HARRISON COUNTY COMMUNITY HOSPITAL

Medical Staff Rules and Regulations

Approved

12.14.2023

https://hcchospitalorg.sharepoint.com/Department Files K Drive/Administration/M
Staff/Rules & Regulations - Medical Staff/Medical Staff Rules and Regulations -TEMF

HARRISON COUNTY COMMUNITY HOSPITAL DISTRICT

MEDICAL STAFF RULES AND REGULATIONS

RULES AND REGULATIONS OF THE MEDICAL STAFF
OF
HARRISON COUNTY COMMUNITY HOSPITAL DISTRICT

ARTICLE 1
GENERAL

1.1 Capitalized terms used in these Rules and Regulations shall have the same meaning as such terms in the Medical Staff Bylaws.

1.2 Each Physician who is an Active Member of the Medical Staff, has a continuous duty to designate another Active Member of the Medical Staff who has equivalent Privileges to be the Physician's official alternate. In case of unavailability of such alternate, the Chief of the Medical Staff shall have the authority to call any member of the Medical Staff should it be considered necessary.

1.3 The meetings of the Medical Staff shall be held at least quarterly or as otherwise provided in Article XI of the Medical Staff Bylaws. One (1) meeting shall be considered an annual meeting for election of officers.

1.4 Regular meetings of the Medical Staff will be held to review the work, reports, and recommendations of the Medical Staff and its committees and to complete Medical Staff administrative duties. The Medical Staff will also encourage educational programs.

1.5 A Physician shall be on-duty or on-call at all times. The Medical Staff shall participate in on-call coverage according to policies established by the Medical Staff and the Hospital Administration. Physicians shall comply with the EMTALA Rules and Regulations as outlined herein.

1.6 The Hospital maintains Disaster Programs for both the handling of mass casualties arising from external disasters and for internal disasters such as fire. All Medical Staff members shall participate in these Disaster Programs as assigned by the Chief of Staff and as otherwise specified in the program documents. These programs shall be reviewed at least once a year by key Hospital personnel.

1.7 The Medical Staff shall participate in Hospital performance improvement activities to improve the quality of care, treatment and Services, and patient safety. Medical Staff Members shall participate in the development and implementation of these activities as required in related Hospital policies.

1.8 The Medical Staff shall abide by Hospital's infection control and safety policies to enable the administration to protect patients from contagious disease or to protect the patients from self-harm.

ARTICLE 2
PROVISION OF PATIENT CARE

2.1 Admission to Care

(a) Authority to admit and supervise treatment of patients is exclusively delegated to Practitioners with status and Privileges required by the Medical Staff Bylaws for admission and treatment of patients. The admitting Practitioner must be in Good Standing under the Medical Staff Bylaws.

(b) If a patient is admitted by a Practitioner other than a Physician, the Practitioner must designate a Physician who has agreed to oversee the medical care provided to the patient.

(c) A provisional diagnosis, justification of admission and continued hospitalization, patient's progress, and response to medications and Services must be recorded on all medical records. Where provision of diagnosis is delayed due to emergency, the provisional diagnosis shall be given as soon after admission as possible.

(d) Practitioners not on staff will be permitted to order outpatient procedures only after verification of both proper licensure and adequate professional liability insurance. These privileges must be approved by the Chief of Staff, and exclude emergency room privileges.

2.2 Medical Necessity and Utilization Review

(a) The admitting Practitioner is responsible for deciding whether the patient should be admitted as an inpatient or receive Services as an outpatient. If the admitting Practitioner expects that the patient will require hospital care for at least two (2) midnights, inpatient admission may be appropriate. The decision to admit a patient is a complex medical judgment which can be made only after the Practitioner has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the Hospital's bylaws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as: the severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient Services (i.e., their performance does not ordinarily require the patient to remain at the Hospital for twenty-four (24) hours or more) to assist in assessing whether the patient should be admitted; and the availability of diagnostic procedures at the time when, and at the location where, the patient presents.

(b) The admitting Practitioner is responsible for completing documentation sufficient to support the medical necessity for an inpatient admission.

Documentation should also support the clinical indications for diagnostic tests and treatments ordered by the Practitioner.

(c) The Hospital has a Utilization Review Coordinator responsible for reviewing the medical necessity of admissions to the Hospital, duration of stays, and professional Services furnished, including drugs and biologicals. Practitioners are expected to cooperate with the Utilization Review Coordinator to ensure medically appropriate treatment and efficient use of Hospital resources in the provision of patient care.

2.3 **Coordination of Care**

(a) A patient's general medical condition shall be managed and coordinated by a Physician, provided that a dentist, psychologist, podiatrist or AHP with appropriate Clinical Privileges may manage and coordinate such care to the extent permitted under the Medical Staff Bylaws, relating to Prerogatives of Practitioners and AHPs and to the extent to which such care is within the scope of practice of the Practitioner or AHP, as permitted by Missouri law.

