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1.0 DEFINITIONS

“Advanced Practice Registered Nurse” or “Nurse Practitioner” means and refers to those registered nurses who have obtained additional, specialized education beyond the basic nursing education through the completion of an advanced degree in nursing from an accredited institution, who are licensed by the Montana Board of Nursing to practice professional nursing, who are certified by a nationally recognized professional organization as having a nursing specialty or otherwise meet the criteria for Advanced Practice Registered Nurses established by the Montana Board of Nursing and who are certified by the Board of Nursing as an Advanced Practice Registered Nurse. Advanced Practice Registered Nurses include certified nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, and nurse practitioners.

“Allied Health Professionals” means and refers to those classes of healthcare professionals, other than Physicians, Dentists, Psychologists, and Podiatrists, whose skills and knowledge have been determined by the Board of Directors to be needed for the care of patients in the Hospital, who have been licensed or certified by their respective licensing or certifying agencies to provide such care or who provide limited care as Medical Assistants or registered nurses under the direct supervision of Members of the Medical Staff and who may be granted, on an individual basis, limited clinical privileges by the Board of Directors. Allied Health Professionals may be employees of the Hospital if an Advanced Practice Registered Nurse or Physician Assistant, independent healthcare providers, or employees of Members of the Medical Staff. Examples of Allied Health Professionals are Advanced Practice Registered Nurses, Physician Assistants, technologists, therapists, and registered nurses and Medical Assistants if employed by Members of the Medical Staff. Nurses provided under contract to the Hospital by staffing agencies shall be treated as employees of the Hospital and credentialed through the Hospital’s human resources department or other internal mechanisms.

“Board of Directors” means the Board of Directors of St. Vincent Healthcare which is the governing body of the Hospital and which has overall responsibility for the conduct of the Hospital and shall include, where appropriate, a committee of the Board of Directors designated to act on behalf of the Board of Directors with respect to a particular function or duty.

“Chief Medical Officer” means the physician appointed by the Hospital to act as the chief administrative medical officer for the Hospital.

“Clinical Privileges” or “privileges” means the permission granted by the Board of Directors to a Practitioner (or, as applicable, to an Allied Health Professional) to render care or perform specific diagnostic, therapeutic, medical, dental or surgical procedures in the Hospital pursuant to the Appointment Policy.

“Dentist” means both a doctor of dental surgery and doctor of dental medicine who has a current license issued by the Montana State Board of Dentistry to practice dentistry.
“Department” means one of the divisions or departments into which the Medical Staff is divided according to professional specialty and to which all Members are assigned for governance, call scheduling and peer review purposes.

“Hospital” means St. Vincent Healthcare and the hospital facilities and ancillary buildings located at 1233 North 30th Street, Billings, Montana constituting St. Vincent Healthcare.

“Joint Commission” means The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or its successor.

“Medical Director” means the Medical Director of a specific service as identified by the Hospital.

“Medical Executive Committee” or “MEC” means the Executive Committee of the Medical Staff.

“Medical Staff” means the collective body of all Physicians, Podiatrists, Psychologists, and Dentists who are appointed thereto by the Board of Directors and who may be granted Privileges to treat patients at the Hospital.

“Medical Staff Bylaws” or “Bylaws” mean these Bylaws of the Medical Staff.

“Medical Staff President” means the person elected to serve as president of the Medical Staff while serving in such capacity.

“Member” means any Physician, Psychologist, Podiatrist or Dentist who has a current Medical Staff appointment and who may have Clinical Privileges granted by the Board to practice at the Hospital.

“Minor” means any person who is under 18 years of age, pursuant to Montana law.

“Patient Status” means patients who will be having general surgery anesthesia shall be classified as follows according to patient classification system of the American Society of Anesthesiologists:

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
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<tr>
<td>Class I</td>
<td>A normally healthy patient.</td>
</tr>
<tr>
<td>Class II</td>
<td>A patient with mild systemic disease.</td>
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<tr>
<td>Class III</td>
<td>A patient with severe systemic disease.</td>
</tr>
<tr>
<td>Class IV</td>
<td>A patient with severe systemic disease that is a constant threat to life.</td>
</tr>
<tr>
<td>Class V</td>
<td>A moribund patient who is not expected to survive without the operation.</td>
</tr>
<tr>
<td>Class VI</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes.</td>
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“Physicians” mean both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”) who have a current license issued by the Montana State Board of Medical Examiners to practice medicine and surgery.
“Podiatrist” means a doctor of podiatric medicine who has a current license issued by the Montana Board of Medical Examiners to practice podiatry.

“Psychologist” means a non-medical doctor (e.g., Ph.D.) who is licensed as a psychologist by the Montana State Board of Psychologists.

“Qualified Medical Person” or “QMP” means an Advance Practice Registered Nurse or Physician Assistant providing services at the Hospital Walk-In Clinic or registered nurses providing services in the Mother/Newborn Unit.

“Physician Assistants” means and refers to those healthcare professionals who provide medical services as employees of and under the direct supervision of Members of the Medical Staff or as employees of the Hospital and who have satisfied the requirements for certification as a physician assistant under Montana law by the Montana State Board of Medical Examiners.

“Rules and Regulations” means the Rules and Regulations adopted by the Medical Staff from time to time and approved by the Board of Directors governing patient care within the Hospital.

“Subcommittee” means any committee that provides guidance for the development of policy, procedure, orders and other operational functions report to the Medical Executive Committee.

Words used in these Rules and Regulations shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

2.0 GENERAL

2.1 SCOPE

The scope of these Rules and Regulations is not intended to be all encompassing of Hospital policies, but only to professional policies and procedures dealing with standards of practice and duties in the care of patients. Since these Rules and Regulations will be changed from time to time as warranted, they are not made a part of the Medical Staff Bylaws or the Appointment and Credentialing Policy of the Board. If any perceived conflict arises between these Rules and Regulations, the Medical Staff Bylaws, the Appointment and Credentialing Policy of the Board or federal or state law, such laws and Bylaws or Appointment and Credentialing Policy of the Board shall prevail. The interpretations of the Medical Executive Committee regarding any perceived conflict shall be final, subject to the approval of the Board.

2.2 DISTRIBUTION AND CONTROL

Each Member having clinical privileges will be furnished a copy of these Rules and Regulations. All Members should become familiar with the contents of these Rules and Regulations.
3.0 SCREENING OF PATIENTS

3.1 PATIENTS

All patients will be admitted to the Hospital without regard to race, creed, color, sex, sexual orientation, national origin, disability or source of payment. Admission is contingent upon adequate and available facilities and personnel being available to care for the patient.

3.2 INITIAL SCREENING OF PATIENTS

A. Initial Screening – All Members and Qualified Medical Persons may perform initial screening examinations of patients presenting to the Hospital requesting treatment for an emergency condition.

