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GOOD SAMARITAN HOSPITAL STAFF RULES AND REGULATIONS

SECTION ONE: ADMISSION OF PATIENTS

1.1 TYPE OF PATIENTS

Patients are admitted without regard to race, creed, color, sex, sexual orientation, disability, national origin, or source of payment. Admission of any patient is contingent upon adequate facilities and personnel being available to care for the patient, as determined by the Chief Executive Officer after consultation with the applicable department director. Admission of any patient shall be consistent with the Ethical and Religious Directives for Catholic Health Facilities.

1.2 ADMITTING PREROGATIVES

1.2-1GENERALLY

Only licensed practitioners in good standing on the Good Samaritan Hospital Medical Staff may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the hospital as may be in effect. Please Note: Other Allied Health Professionals are not entitled to admit patients unless specified in their credentialing privileges.

1.2-2LIMITATIONS FOR DENTISTS, PODIATRISTS AND CERTIFIED NURSE MIDWIVES

Certified nurse midwives, dentists and podiatrists shall co-admit to the hospital with a physician on the medical staff. A physician must perform a basic medical appraisal (including history and physical examination) for each dental and podiatric patient immediately after admission and must perform an evaluation of the overall medical risk and possible effect on the patient's health. A dentist is deemed competent to conduct a complete history and examination to determine the ability of a patient to undergo a proposed dental procedure provided that he has successfully completed a post-graduate program of study incorporating training in physical diagnosis equivalent to that received by one who has successfully completed a post-graduate program of oral and maxillofacial surgery accredited by a nationally recognized body approved by the United States Education Department, and as determined by the Medical Staff is currently competent to perform a complete history and physical examination to determine a patient's ability to undergo the proposed oral-maxillofacial surgical procedure.

Responsibilities and prerogatives of Certified Nurse Midwives are detailed in the Medical Staff policy for same.

1.3 ADMISSION PRIORITIES BASED ON PATIENT CONDITION

1.3-1EMERGENT CONDITION - FIRST PRIORITY

A case may be declared an emergency by the attending physician. Prior to referring an emergency patient for admission to the hospital, the attending physician whenever possible shall call the admitting office to determine bed availability.

Whenever a patient is admitted as an emergency, the attending physician or designee shall provide the following documentation or information within the specified time frames as follows:

(a) within six (6) hours of his notification of the patient's arrival at the hospital, an admission note which indicates his involvement in the immediate care of the patient; and

(b) within 24 hours of the time of admission, sufficient documentation on the chart to justify the emergency admission.

Failure to furnish the above documentation or information, or evidence of willful or continued misuse of this category shall be grounds for disciplinary action as outlined in the Medical Staff Bylaws.

1.3-2 URGENT CONDITION - SECOND PRIORITY

The attending physician must document as part of his request for an urgent admission, the specific reason for admission, including information supportive of the request and of the degree of urgency.

1.3-3 ELECTIVE ADMISSIONS - THIRD PRIORITY

This category includes all scheduled elective medical and surgical patients.

1.4 TIME OF ADMISSION

Except in emergency cases, and whenever possible, the attending physician shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient surgery or same day surgery, the attending physician must comply with hospital policies with respect to presurgical laboratory tests, documentation, and scheduling.

1.5 RESTRICTED BED USE AREAS

Areas of restricted bed utilization and assignment of patients are as follows:

(a) CCU
(b) ICU
(c) ICN
(d) Psychiatric Unit
(e) Substance Abuse

Admission or discharge from these restricted bed units shall be governed by written Medical Staff Policies and Procedures as on file in the Medical Staff Services Department. Questions regarding admission to or discharge from any of the above areas shall be referred to the physician director of the area or designee for clarification or determination.

1.6 ADMISSION INFORMATION

Except in an emergency, a patient shall not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the physician requesting admission. Additional required documentation or information specific to the type of admission involved is detailed in Section 1.3. The admitting physician is also responsible for providing the following information concerning a patient to be admitted: possible communicable disease or significant infection; behavioral characteristics that may disturb or endanger others; need for protecting the patient from self-harm.

1.7 TIMELY VISITATION OF PATIENT AFTER ADMISSION

The attending physician or designee must see the patient within the specified time frames as follows or within shorter time should the patient's condition require.

(a) Patients designated as emergency cases and those admitted directly or transferred to an intensive or critical care area from the admitting office, emergency department, or general care area - within six (6) hours

(b) All other patients - within 24 hours.

