SOUTHEAST HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

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The following Medical Staff Rules and Regulations are adopted pursuant to Article XII, Section 12.01 of the Medical Staff Bylaws and are intended to more specifically address the general principles found within the Bylaws.

Article I
PATIENT ADMISSIONS, TRANSFER OF CARE, AND DISCHARGE

1.01 Who May Admit

Patients shall be admitted only by appropriately licensed practitioners exercising clinical privileges in Southeast Hospital. All patients shall be admitted through established Hospital admitting procedures and protocol.

1.02 Designation of Attending Physician for Emergency Department Patients

The Emergency Department physician on duty shall determine the appropriate specialty for the purpose of arranging for the admission of patients who are initially seen in the Emergency Department. In the event the patient has no local doctor for the purpose of admission, the Emergency Department physician on duty shall contact the physician on-call for the particular specialty required in the judgment of the Emergency Department physician. The physician on-call for that specialty shall then be deemed the admitting and attending physician until such time as care is properly transferred to another physician.

1.03 Transfer of Care - Role of the Attending Physician

The admitting physician is deemed the attending physician (physician of record) until such time as the patient's care is transferred to another physician. To properly effect a transfer of care, the referring physician should obtain the intended receiving physician's consent prior to ordering the transfer of care. If the intended receiving physician objects to the transfer of care, the current attending physician shall remain responsible for the continuous care of the patient until another physician consents to serve as the attending physician. This provision does not affect the involvement of consulting physicians.

The President of the Medical Staff or his designee is authorized to intervene in decisions regarding the transfer of inpatients from one patient care center to another, e.g., the transfer from ICU to a medicine or surgical unit.

1.04 Regular Attendance of Inpatients

The attending physician (physician of record) or designated covering provider shall visit his or her patients daily and a progress note shall be written reflecting a pertinent chronological report of the patient's course in the Hospital and reflect any change in condition and the results of treatment.

Regular, direct visits with inpatient rehabilitation patients will be carried out based on the patient's medical and rehabilitation needs as determined by the rehabilitation physician. The frequency of visits will be appropriate to justify the need for continuation of the Comprehensive Integrated Inpatient Rehabilitation Program. The physician may decide to assign a certain number of those visits to his/her Designee.

Advance practice providers with inpatient privileges shall visit patients whom have been assigned to their care daily. The collaborating physician will review all advanced practice provider charts daily.

Additional guidelines for physician co-signature of advanced practice provider records and rounding are defined by organizational policy.

(Refer also to Medical Staff Rules and Regulations, Article V, Section 5.04, Physician Progress Notes.)

1.05 Discharge

Patients shall be discharged only on the order of the attending practitioner or his Designee. *(Refer also to Medical Staff Rules and Regulations, Article V, Section 5.05, Discharge Summary.)*

Article II
CONSULTATION

2.01 Who May Consult

Any qualified practitioner with clinical privileges in the institution may be called for consultation within his or her area of expertise.

2.02 Response Time for Consultation

A. Emergency - If a member of the Medical Staff is unable to obtain a requested consultation within thirty (30) minutes for a patient in an emergent medical condition, in consideration of the patient's condition and the institution's objective to provide for the efficient delivery of care, the President of the Medical Staff, Chief Medical Officer, or their authorized designee is authorized to designate another Member of the Medical Staff to provide the needed consultation.

(See Also in these Rules and Regulations: Article X, Section 10.02 Emergency Response Times.)

B. Non-Emergency – If a member of the Medical Staff is unable to obtain a requested consultation for a non-emergent patient within 24 hours, in consideration of the patient's condition and the institution's objective to provide for the efficient delivery of care, the President of the Medical Staff or his authorized designee is authorized to designate another member of the Medical Staff to provide the needed consultation.

For specialties with two or fewer providers, or for which inpatient services are not routinely provided, each physician will communicate their availability for dates available for consults. If there is no provider available for the specialty requested for consult, the attending physician will make a determination whether the patient requires a transfer based on the patient's condition.