B. Obstetrical Screening - All Members and QMPs in the Mother/Newborn Unit may perform initial screening examinations of patients presenting to the Hospital in suspected labor.

C. Mental Health Screening – All Members of the Department of Medicine, Department of Emergency Medicine, licensed clinical social workers having appropriate clinical privileges or position description, registered nurses with an appropriate position description, may perform mental health screening examinations of patients presenting to the Hospital with psychiatric conditions identified during the initial screening examination. If the healthcare provider performing the mental health screening is a Member, he or she will arrange for appropriate psychiatric treatment for the patient. If the healthcare provider performing the mental health screening is not a Member, a Member of the Department of Medicine or the Department of Emergency Services will arrange for appropriate psychiatric treatment for the patient.

4.0 ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

4.1 ADMISSIONS TO HOSPITAL

A patient may be admitted to the Hospital by Members who have admitting privileges consistent with the Medical Staff Bylaws. Allied Health Professionals may also admit patients for their supervising/collaborating physician, if granted the privilege.

4.2 PROVISIONAL DIAGNOSIS

Except in an emergency, a patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the Member requesting admission. With respect to his or her admitted patients, the admitting Member is also responsible for providing information concerning the patient to be admitted, including (but not limited to) any source of known or suspected communicable disease or significant infection and behavioral characteristics
that would indicate the need to protect the patient from self-harm or that would disturb or endanger others.

4.3 ADMITTING PHYSICIAN RESPONSIBILITIES

The admitting Member must see his or her patients admitted to the Hospital within twelve (12) hours of admission or earlier in response to the request of Hospital staff, emergency department physician or consultant participating in the care of the patient. The time requirement does not apply to patients that are direct admissions and the physician has seen the patient previously on the day of admission.

4.4 RESPONSIBILITY FOR CARE AND TREATMENT

All patients admitted to the Hospital are assigned to an attending Member. Patients requiring emergency admission will be assigned to the most appropriate attending Member pursuant to the applicable call schedule. The attending Member is responsible for supervising the overall medical care of the patient, for the prompt completeness and accuracy of the patient’s medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to any referring practitioner and to appropriate relatives of the patient. The attending Member or the Member’s credentialed Advanced Practice Registered Nurse or Physician Assistant is responsible for seeing the patient daily. All orders made by the Advanced Practice Registered Nurse or Physician Assistant must be signed within twenty-four (24) hours of writing.

4.5 ADMISSIONS TO THE REHABILITATION CENTER

All Members admitting patients to the Rehabilitation Unit must comply with the Rehabilitation Unit’s case management guidelines.

4.6 NON-DISCRIMINATION

No Member or Allied Health Professional who is responsible for a patient may refuse to treat a patient seeking care or treatment at the Hospital based on the patient’s race, creed, color, sex, sexual orientation, national origin, disability, source of payment for treatment, ability to pay for treatment or any basis prohibited by applicable law. A Member’s or Allied Health Professional’s refusal to examine or treat any patient shall be in accordance with Hospital policies and applicable law.

4.7 REFERRALS

A. A Member or Allied Health Professional, if applicable, must refer a patient to another appropriate healthcare provider or healthcare facility if:

(1) The patient is seeking or requires treatment or services outside of the referring Member’s or Allied Health Professional’s experience, knowledge, area of specialization, or clinical privileges, and if, in the normal course of the Member’s or Allied Health Professional’s practice,
the Member or Allied Health Professional would make a similar referral for other individuals who seek or require the same treatment or services;

(2) The patient has a disability which itself creates specialized complications for the patient’s health that the referring Member or Allied Health Professional lacks the experience or knowledge to address;

(3) The patient or an individual authorized to act on the patient’s behalf requests that the patient be referred to another healthcare provider or healthcare facility; or

(4) The patient seeks non-emergency treatment which the Member or Allied Health Professional does not wish to provide, so long as such refusal to treat does not violate applicable law or Hospital policy.

B. The reason(s) for any referral of a patient to another healthcare provider or healthcare facility and the reason(s) for any refusal to examine or treat a patient shall be documented in the patient’s medical record.

4.8 TRANSFER OF RESPONSIBILITY

A. Generally - When primary responsibility for a patient’s care is transferred from an attending Member to another Member, a note covering the transfer of responsibility and acceptance of the same must be entered on the progress notes and orders transferring and accepting transfer entered on the order sheet. The Member to whom such patient is being transferred shall place on the progress notes or order sheet a note confirming the acceptance of care. No Member will relinquish care of a patient until another Member has agreed to assume care and confirmed such acceptance by entry in the medical record. The patient’s care and the Member’s responsibility shall not be considered transferred until the transfer is accepted by the accepting Member as evidenced by the progress notes or order sheet.

B. Naming Alternates – Unless such requirement is waived by the Board, all Members must name an alternate Member (or alternates) with equivalent clinical privileges at the Hospital to attend patients in the event of such Member’s incapacity or unavailability.

C. Failure to Maintain Alternate - Failure to maintain an appropriate alternate, unless waived by the Board, will result in administrative suspension from the Medical Staff until such time as an alternate is named and confirmed, as provided in the Appointment and Credentialing Policy. In the event an appropriate alternate is not designated or available, the President of the Medical Staff or his/her designee and the on-call representative for administration will be contacted immediately for intervention, follow-up and resolution. The on-call representative for administration in consultation with the Medical Staff President or his/her designee
has authority to designate any qualified Member as an alternate should they consider it necessary.

4.9 TRANSFER OF PATIENTS TO ANOTHER FACILITY

A. **Applicable Law** - In all instances when Hospital services are not available for proper care of a patient, the patient shall be transferred from the Hospital to another facility where such care can be rendered consistent with federal and state laws. Such transfers shall be consistent with the Hospital’s EMTALA policy.

B. **General Procedures** - Except in the event of a disaster and implementation of the Hospital’s Emergency Management Plan, a patient shall be transferred to another medical care facility only (i) upon the order of the attending Member; (ii) after arrangements have been made for admission with the other facility, including the facility’s consent to receive the patient and the agreement of the physician who will be responsible for the care of the patient after the transfer; (iii) after the risks and benefits of transfer have been explained to the patient; (iv) after patient consent is obtained or elicited, if reasonably possible; and (v) after the patient is considered stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient. The Hospital shall be accountable and responsible for the patient’s safety before and during the transfer. The medical care facility accepting the patient shall be accountable and responsible for the patient’s safety once the patient arrives at the facility.

4.10 REQUIRED ORDER FOR DISCHARGE

A patient may be discharged only on the order of his/her attending Member or, when applicable, an Allied Health Professional. The attending Member or Allied Health Professional is responsible for documenting the discharge diagnosis and completing other information on the appropriate form of the patient’s medical record at the time the discharge order is written, including, in the case of an Allied Health Professional, obtaining necessary countersignatures.