SECTION TWO. ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 ATTENDANCE OF PATIENTS

2.1-1 IN-HOUSE PATIENTS

Care for in-house patients shall be coordinated by the admitting physician, provided said physician is a member of the medical staff with appropriate clinical privileges. Patients may choose the physician who is to provide care. The chosen physician shall have the option of accepting the patient for care unless he is the designated physician on call. The admitting physician shall have the responsibility to obtain any necessary consultants. If a selected consultant is unavailable or chooses not to see the patient then the designated physician *on-call* for the emergency department on the day the consult is *requested* shall provide said consult. In those cases where there is no on-call schedule, the appropriate Clinical Department Director shall designate the physician to provide said consult. Authority for administering this policy is given to the appropriate Clinical Department Director. Allegations of misuse or abuse of the above policies shall be grounds for disciplinary action as provided for under Article VI - Corrective Action of the Medical Staff Bylaws.

2.1-2 PARTICIPATION IN THE ON-CALL ROSTER

Unless specifically exempted by the Medical Executive Committee for good cause, each active member of the GSH Medical Staff agrees that when he/she is designated "physician on call", he/she must accept responsibility and provide care to the patient referred to his/**her** service and is **responsible to see the patient at least one time even if the physician's office does not participate in the patients insurance or the patient is not insured. Patient must be offered a timely appointment without unreasonable impediment.** In the event of scheduling conflicts, it is the staff member's responsibility to obtain coverage and to notify the applicable department(s).

SECTION THREE. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERALLY

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of those portions of the medical record for which he is responsible, for necessary special instructions, and for transmittal of reports. The admitting physician bears primary responsibility for these matters except when transfer of responsibility is effected pursuant to Section 3.2.

3.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the admitting or then current attending physician to another staff member, a note covering the transfer of responsibility and acceptance of the same must be entered on both the order sheet and progress notes.

3.3 ALTERNATE COVERAGE

Each physician must assure timely, adequate professional care for his patient in the hospital by being himself available or by providing a qualified alternate physician with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital. A physician who will be unavailable for an extended period of time and who will not be covered by a member of his own group practice must indicate in writing on the order sheet the name of the physician who will assume responsibility for the care of the patient during his absence. In the absence of such designation, the department director shall have the authority to call upon any member of the staff with the requisite clinical privileges. Failure of a physician to meet these requirements may result in disciplinary action as outlined in the Medical Staff Bylaws.

3.4 DENTIST, PODIATRISTS AND OTHER ALLIED HEALTH PROFESSIONALS

Dentists, podiatrists and other allied health professionals may treat patients under the conditions provided in Sections 5.4, 5.5 and 5.6 of the Medical Staff Bylaws and in Section 1.2-2 of these Rules and Regulations. Each dentist, podiatrist and other allied health professional is responsible for documenting in the medical record a complete and accurate description of the services he provides to the patient.

3.4-1GENERAL RESPONSIBILITIES

Dental and podiatric members of the staff are responsible for the following:

(a) A detailed dental/podiatric history and description of the dental/podiatric problem including admitting diagnosis which documents any planned surgery and the need for hospitalization.

(b) A detailed description of the examination of the oral cavity/foot and preoperative diagnosis;

(c) A complete operative report, describing the findings, techniques, specimens removed and postoperative diagnosis;

(d) Progress notes as pertinent to the dental/podiatric condition including documentation of all complications, hospital acquired infections, unfavorable reactions to drugs and anesthesia, and diagnostic and therapeutic orders;

(e) Pertinent instructions at the time of discharge relative to the dental/podiatric condition; and,

(f) A final summary note or clinical resume including final diagnosis.

The dentist or podiatrist is responsible for obtaining informed consent of the patient and properly executed consent forms therewith for procedures and treatments.

3.4-2 PHYSICIAN/DIRECTED ALLIED HEALTH PROFESSIONALS

A Physician/Directed Allied Health Professional is given patient care responsibilities in accordance with his job description and Section 4.4 of the Medical Staff Bylaws. The attending physician is responsible for supervising overall patient care and all actions taken by the Allied Health Professionals shall be reviewed by the supervising physician within 24 hours. An attending physician shall not be responsible for supervising more than two PA's or SA's.

3.5 HOUSE PHYSICIAN

A House physician is given patient care responsibilities in accordance with his granted delineation of privileges. In all matters of patient care, the house physician is responsible to the private attending physician, as applicable, who retains ultimate decision-making and responsibility. In emergency situations the House Physician shall be the responsible physician.

3.6 CONSULTATION

3.6-1 RESPONSIBILITY OF ATTENDING PHYSICIAN

The attending physician is responsible for obtaining consultation when indicated or required pursuant to the guidelines in Section 3.6-2 below.

3.6-2 GUIDELINES FOR OBTAINING CONSULTATION

When an attending physician is not credentialed in the area of the patient's problem, consultation with the appropriate physician is

required, as in the following cases:

(a) When any patient is known or suspected to be suicidal.

(b) When these Rules or the rules of any clinical unit require it including any intensive or special care unit.

