

# EDWARD WHITE HOSPITAL

## MEDICAL STAFF RULES AND REGULATIONS

### A. ADMISSION AND DISCHARGE

1. Only practitioners granted Staff appointment and clinical privileges may admit patients to this Hospital except as provided in the Staff Bylaws and Rules and Regulations (except Temporary Privileges). Only individuals granted clinical privileges may treat patients at this Hospital. All practitioners with authority to admit patients shall be governed by the official admitting policy of the Hospital.
2. (a) The Hospital shall accept patients for care and treatment except as follows:
  - (1) obstetric cases;
  - (2) severe mental disorders;
  - (3) pediatrics (11 or younger);
  - (4) ophthalmology;
  - (5) gynecological cases

(See the Hospital's written plan for the care and/or appropriate referral of patients who are emotionally ill, who become emotionally ill while in the Hospital, or who suffer the results of alcoholism or drug abuse.)

- (b) Patients who are known to be suffering from drug abuse, alcoholism, and mental illness shall not be admitted unless proper safety precautions can be taken to safeguard the patient, other patients, and employees.
  - (c) The Admitting Practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm, and to assure the protection of others whenever his or her patients might be a source of danger from any cause whatever.
3. (a) A physician member-appointee of the Staff shall be responsible for the overall medical care of each patient in the Hospital. The attending practitioner shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner.
  - (b) Whenever physician responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his responsibility shall personally notify the other practitioner to ensure the acceptance of that responsibility is clearly understood. The patient shall be assigned to the service concerned in the treatment of the disease when necessitated admission.

4. In the case of a patient requiring admission who has no practitioner, he or she shall be assigned to the practitioner on-call for the service to which the illness of the patient indicates assignment.
5. Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.
6.
  - (a) In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, (i) record a provisional diagnosis or valid reason for admission as soon as possible; and (ii) contact the nursing service supervisor to ascertain if there is a bed available. A copy of the emergency service record shall accompany the patient to the nursing unit.
  - (b) Practitioners shall be able to justify emergency admissions based on criteria developed by the Staff. The history and physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's medical record as soon as possible after admission. Violators of this rule shall be referred to the MEC for appropriate action.
7.
  - (a) A patient to be admitted on an emergency basis shall be given the opportunity to select an appointee of the Staff to be responsible for the patient while in the Hospital.
  - (b) If a dentist or podiatrist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient. This requirement does not apply to patients admitted to the service of a qualified Oral Surgeon, defined as an individual who has successfully completed a post-graduate program in Oral Surgery, accredited by a nationally recognized accrediting body, approved by the U.S. Office of Education.
  - (c) Where no such selection is made or where the selected practitioner does not assume responsibility for care of the patient for some reason, the on-call practitioner may assume responsibility for the patient.
  - (d) In no event shall a physician member of the staff be required to co-admit any patient.
8. Each appointee of the staff shall name another appointee of the staff as an alternate to be called to attend his or her patients in an emergency when the attending practitioner is not available. If a covering physician is not available, contact shall be made with the on-call physician member of the staff. In case the alternate is not available, the Chief of the Department shall have the authority to assign the on-call practitioner or any other appointee of the staff to attend the patient. Failure of an appointee of the staff to meet these requirements may result in disciplinary action.

9. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:
  - (i) Emergency
  - (ii) Urgent
  - (iii) Pre-operative
  - (iv) Routine

The committee responsible for the Utilization Management functions shall review admissions that do not meet the established criteria for the above categories if there is a need to do so. Unjustified variations and recommended actions shall be reported to the MEC for appropriate action.

10. The patient shall not be transferred within the Hospital without the approval of the attending practitioner or consulting practitioner. The order of priority for the patient transfers shall be as follows:
  - (i) Emergency service to appropriate nursing unit.
  - (ii) From general care unit to intensive care unit.
  - (iii) From intensive care to general care unit.
  - (iv) From temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit for the patient being transferred.
11. Admissions and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the unit or service medical director or special care committee.
12. Practitioners shall abide by the Hospital's case management plan to include:
  - (i) The appropriateness and medical necessity of admissions
  - (ii) Continued stay
  - (iii) Supportive services
  - (iv) Discharge planning
13.
  - (a) Patients shall be discharged from the Hospital only on the written or verbal order of the patient's attending practitioner. If a patient leaves the Hospital against the advise of the attending practitioner, or without proper discharge, a notation shall be made in the patient's medical record.
  - (b) Practitioners shall, when practical, write discharge orders that will allow patients to be discharged from the Hospital by 11:00 a.m. on the day of discharge.
14. In the event of a Hospital patient death, the deceased shall be pronounced dead by a physician or two R.N.'s, one in a charge capacity, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician appointee of the Staff. Policies with respect to release of dead bodies shall conform to local law.
15. For the protection of patients, the Medical and Nursing Staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient. If

any patient being admitted is known or suspected to be suicidal in intent, placement shall be made in an area where appropriate observation facilities are available. Transfer to another institution may be required.

16. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed by the Hospital Pathologist or by a Practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded in the medical record within 48 hours, and the complete protocol should be made part of the record within four weeks.

B. EMERGENCY SERVICES

1. (a) Appointees of the Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures.  
  
(b) The Chief of emergency services or the emergency service committee shall have the overall responsibility for emergency care.
2. Clinical privileges shall be delineated for all practitioners rendering emergency care in accordance with Staff and Hospital procedures.
3. A physician shall be in the Hospital and immediately available for rendering emergency patient care 24 hours per day, seven (7) days per week.
4. Emergency service policies and procedures shall be approved by the Chief of emergency services or the emergency services committee, the Staff and the Trustees.
5. If a patient needs to be admitted to the Hospital as an inpatient, in the judgment of the emergency physician, either for observation or for further treatment, the patient shall be admitted in the name of the patient's practitioner or the practitioner on-call. If in the judgment of the emergency physician the patient's condition requires continuing practitioner attendance the emergency physician shall continue to accept responsibility for the patient until such time as an admission order has been received from the attending physician.
6. Except in cases where transfer to surgery is contraindicated in the judgment of the emergency physician, surgery shall not be performed in the emergency treatment area.
7. In cases where the x-ray interpretation of the radiologist is different from that initially made by the emergency physician, copies of the radiologist's report shall be made available and brought to the attention of the emergency physician, the patient's private practitioner and the patient.
8. An appropriate emergency service medical record shall be kept for every patient receiving emergency service. The emergency service medical record shall include:

- (i) Adequate patient identification;
  - (ii) Information concerning the time of the patient's arrival and by whom transported;
  - (iii) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital and history of allergies;
  - (iv) Description of significant clinical, laboratory and x-ray findings;
  - (v) Diagnosis including condition of patient;
  - (vi) Treatment given and plans for management;
  - (vii) Condition of the patient on discharge or transfer; and
  - (viii) Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.
9. Each patient's emergency medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy and a copy of the emergency service medical record shall accompany patients being admitted as an inpatient.
10. The emergency physician director or the emergency service committee shall coordinate the review of emergency service records with the Staff medical records committee.
11. The emergency physician director or the emergency service committee shall be responsible for monitoring the quality and appropriateness of patient care.
12. Patients with conditions whose definitive care is beyond the capabilities of this hospital shall be referred to the appropriate facility, when in the judgment of the attending practitioner the patient's condition permits such a transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.
13. The emergency physician director or the emergency service committee shall make certain that emergency service procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.
14. Qualified Medical Persons or Personnel ("QMP") – In addition to a physician, Qualified Medical Persons may perform medical screening examinations. Individuals in the following professional categories who have demonstrated current competency in the performance of medical screening examinations and who are functioning within the scope of his/her license and policies of the Hospital, have been approved by the Medical Executive Committee and the Hospital's Governing Board as Qualified Medical Personnel: Physician Assistants and Advanced Registered Nurse Practitioners.

C. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; medical history; physical examination; diagnostic and therapeutic orders; appropriate informed

consent(s); clinical observations including results of therapy, progress notes, consultations, and nursing notes; reports of procedures, tests and results including operative reports; conclusions at termination of hospitalization to include relevant diagnoses, clinical resume; and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within twenty-four hours of admission but prior to surgery. This report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history has been recorded and a physical examination performed within thirty days; a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by an appointee of the staff with privileges to perform H&P's. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded on the day of admission. This update must be on or attached to the H&P within 24 hours of admission or prior to surgery.
3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient. If the history and physical have been dictated but not typed, a progress note entry by the surgeon stating the proposed operation and reason therefore, together with any general medical implications of the proposed surgery, shall be acceptable in lieu of the typed report.
4. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care. The patient's clinical problems shall be clearly identified in such notes and correlated with specific orders as well as treatment. The attending practitioner shall write progress notes at least daily or more often as appropriate to the case so as to reflect accurately the patient's course in the Hospital.
5. Practitioners shall be responsible for obtaining the patient's informed consent. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital policy. Both the patient and the physician shall sign the consent form affirming that the practitioner has personally informed the patient. Space shall be provided on the form for the practitioner to document what was explained to the patient and that the patient understood and agreed to the proposed treatment.
6. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.
7. Within 24 hours, the attending physician shall countersign all orders, the history and physical examination and pre-operative notes and consult and progress notes

when they have been recorded by an intern, resident physician or credentialed Allied Health Professional designee.

8. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written (or dictated) immediately following surgery. In addition, an operative progress note must be entered immediately post-procedure.
9. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
10. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of the patient. This will be deemed equally as important as the actual discharge order.
11. A discharge summary (clinical resume) shall be written or dictated on all medical records of hospitalized patients. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner. A final progress note may be substituted for the resume for patients with problems and interventions of a minor nature who require less than a 48 hour period of hospitalization.
12. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the medical records committee.
13. The attending practitioner shall complete the medical record at the time of the patient's discharge, to include progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at time of discharge, the medical record will be available in the Medical Record Department.
14. All records must be completed by 30 days post discharge. Any physician not completing his/her records will have all admitting, elective surgical and consulting privileges suspended. The only exception to this policy will be patients currently hospitalized under the practitioner's service, and unassigned patients admitted through the emergency room when the practitioner is on ER call. Physicians remaining delinquent for 60 days will be reported at the next Medical Executive Committee for further disciplinary action.
15. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
16. In the interest of patient safety, the use of abbreviations is discouraged. In addition, the Medical Staff will develop a list of "do not use" abbreviations based on recommendations of the JCAHO's National Patient Safety Goals.

17. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute for the purpose of appearance in court, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away without permission of the CEO. In any case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Staff Executive Committee.
18. Free access to all medical records of all patients shall be afforded to appointees of the staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the staff before records can be studied. Subject to the discretion of the CEO, former appointees of the staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
19. The use of rubber stamps within a patient's medical record shall be prohibited.

D. GENERAL CONDUCT OF CARE

1. All orders for treatment shall be in writing. At a minimum, orders are required for diagnostic and therapeutic procedures, operative and special procedures, all drugs and biologicals, blood and blood components, use of restraints/seclusion, laboratory testing, referrals and transfers, rehabilitation care, therapeutic diets, DNR, and admission. All verbal and telephone orders shall be read back to the practitioner and documented as such by the individual receiving the order. A verbal order shall be considered to be in writing if given to a registered nurse, respiratory therapist, physical therapist, registered pharmacist, pharmacy intern or resident, or other allied health professional, functioning within his or her sphere of competence and signed by the responsible practitioner. LPN's are authorized to take verbal orders, with the following condition(s).

Additional training must be provided or obtained, with written documentation or evidence of additional training required. The training required would be specific.

All orders dictated over the telephone shall be dictated by the practitioner or their qualified designee and shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner.

The following potentially hazardous verbal orders must be authenticated by the physician within 24 hours of such order:

Do Not Resuscitate  
Chemotherapy  
Investigational Drugs

## Restraints requiring the order of a licensed independent practitioner

All other verbal orders should be authenticated by the physician as soon as possible.

2. A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission.
3. The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten and understood by the nurse.
4. All previous orders are canceled when patients go to surgery.
5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration. All drugs shall be provided through, or approved by, the Hospital pharmacy (if one exists).
6. The Pharmacy and Therapeutics Committee will develop policies regarding appropriate automatic stop orders for classes of drugs that is consistent with current medical practice. Drugs not specifically outlined in this policy will have an automatic stop order of 30 days. If the practitioner desires to continue these medications, he must reorder them at the end of this period.
7. All medications brought into the hospital by a patient must be sent to the Pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the practitioner has prescribed.
  - (i) Medications brought into the hospital by a patient or his family will not be given to the patient during his hospital stay without the express authorization of the attending practitioner.
  - (ii) All medications received by the pharmacy will have a receipt, the original of which will be attached to the patient's chart, and the duplicate retained in the pharmacy.
  - (iii) Medications shall be returned to the patient at time of discharge upon presentation of receipt attached to patient's chart.
  - (iv) Medications not called for by this method will be kept in the pharmacy for up to 14 days after discharge and then destroyed in an appropriate manner.
8. Blood which has been cross-matched and is being held for a patient will be held for 48 hours at which time the order for the blood will be canceled unless reordered for another 48 hours. Blood will not be released without notifying the appropriate practitioner.

9. Oxygen and respiratory therapy will be administered according to the attending practitioner's orders. In those cases where duration of treatment is indefinite or unspecified, the practitioner of record will be notified on the third (3<sup>rd</sup>) day of treatment for new orders by the fourth (4<sup>th</sup>) day.