4.11 TIME OF DISCHARGE

When possible, communication concerning the anticipated discharge of a patient should be made to the discharging nurse the day prior to discharge. If possible, the attending Member or Allied Health Professional responsible for discharging the patient shall attempt to discharge by noon on the day of discharge.

4.12 LEAVING AGAINST MEDICAL ADVICE

A patient who demands discharge against the advice of the attending Member or Allied Health Professional must be asked to sign a release form that is witnessed by an employee of the Hospital. If a patient leaves the Hospital against the advice of the attending Member or Allied Health Professional without signing a release, or without proper discharge, a notation of the incident and any discussion with the patient must be made in the patient’s medical record by the
attending Member or Allied Health Professional. A notation should also be made documenting the refusal of any patient demanding discharge to sign a release form.

4.13 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his/her own care because of age shall be discharged only to the custody of his/her parents, legal guardian(s), spouse, or custodian as directed by a court of competent jurisdiction. If the parent, guardian, spouse, or custodian directs that discharge be made to someone not in the above categories, he/she shall so state in writing and the statement must be made a part of the patient’s medical record. Discharge of an infant to an adoption agency, the Montana Child and Family Services Division or to adoptive parents shall be conducted in accordance with the infant adoption procedures established for the Hospital’s Mother/Newborn Unit.

4.14 DISCHARGE OF INCAPACITATED PATIENT

Any patient who cannot consent to his/her own discharge from care due to incapacity shall be discharged in accordance with the requirements for obtaining consent of an incapacitated patient as set forth in Section 7.5. The circumstances under which consent for discharge was obtained shall be documented in the patient’s medical record.

4.15 EMERGENCY CALL

Members on emergency call shall be obligated to provide appropriate care in the Department of Emergency Medicine or other areas of the Hospital, if requested by a Member. Members shall respond to requests to provide consultations for and care to: (1) Hospital in-patients who are in need of emergency services; and (2) individuals presenting to the Hospital requesting treatment for emergency medical conditions. Members shall respond within thirty (30) minutes of receiving a call or page.

4.16 GENERAL CALL

Members are assigned to a call list within their specialty except where prior agreements have been reached between particular Departments. Members will be expected to serve their turn in accepting and managing unassigned patients in accordance with the Medical Staff Bylaws, Rules and Regulations, and Hospital policy.

When a Member receives privileges to perform specific clinical procedure, such privileging includes responsibility to participate equitably in any call requirements associated with the procedure.
5.0 GENERAL CONDUCT OF CARE

5.1 ATTENDING MEMBER RESPONSIBILITIES

Members must arrange for coverage for their patients when they are unavailable. In case of failure to provide the Emergency Department with the name of the Member to cover for the unavailable Member or the Hospital staff are unable to reach the Member, the Chairperson of the Department involved or the President of the Medical Staff will be notified and he/she will have the authority to handle the situation. The Member who fails to provide coverage may be subject to disciplinary action, including but not limited to loss of staff privileges, as decided by the Medical Executive Committee.

5.2 CONSULTATIONS

A. Generally - All patient admissions, treatment of patients and performance of operative or other procedures, both medical and surgical will be performed by, or under the direct supervision of, a Member or other qualified Allied Health Professional who has been granted appropriate clinical privileges. When warranted, consultation with another Member or an Allied Health Professional should be requested by any Member or Allied Health Professional participating in the care of the patient. If a consultation is not being appropriately requested in the opinion of other healthcare providers, including Hospital clinical employees, the procedure defined in the Provider Notification Policy shall be followed. It is advisable for the Member or Allied Health Professional ordering the consultation to confer with the patient’s attending Member. All requests for consultation should include the specific rationale as to why the consultation is being requested.

B. Consultations Recommended - Except in an emergency, consultation is recommended in, but not limited to, the following situations as ordered by the attending Member:

(1) in unusually complicated situations where specific skills of another Member or Allied Health Professional may be helpful;

(2) when specifically requested by the patient or his/her family and with concurrence by the attending Member;

(3) when doubt exists as to the diagnosis;

(4) where expected improvement is not evident within forty-eight (48) hours of treatment;

(5) when specialized therapeutic or diagnostic techniques are indicated;

(6) when there is a doubt as to the choice of therapeutic measures to be utilized; or
(7) when any patient exhibits acute psychiatric manifestations (e.g., suicidal ideation/attempt or with potential for harm to self or others).

C. Consultations Required – Consultations are required when a patient's needs exceed the credentials and privileges of the attending Member.

D. Requirements for Consultation

(1) The attending Member is responsible for securing all required consultations.

(2) A consultant must be well qualified to give an opinion in the field in which an opinion is sought. The status of a consultant is determined by the Medical Staff on the basis of the individual's training and experience and competency.

(3) A satisfactory consultation includes an examination of the patient and the medical record.

(4) Each consultation report should contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the medical record, and shall be part of the medical record.

E. Responsibilities of Consultants - Consultants are required to see patients within twenty-four (24) hours or sooner based on clinical need of notification of request or sooner based on clinical need in a case in which responsibility has been accepted or when consultation is requested to be provided sooner by the admitting/attending Member. The consultant, his/her designee or alternate on call is required to examine the patient and document recommendations in the medical record at the time of the evaluation and to submit a written report within twenty-four (24) hours (or sooner if requested or appropriate) of the evaluation. In addition, consultants who are actively involved in the daily medical management of the patient, including decision making, diagnostic and therapeutic intervention or evaluation of responses to treatment, shall make appropriate daily entries on the patient’s progress notes. Consultants who intermittently provide care to patients shall make entries within twenty-four (24) hours of their examination or when prescribing treatment. Consultants shall comply with the medical record completion requirements as outlined below.

5.3 ENTITIES CONTRACTING WITH HOSPITAL

All contracted entities providing patient care services shall be approved by the Medical Staff through the Medical Executive Committee.
5.4 DEATH PRONOUNCEMENT AND AUTOPSIES

Hospital patients shall be pronounced dead within a reasonable period of time after death by a Physician Member and autopsies performed in accordance with the Hospital’s Procedure for Death and Autopsy.

6.0 SURGICAL AND INVASIVE PROCEDURES

6.1 GENERAL AUTHORITY

Policies, procedures and protocols will be developed for the operating and recovery rooms to provide guidance for the effective operation of these facilities. The Operating Room Committee in collaboration with the Departments of Surgery, Anesthesia and Obstetrics & Gynecology and the Hospital administration is responsible for the development and revision of these codes, policies, procedures and protocols as well as their acceptance, implementation of, and assurance of compliance with pertinent regulatory agencies and applicable laws.

6.2 ALLIED HEALTH PROFESSIONALS

Allied Health Professionals may participate in surgical and other invasive procedures only in accordance with the scope of the clinical privileges or scope of practice granted to each such individual and in accordance with applicable Hospital and Medical Staff policies. No Allied Health Professional employed by any Member shall be allowed to enter the surgical suite without first having completed the credentialing process in accordance with the Appointment and Credentialing Policy and having been granted clinical privileges. It is the Member’s responsibility to assure that this process has been completed.

