BAPTIST HEALTH DEACONESS MADISONVILLE, INC.
MEDICAL STAFF
RULES AND REGULATIONS

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BAPTIST HEALTH DEAC ONESS MADISONVILLE, INC.
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*Definitions as specified in the Baptist Health Deaconess Madisonville, Inc. Medical Staff Bylaws are applicable to the Baptist Health Deaconess Madisonville, Inc. Medical Staff Rules and Regulations.

SECTION A. Admission and Discharge of Patients

1. A patient may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. Orders for outpatient hospital services shall be acceptable if the requesting practitioner or allied health practitioner functioning within the appropriate scope of practice is currently licensed and holds a valid NPI number. Individuals ordering such services who are not members of the Baptist Health Deaconess Madisonville, Inc. Medical Staff or Allied Health Practitioner Staff shall be reviewed annually to determine whether or not they have maintained their medical license and NPI number.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special operative and treatment permits, and for transmitting reports of the condition of the patient to the referring practitioner and to any guardian or patient representative to who the patient has authorized the release of information. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the last progress note. Physicians are expected to visit their patients daily except when unavoidably prevented. In case of an emergency any member of the staff that is available may be called upon.

3. Except in an emergency, no patient shall be admitted to the Hospital or placed in an observation bed until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

4. Except in an emergency, in cases in which it appears the patient will have to be admitted to a hospital, the practitioner shall first contact the bed coordinator or house supervisor to ascertain whether there is an available bed and whether the admission meets with all applicable hospital admitting policies.

5. Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the Administration of the Hospital that the said emergency admission was an emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's medical record as soon as possible after admission.

6. A patient to be admitted on an emergency basis who does not have an admitting practitioner may be assigned to a member of the active medical staff on duty.

7. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is resident in the area who may be called to attend medical staff member's patients in an emergency, or until the medical staff member arrives. In case of failure to name such associate, the President of the Hospital, the Medical Staff President, Chief Medical Officer or the Chairman of the department concerned, shall have authority to call any member of the active staff to attend the medical staff member's patients.

8. Each practitioner must assure timely, adequate professional care for patients in the Hospital by being available or having available through the practitioner's office an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements may result in loss of clinical privileges. A practitioner who will be out of town for over twenty-four hours should, on the last progress note of each patient, indicate the name of the practitioner who will be assuming responsibility for the care of the patient during the practitioner's absence.

9. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.

10. Behavioral health consultation and treatment should be requested and offered to all patients who have attempted suicide, have taken a chemical overdose, or who suffer the results of drug abuse.

11. Written criteria for patient admission to, continued stay in, and discharge from, each special care unit, including any needed priority determination, shall be developed by the Medical Staff and the Nursing Service Department. These criteria, as well as any related policies and procedures, concerning the scope and provision of patient care, shall become effective upon review and approval of the Medical Executive Committee and the President of the Hospital. (See Hospital Policies and Procedures for Special Care Units.)

12. Patients shall be discharged only on the order of the attending practitioner or designee. 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 patient's medical record.

13. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased

by a member of the Medical Staff or designee. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of the remains of patients shall conform to local law.

14. It shall be the duty of all staff members to secure meaningful autopsies whenever appropriate. (Reference: Hospital Policies and Procedures - Autopsy Guidelines) An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by a practitioner delegated this responsibility in accordance with the Autopsy Guidelines. Provisional anatomic diagnoses and the complete or final autopsy report will be provided as specified in the Autopsy Guidelines.

SECTION B. General Conduct of Care

1. 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 admissions office should notify the attending 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.

2. In addition to obtaining the patient's general consent to treatment, a specific informed consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure shall be obtained by the practitioner. The Medical Executive Committee, in cooperation with Hospital administration will establish and revise as necessary a listing of treatments and procedures, which shall require specific informed consents.