(c) When the patient is under two (2) years of age.

(d) When the patient requires mechanical ventilation.

(e) When the patient is not a good medical risk for operation or treatment.

(f) When required by state law.

(g) When requested by the patient or family.

(h) In an emergency, post-graduate trainees, nurses or other health care practitioners involved in the care of the patient shall not be precluded from requesting consultation with a specialist physician.

3.6-3 QUALIFICATIONS OF CONSULTANT

A consultant must be a recognized practitioner in the applicable area as evidenced by certification by the applicable specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. Any qualified physician may be called as a consultant regardless of his staff category assignment.

3.6-4 DOCUMENTATION

(a) Consultation Record: When requesting consultation, the attending physician or person requesting consultation shall indicate in writing on the consultation record the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

(b) Consultant's Record: The consultant shall make and sign a report of his findings, opinions and recommendations which reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.

SECTION FOUR. TRANSFER OF PATIENTS

4.1 TRANSFER TO ANOTHER FACILITY

In all cases involving transfer of patients, transfer shall be done in accordance with the guidelines established by the Medical Staff Policy regarding the COBRA Regulations.

4.1-1 GENERAL REQUIREMENTS

A patient shall be transferred to another medical care facility only upon the order of the attending physician, only after arrangements have been made with the other facility including its consent to receive the patient for admission, and only after the patient is sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care shall accompany the patient.

4.1-2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or by a critically ill patient, his family or significant other, shall not be permitted until a physician has explained to the patient, his family, the seriousness of the condition and, in general, not until a physician has demonstrated that the condition of the patient is sufficiently stable for safe transport. In each such case, an appropriate release form shall be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature plus a note indicating said refusal shall be included in the patient's medical record.

4.1-3 EMERGENCY MEDICAL CONDITION/PREGNANCY

The term "emergency medical condition" includes any medical condition which manifests itself by sufficiently severe acute symptoms such that the absence of immediate medical attention could reasonably be expected to result in

a) serious impairment or dysfunction or
b) placing the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

SECTION FIVE. DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

A patient shall be discharged only on the order of the attending physician.

5.2 TIME OF DISCHARGE

The attending physician is responsible for discharging his patient on the day of discharge.

5.3 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the hospital against the advice of the attending physician or otherwise without proper discharge, the attending physician shall be notified and the patient shall be requested to sign an appropriate release form, attested to by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending physician or otherwise without proper discharge, a notation of the incident shall be made by the physician in the patient's medical record.

5.4 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parent(s), legal guardian, person standing in loco parentis or to another responsible party. This discharge direction shall be made a part of the medical record.

SECTION SIX. PHARMACY AND FORMULARY

6.1 FORMULARY

Recommendations for drugs to be included in the Formulary may be made by members of the Medical Staff or the Director of Pharmacy. Requests are reviewed by the Pharmacy and Therapeutics Committee which, transmits its recommendations for action to the Medical Executive Committee.

6.2 PRESCRIBING MEDICATION THERAPY

6.2-1 WHO MAY PRESCRIBE

Medications to be administered to patients at Good Samaritan Hospital shall be prescribed only by licensed authorized and duly appointed members of the Medical Staff and those physicians who shall be granted emergency and/or temporary privileges. House staff physicians shall prescribe medications. Physicians' assistants shall not prescribe medications unless authorized by their specific delineated clinical privileges. All medication orders shall be written in the medical record and signed by the prescriber.

6.2-2 TELEPHONE ORDERS AND VERBAL ORDERS

(a) Telephone or oral orders shall be used sparingly and shall be limited to those medications, tests, procedures, instructions, etc., which are essential for the proper care of the patient prior to the physician’s presence on the unit. Faxing of orders is an acceptable and preferable alternative to orders transmitted verbally. Verbal orders are acceptable in emergent situations, only (e.g. Code 99, at the time of procedures during which the prescriber cannot write the orders, trauma in the ED). All telephone/verbal orders must be immediately reduced to writing in the patient’s record by the nurse who received the order, read back and confirmed with the prescriber; and whenever possible, be witnessed by another member of the professional staff. Orders shall be read back in a manner that confirms proper ordering and recording of names, numbers, frequencies, etc. Verbal/telephone orders must be authenticated and signed by the prescribing practitioner as soon as possible.

(b) Verbal/telephone orders for biological and pharmaceutical agents shall be accepted only by a Registered Professional Nurse or a Registered Pharmacist.

(c) The following personnel, if approved in accordance with hospital policy, may accept verbal orders for treatment and/or procedures except laboratory tests within their respective areas of practice: certified registered respiratory therapists, physical therapists, laboratory technologists, radiation therapy technologists, certified registered nurse anesthetists, occupational therapists, speech pathologists. Such personnel shall not be permitted to accept verbal orders for medications or biologicals.