(b) Every patient must be assessed and reassessed at an interval appropriate to address the medical needs of the particular patient. Patients shall be seen at least once a day by the attending Practitioner or a qualified designee and documentation of such assessment will be entered in the medical record. Swingbed patients shall be seen at least every five days and documentation of such assessment will be entered in the medical record.

(c) Where the admitting Practitioner transfers care to the control and supervision of another Practitioner, such transfer must be clearly documented in the patient's medical record.

2.4 **Radiologic Services**

(a) The Radiology Department and all radiology patient Services shall be under the supervision of a designated Medical Staff Physician who is a radiologist.

(b) Use of radiology equipment and administration of radiology procedures is limited to personnel considered qualified per requirements established with the approval of the Medical Staff.

(c) The interpretation of all radiologic examinations shall be made by Physicians qualified by education and experience in radiology. A written report of the findings and evaluation of each radiological examination performed or course of treatment conducted shall be signed by the Physician responsible for the procedure and shall be made a part of the patient's permanent medical record.

2.5 **Consultation**

(a) A consultant must be a member of the Medical Staff with appropriate Clinical Privileges and qualified to give an opinion in the field in which the consultant's opinion is sought.

(b) A consultation request may be appropriate in the following circumstances:

(i) Any time the nature of the outcome is not clear or diagnosis is obscure;

(ii) The problem is outside the normal scope of practice of the Practitioner;

(iii) Anticipated treatment requires a Practitioner with Privileges in the specialty to properly manage or treat the patient;

(iv) In cases in which the patient exhibits severe psychiatric symptoms, including drug overdose and attempted suicide, except when the attending is a psychiatrist;

(v) When the patient does not respond to conventional treatment or is a poor risk for operation or treatment; or

(vi) When requested by the patient or the patient's family.

(c) The order for a consultation must be documented in the patient's medical record.

(d) The consultant must respond to a consultation request within a reasonable amount of time, taking into account whether the consultation request is urgent or routine.

(e) The consultant shall communicate all findings to the referring Practitioner and document the consultation in the patient's medical record. Such documentation must evidence a review of the patient's record by the consultant, describe pertinent findings on examination of the patient, and provide the consultant's opinion and recommendations. A limited statement such as "I concur" is not an acceptable report of consultation. When operative procedures are involved, the consultation notes shall, except in emergency situations, be recorded prior to the operation.

2.6 **Surgical and Anesthesia Services**

(a) A roster of Medical Staff Members with surgical Privileges shall be maintained in the surgical suite and available to the surgical nurse supervisor.

(b) Except in cases of extreme emergency, a study of the patient shall be completed and recorded before inpatient surgery. This study shall include: complete history and physical examination and recording of the preoperative diagnosis as well as

appropriate laboratory work. If not recorded, the surgery will be deferred. Patient studies for outpatient surgery will be handled according to Hospital's policies and procedures, as amended from time to time.

(c) Surgical assistants may be used at the discretion of the operating surgeon. All surgical assistants must either have applicable Clinical Privileges at Hospital or, if not within a category of AHP provided Clinical Privileges, be approved otherwise by the Hospital to provide patient care.

(d) Written, signed, informed consent shall be obtained by the operating surgeon prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

(e) All tissues removed during an operation shall be the property of the Hospital and shall be examined by a competent Physician, whose report shall form a part of the patient's medical record.

(f) All tissues removed shall be macroscopically examined. If deemed necessary, by written Hospital policies and procedures, tissues shall then be microscopically examined.

(g) There shall be a Department or director of anesthesia that shall be responsible for all anesthetics administered. Anesthesia shall be administered only by a qualified individual with appropriate Clinical Privileges at Hospital and licensure from the state of Missouri.

(h) Each patient requiring anesthesia shall have a pre-anesthesia evaluation by a Physician regarding the choice of anesthesia. This evaluation must be performed within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia Service.

(i) Each patient's condition shall be reviewed immediately prior to induction. This shall include a review of the patient's medical record with regard to completeness of pertinent laboratory data and an appraisal of any changes in the condition of the patient as compared with that noted on the patient's medical record.

(j) Following the procedure for which anesthesia was administered, the anesthetist or a designee shall remain with the patient as long as required by the patient's condition relative to the patient's anesthesia status and until responsibility for proper patient care has been assumed by other qualified individuals. A post anesthesia evaluation completed and documented by the individual qualified to

administer anesthesia must be completed no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia Services.

