SECTION 1 ADMINISTRATIVE PROCEDURES

1.1 Meetings of the Medical Staff:

1.1-1 Shall be held quarterly on the second Monday of the month; and

1.1-2 Shall constitute a review and evaluation of clinical performance from committees and service reports of the Staff.

1.2 Orders:

1.2-1 Standing and Routine Orders

Standing and Routine orders shall be formulated between departments, Active Staff Members and the Administrator/Chief Executive Officer. They can be changed only by mutual consent of the departments and the latter shall notify all personnel concerned. These orders shall be reproduced in detail on the order sheet of each applicable patient's record, dated and signed by the attending physician.

1.2-2 Diagnostic and Therapeutic Orders

Diagnostic and Therapeutic orders shall be in writing, dated, timed and signed by Active, Active Emergency Department, Courtesy, Consulting and Health Professional Affiliate Staff Members.

1.2-3 Verbal orders

Verbal orders shall be accepted and transcribed by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Pharmacist; Physical Therapist (PT); Speech Therapist; Registered, Licensed and/or Certified Imaging Personnel; Registered, Licensed and/or Certified Laboratory Personnel; and Registered, Licensed and/or Certified Licensed Respiratory Personnel, as dictated by a licensed independent practitioner. These orders must include the licensed independent practitioner's name, name of the person accepting the orders, date and time the orders were accepted. All verbal orders shall be read back to the licensed independent practitioner. The licensed independent practitioner must countersign all verbal and telephone orders in the electronic health record within forty-eight (48) hours from the time the order was given.

1.2-4 Stop Orders

Stop orders shall be required on narcotics (drugs in Classes, II, III, IV, and V) every 120 hours or five (5) days; antibiotics after 10 days; and anticoagulants after five (5) days. Automatic stop order does not apply when the number of doses or exact period of time is specified by the prescriber.

1.2-5 Order Renewals

General drug orders do not need to be renewed by the physician for the duration of the patient's length of stay.

1.2-6 Automatic Cancellation of Orders

(a) Standing drug orders shall be automatically canceled when a patient undergoes surgery, invasive procedure, or conscious sedation; and

(b) All drug orders are automatically canceled upon admission to and/or discharge from ICU.

1.2-7 Questioning Physician's Orders

(a) A nurse is legally liable for any medication or treatment which he or she administers;

(b) Questioning a medical order must be done in a professional manner and through proper channels;

1. Before questioning an order, enough personal experience or research should have been accumulated and be available to substantiate the controversy;

2. Double-check with the physician who wrote the order;

3. Notify the Head Nurse or Supervisor of the situation;

4. If necessary, the Head Nurse or Supervisor will contact the Chief Nursing Officer or Chief of Staff;

5. All actions and explanations must be recorded in the nurses' notes.

(c) Problems related to incompatibilities of drugs should be referred to the Pharmacist by the Head Nurse or Supervisor. The Pharmacist and Head Nurse or Supervisor will confer with the physician.

1.2-8 Withholding or Withdrawal of Life-Prolonging Procedures

It is widely recognized that in some clinical situations the initiation or continuation of life-prolonging interventions is inappropriate. This policy covers only the issues surrounding the question of whether or not to withhold or withdraw life-prolonging interventions as hereinafter defined. Further, this policy does not address the question of whether or not to initiate cardiopulmonary resuscitation through a "do not resuscitate" (DNR) order.

(a) Definitions

1. **Death** – The announced determination of the attending physician and an independent consulting physician who has personally examined the patient, which determination is made in accordance with reasonable medical standards and the hospital's policy on determination of brain death, that the patient has sustained irreversible cessation of all functioning of the brain.

2. **Incapacity** – The inability, because of physical or mental impairment, to appreciate the nature and implication of a health care decision, to make an informed choice regarding the alternatives presented, and to communicate that choice in an unambiguous manner.

3. **Life-Prolonging Interventions** – Any medical procedure or interventions which, in the judgment of the attending physician and second physician, when applied to a patient with a terminal condition, or in a persistent vegetative state, would serve only to artificially prolong the dying process or to maintain the person in a persistent vegetative state.

4. **Terminal Condition** – An incurable condition caused by injury, disease or illness, which, regardless of the application of life-prolonging interventions would within reasonable medical judgment, cause natural death and would result in death within a relatively short time.

5. **Persistent Vegetative State** – A permanent and irreversible state as diagnosed by the attending physician and a second physician in which the person has intact brain stem function but no higher cortical function and has neither self-awareness or awareness of the surroundings in a learned manner.

6. **Family** – The patient's immediate family, which includes spouse, children and those family members actively participating in the care of the patient.

(b) Presumption in Favor of Sustaining Life

When patients' wishes are not otherwise known, it is a standing order of the Hospital, unless otherwise indicated as hereinafter stated, to attempt to sustain life by all reasonably available means. In order to countermand this standing order, a written order must be entered withholding or withdrawing life-prolonging interventions.

(c) Medical Condition Justifying Withholding or Withdrawal of Life-Prolonging Procedures

An order to withhold or withdraw life-prolonging interventions is appropriately recommended when:

1. death as defined herein has occurred; or

2. the attending physician and a consulting physician who has personally examined the patient and who is not associated with the attending physician have both certified, in writing, that the patient suffers from a terminal condition or persistent vegetative state, as herein defined, and that withholding or withdrawal of life-prolonging interventions is medically appropriate.

(d) Ethics Committee

Any physician, employee, patient and/or patient's family member may refer potential issues of a medical ethical nature involving withholding or withdrawal of life-prolonging interventions to any member of the Ethics Committee of the Medical Staff. The committee shall decide whether to review a specific case after discussion with the attending physician. The recommendation of the committee shall be made to the attending physician and shall be advisory and supportive in nature, not binding or final.

(e) Informed Consent of Capable Patient

In the case of a capable patient, if the attending physician and the consulting physician determine that withholding or withdrawal of life-prolonging interventions is medically appropriate, the attending physician shall explain the basis for and the consequences of withholding or withdrawal of such interventions to the patient and the patient's informed consent shall be obtained before implementation of such order. The attending physician shall then indicate on the patient's medical record all such discussions, including the fact that the patient's consent was obtained and the method by which such consent was obtained.

