GENERAL

MEDICAL STAFF MS-001
RULES AND REGULATIONS

Reappointment/Reappraisal
The St. James Healthcare Medical Staff, through its organized structure has a responsibility to monitor, oversee and make appropriate recommendations to the governing body of St. James Healthcare regarding the quality and safety of professional services provided by individuals with clinical privileges.103

Biannually, members of the Medical Staff and Allied Health Professionals are considered for reappointment and reappraisal of clinical privileges. Reappointment and/or the renewal or revision of clinical privileges is based on a reappraisal of the individual at the time of reappointment and/or the renewal or revision of clinical privileges. Such renewal of privileges and/or membership may not exceed a period of two years.

The reappraisal includes information concerning:

2. Ability to perform requested privileges.104
5. Outcomes pertaining to clinical and/or technical skills, as reviewed through the Performance Improvement activities of the Medical Staff.105
6. Whether provider's practice is currently subject to review by outside agencies or by other health care facilities.
7. Current evidence of adequate professional liability insurance.
8. Participation in continuing education.
9. Medical record deficiencies or delinquency.
10. Malpractice claims history.
11. Medication and blood usage.
13. Operative and other procedure review.106
14. Computer printouts of all the practitioner's procedure performed in the hospital for the most recent past two years available.
15. Information which ensures that the practitioners do not practice outside their scope of privileges.

PROCEDURE:

1. During the second quarter of the appropriate year of reappointment, the Medical Staff Reappraisal/Reappointment form will be sent to each physician and allied health professional.107

2. The form will be returned to the Administrative Medical Staff Coordinator and prepared for the appropriate Section meeting. If no response has been received after a period of 60 days from the mailing of the application for reappointment, a second letter will be sent by certified mail to the applicant requesting immediate return of application (within 14 days) or it will be considered that the applicant no longer wishes affiliation with St. James Healthcare.

3. The appropriate Section Chief or designee will review the pertinent information regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reason for such recommendations shall be stated and documented. The form will then be transmitted to the Medical Executive Committee.

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4. The Medical Executive Committee will review all pertinent information regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reasons for such recommendation shall be stated and documented and forwarded to the Medical Executive Committee.

5. The Medical Executive Committee will review all pertinent information and make written recommendation to the Board of Directors, through the Chief Executive Officer regarding the reappointment, non-reappointment, and/or clinical privileges of reappointment. If a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

6. As a part of the Hospital's Performance Improvement Program, opportunities to improve care will be addressed and important problems in patient care will be identified and resolved. Monitoring is based on the rise of objective criteria that reflect current knowledge, clinical experience, and relevant literature. Conclusions, recommendations, actions taken, and results of actions taken are identified and reported. Educational opportunities will be identified that will support and increase quality patient care.

7. The Medical Staff Bylaws identify appropriate action, including a fair hearing, when the review of credentials and the recommendations regarding reappointment are adverse to the applicant.
   a. Initial appointment is for a provisional period, as specified in the Medical Staff Bylaws, and follows the same procedure as noted above.

8. Records and statistical information are stored within the hospital for the statutes of limitation.

9. The Medical Staff of St. James Healthcare has elected to adopt an electronic credentialing program. The program in effect shall be followed for delineation of privileges, appointment, and reappointment.
Protocol for the Physician Health Committee
In response to Article V, Part D, Section 5, Paragraph C, the following protocol has been developed:

The Medical Staff recognizes that impaired providers are individuals who have dedicated their lives to helping others and are now in need of help and recognizes that providing this help to impaired staff members is a primary goal of the Physician Health Committee. This Physician Health Committee will follow a non-punitive approach in which it and the Medical Staff work as advocates for, rather than adversaries of, the member while protecting patients and others from harm. The Bylaws and the Medical Staff also recognize that if there is a problem, necessary action must be taken for the protection of patients and the provider\textsuperscript{107}.

For all purposes except to ensure compliance with these Bylaws and to protect patients, hospital staff, and other staff members from harm, and to ensure quality and continuity of patient care, the proceedings of the Physician Health Committee will be held in strict confidence. Reports to the Medical Executive Committee should replace the provider's name with a code. The identity of persons reporting to the Physician Health Committee or informants about the possible impairment of a staff member should be held in strictest confidence and should not be released to the impaired provider\textsuperscript{108}.

The Physician Health Committee shall meet yearly or as often as necessary to discharge its duties. Special meetings of the Physician Health Committee may be called by its Chairperson upon request by any of the permanent or special members, other staff Committee Chairpersons, Section Chiefs, the President of the Medical Staff, the Chief Executive Officer, or the Board of Directors.

The Physician Health Committee will advise the Medical Executive Committee, the Chief Executive Officer, or the Board of Directors about questions pertaining to its area of expertise, which may arise in the processing of new applications for appointment. The Physician Health Committee, in the discharge of its duties, will avail itself of the help and advice of the appropriate Professional Assistance Program. One of the Physician Health Committee's initial duties will be to ensure, at least annually, that this program is still available and functioning\textsuperscript{109}.

The manner in which the Physician Health Committee discharges its duties will necessarily depend upon the manner in which its attention is drawn to the needs of a possibly impaired provider. The Physician Health Committee will evaluate all referrals regarding provider's impairment. If the Physician Health Committee finds that no impairment exists, the complaint will be dismissed. If the Physician Health Committee finds that impairment does exist, with the assistance of the appropriate Professional Assistance Program, the Physician Health Committee will proceed as follows\textsuperscript{110}.

If the Physician Health Committee has received "official" notice of impairment of a provider from a staff Committee, the President of the Medical Staff, the Chief Executive Officer, or the Board of Directors, it will meet, formulate a plan of action as circumstances dictate, and designate one of its members to approach the possibly-impaired provider with available information and to offer assistance. The Physician Health Committee should then make a report to the Committee or individual making the "official" request for investigation or intervention. This report needs only to indicate that the matter has been recognized and is being resolved. A fuller report needs to be made to the Medical Executive Committee and to the Board of Directors without identifying the impaired provider\textsuperscript{111}.

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If provider impairment is brought to the attention of the Physician Health Committee or one of its members through "unofficial" channels (concerned fellow staff member; hospital personnel; the member’s friend; family; or the impaired member him/herself), the Physician Health Committee shall meet (by telephone is not precluded) and formulate a plan. The plan may vary as circumstances dictate, from watchful waiting to direct immediate confrontation and offer of assistance\(^\text{112}\).

Regardless of the manner in which the suspected impairment is reported to the Physician Health Committee, there must be an evaluation of the credibility of the complaint, allegation, or concern by the Physician Health Committee\(^\text{113}\).

If the provider refuses assistance, and if, in the opinion of the Physician Health Committee, the possibility exists of danger to the health and well-being of patients, other staff members, or hospital personnel, the Chairman of the Physician Health Committee will notify the President of the Medical Staff and the Chief Executive Officer. The individual provider so suspected of being impaired shall be apprised of this notification, if possible before notification of the President of the Medical Staff and the Chief Executive Officer. The matter then can be resolved as indicated by circumstances under other portions of the Bylaws of the Medical Staff\(^\text{114}\).