6.2-3 STANDING ORDERS

Medications which are prescribed as part of approved standing orders may be administered.

6.2-4 USE OF ABBREVIATIONS AND METRIC SYSTEM

An official list of prohibited abbreviations, acronyms and symbols is available at each nursing station in the Patient Services Manual. This list shall apply to all patient specific documentation, including all types of orders, progress notes, consultation reports and operative notes. Only the metric system is to be employed when stating weight, strength or volume in connection with medications.

6.2-5 STANDARD TIMES OF ADMINISTRATION

Unless otherwise specified by the prescriber, all medication therapy shall be initiated and administered in accordance with the Standard Times for the Administration of Medications, as approved by the Medical Executive Committee.

6.2-6 CLARITY AND CONTENT OF ORDERS

Physicians' orders shall legible and clear as to content. All orders shall contain the following:

- Name of medication
- Strength per unit, volume and/or number of units to be administered
- Route of administration, unless the dosage form clearly dictates the route. Determination of the route of administration, except as stated herein, is the sole responsibility of the prescriber.
- Frequency of administration. The designation "PRN" without specific qualification of dose interval or clinical parameters is not valid.
- Duration of therapy, when appropriate.

6.3 AUTOMATIC STOP ORDERS

In order to assure that the proper and complete therapeutic regimen is carried out, as intended by the prescribing physician, the exact total dosage or total period of time for treatment should be specified. In the event that this has not been specified, then a termination date and time for the valid period of the order shall be assigned in accordance with the automatic stop order policies approved by the Medical Executive Committee. A copy of said policy shall be kept on file in the Medical Staff Services Department and the Pharmacy. Pharmacists and nurses shall calculate the period of hours for which an order is valid in accordance with approved stop order policies so as to cover the maximum permissible duration of therapy, unless a shorter duration of therapy is specified by the last effective order. An order, which states duration of treatment in excess of the period stated in the stop order policy, is not valid.

6.3-1VALID STOP ORDER

Periods shall be specified in the automatic stop order policies approved by the Medical Executive Committee and kept on file in the Medical Staff Services Department and the Pharmacy Department.

Certain categories of drugs may be administered beyond the stop order point at the discretion of the nurse, in consultation with the pharmacist, provided all of the following conditions are satisfied:

1. The order expired after 8:00 P.M., and

2. Continuation of therapy does not present foreseeable risk to the patient, and

3. The physician has not issued instructions to the contrary.

In such cases, courtesy doses will be provided through 8:00 A.M. the following morning.

6.3-2 RENEWAL OF ORDERS
If an order is to be renewed, the prescriber shall rewrite the order, including name, strength, route and frequency of administration of the medication. The statement "Renew all medications" is not a valid order.

6.3-3 NOTIFICATION OF STOP ORDERS
The prescribing physician shall be notified of pending stop order deadlines 12-24 hours prior to expiration. A stop order deadline may be extended by one dose interval in the event that an order has not been acted upon and the prescriber has not been contacted.

6.3-4 AUTOMATIC CANCELLATION OF ORDERS
Orders for medications are automatically canceled in accordance with the following established policy:

- at midnight prior to surgery unless otherwise specified by the attending physician or anesthesiologist
- Upon admission to or discharge from the Intensive Care Unit

6.4 PATIENT'S MEDICATION

6.4-1PATIENT'S OWN MEDICATION

Medication brought into the hospital by a patient shall not be administered unless there is an appropriate order from the attending physician which specifies drug, dose, and frequency. In addition, a pharmacist must positively identify any medication brought into the Hospital by a patient prior to its administration. If the medication in question is available through the Pharmacy Department as an approved formulary item, the patient shall not use his own medication. If the medication is not available as stated above, the physician is encouraged to prescribe a therapeutically equivalent medication which has approved formulary status. All medication shall be given to the

nurses to be distributed by them in accordance with physician orders. (See 6.4-2 for exceptions).

6.4-2 SELF-ADMINISTRATION OF MEDICATIONS

The following medications may be left at the patient's bedside for self-administration, provided the attending physician issues a specific order to do so:

Antacids	Eye Drops
Sublingual Vasodilators	Ear Drops
Topical Preparations	Nose Drops
Nebulizers/Inhalers	Oral Contraceptives

6.5 INVESTIGATIONAL DRUGS

Use of investigational drugs shall be in full accordance with all regulations of Food and Drug Administration and shall be approved by the hospital's Institutional Review Board prior to use. Investigational drugs shall be used only under the direct supervision of the principal investigator or an authorized and approved co-investigator. The investigator shall be responsible for receiving all necessary consents and for completing all necessary forms and shall furnish clear and unambiguous directions for the administration of investigational drugs with respect to:

1. untoward symptoms and side effects
2. precautions in administration
3. labeling of the container
4. storage of drugs
5. recording doses, and
6. method of collecting and recording urine and/or other specimens.