(f) Consent on Behalf of an Incapacitated Patient

1. **Living Will.** In the case of an incapacitated patient who has executed a living will in conformance with the West Virginia Natural Death Act, WV Code §§ 16-30-1, et seq., and who is in a persistent vegetative state or has a terminal condition, two determinations shall be documented in the patient's medical record before entering an order withholding or withdrawing life-prolonging intervention. First, the attending physician and one other physician or one licensed psychologist who has personally examined the patient shall certify in writing that the patient is incapacitated. Second, the attending physician and a consulting physician shall certify in writing that the patient suffers from a terminal condition or persistent vegetative state and that withholding or withdrawal of life-prolonging intervention offers no hope of medical benefit. Revisions to the West Virginia Natural Death Act, WV Code §§ 16-30-4 in June 2000, require only one physician's determination to be documented in the patient's medical

record before entering an order withholding or withdrawing life-prolonging intervention.

Once confirmation, written certification and documentation of the declarant's terminal condition is made, the attending physician shall verbally or in writing inform the patient or the patient's health care representative, next of kin or other responsible person of his or her terminal condition, if the patient lacks capacity to comprehend such information. The attending physician shall also document such communication in the patient's medical record.

2. **Medical Power of Attorney.** In the case of an incapacitated patient who has executed a medical power of attorney in conformance with the West Virginia Natural Death Act, W.Va. Code §§ 16-30-1, et seq., and who is in a persistent vegetative state or has a terminal condition, several determinations (as specified below) and informed consent shall be documented in the patient's medical record before entering an order withholding or withdrawing life prolonging intervention. First, the attending physician and one other physician or one licensed psychologist who has personally examined the patient shall certify in writing that the patient is incapacitated. Second, the attending physician and a consulting physician shall certify in writing that the patient suffers from a terminal condition or persistent vegetative state and that withholding or withdrawal of life-prolonging intervention is medically appropriate. Once confirmation, written certification and documentation of the declarant's terminal condition is made, the attending physician shall verbally or in writing inform the patient or the patient's health care representative, next of kin or other responsible person of his or her terminal condition, if the patient lacks capacity to comprehend such information. The attending physician shall also document such communication in the patient's medical record. Finally, the attending physician shall examine the medical power of attorney to determine whether the representative has been denied the authority to consent to the contemplated withdrawal of treatment. If authority to consent to the withdrawal has not been excluded, the attending physician shall obtain informed consent from the holder of the patient's medical power of attorney, and shall document the consent.

Revisions to the West Virginia Natural Death Act, WV Code §§ 16-30-4 in June 2000, require only one physician's determination to be documented in the patient's medical record before entering an order withholding or withdrawing life-prolonging intervention.

3. **Committee or Guardian.** In the case of an incapacitated person who has a committee or guardian and is in a persistent vegetative state or has a terminal condition, two determinations and informed consent shall be documented in the patient's medical records before entering an order withholding or withdrawing life-prolonging intervention. First, the attending physician and one other physician or one licensed psychologist who has personally examined the patient shall certify in writing that the patient is incapacitated. Second, the attending physician and a consulting physician shall certify in writing that the patient suffers from a terminal condition or persistent vegetative state and that withholding or withdrawal of life-prolonging intervention is medically appropriate. Once confirmation, written certification and documentation of the declarant's terminal condition is made, the attending physician shall verbally or in writing inform the patient's committee or guardian (as the case may be) [and the patient

himself, despite the incapacity, if the patient is conscious and has any capacity to comprehend language.] The attending physician shall also document such communication in the patient's medical record. Third, the attending physician shall examine the appropriate documents to determine whether the committee or guardian has authority to make the health care decision at issue and finally, the attending physician shall obtain informed consent from the patient's committee or guardian and document the consent.

4. **Incapacitated Patient Who Does Not Have a Living Will, Medical Power of Attorney, Committee or Guardian.** In the case of an incapacitated patient who does not have a living will, medical power of attorney, committee or guardian, or in the case of a patient who has a representative under a medical power of attorney but the representative(s) is (are) unable or unwilling to serve, then the attending physician shall appoint a health care surrogate pursuant to W.Va. Code § 16-30-B-1, et seq. and in accordance with the Hospital's Health Care Surrogate policy, before entering an order to withhold or withdraw life-prolonging intervention. The patient's attending physician and one other physician or one licensed psychologist must personally examine the patient, concur in the determination that the patient is incapacitated, and contemporaneously document in the patient's medical record the basis for the determination of the patient's incapacity, including the cause, nature, and expected duration of the patient's incapacity, if these are known.

   Next, if the patient is conscious, the attending physician shall inform the patient that he or she has been determined to be incapacitated and that a surrogate decision-maker may be making decisions regarding life-prolonging intervention for the patient. Any evidence of the patient's objection to the determination of incapacity shall be noted in the patient's medical records.

   Finally, the attending physician shall obtain informed consent from the patient's surrogate and document the consent. No order (based on surrogate consent) withdrawing life sustaining intervention shall be entered if the physician or Hospital has actual notice that the withdrawal would be in contravention of the wishes of the patient expressed in a medical power of attorney or living will, or the known religious beliefs of the patient. Before the order may be entered there must have been a reasonable inquiry as to whether there is available a representative under a valid medical power of attorney and as to whether there is any other applicable advance directive. Further, the order will not be acted on, if the Hospital has actual notice of opposition to the decision by a person in the same or higher classification (under W.Va. Code § 16-30B-7 (a) as the designated surrogate. In the case of notice of such opposition, the medical ethics committee and legal counsel shall be consulted prior to implementation of the order.

(g) Formal Order; Discussion with Staff; Review

Once the decision to implement an order to withhold or withdraw life-prolonging interventions is made pursuant to the interventions described above, the attending physician shall write a formal order in the patient's medical record (any designation/abbreviation should be specified and uniformly used). Oral orders to withhold or withdraw life-prolonging interventions will not be implemented. Unless there is a written order to withhold or withdraw life-prolonging interventions in the patient's medical record, all reasonably available life-prolonging interventions will

continue to be undertaken pursuant to the hospital's standing order as described above. Upon entry of the order to withhold or withdraw life-prolonging procedures, the attending physician shall discuss the order and its meaning with appropriate members of the Hospital staff to insure that the decision is implemented as intended. Further, the order shall be reviewed as deemed appropriate by all concerned parties, including the attending physician, and may be rescinded at any time.