6.3 EXPECTED CONDUCT

A. A Member having surgical privileges shall provide sufficient information at the time a surgical case is scheduled to permit a realistic estimate of operating time needed, surgical set-up required and required Hospital personnel. Scheduling of procedures, canceling of procedures, and emergency procedures shall be conducted in accordance with the Hospital’s Operating Room Scheduling Policy.

B. Members will be allowed to schedule only those procedures for which they have been granted specific clinical privileges to perform. Department of Surgery staff will screen the requested procedure against the Member’s privileges.

C. The primary surgeon shall be present and available in the medical campus and ready to commence surgery prior to the scheduled start time and in no case shall the room be held for longer than thirty (30) minutes beyond the scheduled start time.

D. Informed consent will be obtained prior to all surgical or other invasive procedures except in situations where the patient’s life or limb is in serious
jeopardy or danger of serious bodily impairment or dysfunction and suitable signed consents cannot be obtained due to the condition of the patient.

E. When surgical findings in the perioperative phase warrant consultation in the opinion of the operating surgeon, a request shall be made for consultation with a Medical Staff Member with privileges in the area of expertise needed.

F. No operative procedure shall be undertaken until a record consisting of history, physical findings, appropriate diagnostic tests, and appropriate consultations is completed. An exception to this rule may be made in emergencies during which a working diagnosis may be accepted temporarily in place of a more complete record.

G. Patients scheduled for outpatient surgery shall have necessary diagnostic tests completed prior to surgery.

7.0 CONSENTS

7.1 INFORMED CONSENT FOR TESTS AND PROCEDURES

Each patient’s medical record must contain specific evidence of the patient’s informed consent for invasive diagnostic or therapeutic procedures, including blood administration, and such other specific matters as are required by Hospital policy. Consents for minors or incapacitated patients shall be obtained according to applicable law as described below.

7.2 SPECIFIC CONSENTS

Specific consent for each of the following treatments or procedures must be obtained:

A. General admission consent for treatment during hospitalization;
B. Anesthesia;
C. Surgical and other invasive procedures;
D. Receipt of blood or blood products;
E. Donation of bone or bone marrow to bone bank;
F. Receipt of tissue or organ;
G. Organ donation;
H. Release of Hospital from responsibility when patient refuses blood transfusions or other therapy;
I. Radiation or chemotherapy;
J. Autopsy;
K. Urgent treatment;
L. Outpatient treatment;
M. Discharge without medical authorization;
N. Where otherwise required by applicable law.
7.3 DOCUMENTING CONSENT

A. Documentation of each consent to medical treatment must include at least the following information:
   (1) Identity of the patient;
   (2) Date;
   (3) Nature of the procedure or treatment to be rendered;
   (4) Name(s) of the Member(s), Nurse Practitioner(s) or Physician Assistant responsible for informing the patient and obtaining the consent; and who will perform and/or administer the intended procedure or treatment
   (5) Authorization for any required anesthesia;
   (6) Indication that those alternate means of therapy, if any, and those risks, benefits, and complications that a reasonable patient would consider material to the decision whether or not to undergo treatment or diagnosis have been explained to the patient by the Member, Nurse Practitioner(s) or Physician Assistant performing the procedure; and
   (7) Authorization for disposition of any tissue or body parts as indicated.

B. Except in an emergency, each such consent form must be signed by the patient or on the patient’s behalf by a duly authorized representative and witnessed by a legally competent third party. The Member, Nurse Practitioner(s) or Physician Assistant providing the information to the patient shall confirm by his/her notation in the patient’s medical record that the information described above was provided by him/her to the patient. Where an emergency or other life threatening events preclude or advise against obtaining the consent as described in this Section, the circumstances must be explained in the patient’s medical record.

7.4 CONSENT FOR MINOR PATIENT

A. When Minor Can Consent - A Minor who has or professes to have been married, had a child, graduated from high school, or separated from the Minor’s parent(s) or legal guardian can consent to the provision of healthcare services. A Minor may consent for his/her own treatment in the case of pregnancy (other than abortion), any reportable communicable disease, or drug or substance abuse. Any Minor parent of a child may consent for his/her child.

B. When Minor Cannot Consent - Consent for a procedure or treatment of a Minor who cannot consent for himself or herself shall be obtained from the individual’s parent, legal guardian, person standing in loco parentis (only in an emergency), spouse, or as otherwise directed by a court of competent jurisdiction.

7.5 CONSENT FOR INCAPACITATED PATIENT

Any person who cannot consent to his/her own care due to incapacity shall be admitted:
A. with the consent of his/her legal guardian, if a legal guardian has been appointed by a court;

B. with the consent of a person authorized and empowered to consent (generally the person who presents with visible evidence of an appropriate power of attorney) where no legal guardian has been appointed by a court;

C. without consent in emergency cases (where no legal guardian or other authorized and empowered person is available); or

D. as otherwise directed by a court of competent jurisdiction.

The circumstances under which consent to admission was obtained shall be documented in the patient’s medical record.

7.6 IMPLIED CONSENT

All healthcare providers may render emergency medical treatment to any injured person if the healthcare provider believes the patient may suffer probable death, serious physical damage, or serious mental damage in the event the emergency medical treatment is not provided. All healthcare providers may render non-emergency medical treatment to Minors without obtaining consent if the healthcare provider believes that delaying services would endanger the health or life of a Minor. In both circumstances, consent for medical treatment is implied.

8.0 MEDICAL RECORD REQUIREMENTS

8.1 CONFIDENTIALITY OF RECORDS

All information contained in patient records is to remain confidential at all times, with access limited to those individuals directly involved in the care of the patient. Members and Allied Health Professionals must assure the confidentiality of patient information, protect it from unauthorized disclosure and act in accordance with Hospital policies and procedures regarding the privacy and security of patient information. Written consent of the patient or his/her legally qualified representative is required before patient information may be released to persons not otherwise authorized under these Rules and Regulations or by law to receive such information. Medical records may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena, statute or regulation except for the purposes of processing for storage or restoration as approved by the Board of Directors.

8.2 RESPONSIBILITY FOR PREPARING AND AUTHENTICATING RECORD

A. Member and Allied Health Professional Responsibilities - Each Member and Allied Health Professional is responsible for the timely, legible, and complete preparation of that portion of the medical record relating to his/her diagnosis, evaluation, treatment or orders for each of his/her patients who is evaluated and treated at the Hospital.
B. **Authentication of Records** - All entries must be complete, legible, written in English and authenticated, dated and timed promptly by the author. The following records may be authenticated either by written signature, electronic signature or computer key:

1. History and physical examinations;
2. Progress notes;
3. Physician orders;
4. Consultations;
5. Operative reports/procedures; and
6. Discharge summaries.