2.7 **Dental Services**

(a) In order to be granted Clinical Privileges in dentistry and/or oral and maxillofacial surgery, a Dentist shall complete the initial Application process as outlined in the Medical Staff Bylaws.

(b) The preoperative history and physical examination will be performed by a physician. The operative report and post-operative progress record may be completed by the oral and maxillofacial surgeon to the extent that they have such Clinical Privileges in accordance with the Medical Staff Bylaws, in order to assess the medical, surgical and anesthetic risks of the proposed procedures.

(c) Dentists may write orders and prescribe medications within the limits of their licensure and Clinical Privileges granted by the Medical Staff.

2.8 **Podiatry Services**

(a) Podiatric Privileges shall be delineated pursuant to the Medical Staff Bylaws. Podiatrists with Clinical Privileges may provide consultation on the request of a member of the Medical Staff.

(b) Podiatric patients will be admitted by a Physician Member of the Medical Staff who shall be responsible for the pre-operative medical evaluation of the patient, care of any pre-existing or inter-current medical problems, and completion of the medical record planning discharge instructions. The podiatrist may write orders directly related to the operative procedure. Patient studies for outpatient surgery will be handled according to hospital policies and procedures.

(c) The preoperative history and physical will be performed by a physician. The operative report and post-operative progress record may be completed by podiatrist as permitted by the Medical Staff Bylaws. The Podiatrist shall complete all patient medical records in compliance with the Hospital's medical records, rules, and regulations. The justification for the operative procedure shall be clearly delineated in the report.

2.9 **Psychologist Services**

(a) In order to be granted Clinical Privileges in psychology, a Psychologist shall complete the initial Application process as outlined in the Medical Staff Bylaws.

(b) All patients admitted to the Hospital by a Psychologist must also be under the care of a Physician Member of the Medical Staff.

(c) A Psychologist may perform the medical history and physical examination, to the extent that the Psychologist has such Clinical Privileges in accordance with the

Medical Staff Bylaws, in order to assess the psychological condition and treatment of the patient. An admitting history and physical shall be submitted or supplemented by a Physician Member of the Medical Staff who is selected by the Psychologist.

(d) A Psychologist may write orders and prescribe medications within the limits of the Psychologist's licensure and Clinical Privileges granted by the Medical Staff.

2.10 **Discharge from Care**

(a) Patients shall be discharged only on the order of a Practitioner and, in the case of post-operative patients, by approved post-operative discharge criteria.

(b) Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the medical record. An AMA form shall be signed by the patient and witnessed by either nursing personnel or the attending practitioner and shall become a permanent part of the patient's medical record. Refusal to sign the AMA form will be documented in the medical record if the patient will not sign.

(c) Discharge planning and evaluation shall begin at the time of admission. Patients who are likely to suffer adverse health consequences upon discharge, if there is no adequate discharge planning, must be identified. A registered nurse ("RN"), social worker, or other appropriately qualified personnel must develop or supervise the development of a discharge planning evaluation for such patients. Medical Staff shall support and coordinate discharge planning with Hospital Staff.

ARTICLE 3
MEDICAL RECORDS

3.1 **General**

(a) Entries in the medical record are made only by authorized individuals. All entries must be timed, dated, authenticated by the person making the entry, and legible. At a minimum, medical records shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately.

(b) Each medical record shall include, at a minimum: admitting diagnosis; results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient; documentation of complications, Hospital acquired infections, and unfavorable reactions to drugs and anesthesia;

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; all Practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition; discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care; and final diagnosis.

(c) In addition to the above listed elements, each inpatient medical record shall include a unique identifying record number; pertinent identifying and personal data; history of present illness or complaint; if injury, how the injury occurred; past history; and family history.

(d) An appropriate record shall be maintained for every patient receiving emergency service and will be incorporated in the patient's medical record, if one exists. Its contents shall include patient identification; time and method of arrival; history; physical findings; treatment; and disposition. The emergency room record shall be signed by the Physician in attendance who is responsible for its clinical accuracy. This record shall be separate from and in addition to any centralized Emergency Services Log.

(e) Each medical record shall be treated as confidential in accordance with the Hospital's privacy and security policies for the protection of individually identifiable health information. Records may only be accessed by individuals authorized by Hospital policies and procedures.

(f) An appropriate record for outpatient observation (less than twenty-four (24) hours) shall be maintained.

(g) Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a 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. In case of re-admission of a patient, all previous records shall be available for the use of the attending Physician. This shall apply whether the patient is attended by the same Physician or another Physician.

(h) All Discharge Summaries shall identify the patient, and contain sufficient information to support the diagnosis, justify the treatment, document the course and results of the treatment, and permit adequate continuity of care among health care providers. Discharge Summaries shall also contain instructions given to the patient relating to physical activity, medication, diet, and follow up care.