The practitioner will write new orders as soon after notification on the third (3<sup>rd</sup>) day as possible, not to exceed the fourth (4<sup>th</sup>) day. If new orders are not given, the nurse will contact the practitioner for orders regarding continuing or discontinuing the respiratory therapy.

10. Standing orders and/or instruction sheets shall be instituted only after approval of the Executive Committee of the Staff. Such standing orders and/or instruction sheets shall be reviewed at least annually and revised as necessary. All standing orders and/or instruction sheets must be signed and dated by the responsible practitioner when utilized, as required for all orders for treatment.
11. The attending practitioner or their designated consultant is primarily responsible for requesting consultation when indicated or when mandated by Hospital policy, and for calling in a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.
12. Consultations shall be held, except in extreme emergencies, under the following conditions:
  - (i) when requested by the patient or his family
  - (ii) when required by the policy of a special care unit

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his area of expertise.

13. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she or he shall call this to the attention of her or his superior who in turn may refer the matter to the Director of Nursing Service. If warranted, the Director of Nursing may bring the matter to the attention of the attending practitioner, the CEO, or the Chief of Staff, or the Chief of Service as appropriate. Where circumstances are such as to justify such action, the Chief of Staff may request a consultation.
14. The attending physician or appropriate consultant should attend his/her patient at the bedside on not less than a daily basis. The attending is responsible for seeing that such coverage is provided.

#### Availability of Consultation Services

Qualified staff members in the hospital can be called upon for consultation within their area of expertise and, if they accept the patient, are expected to respond within twenty-four (24) hours or sooner if clinically indicated.

#### Intensive Care Unit

When a patient is admitted to the Intensive Care Unit, the attending must see the patient within twelve (12) hours or sooner if clinically indicated. Thereafter, the attending physician or consultant must perform a daily visit to his/her patient in these units.

### E. DEPARTMENT OF SURGERY

1. Department of Surgery-General Department Rules-Reference is made to the Bylaws, Rules and Regulations of the Medical Staff of Edward White Hospital, particularly to those portions pertaining to the Department of Surgery, its sections and officers, qualifications, and general privileges. The Department Chief will be elected in accordance with the Medical Staff Bylaws. To be eligible for privileges in the Department of Surgery and specialties falling within the Department, an applicant must have completed formal training required for Board Certification within the specialty. The applicant must be Board Certified or have recently completed a residency which qualifies the applicant as an active candidate for certification.
2. Except in emergencies, a history and physical examination, the pre-operative diagnosis, appropriate consents, required laboratory and radiology reports, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure. In the case of an emergency, where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition prior to induction of anesthesia and the start of surgery.) In all other cases the responsible nurse shall notify the operating surgeon, preferably no later than the night before surgery is scheduled. In no case shall the patient be taken from the pre-op holding area to the surgical suite until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.
3. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he or she may have his or her privilege to schedule surgery suspended or may be referred to the Executive Committee for action.
4. The anesthesiologist is responsible for maintaining a complete anesthesia record to include evidence of pre-anesthetic evaluation and for writing a pre-anesthetic note in the medical record. The note shall indicate a choice of anesthesia and the surgical procedure anticipated.

5. The anesthesiologist is responsible for post-anesthetic follow-up and for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care to include at least a description of the presence or absence of anesthesia-related complications.
6. If, in the opinion of the operating surgeon and/or the Chief of Surgery, there is in any surgical procedure an unusual hazard to life, there shall be present and scrubbed, a first assistant, a qualified assistant.
7. All supervision of recently credentialed staff will be at the discretion of the department and section.
8. A patient admitted for dental care is a dual responsibility of the dentist and physician appointee of the Staff.
  - (a) Dentist's responsibilities:
    - (1) A detailed dental history justifying hospital admission.
    - (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
    - (3) A complete operative report, describing the findings and techniques.
    - (4) The dentist is totally responsible for the oral or dental care.
    - (5) Progress notes as are pertinent to the oral condition.
    - (6) Discharge summary.
  - (b) Physician's responsibilities:
    - \*(1) Medical history pertinent to the patient's general health.
    - \*(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
    - \*(3) Supervision of the patient's general health status while hospitalized.
    - \*(4) Physician is not responsible for any dental care or consequences thereof.

\*Can be performed by a qualified oral surgeon.
9. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and physician appointee of the staff.
  - (a) Podiatrist's responsibilities:
    - (1) A detailed history justifying hospital admission.
    - (2) A detailed description of the examination of the feet and pre-operative diagnosis.
    - (3) A complete operative report, describing the findings and technique. All tissue removed shall be sent to the hospital pathologist for examination.
    - (4) Progress notes.
    - (5) The podiatrist is solely responsible for the care of the feet.
    - (6) Discharge summary (or summary statement).
  - (b) Physician's responsibilities:
    - (1) Medical history pertinent to the patient's general health.