3. All orders for treatment shall be in writing or electronically documented. A verbal/telephone/standard protocol order shall be considered to be in writing or electronically documented if dictated to a duly authorized person functioning within the authorized person’s sphere of competence and signed by the responsible practitioner (or appropriate member of the house staff). All verbal/telephone/standard protocol orders shall be signed by the practitioner per the name of the duly authorized person taking the order. The responsible practitioner shall authenticate such orders as soon as possible or in the event the patient was discharged prior to the order being authenticated, within 15 days of the patient’s discharge or as otherwise set forth in the medical record completion policy adopted by the medical staff. Any nurse responsible for carrying out a verbal/telephone/standard protocol order should contact the responsible physician should he have any questions regarding that verbal/telephone/standard protocol order.

4. Individuals who may give and receive verbal/telephone/standard protocol orders;

   A. Individuals authorized to give verbal/telephone/standard protocol orders are those authorized to prescribe medications or other therapeutic interventions legally by their licensure board and by the Baptist Health Deaconess Madisonville, Inc. Staff Rules and Regulations. An individual, authorized by the prescriber, may act as the prescriber's agent to transmit a verbal/telephone/standard protocol order. Authorized individuals receiving a verbal/telephone/standard protocol order may refuse to receive the order or request to speak to the prescriber if they have any question or concern regarding the order.

   B. The duly authorized personnel that may take verbal/telephone/standard protocol orders are:
      1. House Staff Members may accept verbal/telephone/standard protocol orders.
      2. Certified Physician Assistants may accept verbal/telephone/standard protocol orders within the scope of their license.
      3. Licensed Nurses may accept verbal/telephone/standard protocol orders within the scope of their license.
      4. Registered Pharmacists may accept verbal/telephone/standard protocol orders within the scope of their license.
      5. Licensed Physical and Occupational Therapists may accept verbal/telephone/standard protocol orders within the scope of their license.
      6. Licensed Speech therapists may accept verbal/telephone/standard protocol orders within the scope of their license.
      7. Licensed Clinical Social Workers may accept verbal/telephone/standard protocol orders for discharge planning.
      8. Respiratory Care Personnel, certified eligible, registered and registered eligible, may accept verbal/telephone/standard protocol orders within the scope of their license.
      9. Registered Radiologic and Nuclear Medicine Technologists may accept verbal/telephone/standard protocol orders within the scope of their license.
      10. Registered dietitians may accept verbal/telephone/standard protocol orders within the scope of their license.
      11. Registered echocardiographers may accept verbal/telephone/standard protocol orders within the scope of their license.

5. The practitioner's orders must be entered electronically including date, time and signature. Orders which are illegible or improperly entered electronically will not be carried out until entered electronically or understood by the personnel who must act on them. Paper orders received from practitioners who do not have medical staff

clinical privileges and/or access to the EHR and entered electronically as "transcribed by paper" shall be scanned into EHR.

6. For reinstatement of previous medication orders, the required elements must be stated including the brand or generic name, the dose, strength and rate when applicable, the route, the frequency and for as needed medications, the indications for usage. A blanket reinstatement of previous orders for medications is not acceptable.

7. All orders must be re-evaluated and re-authenticated when patients change a level of care, e.g., going to surgery or to or from special care areas. A patient's code status, once established, remains in effect unless otherwise ordered by the physician.

8. All physicians and providers shall first attempt to administer drugs and medications that are listed in the Hospital Formulary. The Pharmacy and Therapeutics Committee recognizes that physicians must be able to prescribe drug therapy based on the individual situation and therefore cannot always order medications contained on the formulary. Requests for non-formulary drugs will be honored in accordance with appropriate policy and procedure.

Policies governing research and the use of investigational drugs shall be formulated by the Pharmacy and Therapeutics Committee and the Institutional Review Board in accordance with federal guidelines established by the Department of Health and Human Services, Office of Human Research Protections (OHRP) and the US Food & Drug Administration (FDA).