1.2-9 Brain Death

(a) Purpose

The term brain death refers to irreversible cessation of the functions of the entire brain. This includes higher mental activities, cephalic reflex activities, and autonomic activities. The brain dead patient is comatose and respirator dependent with cerebral unresponsiveness. Brain stem reflexes will be absent, but spinal reflexes may persist in the brain dead patient. Central nervous system depressants such as hypothermia, shock, and drug or metabolic intoxication must be excluded. Specific criteria for determination of brain death may be set by the Hospital. Whenever possible, the physician should determine the apparent cause of brain death. If the cause is not apparent, studies such as EEG, CT, nuclear brain blood flow studies or angiography will often clarify the diagnosis. Utilization of such confirmatory tests makes it possible to shorten the period of observation and improve recovery of organs from brain dead donors with intact circulation.

(b) West Virginia Brain Death Law

The Uniform Brain Death Act of West Virginia, titled 16-20-2, Brain Death, states "for legal medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain is dead." A determination under this section must be made in accordance with reasonable medical standards (1980, c.58). Potential cadaveric organ donors must meet brain death criteria.

(c) Determination of Brain Death

The specific procedures to be followed shall be those set forth from time to time as a formal hospital policy on brain death.

(d) Organ Procurement

Procurement of organs and tissues for transplantation shall occur in accordance with the Hospital's Organ, Tissue, Eye Donation Policy and Procedure.

1.2-10 <u>DNR Orders</u>

Guidelines - DNR Orders – It is widely recognized that in some clinical situations the initiation of life-prolonging interventions is inappropriate. This policy covers only the issues surrounding the question of whether or not to initiate cardiopulmonary resuscitation (CPR) when the patient experiences an acute cardiac or respiratory arrest and does not address other instances involving the withholding or withdrawal of medical treatment.

(a) Definitions

1. **DNR Order** – Do Not Resuscitate order indicating that in the event of acute cardiac or respiratory arrest, cardiopulmonary resuscitation will not be initiated.
2. **Family** – The patient's immediate family, which includes spouse, children and those family members actively participating in the care of the patient.

(b) Standing Orders to Resuscitate

It is a standing order of the Hospital that, unless otherwise indicated as hereinafter stated, if acute cardiac or respiratory arrest occurs in a patient during an admission and the desires of the patient are unknown, full resuscitation measures will be

taken. The known desires of the patient are paramount and shall be followed. If the desires of the patient are unknown, a good faith effort shall be undertaken to determine the desires of the patient and documented.

(c) Medical Condition Justifying DNR Order

DNR orders are appropriately recommended when the patient suffers from a known terminal condition or persistent vegetative state meaning an incurable condition caused by injury, disease or illness, which regardless of the application of CPR would, within reasonable medical judgment, cause natural death and where the application of CPR serves only to postpone the moment of death. A DNR order is compatible with maximal therapeutic care. The patient may be receiving vigorous support in all other therapeutic modalities and yet justifiably be considered a proper subject for the DNR order. An appropriate knowledge of the patient's medical condition is necessary before consideration of a DNR order. A consulting physician may be used at the discretion of the attending physician.

(d) Ethics Committee

Any physician, employee, patient and/or patient family member may refer potential issues of a medical ethical nature involving DNR orders to any member of the Ethics Committee of the Medical Staff. The Committee shall decide whether to review a specific case after discussion with the attending physician. The recommendation of the Committee shall be made to the attending physician and shall be advisory and supportive in nature, not binding or final.

(e) Informed Consent of Capable Patient

In the case of a capable patient, if the attending physician determines that a DNR order is medically appropriate, the attending physician shall explain the basis for and consequences of a DNR order to the patient and the patient's informed consent shall be obtained before implementation of the order. The attending physician shall then indicate on the patient's record all such discussions, including the fact that the patient's consent was obtained and the method by which such consent was obtained.

(f) Consent on Behalf of the Incapable Patient

In the case of an incapable patient, in the event the attending physician certifies, in writing, that the patient suffers from a terminal condition and that the DNR order is medically appropriate, and the patient has previously, while capable, executed a declaration in conformance with the West Virginia Natural Death Act, W. Va. Code 16-30-1 et seq. (1984), requesting the withholding of life-sustaining procedures such as CPR, a DNR order may be entered after the attending physician has explained the basis for and consequences of a DNR order to the patient's immediate family and, if appointed, legal guardian. In addition, in the case of an incapable patient who has previously, while capable, executed a declaration in conformance with the West Virginia Durable Power of Attorney Act, W. Va. Code 16-30A-1, et seq. (1990), and the named representative has requested on behalf of the incapable patient the withholding of life-sustaining procedures, an order withholding or withdrawing such procedures may be entered after the attending physician has explained the basis for and consequences of such an order to the patient's family and, if appointed, legal guardian. If the patient has not previously executed such a declaration in proper form, the physician shall obtain the informed consent of all immediate family members and, if appointed, a legal guardian of the patient before entering a DNR order. The attending physician shall then indicate on the patient's medical record all such discussions and, if all immediate family members and, if appointed, the guardian consent to order, the fact that such consent was obtained and the method by which consent was obtained. If there is any disagreement by the consulting physician, an immediate

family member or, if appointed, the legal guardian of the patient, no DNR order may be implemented and the matter shall be referred to the Ethics Committee for review and recommendation, provided that the patient's immediate family members and, if appointed, legal guardian consent to such review. If any immediate family member or legal guardian, if appointed, continues to disagree with the recommendation of the Ethics Committee, no DNR order may be implemented. If the attending physician disagrees with the determination of the Ethics Committee or if a consulting physician or any immediate family member or guardian, if appointed, continues to disagree with the attending physician's determination, the attending physician may ask the family to obtain a new attending physician and resign from the case.

(g) Formal Order, Discussion with Staff, Review

Once the decision to implement a DNR order is made pursuant to the procedures described above, the attending physician shall write a formal DNR order in the patient's medical record using the designation "DNR". Oral DNR orders will not be implemented, except that telephone orders may be taken if witnessed by one RN and another member of the nursing staff and countersigned within 24 hours. Unless there is a written DNR order in the patient's record, CPR shall automatically take place in the event of cardiac or respiratory arrest pursuant to the hospital's standing order as described hereinabove. Upon entry of the DNR order, the attending physician shall discuss the order and its meaning with the appropriate members of the medical staff to insure that the decision is implemented as intended. Further, the DNR order shall be reviewed as deemed appropriate by all concerned parties, including the attending physician, and may be rescinded at any time.

1.3 Drugs

1.3-1 Drugs shall meet the standards of the U.S. Pharmacopoeia Dispensing Information (USPDI) handbook.

1.3-2 The prescriber shall be licensed by federal authority to dispense narcotics in the State of West Virginia.