The use of investigational drugs shall be coordinated through the Director of Pharmaceutical Services in accordance with FDA Regulations, the policies and procedures of the Good Samaritan Hospital Human Research Committee, and the Department of Pharmaceutical Services.

SECTION SEVEN. INPATIENT MEDICAL RECORDS

7.1 REQUIRED CONTENT

The attending physician, other Medical Staff members as applicable and house staff involved in the care of the patient shall be responsible for the preparation of a complete and legible medical record for each patient. The content of the record shall be pertinent, accurate, legible, timely and current. The record shall include:

(a) Identification data
(b) Personal and family medical histories
(c) Description and history of present complaint and/or illness
(d) Physical examination findings
(e) Admitting diagnosis
(f) Summary of psychosocial needs
(g) Diagnostic and therapeutic orders
(h) Evidence of appropriate informed consent
(i) Treatment provided
(j) Progress notes and pertinent clinical observations, including results of therapy
(k) Special reports, when applicable (e.g.), laboratory, radiology, radiation therapy, EEG, ECG, consultation, pre- and post-anesthesia data, surgical operative notes, and other diagnostic and therapeutic procedures, etc.)
(l) Pathology reports
(m) Documentation of all complications
(n) Hospital acquired infections
(o) Unfavorable reaction to drug or anesthesia
(p) Final diagnosis (without the use of symbols or abbreviations)
(q) Discharge summary, including the outcome of hospitalization and the disposition of the case along with post hospital instructions
(r) Autopsy report, when available
(s) Physician's attestation sheet, signed by a licensed attending physician, which includes the patient's age, sex, principal and other diagnoses and principal and other procedures performed.

7.2 HISTORY AND PHYSICAL EXAMINATION

7.2-1 GENERALLY

A complete history and physical examination shall be recorded in the chart or dictated within 24 hours after admission of the patient. If dictated, the chart shall at least contain an abbreviated admission note and physical examination. The history and physical examination report shall include:

1. chief complaint;
2. details of the present illness;
3. all relevant past medical social and family histories
4. the patient's emotional behavioral and social status when appropriate;
5. all pertinent findings resulting from a comprehensive current

assessment of all body systems;

6. admitting diagnosis and treatment plan;
7. a screening uterine cytology smear on women 21 years of age and over, unless such test is medically contraindicated or has been performed within the previous three years;
8. the results of breast palpation examination for all women over 21 years of age, unless medically contraindicated; and
9. patients who may be susceptible to sickle cell anemia shall be examined for the presence of sickle cell hemoglobin unless such test has been previously performed and the results recorded in the patient's medical record or elsewhere, such as on an identification card.

The attending practitioner shall review and countersign the history and physical examination if not personally performed by him or her.

7.2-2 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

(a) External to Hospital: If a qualified member of the hospital's medical staff has obtained a complete history or has performed a complete physical examination within seven (7) days prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval admission note is additionally recorded that includes all pertinent additions to the history and changes in physical findings subsequent to the original report.

(b) On Prior Admission: When a patient is readmitted to this hospital within 30 days of a previous hospitalization for the same or a related problem, an interval history and physical examination may be provided which reflects pertinent interval history and changes in physical findings, provided the original information is readily available.

7.3 PREOPERATIVE DOCUMENTATION

7.3-1 HISTORY AND PHYSICAL EXAMINATION

A complete history and physical examination is required on each patient having surgery. Except in an emergency situation so certified in writing by the operating physician, surgery or any other potentially hazardous procedure shall not be performed until after the pre-operative diagnosis, history, physical examination, required laboratory tests and x-rays shall have been recorded in the chart. Where the history and physical examination has been dictated but not yet recorded in the patient's chart, an abbreviated admission note shall be prepared and signed by the practitioner who admitted the patient. Such reports shall be signed to attest to the adequacy and currency of the history and physical examination or countersigned by the attending surgeon prior to surgery.

7.3-1 A) Outpatient Procedure with Sedation or Anesthesia (endo, rectal, etc); H&P “Outpatient” Short Form

7.3-1 B) Outpatient-Local/Topical Anesthesia Only (i.e. eye laser, cutaneous simple procedures) Use of Procedure Form with Significant Medical History Documentation

If the chart is not recorded, then the anesthesiologist (or other licensed professional responsible for the patient's anesthesia care) shall not allow the surgery to proceed. In case of emergency, the responsible physician shall make a comprehensive note with respect to the patient's condition prior to induction of anesthesia and the start of the procedure. The history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with Section 6.4-4 of the Medical Staff Bylaws and Section 5.3-3 of the Credentialing Procedures Manual.