If the impaired provider\(^\text{115}\) accepts the assistance of the Physician Health Committee, he/she must:

(a) agree to be responsible for all cost of diagnosis/treatment incurred.
(b) sign a waiver of provider/patient\(^\text{116}\) privileges with respect to diagnosis/treatment required pursuant to the plan of the Physician Health Committee. These reports from treating physician should be made directly to the Physician Health Committee and should be held in strictest confidence. Various nondisclosure laws such as Confidentiality of Alcohol and Drug Abuse Patient Record (part of Federal Law) would restrict release of such documents without a specific written release.
(c) acknowledge that by coming under the purview of the Physician Health Committee, he/she agrees to follow the plan formulated by the Physician Health Committee and the appropriate Professional Assistance Program, the matter then comes under the jurisdiction of the Bylaws of the Medical Staff and whatever corrective action is necessary will be recommended by the Physician Health Committee to the Medical Executive Committee.

It must be recognized by the Physician Health Committee that when a provider who is experiencing a mental/emotional disturbance, which has not impaired professional performance, seeks help with said mental/emotional disturbance, neither the provider nor the Physician Health Committee is obligated to inform anyone, and this protocol is not operative. All persons involved in these deliberations need be always aware that if a provider suffers from an emotional disturbance, it does not necessarily follow that his/her professional performance is impaired\(^\text{117}\).

If the impaired provider accepts the help of the Physician Health Committee, the Physician Health Committee may recommend, but not be limited to recommending\(^\text{118}\):

(a) continued practice by the impaired provider with careful oversight by the Physician Health Committee or a designated representative to ensure that no harm comes to patients, hospital personnel, or the impaired provider himself/herself\(^\text{119}\).
(b) restriction of certain clinical privileges.
(c) the provider voluntarily agreeing not to admit or otherwise care for patients at St. James Healthcare for a designated time. The agreement that the impaired provider makes with the Physician Health Committee...
Committee or its designee does not constitute voluntary or involuntary relinquishment of Medical Staff privileges. He/she would simply not be admitting, consulting upon, and otherwise caring for hospital inpatients during the time of the agreement. Any inpatients under the care of the impaired provider at the time of signing of the agreement would be assigned to the care of another Medical Staff member by the Chairperson of the Physician Health Committee or the President of the Medical Staff after taking the patient's wishes into consideration.\footnote{120}

(d) voluntary formal leave of absence from practice at the hospital.

(e) physical exam, psychiatric exam, substance abuse evaluation, and appropriate treatment by physicians or entities acceptable to both the impaired member and the Physician Health Committee. The treating physicians or entities must make at appropriate intervals and especially at the end of the treatment period reports to the Physician Health Committee. The Physician Health Committee will utilize these reports and other communications when it makes its recommendation to the Medical Executive Committee and the Hospital Board of Directors.

(f) periodic reevaluation and/or retesting of the impaired provider\footnote{121} mental/physical status including blood and urine testing. This is especially important during the "reentry into practice" phase of his/her rehabilitation.

After an impaired provider\footnote{122} has undergone appropriate treatment and is ready to reenter practice, the Physician Health Committee may recommend to the Medical Executive Committee and the Hospital Board of Directors that whatever limitations of privileges or practice restriction have been imposed be lifted and the provider\footnote{123} be allowed to reenter practice at the hospital. However, it must be remembered that fulfillment of any contracts with the Physician Health Committee by an impaired provider\footnote{124} does not automatically entitle the practitioner to reinstatement of any staff privileges which may have been affected by his/her impaired condition. Reinstatement is at the discretion of the Hospital Board of Directors.

The Physician Health Committee will report its activities to the appropriate\footnote{125} Professional Assistance Program. It is the responsibility of the appropriate\footnote{125} Professional Assistance Program to report to its licensing Board.\footnote{126}

"Impaired provider;" "impaired member," or "impaired physician or dentist" is a physician or non-physician member who, because of physical illness, psychiatric illness, or substance abuse, has impairment of his/her clinical judgment or ability and who may be unable to provide appropriate patient care or may otherwise constitute a direct and immediate threat to the health and safety of patients, hospital personnel, or other staff members.

"Substance abuse" refers to the inappropriate use of illegal drugs, alcohol, or over-the-counter drugs or prescription drugs while a member is "on call" or otherwise directly responsible for the care of hospital inpatients or outpatients. While not to be used as the only indicator of substance abuse, blood and/or urine concentration of alcohol or other altering-altering drugs in concentration deemed significant by the United States Department of Health and Human Resources during such a time is clear evidence of substance abuse. For clarity and to prevent controversy, a blood alcohol level greater than 0.030 gm/dl at such a time will be considered significant. If, with reasonable certainty, blood or urine concentration of a specimen collected at a time when the member is not "on call" or otherwise directly responsible for patient care can be extrapolated to give probable levels at a time when the member was "on call" and directly responsible for patient care, then this also would be clear evidence of substance abuse.
GENERAL

MEDICAL STAFF MS-003
RULES AND REGULATIONS

ADMISSION AND DISCHARGE OF PATIENTS

1. **Admission Diagnosis:** No patient shall be admitted to the hospital until a provisional diagnosis has been stated. At the time admission orders are given to the admitting nurse, the attending physician will give the patient's diagnosis(es) and anticipated surgery, if any, in order to initiate the Utilization Review assignment of "length of stay."

2. **Admission Privileges:** A patient may be admitted to the hospital only by a member of the Active Medical/Dental Staff. The official admitting policy of the hospital shall govern all practitioners.

3. **Care by an Allied Health Professional:** Patients being admitted to receive the care of an Allied Health Professional shall be admitted by the sponsoring physician member of the Active Medical Staff or a Certified Nurse Midwife with admitting privileges. The Active Medical Staff member shall assume overall responsibility for the care of the patient throughout the hospital stay. If provided for by licensure or scope of care, the Allied Health Professional may be responsible for recording Patient Care Orders, Progress Notes, History and Physical, Discharge Summary, Consultations, or Operative Reports, and make other notations in the patient records, but during his/her provisional period the attending physician must authenticate each. Patient care orders will be carried out before authentication. All Allied Health Professionals, except Certified Registered Nurse Anesthesia providers, must have a non provisional Active Staff member assigned to them for supervision. The provisional Certified Registered Nurse Anesthesia providers must be proctored by a non provisional Active Staff Anesthesiologist or a non provisional Certified Registered Nurse Anesthesia provider.

4. **Admissions by Dental Staff:** The Dental Staff shall conform in general to the Rules and Regulations of the Medical Staff with the following additions.
   
   (a) Patients admitted for dental service shall be admitted on the Surgical Service and shall be the responsibility of that service.
   (b) An adequate history and physical by a physician member of the Active Medical Staff shall be required on each patient before surgery. This medical supervision shall continue until the dismissal of the patient.
   (c) Complete records, both dental and medical, shall be required on each patient and shall be a part of the hospital records.
   (d) An oral surgeon with credentials for patient management is able to do such without assistance from Medical Staff member as delineated in the bylaws.

5. **Danger to Patients:** Practitioner’s admitting private patients shall be responsible for giving such information as may be necessary to assure protection of other patients from those who are a source of danger. Suspected infections should be identified and delineated to such extent as possible by the attending physician on admission.