1.4 Consultations

1.4-1 Responsibility

Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment of a patient is the responsibility of the attending physician. However, it is the duty of the organized Staff through the Department Chairperson of the service that those with clinical privileges do not fail in calling Consultants as needed.

The attending physician shall make the request for consultation by written or verbal order and it is recommended that the attending physician specify the reason for the consult. It is highly recommended in an emergency situation that the attending contact the consulting physician. In non-emergent situations, nursing personnel may notify the consulting physician of the consult.

1.4-2 Required Consultation Shall Occur Under the Following Circumstances:

Except when consultation is precluded by emergency circumstances or is otherwise not indicated, the attending practitioner shall consult with another qualified medical staff member in the following cases:

1. When diagnosis is obscure after ordinary diagnostic procedures have been completed;

2. When there is doubt as to the choice of therapeutic measures to be used;

3. For high risk patients undergoing major operative procedures;

4. In situations where specific skills of other physicians may be needed; or

5. When otherwise required by the medical staff or hospital policies.

1.4-3 Consultant

The Consultant must be qualified to give an opinion in the field in which his opinion is sought. The status of the Consultant is determined by the Staff on the basis of the individual training, experience and competence.

1.4-4 Essentials of a Consultation

A satisfactory consultation is based on an examination of the patient and his record. A written opinion by the Consultant shall be included in the patient record within twenty-four (24) hours. When surgical procedures are involved, except in an emergency, the consultation note shall be recorded prior to surgery.

1.4-5 Time Limits

Routine consultation requests should be seen within twenty-four hours (24), if the consultant is available, unless prior arrangements have been made between the two physicians involved. Emergency consultation requests should be seen as soon as possible, with arrangements being made between the two physicians involved.

1.5 On Call and Back-up Procedures:

1.5-1 Active Staff Physicians who meet the requirement for established medical or surgical call shall be on an approved on-call schedule. A schedule will be posted in advance in the Emergency Department;

1.5-2 if the physician on call will not be available to take call, he is responsible to obtain a back-up and notify the Emergency Department; and

1.5-3 when a physician is not on call and will not be available, he shall contact the Emergency Department to advise them of his back-up for his patients.

1.5-4 The physician on call is the designated back-up for the Emergency Department.

1.6 Emergency:

An emergency is defined as any condition in which serious permanent harm could result to a patient or in which the life of a patient is in immediate danger and any delay in treatment would add to the danger. In an emergency, a staff member (physician) shall do everything possible to save the patient's life to the degree permitted by his license or clinical privileges.

1.7 Internal and External Disaster Plan:

These plans are developed between the Hospital and the Staff, establishing policies and procedures for the care of casualties and hospital patients. All Active Staff Members shall accept assignment and participate in rehearsal of these plans at least twice a year.

SECTION 2 ADMISSION AND DISCHARGE

2.1 Hospital Policy

The Admissions Office will admit patients on the basis of priority as follows:

2.1-1 The Nursing Supervisor is in complete control of the beds. Staff members do not determine rooms to be assigned.

2.1-2 A general consent form, shall be signed by or on behalf of every patient admitted to the Hospital.

2.2 Medical Staff Responsibility:

2.2-1 All admissions to Stonewall Jackson Memorial Hospital shall be governed by the official admitting policies of the Hospital and shall be made only by members of the Medical Staff in good standing with admitting privileges.

2.2-2 Patients shall be under the care of a member of the Staff who shall be directly responsible for their treatment. Practitioners of the Medical Staff shall be responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure the protection of the patient from self-harm.

2.2-3 For the protection of patients, the medical and nursing staffs and the Hospital, precautions to be taken in the care of potentially suicidal or disruptive patient include: Any patient known or suspected to be suicidal shall be admitted to a private room. The family or responsible person will be required to provide private duty nurses at all times. Otherwise, a responsible adult member of the family must remain with the patient. If no private rooms are available, the patient shall be referred, as soon as possible, to another institution where suitable facilities are available.

2.2-4 Podiatrists with clinical privileges who do not qualify for history and physical privileges, may, with the concurrence of an appropriate physician member of the medical staff, initiate the procedure for admitting a patient. The concurring medical staff member shall assume overall responsibility for the overall aspects of patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the Hospital for podiatric care must be given the same basic medical appraisal as patients admitted for other services.

2.2-5 No patient shall be admitted to the Hospital until a provisional diagnosis has been stated, except in an emergency. In case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission.

2.2-6 Each member of the medical staff shall designate another member of the staff who may be called to attend his patient in any emergency. If no alternate is so designated, any member of the staff may be called if immediate service is required

2.2-7 The attending physician is required to document the need for admission for acute care and the need for continued hospitalization after specific periods of stay as identified by the Integrated Quality Management Committee of this Hospital and approved by the medical staff. Such documentation shall include:

(a) an adequate, written record of the reason for admission for acute care and for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;

(b) the estimated period of time the patient will need to remain in the hospital; and

(c) plans for post-hospital care.

Upon request of the Integrated Quality Management Committee, the attending physician must provide written justification of the necessity for admission for acute care and continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within one working day of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

2.2-8 Patients shall be discharged only on written order of the attending physician or staff member designated to attend his patients during his absence. At the time of discharge, the attending physician shall be responsible for the completion of the medical record (refer to Medical Records, Section 5).

2.2-9 No patient shall be transferred from this facility without being evaluated by the attending physician; provided, however, in the event of an emergency, the evaluation may be conducted by the alternative or other member of the staff designated under 2.2-6 if the attending physician is unavailable and the delay would cause harm to the patient.

SECTION 3 ANCILLARY SUPPORT SERVICES

3.1 Ancillary and support services are identified as Laboratory/Pathology, Rehabilitation Services, Radiology/Nuclear Medicine, and Respiratory Therapy/EKG.

3.2 These services will be staffed by trained, qualified, competent personnel employed by the hospital and will be under the direction of a competent Active Staff Member, appointed by the Chief of Staff, who will serve as Department Chairperson of the service.

SECTION 4 EMERGENCY DEPARTMENT SERVICE

4.1 Emergency Department Service provided by Stonewall Jackson Memorial Hospital is under the direction and responsibility of the Medical Staff.

4.2 The current approved Policies and Procedures for the Emergency Department Service shall govern and be the Medical Staff Rules and Regulations for this service.

4.3 The ED Record for a discharged patient must be completed and signed by the next day. The ED Record for admissions or transfers from the ED must be completed within sixty (60) minutes.