When computer signing is authorized and used, the individual whose signature the computer key represents sign a statement that he/she alone possesses and will use such code.

C. **Delinquent Medical Records** – Members and Allied Health Professionals must complete their medical records in a timely manner in compliance with the Medical Staff Bylaws, Appointment and Credentialing Policy, and state and federal regulatory requirements. Any records which remain incomplete (e.g., lack required signature or content) for twenty-one (21) days of discharge will be considered delinquent and an administrative suspension will be imposed on the Member or Allied Health Professional in accordance with the Physician Incomplete/Delinquent Records and Suspensions Policy.

D. Records that are not completed and on the patient chart within the required timeframes will be trended. Repeated omissions within a six (6) month period will be referred the Medical Staff Quality Improvement Committee (MSQIC) and/or to the Medical Executive Committee for review and intervention.

8.3 **REQUIRED CONTENT OF MEDICAL RECORDS**

The content of the patient’s medical record is the responsibility of the attending Member, or Allied Health Professional, and any consultant participating in the patient’s care. The medical record must contain sufficient information to: identify the patient; support the diagnosis; justify and document the care and treatment provided to the patient; promote continuity of care among providers; and permit transfer, as applicable. Progress notes shall be recorded at the time of observation and shall be legible and written at least daily on acute care patients and those patients for whom there is difficulty diagnosing or managing their clinical condition. All Members and Allied Health Professionals are responsible for clearly designating in the medical record the intended level of care for patients (e.g., inpatient, observation, skilled, same day surgery, invasive diagnostic). In addition to the above, the medical record shall include the following dated, signed, timed, and authenticated entries:
A. **Identification Data** - Identification data shall include, but not limited to, the full name, address, date of birth, gender, and social security number (if available) of the patient.

B. **History and Physical** - Except in an emergency, an appropriate history and physical examination pertinent to the admitting diagnosis on all patients must be performed and be present in the medical record within twenty-four (24) hours of admission and in all events must be completed and be present in the medical record before any diagnostic or therapeutic procedures are performed. A recorded history and physical examination taken by a qualified Member, Resident, or Allied Health Professional within thirty (30) days of the patient’s admission (or readmission) to the Hospital may be used in the patient’s Hospital medical record provided that: an interval admission note is recorded documenting an examination for any changes in the patient’s condition; all additions to the history and any changes in the physical findings subsequent to the original report are completed and present in the medical record within twenty-four (24) hours after admission or before any diagnostic or therapeutic procedures are initiated, whichever comes first. History and physical examination updates may be made by a qualified member, Resident or Allied Health Professional. Surgical history and physical examinations must be completed by a qualified member or Allied Health Professional that is licensed in the State of Montana. In addition to the above and as detailed below, each history and physical examination must contain elements appropriate to the patient’s type of admission:

(1) **Acute, Non-Obstetric Inpatient Admission**

   (a) Chief complaint
   (b) History of present illness
   (c) If injury, how injury occurred
   (d) Past medical history
   (e) Family history
   (f) Physical examination including a review of:
      i. Vital signs
      ii. Heart
      iii. Lung
      iv. Pertinent findings based on the history
   (g) Provisional diagnosis
   (h) Treatment plan

(2) **Obstetric Admission for Delivery** – The obstetric record must contain the prenatal office record, labor notes, obstetric anesthesia notes, and delivery record. The prenatal office record may be used in lieu of an admitting history and physical if performed within thirty (30) days of admission or, if not performed within thirty (30) days, routinely updated and current within thirty (30) days of admission. In either event, the history and physical must be updated by an interval note which must be present in the
medical record at time of delivery and reflect the patient’s condition upon admission. If an emergency Cesarean section becomes necessary, a detailed progress note must be entered into the medical record describing the rationale and indication for the Cesarean section.

(3) Neonates – In addition to all information required for an obstetric admission for delivery, the neonatal patient record must include:

(a) Observations of the neonate after birth
(b) Descriptions of delivery room care of neonate and delivery complications, if any
(c) Descriptions of physical examination performed on the neonate including the complete physical examination conducted within twenty-four (24) hours of birth
(d) A review of maternal perinatal history
(e) The temperature of the neonate
(f) The weight of the neonate
(g) The time of the neonate’s first urination
(h) The number, character, and consistency of the neonate’s first stool
(i) The type of feeding administered to the neonate
(j) Required laboratory testing
(k) The name of the person to whom the neonate is released upon discharge.

(4) Admissions to the Observation Unit - The history and physical examination of a patient admitted for observation must include all elements required for an acute, non-obstetric inpatient admission.

(5) Same Day Surgery/Invasive Diagnostic Procedures – The history and physical examination (or updated note, as applicable), completed by appropriate Member, Resident, or Allied Health Professional, must be present on the chart prior to any same day surgery or invasive diagnostic procedure. All history and physical examinations for same day surgery/invasive diagnostic procedures performed under moderate sedation or general anesthesia, or identified as high risk shall include the following:

(a) Indications/symptoms for surgical procedure
(b) A list of current medications and dosages
(c) Any known allergies, including medication reactions
(d) Existing co-morbid conditions
(e) A history and physical examination performed within thirty (30) days (updated as provided above) and reflecting the type of anesthesiology plan as follows:

i. No anesthesia, topical or local
1) Assessment of mental status
2) Examination specific to the proposed performed procedure
3) Physical examination including a review of:
   a) Vital signs
   b) Heart
   c) Lung
   d) Pertinent findings based on the history

ii. Moderate sedation and regional block
1) Assessment of mental status
2) Examination specific to the proposed performed procedure
3) Physical examination including a review of:
   a) Vital signs
   b) Heart
   c) Lungs
   d) Pertinent findings based on the history
4) Airway assessment (for moderate sedation)
5) Evaluation of personal and family history of sedation/anesthesia complications (for moderate sedation)
6) Sedation risk assessment (for moderate sedation)
7) Plan for sedation (for moderate sedation)

iii. General spinal epidural or caudal anesthesia
1) Assessment of mental status
2) Examination specific to the proposed performed procedure
3) Physical examination including a review of:
   a) Vital signs
   b) Heart
   c) Lungs
   d) Pertinent findings based on the history
4) Assessment and written statement about the patient’s general condition

(6) Forms for Anesthesia and Sedation - For those patients undergoing procedures with anesthesia, the anesthesia preoperative evaluation shall be documented on the Perioperative Anesthesia Record. For those patients undergoing procedures with conscious sedation, the evidence of re-evaluation shall be documented on the Practitioner Assessment for Sedation form. The Perioperative Anesthesia Record may be used as the history and physical for Outpatient Radiology imaging studies requiring moderate or general anesthesia.
(7) **Short Stays** - A Medical Staff approved short stay history and physical examination form or Emergency Room Assessment may be substituted for a dictated history and physical examination for observation records, outpatient surgery records and inpatient records for patients who are expected to be hospitalized for twenty-four (24) hours or less.

