RULES AND REGULATIONS

OF

THE MEDICAL STAFF

OF

INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL, INC.

(See Appendix for Revision History)

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RULES AND REGULATIONS

INDIANA UNIVERSITY HEALTH BALL MEMORIAL HOSPITAL, INC.

ARTICLE I

ADMISSION

PART A: WHO MAY ADMIT PATIENTS

Patients may be admitted to IU Health Ball Memorial Hospital only by physicians and dentists who have been appointed to the Medical Staff and have been granted specific privileges to admit patients or by House Staff physicians in accordance with relevant provisions of the Medical Staff Bylaws. Patients may be admitted for the treatment of conditions and diseases for which the Hospital has facilities and personnel. However, patients shall not be admitted for the performance of an abortion unless the abortion is necessary to prevent a substantial impairment of the life or physical health of the pregnant woman. When the Hospital does not provide the services required by a patient or for any reason cannot be admitted to the Hospital, the Hospital or admitting physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

PART B: ADMITTING PHYSICIAN'S OR DENTIST'S RESPONSIBILITIES

Each patient shall be the responsibility of a physician or dentist appointed to the Medical Staff or a House Staff member. Such physician or dentist shall be responsible for the medical or dental care and treatment, for prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician or dentist and to relatives of the patient. The admitting physician or dentist shall be responsible for completing a medical history and performing an appropriate physical exam.

The admitting physician or dentist shall be primarily responsible for providing the Hospital with such information concerning the patient as may be necessary to protect the patient, Hospital personnel, or other patients from infection, disease or other harm, and to protect the patient from self-harm.

PART C: TIMELINESS OF INITIAL EVALUATION

Each patient admitted to the hospital shall be seen by a licensed independent practitioner (LIP) for initial assessment in a timely fashion and usually no later than eighteen (18) hours after admission.

Patients with acute processes which compromise or threaten cardiopulmonary stability
should be evaluated by a LIP generally no later than four (4) hours after admission. This would include, for example, patients admitted to the Intensive Care Unit.

PART D: PODIATRIST’S RESPONSIBILITIES

(1) For patients admitted as an inpatient:

A podiatric physician (D.P.M.) who has clinical privileges may admit patients in conjunction with an allopathic/osteopathic physician (M.D./D.O.). The podiatrist is responsible for appropriate podiatric medical care and the co-admitting/consulting physician is responsible for the general medical care and concomitant health problems.

1. Podiatric Physician’s Responsibilities:
   (a) A detailed podiatric history and physical justifying hospital admissions and/or surgical procedures;
   (b) Progress notes pertinent to the podiatric condition;
   (c) A complete dictated report of all procedures performed;
   (d) Discharge orders and dictated discharge summary when appropriate.

2. Co-admitting/Consulting Physician’s Responsibilities:
   (a) A medical history and physical pertinent to the patient’s general health and condition prior to anesthesia and surgery;
   (b) Supervision of patient’s general health status while hospitalized.

(2) For outpatients:

Podiatric patients admitted for outpatient surgery should be seen prior to admission for appropriate medical history and physical. The podiatrist may be allowed to complete a medical history and physical examination for ASA Class 1 and 2 patients if they are deemed qualified to do so by the Credentials Committee and Executive Committee. For non-ASA Class 1 and 2 patients, the medical history and physical examination is to be completed by a physician who is an appointee to the Medical Staff, and the podiatrist shall be responsible for the podiatric history and podiatric physical examination. All appropriate pre-operative labs and testing should be ordered by the admitting podiatric physician or medical physician.

PART E: ALTERNATE COVERAGE.

Each appointee to the Medical Staff shall provide assurance of availability of adequate professional care for his or her patients in the Hospital by being available or having available an alternate practitioner with whom prior arrangements have been made and who has clinical privileges at the Hospital sufficient to care for the patient. Failure of the appointee to meet the above requirements is sufficient reason for an investigation by the Credentials Committee and further action according to the Medical Staff Bylaws.
PART F: ADMISSION OFFICE PROCEDURES

All patients admitted to the Hospital shall sign the consent to treatment form prior to admission or as soon thereafter as possible. The form shall be signed by a person authorized to consent on the patient's behalf if the patient is unable to sign the form.

