of each department. Any disagreements regarding service assignments shall be settled at the department level.

ARTICLE 15

SEXUAL HARASSMENT POLICY

IU Health Ball Memorial 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.

(1) 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:

(a) Submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment;

(b) 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

(c) 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.

(2) 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:

(a) Demanding sexual favors in exchange for favorable reviews, assignments promotions, continued employment or promises of the same;

(b) Continued or repeated sexual jokes, language, epithets, flirtation, advances or propositions;

(c) Verbal abuse of a sexual nature;

(d) Graphic verbal commentary about an individual's body, sexual prowess or sexual deficiencies, including social life;

(e) Sexually degrading or vulgar words to describe an individual;

(f) Leering, whistling, touching, pinching, brushing the body, assault, coerced sexual acts or suggestive, insulting or obscene comments or gestures;

(g) The display in the workplace of sexually suggestive objects, pictures, posters or cartoons;

(h) Name calling, relating stories, gossip, comments or jokes that may be derogatory toward a particular sex;

(i) The display of sexually suggestive graffiti;

(j) Retaliation against Hospital employees for complaining about such behavior;

(k) Asking questions about sexual conduct or sexual orientation or preferences; and

(l) Harassment consistently targeted at only one sex, even if the content of the verbal abuse is not sexual.

(3) 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 assistance or medical associate should promptly report the facts of the incident

or incidents and the names of the persons involved directly to a supervisor, the Chairman of the Medical Staff, Chairman of the Executive Committee, Chairman of any Clinical Department, Chairman of any committee, the Chief Executive Officer or the Chairman of the Board. All claims will be investigated and appropriate corrective action will be taken. In the event a physician, dentist, medical assistant or medical associate engages in unlawful discrimination, including sexual harassment, which has been substantiated, corrective action will be taken which may include revocation of staff appointment. Any disciplinary action in excess of counseling and monitoring shall be in compliance with the Bylaws of the Medical Staff of Indiana University Health Ball Memorial Hospital, Inc.

(4) 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.

ARTICLE 16

DISRUPTIVE PROVIDER PROGRAM

It is the policy of IU Health Ball Memorial Hospital that all Medical 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 Medical Staff. Medical Staff members are further expected to work harmoniously with others in order to preserve the orderly operation of the hospital and the Medical Staff organization. All conflicts caused by the failure to abide by such expectations shall be resolved in the following manner and a written report shall be generated and forwarded to the Professional Standards Committee:

If a medical emergency exists at the point of conflict, the matter will be resolved in the following manner.

(1) First Level Resolution: The complainant will report the conflict to their supervisor (if a medical staff member-his/her department chair). The complainant and their supervisor will make every effort to resolve it on an interpersonal basis with the involved physician.
(2) Second Level Resolution: The supervisor and the involved provider's department chair will work to resolve the conflict and take care of the medical emergency in a manner appropriate to the situation.
(3) Third Level Resolution: If the department chairs cannot resolve the situation to both parties' satisfaction the Hospital administrator on call and the chairman of the Executive Committee shall resolve the conflict and take care of the medical emergency in a manner appropriate with the situation. If the chairman is not available the following chain shall be followed: Vice Chair of the Executive Committee, Secretary/Treasurer of the Executive Committee, and finally the Chief Medical Officer.

If no medical emergency exists at the point of conflict, the matter will 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 an interpersonal basis. Supervisory personnel and/or other physicians may assist at this level through informal mediation and will generate a report to the Professional Standards Committee.
(2) Second Level Resolution: When the first level resolution fails, the chairman of the department in which the involved provider practices shall be notified. The department chair shall then attempt to settle the conflict to the satisfaction both parties. A written report will be forwarded to the Professional Standards Committee with a summary of the resolution.
(3) Third Level Resolution: When the third resolution fails, the matter will be referred to the Chair of the Executive Committee, who shall conduct an investigation and make all appropriate recommendations in accordance with the Bylaws of the Medical Staff of Indiana University Health Ball Memorial Hospital, Inc.

The reports on unprofessional behavior shall be maintained by the Chief Medical Officer in a secure manner and shall be considered peer review protected. These records shall be used for the purposes of tracking behavior and shall be kept indefinitely. They will be accessible to the Credentials Committee for purposes of re-credentialing, the Professional Standards Committee and to the Executive Committee. The Provider named in the reports shall have the right to review their record and respond in writing. This written response shall also be kept indefinitely.

ARTICLE 17

CONTINUING MEDICAL EDUCATION

To be eligible for appointment or reappointment, the Medical Staff candidate must show evidence to the Medical Staff, through its offices, of earning fifty (50) hours of AMA approved Category I continuing medical education credits during the preceding reappointment cycle. For non-certified members of the Medical Staff who have been "grandfathered" under the board certification and recertification requirements in effect at the time of their initial appointment and those members who are non-certified who have been granted a waiver of the board certification and recertification requirements, the CME requirement will be 75 Category I AMA approved CME hours for each reappointment cycle. Exceptions to this requirement are stipulated below:

Board Certification/Re-certification
Practitioners who become Board-certified or Re-certified during a reappointment cycle will still be required to meet the CME requirements for that and the subsequent reappointment cycle.

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

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

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

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

ARTICLE 18

DRUG SCREENING

For completion of an application to the IU Health Ball Memorial Hospital Medical Staff, the applicant is required to submit to a substance screening procedure, unless they are part of the IU Health System and have an acceptable screening on file. The Credentials Committee shall determine the scope and methods of the screening process.

ARTICLE 19

STATE AND FEDERAL NARCOTIC LICENSE

All Medical Staff Members are required to maintain a continuous valid state and federal narcotic license except those physicians who by nature of their practice may be excused from this requirement by the Credentials Committee.

ARTICLE 20

IMPAIRED MEMBERS OF THE MEDICAL 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 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

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 Employee Health Services. If the situation arises after hours, then the Administrator On-Call will call Nursing Services to coordinate testing in Employee Health Services 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. Employee Health Services will also keep record 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.

Article 21

AUTHORITY FOR FINES / FEES

The Medical Executive Committee has the authority, among other options, to assess reasonable assessments and/or fines on members of the Medical Staff for failure to comply with requirements of the Medical Staff Bylaws, Rules and Regulations and Hospital Policies.

Article 22

CHEMICAL DEPENDENCY TREATMENT

Chemical Dependency treatment is now considered an outpatient process and provided through outpatient programs.

Patients needing acute detoxification may be cared for in acute care but once stabilized, should be referred to an appropriate outpatient chemical dependency program.

Article 23

UNRESOLVED PATIENT CARE AND SAFETY CONCERNS

When a member of the medical staff has concerns about patient care or safety in the hospital, the member should contact hospital administration.

If the concerns cannot be resolved through the hospital, the member may contact, without disciplinary or retaliatory actions, regulatory or accreditation agencies such as the Indiana State Department of Health, Joint Commission or CMS (Center for Medicare/Medicaid Services).

ARTICLE 24

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

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