(i) Only abbreviations and symbols approved by the Medical Staff may be used in the medical records. Each abbreviation or symbol shall have only one (1) meaning and an explanatory legend shall be available for use by all concerned.

(j) A medical record shall not be permanently filed until it is completed by the responsible practitioner. The completed medical record will contain:

(i) On admission (within twenty-four (24) hours):

(1) Identifying information

(2) Chief complaint

(3) History of present illness

(4) Past history

(5) Personal, family, and occupational history

(6) Complete physical examination including such special examinations as indicated

(7) Results of initial laboratory and x-ray examinations

(8) A presumptive diagnosis in proper terminology

(ii) During hospitalization:

(1) Progress notes in sufficient frequency to record the significant changes in the patient's condition. Progress notes should be legible, handwritten, typed and/or dictated and should be entered at the time of the observation of the patient. Progress notes in the first twenty-four (24) hours of admission will be at the discretion of the attending physician. Discharge notes are required on all patients. Progress notes will be written for all surgical patients within twenty-four (24) hours following completion of the postoperative report. Progress notes will be written and/or dictated and placed on the chart once every twenty-four (24) hours for all inpatients and observation patients. Swingbed patients require progress notes once every seven (7) days.

(2) Reports of operations and surgical treatments

(3) Reports of laboratory and x-ray examinations

(4) Doctor's orders

(5) Nurses' notes including record of medication and treatment

(6) Charting of vitals

(iii) On Discharge:

(1) Discharge summary

(2) Condition of patient at discharge

(3) Where patient was discharged to

(4) Special instructions to patients, i.e., diet, medications, and activity

(5) Final diagnosis by principal and secondary diagnoses.

PRINCIPAL DIAGNOSIS: The condition determined after study to be chiefly responsible for admission to the Hospital.

SECONDARY DIAGNOSES: The most important diagnoses, after the principal diagnosis, listed by severity.

OPERATIONS-PROCEDURES-DATES: Proper terminology, as defined by the International Classification of Diseases, Current Edition, shall be used. Symptoms will not be considered suitable diagnoses.

3.2 **History and Physical**

(a) A medical history and physical examination must be completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to a surgery or a procedure requiring anesthesia Services. The medical history and physical examination must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring general anesthesia Services.

(b) An updated history and physical examination must be completed and documented, including any changes in the patient's condition, when the medical history and physical examination are completed within thirty (30) days before admission or registration. Documentation of the updated examination must be placed in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring general anesthesia Services.

(c) At minimum, the history and physical must include the family histories and inventory of body systems. The physical examination shall reflect a comprehensive current physical assessment. If a complete history and physical has been performed within forty-eight (48) hours prior to admission in the office

of a physician staff member, a durable, legible copy of this report may be used in the patient's Hospital medical record in lieu of the admission history and report of physical examination. In such instances, all additions to the history and any subsequent changes in the findings must always be recorded. If there were no new findings, this must be stated. All history and physical reports must be authenticated by the physician. If a history and physical examination has been dictated, a handwritten note stating this fact must be on the chart.

(d) An Advanced Practice Registered Nurse ("APRN") or Physician Assistant ("PA) with appropriate Clinical Privileges working in collaboration with a Physician may perform a history and physical examination. Physician shall co-sign the history and physical examination.

3.3 **Operative Records**

(a) Preoperative and postoperative medical records must be completed in an accurate and timely manner. An accurate and complete description of findings and techniques of operation shall be completed immediately after surgery, and the surgeon must enter a progress note in the patient's chart prior to transferring the patient to the next level of care. The surgeon must dictate or chart in EMR the operative report to be placed in the medical record immediately after surgery.

3.4 **Anesthesia Records**

(a) The Anesthesia Department shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, inter-operative anesthesia, and post-anesthetic follow-up of the patient's condition. The surgeon/Physician should note use of anticipated general, spinal or other regional anesthesia, and the anesthesiologist or anesthetist shall document the type of anesthesia administered on the anesthetic record.

(b) A record of events taking place during the induction and maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions, shall be made.

3.5 **Signature Requirements**

(a) All clinical entries in the patient's medical record shall be accurately timed, dated and authenticated by the individual making the entry. The method of acceptable authentication used shall be either:

(i) Legible full signature;

(ii) Legible first initial and last name;

(iii) Illegible signature or initials over a typed or printed name;

(iv) Illegible signature or initials matching a signature log maintained on file by the Medical Records Department; or

(v) An electronic signature.

(b) Where an authentication is made by electronic signature, the individual authenticating the record must have signed an electronic signature agreement agreeing to maintain the confidentiality and integrity of the user log-on and password. Medical Staff Members found to be in violation of the Hospital's electronic signature policies may be subject to discipline under the Medical Staff Bylaws.