At the time of admission or as soon as possible thereafter, each patient shall be fitted with the Hospital's means of patient identification.

PART G: PRIORITIES FOR ADMISSION

The physician or dentist shall first contact the Admitting Department to ascertain whether there is an available bed. Except in an emergency, no patient shall be admitted until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon after admission as possible. The Admitting Office will admit patients on the basis of the following order of priorities:

(1) Emergency Admissions - This category includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permit harm and any delay in admitting the patient for treatment would add to that harm or danger. The physician or dentist can be required to furnish to the Utilization Review Committee, a signed, complete documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued inappropriate utilization of this category of admission, will be brought to the attention of the Executive Committee for appropriate action.

(2) Urgent Admissions - This category includes patients so designated by a physician or dentist and shall be reviewed as necessary by the Utilization Review Committee to determine priority when all such admissions for a specific day are not possible. This category of patient will be given first priority on available beds other than those needed for emergency patients and, in no case, will an urgent admission be delayed beyond 72 hours.

(3) Pre-operative Admissions - This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Utilization Review Committee may decide the urgency of any specific admission.

(4) Routine Admissions - This will include elective admissions involving all services.

If there is any question concerning the admission of a patient, the Chair of the Utilization Review Committee shall determine the necessity for, or deferment of, the admission.

PART H: EMERGENCY ADMISSIONS

The history and physical examination must clearly justify any admission on an
emergency basis and must be recorded on the patient's chart as soon as possible after admission or within twenty-four (24) hours.

In the case of emergency admissions, patients who do not already have a personal admitting physician or dentist and who have not requested the services of a specific physician or dentist who is reasonably available shall be assigned to an appointee to the Medical Staff or a member of the House Staff according to the appropriate clinical call schedule. The chair of each clinical department shall provide a call schedule for attendance to such patients.

PART I: PRE-ADMISSION AND POST-ADMISSION LABORATORY TESTS

The admitting physician or dentist shall authorize pre-admission testing for elective surgical patients.

PART J: CONTINUED HOSPITALIZATION

The attending physician or dentist is required to routinely document the need for continued hospitalization.

Upon request of the Utilization Review Committee, the attending physician or dentist must provide written justification of the necessity for continued hospitalization of any patient within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for appropriate action.
ARTICLE II

MEDICAL ORDERS

PART A: GENERAL REQUIREMENTS

Orders must include date and time and be written clearly, legibly, and completely. An order shall be considered to be in writing if dictated to an authorized person (See Part C Below) and signed by the prescribing practitioner. Orders, which are illegible, will not be carried out until they are rewritten and are understood.

Only the abbreviations, signs, and symbols listed in Appendix A to these Rules and Regulations shall be used in the medical record.

Blanket orders for reinstatement of previous medications are not permitted.

PART B: WHO MAY GIVE ORDERS

Only licensed independent practitioners with appropriate Medical Staff privileges shall have the authority to give orders for the care and treatment of inpatients. All orders must be entered in the patient's record, dated, and signed by the responsible appropriate licensed independent practitioner.

Only licensed independent practitioners who are authorized under Indiana law and their respective professional licensing statute to order outpatient tests and procedures shall have the authority to give orders for outpatient tests and procedures. Practitioners who wish to order outpatient tests/procedures are not required to obtain and/or maintain Medical Staff privileges.

PART C: VERBAL ORDERS

Verbal orders for chemotherapy agents shall not be accepted. Verbal orders (either in person or via telephone) for all other medications or treatments shall be accepted only under urgent circumstances when it is impractical for such orders to be given in a written manner by the responsible licensed independent practitioner. Only qualified personnel listed below may accept a verbal order. All verbal orders must be immediately read back to verify accuracy. The individual taking the order shall transcribe the orders in the proper place in the medical record. The order shall include the date, time, signature and title of the person taking the order.