2.03 Procedure for Obtaining

Members of the Medical Staff are responsible for arranging for consulting physicians. The attending physician of record will determine if the consult is emergent or non-emergent. If the consult requires that the patient be seen within 24 hours or less, physician to physician communication is required. The requesting physician is ultimately responsible for obtaining the consultant's consent. Should the requesting physician be unable to personally contact the requested consultant, Hospital staff may assist with communications for non-emergent consultations which do not require the patient to be seen within 24 hours. When the patient's condition mandates consultation during the course of hospitalization, the Emergency Call list will be utilized to obtain the consult (i.e. when the requesting physician has been unable to secure consent from the named consultant or when the consultant has not been named). *(See also Medical Staff Rules and Regulations, Article XIV, Section 14.01.)*

2.04 Report of Consultation

A physician providing consultation shall prepare a Report of Consultation for entry in the medical record. Consulting reports shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record; review of findings; recommendations made; and impression. When operative procedures are involved, the surgical consultation note shall, except in emergency situations so verified on the record, be recorded prior to

the operation.

2.05 When Consultation Is Required

Except in emergency situations, consultation with an appropriate appointee to the consulting or active staff shall be required in the following situations:

A. Cases where, in the opinion of the attending practitioner, circumstances are such that the patient will be benefited by the consultation.

B. Therapeutic abortions.

C. Patients admitted as attempted suicide or with drug overdoses.

Article III
ARRANGEMENTS FOR ALTERNATE COVERAGE

3.01 A Medical Staff appointee shall designate an alternate from the Medical Staff of Southeast Hospital to care for his patients at this Hospital or for emergency patients which are his designated responsibility whenever he is unable to serve for any reason. Such designation shall be made on the application for appointment and reappointment to the Medical Staff or as a practitioner may from time to time desire to make permanent changes. Failure to comply will be justification for automatic suspension of clinical privileges as provided for under Article IX, Section 9.07 of the Medical Staff Bylaws.

Article IV
CLINICAL ORDERS

4.01 Who May Accept Clinical Orders - Authentication of Orders

Orders dictated or transmitted by the practitioner or designee in person or over the telephone can be received only by personnel described in Appendix A ("Personnel Authorized to Accept Clinical Orders") of these Rules. The verbal/telephone order is to be entered into the Electronic Medical Record (EMR) and read back for confirmation. The order shall include the date and time.,.

4.02 Authentication of Orders

All orders including verbal orders must be dated, timed, and authenticated promptly by the ordering practitioner, or another practitioner that is responsible for the care of the patient and authorized to write orders.

Inpatient admission orders will be authenticated prior to the patient's discharge. The admitting physician, or a physician who has knowledge of the patient, may authenticate the order. If a patient transitions from observation to inpatient the new order (admission order) must be authenticated.

Verbal orders shall be authenticated by electronic signature, date, and time, by the time the record is otherwise complete. Verbal orders from the practitioner, or his designee, can only be received by those personnel listed in Appendix A. Personnel recording the verbal orders will enter the order(s) into the EMR and read back for confirmation.

When electronic signatures are authorized, the practitioner whose signature is electronically affixed shall provide the President of the Hospital a signed statement that he will safeguard the electronic signature code to assure that he is the only one who will use it.

The method of authentication shall be an electronic signature. Use of signature stamps shall not be considered an acceptable form of authentication.

4.03 Preprinted Orders

Preprinted orders may be used during computer downtime, ensuring downtime policy and procedure is followed.
To be applicable to a patient, an order to follow the preprinted orders must be entered in the patient's record, dated, timed, and signed by the practitioner.

In the case of a pre-established electronic order set, the practitioner must date, time and authenticate the final order that resulted from the electronic selection/annotation process, with the exception that pages with internal changes would not need to be initialed or signed if they are part of an integrated single electronic document.