6. **Orders for Treatment/Requests for Consultation:** All orders for treatments or requests for consultation shall be in writing. Telephone orders, verbal orders, or requests for consultations are to be authenticated, as set forth in the Medical Staff Bylaws. An order for treatment, diagnostic tests, and so forth, or request for consultation shall be considered to be in writing if dictated to registered nurses, Pharmacists, dieticians, speech therapists, occupational therapists, Care Management, physical therapists, and respiratory therapists. All standing orders will be reviewed annually and signed by the physician. A physician is responsible for contacting his own consultant except in the case of an emergency, at which time a member of the nursing staff may be asked to contact the consultant. Consultation of Trauma Team shall follow trauma protocol.

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127 Revision(s) made July 2009
7. **Care and Treatment of Patient**: A member of the Active Medical Staff shall be responsible for the medical care and treatment of each of their patient(s) in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

8. **Patient Assignment**

(a) **Patients Presenting to Emergency Department**: A patient presenting to the Emergency Department with a problem that, in the opinion of the Emergency Department nurses and/or the Emergency Department physician, requires intervention, will be seen by the Emergency Department physician with the appropriate attending physician being notified as indicated by circumstances, following as much as possible the wishes of the patient and/or family. In case of the patient and/or family not having a choice and the patient needing admission to the hospital, selection of an attending physician shall be made from the appropriate rotating roster of Medical Staff members for unassigned patients. The following procedure will be followed to define an unassigned patient:

1. Patients are assigned if there is evidence of an ongoing doctor-patient relationship as evidenced by:
   - The patient’s verbal history
   - Hospital medical records
   - In-hand prescriptions

2. Patients are unassigned if:
   - None of the above exist
   - Fired from a physician’s practice with a letter sent from the physician to the patient. Physician must provide documentation to the Emergency Department upon request.
   - The patient’s primary care practitioner does not have admission privileges at St. James Healthcare.
   - Patient has not seen the primary care provider for the past three years.

3. The primary medical indication for admission of the unassigned patient shall be the determining factor used by the Emergency Department physician to decide which “unassigned physician” on call is contacted for the admission.

4. The Emergency Department physician has the final say. This does not, however, preclude discussion between the Emergency Department physician and the on-call physician contacted. Any such discussion shall, however, be conducted in a professional and polite manner.

5. Once the “unassigned” patient is admitted to the “unassigned physician” on call, the patient is no longer unassigned for the purposes of that hospital admission.

(b) **Medical Screening Examination**: Each patient presenting to the Emergency Department will have a screening medical examination. This screening medical examination shall be completed by an individual who is credentialed through the Medical Staff. All patients being admitted must be seen by a physician.

(c) **Call List for Unassigned Patients**: Rotating rosters shall be prepared at the direction of the Medical Executive Committee and shall be posted in the Emergency Department and distributed to all involved Medical Staff members. The Sections may direct how the rotating roster will be set up for their Section members by a vote at a Section meeting. There will be a rotational call list prepared when there are two separate practices for a particular specialty.
(d) **Non-Emergent Problems**: A patient who comes to the Emergency Department for a non-emergent problem may be seen by the Emergency Department physician on duty or the patient's attending physician, depending on patient/family choice with a 30-minute limitation on patient waiting for attending physician. If 30 minutes expire, the patient will be asked whether he/she wants to be seen by the Emergency Department physician or other physician of his/her choice. If physician cannot be contacted within ten (10) minutes, the Emergency Department physician will see the patient.

9. **Call Coverage**: Each member of the Medical Staff shall name a physician to take his call should he/she be out of town or unable to be located. This list will be available in the Emergency Department.

10. **Laboratory Work Prior to Admission**: Any laboratory work performed within one (1) week prior to admission may be entered into the patient hospital record and accepted as part of the basic medical evaluation of the patient. Easily legible copies or the original may be accepted.

11. **Admissions to Intensive Care Unit and Cardiac Care Unit**: If any question as to the validity of admission to or discharge from the Intensive or Cardiac Care Units should arise, that decision is to be made through consultation with the Chief of Surgery Section and/or Chief of Medicine Section.

12. **Need for Continued Hospitalization after Specific Periods of Stay**: The attending practitioner is required to document the need for continued hospitalization after specific periods of stay (per disease category) as identified by the Utilization Review Committee of this hospital.
   
   (a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

   (b) The estimated period of time the patient will need to remain in the hospital.

   (c) Plans for post-hospital care.

Upon request of the Utilization Review Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized thirty (30) days or longer, including an estimate of additional days of stay and the reason therefore. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

13. **Discharge of Patients**: Patients shall be discharged only upon written order of the attending physician. An exception to this rule is that, as part of the disaster plan and during a disaster, the physician designated to dismiss patients may do so with the approval of the hospital administration and without the approval of the attending physician. For medical/legal reasons, if it should be necessary for a patient to leave the hospital, the physician will write a discharge order. If the patient returns within the same date, an order to readmit the patient will be written on the physician's order sheet, and the same medical record will be utilized. If the patient returns on a later date, this will constitute a new admission.

14. **Patients Leaving Against Medical Advice (AMA)**: Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

15. **Floor and Room Assignment of Patients**: Floor and room assignment of patients will be made by the Nursing Supervisor through the Admissions Office. It is understood that when deviations are made from assigned areas, the Nursing Supervisor will correct these assignments at the earliest possible moment. If a patient is transferred, the attending physician shall be notified.
16. **Protocol for Patients Needing Psychiatric or Substance-Abuse Service**: Since St. James Healthcare does not provide inpatient psychiatric or substance-abuse services, the Medical Staff's role in the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the hospital, or who suffer the results of alcoholism or drug abuse and need additional care, is delineated in the St. James Healthcare Administrative Policies regarding:

(a) Patient Transfers

(b) OBRA Anti-Dumping 1987

(c) Transferring Patients to Mental Health Facilities

(d) Violent/Suicidal Patients.

17. **Physicians Notified of Death of Patient**: When a patient dies in this hospital, the attending physician shall be notified at the time of death.

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Revised June 2015
GENERAL

THE MEDICAL STAFF MS-004
RULES AND REGULATIONS

MEDICAL RECORDS:

A. **History and Physical Report:** A History and Physical Report may be completed no more than thirty (30) days before each admission to inpatient services. Any history of physical examination performed prior to admission must be updated within 24 hours after admission. Inpatients and outpatients undergoing invasive or therapeutic procedures aside from routine lab procedures and diagnostic radiological procedures must have a History and Physical Examination Report completed and recorded on the chart prior to the performance of the procedure. Any history and physical examination performed prior to the date of the invasive or therapeutic procedure must be updated by the provider performing the invasive or therapeutic procedure on the day of and prior to initiation of such procedure.

Outpatients undergoing invasive or therapeutic procedures aside from routine laboratory procedures and diagnostic radiological procedures must have a History and Physical Examination Report completed and recorded on the chart prior to performance of the procedure. A History and Physical Examination Report shall be completed no more than thirty (30) calendar days prior to outpatient procedures. Any history of physical examination performed more than 24 hours prior to the outpatient admission must be updated prior to the outpatient procedure. The medical record shall be considered delinquent if these standards are not met. A complete History and Physical Report has the following components:

1. Chief complaint.
2. History of present illness.
3. Past medical history (including allergies, medications, clotting disturbances, and habits).
4. Family History.
5. System Review:
6. Appropriate physical examination:
7. Course of action planned during the hospital stay.
8. Impression/Diagnosis.