C. **Progress Notes**

(1) **Timing** – At a minimum, pertinent progress notes must be made at regular intervals by the Member, Resident, Allied Health Professional or, if applicable, consultant who is actively involved in the daily medical management of the patient (e.g., decision making, diagnostic and therapeutic interpretation or evaluation of responses to treatment) and when there are any significant changes in the patient’s condition or diagnosis. Pertinent progress notes shall be recorded at the time of observation and shall be sufficient to permit continuity of care and transfer. Progress notes shall be legible and written at least daily on acute care patients and those patients for whom there is difficulty in diagnosing or managing clinical problems. Progress notes shall be completed in accordance with the following timetables, unless a change in acute condition warrants more often observation and documentation by the Member, Resident or Allied Health Professional:

(a) Acute care patients - daily  
(b) Rehabilitation patients - minimum four times a week  
(c) Newborns - every twenty-four (24) hours

(2) **Content** - Diagnostic or therapeutic orders shall denote the rationale for the intervention and shall reflect the evaluation and management by the attending or consulting Member. Pertinent progress notes shall be recorded to document discussions with patient or family when a no code blue is ordered. Such notes shall reflect the identity of family members or others present, the date of discussion, treatment, preferences, condition of the patient and circumstances. A progress note must be written by the surgeon/performing physician Member immediately following any surgery/procedure requiring sedation. “Immediate” shall mean upon completion of the surgery/procedure, before the patient is transferred to the next level of care. This post-surgery/procedure progress note must include the following: identify the surgeon and his/her assistant(s), findings, procedure(s) performed, specimen, postoperative diagnosis, complications, tissue(s) removed (unless otherwise noted), and amount of blood loss.

D. **Organ Donor Medical Records** - Organ donor medical records should contain an operative report that identifies the method of organ retrieval and life support
maintenance, date and time of death, and Member responsible for pronouncement of death.

E. **Special Reports** - Special reports may include, but are not limited to, clinical laboratory, cardiopulmonary, radiology, consultation, pre- and post-anesthesia, pathology, operative and other diagnostic and therapeutic procedures.

F. **Consultation Notes** - Consultation notes shall evidence review of the patient's medical record, pertinent findings on examination of the patient, and the consultant’s opinion and recommendations. The report shall be made a part of the patient's medical record. A limited statement such as “I concur” does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations verified on the medical record, be recorded prior to the operation.

G. **Discharge Orders and Summaries**

   (1) **General** - Discharge orders and discharge summaries including discharge medications, discharge instructions (e.g., diet, activity, follow up) and discharge diagnoses (e.g., primary procedures, principal and secondary diagnoses, and complications) must be recorded in the medical record for all patients.

   (2) **Discharge Summary** - Discharge summaries must be recorded and signed by the Member, Resident, or Allied Health Professional for all patients within fourteen (14) days of discharge. A discharge summary must be completed in the event of a patient’s death and include the course of hospitalization, subsequent findings, cause of death (if known) and final diagnosis.

   (3) **Discharge Order** - Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Member or Allied Health Professional at the time of discharge of all patients. A short stay summary including the required elements of a short stay inpatient history and physical examination and the elements of a discharge summary may be completed for patients whose length of stay is twenty-four (24) hours or less. Discharge orders issued by Residents must be countersigned by the supervising Member. Discharge orders issued by Allied Health Professionals must be written in consultation with his/her collaborating Member. A final progress note may be substituted for a discharge summary only for those patients who require less than a forty-eight (48) hour stay where the history and physical has been completed within the twenty-four (24) hour required timeframe and in the case of normal newborn infants in Level I care and uncomplicated obstetrical deliveries.
H. **Appropriate Content** - Medical records should not contain inflammatory remarks. Suspected inappropriate entries will be referred to the quality assurance department for review and follow-up.

8.4 **HIGH RISK PROCEDURES AND SURGERY**

High risk procedures and surgery reports shall be prepared following the procedure or surgery and must contain the pre-operative diagnosis, reasons for surgery/procedure, a detailed account of the findings (including any complications encountered), the technical procedures used, the specimens removed, estimated blood loss, fluids received, any perioperative consultations requested, the post-operative diagnosis, and the name of the primary performing Member and any assistants. A high risk procedure or surgical progress note or completed record which provides sufficient information for use by those individuals directly involved in the care of the patient must be entered into the medical record prior to transfer of the patient to the next level of care. If the report is dictated and not immediately transcribed or not written in the record immediately after the procedure, the Member must enter an operative progress note in the medical record immediately after the procedure providing sufficient information for use by the Member or other provider who is required to attend the patient. The complete report must be dictated or written immediately following the procedure and authenticated in accordance with Section 8.2 and filed in the medical record as soon after the procedure as possible.

8.5 **USE OF SYMBOLS AND ABBREVIATIONS**

Symbols and abbreviations should have only one meaning and should be used only when they have been approved by the Medical Executive Committee. An official record of approved symbols and abbreviations and a list of prohibited abbreviations are available in the Health Information Management.

8.6 **ACCESS TO RECORDS**

A patient or the patient’s legally authorized representative shall have access to his/her medical record in accordance with applicable law. Access to a patient’s medical records shall be limited to those individuals directly involved in the patient’s care, individuals monitoring the quality of the patient’s care, individuals authorized by applicable law, or individuals to whom the patient or his/her legally designated representative has given written consent.

8.7 **FILING OF MEDICAL RECORDS**

No medical record shall be filed until it is complete and properly authenticated. In the event that a chart remains incomplete due to the death, resignation, disability, absence or inability of the Member or Allied Health Professional responsible to complete the record and if no other Member is available and appropriate to complete the record, the Medical Executive Committee shall consider the circumstances and may enter such reasons in the record and order it filed. The Medical Executive Committee may also consider other extenuating circumstances and take appropriate action to ensure the completion and filing of the chart.
8.8 TRANSCRIBED REPORTS

It is the responsibility of the Member, Resident or Allied Health Professional to review and correct as necessary the content of any dictated and transcribed reports in the medical record to assure accuracy of such transcribed reports.

8.9 OPERATIVE REPORTS

A. Each operative report must document: the name of physician, the name of assisting physician (if any), a description of the technical procedures used, operative findings, specimens removed, estimated blood loss and preoperative and postoperative diagnosis. If the full operative report cannot be entered into the medical record immediately after the operation or procedure, an operative progress note must be written before the patient can be transferred to the next level of care.

B. An operative report must be dictated or written by the performing physician immediately following surgery or a procedure requiring sedation. “Immediately” means upon completion of the operation but before the patient is transferred to the next level of care.

C. The operative report must be authenticated by the performing Member as soon as possible after the operation.

8.10 POST ANESTHESIA EVALUATION

Post anesthesia evaluation for inpatients may be completed and documented by any Member, Resident or Allied Health Professional individual qualified to administer anesthesia.