7.3-2 LABORATORY TESTS

Appropriate advance laboratory tests shall be performed within seven (7) days prior to admission for elective surgery and for outpatient or same day surgery and the results shall be recorded in the chart prior to induction of anesthesia.

7.3-3 PREOPERATIVE ANESTHESIA EVALUATION

The anesthesiologist (or other licensed professional responsible for the patient's anesthesia care) shall conduct a pre-anesthesia evaluation of the patient within 48 hours of surgery, and shall document same. Pre-anesthesia evaluation of the patient shall include pertinent information with respect to the choice of anesthesia and the anticipated procedure, pertinent drug history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiologists patient status classification, and orders for pre-operative medication. Except in cases of emergency, this evaluation shall be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.4 POST-OPERATIVE RECOVERY

Patients are evaluated upon admission to post-operative recovery, during the recovery period and prior to discharge in accordance with post-operative recovery policies. Such policies include Department of Anesthesiology #502 <u>Pre and Post Anesthesia Evaluations.</u> Patients are discharged from post-operative recovery by a physician or other qualified licensed practitioner in accordance with discharge criteria see Department of Anesthesia Policies #502 <u>Pre and Post Anesthesia Evaluation</u> and <u>#507 Post Anesthesia Recovery Discharge Criteria.</u>

7.5 PROGRESS NOTES

7.5-1 GENERALLY

All progress notes shall reflect date and time of observation. Final responsibility for an accurate description of the patient's medical condition rests with the attending physician. Progress notes by the attending physician shall be written daily. Progress notes written by a physician-directed Allied Health Professional shall be countersigned by the supervising physician within 24 hours.

7.6 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

7.6-1OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and special procedure reports shall contain a detailed account of all pertinent findings including but not limited to:

1. the name of primary physician and any assistants,
2. the pre and postoperative diagnosis,
3. finding,
3. the technical procedures used,
5. complications,
6. description of patient's general condition, and
7. the tissues removed,
8. use of anesthesia.

The physician must enter an operative progress note on the progress sheet immediately after the procedure is completed which provides all pertinent information which may be required by other physicians who attend the patient. The complete operative report shall be dictated <u>immediately</u> following surgery and subsequently signed by the surgeon.

7.6-2 TISSUE EXAMINATION AND REPORTS

All tissues, foreign bodies, artifacts, and prostheses removed during a procedure shall be identified as to patient and source in the operating room or suite at the time of removal, and shall be properly labeled, packaged in preservative as designated, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at an appropriate pathology diagnosis. Each specimen shall be accompanied by pertinent clinical information including preoperative and postoperative diagnoses. The pathologist's authenticated report shall be made a part of the medical record.

7.7 OBSTETRICAL RECORD

The obstetrical record shall include a complete updated prenatal record, a part of which shall be a history and physical. The prenatal record may be a durable, legible copy of the attending physician's office or clinic record transferred to the hospital prior to admission. In addition, an interval admission note shall be written that includes all pertinent additions to the history and significant changes in the physical findings.

7.8 DISCHARGE SUMMARY

A discharge summary shall be recorded for all patients. The summary shall contain the reason for hospitalization, the significant findings, the outcome of hospitalization, the disposition for case, the provisions for followed care, and the condition of the patient on discharge. Medical records shall be completed within 30 days of discharge.

A final progress note may be substituted for the discharge summary in those cases that require less than 48 hours of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries. The final progress note shall then include the outcome of hospitalization, disposition of case, and provisions for follow up care.

A transfer summary may be substituted for the discharge summary if the patient is transferred to a different level of hospitalization or residential care within the organization.

7.8-1 INSTRUCTIONS TO PATIENT

The discharge instruction sheet shall indicate any specific instructions given to the patient and/or other significant instructions relating to physical activity, medication, diet and follow-up care.

7.9 AUTHENTICATION

All clinical entries in the patient's record shall be accurately dated and authenticated. "Authentication" means to establish authorship by written signature, identifiable initials or computer key.

7.10 USE OF SYMBOLS AND ABBREVIATIONS

An official list of prohibited abbreviations, acronyms and symbols is available at each nursing station in the Patient Services Manual. This list shall apply to all patient specific documentation, including all types of orders, progress notes, consultation reports and operative notes. Only the metric system is to be employed when stating weight, strength or volume in connection with medications.

7.11 FILING

A medical record shall not be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation or other inability or unavailability of the responsible physician, the Medical Executive Committee shall consider the circumstances and such information shall be entered in the record and filed.

7.12 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray films, imaging records, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena, or statute. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization. Unauthorized removal from the hospital shall be grounds for disciplinary action as provided for under Article VI - Corrective Action of the Medical Staff Bylaws.