4.04 Orders for Surgery and Critical Care Patients

A. All orders will be suspended for patients undergoing surgery and will be reviewed and reconciled post-operatively.

B. All orders are reviewed and reconciled (continued or discontinued) for patients transferred into critical care areas .

4.05 Medication Review

A. The Pharmacy will review all medications on the patient's seventh (7th) day of admission and each successive seventh (7th) day.

B. The following entry will be documented in the Electronic Medical Record (EMR):

"This patient's medications have been reviewed."
/s/ "Pharmacist's Signature and Date."

C. Recommendations for change (if any) will be communicated to the attending physician.

4.06 Admission Orders

A. If the admission order is a verbal order, it must be authenticated prior to discharge.
B. The inpatient admission order may not be a standing order/protocol. The admission order may be placed into a preplanned state (i.e. scheduled surgery/procedure) but must be initiated at the time of the formal admission and may not be a retroactive order.

Article V
MEDICAL RECORDS

5.01 Medical Records

A. Electronic documentation will be expected in the medical record for orders, history and physical, operative notes, progress notes and discharge summary except during computer downtime. During downtime all patient medical record entries must be complete, legibly prepared in ink or typewritten, dated, timed and authenticated in written form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. If any handwritten document is not legible by the receiver, the ordering provider will be contacted for clarification. If the provider cannot be reached or does not provide clarification, the Chief Medical Officer or President of the Medical staff should be notified to review and obtain clarification.

B. All practitioners shall be held responsible for the preparation of their portion of the complete medical records.

C. All information contained within patient medical records is the property of the Hospital. Physicians shall maintain the confidentiality of all information contained within patient medical records and follow all Hospital policies and procedures related to the confidentiality of protected health information. Information contained within the medical record may only be released with an appropriate consent form signed by the patient or the patient's legal guardian.

D. In case of readmission of a patient, all previous records shall be available for use by the attending practitioner. If such readmission occurs within thirty 30 days of dismissal for the same or related condition, an appropriate readmission note and interval history shall be considered acceptable in lieu of a repeat history and physical examination.

E. The attending practitioner shall see that the record is completed, state his final diagnosis without use of unapproved symbols or abbreviations, and sign, date, and time the record.

5.02 History and Physical Documentation Requirements

A. A history and physical examination shall be completed on each of the following categories of patients:

(1) inpatients
(2) observation patients
(3) outpatients undergoing any kind of surgery
(4) outpatients undergoing an invasive procedure
(5) outpatients who will receive sedation analgesia.

B. Emergency Department physician notes or other reports of E.D. physicians shall not be used in lieu of the admitting or attending physician's own history and physical report. Every physician who admits an inpatient or is primarily responsible for treatment of an outpatient as described in 5.02 (A) shall perform a history and physical examination and prepare a report of the same. The admitting or attending physician may delegate this responsibility to another practitioner who has been appropriately granted privileges to do so.

C. The history and physical examination shall contain the following:

(1) Chief complaint
(2) History of present illness
(3) List of allergies
(4) List of current medications or attest to the accuracy of the medication reconciliation document
(5) Relevant review of body systems
(6) Relevant past, social and family history
(7) Relevant physical exam
(8) Impression
(9) Plan of care
(10) If indicated, information necessary to prevent harm to other patients or to the Hospital's employees or other medical providers if the physician reasonably believes that the patient poses a risk of harm to others.

D. The time frame for completion of the history and physical examination is as follows:

(1) A history and physical (H&P) examination shall be recorded and/or dictated and placed in the medical record on each inpatient or observation patient within twenty-four (24) hours of admission to the hospital. A history and physical examination completed no more than 30 days prior to the procedure is acceptable; however, an update to the patient's condition since it was last assessed is required at the time of admission and must be placed in the medical record within 24 hours of admission

(2) The medical record of any outpatient or observation patient presenting for surgery, an invasive procedure, or any procedure involving sedation analgesia must contain a history and physical examination prior to the procedure being performed, except in an emergency. When the history and physical has been performed prior to the day of the procedure, there must be an update to the patient's condition entered into the record by an appropriately privileged practitioner prior to the start of the procedure.