- (2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
  - (3) Supervision of the patient's general health status while hospitalized.
  - (4) Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.
10. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
11. All tissues and non-tissues removed surgically, or via instrumentation within the hospital shall be forwarded to the laboratory where a pathologist shall make such examination as he or she feels necessary for diagnostic or identification purposes. An authenticated copy of each report shall be made part of the patient's permanent record.

Bullets or other foreign objects of legal importance which are removed shall be forwarded to the pathologist who shall describe them and hold them indefinitely or until authorities request the specimen. The authorized individual requesting the specimen must show proper photographic identification and sign the release form before the specimen is released.
12. The rules for scheduling of elective or non-emergency surgery will be as follows:
  - (a) The schedule is available for posting of cases at all times.
  - (b) The following information is required in order to post a case:
    - (1) The patient's full name
    - (2) Age
    - (3) Sex
    - (4) Surgery procedure
    - (5) Type of anesthesia
    - (6) Anesthesiologist
    - (7) Operating surgeon
    - (8) Time and name of person posting the case
  - (c) After the first time slots are filled the order of cases will be based on the time of the cases posted, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor.
13. For patients undergoing general anesthesia, the following are the minimum preoperative requirements recommended by the Department of Surgery:
  - (a) Hemoglobin and Hematocrit done within seven (7) days of surgery.
  - (b) All diabetics must have a fasting blood sugar performed the day of surgery.

- (c) EKG and chest x-ray within three (3) months of surgery:
  - 1. For all patients 50 and over
  - 2. For all patients with cardiopulmonary problems
  - 3. A repeat test to be done for all known patients with any previous significant abnormalities.
- (d) All patients on diuretics must have a potassium study performed within seven (7) days of surgery.
- (e) All fertile patients within childbearing years must have a pregnancy test performed.

The Department of Surgery recognizes that these are general guidelines for preoperative requirements and that the clinical presentation and patient history should be considered by the surgeon and anesthesiologist.

F. DEPARTMENT OF MEDICINE

Reference is made to the Bylaws, Rules & Regulations of the Medical Staff of Edward White Hospital, particularly to those portions pertaining to the Department of Medicine, its sections and officers, qualifications, and general privileges. The Department Chief will be elected in accordance with the Medical Staff Bylaws.

To be eligible for privileges in the Department of Medicine and specialties falling within the Department, an applicant must have completed formal training required for Board Certification within the specialty. The applicant must be Board Certified, or have recently completed a residency which qualifies the applicant as an active candidate for certification.

All supervision of recently credentialed staff will be at the discretion of the department and section.

G. DISASTER PLAN

- 1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Staff and the Trustees.
- 2. The disaster plan should make provision within the Hospital for:
  - (a) Availability of adequate basic utilities and supplies, including water, food and essential medical and supportive materials;
  - (b) An efficient system of notifying and assigning personnel;
  - (c) Unified medical command under the direction of the Chief of Staff or his or her designated substitute.
  - (d) Conversion of all usable space into clearly defined areas of efficient triage, for patient observation and for immediate care;
  - (e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;
  - (f) A special disaster medical record, such as an appropriately designated tag, that accompanies the casualty as he or she is moved;

- (g) Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;
  - (h) Maintaining security in order to keep relatives and curious persons out of the triage area; and
  - (i) Pre-establishment of public relations liaison duties to a qualified individual.
3. All practitioners may be assigned to posts, and it is their responsibility to report to their assigned stations. The Chief of Staff in the Hospital and the CEO will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Chief of Staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief of Staff and the CEO of the Hospital. In their absence, the Vice Chief of Staff and alternate in administration are next in line of authority respectively.
  4. The disaster plan shall be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

#### H. MISCELLANEOUS

1. The Infection Control Committee, through its Chairperson or practitioner members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors or personnel exists.
2. Policies and procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Staff and approved by its Executive Committee and the Trustees, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of all current directives. Policies and Procedures referred to above, and elsewhere in these Rules and Regulations, are to be found in the Policy and Procedure Manual of the Hospital.
3. The case management and quality assurance plans of this Hospital as approved by the Medical Executive Committee of the Staff and the Trustees shall be adhered to by all attending practitioners.

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**MEDICAL STAFF**  
**RULES AND REGULATIONS**

**ORIGINALLY ADOPTED: FEBRUARY 21, 1995**

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**REVIEWED & REVISED: JUNE 20, 2006**

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**REVIEWED & REVISED: JUNE, 15, 2010**

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All changes incorporated