7.13 ACCESS TO RECORDS

7.13-1 BY PATIENT

A patient may, upon written request, have access to all information contained in his medical record, unless such access is specifically restricted by the attending physician for medical reasons in accordance with Public Health Law Section 18, or unless such access is prohibited by law.

7.13-2 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

As permitted by applicable federal or state laws pertaining to patient confidentiality, patient medical records shall be made available to authorized hospital personnel, medical staff members, and other persons who have an interest approved by the hospital for the following purposes:

(a) Automated data processing of designated information;

(b) Activities concerned with assessing the quality, appropriateness and efficiency of patient care;

(c) Clinical unit/support service review of work performance;

(d) Official surveys for hospital compliance with accreditation, regulatory and licensing standards;

(e) Approved educational programs and research studies.

Patient records used for any of these purposes shall be protected, insofar as is possible from revealing patient identification. Confidential personal information extraneous to the purpose for which the data are sought shall not be used.

7.13-3 ON READMISSION

In the case of readmission of a patient, all previous records shall be made available to the current attending physician.

7.13-4 TO FORMER MEDICAL STAFF MEMBERS

Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted access to information from the medical records of their patients for periods during which they attended such patients to the hospital.

7.13-5 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES

Written consent of the patient or his legally qualified representative shall be required for release of medical information to persons not otherwise authorized to receive this information under this Section 7.13 or by law.

SECTION EIGHT. CONSENTS

8.1 GENERAL

Each patient's medical record shall contain evidence of general consent of the patient or his legal representative for treatment during hospitalization.

8.2 INFORMED CONSENT

The physician shall be responsible for obtaining informed consent from the patient or his legally authorized representative.

8.2-1 DOCUMENTATION REQUIRED

Informed consent shall be documented in the patient's medical record or on a form appended to the record and shall include the following information:

(a) Patient identity;
(b) Date when the patient was informed and the date when the patient signed the form, if different;
(c) Nature of the procedure or proposed treatment;
(d) Name(s) of the individual(s) who will perform the procedure or administer treatment;
(e) Authorization for anesthesia if required;
(f) Indication that the anticipated benefits outweigh the risks and possible complications of the procedure or treatment, and of the available possible reasonable alternatives, if any; and that the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient or the patient's legal representative. All information that a reasonable practitioner under similar circumstances would have disclosed or that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment, shall be explained in terms that the patient can understand and in a manner permitting the patient to make a knowledgeable evaluation and render an informed consent.
(g) Authorization for disposition of any tissue or body parts as indicated.

8.2-2 SIGNATURES

An informed consent shall be signed by the patient (or on behalf of the patient by the patient's authorized representative), and witnessed by a legally competent third party.

8.2-3 EMERGENCIES

If circumstances arise where it is deemed medically necessary to proceed with a procedure or treatment without first obtaining informed consent as required in Section 8.2-1 i.e. when, in the physician's reasonable judgment, a medical emergency exists with the patient in

immediate need of medical attention, and when an attempt to secure consent would result in delay of treatment and thus would increase the risk to life or health, such circumstances shall be explained in writing in the patient's medical record. It shall also be documented that Administration was so informed. Where possible, two physicians shall independently document the medical advisability of proceeding without informed consent.

SECTION NINE. SPECIAL SERVICES UNITS AND PROGRAMS

9.1 DESIGNATION

Special services units and programs include, but are not limited to the following:

(a) Intensive care units of all types (ICU, CCU & ICN)
(b) Emergency Room
(c) Operating Room
(d) Recovery Room
(e) Labor and Delivery
(f) Newborn nurseries
(g) Day-Surgery Program
(h) Outpatient Department
(i) Renal Dialysis
(j) Psychiatric Unit
(k) Chemical Dependency Unit

9.2 POLICIES

Appropriate officers, committees, and representatives of the medical staff and its departments shall develop specific policies for the special services units and programs in coordination with applicable hospital departments. These policies shall cover but not be limited to the following:

1. the admission, discharge and transfer of patients;
2. a system for informing the physician responsible for a patient of changes in the patient's condition;
3. explicit directions as to the location and storage of medications, supplies and special equipment;
4. the methods for the procurement of equipment and drugs at all times;
5. responsibility for maintaining the integrity of the emergency drug system;
6. infection control;
7. the procedures to be followed in the event of a breakdown of essential equipment;
8. pertinent safety practices;
9. regulations for the control of traffic, including visitors;
10. the role of the unit in the Hospital's external and internal disaster plans;
11. specification as to who may perform special procedures, under what circumstances, and under what degree of supervision;
12. the use of standing orders;
13. the protocol for handling specific emergency conditions;
14. responsibility for care of patients in the unit/program;
15. requirements for consultation,
16. direction/organization of the unit/program;
17. authority of the physician director of the unit/program;
18. special record keeping requirements; and

19. scheduling of patients;
20. use of physical restraints;
21. criteria for discharge from post-operative recovery;
22. criteria for autopsies.