(c) Use of rubber stamp signatures is strictly prohibited.

Where possible, authentication should be made at the time of the creation of the record. All authentication must be made within thirty (30) days of the creation of the record or as otherwise required by these Rules and Regulations or Hospital policy.

3.6 Delinquent Records

(a) Medical records are considered delinquent if they remain incomplete for more than twenty-one (21) days following the patient's discharge from the Hospital. Incomplete record items include: missing dictation or reports such as discharge summaries, history and physical examination records, operative reports, and consultations; unsigned dictation and reports; unsigned verbal orders; and other unsigned written entries in the chart (e.g. progress notes, post-operative notes, and consents). In addition, history and physical examination records are considered delinquent if they are not dictated within twenty-four (24) hours of admission and operative reports are considered delinquent if they are not dictated immediately following the procedure. Medical records which are unavailable to the Practitioner, and remain incomplete for twenty-one (21) days following the patient's discharge, will not be considered delinquent.

(b) The Practitioner whose records are delinquent will be notified via written notice that records must be completed within one week from the date on which the notice is sent. If the records are not complete within one (1) week, admitting Privileges will be suspended.

(c) Suspension of a Practitioner shall be interpreted in accordance with Subsection 12.11(c) of Article XII of the Medical Staff Bylaws to mean that the Practitioner may not admit patients under the Practitioner's own or any other Practitioner's name during the period of suspension, may not provide consultation Services, and may not schedule surgeries or procedures. The suspended Practitioner will continue to be responsible for attending the Practitioner's own patients admitted to the Hospital prior to the suspension, proceed with patient

surgeries/procedures scheduled prior to the suspension, deliver pregnancies as applicable, and provide evaluation and treatment of emergency cases at the request of the Chief Executive Officer or President of the Medical Staff. The suspended Practitioner also will be consulted regarding which alternate Practitioner should assume responsibility for admitting the suspended Practitioner's patient's to the Hospital during the period of suspension. The Practitioner's Privileges will be automatically reinstated upon completion of the delinquent records.

ARTICLE 4
ORDERS

4.1 Medication and Treatment Orders

(a) Medication or treatment shall be administered only upon written and signed orders of a Practitioner or AHP who is acting within the scope of that Practitioner's or AHP's license and who is qualified according to the Medical Staff Bylaws. Invasive treatments or IV therapy shall have a Physician co-sign the orders.

(b) Each Practitioner or AHP is responsible for the monitoring and review of the medications the Practitioner or AHP has ordered for a Patient. Pharmacy Staff may periodically request a Practitioner or AHP review an order for continuation and each Practitioner or AHP is expected to cooperate with such request.

(c) Medication orders shall be written according to policies and procedures and those written by persons who do not have independent statutory authority to prescribe shall be included in the quality improvement program.

(d) Automatic stop orders for all medications shall be established and shall include a procedure to notify the prescriber of an impending stop order. A maximum stop order shall be effective for all medications which do not have a shorter stop order. Automatic stop orders are not required when the pharmacist continuously monitors medications to ensure that the medications are not inappropriately continued.

(e) Respiratory Services must only be provided under the orders of a qualified and licensed Practitioner who is responsible for the care of the patient, acting within the Practitioner's scope of practice. All respiratory care orders must be documented in the patient's medical record. If an order for therapy is not adequate or explicit, further written explanation and instructions will be requested from the Practitioner. The ordering physician or independently licensed provider is not required to maintain Clinical Privileges at the Hospital to order outpatient Services. Certain outpatient services may require the ordering physician or independently licensed provider to coordinate with a Practitioner or AHP who has appropriate Clinical Privileges to coordinate the outpatient Services to be provided.

(f) The ordering physician or independently licensed provider is not required to maintain Clinical Privileges at the Hospital to order outpatient Services. Certain outpatient services may require the ordering physician or independently licensed provider to coordinate with a Practitioner or AHP who has appropriate Clinical Privileges to coordinate the outpatient Services to be provided.

4.2 Standing Orders

(a) All medication orders shall be written in the medical record and signed by the ordering Practitioner or AHP with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per Physician-approved Hospital policy/protocol after an assessment for contraindications. When medication therapy is based on a protocol or standing order and a specific medication order is not written, a signed copy of the protocol or of an abbreviated protocol containing the medication order parameters or of the standing order shall be placed in the medical record with the exception of Physician-approved policies/protocols for the administration of influenza and pneumococcal polysaccharide vaccines after an assessment for contraindications. The assessment for contraindications shall be dated and signed by the registered nurse performing the assessment and placed in the medical record.