(3) In the situation where the patient is going to surgery within the first 24 hours of admission and the H&P was completed prior to admission, then the update to the patient's condition and the pre-anesthesia assessment will be accomplished in a combined activity.

(4) Completion of H&P forms approved by the MEC are acceptable for an outpatient or observation patient presenting for surgery, an invasive procedure, or any procedure involving sedation analgesia.

(5) A history and physical examination completed by an appropriately privileged allied health practitioner must be authenticated by the collaborating/supervising physician by the time the medical record is otherwise complete.

5.03 Admit Note

At the first visit, an admitting progress note shall be written or dictated and shall include a pertinent history and the clinical findings on admission. The admission note shall state briefly the chief complaint, the symptoms, and the physical findings that led to the working diagnosis, the expected therapy, and possible consultation.

5.04 Progress Notes

Progress notes shall be kept current during the patient's hospitalization and shall give a pertinent chronological report of the patient's course in the Hospital and reflect any change in condition and the results of treatment. Documentation of patient care shall be done on a daily basis.

5.05 Discharge Summary

The discharge summary will include the discharge diagnosis, reason for hospitalization, significant findings, procedures performed and treatment rendered, condition of patient at discharge, and instructions that include activities, diet, medications, and provision for follow-up care. For patient stays less than 48 hours, the final progress notes may serve as the discharge summary if they include the same elements.

5.06 Outpatient and Emergency Records

A complete and accurate patient record shall be maintained on all outpatient services and emergency services, and shall be made a part of the patient's total medical records. *(See also Medical Staff Rules and Regulations, Article V, Section 5.02 History and Physical Documentation Requirements, for history and physical examination requirements on outpatients.)*

5.07 Chart Completion Rules *(See also Medical Staff Bylaws, Article IX, Section 9.07 (A) (1))*

A. Incomplete charts are those which are deficient of a history and physical report, a discharge summary, operative notes, authenticated physician orders, reports of consultation, or the absence of signatures.

B. Overdue charts are those incomplete charts which have remained incomplete over 21 days from the date of discharge.

D. C. Health Information Management (HIM)will determine which providers have deficient records. A notification specifying the deficient records will be sent to each provider . Records that remain deficient for greater than 30 days become delinquent records and

result in ill be deemed the voluntary relinquishment of certain privileges and prerogatives as described in E, below. Illness or absence from the community neither shortens nor lengthens the time available to complete such records. If an attribution error is identified and reported to HIM, the deficiency will be reassigned to the correct provider. If the attribution error occurs more than 30 days after discharge, the provider to whom attribution has been correctly reassigned will be notified of the deficiency and given seven (7) days to complete the deficiency prior to suspension. Voluntary relinquishment of privileges shall be in effect pursuant to Article IX, Section 9.07 (A) (1) of the Medical Staff Bylaws. Voluntary relinquishment of privileges is considered administrative in nature, and is therefore not reportable to the National Practitioner Data Bank.

E. During the period of time when privileges are relinquished:
   (1) practitioners shall not:
      (a) perform elective procedures or surgery
      (b) admit inpatients or observation patients
      (c) accept an inpatient in transfer
   ((2) Provided that, this section shall not apply to emergency situations or relieve physician of established on-call responsibilities.

F.. This policy is intended to ensure that medical records are kept current.
G.. , In an emergency situation, the President of the Medical Staff or his designee, in collaboration with the CEO, may waive or defer the enforcement of the automatic suspension rules on a practitioner on a case-by-case basis. In the event a waiver occurs, this will be reviewed through the Medical Staff peer review process.

Article VI
PATIENTS FOR SURGERY

6.01 Arrangements

Time of surgery, procedure to be followed, and type of anesthesia shall be arranged as early as possible with the Departments of Surgery and Anesthesia.