Verbal medication orders shall include the name of the patient, the bed number, if appropriate, name and strength of the medication, dose, route of administration, directions for use and the name of the prescribing practitioner.

The practitioner who issued the order shall countersign the verbal order within thirty (30) days of the patient’s discharge from the hospital.
Acceptance of a verbal order is limited to the following personnel, with noted restrictions:

1. Physician or dentist;
2. Registered nurse;
3. Pharmacist who may transcribe verbal orders pertaining to drugs;
4. Physical therapist who may transcribe verbal orders pertaining to rehabilitation services;
5. Respiratory therapist who may transcribe verbal orders pertaining to respiratory therapy treatments;
6. Registered dietician who may transcribe verbal orders pertaining to nutritional care;
7. Occupational therapist who may transcribe verbal orders pertaining to rehabilitation services;
8. A physician's assistant, who may transcribe verbal orders from his or her supervising physician or from a physician designated by the supervising physician as an agent in accordance with the conditions established by the Board of Directors of the hospital regarding the scope of practice permitted for physicians' assistants at the hospital.
9. Social workers who may transcribe verbal orders pertaining to social work services.
10. Speech-Language Pathologists who may transcribe verbal orders pertaining to rehabilitation services.

PART D. OUTPATIENT ORDERS

All orders for tests/procedures that will be performed on an outpatient basis must include the following data elements in order for the test/procedure to be performed:

1. Name of the practitioner ordering the test/procedure;
2. Signature of the practitioner;
3. Address of the practitioner;
4. Phone number of the practitioner;
5. Date;
6. Patient name;
7. Test(s)/Procedure(s) ordered;
8. Diagnosis, sign, symptom, and/or ICD-9-CM Code associated with the
Providing the above data elements is the responsibility of the ordering practitioner.

PART E. ORDERS FOR CHEMOTHERAPY AGENTS

All orders for chemotherapy agents will be written by attending physicians. This includes all dosage forms of chemotherapy, (e.g., oral, intravenous, intramuscular, etc.) Attending physicians shall write all orders for intravenous chemotherapy on the hospital-approved “Chemotherapy Order Form.” Orders for oral or intramuscular chemotherapy may be written on a standard order form. Verbal orders for chemotherapy agents will not be accepted.

PART F: TELECOPIER (FAX) ORDERS

In order to facilitate patient care, the hospital agrees to accept orders through the use of facsimile transmission. Since such transmissions constitute part of the permanent medical record and proper receipt is critical to patient care, the following procedures should be followed:

The hospital requires that all orders transmitted by telecopier clearly state the following:

1. Name of the patient;
2. Name of the practitioner;
3. Patient’s medical record number or patient’s social security number and date of birth;
4. Name and telephone number of the individual who transmitted the order;
5. Number of pages transmitted;
6. Signature of the practitioner.

The ordering practitioner or the practitioner’s staff shall be responsible for:

1. Documentation or proof that the faxed order was sent, such as a mechanically produced transmission log;
2. Ensuring that a fax cover sheet containing a confidentiality notice accompanies the fax order.

Following receipt of telecopier orders, hospital staff will:

1. Review orders for legibility and completeness;
2. Contact the practitioner’s office if the order requires clarification;
3. Place the order on the patient’s chart or file the order in a secure area until the patient arrives for services.
ARTICLE III
CONSULTATIONS

PART A: WHO MAY GIVE CONSULTATIONS

Any qualified practitioner with appropriate clinical privileges in this hospital can be asked for consultation within his or her area of expertise. Practitioners having privileges in the requested area shall perform mandated consultations. In circumstances of grave urgency, or where consultation is required by the rules of the Hospital, the hospital president or his/her designee and the Chair of the Executive committee or in his or her absence the appropriate department chair, acting together shall at all times have the right to call in a consultant or consultants.