9.0 ORDERS

9.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be written legibly and completely and authenticated by the Member, Resident, or Allied Health Professional who is responsible for the order. Orders that are illegible, unclear or improperly written will not be carried out until they are rewritten or clarified by the ordering Member, Resident, or Allied Health Professional and properly understood by the authorized personnel responsible for carrying out the order. Orders for diagnostic tests that require the administration of test substances or medications will be considered to include the order for the administration of such test substances or medications by the ordering Member, Resident or Allied Health Professional. Diagnostic or therapeutic orders should include pertinent information, including the reasons for the requested examination or intervention and shall include the date and time of the order. This does not include routine laboratory tests.
9.2 VERBAL AND TELEPHONE ORDERS

A. Verbal Orders - Verbal orders for medication or treatment may be given by a Member, Resident, or Allied Health Professional only when it is impractical for such orders to be given in writing. Except for telephone orders, verbal orders are to be communicated only to healthcare providers who are in the same room as the Member, Resident, or Allied Health Professional. Except for Do Not Resuscitate orders described below, verbal orders may be received by a healthcare provider only if the order relates to the clinical area in which the healthcare provider receiving the order practices in accordance with the Hospital’s Provider Orders Policy. All verbal orders will be recorded and identified as a verbal order in the medical record and verified by the healthcare provider receiving the order by reading such order back to the Member, Resident or Allied Health Professional giving such order. If protocol or procedures dictate that a progress note be written in conjunction with the order, the Member, Resident or Allied Health Professional will complete the appropriate progress note at the time of authenticating the order.

B. Telephone Orders - Telephone Orders may only be given by a Member, Resident or Allied Health Professional when it is impractical for such orders to be given in writing. All telephone orders will be repeated and verified by the healthcare provider receiving the order. Except for Do Not Resuscitate orders described below, telephone orders may be received by a healthcare provider only if the order relates to the clinical area in which the healthcare provider receiving the order practices in accordance with the Hospital’s Provider Orders Policy. All telephone orders shall be recorded in the proper place in the medical record, shall include the name and credentials of the person taking the order, his/her signature, date and time of receipt, and the name of the Member, Resident, or Allied Health Professional giving the order. If protocol or procedures dictate that a progress note be written in conjunction with the order, the Member, Resident, Allied Health Professional, or other Member participating in the care of the patient will complete the appropriate progress note at the time of authenticating the order.

C. Authentication - All verbal and telephone orders will be authenticated by signature of the ordering Member, Resident or Allied Health Professional as soon as practical. Such authentication shall include the day and time of authentication.

9.3 ORDERS BY RESIDENTS

Residents may write orders in patient charts, including the prescription of controlled medications if the Resident has a DEA registration number. Resident’s orders need not be countersigned by the patient’s attending Member.

9.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

Allied Health Professionals may order tests, diagnostic laboratory and radiological services, and therapeutic procedures approved by their collaborating Physician Member. Allied Health
Professionals shall not prescribe or dispense any medication, device or therapy independent of consultation with the collaborating Physician Member.

9.5 OUTPATIENT DIAGNOSTIC TEST ORDERS

Healthcare providers authorized by their license to write orders, including, but not limited to, Physicians, Dentists, and Podiatrists who do not have clinical privileges at the Hospital, may order outpatient diagnostic and non-invasive therapeutic tests and treatments (e.g., lab work, x-rays and ECGs) provided that such order is in writing, includes pertinent information, including the diagnosis, diagnostic code or reasons for the test, and is delivered to the Hospital’s lab or radiology department either upon or prior to the patient’s (or, as applicable, specimen’s) arrival and is otherwise in accordance with state laws and regulations.

9.6 SELF-REFERRED ORDERS

Patients may self refer for mammograms and bone density examinations without an order from a Member, Resident, or Allied Health Professional.

9.7 AUTOMATIC CANCELLATION OF ORDERS

All current orders for medications and treatments are canceled and re-written when patient changes level of care. Upon admission/readmission from surgery to a patient care area, a complete list of the patient’s medication(s) and other treatment(s) must be documented in the patient’s medical record. Each medication or treatment must be written as an individual order on the physician order form with respect to the patient’s condition at the time of ordering.

9.8 DISCHARGE ORDERS

Discharge orders from the attending Member, Resident (if countersigned by the attending Member), or Allied Health Professional must be present in the medical record at the time of discharge.

9.9 MEDICATION ORDERS

A. Required Elements of Medication Orders - All medication orders must contain the following elements:

(1) medication name (brand or generic name is acceptable except when ordering chemotherapy, investigational medication or other high risk medications specified by the Medical Executive Committee);

(2) dosage;

(3) route of administration;

(4) frequency or rate of administration;

(5) duration, when appropriate; and
signature of the ordering Member, Resident, or Allied Health Professional.

B. No Unacceptable Abbreviations - The order should be free of unacceptable abbreviations as identified by Joint Commission and approved by the Medical Executive Committee.

C. Indication for Use - An indication for use must be included in the medication order when ordering an investigational or chemotherapy medication.

D. Patient Medication History – Prior to initiating a medication regimen, Members, Residents, and Allied Health Professionals must verify the patient’s medication history relevant to the planned therapeutic medication intervention, assess the presence or absence of allergies to prescribed or related medications, and assess the absence of obvious contraindications to present medications or their common side-effects prior to initiating a medication regimen.

E. Administration of Medications - Medications may be administered only upon the order of Members, Residents, and Allied Health Professionals. The ordering Member, Resident, or Allied Health Professional is responsible for documenting in the medical record the required elements described in Section 9.9(A). All medications, including IVs and injectables, must be administered in accordance with applicable law, regulations, and Hospital and Medical Staff policies and by or under the supervision of appropriately licensed personnel. All personnel who administer medications must have been trained in the pharmacological category of medication that they administer if such administration is within the scope of their practice. Personnel who do not have statutory authority to administer shall not administer parenteral medications, controlled substances or medications that require professional assessment at the time of administration. Personnel who have statutory authority to administer shall always be readily available at the time of administration of any medication.

F. Medication Interchanges – Interchange of ordered medications with medications comparable in efficacy and safety as approved by the Pharmacy and Therapeutics Committee may be made by the Hospital’s pharmacy. Orders for the formulary equivalent will be rewritten in the medical record by the Hospital’s pharmacy for the substituted medication product except for select items for which the Pharmacy and Therapeutics Committee has determined that a rewritten order is not necessary.

G. Patient’s Own Medications and Self-Administration - Medications brought into the Hospital by a patient may not be administered to the patient unless the medications have been identified by a Hospital pharmacist and there is a written order from the attending Member to administer the medication.

H. Formulary Medications - Formulary medications are those medications that have been reviewed by the Pharmacy and Therapeutics Committee and evaluated as to
indications for use, efficacy, safety, and cost and compared to other medications in the same therapeutic class. Only those formulary medications shall be stocked in the Hospital’s pharmacy and made available to patients. Only those medications which are among those listed in the latest edition of United States Pharmacopoeia National Formulary, American Hospital Formulary Services, or American Medical Association Drug Evaluations, except medications for approved, bona fide clinical investigations, shall be administered to patients within the Hospital.