6.02 Informed Consent

Informed consent is required for all invasive procedures. An invasive procedure is a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, but excluding venipuncture, arterial line placement, intravenous therapy, intramuscular or subcutaneous injections, urinary catheter insertion, laceration suturing, and naso-orogastric tubes other than those for nutritional purposes.

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The primary purpose of the informed consent process for surgical/procedural services is to ensure that the patient, or the patient's representative, is provided information necessary to enable him/her to evaluate a proposed procedure before agreeing to the procedure. Typically, this information would include potential short- and longer-term risks and benefits to the patient of the proposed intervention, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's professional judgment.

A properly executed informed consent form contains the following minimum elements:
• Name of the hospital where the procedure or other type of medical treatment is to take place;
• Name of the specific procedure, or other type of medical treatment for which consent is being

given;
• Name of the responsible practitioner who is performing the procedure or administering the medical treatment;
• Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative
• Signature of the patient or the patient's legal representative; and
• Date and time the informed consent form is signed by the patient or the patient's legal representative.

Informed consent must be obtained, and documentation of informed consent must be included in the patient's medical record, prior to the performance of the procedure, except in the case of emergency surgery, legally mandated, or court-ordered treatment. The informed consent form may only be signed after the physician or designated licensed independent practitioner (LIP) has had the informed consent discussion with the patient or the patient's authorized representative, and prior to the administration of any pre-operative medication or mind-altering drug.If applicable, the need for blood transfusion or blood components and possible alternatives will be discussed with the patient and family. If the physician anticipates the potential use of blood or blood products and orders type and screen or type and crossmatch, an informed consent will be obtained.

6.03 Pre-operative History and Physical

See Medical Staff Rules and Regulations, Article V, Section 5.02 Documentation Requirements, for history and physical examination documentation requirements for patients presenting for a surgical or invasive procedure or for a procedure that involves the administration of sedation analgesia. The operative permit must be properly timed, dated, and signed. The record shall indicate the diagnosis and the indication for the procedure.

6.04 Operative Reports

Operative reports/procedure notes shall be completed in accordance with CMS regulations and documented in the EMR immediately after the procedure/surgery (prior to transition to the next level of care).If the complete operative report is not documented immediately, an immediate postoperative note must be recorded in the EMR. For computer downtime procedures, postoperative notes/reports must be recorded manually.

A. The immediate postoperative note, if completed, shall include at least
   (1) name of the procedure,
   (2) name of primary surgeon(s) and any assistant(s),
   (3) findings of each procedure performed,
   (4) complications, if any
   (5) estimated blood loss, if applicable,
   (6) specimens removed and
   (7) postoperative diagnosis.

B. The complete operative report shall include at least
   (1) name of specific surgical procedure(s) performed
   (2) name of primary surgeon(s) and any assistant(s)
   (3) description of procedure(s) performed
   (4) findings of each procedure performed
   (5) complications, if any
   (6) any estimated blood loss, if applicable
   (7) any specimen(s) removed
   (8) prosthetic devices or implants used, if any and
   (9) post-operative diagnosis.

C. The operating room registry shall show the pre-operative diagnosis, operation performed, and post-operative diagnosis. A resume of this registry shall be prepared by Hospital personnel for use in surgical case review.

6.05 Anesthesia Reports

The anesthesiologist or anesthetist must check pre- and post-operatively each of their patients and enter a pre- and post-anesthetic follow-up progress report for the patient's record.

Article VII
DENTISTRY

7.01 Medical Appraisal

A medical appraisal of the patient shall be conducted in accordance with Article I, Section 1.02 (B) (1) (b) and (c) and Article VIII, Section 8.04 of the Medical Staff Bylaws.