SECTION 5 MEDICAL RECORDS

5.1 The Hospital's Responsibility:

5.1-1 All medical records are the property of the Hospital and shall be maintained in such a manner as to safeguard the records and their content.

5.1-2 There must be written consent of the patient or legally qualified representative for release of medical information to persons not authorized to receive this information. In addition, pursuant to applicable state and federal regulations, specific permission must be granted by the patient or legal representative when the medical information requested involves the result of an HIV test of HIV-related disease or information concerning alcohol or substance abuse or psychiatric disease. Such permission shall be obtained each and every time a request for the above medical conditions is made and shall include the following statement:

For alcohol, or substance abuse records:
This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations.

For medical records containing HIV related information:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise

permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

5.1-3 Records may be removed from the Hospital premises in compliance with state or federal statute or regulations, or by written permission of the Chief Executive Officer. Unauthorized removal of records from the Hospital premises by staff members is grounds for suspension of the staff member for a period to be determined by the Staff.

5.1-4 Medical records containing information regarding alcohol addiction, substance abuse or psychiatric treatment may not be released pursuant to subpoena, but require either the written consent of the patient or an appropriate order from a court of competent jurisdiction. Unauthorized removal of records from the hospital premises by staff members shall constitute grounds for summary suspension of the staff member pursuant to Article VIII, Section 8.2 of the Medical Staff Bylaws.

5.1-5 In case of readmission of a patient, all previous records shall be available for use by the attending staff member.

5.1-6 Staff members shall have free access to medical records for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All studies shall be approved by the officers of the staff.

5.1-7 Subject to the discretion of the Chief Executive Officer, former members of the Staff shall be permitted access to information from the records of their patients covering all periods during which they attended such patients in the hospital.

5.2 Medical Staff Responsibility:

5.2-1 The attending physician shall be responsible for a complete medical record for each patient.

5.2-2 The quality of the record is the responsibility of the attending physician in that all entries and activities made by him are legible, timely, meaningful, accurately timed, dated and signed.

5.2-3 Abbreviations and symbols on the Prohibited (DO NOT USE) Abbreviations list approved by the Integrated Quality Management Committee will not be used when making entries in the medical record. See Appendix A.

5.2-4 All records shall be completed within fourteen (14) days of discharge. If the medical record is incomplete after seven (7) days, the physician is notified accordingly by a deficiency letter from Health Information Management. The physician then has seven (7) days to complete the medical record. If a record remains incomplete after the fourteenth (14^{th}) day, all privileges shall be suspended until the records have been completed, except for patients admitted from the Emergency Department while the physician is on call; no studies that require the suspended physician to perform the study or interpret the study shall be performed, for example, stress tests, reading of echoes, EKGs, vascular studies, consults, etc.; each consecutive week of incomplete charts shall count as another suspension; exceptions include justified reasons for delay listed in Article VIII, Section 8.3-4 of the Bylaws and other exceptions made by the Chief Executive Officer. It shall be the responsibility of the Chief of Medical Staff that notification be given to the physician when privileges to admit have been suspended. The physician shall not be entitled to the procedural rights provided in Article IX of the Bylaws for suspension for medical records in a timely fashion as provided in Article VIII, Section 8.3-6 of the Bylaws. Three suspensions within a twelve (12) month period shall be cause for corrective action pursuant to Article VIII, Section 8.1 of the Medical Staff Bylaws.

5.2-5 An incomplete medical record shall not be filed except by order of the Medical Staff Executive Committee.

5.2-6 Entries and documentation by an attending physician for medical and/or surgical treatment during hospitalization shall include:

(a) provisional diagnosis on admission (except in an emergency then it should be stated as soon as possible);

(b) a complete history and physical within twenty-four (24) hours after admission. Details of requirements for completing a history and physical for inpatient and outpatient settings are found in Appendix B. Outpatient blood transfusions for patients requiring a blood transfusion(s) with a chronic diagnosis need an H&P every ninety (90) days. An interval history may be substituted for a complete history if a patient's readmission for a related illness is within thirty days of discharge;

(c) daily physician contact with the patient either by the attending or his designee in his absence shall be documented in the record;

(d) progress notes at least daily that give a report of the patient's course in the hospital, change in condition and the results of treatment;

(e) a written, signed special informed consent shall be obtained from the patient by the physician, physician assistant or midlevel provider and incorporated in the record prior to:

1. administration of general, spinal or local anesthesia for surgical procedures (See Appendix C);

2. sterilization;

3. blood and blood products transfusions;

(f) a record and authentication of the pre-operative diagnosis prior to surgery;

(g) an operative report should be dictated immediately after surgery giving a description of the findings, technical procedures, specimens removed, post-operative diagnosis and authenticated by the surgeon and filed in the record as soon as possible after surgery;

(h) consultations, when applicable, as stated in Administrative Procedures, Section 1, Item D; and

(i) as appropriate to the age of the patient, a summary of the patient's psychosocial needs.

On discharge the following entries and documentation shall be made:

(j) a discharge summary will be completed and signed within three (3) days of discharge on any patient discharged to home. Any patient transferred, including skilled nursing facility, shall be completed and signed within sixty (60) minutes from departure; and

(k) discharge summary when hospitalized over forty-eight (48) hours or patient expires, a final progress note can be substituted for a discharge summary for an uncomplicated stay of forty-eight hours or less.

In the event of death the following entries and documentation shall be made:

(l) it shall be documented that the patient was examined and pronounced dead by a physician or registered nurse;

(m) the expiration note to be written as the final note on the progress sheet by the physician or the expiration note to be written on the nurses note by the registered nurse in attendance at the time of death, shall include:

1. any intervention on the part of the physician or registered nurse in attendance at the time of death;

2. physical findings leading to ascertainment of death;

3. documentation of interaction with family or responsible party regarding an autopsy;

(n) if patient death determined by registered nurse, the nurse will complete pronouncement section of the death certificate;

(o) a summation statement to be completed by the attending physician; and

(p) the attending physician shall sign the death certificate.

5.2-7 **Entries and documentation by the attending physician in the Obstetrical and Newborn Records:**

Obstetrical Records Shall Include:

(a) a record of prenatal care (except if patient was not previously seen by physician);
(b) completion of obstetrical record;
(c) physician orders dated and authenticated by signature; and
(d) consultations, when applicable (refer to Administrative procedures, Section 1, Item D).

Newborn Records:

(a) complete record of newborn; and
(b) progress notes indicating that infant was examined within twenty-four hours after admission to nursery and examined daily until discharge.