The Pharmacy and Therapeutics Committee shall develop policies and procedures regarding medications. Such policies and procedures shall be subject to approval by the Medical Executive Committee.

9. Any qualified practitioner with clinical privileges in the Hospital may be called for consultation within the practitioner's approved clinical privileges.

10. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. The practitioner will provide written authorization to permit another attending practitioner to attend or examine the patient except in an emergency.

11. If a member of the patient care team 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, the team member shall call this to the attention of the team member's

superior who in turn may refer the matter to the chief administrative officer of the Nursing Service. If warranted, the matter may be brought to the attention of the chairman of the department wherein the practitioner has clinical privileges, and then may bring the matter to the attention of others in accordance with the medical staff bylaws, rules and regulations, and applicable policies. Where circumstances are such as to justify such action, the chairman of the department may request a consultation.

12. Unless otherwise specifically indicated in the medical record, the admitting physician shall be responsible for coordinating all care rendered on behalf of the patient. The admitting physician may assign that coordination to the alternate physician when off duty or unavailable; however, the admitting physician remains responsible for the overall care of the patient admitted to the service.

13. Policies, procedures and processes related to patient care provided in the hospital shall be developed and maintained through an interdisciplinary collaboration. Review and approval includes as applicable the Medical Executive Committee and any other appropriate medical staff committee, medical departments, Nursing shared governance, and other healthcare discipline committees.

SECTION C. General Rules Regarding Surgical Care

1. The policies, rules and regulations of the surgical suite shall be developed and maintained by a committee of the Medical Staff and Nursing Service and shall be effective upon approval by the Medical Executive Committee and the Hospital President. Policies, procedures and processes related to patient care provided in the hospital shall be developed and maintained through an interdisciplinary collaboration. Review and approval includes as applicable the Medical Executive Committee and any other appropriate medical staff committee, medical departments, Nursing shared governance, and other healthcare discipline committees.

2. A complete physical examination of each patient, with clinical and laboratory findings, shall be made and recorded before a general anesthetic is administered. This examination shall include a thorough physical examination, including the heart, lungs, mouth, nose, throat, and blood pressure. Reports of laboratory examinations must be noted and a statement made relative to surgical risk. An abbreviated history and physical that includes a minimum examination of heart, lungs and mental status may be accepted for certain minor surgery procedures. In all cases of an emergency, at least a rapid examination of the heart and lungs, with blood pressure readings, is essential. The types and timing of laboratory examinations shall be acceptable to the surgeon and the individual administering anesthesia.

3. A complete record on the prescribed form shall be made of each anesthetic administered. This shall provide data pertinent to the patient's condition previous to and throughout the time of anesthesia, with a notation of pre-anesthetic and post-anesthetic medication and a brief statement of the patient's condition at the close of the operation.

4. The individual administering anesthesia shall monitor the patient's condition until all effects of the anesthetic have passed.

5. The individual administering anesthesia shall record the patient's record of post-anesthetic condition after termination of the operation.

6. A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and physician member of the Medical Staff.

a. Dentist/Podiatrist responsibilities:

1) A detailed dental/podiatric history justifying hospital admission. Podiatrists and dentists may perform the entire history and physical for patients admitted for inpatient or outpatient care if they have been granted privileges to do so.

2) A detailed description of the examination of the oral cavity/foot and a pre-operative diagnosis;

3) A complete operative report, describing the finding and technique. In cases of extraction of teeth the dentist shall clearly state the number of teeth and fragments removed. All tissue shall be sent to the Hospital Pathologist for examination in accordance with the Exceptions to Sending Surgical Specimens to the Laboratory Policy.

4) Progress notes as are pertinent to the oral/podiatric condition;

5) Clinical resume or summary statement.

6) Discharge of the patient

b. Physician's responsibilities:

1) Medical history pertinent to the patient's general health;

2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

Any patient admitted to inpatient or outpatient services shall have a history and physical performed by a member of the Medical Staff of Baptist Health Deaconess Madisonville, Inc.