PART B: REQUIRED AND RECOMMENDED CONSULTATIONS

Consultation shall be required in all cases in which, in the judgment of the attending licensed independent practitioner:

(1) The diagnosis is obscure after ordinary diagnostic procedures have been completed; or,
(2) There is doubt as to the best therapeutic measures to be used.

A reasonable effort to obtain consultation shall be made whenever the practitioner is requested to do so by the patient or by those responsible for the patient's care.

Consultation shall be recommended in all cases in which, in the judgment of the attending practitioner:

(1) Unusually complicated situations are present that may require specific skills of other practitioners;
(2) The patient exhibits severe symptoms of mental illness or psychosis.

The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant.

Each clinical department as required may establish additional requirements for consultation. It shall be the responsibility of the practitioner to obtain any required consultation, and the request for a consultation shall be entered on the order sheet in the medical record. If the history and physical are not on the chart, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.

If a nurse or other healthcare professional, after speaking to the attending practitioner p has reason to doubt or question the care provided to any patient or believes that
appropriate consultation is needed and has not been obtained, he or she shall call this to
the attention of their superior who, in turn, shall refer the matter to the Vice President/
Operations. The Vice President/Operations shall bring the matter to the attention of the
chair of the department in which the practitioner has clinical privileges. In all situations,
which require it, the chair of the department may request a consultation after appropriate
discussion with the attending practitioner.

If, in the opinion of the department chair, a practitioner has not requested consultations
when needed, the Credentials Committee shall investigate the matter following receipt of
a written request to do so. Failure of a practitioner to request consultations when needed
is sufficient reason for an investigation by the Credentials Committee and further action
according to the Medical Staff Bylaws.

PART C: CONTENTS OF CONSULTATION REPORT

For required content of consultation report, see Article IX, Medical Records, Part G.

PART D: PATHOLOGY INTRAOPERATIVE CONSULTATIONS

At the time an operating surgeon requests intra-operative consultation, it shall be the
responsibility of the assigned pathologists to obtain certain historical information
concerning the patient or procedure in question. This will generally be accomplished at
the time the pathologists pick up the tissue in the operating room suite. At this time,
there should be a personal conversation between the operating room surgeon and the
pathologist to include pertinent historical information and x-ray findings.
The subsequent examination (with or without frozen section) shall be done in a timely
fashion.

Results shall be delivered personally by the pathologists to the operating room surgeon
and will be confirmed by written documentation, which will immediately become part of
the patient's medical record.

PART E: SECOND OPINION BEFORE THERAPY FOR PATIENTS WITH A CANCER
DIAGNOSIS

1) A second opinion of pathologic interpretations will be obtained on non-emergent
cases where major therapeutic interventions are planned based on a tissue or
cytology diagnosis.
2) For those cases where the initial diagnosis was received from an outside source, a
second opinion shall be rendered by a member of the IU Health Ball Memorial
Hospital Medical Staff prior to therapy.
3) Issues of diagnosis disagreement will be resolved before therapy is instituted.

ARTICLE IV
SURGICAL CARE

PART A: SCHEDULING SURGERY

The presence of all members of the Operating Team is required at the scheduled time for surgery. In no case shall anesthesia be started until the operating surgeon is on the hospital campus, has notified the OR of their presence and is readily available. Surgeons arriving in the operating room later than fifteen (15) minutes without prior notification will be addressed according to the Late Physician Policy below:

Guidelines:

(1) Surgeons who have scheduled operating room time and arrive greater than fifteen (15) minutes late without notifying surgery will be given a written warning to be issued by the Chair of Surgical Council.

(2) When a third written warning is issued within a calendar year, the issue will be referred to Surgical Council for determination of further course of action. The surgeon in violation will be invited to attend.

(3) When deemed appropriate by Surgical Council, the issue can be referred to the Executive Committee, along with a recommendation from Surgical Council as to the considerations to be made in each case.

Elective scheduling and cancellations shall be accepted from the surgeon and their designated office personnel following OR scheduling policy guidelines.

Only Urgent/Emergent cases shall be scheduled for Sundays and holidays. The call team will be activated for urgent/emergent cases only.