These polices and procedures of the various units and programs shall be subject to the approval of the Medical Executive Committee, and shall be coordinated by the applicable committee, reviewed at least annually and revised as necessary.

SECTION TEN. HOSPITAL DEATHS AND AUTOPSIES

10.1 HOSPITAL DEATHS

10.1-1 PRONOUNCEMENTS

In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his physician designee.

10.1-2 REPORTABLE DEATHS

Reporting of deaths as required by the Medical Examiner's Office shall be the responsibility of the attending physician.

10.1-3 DEATH CERTIFICATE

The death certificate shall be issued by the attending physician unless the death is a Medical Examiner's case, in which event the death certificate shall be issued by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician shall issue the death certificate.

10.1-4 RELEASE OF BODY

The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the medical staff. In a Medical Examiner's case, the body shall not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" issued by the Medical Examiner.

10.2 AUTOPSIES

It is the responsibility of every member of the Medical Staff to secure autopsies in all deaths that meet the criteria specified in Medical Staff policy entitles Policy #3301 Autopsies Protocol. Proper written consent for an autopsy shall be obtained in accordance with the Autopsy Policy as required under 10 NYCRR § 405.4. All autopsies shall be performed by a hospital pathologist or his qualified designee who shall notify the appropriate Medical Staff member, including the attending physician when an autopsy is performed.

SECTION ELEVEN. INFECTION CONTROL

11.1 STATEMENT OF AUTHORITY

The Infection Control Committee, acting through its Infection Control Officer has the authority to institute an investigation and/or appropriate control measures when there is reason to believe that a danger to patients and/or personnel exists.

11.2 CULTURES

All suspected clinically significant infections of the skin or surgical incisions shall be cultured for organism and antibiotic sensitivity. Suspected infection of other organs by communicable organism shall be cultured when practical. Cultures shall be ordered by the physician, but may be obtained as well by nursing personnel as per policy without order.

11.3 PATIENTS WITH INFECTIONS/COMMUNICABLE DISEASES

A patient with a known or suspected infectious or communicable disease as defined by the Center for Disease Control or by the State of New York shall be treated using appropriate isolation/precaution techniques, as ordered by the attending physician and consistent with the principles outlined in the Infection Control Manual of Good Samaritan Hospital. The Infection Control Coordinator shall call to the attention of the attending physician cases which may need isolation. If isolation protocol is not followed by the attending physician, the infection control chairman and the specific department director shall be notified and shall make a determination concerning isolation in consultation with the attending physician for the safety and protection of hospital patients and/or personnel.

11.4 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

All cases of infection and communicable disease shall be reported to the Infection Control Committee. The attending physician is strongly advised to report promptly to the infection control committee those infections which develop after discharge and which may have been acquired in Hospital.

11.5 HIV TESTING

In accordance with New York State law, written informed consent shall be obtained by the attending physician from the patient (or the person lawfully authorized to consent to health care for that patient) prior to testing. HIV Test Requisition shall be completed by the attending physician who shall maintain patient confidentiality. Documentation of consent, counseling and results shall be recorded in the medical record by the attending physician.

SECTION TWELVE. AMENDMENT

12.1 AMENDMENT

These general Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by any one of the following mechanisms:

(a) resolution of the Medical Executive Committee recommended to and adopted by the Board of Trustees:

(b) action by the Board of Trustees on its own initiative, after notice has been given of its intent to the Medical Executive Committee in accordance with the procedures outlined in Section 14.3-2 of the Medical Staff Bylaws.

(c) Action by the affirmative vote of a majority of the Full and Associate Attending Medical Staff practitioners in good standing present at a regular or special Medical Staff meeting at which a quorum is present, provided that a copy of the appropriate documents or proposed amendments has been given or made available to each Medical Staff member entitled to vote thereon. Affirmative action of the Medical Staff shall be transmitted by the Bylaws Committee to the Board of Trustees for their final review and approval.

12.2 RESPONSIBILITIES AND AUTHORITY

The procedures outlined in Article Fourteen of the Medical Staff Bylaws shall be followed in the adoption and amendment of these Rules and Regulations, provided that the Medical Executive Committee may act for the staff in making the necessary recommendations.

12.3 REVIEW

The Medical Staff Rules and Regulations shall be reviewed every two (2) years and revised as necessary.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff of Good Samaritan Hospital on June 26, 2008

President of the Medical Staff
Good Samaritan Hospital of Suffern,

Approved by the Board of Trustees of N.Y. Good Samaritan Hospital on July 17, 2008

Chairperson, Board of Trustees

Cliff L.Wood

Chief Executive Officer

Dominick Stanzione, CEO