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

7. Written, signed, informed, surgical consent shall be obtained by the practitioner 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 on the patient's medical record. A consultation in such instances is required before the emergency operative procedure is undertaken, if time permits.

8. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed. When a procedure predictably involves substantial risk to the patient's life, the assistant should be a qualified physician.

9. All tissue removed at the operation shall be sent in accordance with hospital policy to the Pathologist who shall make such examination as deemed necessary to arrive at a tissue diagnosis. The Pathologist's authenticated report shall be made a part of the patient's medical record. (Reference: Laboratory Policy)

SECTION D. Emergency Service

1. For purpose of these rules and regulations, the following definitions will apply: "Medical Screening Exam" (MSE) is the process required to reach, with reasonable clinical confidence the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The Medical Screening Examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either stabilized or appropriately transferred.

"Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain, psychiatric disturbances and/or 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, a) placing the health of the individual in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction to any body part of organ, or with respect to a pregnant woman who is having contractions, a) that there is an inadequate time to affect a safe transfer to another hospital for delivery, or b) that the transfer may pose a threat to the health and safety of the woman and unborn child.

2. The Medical Staff shall maintain appropriate physician and mid-level provider coverage in the Emergency Services area. This shall be in accordance with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians and nurse practitioners, who render emergency care. All personnel serving patients within the Emergency Services area shall comply with the Baptist Health Deaconess, LLC. Emergency Medical Treatment and Labor Act (EMTALA) Policy.

3. An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's permanent hospital record.

4. Each patient's medical record shall be signed by the practitioner providing care for the patient who is responsible for its clinical accuracy.

5. Baptist Health Deaconess Madisonville Inc.'s Emergency Department shall provide upon request to an individual, regardless of eligibility for Medicare/Medicaid benefits, an appropriate medical screening examination, within the capabilities of the hospital's Emergency Department, including ancillary services routinely available to the Emergency Department, to determine whether or not an emergency medical condition exists. Appropriately licensed and credentialed physicians and allied health practitioners, subject to appropriate physician supervision (if supervision is required pursuant to the Bylaws and applicable policies) and established protocols, are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition. Said examination and OB Emergency Medical Treatment and Labor Act (EMTALA) Score Sheet for obstetrical patients over 20 weeks gestation who present with pregnancy related complaints may be performed by Obstetrical Registered Nurses who have one or more years' experience and an RN in an OB department of this or another licensed hospital and who has been deemed competent by the Department of Obstetrics.

Inquiries about the individual's method of payment or insurance shall not delay the medical screening examination.

If an individual has an emergency medical condition, the hospital shall either provide for further examination and treatment (within it capabilities) to stabilize the patient or make an appropriate transfer of the patient to another medical facility, unless the treatment or

transfer is refused. All reasonable steps shall be taken to secure such refusal of treatment or transfer by written informed consent.

6. A physician on call for the emergency room will respond for acute emergency conditions in 30 minutes if at all possible and in 15 minutes if at all possible for acute emergency trauma.

Non-Compliance with the physician response time, transfers in and out of the facility will be reported to the Intake Registry**.** Appropriateness of physician response will be determined by the Medical Executive Committee after consultation with the department chairman.

