

*St. Elias Specialty Hospital Medical Staff Rules and Regulations Revised and Adopted 11/06; Revised 3/13/07; Revised 4/30/09; Revised 04/29/10; October 2012; 11/2014 Reviewed: 01/2008; 01/2009; 01/2010; 01/2011; 01/2012; 01/2013; 01/2014; 01/2015, 01/2016, 12/2016; 01/2017, 01/2018, 09/2019*

**St. Elias Specialty Hospital**

**MEDICAL STAFF  
RULES  
AND  
REGULATIONS**

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## **CARE OF PATIENT**

### **I. Rights of Patients and Organization Ethics**

- A. The "Patient's Bill of Rights" must be adhered to by all practitioners.
- B. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting office should notify the Active practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.
- C. Each adult patient will be informed upon admission about their right to accept or refuse medical treatment and to execute an advance directive and/or a durable power of attorney. The hospital will not condition the provision of care or otherwise discriminate against individuals based on whether the individual has or has not executed an advance directive. If an advance directive is produced, a copy shall be filed in the active medical record. The treating practitioner should review the advance directive with the patient on admission and periodically throughout the course of treatment. When a practitioner cannot personally and ethically comply with advance directives stated by the patient, the practitioner shall discuss this with the patient, or patient's family, if the patient is unable to understand, and offer the option to transfer his/her care to another provider.
- D. Specific consent must be obtained for any diagnostic or therapeutic intervention required by the hospital policy on informed consent. The Active and/or treating practitioner is responsible for documenting in the medical record the information provided to the patient relative to the intervention anticipated. Exceptions to obtaining the patient's timely specific consent shall be limited to emergency and other situations defined in the hospital's informed consent policy. All regulatory requirements relating to disclosure shall be followed.
- E. Research involving human subjects is approved and monitored by the Medical Executive Committee. Request to use patient information for research purposes, to use investigational drugs on humans and to use human subjects in other medical research are governed by hospital policy and federal and state regulations.
- F. Written consent of the patient (per hospital policies and procedures on confidentiality of medical records) is required for release of medical information to persons not otherwise authorized to receive this information.

### **II. Medical Staff Responsibilities**

- A. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for prompt special instructions, and for transmitting reports of the conditions of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

- B. The Active practitioner shall be responsible for the preparation of a complete and legible medical record for inpatient care. The medical record shall contain sufficient information to identify the patient clearly, to justify diagnosis and treatment, and to document the results accurately. This record shall include the patient's name, address, date of birth, and next of kin; the reason for admission to the hospital and any special programs; the medical history of the patient, including the following information: the chief complaint; details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status needs relative to the age of the patient; an inventory of body systems; a statement of the conclusions or impressions drawn from the admission history and physical examination; a statement of the course of action planned for the patient while in the hospital; the goals of treatment; reports of procedures and tests, and their respective results; conclusions at termination of hospitalization; and autopsy report, when performed.
- C. Practitioners shall abide by admitting/discharge requirements that, for their relevance to the subject manner in those sections, have been delineated in other sections of these bylaws, rules and regulations.

### **III. Assessment of Patients**

#### **A. Preadmission Process**

- 1. The hospital shall accept patients for care and treatment who will benefit from the services afforded by the hospital. The patient's condition must require twenty-four (24) hour availability of a physician, and daily rounding.
- 2. The patient must meet admission criteria for the level of services indicated by medical condition.
- 3. Patients may be referred for possible admission by any physician, agency, or may be self-referred. All referred patients will be evaluated for compliance with admission criteria. The hospital admissions committee will review patients whose compliance with admission criteria is uncertain.
- 4. Only a member of the Active staff may admit the patient to the hospital. Patients will be assigned to an Active physician as requested by the patient or referring entity. All unassigned patients will be assigned utilizing a rotation of the Active Medical Staff. The official admitting policy of the hospital shall govern all practitioners. Any variation to the referral and admission policies can only be granted in advance by the Chief Executive Officer. All policies concerning the assignment of unassigned patients are reserved for the Governing Board.