7.02 Records

Complete records, both dental and medical, shall be required on each patient. The dentist shall be responsible for the dental portion of the record while a physician shall be responsible for the medical portion of the record. In the case where a dentist has certification in oral surgery which included training and experience in history and physical evaluation of patients, the oral surgeon may do the history and physical without a dual admission. A physician member of the Medical Staff shall be consulted and be made responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of dental and oral maxillofacial patients, as provided for in Article I, Section 1.02 (B) (1) (b) and (c) and Article VIII, Section 8.04 of the Medical Staff Bylaws.

Article VIII
PODIATRY

8.01 Medical Appraisal

A medical appraisal of the patient shall be conducted in accordance with Article I, Section 1.02 (B) (1) (c) and Article VIII, Section 8.04 of the Medical Staff Bylaws.

8.02 Records

Complete records shall be required on each patient. The podiatrist shall be responsible for the podiatric portion of the records, and may complete the H&P if he/she holds the privilege to do so. A member of the Medical Staff shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of podiatric patients as provided for in Article I, Section 1.02 (B) (1) (c) and Article VIII, Section 8.04 of the Medical Staff Bylaws.

Article IX
ALLIED HEALTH

9.01 Authorization to Practice

Allied health practitioners who have authorization to practice in collaboration with or under the supervision of members of the Medical Staff at Southeast as determined in accordance with the LHP/PPE Policy, may exercise privileges granted to them as specified in their individual privilege lists.

Physicians may utilize their own employees in the course of providing care to their patients at the Hospital. Physicians shall be responsible for ensuring that their employees are properly credentialed pursuant to the Medical Staff Policy on Limited Health Practitioners and Physician Paramedical Employees.

9.02 Patient Rounds

The visit of the allied health practitioner does not fulfill the attending physician's responsibility to visit his or her patients daily, except as expressly stated with regard to inpatient rehabilitation patients, adult hospitalist patients, and with regard to authorization to discharge in collaboration with the attending physician.

9.03 Physician Authentication

Record entries made by allied health practitioners that are required through the grant of privileges to be signed or validated by the collaborating or supervising physician, must be signed by the physician by the time the medical record is otherwise complete.

A. The History and Physical, Progress Notes, and Discharge Summary dictated or written by an appropriately privileged Licensed Physician Assistant must be validated (countersigned) by the supervising physician or designated backup physician.

B. The History and Physical and Discharge Summary dictated or written by an appropriately privileged Advanced Practice Nurse must be validated (countersigned) by the collaborating physician or designated backup physician.

Article X
GENERAL PROVISIONS

10.01 Proximity Requirement

Each active, associate, and consulting staff appointee shall be physically within 20 miles of the Hospital while On Call for patient care unless expressly excused in advance by the Medical Executive Committee.

10.02 Emergency Response Times

A. Attending Physician's Availability. The attending, on-staff physician shall have the responsibility to identify a physician to be available to address emergent situations, outside the Emergency Department, in the event he/she is not available. In an emergency medical situation the attending physician shall respond within 30 minutes. Failure to comply will be justification for corrective action pursuant to Article IX, Section 9.05 of the Medical Staff Bylaws.

B. Office Hours. During office hours, if the attending on-staff physician is unavailable, he/she will have the responsibility to identify a physician to respond to the emergency.

C. Evenings, weekends, and holiday schedules. Refer to the published on-call schedule applicable to the particular physician's medical group.

D. Emergency Guidelines– Inability to Reach Physician On-Call. If a physician who is needed to respond to an emergency cannot be reached, the following protocol shall be implemented immediately. This rule includes a Chain of Command Protocol which shall be implemented until the necessary response is obtained. The process is intended to be completed within thirty (30) minutes.