SECTION E. Medical Record Documentation

1. Entries in the electronic medical record should only be documented by practitioners and allied health practitioners who have been granted medical staff privileges at the Hospital as specified in the Hospital and Medical Staff policies, approved by the Medical Executive Committee and President. All services rendered to individuals who are evaluated or treated as a patient of the Hospital shall be documented in the electronic medical record. Each practitioner and allied health practitioner rendering services on behalf of the patient is responsible for timely documentation in the electronic medical record.
2. All entries in the electronic medical record should be authenticated with electronic signature including date and time. Paper documentation should be authenticated with physician name, date and time.
3. Late entry or back charting of documentation, the practitioner or allied health practitioner can correctly document the date of service the information, procedure or clinical care was provided. When the practitioner or allied health practitioner authenticates the late entry, the current date and time will be recorded on the signature stamp which correctly reflects when entry was documented. All late entries shall be documented in accordance with the Baptist Health Deaconess, LLC. late Entry to the Medical Record in the Acute Care Setting Policy.
4. All practitioners and allied health practitioners with hospital privileges have access to the electronic health record. It is each practitioner's and allied health practitioner's responsibility to ensure the login and password remain confidential and that at no time this information is shared with other individuals.
5. When members of the house staff and other specified professional personnel including allied health practitioners are involved in patient care, sufficient evidence should be documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by the responsible practitioner. All clinical entries should be accurately dated, timed and authenticated.
6. Symbols and abbreviations should be documented only when they have been approved by the appropriate committees and in accordance with the Hospital Wide

Dangerous Abbreviations Policy and System-Wide Abbreviations in the Medical Record Policy

7. Record Content

The legal medical record shall contain those documents set forth in the Baptist Health Deaconess, LLC. Legal Medical Record Policy

Identification Data shall include:

- Patient's name
- Address
- Date of birth
- Age
- Sex, to the extent available
- Marital status, to the extent available
- Dates and times of admission and discharge
- Full name of physician
- Name and address of nearest relative or person or agency responsible for patient and occupation of responsible party
- Name, address and telephone number of person(s) to notify in case of emergency
- Medical record number
- General consent for medical treatment and care

An adequate medical record shall be maintained for every individual who is evaluated or treated as an inpatient, outpatient, observation patient or emergency patient, or who received patient services in a Hospital hospice program. The admitting practitioner unless the practitioner formally transfers the patient to another practitioner, shall be responsible for the timely preparation of a complete and legible medical record for each patient. The medical record contents shall be pertinent and current and each entry must be dated and authenticated. All medical records shall include the following:

All inpatient, observation and surgical outpatient medical records shall include at least the following:

8. Clinical Reports

All clinical reports shall be a comprehensive document and contain all required elements. All information must be documented in the report. Note: The practice of referring to other documents within the electronic medical record is not acceptable.

- An admission progress note outlining the provisional diagnosis shall be

documented at the time of admission.

- A pertinent history and physical (H & P) will be performed and documented prior to any planned admission or procedure.
- A History & Physical (H&P) must also be completed within 24 hours of an unscheduled admission. An H & P completed no more than 30 days prior to the current admission or procedure may be used. However, it must be amended/updated to reflect any change, or lack thereof, in the patient' current status within 24 hours of admission or prior to a procedure. H & Ps done greater than 30 days prior to the admission or procedure are not valid and a new H & P is required. An H & P or addendum must document changes in the patient' status, including complaint, present illness and emotional, behavioral and social status. If there are no changes, this is specifically noted on the update addendum or directly on the H & P. The notation confirms that the patient was examined and reassessed, no significant changes were noted, the necessity for the procedure or care is still present and the H & P is still current. Changes in patient status and notes specifying no change must be dated and signed by the practitioner. If the H & P or the update addendum is done the same day as the procedure, the document must be dated, timed, and signed prior to the procedure. When the H & P examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the operation or procedure shall be cancelled unless the attending practitioner states in writing that such a delay would be detrimental to the patient.

History and Physical report includes the following elements. The following items contained in the list below may be missing from the History and Physical report for good and legitimate reasons described by the practitioner:

- History of Present Illness (Chief Complaint, Reason for Visit)
- Review of Systems
- Allergies
- Medications (Current, Home, Prior to Admission)
- Past Medical and Surgical History
- Family History (appropriate, assessment of the patient's emotional and behavioral status)
- Social History
- Physical Exam (objective) with physical findings prior or current diagnostic test results, general multisystem exam, diagnostic procedures ordered
- Assessments, Clinical Impressions or Conclusions
- Planned Course of Action or Treatment Plan
- For surgical patients or those requiring sedation, indications for the procedure and the proposed procedure must be documented

Children and adolescents, additional History &Physical elements required.