#### **B. Initial Assessment Process**

- 1. The Active physician or his/her designee shall complete and document an admission history and physical examination within twenty-four (24) hours after admission to the hospital. This report should include all pertinent findings resulting from an assessment of all systems of the

body. The following items are to be included:

- i. Chief complaint
  - ii. History of present illness
  - iii. Past medical history
  - iv. Relevant family history/ social history
  - v. Review of systems
  - vi. Physical exam
  - vii. Clinical Assessment
  - viii. Plan of care
2. If a complete history and physical examination has been performed within 30 days prior to admission, a durable, legible copy of this report (provided it is on a form acceptable to the hospital) may be used in the patient's hospital medical record, provided there is an updated examination of the patient, including any changes in the patient's condition, which must be completed and documented by the physician.
  3. If a patient is being admitted directly from an acute stay admission, a copy of the discharge summary may be used if a durable, legible copy of the report is placed in the patient's hospital record, provided: (i) it includes all outlined elements, (ii) there is an update to the patient's condition within 24 hours of admission, and (iii) it was performed by a physician privileged by the hospital.
  4. The Active practitioner shall countersign the history and physical examination when the report has been recorded by another authorized individual.
  5. The Active physician is responsible for assuring that the multidisciplinary treatment plan is appropriate and is involved in the development of and approves the multidisciplinary treatment plan.

C. Reassessment Process

1. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. 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 treatments. Progress notes shall be written with each patient daily encounter.
2. The patient's medical record must reflect evidence of a coordinated multi-specialty program, including documentation that interdisciplinary team conferences:
  - 1) assess the patient's progress toward achieving his/her goals or the problems impeding progress;
  - b) consider possible resolutions to such problems and/or develop a new treatment plan;
  - c) re-assesses the validity of the goals initially established.

These conferences must be held at least weekly.

3. Upon the request of the Medical Executive Committee or any of its members, the Active practitioner must provide written justification of the necessity of continued hospitalization in accordance with the procedures outlined in the utilization review plan. Failure to comply with this policy will be brought to the attention of the Medical Executive Committee for action. The document must include:
  - a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
  - b) The estimated period of time the patient will need to remain in the hospital.
  - c) The plan for post-hospital care.

#### **IV. Treatment of Patients**

##### **A. Medical Staff Responsibilities**

1. All orders for treatment and medication shall be in writing and authorized only by a licensed physician, dentist, or podiatrist appropriately credentialed pursuant to the Medical Staff bylaws.
2. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence and signed by the responsible ordering practitioner. All orders dictated over the telephone shall be documented to include the name of the ordering practitioner, the date and time the order was given and the full signature of the authorized person taking the order. The ordering practitioner or other practitioner responsible for the care of the patient and who is authorized to write orders by hospital policy and in accordance with State Law shall authenticate such orders within three (3) days, excluding DNR and restraint orders. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action. Duly authorized persons to take verbal orders are as follows: a practitioner, a professional nurse, a licensed practical nurse, a licensed pharmacist, a Respiratory Therapist, a physical therapist, occupational therapist or speech therapist who may transcribe verbal orders pertaining to physical therapy, occupational therapy or speech therapy regimens, respectively, a registered dietitian who may transcribe verbal orders pertaining to nutritional management. .
3. The practitioner's orders must be written clearly, legibly, and complete. Orders that are illegible or improperly written will not be carried out until rewritten properly. The use of "Renew", "Repeat", and "Continue" orders is not acceptable. Orders to hold medication or treatment will be interpreted as discontinued and require that the order be rewritten.
4. Orders shall be rewritten when a patient is transferred to a different level of care.

- 5 The admitting practitioner is responsible for providing such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others (patients, staff, and visitors) if the patient is considered to be a source of danger, either from the patient personally or due to the patient's medical status.