I. **Investigational Medications** - All investigational medications prescribed for patients must be in full compliance with all regulations of the federal Food and Drug Administration and applicable law. The Hospital pharmacy shall manage the storage and dispensing of all investigational medications within the Hospital. All clinical investigations for which the Hospital is a study site must be approved by the Institutional Review Board of Billings. If approved, the continued administration of investigational medications in patients of the Hospital will be allowed and the applicable pharmacy policy regarding administration will be implemented.

J. **Pediatric and Underweight Patient Medication Orders** – All medication orders for patients age twelve (12) years or younger, and all medication orders for patients who weigh less than fifty (50) kilograms, should include the patient’s current weight listed in kilograms (kg) and body surface area, if applicable, and shall include the dose of the medication needed and the weight-based dosing parameter to be used. Any incomplete order must be clarified prior to dispensing.

K. **PRN Orders** – “PRN” or “as needed” orders are used when medications are to be given based on the occurrence of a specific indication or symptom. All PRN orders for medications must include the specific indication or symptom for administration. PRN orders without indications will be clarified with the prescribing Member, Resident or Allied Health Professional by an appropriate member of the Hospital staff.

L. **Hold Orders** – All medications ordered to be held will be discontinued from the patients’ profile unless the Member, Resident or Allied Health Professionals writes a specific date or time to resume. A discontinued order must be rewritten on order for the patient to receive the medication.

M. **Resume Orders** – Blanket orders to resume medications or blanket reinstatements of previous orders for medications are not allowed. The medication reconciliation process will be followed to facilitate the reordering of these medications. Each medication or treatment must be individually ordered and written on the physician order form with respect to the patient’s condition at the time of ordering.

N. **Titration Orders** – Titration orders are only accepted in care settings where the equipment and resources are present to monitor the titration. Orders to titrate a
medication based upon the patient’s status must have the parameters written by
the Member, Resident, or Allied Health Professional pursuant to protocols
approved by the Medical Executive Committee. Orders must include a starting
dose, parameters for monitoring dose changes, the frequency at which to monitor
dose changes, and the incremental dose changes as necessary (e.g. Dopamine
5mcg/kg/min IV, Titrate per protocol to maintain systolic BP over 90 mm Hg.
Call for dose exceeding 20 mcg/kg/min. – Cardizem 5mg per hour IV. Titrate 2.5
mg per hour to maintain HR less than 120).

O. Range Orders – Range orders are those that allow multiple doses, frequencies, and
or routes of a medication to be given. The Hospital discourages the use of these
orders by Members, Residents, and Allied Health Professionals. In lieu of
range/blanket orders specific instructions should be provided by the Member,
Resident, or Allied Health Professional. Orders must include a starting dose and
clear parameters for dose changes. If no starting dose is documented, the initial
dose and frequency will be selected after careful assessment of the patient’s
condition, taking into consideration the patient’s response or lack of response to
previous doses and the expected onset of action of the drug (e.g. Morphine 4 mg
IV now, and then 2 to 4 mg IV q 4 hours prn pain level above 4). Range/blanket
orders not meeting these parameters for dosing will be addressed in accordance
with the Provider Orders Policy. Only one (1) range parameter is allowed.

P. Compounded Mixture Orders - Compounded mixtures, other than routine IV
fluids, must have clear medication amounts (e.g., weight, concentration, volume)
desired for each constituent medication stated along with a total quantity to
prepare.

Q. Medication Delivery Devices - Medication delivery devices, where appropriate,
should be noted as part of the order. Only pumps or devices approved by the
Pharmacy and Therapeutics Committee may be utilized or refilled at the Hospital.
To the extent possible, standard concentration(s) of medication(s) will be utilized
within these devices. Non-standard concentrations will be accepted, but the
rationale for such concentration should be noted in the order so that it can be
included on the medication administration record.

9.10 SPECIAL ORDERS

A. Advance Directives - Members, Residents and Allied Health Professionals are
expected to comply with Hospital policy and procedure in acknowledging and
following advance directives. Members, Residents and Allied Health Professionals who are unable to comply with the advance directive of a patient
shall inform their respective department chairperson of their inability to comply.
No Member, Resident, or Allied Health Professional shall relinquish care of such
patient until such time that another Member, Resident, or Allied Health Professional has agreed to assume care. The department chairperson has the
responsibility and authority to request appropriate intervention and consultation as needed.

B. Code Blue Orders - Code Blue will be ordered for all patients having a cardiac or respiratory arrest, unless there is an order to the contrary by the attending Member, a declaration to withhold or withdraw death prolonging procedures, or an advance directive which has been enacted. A Do Not Resuscitate order given by a Resident must be countersigned by the attending Member. A Do Not Resuscitate order may be accepted by telephone or verbally by an Advanced Practice Nurse or two (2) registered nurses consistent with the requirements for verbal and telephone orders set forth above. The attending Physician Member must countersign the order as soon as practical.

C. Restraints

Restraint orders will be written according to Hospital policy.

10.0 INTENSIVE CARE UNIT REQUIREMENTS

10.1 ADMISSIONS TO INTENSIVE CARE UNIT

A patient will be admitted to the Intensive Care Unit (ICU) or Pediatric Intensive Care Unit (PICU) if, in the judgment of the attending Member or consultant, such care is warranted. Specific admission criteria guidelines are available in the ICU. If any questions arise concerning the validity of an admission to or discharge from the ICU, they should be referred for consultation to the ICU Medical Director, or his/her designee. Admission criteria are defined by Hospital policy.

11.0 INFECTION CONTROL

11.1 GENERAL AUTHORITY

The Hospital’s Infection Control Committee, through its oversight of the infection control program, has the authority to conduct surveillance, control and prevent infections. Based upon patterns or trends, intensive evaluation may be initiated.

11.2 POLICIES

Infection control policies shall reflect the recommendations and requirements of pertinent regulatory agencies. The details necessary for effective implementation shall be in the Infection Control Manual and approved by the infection control team. Each department and nursing unit shall have available access to the Infection Control Manual. Each Member and Allied Health Professional is required to understand and comply with current Hospital infection control policies and practices.
12.0 AMENDMENTS

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws and Rules and Regulations as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, Rules and Regulations, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. Such amendment shall be effective immediately and shall be permanent. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee.

Date: June 9, 2016

Lionel Tapia, MD
President of the Medical Staff

Date: June 9, 2016

James Bentler, MD
President-elect of the Medical Staff

These Rules and Regulations are hereby approved by the Board of Directors of St. Vincent Healthcare.

Date: June 9, 2016

Steve Loveless
President/CEO, St. Vincent Healthcare