The following items contained in the list below may be missing from the History and Physical report for good and legitimate reasons described by the practitioner:

- Evaluation of the patient's developmental age
- Consideration of educational needs and daily activities
- Immunizations
- Family's and/or guardian's expectation for and involvement in the assessment, treatment, and continuous care of the patient.

Obstetrical, additional History & Physical elements required:

- Prenatal information; office or clinical prenatal record

Operative reports shall be documented immediately following surgery. A post-operative note shall be immediately documented when physician is unable to complete the comprehensive operative report.

Operative or procedure notes include the following. The following items contained in the list below may be missing from the operative report or note for good and legitimate reasons described by the practitioner:

- Pre-operative diagnosis
- Post-operative diagnosis
- Procedure performed
- Name of Surgeon
- Name of Assistant(s)
- Type of Anesthesia
- Estimated Blood Loss
- Complications
- Specimens Removed
- Implants
- Findings
- Indications
- Size of lesions or mass removed
- Description of procedure

Discharge summaries should be completed on any patient. The discharge summary should be documented at time of discharge. Patients leaving Against Medical Advice (AMA) require a discharge summary.

9. Discharge Summary or Death Summary includes:

- Principal Diagnosis (Final diagnosis)
- Secondary Diagnosis (additional or associated diagnosis)
- Procedures Performed
- Hospital Course

- Significant Findings
- Medical or Surgical Treatment Rendered
- Patient Condition on Discharge
- Discharge Instructions
    a. Medications, at discharge
    b. Physical activity
    c. Diet
    d. Follow up care
    e. Referrals to other providers

10. Emergency Services

Emergency services documentation should be completed on every patient receiving emergency service. Patients with a stay greater than 24 hours require a daily progress note.

Emergency Department/ED Practitioner/Allied Health Practitioner Note include:

- Patient Identification
- Time of patient's arrival
- Transportation mode (walk, car, ambulance, police, etc.)
- History of present illness including treatment prior to arrival
- Review of Systems
- Past Medical and Surgical History
- Social History
- Allergies
- Physical Exam
- ED Procedures
- Description of clinical, laboratory and radiological findings
- Medical or Surgical Treatment Rendered
- Final diagnosis
- Patient condition on discharge
- Final disposition
- Completed EMTALA transfer form to the extent patient is transferred to another facility.

11. Diagnostic and Therapeutic Orders

1. These orders shall be documented by practitioners and allied health practitioners within the authority of their clinical privileges.
2. Verbal/Telephone/Standard protocol orders of practitioners should be limited and shall only be accepted by authorized personnel as specified elsewhere in the Rules and Regulations.
3. Verbal/Telephone/Standard protocol orders should be authenticated by the responsible practitioner as soon as possible or in the event the patient was

discharge prior to authenticated, within 15 days of the patient's discharge date.

4. Protocol orders shall be authenticated by the practitioner.

12. Evidence of Informed Consent

1. The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. This information should include the identity of the patient, date, procedure, or treatment to be rendered, the name or names of the individual or individuals who will perform the procedure or administer the treatment, authorization for anesthesia if indicated, an indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient, and authorization for disposition of any tissue or body parts as indicated. The signature of the patient or other individual empowered to give consent should be witnessed.
2. The practitioner with clinical privileges who informs the patient and obtained the consent shall be identified and document the consent in the medical record.
3. Informed consent for PICC line insertion may be performed by individuals who are authorized to perform the procedure including but not limited to physicians, nurses, radiology technologists and radiology practitioner assistants.