EMERGENCY GUIDELINES FOR SUMMONING A PHYSICIAN IN THE EVENT OF AN EMERGENCY

If unable to reach the physician on call, the following individuals will be contacted in the order listed below:

1. Access Center/House Supervisor
2. Director on call
3. Administrator on call
4. President of the Medical Staff
5. Chief Medical Officer

Alternative Contact in Case of Emergency: Notify the Hospitalist On-Call

Article XI
STERILIZATIONS

11.01 Voluntary Sterilization Shall Be Defined As:

A. Tubal ligation.

B. Vas ligation.

C. Hysterectomy (when done for purposes of sterilization).

11.02 The Following Requirements Should Be Met:

A. Complete instruction to the patient (and spouse, if available) as to the details of the surgery and its consequences.

B. A sterilization permit must be signed by the patient requesting the procedure. The signature of the patient's spouse, while not required, should be obtained when possible.

11.03 Patient Requested Sterilization

When a patient initiates the request for sterilization, the practitioner receiving the request need not have a consultation. If the sterilization procedure is initially suggested by a practitioner, the patient should be encouraged to be seen by another practitioner on a consultation basis.

Article XII
AUTOPSIES

12.01 Medical Staff members with admitting or consulting privileges may request and obtain permission for autopsy for purposes of validating and substantiating medical diagnosis.

12.02 Autopsies, with the exception of those requested by law enforcement or the coroner, shall be performed by the hospital pathologist or by a physician to whom the duty may be delegated. The pathologist will notify the attending practitioner when an autopsy is being performed, prior to the start of the autopsy. The post mortem findings, including the results of microscopic sections, shall be included in the patient's medical record and results made available to the requesting physician.

Article XIII
DISCONTINUATION OF LIFE SUPPORTING EQUIPMENT

13.01 The determination of whether a patient has a total and irreversible cessation of all brain function shall be made by a licensed physician. The pronouncement of death is a medical decision and a medical diagnosis, and is not a decision or diagnosis to be made by a nurse.

13.02 .

13.03 Before the life support equipment is discontinued:

A. a thorough explanation of the procedure shall be given by the attending physician to the family, and

B. verification that the explanation for the discontinuation of life support equipment has occurred shall be documented by the ordering physician in the EMR.

13.04 The physician shall enter an order in the EMR to discontinue the operation of any mechanical life support equipment following discussion with the patientand/or any individuals authorized or empowered to make decisions on behalf of the patient

Article XIV
STAFF RESPONSIBILITY FOR INDIGENT PATIENTS AND EMERGENCY ADMISSIONS

14.01 Hospital privileges include the responsibility for the attendance, care, and treatment of indigent patients, for emergency admissions of patients and persons having no designated physician, for urgent/emergent consults for inpatients having no designated physician, and for follow-up assignment of patients treated and released from the emergency department having no designated physician. The President of the Medical Staff and the Medical Executive Committee shall be responsible to establish a process for a current and periodic roster and call system for such attendance, care, and treatment at Southeast Hospital which will be communicated as appropriate. This call roster will be used to assign patient care responsibility for patients presenting to the emergency department with no designated physician and to assign responsibility for hospitalized patients with no designated physician who require consultative services during their stay and the attending physician has not contacted or specified the consulting physician to be contacted. Responsibility for the preparation and establishment of a roster and call system may be delegated by the President of the Medical Staff and the Medical Executive Committee to the Cape Girardeau County Area Medical Society.

14.02 An initial medical screening examination will be provided to patients presenting to the Hospital with a request or implied request for emergency medical treatment. This initial medical screening examination, to determine whether a medical emergency exists, may be performed by the following qualified individuals: emergency department advanced practice registered nurse, obstetrical registered nurse, emergency physician, any MD/DO with medical staff privileges to do so, or a Limited Health Practitioner – Advanced holding privileges to do so.

14.03 Staff appointees sixty (60) years of age or older may be exempt from routine assignment for on-call responsibilities for the Emergency Room.

14.04 Failure of Staff appointees to accept assignments and emergency call as provided herein without just and reasonable cause or substitution, shall be cause for corrective action under the Medical Staff Bylaws. Staff appointees must give thirty (30) days advance notice of intent to resign from the emergency call rotation or make arrangements for coverage of already assigned emergency call dates.