B. **Abbreviated History and Physician Exam:** May be recorded (for non-inpatients undergoing minimally-invasive diagnostic or therapeutic procedures {minimally invasive is defined as those requiring local anesthetic}, which require outpatient nursing observation). An abbreviated history and physical exam has the following components:

1. History of present illness.
2. Abbreviated past medical history.
3. Abbreviated systems review.
4. Indications for the procedure contemplated.
5. Current medications and allergies.
6. Past surgical and/or anesthesia complications.
7. Course of action planned during the hospital stay.
8. Impression/diagnosis.

C. **Operative Reports:** The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The medical

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record shall be considered delinquent if this standard is not met. The operative reports dictated or written after procedure record will contain:

1. Preoperative diagnosis.
2. Primary surgeon and assistant(s).
3. Description of findings.
4. Technical procedures used and description.
5. Specimens removed.
7. Estimated blood loss.

D. **Verbal/Telephone Orders:** Each verbal order is dated and is identified by the name of the licensed practitioner with appropriate privileges who gives the order and the qualified individual who receives it. Qualified individuals are registered nurses, pharmacists, dietitians, speech therapists, occupational therapists, care management, physical therapists, and respiratory therapists.\(^\text{132}\) Verbal/telephone orders are to be authenticated (signed) within 48 hours\(^\text{133}\) by the practitioner responsible for the patient, except for orders for restraint that are to be authenticated (signed) within 24 hours.

E. **Discharge Summaries:** Discharge Summaries are to be completed (dictated) within the 30-day completion requirement for the entire record. The components of a Discharge Summary are:

1. Final diagnoses (principal diagnosis and additional diagnoses identified during the hospital stay).
2. Operative procedures performed.
3. Admitting diagnosis or reason for the admission.
4. Pertinent findings, which may include laboratory, x-ray, physical.
5. Medical and/or surgical treatment which include the patient's response, complications (hospital infection or other complication), and consultations.
6. Patient's condition on discharge (stated in measurable terms so that a comparison can be made with the admitting condition).
7. Discharge instructions (physical activities, medication, diet, follow-up care).
8. Where patient discharged to: home, other hospital, nursing home, home health, other.

F. **Quality of Medical Records:** The quality of the medical record depends in part on timeliness, accuracy, meaningfulness, authentication, and legibility of the informational content. A record may be considered delinquent if the Medical Executive Committee determines the medical record does not fulfill the standards of quality.

G. **Transfer of Patient Care to Second Physician:** If the first physician states immediately in the Progress Notes that the total care of the patient is transferred to the second physician, then the second physician is responsible for the History and Physical Report. However, if twenty-four (24) hours elapse before the second physician can assume\(^\text{1}\) the care of the patient, the first physician is responsible for the History and Physical Report.

H. **Reproduced Office Records:** Reproduced office records that are to be entered in the hospital medical records shall be on hospital-size paper of permanent type and legible enough to reproduce. A reproduction of office records meeting these requirements shall be acceptable. All of these shall include dates.

I. **Progress Notes:** Legible pertinent Progress Notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Each of the patient's clinical problems should be clearly identified in the Progress Notes. Progress Notes shall be written at least daily on

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\(^{132}\) Revision(s) made July 2009  
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critically-ill patients and on those where there is difficulty in diagnosis or management of the clinical problems.

J. **Consultations:** Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report shall be made a part of the patient's medical record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. A request for consultation signed by the physician requesting the consultation shall include a brief statement of information regarding the patient (e.g., the diagnosis, special conditions affecting the report of the consultant, and the specific information which is expected from the consultant). The request should be directed to a specific physician or service in general.

*Requests for Consultation:* Any physician requesting a consultation is personally responsible for contacting the consultant and defining the parameters. Request for consultation may take the following forms:

1. Consultation - the physician will see and evaluate the patient and document the assessment on the consultation form.
2. Consult and write orders - the physician will see and evaluate the patient, document the assessment on the consultation form, and write orders for treatment and diagnostic modalities.

*Time Limit for Consultation:* Consultation must be answered in a timely fashion (within 24 hours).

K. **Obstetric Record:** The current obstetric record shall include a complete History and Physical Report. The History and Physical may be the original copy of the attending physician's office prenatal record transferred to the hospital before admission. Pertinent additions to the History and subsequent changes in physical findings will be added on admission. This will include patients requiring Cesarean Section.

L. **Dates and Authentication:** All clinical entries in the patient's medical record shall be accurately dated and authenticated. Orders and progress notes shall have the time recorded.

M. **Symbols and Abbreviations:** Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Record Department. Copies are provided at each Nursing Station.

N. **Release of Medical Information:** Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

O. **Removal of Medical Records:** Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In cases of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or another. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner's privileges for a period to be determined by the Medical Executive Committee of the Medical Staff.

P. **Access to Medical Records:** Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. The Medical Executive Committee shall be notified of all such projects of the Medical Staff. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
Q. **Routine or Standing Orders**: A practitioner’s routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner. The Routine or Standing Orders shall be reviewed and signed annually by the physician.

R. **Readmission for Same Condition**: If a patient is readmitted within seven (7) days’ time for the same condition, the previous History and Physical examination, with an interval note stating the condition of the heart and lungs, will suffice.

S. **Emergency Department Records**: Emergency Department records are to be completed at the time care is rendered.

T. **Completion of Medical Records**: In the event there are incomplete records for a physician who has left, died, or is no longer on the Medical Staff, his/her records will be completed by the President of the Medical Staff or his appointee.

U. **Privacy Practice and Organized Health Care Arrangement**: All members of St. James Healthcare’s Medical Staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

V. **Failure to Complete Medical Records**:  

   a. Medical Records Department will tabulate the number of delinquent records every other week notifying each Medical Staff member of the number of delinquent records. The Medical Record Department will notify the President of the Medical Staff of any Medical Staff member with any delinquent records. The Medical Records Department will notify the Medical Staff member at least 14 days before medical records are delinquent. Any Medical Staff member that has not completed his/her medical records within 30 days of discharge of a patient will be fined $200.00. If the records are not completed within 45 days, an additional fine of $500.00 will be levied. If the records are not completed within 60 days, the Medical Staff member will receive a certified letter from the Medical Staff President notifying him/her that admitting, consulting, and procedure performance (both inpatient and outpatient) privileges shall be voluntarily relinquished. This relinquishment shall continue until all records of the Medical Staff member are no longer delinquent. As per the Montana Code Annotated, the voluntarily relinquishment or privileges will be forward to the Montana State Medical Examiners. The Medical Staff member may provide a written reason for the failure to complete medical records to the Medical Executive Committee for review and action.

   b. For failure to complete medical records in a timely manner, a Practitioner’s clinical privileges (except with respect to his/her patients already in the Hospital and his/her rights to admit patients, to perform surgeries or procedures already scheduled, and to consult with respect to patients,) shall after written warning of delinquency, be automatically relinquished and shall remain relinquished until medical records are complete. In cases of emergencies, the President of the Medical Staff or his/her designee may provide exceptions to this policy on a case-by-case basis. Due consideration will be given to those Practitioners who are on vacation or who are ill.

   c. The money received from the fines will be donated to the St. James Healthcare Medical Staff’s Bank Account.

   d. If the fines are not paid by the time of the next reappointment, the Medical Staff member will not be in good standing and the Medical Executive Committee could potentially not approve the Medical Staff member’s request for reappointment.