(b) Hospitals may adopt policies and procedures that permit the use of standing orders to address well-defined clinical scenarios involving medication administration. An order that has been initiated for a specific patient must be added to the patient's medical record at the time of initiation, or as soon as possible thereafter. The Practitioner or AHP is responsible for acknowledging and authenticating all standing orders, with the exception of influenza and pneumococcal polysaccharide vaccines. When Hospital-based agreements, protocols or standing orders are used, they shall be approved by the pharmacy and therapeutics or equivalent committee.

4.3 Verbal Orders

(a) Telephone/verbal orders for medication or treatment shall be accepted only from authorized individuals when it is impractical for such orders to be given in writing. Telephone/verbal orders may be accepted by a registered professional nurse or other person qualified and authorized under Hospital policy to accept such orders. All verbal orders shall include the name of the dictating Practitioner, the date and time the order was taken, and the name and signature of the authorized person transcribing the order.

(b) Verbal orders/telephone orders, shall include the date, time and signature of the person recording them. The prescribing or covering Practitioner shall authenticate the order within seventy-two (72) hours of the patient’s discharge or thirty (30) days, whichever occurs first.

4.4 **Do Not Resuscitate Orders**

(a) The patient has the right to accept medical care or to refuse it to the extent permitted by law and to be informed of the medical consequences of refusal. The patient has the right to appoint a surrogate to make health care decisions on the patient's behalf to the extent permitted by law. Each Practitioner is expected to cooperate with the patient's rights or notify Hospital if the request conflicts with the Practitioner's personal belief or ethics.

(b) Where a patient diagnosed with a terminal illness executes a Declaration directing the withholding or withdrawal of death-prolonging procedures, the patient's Physician is responsible for completing additional documentation required by Hospital policy. If the Physician refuses to comply with the directive, the Physician must transfer the care of the patient to another Physician on the Medical Staff.

(c) If a conflict arises with a Do Not Resuscitate Order or Advance Directive, the issue may be directed to the Medical Staff Executive Committee.

ARTICLE 5
ALLIED HEALTH PROFESSIONALS

5.1 **Categories of AHP**. The Hospital currently credentials the categories of AHPs as provided in this Article 5. Other licensed healthcare professionals may provide patient care services at the Hospital as Hospital employees or under contract with the Hospital, but are not issued Privileges to provide clinical services to Hospital patients independently. All Privileges extended to AHPs must be provided consistent with the Medical Staff Bylaws.

5.2 **Advanced Practice Registered Nurse**

(a) An Advanced Practice Registered Nurse (APRN) may provide services to a Hospital inpatient or outpatient under a collaborative practice agreement that complies with the provisions of Missouri law. If the collaborating physician is not on the Hospital's Medical Staff, the APRN must have a Physician on the Medical Staff serve as a sponsor for supervision of Hospital patients.

(b) An APRN may order diagnostic tests and therapies at Hospital consistent with the APRN's licensure and collaborative practice agreement. An APRN may only order medications to the extent authorized under the collaborative practice agreement. To order controlled substances, the APRN must have appropriate authority under the collaborative practice agreement and hold a current BNDD and DEA registration.

(c) A separate privileging form is maintained for APRNs, and an APRN may only be granted privileges for services designated on the APRN privileging form.

5.3 **Chiropractor**

(a) For a Chiropractor provide services to a Hospital inpatient, the patient must be under the medical care of a Physician on the Hospital's Medical Staff.

(b) The Hospital may provide outpatient services to a patient on the order of a Chiropractor so long as the order is within the scope of practice of the Chiropractor. The Hospital may designate outpatient services that require the order of a Chiropractor to include designation of the Physician responsible for the medical care of the patient.

(c) A separate privileging form is maintained for Chiropractors and a Chiropractor may only be granted privileges for services designated on the Chiropractor privileging form.

5.4 **Certified Registered Nurse Anesthetist**

(a) A Certified Registered Nurse Anesthetist (CRNA) is a qualified anesthesia provider in the Hospital. A CRNA may be granted privileges relating to the provision of anesthesia, including pre- and post-anesthesia care.

(b) All services performed by a CRNA must be supervised by the attending physician. Both the CRNA and the attending physician are responsible for ensuring that the procedure and the level of anesthesia to be administered are within the scope of Services for which the physician is credentialed to perform and supervise.

(c) A separate privileging form is maintained for CRNAs, and a CRNA may only be granted privileges for Services designated on the CRNA privileging form.

5.5 **Physician Assistant**

(a) A Physician Assistant (PA) may provide Services to a Hospital inpatient or outpatient under a physician supervision agreement with a Physician on the Hospital's Medical Staff. The PA's supervising Physician must be available in person or by phone at all times during which the PA provides patient care Services at the Hospital.