Urgent cases are defined as cases that need to be done within twenty-four (24) hours.

Emergent cases are defined as cases in which the life of the patient is in immediate danger or where a lack of immediate treatment could result in serious or permanent harm and any delay in surgery would increase the harm or danger.

If a surgeon determines that an emergency case needs to bump a scheduled case, the Bump Policy shall be followed:

BUMP POLICY

If a surgeon determines that a case must be done as soon as possible, the bumping surgeon must notify the surgeon that is being bumped (surgeon to surgeon communication).
Guidelines

- Bump own scheduled case;
- Bump first available room in order: Partner, Specialty;
- Time the bump so as to cause the least disruption to the OR schedule;
- The final decision on which case is bumped rests with the OR Charge Nurse and Anesthesiologist in charge;
- The bumping surgeon will follow with his/her scheduled case if it does not delay following surgeon’s cases and/or there is an “open” available staffed OR suite.

In case of a dispute that cannot be resolved by the two surgeons, then the anesthesiologist shall cast the deciding vote.

In the event that either of the two surgeons is dissatisfied with the anesthesiologist’s decision, a request can be submitted for a bump-case review to be conducted at the next scheduled Surgical Council meeting.

PART B: SURGICAL RECORDS

Except in emergencies, the following data shall be recorded in the medical record prior to surgery:

(1) Verification of identity of patient.

(2) Medical history and supplemental information regarding drug sensitivities and other pertinent facts.

(3) General physical examination.

(4) Provisional diagnosis.

(5) Laboratory test results.

(6) Consultation reports, if applicable.

(7) Signed informed consent.

The patient shall not leave the holding area for the Operating Room until the chart is complete and contains the seven data elements outlined above. In an emergency situation, the attending surgeon shall write a note or post-operative note on the patient's condition, stating that delay for recording these requirements would constitute a danger to the health or safety of the patient and that he or she accepts responsibility for the patient's physical condition before the operation may begin.

Operative reports shall be dictated or written immediately after surgery. The report shall
record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and the post-operative diagnosis. The completed operative report shall be dictated and authenticated by the surgeon in the electronic medical record as soon as possible after surgery. If it is not possible to dictate the report in the electronic medical record immediately after surgery – e.g., there is a transcription or filing delay – an operative progress note shall be entered in the medical record immediately after surgery to provide pertinent information for anyone required attending the patient.

PART C: ANESTHESIA RECORDS

Except in an emergency, there shall be an appropriate pre- and post-operative patient evaluation by the Anesthesiologist with appropriate notation on the patient's chart.

PART D: RECOVERY AREA

The surgeon is to remain readily available until their patient is admitted to the appropriate recovery area. Post-operative orders must be written before the patient leaves the Surgery Department area. An anesthesiologist must participate in establishing policies for the discharge of patients from post-anesthetic care.

At least two registered nurses shall be on duty in the Recovery Room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

PART E: DENTAL PATIENTS

A patient without medical problems who is admitted for dental surgery by a qualified oral surgeon who has clinical privileges to perform histories and physical examinations is the responsibility of the qualified oral surgeon. A patient with medical problems, or a patient who is admitted by a dentist, who is not a qualified oral surgeon with clinical privileges to perform histories and physical examinations, is the dual responsibility of the dentist and a physician with appropriate clinical privileges.

(1) Dentist's responsibilities:

(a) A detailed dental history justifying hospital admission;

(b) a detailed description of the examination of the oral cavity and pre-operative diagnosis;

(c) a complete operative report, describing the findings and techniques used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth, and fragments removed appropriate tissue shall be sent to the Pathologist for examination;

(d) Progress notes pertinent to the oral condition;
(e) Clinical summary of statement;

(f) Discharge order.

(2) Physician's responsibilities;

(a) History pertinent to the patient's general health;

(b) Physical examination to determine the patient's condition prior to anesthesia and surgery;

(c) Supervision of the patient's general health status while hospitalized.