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134 Revisions made to this section June 2012
GENERAL

MEDICAL STAFF MS-005
RULES AND REGULATIONS

GENERAL CONDUCT OF CARE

A. Consent Form: A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission by the Admissions Clerk.

B. Informed Consent Form for Surgery: An informed consent must be obtained from the patient, or from his legal representative, prior to surgery, for all surgical procedures, except in emergencies. This consent must be dated, timed, and witnessed. If an informed consent cannot be obtained in an emergency situation, it should be documented as to why the informed consent cannot be obtained.

C. Legibility of Orders: The practitioner's orders must be written clearly, legibly, and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.

D. "Blanket" Orders: The use of "Renew," "Repeat," "Continue" or "Resume Previous Orders" is not acceptable.

E. Orders Canceled at Surgery: All previous orders are canceled when patients go to surgery.

F. Stop Orders:
   1. In acute care patients, all IV therapeutic antibiotics will be stopped after ten (10) days, unless the physician has requested a different specific duration or stop date. The physician will be notified in writing on the chart twenty-four (24) hours prior to the impending stop of IV therapeutic antibiotics.
   2. For Transitional Care Unit (TCU) patients, all therapeutic antibiotics, (PO, IV, and IM) will be stopped after ten (10) days, unless the physician has requested a different specific duration or stop date. The physician will be notified in writing and by phone twenty-four (24) hours prior to the impending stop of the antibiotics.

G. Drug Enforcement Administration (DEA) License: If a practitioner's DEA license expires, that practitioner will not be allowed to writer orders for controlled substances covered under that certification until a copy of the license and/or primary source verification is supplied to the Administrative Medical Staff Coordinator.

H. Drugs and Medications: All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service of A.M.S. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

I. Drugs Brought to Hospital by Patient: Drugs brought into the hospital by patients shall not be administered. The only exception to this rule will be drugs not available in the Hospital Formulary, which are identified and are specifically ordered by the physician. Drugs not used during a patient's hospitalization should be packaged and sealed, then either given to the patient's family or stored and returned to the patient at the time of discharge.

J. Anesthesia Record: A signed and dated postoperative notation describing the presence or absence of anesthesia-related complications will be completed prior to discharge.

K. Consult Indicated: The patient's physician is responsible for requesting consultation when indicated. If an indicated consult is not obtained, the matter may be subject to consideration by the Medical Staff.
L. **Care Questioned by Nursing Staff:** If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her Nursing Supervisor who, in turn, may refer the matter to the Vice President of Clinical/Patient Services or an appropriate designee). If warranted, the matter may be brought to the attention of the Chief of the Section wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chief of the Section may request a consultation.

M. **Availability of Physician and Coverage of In-Hospital and Emergency Department Patients:**
The purpose of these recommendations is to codify physician responsibility to respond to patient care needs when the physician is not physically present in the hospital. The recommendations include, but are not limited to, telephone response; physician in-person response to the patient care area; weekend, holiday, and vacation call coverage; and consultation availability. Unless otherwise stated, times given are approximate and refer to situations that are immediately threatening to the patient's life or health.

N. **Timely Continuous Care:** The members of the Medical Staff of St. James Healthcare shall provide timely continuous care to any hospital inpatients for whom they are the primary physician. If a member of the Medical Staff is the primary physician for an inpatient at St. James Healthcare and he/she anticipates that he/she will become unavailable, then he/she shall arrange for another member of the Medical Staff to provide coverage. Covering physicians are expected to respond to patients’, nursing staff, and Administrative concerns about care of a particular patient's problem with the same timeliness expected of the primary physician.

O. **Unavailability:** In the event that the member of the Medical Staff who is primarily responsible for the care of a patient becomes unavailable as defined in these Rules, other physician members of the Medical Staff involved in the care of that particular patient will assume primary responsibility for the care of that particular patient. In the event that a physician is unavailable to provide emergent bedside patient care, the following procedures shall go into effect:

1. The Emergency Department physician on duty shall be asked to see the patient immediately and to provide necessary care to preserve life and limb until the primary attending physician or an appropriate covering physician is physically present to provide care.

2. Nursing Supervisor is to be notified. He/she shall interrupt a busy phone if that is the problem causing the unavailability. If, after retrying backup phone numbers and other telecommunication modalities, the Nursing Supervisor is unable to locate the primary physician or a covering physician, the first available physician from the following list shall be contacted in the order listed to either assume or direct care for that patient's immediate problem or to ask another member of the Medical Staff to do so:

   (a) President of the Medical Staff.
   (b) Vice President of the Medical Staff or the Chief of the Section involved.
   (c) Chief of the Section involved or the Vice President of the Medical Staff.
   (d) Other Section Chiefs.
   (e) Secretary/Treasurer of the Medical Executive Committee.
   (f) Member-at-Large of the Medical Executive Committee with the longer tenure.
   (g) Member-at-Large of the Medical Executive Committee with the shorter tenure.
   (h) Immediate Past President of the Medical Staff.
   (i) The Chief Executive Officer or representative.

P. **Phone Availability:**
Medical staff phone response time is 10 minutes to all departments except Recovery Room, which is five (5) minutes.
Response Time
Emergency Department for Medical Staff members on the appropriate call list – 30 minutes

Q. **Availability to Patient Care Area:** Availability to the patient care areas shall be 30 minutes after the physician has been notified that there is a problem immediately threatening MORTALITY or MORBIDITY to the patient for whom the physician is the primary physician.

R. **Discharge of Attending Physician by Patient:** In the event that a hospital patient discharges as attending his/her physician and does not have a preference for another physician or if his/her preferred replacement physician is unavailable or is otherwise unable to provide care for the patient, the President of the Medical Staff or his designee will be contacted to arrange for a replacement physician.

S. **Preoperative Laboratory and Diagnostic Studies for Outpatients Requiring General Anesthesia:** Outpatients who receive a general anesthetic require the same laboratory and diagnostic studies as inpatients who receive a general anesthetic, as defined in the Preoperative Minimum Laboratory Testing (General, Spinal, Epidural, or Peripheral Anesthesia) Guidelines (OR-112). These may be accomplished in the outpatient area or physician's office prior to the time of the scheduled case.

T. **Preoperative Laboratory and Diagnostic Studies for Outpatients Requiring Local Anesthesia or Moderate Sedation:** Patients receiving local anesthesia or moderate sedation must sign an Operative Consent Form prior to surgical intervention and, further, they must have a written history and physical examination documented on their chart.

U. **Preoperative Workup for Emergency Procedures:**

1. **Emergency Procedure:** When a patient is in an emergent condition (an immediate threat to the life or health of the patient) and immediate treatment is required to prevent catastrophic disability, immediate surgical treatment may be required. Physician's documentation as to the state of the emergency must be on the chart. If the emergent condition does not allow written consent, treatment may be administered without the necessity of written and signed consent. Blood must be drawn prior to commencing the procedure and must be sent to the laboratory for results. Blood work may also be waived by the physician with consultation and approval by anesthesiology, if the patient's emergent condition so dictates. This must be documented on the chart.