B. Coordination of Care

1. In a case of readmission of a patient, all previous records shall be available for the use of the Active practitioner. This shall apply whether the patient is attended by the same practitioner or by another.
2. Consultation is required:
  - a) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
  - b) When there is doubt as to the appropriateness of the therapeutic measures used or proposed or when such measures have failed to help the patient;
  - c) When the patient's response to therapy is not as anticipated;
  - d) In unusual complicated situations where specific skills or other practitioners may be needed;
  - e) In any instance in which a patient exhibits severe psychiatric symptoms;
  - f) When there is a question of criminal action.
3. The Active practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He/she will provide reason for consultation.
4. Any qualified practitioner with clinical consulting privileges in this hospital can be called for consultation within an area of his/her expertise. It is the Medical Staff's responsibility, through the Medical Director and/or the Medical Executive Committee, to monitor that consultants are used appropriately.
5. When the required consultative expertise is not available through the existing categories of Medical Staff membership and the patient cannot be transported elsewhere safely, consultation may be obtained by the granting of temporary privileges to a qualified practitioner, who is not currently a staff member, as provided in the Medical Staff bylaws.
6. Consultations shall show evidence of a review of a patient's records by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's records.
7. If a nurse or other allied health professional has any reason to doubt or question the care

provided to any patient, or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nurse's superior who in turn may refer the matter to the Chief Clinical Officer. If warranted, the Chief Clinical Officer may bring the matter to the attention of the Medical Director, or Chief Executive Officer in cases where the Medical Director's care is in issue, who will assess and act on the situation.

8. Each patient in the hospital will be seen at least daily by either the active physician or consulting physician. Physician visitation will meet requirements of all licensure and accrediting organizations. Additionally, the Active physician, or qualified designee, must be available on a twenty-four (24) hour basis or provide alternative coverage.
9. Oxygen and respiratory therapy shall be administered in accordance with the established policy approved by the Medical Staff through its designated mechanism. However, when the duration or treatment is not specified or is stated indefinitely, the treatment shall be clarified or ordered discontinued by the Medical Director. The nurse or therapist shall notify the responsible practitioner of any intent to discontinue the treatment.

C. Use of Medications

1. All drugs and medications administered to the patients shall be in accordance with the Hospital Formulary System. Orders for medication administration should include the name of the drug, the dosage, the route of administration, and the frequency. When so ordered by the physician, the only medications are those approved through policy by the Medical Executive Committee. A patient may be allowed to participate in a self medication program when ordered by the physician and supervised by the nursing and pharmacy staff.
2. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of a patient's record, dated, and signed by the practitioner.
3. Drugs brought into the hospital by patients may be administered by the nursing staff only if the drugs have been identified by the Active practitioner, or another responsible prescribing practitioner, or the hospital pharmacist, and there is a written order from the responsible practitioner to administer the drugs.
4. The pharmacist shall have the authority to substitute the same drug that has a different brand name or a generic drug in the same dosage, after informing the Active practitioner, unless specifically otherwise ordered.
5. All drug orders for Schedule II substance, anticoagulants, and antibiotics shall be automatically discontinued after the approved number of days as detailed in the policy approved by the Medical Executive Committee and pursuant to CDC ("Centers for Disease Control") protocol.
6. The Medical Executive Committee may restrict the use of a specific antibiotic, either entirely, or for use only in stated conditions or for use only with consent of the Medical



Director or the physician responsible for infection control, pharmacy or therapeutic functions. All practitioners will abide by such restrictions.