5.2-8 A written, signed consent shall be obtained from the patient by the physician, physician assistant, or midlevel provider and incorporated in the record for any invasive or non-invasive procedures of significant risk, including but not limited to the list in Appendix C.

5.2-9 **Ambulatory/Clinic:**
Appropriate documentation shall be recorded for every patient receiving care in the ambulatory care/clinic setting. Each patient's medical record shall be completed, authenticated, dated, and timed by the attending physician within seven (7) days of the visit.

SECTION 6 OBSTETRICS

The Obstetrical service at Stonewall Jackson Memorial Hospital consists of seven (7) beds in two semi-private rooms, and three LDRP rooms (combined labor, delivery, recovery and postpartum room).

6.1 The current approved Policies and Procedures for the Obstetrical Department shall govern the use of this service.

6.2 Only those patients who qualify by diagnosis according to OB and Infection Control Policies and Procedures may be admitted to the OB service.

6.3 OB patients delivered outside the hospital may be admitted to the OB service but shall not be assigned to a room with a recently delivered patient.

6.4 Physicians must notify the Emergency Department and OB Department when they will not be available and who their back-up will be for their OB patients.

6.5 Except in the event of a premature admission or a patient not previously seen by the attending physician, a prenatal record shall be submitted to the OB Department in her seventh month and updated at thirty-six (36) weeks gestation. Further updates with subsequent office visits are encouraged, but not mandatory.

6.6 The responsibility for the patient in the OB Department (labor, delivery and recovery room) remains solely with the attending physician.

6.7 Patients in labor should be examined within a reasonable period of time after admission by the attending physician.

6.8 The attending physician or certified nurse midwife should either be in the hospital or be readily available when he has a patient in labor.

6.9 No attempt shall be made to delay the delivery by physician means nor deep anesthesia.

6.10 The attending physician shall be required to request consultation as specified in the Administrative Procedures, Section 1.4-2 of these Rules and Regulations.

6.11 As appropriate, post-partum orders may be followed according to each private physician's "routine orders". These should be signed by the physician or certified nurse midwife at the initiation of treatment.

6.12 When the attending physician is not present for delivery, he should see the patient as soon as physically possible after delivery.

6.13 The infant's physician will examine the newborn within twenty-four hours of birth and daily while in the hospital.

6.14 The weight of an infant at discharge does not have to be five (5) pounds if in the physician's judgment, the baby is ready for discharge and with parent(s) who can provide appropriate care and the infant has an office visit scheduled within one week.

6.15 A patient that is a candidate for induction of labor shall have the reason for induction documented (as justified by attending physician) as follows:

(a) inevitable, incomplete or missed abortion;
(b) stimulation or re-enforcement of labor in uterine inertia;
(c) for mild pre-eclampsia or when premature rupture of membranes occur and labor does not ensue normally within twelve (12) hours;
(d) achievement of gradual effacement in responsive cervix when early vaginal delivery (36 weeks or more) is necessary for fetal reasons; and
(e) induction for post-maturity and other medical reasons if presentation is normal and conditions are favorable.

For scheduling an induction, the attending physician must make prior arrangements with the OB service as an elective admission.

6.16 The attending physician or certified nurse midwife shall be responsible for documentation and completion of Obstetrical and Newborn Records as specified in Medical Record, Section 5, of these Rules and Regulations.

SECTION 7 SURGICAL SERVICE

The Surgical Service of Stonewall Jackson Memorial Hospital includes General Surgery, Anesthesia and PACU. To provide this service the Operating Room Suites, Anesthesia and PACU will be staffed by the hospital with trained, competent, qualified personnel whose status, qualifications, responsibilities and duties are specified in the Policies and Procedures Manual for the Operating Room Suite, Anesthesia and PACU.

7.1 Except as provided below, the current approved Policies and Procedures adopted for the Surgical Service (Operating Room Suites, Anesthesia and PACU) shall govern the use of this service. This includes infection control and scheduling of operations.

7.2 Only physician appointees of the staff with appropriate clinical and administrative experience may direct anesthesia services. Such physician shall, either directly or indirectly, provide for a uniform quality of anesthesia services throughout the hospital.

7.3 **Pre-operative evaluation and documentation:**

(a) the surgeon shall record and authenticate a pre-operative diagnosis prior to surgery;

(b) To meet CMS (Medicare) requirements, all records must document the following, as appropriate:

(i) Evidence of a medical history and physical examination completed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to 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 anesthesia services.

(ii) Evidence of an updated examination of the patient, 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 anesthesia services.

(iii) The updated note must be on or attached to the history and physical and made a part of the patient's record, except in emergency situations, prior to surgery.

(iv) If the history and physical have been dictated, but are not on the record, the surgeon must write a statement to the effect with date and time dictated documented along with an admission note to include the heart rate, respiratory rate and blood pressure prior to the procedure.

Details of requirements for completing a history and physical for inpatient and outpatient settings are found in Appendix B.

(c) consultations when applicable (refer to Administrative Procedures, Section 1, Item D);

(d) each patient, except in an emergency, shall have the following laboratory procedure performed and recorded on the chart prior to the time of operation:

Female patients between menarche and menopause must have a pregnancy test performed the day of surgery unless there is documented evidence of hysterectomy or the patient is fifty (50) years of age or older and has not had a menstrual cycle for twelve (12) months. Pregnancy tests for cases under local anesthesia will be at the discretion of the physician.

(e) a signed and witnessed informed consent of anesthesia and surgical procedures to be performed shall be obtained from the patient by the physician, physician assistant, or midlevel provider and incorporated in the record prior to the start of anesthesia, except in a true emergency when this is not possible. In emergencies involving a minor, mentally incompetent or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, and delay could increase the danger to life and health, an immediate treatment permit shall be signed. The surgeon, preferably with consultation, must sign this permit with two witnesses and it is incorporated in the patient's permanent record; and

(f) immediately prior to the induction of anesthesia the patient will be assessed to determine that patient's physiological status has not changed, and patient is still a candidate for selected anesthesia. The equipment, drugs and gas supply are checked. The patient shall be appropriately monitored during anesthesia and all observations, findings and results shall be documented.

7.4 **Post-operative evaluation of the anesthesia patient:**

(a) the post-operative status of the patient is evaluated on admission to and discharge from the post-anesthesia recovery area; and

(b) a physician with surgical privileges or an independent operating practitioner who is familiar with the patient is responsible for the decision to discharge the patient from the post-anesthesia recovery area.