2. **Urgent Procedure:** Patient requires rapid, but no immediate intervention. Urgent procedures include most emergencies and imply that the procedure will be performed within several hours. These patients will require preoperative laboratory work, history and physical examination, and informed operative consent.

V. **Pediatric Age:** The pediatric patient will be any person less than 18 years of age.
PROCEDURE IN THE EVENT OF PATIENT EXPOSURE TO PHYSICIANS’ BLOOD

1. Any report of such an event will be kept in the strictest confidence. If it is an incident report or any other manner of report, it will be communicated directly to the Chairman of the Infection Control Committee (ICC).

2. If the Chairman of the ICC feels that there is no data to substantiate the report of exposure after interviewing the parties involved, the issue will be dropped.

3. If the Chairman of the ICC feels the potential for exposure does exist, a committee of three people will convene to determine whether or not that concern is substantial enough to be acted on. This Committee would consist of the physician involved, the Chief of the appropriate Section, and the Chairman of the ICC. If two out of three of these members feel there is reason to proceed, the testing as described below will be done. If any member of the Committee feels the patient's rights have been infringed by the majority opinion of the Committee, the disagreement will be arbitrated by the President of the Medical Staff. If there is concern about exposure of the patient to physician’s blood, the testing and counseling for the patient will be the same as it would be for the physician. It is recognized in nearly all these instances that there is simultaneous exposure of both parties. In any event, the procedures for counseling the patient and/or the physician will be the same.

4. If blood testing is performed, the reports will be reviewed by the Chairman of the ICC to determine whether there exists any potential for harm of the patient by the exposure. These results will be communicated to the patient by the Chairman of the Infection Control Committee, as they are communicated to any physician who is exposed to patients’ blood or body fluids.

5. In the event the Chairman of the Infection Control Committee is the physician involved, the pathologist or another physician member of the ICC of the physician’s choosing can take his place. In the event the President of the Medical Staff is involved, the Vice-President of the Medical Staff will take his place on the reviewing Committee. In the event that the Chief of the appropriate Section is the physician involved, the Assistant Chief of the appropriate Section will take his place on the reviewing Committee. If the physician involved is concerned about the particular individual who is Chairman of the Infection Control Committee being involved, the pathologist or any other physician member of the Infection Control Committee would be designated by the physician involved as a member of the reviewing Committee.

6. Any failure by the physician involved in the exposure to cooperate with the above procedures to assure the safety of the patients under our care, would be reported immediately to the Medical Executive Committee. The Medical Executive Committee would be responsible for deciding further action, if any.
GENERAL

MEDICAL STAFF MS-007
RULES AND REGULATIONS

REVIEW OF PATIENT-CARE POLICIES

The Medical Staff of St. James Healthcare will utilize, review, implement, and effect necessary changes to certain Policies developed by the Hospital Administration, as they affect patient care. These include, but are not limited to:

1. Restraints,
   a. Medical/Surgical, V-A 28.1
   b. Behavioral, V-A 28.2
2. Living Will/Advanced Directives, V-A 19,
3. Organ Donation
   a. Organ Tissue Donation, V-A 1
   b. Organ Donation after Cardiac Death, V-A 24
4. Sedation/Analgesia (Moderate Sedation), V-A 38
5. EMTALA, V-A 23,
6. Autopsy, V-A 50
7. Herbal Products, V-J 33
8. Sentinel Events, I-I 4
GENERAL

MEDICAL STAFF MS-008
RULES AND REGULATIONS

PROVISIONAL PERIOD AND PROCTORING

1. The provisional period for each new Medical Staff member and the provisional period for the exercise of any new or increased clinical privileges by an established Medical Staff member shall be monitored by a proctor appointed by the Section Chief of the appropriate Clinical Section.

2. Proctors shall report to the Section Chief as directed by in the Medical Staff Bylaws on the appropriate form approved by the Medical Staff. If a proctor does not wish to utilize the provided form, he/she shall provide in his/her written report all of the information that would be provided by executing the appropriate form.

3. The number of charts/cases to be reviewed for provisional period is to be determined by the Clinical Sections. If a Clinical Section has not determined that number of charts/cases to be reviewed for a provisional period, 12 charts/cases or 10% of the charts/cases for the provisional period shall be reviewed.

4. If a Active Provisional Medical Staff Member or a Active Medical Staff Member with provisional new or additional clinical privileges has not accumulated 12 charts/cases (or the number designated by the Clinical Section) during the designated Provisional Period (one year unless otherwise specified by the Clinical Section), the Provisional Period shall be extended as determined by the Clinical Section and the Medical Executive Committee. Case/chart review for Provisional Allied Health Professionals, Courtesy, Consulting and Visiting staff will be determined in accordance with Article VI – Part B Section 1, Paragraph d, Initial Provisional Appointment of these Bylaws.
CHARTS SENT FOR OUTSIDE REVIEW

If a Section Chief or Clinical Section, or MultiSpecialty Peer Review Committee, as an Adhoc Committee of the Medical Executive Committee, is unable to make a recommendation to the Medical Executive Committee regarding credentialing or proper disposition of a problem with the management of a particular case, the Section Chief may recommend to the Medical Executive Committee that a patient's chart or charts be sent for review by an outside reviewer expert in the area questioned. The Medical Executive Committee will then determine if the chart (or charts) do(es) indeed need outside review. If the chart is deemed to need outside review, the Section Chief may then send the relevant material for that outside review. All reports by the outside reviewer will be addressed to the Section Chief and/or the Medical Executive Committee.135

135 Revised Paragraph October 2014
GENERAL

MEDICAL STAFF MS-010
RULES AND REGULATIONS

SEXUAL HARASSMENT AND THE MEDICAL STAFF

The Federal Equal Employment Opportunity Commission has declared that sexual harassment constitutes illegal discrimination under Title VII of the Civil Rights Acts of 1964. It is the position of St. James Healthcare Medical Staff that sexual harassment of or by Medical Staff members and Allied Health Professionals (independent or dependent) has no place and will not be tolerated in this hospital.

By authentication of having received and read the Bylaws, all practitioners are aware of the Medical Staff’s position regarding sexual harassment and know that adequate procedures are in effect to facilitate prompt reporting of specific acts of sexual harassment that may occur in the hospital. Prompt action will be taken on all complaints made. Practitioners shall be defined as all individuals who are not employed by the hospital, but have been granted privileges to practice or provide services in St. James Healthcare or on hospital-affiliated business, including, but not limited to physicians, dentists, and specified professional personnel.

Sexual harassment undermines an individual’s integrity and human dignity. St. James Healthcare’s Medical Staff prohibits all sexual harassment, including, but not limited to prohibiting persons connected with the Hospital from making unwelcome sexual advances, requesting sexual favors, or engaging in other verbal, physical, non-verbal, and non-physical conduct of a sexual nature, whereby an individual’s submission to or rejection of such conduct is made an explicit or implicit condition of employment or care; or is used as the basis of an employment decision affecting the individual; or where such conduct has the purpose or effect of interfering with an individual’s job performance or care, or creates an intimidating, hostile, or offensive environment.