7. When in the opinion of the nursing staff or the pharmacist a drug dosage ordered represents a potential hazard (e.g., excessive dose, incompatibility problem, contraindicated or patient's condition) to the patient and the prescribing practitioner disagrees, the Medical Director shall be consulted. Whenever the Medical Director agrees that a procedure is hazardous, the issue will be referred to the Medical Executive Committee to determine appropriate action under the Medical Staff Bylaws.
8. The use of a new drug for investigational purposes will only be permitted when the patient involved is continuing therapy initiated at a research center prior to admission. A treatment plan utilizing new drugs for investigational purposes will not be initiated during the hospital stay.
9. Drugs for bona fide clinical investigations shall be in compliance with the Statement of Principles involved in the Use of Investigational Drugs in hospitals and all regulations of the Federal Drug Administration.
10. The metric system must be used when prescribing all medications. The use of a leading decimal point should be avoided. The practitioner should place a zero before the decimal point.
11. Emergency drug carts/trays or emergency drug storage areas shall be checked by an appropriate individual at least once per shift and after each use to assure that all required items are immediately available and in usable condition. In addition, there must be a system that assures the continued integrity of the cart/tray or emergency drug storage area contents between periods of use.
12. Practitioners shall abide by drug and medication requirements that, because of their relevance to the subject matter in those sections, have been delineated in other sections of these rules and regulations.
13. Practitioners shall abide with the use of approved abbreviations as defined by The Joint Commission.

D. Use of Special Precautions

1. Use of safety devices, restraints, and seclusion will follow the policy and procedure approved by the Medical Staff. Any practitioner may immediately order such items to protect against immediate harm to or by a patient, provided that such order is reviewed as outlined in ADM-115: Patient Restraint. Use will be evaluated during team conferences.
2. If it is determined that the use of restraints or seclusion is necessary for the protection of the patient or the protection of others, the Active physician is responsible for providing a written or verbal time limited order. Verbal orders must be reduced to writing immediately, and countersigned by a practitioner within the time specified in ADM-115:

**Patient Restraint.**

3. Patients in restraints or seclusion must be observed and monitored by nursing staff with concurrent documentation in the medical record as to the patient's status at the time of the observation.
4. For the protection of the patients, the staff, and the hospital, precautions will be taken in the care of the potentially suicidal/ psychiatric unstable patient to include:
  - a) Any patient known or suspected to be suicidal or have a psychiatric history will be screened prior to admission to assure patient is stable and has received needed treatment.
  - b) Any patient exhibiting suicidal behavior or behavior reflective of a psychiatric emergency subsequent to admission will require a Psychiatric consult.
    - i. This patient should be considered for transfer to a psychiatric unit in another hospital if clinically indicated.
    - ii. When transfer is not possible, or indicated, the psychiatrist or psychologist may order one to one nursing or other suicide precautions if clinically indicated.

**E. Use of Diagnostic Procedures**

1. Patients admitted to the hospital shall have diagnostic procedures as identified by the physician with written reason as to why it is ordered.
2. Practitioners requesting diagnostic examinations by the radiologist must provide in the written request all relevant information available to help assure an accurate diagnostic impression and proper use of resources.
3. Clinical laboratory tests/examinations shall be done by an outside (reference) laboratory recommended by the Medical Director and/or the President of the Medical Staff and approved by the Medical Executive Committee. Practitioners who have such tests/examinations performed by laboratory sources other than these may enter the results in the history or progress note section of the medical record, but the report itself shall not be considered the official hospital medical record report. The Medical Staff shall assure itself that any outside laboratory sources, from which test reports are used as the official hospital medical record report, have an acceptable internal quality control and external proficiency testing system in place, monitored by qualified individuals.
4. The radiology department shall provide authenticated reports for all radiological examinations performed in the hospital and, when requested, for review of examinations performed outside the hospital. In either case, this will provide the official report for the medical record. Otherwise the Active practitioner may record his/her own interpretation in the history or progress note section of the medical record. When special cardiovascular

radiological procedures can be properly interpreted only with the findings and observations of the authorized practitioner (e.g., cardiologist) performing the procedure, this individual shall be responsible, based on approved privileges to do so, for rendering the official report for the medical record.

5. A practitioner who receives financial gain from the operation of an outside clinical lab, radiology or other diagnostic service used by the hospital for patient referrals must disclose his interest in writing to the Chief Executive Officer and to all persons required by law.