(b) An PA may order diagnostic tests and therapies at Hospital consistent with the PA's licensure and physician supervision agreement. A PA may only order medications to the extent authorized under the physician supervision agreement. To order controlled substances, the PA must have appropriate authority under the collaborative practice agreement and hold a current BNDD and DEA registration.

(c) A separate privileging form is maintained for PAs, and a PA may only be granted privileges for Services designated on the PA privileging form.

ARTICLE 6
RESTRAINTS AND SECLUSION

6.1 **Patient Rights.** All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by Staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, Hospital personnel, Staff Members, or others and must be discontinued at the earliest possible time. Restraint or seclusion shall never be used as a punishment or for the convenience of the staff.

(a) The term "restraint" includes either a physical restraint or a drug that is being used as a restraint.

(b) A physical restraint is any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that the patient cannot easily remove that restricts freedom of movement or normal access to one's body.

(c) A drug used as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

(d) A restraint does not include devices, such as orthopedically prescribe devices, surgical dressing or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(e) "Seclusion" is the involuntary isolation of a patient alone in a room where the patient's freedom to leave is restricted.

6.2 **Use of Restraints or Seclusion**. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, Hospital personnel, or others from harm. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, Hospital personnel, or others from harm.

6.3 **Physician Order**. Use of restraint or seclusion must be in accordance with the order of a Physician with appropriate Clinical Privileges under the Medical Staff Bylaws. The order for restraint or seclusion must be:

(a) followed by consultation with the patient's treating Physician, as soon as possible, if restraint or seclusion is not ordered by the patient's treating Physician;

(b) in accordance with a written modification to the patient's plan of care;

(c) signed within one (1) hour of implementation;

(d) implemented in the least restrictive manner possible;

(e) in accordance with safe and appropriate restraining techniques;

(f) ended at the earliest possible time; and

(g) time limited and never written as a standing order or on a PRN basis.

6.4 **Renewal of Order**. The order may only be renewed in accordance with the following limits for *up to a total of twenty-four (24) hours*:

(a) three (3) hours for adults eighteen (18) years of age and older;

(b) two (2) hours for children and adolescents nine (9) to seventeen (17) years of age;

(c) one (1) hour for children under nine (9) years of age; or

(d) after twenty-four (24) hours, before writing a new order for the use of restraint or seclusion, the Physician responsible for the care of the patient must see and assess the patient.

6.5 **Face-to-Face Evaluation**. When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of a patient, Hospital personnel, or others, the patient must be seen face-to-face within one (1) hour after the initiation of restraint or seclusion by a Physician, APRN, a licensed independent Practitioner, Registered Nurse ("RN"), or PA who has been trained on the restraint and seclusion policies and is approved by the Medical Staff for such evaluation. The evaluation must include the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; and the need to continue or terminate the restraint or seclusion. If the face-to-face evaluation is performed by an APRN, RN or PA, such individual must consult the attending Physician as soon as possible following the completion of the examination.

6.6 **Monitoring**. The condition of the patient who is restrained or secluded must be monitored by a Physician, other licensed independent practitioner, or trained Staff. Such monitoring of the patient's condition shall be at a frequency determined by the treating Physician, which shall be no less than once per each fifteen (15) minutes.

6.7 **Documentation**. Documentation must be present showing that the patient is in danger to the patient and/or others. Specifically, when restraint or seclusion is used, there must be documentation in the patient's medical record of the following: (i) the one (1)-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) a description of the patient's behavior and the intervention used; (iii) alternatives or other less restrictive interventions attempted (as applicable); (iv) the patient's condition or symptoms(s) that warranted

the use of the restraint and seclusion; (v) the patient's response to the interventions(s), including the rationale for continued use of the intervention; and (vi) the reason for the restriction, the time of starting and ending the restriction. Nursing notes should reflect the continuous monitoring of the secluded or restrained patient. A Physician must sign a statement explaining the necessity for the use of any restraint or seclusion and shall make such statement part of the patient's permanent medical records.

6.8 **Simultaneous Restraint and Seclusion**. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored (i) face-to-face by an assigned, trained staff member; or (ii) by trained staff using both video and audio equipment, in close proximity to the patient.

6.9 **Intake and Output**. Patients must have the opportunity for regular meals, adequate fluids and use of the bathroom.

6.10 **Training**. Physicians and other Hospital personnel shall complete training on use of restraints and seclusion as required under Hospital policy.

ARTICLE 7
EMERGENCY SERVICES

7.1 **Organization**. Emergency Services shall be organized under the direction of a qualified member of the Medical Staff and shall be integrated with other Departments of the Hospital.