The key idea to help people decide if a behavior is or is not sexual harassment is the word “unwelcome.” If any individual finds behaviors or comments offensive or is made the object of unwelcome sexual attention:

1. If reasonable, the complainant is encouraged to inform the individual doing the harassment that he/she believes the conduct of that individual is sexual harassment and unwelcome. If the complainant is unable or unwilling to approach the individual doing the harassment, then the complainant should do as follows:

   A. If the complainant is an employee: A report should be filed by the individual in accordance with St. James Healthcare Sexual Harassment Policy.

   B. If the complainant is a patient or practitioner: A written, signed, report should be filed in accordance with the Procedure for Questions Involving Medical Staff Members (in the Medical Staff Bylaws).
DISRUPTIVE BEHAVIOR AND THE MEDICAL STAFF

St. James Healthcare Medical Staff believes that all individuals within the Hospital shall be treated courteously, respectfully, and with dignity. To that end, the Hospital expects all practitioners to conduct themselves in a professional and cooperative manner in the Hospital.

By authentication of having received and read the Bylaws, all practitioners are aware of the Medical Staff’s position regarding disruptive behavior and know that adequate procedures are in effect to facilitate prompt reporting of acts of disruptive behavior that may occur in the hospital. Prompt action will be taken on all complaints made.

Problems may arise when a practitioner’s behavior is so disruptive to Hospital operations that the positive value of the practitioner’s clinical skills is outweighed by the negative impact of his/her behavior(s). That a practitioner’s behavior is unusual, unorthodox, or different is not a sufficient basis to justify disciplinary action; however, when the practitioner’s behavior has a significant negative impact on patient care, this will not be tolerated. Unacceptable disruptive conduct can include, but is not limited to, attacks leveled at other practitioners/healthcare providers which are personal, irrelevant, or go beyond the bounds of fair professional comment; comments written, illustrations drawn, or other material placed in a patient’s medical records or other official documents, impugning the quality of care in the Hospital or attacking other practitioners, healthcare providers, or Hospital policy; non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence; participation on a Medical Staff Committee or Section meeting in a disruptive or unprofessional manner; and/or imposing medical idiosyncratic requirements on other healthcare providers which have nothing to do with appropriate patient care, but serve only to burden the healthcare providers with unnecessary procedures.

Where reasonable, the concerned healthcare practitioner/provider is encouraged to inform the practitioner or the practitioner’s Section Chief, the President of the Medical Staff, or the Chief Executive Officer, that he/she believes the conduct of that individual is disruptive.

If the concerned healthcare practitioner/provider is unable or unwilling to approach the practitioner or the aforementioned parties, or is not satisfied with the response from the aforementioned parties, then a written, signed report should be filed in accordance with the Procedure for Questions Involving Medical Staff Members (in the Medical Staff Bylaws).

136 Revised Paragraph October 2013
GENERAL

MEDICAL STAFF MS-012\textsuperscript{137}
RULES AND REGULATIONS

ORDERING OF DIAGNOSTIC AND THERAPEUTIC PROCEDURES

Physicians and other licensed providers may order diagnostic testing on outpatients at St. James Healthcare. Examples include (but are not limited to) laboratory testing, radiology exams, pathology specimen evaluation, electrocardiograms, echocardiograms, fitness testing and therapy evaluation.\textsuperscript{138}

Physicians and other providers licensed in the State of Montana may order non-invasive and non-injectable therapeutic intervention on outpatients at St. James Healthcare. Examples included (but are not limited to) physical, occupational and speech therapy and tetanus toxoid.

In order to assure quality improvement, peer-review and to protect patients, only physicians and other Montana licensed providers who are credentialed by the medical staff, may order therapeutic interventions which require injection, infusion and/or invasive modality. Examples include (but are not limited to) injectable antibiotics, chemotherapy and blood transfusions.

\textsuperscript{137} Medical Staff MS-012 Added to Rules and Regulations October 2010
\textsuperscript{138} Revisions made to this paragraph June 2012
SURGERY SECTION
RULES AND REGULATIONS

1. **Surgical Consent:**
A written, signed informed surgical consent shall be obtained prior to any operative procedure except in those situations where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the patient's condition. In emergency situations involving a minor or an unconscious patient, in which consent for surgery cannot be immediately obtained from the parents, guardian, or next of kin, the circumstances should be fully explained on the patient's medical record. If time permits, a consultation may be desirable before the emergency operative procedure is undertaken. A telephone consent may be obtained according to hospital policy. The consent is valid for 30 days. 139

2. **Pre-Operative Testing:**
Preoperative minimum laboratory work will be done and will be noted on the chart prior to surgery for all patients having a surgical procedure under general, regional, or monitored anesthesia care with the following exceptions:

A. Emergency cases in which life or health would be endangered.
B. Emergency cases in which it is impossible to get a voided or catheterized urine specimen preoperatively.
C. Cases scheduled under local anesthesia.
D. If an infant cannot provide a urine specimen, the urinalysis should be obtained as soon as possible post-operatively.
E. EKGs at St. James Healthcare must be done prior to surgery, in order to be read and confirmed.140
F. Blood Bank: Type-and-screens and type-and cross matches should be done within the 72 hours prior to surgery.
G. The patient is unable to cooperate for preoperative testing.141

Preoperative minimum laboratory testing is reviewed and approved by Surgery Section.142

3. **Tissue or Foreign Bodies Removed at Surgery:**
All tissues or foreign bodies removed at surgery, with the exception of those listed below, will be sent to the hospital pathologist who shall make such examination as he considers necessary. The exceptions are:

A. Myringotomy tubes. These may be given to the family at their request.
B. Foreign bodies, i.e. rocks, coins, IUDs, etc. These may be given to the patient or their family after they have been properly recorded.
C. Skin scars, at the option of the physician. Scars from surgeries that might possibly harbor other disease such as recurrent neoplasm should be sent.
D. Surgical appliances such as orthopedic screws, plates, etc.
E. Placentas that are grossly normal and have been removed in the course of operative or non-operative obstetrics.
F. Cataracts.
G. Bone, cartilage, and adjacent structures taken incidental to other operative procedures.
H. Clots from aneurysms.
I. Bullets and other foreign objects removed from patients who may have been injured during a criminal activity should be kept by the operating surgeon and given directly, in person, to the police. Bullets should be grasped by the base to avoid marking them.
J. Pacemakers.
K. Teeth.

139 Revised October 2013
140 Revised October 2013
141 Added Sentence October 2013
142 Revised October 2013
4. **General Rules – First Assistant:**

   A. It is the responsibility of the operating surgeon, considering the patient's clinical condition and the surgical procedure, to determine the need for a surgical assistant.
   
   B. The first assistant may be a Medical Staff Member or an Allied Health Professional credentialed to first assist.
   
   C. When an assistant is required, the assistant must be in the hospital and ready to begin the operation with the surgeon before the anesthetic is to be initiated.
   
   D. The assistant will remain at the operating table in assistance until all but the subcutaneous tissues and skin have been closed, except if called away by an emergency. Upon resolution of the emergency, the assistant will return.
   
   E. The name of the assistant will be given to the Director of Surgery or the Surgery Secretary when a case is scheduled or as soon as possible thereafter.
   