7.5 In any surgical procedure with unusual hazards to life or in any surgical procedure in which, because of technical difficulty of the procedure, a qualified assistant can reasonably be expected to be needed, the surgeon is expected to have a qualified assistant present and scrubbed. The surgical assistant should be a person of adequate knowledge, skill and competence and one with the requisite abilities to keep the patient from being endangered in the event the surgeon becomes incapacitated during the procedure.

7.6 **Nursing Services - Anesthesia:** A registered nurse, qualified by relevant education, training, experience and documented competence, is responsible for planning and directing the nursing care of patients who undergo surgery and other invasive procedures when receiving anesthesia.

7.7 **Nursing Services - O.R.:**

(a) there are mechanisms to assure a comparable level of quality of surgical nursing services throughout the hospital:

(b) documentation identifies who provided direct patient care services and who supervised that care if it was provided by one other than a registered nurse; and

(c) hospital policy and procedures define when pre-operative nursing assessments are performed and what information is to be documented in the patient's medical record.

7.8 All specimens removed during surgery, except those listed below, are to be sent to the pathologist who shall make such examination as may be necessary to arrive at a pathological diagnosis. He shall sign his report. The following surgically removed specimens shall not be sent for pathological examination unless requested by the physician/surgeon: tonsils and adenoids (of patients less than sixteen (16) years of age), toenails, scar tissue, foreign bodies (except for legal purposes),

teeth, foreskins (eight (8) years old or younger), intrauterine devices, bunions, orthopedic hardware, bone fragments from acute fractures, osteophytes (bone spurs) and placentas (Routine placentas do not need to be sent. However, if there is fetal distress or if the infant delivery shows a potential problem, it is recommended to send the placenta.)

7.9 An instrument, needle and sponge count shall be taken unless otherwise indicated.

7.10 A physician shall sign for patient's discharge from the PACU.

7.11 Operative reports shall be dictated immediately after surgery. If a full operative report cannot be done prior to the patient going to the next level of care and a post procedure note is utilized, the full operative report must be recorded within twenty-four (24) hours by the surgeon, and shall include the following information:

(a) The name(s) of the licensed independent practitioner(s) who performed the procedure and his/her assistant(s);
(b) The name of the procedure performed;
(c) A description of the procedure;
(d) Findings of the procedure;
(e) Any estimated blood loss;
(f) Any specimen(s) removed; and
(g) The postoperative diagnosis.

7.12 When a full operative or other high-risk report cannot be entered immediately into the patient's medical record after the operation or procedure, progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his/her assistant(s), procedure performed, and a description of each procedure finding, estimated blood loss, specimen removed, and postoperative diagnosis.

7.13 All members to the staff must obtain a signed consent form from the patient before taking photographs in the surgical suite or recovery room for use other than for diagnosis and treatment of the patient. The original consent form is to be placed in the medical record.

7.14 All members of the staff must obtain a signed consent form from the patient before allowing individuals beyond the purview of authorized personnel to observe any type of surgical procedure. The original consent form is to be placed in the medical record.

SECTION 8 AUTOPSY CRITERIA

8.1 **Circumstances of Death that Mandate Report to the Medical Examiner**

8.1-1 Any death resulting directly or indirectly from antecedent conditions or injuries received as the result of an accident, homicide, or suicide gesture; or if a reasonable suspicion of death due to accident, homicide or suicide exists. This criterion applies irrespective of the duration of survival of the individual.

8.1-2 Any death associated with evidence of physical abuse or suspected physical abuse; or of significant neglect of a child or incapacitated/incompetent person.

8.1-3 Any sudden unexpected death where circumstances, such as age less than 65, do not allow the attending physician to reasonably infer that death is due to ~~a~~ natural disease process.

8.1-4 Any death where there is reasonable suspicion that there exists an underlying contagious disease or other condition that may constitute a threat to the public health or safety.

8.15 Any death where thought to be due to, or arising out of complications of drug abuse/intoxication.

8.16. Any death during or associated with a therapeutic procedure, where the death may have resulted from a complication of the procedure, treatment or therapy, or where the death is not readily explained as a consequence of pre-existing natural disease.

8.17 Any death occurring as a result of, associated with, or following a police intervention, transport or custody; or death during court ordered custody or incarceration, even if reasonably due to natural disease processes.

8.18 Any death occurring in a medical, mental health or convalescent care facility, where the cause of death cannot be inferred as being solely to a natural disease process, or where there is suspicion of grossly inadequate or improper care, or willful abuse of the decedent.

8.2 An autopsy should be considered if:

8.2-1 Needed to determine a diagnosis; or

8.2-2 The family requests one.

8.2-3 For any autopsy performed for reasons listed in section 8.2, it is the physician's responsibility to document permission. The physician will request permission for the autopsy from the next of kin.

8.3 As soon as the physician has pronounced the patient dead, he/she will notify the relatives, and if the patient's cause of death is one of those listed in Section 8.1, the physician must also notify the medical examiner.

NOTE: The term "autopsy" must be considered from the lay point of view and appropriate steps taken to insure complete understanding between the family and the physician concerning the procedure involved. Specific permission must be obtained for examination of the head (or brain), and this must be indicated on the signed permission. Entering the word "none" on the limitations line will be adequate for this purpose. If any restrictions are agreed to, they must be clearly indicated on the permit as well. The autopsy cannot be performed unless the line "Limitations:_____" is completed and its meaning perfectly clear. For instance, the single word "head" is not acceptable since the prosector does not know whether examination is limited to the cranial contents, or whether permission to examine the cranial contents was specifically refused. Acceptable terms include: "none", "head may not be examined", "examination restricted to heart and lungs only", etc.

The physician talking with the family is legally responsible for the correctness of the signed autopsy permit. Every permit must be witnessed by two (2) people of legal age, one of whom is the physician obtaining the permit and the other witness must be a hospital employee. If, because of mental incompetence of the legal next-of-kin, permission must be obtained from another person, the reason must be stated on the permit; such authorization must come from the next-of-kin in order of legal priority (See below).