**F. Use of Invasive Procedures**

Invasive procedures will be ordered and performed following approved Medical Staff utilization guidelines.

**G. Use of Emergency Services**

Before transferring a patient to an acute care hospital, the facility shall provide services within its capacity in order to minimize any deterioration of the patient's condition.

**V. Education of Patients and Family**

- A. The Active practitioner is responsible for assuring that all patients and families receive appropriate education. This should be reflected in each treatment plan and each team conference report.
- B. Printed instruction sheets or patient brochures (from clinical department/specialties, patient care units, or individual practitioners) provided to patients and/or families either in the hospital or at time of discharge shall be approved for clinical relevance and patient safety by the Medical Staff through its designated mechanism. Such sheets or brochures shall not, however, be used by the practitioner as the sole source of information for purposes of obtaining the initial informed consent form.

**VI. Continuity of Care**

- A. All practitioners shall participate in patient discharge planning in accordance with the utilization review plan.
- B. It shall be the responsibility of the Active practitioner to discharge his/her patients from the hospital in a timely manner on the day of discharge.
- C. Functional status within twenty-four (24) hours of the time of discharge will be recorded. Instructions to be given to the patient and the family will include information about medications, diet, activity, equipment and follow-up plan.
- D. Patients requiring transfer to acute medical services will be sent to the facility of their choice unless a life threatening situation requires an alternate facility.

- E. The Active practitioner or his/her designee will notify the acute care hospital prior to a transfer. In all cases, except in transfer to an emergency room, there will be a practitioner who agrees to accept the patient. The Active practitioner or his/her designee will explain in all cases the reason for the transfer to the accepting practitioner.
- F. In the event of an emergency, the receiving emergency room practitioner will be contacted regarding the patient's immediate transfer. Medical care within the capabilities of the facility shall be provided to the patient.
- G. When a patient is being transferred to a nursing home or other health care facility, the responsible practitioner shall provide the necessary information in writing when required.
- H. Appropriate personnel and equipment shall accompany the patient on the transfer. Copies of all appropriate medical records, including advance medical directives such as living will, durable powers of attorney for health care and do not resuscitate orders, shall be transferred with the patient.
- I. The patient shall be discharged only on the written order of the responsible practitioner. If a patient leaves the hospital against medical advice ("AMA"), without proper discharge, the patient or responsible other shall be requested to sign an AMA release statement. Whether or not such a statement can be obtained, the event must be noted in the statement. Whether or not such a statement can be obtained, the event must be noted in the patient's medical records along with any reason given. An AMA release statement must indicate with the patient's or responsible other's signature that he/she is voluntarily leaving the hospital against the advice of the practitioner and that in so doing he/she absolves the practitioner and the hospital from any and all direct and indirect consequences presently or subsequently resulting there from. A patient leaving the hospital on his/her own accord without signing the appropriate documents shall be considered to be officially discharged and his/her medical records shall reflect that circumstance.
- J. In the event of a patient death, the deceased shall be pronounced dead by the attending practitioner or another practitioner who is authorized by law to pronounce a patient dead, within a reasonable time. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease where in the patient's course has been adequately documented to within a few hours of death. In all cases, the attending practitioner or another practitioner authorized by law shall complete and execute the patient's death certificate. Policies with respect to release of dead bodies shall conform to local and state laws
- K. It shall be the duty of all staff members to secure meaningful autopsies, the criterion for which is defined as "an unanticipated and/or unexplained death of a patient." An autopsy may be performed only with a written consent, signed in accordance with state law. When an autopsy is performed, provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within three months.
- L. A practitioner who received financial gain from the operation of an outside therapy center, treatment center, skilled nursing facility or nursing home used by the hospital for patient referrals must disclose his/her interest in writing to the Chief Executive Officer and to all other persons