   F. Surgeons must be in the operating room and ready to commence operation at the time scheduled. Start time will be defined as when the patient is anesthetized and ready to be positioned. Only in extenuating circumstances will the operating room be held longer than ten (10) minutes after the time scheduled. If the surgeon is late three times in a six-week period, the following actions will occur:

      1) Verbal warning by Director of Surgery
      2) Written warning from Director of Surgery
      3) Letter from Director of Surgery and/or Chief of Surgery informing surgeon that the surgeon shall not be allowed to perform or schedule 8:00 a.m. cases for two weeks.

   G. For patients with life-threatening conditions or medical complications, surgeons should request appropriate consultation from specialists on the Medical Staff.
   
   H. Clinical privileges in surgery for dentists and oral surgeons are outlined in the Bylaws.

5. **Trauma Call**
   General surgeons are required to take trauma call; exceptions can be granted on an individual basis through Surgery Section.

6. **Emergency/After Hours Surgery Cases:**
   Only Class I, Class II, Class III, and Class IV cases may be done after normal surgery hours.

7. **Anesthesia-Related Rules and Regulations:**

   A. Type of Anesthesia: Anesthesia providers will determine the appropriate type of anesthesia in consultation with the operating surgeon. Conflicts will be referred to the Chief of Surgery.

8. **Procedure-Specific Rules:**

   A. Pacemaker Insertion:
      1) The surgeon is responsible to dictate and/or record the cut down and location of the vein.
      2) The internist is responsible to dictate and/or record the guidance and location of the electrode into the ventricle.

   B. Uterine curettage or endometrial biopsy: If a uterine curettage or endometrial biopsy is contemplated and there is a possibility of a viable pregnancy, consultation with a gynecologist is required.

   C. Obstetric record: A current obstetric record shall include a complete history and physical. The attending physician must update the history and physical on admission.

   D. Early termination of pregnancy will require:
1) **Consultation:** Two consultants, in addition to the attending physician, must confirm that they have examined the patient and agree with the proposed procedure as medically necessary to preserve the patient's life. These consultations shall be written or typed.

2) **Discussion with Hospital Administrator:** The attending physician must discuss the proposed procedure with the hospital administrator, establishing the fact that the patient's life can be saved only by terminating the pregnancy.

3) **Permits required:** Therapeutic Abortion Form and Informed Surgical Consent Form.

9. **Autopsies**
Development of criteria for autopsies shall be performed by the Surgery Section.

10. **ICU/CCU Admission and Discharge**
Establishes criteria for admission and discharge of patients from the unit, including a methodology to address when patient load exceeds patient capacity.

A. Admission to the ICU/CCU is dependent upon the need for intensive and specialized nursing care. A "Do not resuscitate" order or an Advance Directive does not automatically prohibit admission to the ICU/CCU. Criteria for admission is:

1) Monitoring and assessment of biophysical parameters (i.e., temperature, cardiac function, respiratory function, and cerebral function more frequently than every four hours).

2) Continuous monitoring of biophysical parameters with a high potential for requiring immediate nursing intervention.

3) Patients requiring pharmacologic interventions to manage cardiac dysrhythmias, vaso-active infusions, sedation, or barbiturate anesthesia/paralyzing medications.

4) Patients requiring acute interventions to manage respiratory status, circulating blood volume, or cardiac rate or rhythm.

5) Patients requiring the following monitoring modalities: arterial pressure monitoring, Swan-Ganz monitoring, or intracranial pressure monitoring.

In the event that patient needs exceed unit capacity, the attending physician of the new admission contacts the unit for candidates for transfer from the unit. The physician then contacts the attending physician of the discharge candidate to discuss and prioritize bed availability.

B. Discharge from the ICU/CCU is appropriate when:

1) The patient's neuro-vital signs, blood pressure, cardiac or respiratory status is maintained without intravenous medications or mechanical interventions.

2) There is an absence of arterial and/or Swan-Ganz monitoring lines or intracranial pressure monitoring.

3) The need for monitoring and evaluation of the patient's biophysical parameters is every four hours or greater.

11. **ICU/CCU Pediatric Patients**
All patients under the age of 12 years who are admitted to the ICU/CCU shall be seen in consultation by a Pediatrician.

12. **ICU/CCU Notification of Test Results**
The physician ordering tests will be notified of abnormal or clinically significant lab values. If the ordering physician is different from the attending physician, the attending physician will also be notified.

13. **ICU/CCU Patients Admitted from Emergency Department**
Patients admitted to the ICU/CCU from the Emergency Department must be seen by the attending physician within 6 hours of admission to the unit or earlier as dictated by the patient's condition.
14. **ICU/CCU Conflicting Orders**
   If conflicting orders are written, the physicians writing the orders will be notified and will be responsible for resolving the conflict and writing revised orders.

15. **ICU/CCU Sudden Change in Patient's Condition**
   If there is a sudden change in the patient's condition, the attending physician will be notified and queried regarding notification of the consulting physician.
1. **Blood and Blood Product Review**
   Blood and blood product review shall be performed by the Medicine Section.

2. **ICU/CCU Admission and Discharge**
   Establishes criteria for admission and discharge of patients from the unit, including a methodology to address when patient load exceeds patient capacity.

   A. Admission to the ICU/CCU is dependent upon the need for intensive and specialized nursing care. A "Do not resuscitate" order or an Advance Directive does not automatically prohibit admission to the ICU/CCU. Criteria for admission is:
      1) Monitoring and assessment of biophysical parameters (i.e., temperature, cardiac function, respiratory function, and cerebral function more frequently than every four hours).
      2) Continuous monitoring of biophysical parameters with a high potential for requiring immediate nursing intervention.
      3) Patients requiring pharmacologic interventions to manage cardiac dysrhythmias, vaso-active infusions, sedation, or barbiturate anesthesia/paralyzing medications.
      4) Patients requiring acute interventions to manage respiratory status, circulating blood volume, or cardiac rate or rhythm.
      5) Patients requiring the following monitoring modalities: arterial pressure monitoring, Swan-Ganz monitoring, or intracranial pressure monitoring.

   In the event that patient needs exceed unit capacity, the attending physician of the new admission contacts the unit for candidates for transfer from the unit. The physician then contacts the attending physician of the discharge candidate to discuss and prioritize bed availability.

   B. Discharge from the ICU/CCU is appropriate when:
      4) The patient's neuro-vital signs, blood pressure, cardiac or respiratory status is maintained without intravenous medications or mechanical interventions.
      5) There is an absence of arterial and/or Swan-Ganz monitoring lines or intracranial pressure monitoring.
      6) The need for monitoring and evaluation of the patient's biophysical parameters is every four hours or greater.

3. **ICU/CCU Pediatric Patients**
   All patients under the age of 12 years who are admitted to the ICU/CCU shall be seen in consultation by a Pediatrician.

4. **ICU/CCU Notification of Test Results**
   The physician ordering tests will be notified of abnormal or clinically significant lab values. If the ordering physician is different from the attending physician, the attending physician will also be notified.

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   Patients admitted to the ICU/CCU from the Emergency Department must be seen by the attending physician within 6 hours of admission to the unit or earlier as dictated by the patient's condition.
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   If conflicting orders are written, the physicians writing the orders will be notified and will be responsible for resolving the conflict and writing revised orders.

7. **ICU/CCU Sudden Change in Patient's Condition**
   If there is a sudden change in the patient's condition, the attending physician will be notified and queried regarding notification of the consulting physician.