7.2 **On-Call Coverage**. Emergency Department coverage is provided by a contracted agency. The ER Contracting Agency will develop the coverage schedule. The failure of a physician to present for an assigned shift will be reported to the Executive Committee for consideration and recommendation. Active Medical Staff Members are required to participate in on-call coverage as determined necessary by the Hospital and in accordance with the Medical Staff Bylaws.

7.3 **Response Time**. On-call Practitioners shall respond within a reasonable period of time after receiving a page or telephone call from emergency personnel. It is the intent of HCCH and the Medical Staff that all emergent/urgent patients will be seen as soon as possible by a physician and certainly within thirty (30) minutes after notification. All patients will be triaged by an appropriately trained Registered Professional Nurse.

7.4 **Screening Examination**. The Hospital will provide an appropriate medical screening examination within its capability, including ancillary Services routinely available to the Emergency Department, for persons (who are not already inpatients) on the Hospital's property requesting examination for what might be an emergency medical condition.

(a) An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the

health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

(b) The "Hospital's property" means the entire main Hospital campus including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the Hospital's main building that are not part of the Hospital, such as Physician offices, rural health clinics, or other entities that participate separately under Medicare, or other nonmedical facilities.

(c) All emergency room patients requesting to be seen will be evaluated by a physician who must provide a medical screening examination beyond initial triage. This screening process shall reasonably calculate and determine whether an emergency medical condition exists and may entail a spectrum ranging from a simple process involving a brief history and exam to a complex process that also involves ancillary studies and procedures.

7.5 **Stabilizing Treatment**. If an emergency medical condition is found to exist, the Hospital will provide necessary stabilizing treatment or an appropriate transfer.

(a) "Stabilizing treatment" is considered as the treatment necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or that, with respect to a pregnant woman who is having contractions, the woman delivers the child and the placenta. If an individual at Hospital has an emergency medical condition that has not been stabilized, the Hospital will not transfer the individual unless it is an “appropriate transfer” (as defined below).

(b) To make an "appropriate transfer” to another medical care facility, the Hospital must (i) provide the stabilizing medical treatment within its capacity minimizing the risk to the individual or to the woman and unborn child, (ii) verify that the receiving facility has the space and qualified personnel available for the treatment of the individual, (iii) verify that the receiving hospital has agreed to accept the transfer of the individual and to provide the appropriate medical treatment, (iv) send pertinent medical records available at the time of the transfer to the receiving hospital (including available history, records related to the emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies, treatment provided, and the name/address of any on-call Physician who refused or failed to appear within a reasonable time to provide necessary stabilizing treatment), and (v) effect the

transfer through qualified persons and transportation equipment, including life support measures.

(c) An appropriate transfer, defined above, is only permitted where the patient (or the patient's authorized representative) requests the transfer or a Physician has signed a certification that, based upon information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual or, in the case of a woman in labor, to the woman or unborn child.

(i) A patient's (or authorized Representative's) request for transfer must be in writing and must indicate the reasons for the request and indicate that the patient is aware of the risks and benefits of transfer.

(ii) A written Physician certification must summarize the risks and benefits of the transfer.

If a Physician is not physically present in the Emergency Department at the time of transfer, a qualified medical person may sign the certification after consultation with a Physician who agrees with the certification. A qualified medical person is a PA, APRN, or emergency room Registered Professional Nurse. The consulting Physician must subsequently countersign the certification.

7.6 **Off-Campus Departments**. When a patient with an emergency medical condition presents to an off-campus Hospital department that does not include an emergency department, the patient will be provided screening and stabilization services at such off-campus department consistent with available resources and Hospital policy.

7.7 **Reporting**. The Hospital will report to the Center for Medicare and Medicaid Services or the Missouri Department of Health and Senior Services any time the Hospital believes it has received an individual who has been transferred from another hospital in violation of EMTALA. This report must be made within seventy-two (72) hours of the occurrence.

ARTICLE 8
AUTOPSIES

8.1 **Securing Autopsies.** Every member of the Medical Staff is expected to be actively interested in securing autopsies and should attempt to secure an autopsy in all cases of unusual deaths and of medical-legal and educational interest. No autopsy shall be performed without written consent of a relative or legally authorized agent. All autopsies shall be performed by the Hospital pathologist or by a pathologist to whom the Physician may delegate the duty. The attending Physician shall be notified when an autopsy is being performed.

HARRISON COUNTY COMMUNITY HOSPITAL DISTRICT

MEDICAL STAFF RULES AND REGULATIONS

Adopted by the **Medical Staff** on December 14, 2023.

Chief of Staff

Secretary of Medical Staff

Adopted by the **District Board** on January 29, 2024.

Chairman HCCH District Board of Directors

Secretary HCCH District Board of Directors

Summary of Revisions

Page	Section	Original	Revised 12.2022