13. Clinical Observations

1. Progress notes documented by the practitioner should give a pertinent chronological report of the patient's course in the Hospital and should reflect any changes in condition and the results of treatment.
2. Progress notes shall be documented at least daily on all patients.
3. Admitting progress note and/or history & physical report will be considered the progress note on the admission date. On date of discharge, the discharge summary may be used as the final progress note.
4. Each consultation report should contain a documented opinion by the consultant that reflects, where appropriate, an actual examination of the patient and the patient's medical condition. The requesting physician will provide the reason for the consultation, the required time frame in which the consultation is to be completed and any other pertinent information regarding the patient’s acuity.
5. When operative procedures are involved, the consultation note should be documented prior to the operation, except in emergency situations.
6. Opinions requiring medical judgment should be documented and authenticated only by practitioners.
7. Individuals outside the credentialed practitioners and allied health practitioners who may document entries in the progress notes may be determined as an exception to normal process, from time to time, by the Medical Executive Committee.
8. The responsible practitioner treating and diagnosing oncology patients should document the American Joint Committee of Cancer (AJCC) stage of Oncology patients.

14. Anesthesia

1. The pre-anesthesia record should include the patient's pertinent past and current medication history, other anesthetic experiences and any potential anesthetic problems. The documentation should reflect which practitioner or Independent AHP was responsible for the patient's release from the post-anesthesia area. Post-anesthesia visits shall be documented with the date and time. There shall be a postoperative anesthesia note documented after complete recovery from the anesthesia by a practitioner or designee. When it is not feasible for anesthesia personnel to document the post- anesthesia note, the practitioner who discharges the patient shall document the anesthesia personnel's entry.
2. Post-anesthesia care information should include the patient's level of consciousness on entering and leaving the unit; vital signs; and, where appropriate, the status of infusions, surgical dressings, tubes, catheters, and drains. Similar information should be documented whose post-anesthesia recovery is accomplished in other than a special care unit.
3. The responsible practitioner and, if appropriate, the Independent AHP should document and authenticate a preoperative diagnosis prior to surgery with pertinent information relative to the choice of anesthesia and the surgical or obstetrical procedure anticipated. Except in emergency, this should be documented before preoperative medication has been given.

15. Psychiatric Admissions

1. Admitting documentation shall specify the need or use of special treatment.
2. Restraint or seclusion: a practitioner's or allied health practitioner's verbal or CPOE time-limited order is obtained for each use of restraint or seclusion. The time within which the order should be obtained after each use of restraint or seclusion and the maximum time for use of either intervention are established in hospital policy.
3. Multi-disciplinary treatment plans are developed for all patients. There must be a documented policy that addresses these plans and their execution.

16. Outpatient Treatment

1. Documentation should contain a description of significant clinical, laboratory, and radiological findings, diagnosis and treatment given, the condition of the patient on discharge or transfer, and final disposition, including instructions given to the patient and/or patient representative, relative to necessary follow-up care.
2. Outpatient diagnostic orders can be received both in paper form from non-Baptist Health Deaconess Madisonville, Inc. practitioners or electronic form from Baptist Health Deaconess Madisonville, Inc. practitioners. All orders must be authenticated with name, date and time.

17. Medical Record Completion

1. All entries in the medical record, including dictation, orders, notes and signatures must be completed within 15 days of discharge, date of service or completion of therapy. (Reference: Provider Suspension Policy for Delinquent Medical Records or such other policy adopted by the medical staff from time to time.)
2. Deficiencies not completed within 15 days of discharge will result in a process for informing practitioners of pending suspension and suspension of privileges.
3. A medical record should not be permanently filed until it is completed by the responsible practitioner or is ordered filed as incomplete by the HIM/Medical Record Committee.
4. Written consent of the patient, court order or subpoena is required for release of medical information to persons not otherwise authorized to receive this information.
5. Members of a practice group, i.e., partnership, professional association, limited liability company, or similar organization, are authorized to sign all necessary signatures of the medical record in the absence of another member of the practice group.
6. Resignation from the Medical Staff will not be accepted as being in good standing if the practitioner or allied health practitioner has incomplete medical records. The resigning practitioner's or allied health practitioner's incomplete medical records will be referred to the Medical Executive Committee and President.