8.4 If autopsy permission is granted, the physician will fill out and have signed and witnessed, the Consent for Autopsy Form. The State law, quoted below, sets forth as follows <u>precisely</u> who may legally authorize an autopsy:

8.4-1 The medical power of attorney;

8.4-2 The surviving spouse of the deceased;

8.4-3 If there be no surviving spouse, then any child of the deceased over the age of eighteen (18) years: Provided, that the child's permission shall not be valid, if any other child of the

deceased over the age of eighteen (18) years objects prior to said autopsy and the objection shall be made known in writing to the physician who is performing the autopsy;

8.4-4 If there be no surviving spouse, nor any child of deceased over the age of eighteen (18) years, then the mother or father of the deceased;

8.4-5 If there is no mother or father or father of the deceased, the health care surrogate, if one is appointed;

8.4-6 If there be no surviving spouse, nor any child over the age of eighteen (18) years, nor mother or father, then the duly appointed and acting fiduciary of the estate of the deceased; or

8.4-7 If there be no surviving spouse, nor any child over the age of eighteen (18) years, nor mother or father, nor duly appointed and acting fiduciary of the estate of the deceased, then the person, firm, corporation or agency legally responsible for the financial obligation in disposing of the body of the deceased.

8.4-8 In the event the medical power of attorney representative, the health care surrogate, spouse, child or parent of the deceased be mentally incompetent, then the person authorized to consent to such autopsy shall be the next in order of priority hereinabove defined.

> NOTE that the State of West Virginia does not recognize Common Law Marriage, and permission obtained from a Common Law spouse is not valid. Prolonged separation (without divorce) does not alter the separated spouse's authority to grant or refuse autopsy permission. Separated spouse may disclaim all interest.

The physician will complete and sign the Physician's/Medical Examiner's Certificate of Death and complete the staff progress notes on the chart.

8.5 The pathologist performing the autopsy will notify the physician at the time the autopsy is to commence.

***NOTE**: Refer to Autopsy Policy (AD 15) in the Administration Manual for detailed information.*

SECTION 9 EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (COBRA)

9.1 **Provisions for Assessment/Triage of Patients:**

9.1-1 **Referral to Emergency Department:**
Except as provided below, persons who present to any department of the Hospital seeking a medical evaluation or assessment should be referred to the emergency department for assessment, unless extraordinary circumstances dictate that an immediate admission and treatment in some other department is warranted. Any such departure from the standard protocol shall be made only on a physician's orders and in extraordinary cases where referral to the emergency department would create significant medical risks. Obstetric patients, however, and women actually or potentially in labor, may be admitted directly to the obstetrics department for screening and assessment.

A person who is unconscious shall be deemed to have made a request for such assessment and treatment as shall be necessary to preserve his or her life and health.

9.1-2 **Basic Requirement of Assessment of Persons:**
Persons who present to the Hospital and request a medical assessment, treatment or screening shall be assessed prior to their discharge, transfer or admission. The only exception shall be for those persons who, after requesting any such assessment, screening or treatment, explicitly withdraw their request or explicitly refuse to undergo the assessment or screening. In case of such a refusal or the withdrawal of the request, then the staff shall take all reasonable steps to obtain an informed written refusal of the assessment. An "informed" refusal in the context of this provision means that the person has been advised of the risks and benefits of refusing or failing to undergo the assessment, and has also been advised that the Hospital has a legal obligation to provide an assessment and to stabilize the person's condition, without regard to the person's ability to pay. The person shall be further advised of any other matters required by any laws, such as the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "COBRA").

9.1-3 **Persons Authorized to Provide Assessment of Emergency Conditions:**
Except as provided in the bylaws or rules of the hospital, all persons presenting themselves to any area of the Hospital requesting assessment, screening or treatment for any condition, must be referred to the emergency department.

Obstetric patients may be taken directly to the obstetrics unit for assessment. The person presenting may initially be assessed by a nurse, who shall perform the initial triage as to persons requesting screening, assessment or treatment. The nurse may also perform screening to determine whether an emergency medical condition exists. Nurses may also perform screening in the emergency department.

The nurses authorized by this Section to perform the assessment include registered nurses, certified nurse midwives, and nurse practitioners.

In addition to nurses, the initial assessment required by this Section may be performed by physician's assistants and physicians. The authorization granted to nurses to perform an initial triage or an assessment does not limit the capability of a physician or physician's assistant to perform the assessment in the first instance. In all cases, good medical practice and the interests of the patient's health and safety shall be paramount. Nothing in these provisions authorizes any nurse or physician's assistant to attempt to perform an assessment that is beyond the scope of his or her training and experience. Whenever indicated by the patient's condition, a nurse or physician's assistant performing a screening authorized by this section shall refer the patient to a physician for a medical assessment.

9.1-4 **Nature of the Assessment:**
Individuals for whom an assessment is required shall be assessed to determine whether they have an emergency medical condition. An emergency medical condition exists, within the meaning of the Section, for any woman in active labor when there is insufficient time to effect a transfer to another facility prior to the completion of labor, including delivery of the placenta. In addition, an emergency medical condition exists whenever, within a reasonable medical probability, the absence of medical treatment, 1) could reasonably be expected to result in serious jeopardy to the life or safety of the patient; or 2) could reasonably be expected to result in serious impairment or dysfunction of any bodily function or part.

If a nurse or physician's assistant cannot, within the scope of his or her training, make an assessment that no emergency medical condition exists, then he or she shall refer the patient for an examination by a physician.

9.1-5 **Staff Member Duties to Assist in Assessment:**
All personnel and facilities routinely available for the treatment of patients shall be made available to patients requesting an assessment or screening. No staff member shall refuse

to provide assistance in the assessment of a patient who has sought a screening or examination, if, 1) the staff member is on call and is requested to provide such an assessment or 2) the staff member is routinely available, in the particular circumstances, to provide consultation or assessment to regular patients. Thus, a physician who, while in the hospital, makes himself or herself routinely available for other physicians to consult on or provide assessments of patients, shall, while in the hospital and if requested to do so by an emergency department physician or other staff member, provide the same for persons seeking an assessment or screening. Such a physician has no duty to provide an assessment or screening when not on call or in circumstances when the physician would not normally provide consultation, assessment or other services upon request of staff members or other hospital personnel.

9.1-6 **Actions in the Event of Emergency Medical Condition:**
In the event a determination is made that a patient is in an emergency medical condition, then the person shall not be transferred, discharged or released unless the patient has been stabilized, or the other requirements of Hospital policy and the law, including EMTALA, have been met.

SECTION 10 METHODOLOGY

These Medical Staff Rules and Regulations may be adopted, amended or repealed by the affirmative vote of a majority of the Staff Appointees eligible to vote on this matter, provided that at least ten (10) days written notice has been given of the intention to take such action, accompanied by the proposed bylaws and/or alterations, or a summary thereof.

Date	President of the Medical Staff
Date	Secretary of the Medical Staff
Date	President of the Board of Directors
Date	Secretary of the Board of Directors

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