## **ORGANIZATIONAL FUNCTIONS**

### **VII. Management of Information**

- A. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated by persons authorized to assess, write orders, and treat patients. The medical record must be clear, concise, complete and accurate.
- B. If an error is made when documenting the medical record, a single line will be drawn through it with a designation above the entry showing "error". The correct entry is then written with the date and authentication of the practitioner. In no event shall the erroneous entry be obliterated or erased.
- C. As per HIM-405 Abbreviations, Acronyms and Symbols, all practitioners shall adhere to the Prohibited Abbreviation List.
- D. Individuals authorized to use signature stamps or electronic signatures in the medical record shall place in the administrative offices of the hospital a signed statement that he/she is the only one who has the stamp or electronic signature identification and is the only one who will use it. There shall be no delegation of the use of such stamps/electronic signatures to another individual. Authorized individuals assume full legal responsibility for wherever the signature stamp/electronic signature appears. The person using such signature stamp or electronic signature shall note next to such signature that he was the person who affixed the signature.
- E. Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has responsibility for the order or the information bearing his/her authentication.
- F. Orders for radiology services will indicate the reason for the request and record relevant clinical information.
- G. Pertinent progress notes shall be recorded at the time of observation and shall suffice to assure continuity of care and transferability. The notes should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. The patient's clinical problems/treatment goals should be clearly identified and correlated with specific orders as well as test, procedure, and treatment results. Progress notes shall be written at least daily on critically ill patients, on patients with difficulty in diagnosis/management, and on patients as required by third-party payors or regulatory agencies. Progress notes will be written no less frequently than three times a week by the physician involved in the care of a patient. Progress notes should be integrated for continuity of care.
- H. Special procedure reports must be dictated or written in the medical record immediately after the procedure and will contain a description of the findings, the technical procedures used, any specimens removed, the procedure diagnosis, and the condition of patient on conclusion of procedure. When there will be a transcription and/or filing delay, a progress note, comprehensive enough to permit continuity of care, must be entered in the medical record immediately after the

- I. Radiographs are the property of the hospital and may be lent to other hospitals, practitioners, or research institutions for valid reasons and only with the permission of the patient, the chairman of the service, and the Chief Executive Officer. Their release shall be treated in the same manner as medical records.
- J. Final diagnosis should be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. All infections treated shall be included in the final diagnosis.
- K. The discharge summary shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures and treatment rendered, the condition of the patient on discharge, and any specific pertinent instructions given to the patient, family or other persons. The condition of the patient on discharge shall be stated in terms of functional status that permits a specific measurable comparison with the functional status on admission, avoiding the use of vague relative terminology, such as "improved", "satisfactory", "good", etc.
- L. A discharge summary (clinical resume) shall be written or dictated on all medical records within thirty (30) days of discharge of patients hospitalized. In all instances, the content of the medical records shall be reviewed to assure that the treatment was sufficient to justify the diagnosis and warrant the treatment and end result. The responsible practitioner shall sign all discharge summaries.
- M. Medical records must be completed within thirty (30) days of the patient discharge.
- N. All medical records shall not be permanently filed until completed by the responsible practitioner(s) or as ordered filed by the Medical Executive Committee. An incomplete record will not ordinarily be filed if the responsible practitioner is still a member of the Medical Staff or hold clinical privileges in the hospital. No Medical Staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the practitioner who is responsible for completing the record.
- O. All standing and routine orders (particularly those involving medications) shall be initially evaluated, and if approved, shall be evaluated at least annually thereafter by the Medical Executive Committee. Any change in such orders shall also require approval of the Medical Executive Committee.
- P. Appropriate safeguards shall be applied to protect confidential records and to minimize the possibility of loss and/or destruction of the records.
- Q. Records may not be removed from the hospital's jurisdiction and safekeeping. The medical record or copies of the record may be released in accordance with a properly issued court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. Unauthorized removal of any hospital property, including medical records, is ground for referral to appropriate personnel for corrective action under the Medical Staff Bylaws.