Suspension Process – Refer to Provider Suspension Policy for Delinquent Medical Records or such other policy adopted by the medical staff from time to time.

18. Medical Record Access

1. Readmission of a patient, previous medical records should be available in the electronic medical record for continuity of care for the attending practitioner.
2. Access to all medical records of all patients should be afforded to members of the medical staff in good standing for bona fide study and research consistent with any required consents or authorizations preserving the confidentiality of personal information concerning the individual patients.
3. Subject to the discretion of the President, former members of the medical staff should be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Primary means of access should be through the Release of Information process with authorization provided by patient.

19. Medical Records, Video and Computerized Recording Removal

1. All paper medical records, videotapes, computer disks, optical disks, photographs or any other original memorialization of the patient's care are the property of the hospital. These records may only be removed from the possession and control of the hospital with specific written permission of the President and a subpoena.
2. Unauthorized removal of paper medical records, original videotapes, computer disks, optical disks, photographs or any other original memorialization of the patient's care from the hospital is grounds for suspension of the practitioner.

SECTION F. Miscellaneous

1. Treatment protocols shall be formulated or changed by conference between the involved portion of the Medical Staff and the hospital operations and clinical staff. They may be effective only after their approval by the Pharmacy and Therapeutics Committee as delegated by the Medical Executive Committee. Reference: Order Sets, Standing Protocols and Protocols Policy, Development and Maintenance of Policies and Procedures.

2. Laboratories shall be provided in the Hospital to insure as complete a service as possible. Examinations which cannot be made in the Hospital shall be referred to an outside laboratory approved by the Chief Hospital Pathologist and BHS or designee. Laboratory examinations of patients made in laboratories outside the hospital will be accepted in lieu of such being by the hospital laboratory if these examination results are current (have been completed within seventy-two hours), are available at the time of admission, and if the work was done in a laboratory of comparable standards, approved by the Chief Hospital Pathologist.

3. Clinical information is required on all requisitions for all inpatient and outpatient procedures.

SECTION G. Amendments

The Rules and Regulations of the Medical Staff of Baptist Health Deaconess Madisonville, Inc. may be amended from time to time through the following procedure:

1. Any proposed amendment shall be submitted in writing to the Medical Executive Committee by a member or members of the Medical Staff, who shall recommend the adoption of the proposed amendment by affixing their signature or signatures thereto.

2. The Medical Executive Committee may request assistance, including comments and recommendations, from any other standing or special committee of the Medical Staff, Administration or Legal Counsel.

3. The proposed amendment, together with the recommendations of the Medical Executive Committee, any other recommendations or comments of other committees, members of the staff, legal counsel or administration, shall be submitted to the next regular meeting of the Medical Staff at least seven days following submission of the proposed amendment to the Medical Executive Committee. It may then be adopted by the Medical Staff by a two-thirds (2/3) affirmative vote of the members of the Medical Staff present at such meeting provided that a quorum of the Medical Staff is present at such meeting.

4. The Medical Staff shall certify the adoption of the proposed amendment in writing to the Board of Directors of Baptist Health Deaconess Madisonville, Inc., together with their recommendations that the proposed amendment be approved by the Board of Directors.

5. Upon approval by the Board of Directors, the proposed amendment shall become effective immediately. In the event the Board of Directors declines to approve such proposed amendment, the Medical Executive Committee shall be notified of such action. The Governing Body shall not unreasonably withhold approval of the rules and regulations of the Medical Staff.

6. Following approval by the Board of Directors, information regarding amendments to the Rules and Regulations will be made available to all members of the Medical Staff and other concerned individuals.