14.05 EMTALA Compliance: The hospital is obligated to care for the patient's emergency medical condition which brought him/her to the Emergency Department. If the physician on call does not perform the required procedure/service, they will stabilize the patient to their capability and arrange for an appropriate transfer. The physician on call may schedule an elective procedure while on call but must have a back-up plan in place for emergency cases. Failure of Staff appointees (or physicians granted privileges for the purpose of covering a Staff appointee in a locum tenens arrangement) to accept patients in transfer from another medical facility through the Emergency Department Call Assignment Process without just and reasonable cause, shall be cause for corrective action under the Medical Staff Bylaws (Article IX, Section 9.04).

Transfers out will occur when the individual (patient) requests the transfer or the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the Emergency Medical Condition (EMC), or the capability or capacity to admit the individual. Prior to transfer, a patient must be stabilized within the facility's capability such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the transfer and an accepting physician has been obtained at the receiving facility. Risks and benefits of transfer will

be explained to the patient. The Medical Staff will adhere to the organizational policies "EMTALA," and "Transfer of Patients to Other Acute Care Facilities."

Article XV
MASS CASUALTY ASSIGNMENTS

15.01 Medical Staff appointees shall be assigned in a medical emergency/disaster situation to a treatment area in accordance with the provider disaster roster. In the event medical resources need to be shifted based on the incident, assignments may be adjusted at the direction of Incident Command and Operations Medical Branch Director. Assignments will be documented in the Hospital's All Hazards Emergency Operations Plan and distributed by Medical Staff Services to all providers annually.

The President of the Medical Staff and the President of the Hospital will work as a team to coordinate activities and directions. All practitioners on the Medical Staff of the Hospital specifically agree to relinquish direction of the professional care of their patients to the President of the Medical Staff or his designee, in cases of emergency evacuation of patients from the Hospital, for the duration of the emergency. This plan for the emergency management of casualties shall be rehearsed in accordance with standards of The Joint Commission.

Appendix A
PERSONNEL AUTHORIZED TO ACCEPT CLINICAL ORDERS

A.01 The following personnel are authorized to accept clinical orders as indicated:

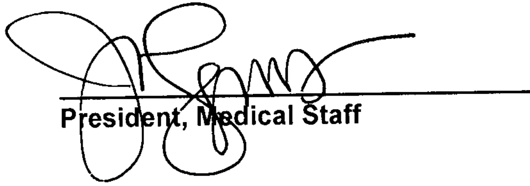
A. All nurses licensed pursuant to Chapter 335 of the Revised Statutes of Missouri may accept clinical orders from physicians or limited health practitioners providing orders consistent with their licensure;

B. Other personnel authorized to accept verbal orders within the scope of their certification, registration, or licensure are:

(1) Certified, Registered, or Graduate respiratory therapists
(2) Speech-language pathologists
(3) Licensed physical therapists
(4) Licensed physical therapist assistants
(5) Licensed occupational therapists
(6) Licensed occupational therapist assistants
(7) Licensed dieticians
(8) Pharmacists
(9) Certified Medical Imaging Technologist
(10) Lab Secretary/Phlebotomist
(11) Lab Technical Staff
(12) Social Workers
(13) Licensed Physician Assistants
(14) Appropriately privileged Physician Paramedical Employees

ADOPTION OF RULES AND REGULATIONS

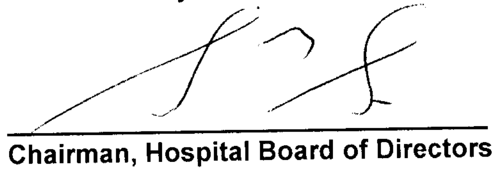
APPROVED by the Medical Staff this __17__ day of __Dec.__ 2019.



President, Medical Staff

Secretary, Medical Staff

APPROVED by the Board of Trustees this __30__ day of __Jan.__ 2020.



Chairman, Hospital Board of Directors

Secretary, Hospital Board of Directors