- R. Access to medical records of patients shall be afforded to non-active members of the Medical Staff only upon written authorization of the Chief Executive Officer for bona fide study and research consistent with hospital policy. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the hospital records of their patients covering all periods during which they attended such patients in the hospital.
- S. Practitioners shall abide by information management requirements that, because of their relevancy to the subject matter in those sections, have been delineated in other sections of these bylaws, rules and regulations.

#### **VIII. Management of Human Resources**

- A. The Medical Staff is strongly encouraged to support and participate in the hospital's continuing education program.
- B. Yearly review shall be conducted by the Medical Executive Committee of the hospital's human resources activities, continuing education programs and competency programs. Recommendations shall be submitted to the Governing Board.

#### **IX. Management of the Environment**

- A. The hospital's safety officer has the authority to institute appropriate control measures or studies at any time that he/she makes a reasonable finding that such measures or studies are necessary to protect patients, visitors, or personnel from environmental hazards.
- B. The hospital will not accept mass casualties or influx of infectious patients, based upon the hospital's capabilities, in conjunction with other emergency facilities in the community. It shall be reviewed and approved annually by the Medical Staff and Governing Board.

#### **X. Emergency Operations**

- A. The Emergency Operations Plan makes provision within the hospital for:
  - 1. Availability of adequate basic utilities and supplies, including gas, water, food, and essential medical and supportive materials;
  - 2. An efficient system of notifying and assigning people;
  - 3. Unified medical command under the direction of designated physicians;
  - 4. Transfer of patients, when necessary, to the facility most appropriate for administering definitive care;

5. A special disaster medical record that accompanies the patient if transferred;
  6. Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy;
  7. Maintaining safety and security; and
  8. Assignment of public relations liaison duties to a qualified, designated individual.
- B. All practitioners shall be assigned to posts by the Disaster Medical Officer (DMO), and it is their responsibility to report to their assigned stations. The staff will work as a team to coordinate activities and directions. In case of evacuation of patients from the hospital to another location, or evacuation from hospital premises, the Chief Executive Officer or his/her designee will authorize the movement of patients.
- C. During disasters, the hospital Chief Medical Officer, President of the Medical Staff or other designated hospital official grants disaster privileges to volunteer licensed independent practitioners when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.
- During disasters, the Chief Medical Officer, President of the Medical Staff or other designated hospital official may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.
- D. The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administration, nursing, and other hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.
- E. Physicians should be familiar with all the Emergency Management policies and procedures. The hospital Emergency Management Policy, EM-101 The All-Hazards Emergency Operations Plan, serves as written communication with the physician regarding his/her role in an emergency response and to whom he/she reports to in an emergency.

#### **XI. Collaboration with Management and Administration**

- A. The Medical Staff shall collaborate with management to achieve effective communication and efficient planning, directing, coordinating, providing and improving health care services.
- B. The Medical Director is a member of the top leadership team and shall participate in strategic business planning, budgeting, and operational management of the hospital.
- C. All practitioners shall comply with requirements of the Hospital Occurrence Reporting Program.
- D. The Medical Staff shall collaborate with any other persons in order to provide appropriate employee health services at the hospital.



- E. Emergency services involving basic life support and/or first aid measures shall be provided to visitors and staff members. The hospital's first responder protocols shall be followed. A medical record shall be prepared for all treatments.

## **XII. Collaboration with Nursing**

- A. The Medical Staff shall collaborate with nursing staff members in making decisions regarding each patient's treatment plan and needs for nursing care.
- B. The Medical Director shall regularly communicate with the nurse executive in preparing, activating, and achieving the plan for nurse staffing and provision of nursing care.

## **XIII. Hospital Employees**

- A. Nothing in these rules and regulations shall be construed to interfere with the hospital's right to terminate hospital employees in accordance with Hospital personnel policies.

On behalf of, and representing the Medical Executive Committee

Accepted: \_\_\_\_\_



Lucinda MacNeal, MD  
Chief Medical Officer