(3) If a patient without medical problems is admitted by a qualified oral surgeon who has clinical privileges to perform histories and physicals, that oral surgeon shall perform the responsibilities stated above; provided, in the event any medical problem arises, the oral surgeon shall promptly involve a physician with appropriate clinical privileges in the care of the patient.

PART F: OPERATING ROOM RECORDS

A roster of physicians and dentists with a delineation of the surgical privileges of each, shall be maintained in the surgical area and available to the Operating Room Nurse Manager.

An Operating Room log shall be maintained on a current basis.

PART G: ATTIRE

Anyone entering the operating room will comply with the surgical service dress code policy.

PART H: PATHOLOGY REPORT

All appropriate tissues or exudates removed during a surgical procedure shall be properly labeled and sent to the laboratory for examination. Certain specimens outlined in the Surgical Specimen Policy may be excluded from gross examination by the laboratory. The pathologist shall sign his or her report following examination which becomes a part of the patient medical record.
ARTICLE V
INTENSIVE CARE UNIT

PART A: CRITERIA FOR REVIEW OF ADMISSIONS TO THE INTENSIVE CARE UNIT

The decision for admission or discharge of a patient to the Intensive Care Unit is made by the attending physician based on the admission and discharge review criteria for the multi-disciplinary Intensive Care Unit. The final decision on admission/discharge of a patient will be made by the Critical Care Medical Director or designee.

To be admitted to the Intensive Care Unit a patient must have a physician's order and must meet one or more of the following criteria:

(1) Respiratory compromise, defined as any one of the following:
   (a) use/anticipated use of mechanical ventilation of artificial airway;
   (b) unstable respiratory status requiring nursing assessment/intervention and/or pulmonary toilet every two hours or more frequently.

(2) Hemodynamically unstable, defined as any one of the following:
   (a) unstable vital signs that require monitoring q2h or more frequently;
   (b) anticipated use of vasoactive drugs requiring frequent titration and monitoring;
   (c) unstable cardiac rhythm requiring frequent drug or mechanical intervention and/or at high risk for cardiac arrhythmia;
   (d) use/anticipated use of invasive monitoring devices, i.e., pulmonary artery catheters, arterial lines.

(3) Neurologically unstable, defined as any one of the following:
   (a) abnormal Glasgow Coma Scale requiring frequent neurological assessments;
   (b) high risk for neurological deterioration;
   (c) use or anticipated use of intracranial pressure monitoring.

(4) Metabolically unstable, requiring:
   (a) intensive nursing assessment/intervention who are at significant risk for metabolic or hemodynamic deterioration;
(b) anticipated at risk for metabolic deterioration, i.e., toxic overdose, diabetic ketoacidosis, sepsis and endocrine emergencies and/or acute renal failure.

(5) Patients who fall outside the above diagnostic categories, i.e., CCU overflow admissions, may be admitted to the Intensive Care Unit. (See CCU Admission Review Criteria.)

(6) The Intensive Care Unit may accept telemetry admissions in the event that no telemetry monitors are available.

PART B: ADMISSIONS

All admissions to the Intensive Care Unit will be made at the request of a physician. In the event of a bed shortage, the chairman of the Critical Care Committee will resolve conflicting requests for admission.

(1) Direct Admissions: A patient may be admitted to this Unit directly from outside the hospital at the request of a physician. The physician requesting such admission will notify Admissions of the nature of the patient's illness and state that admission to the Intensive Care Unit is desired.

(2) Emergency Room: Need for admission to the Intensive Care Unit from the Emergency Room will be determined by the physician examining the patient. Admission to the Unit will be made directly from the Emergency Room with the proper information being conveyed to Admissions and the Intensive Care Unit.

(3) In extenuating circumstances a patient may be admitted to the Unit without first being examined by a physician, per verbal phone order from a physician. A physician then will see the patient as soon as possible.

PART C: TRANSFERS FROM SURGERY & DELIVERY

In the event that the surgeon or the anesthesiologist feels that because of some complicating factor a patient will require admission to the Intensive Care Unit, the Intensive Care Unit charge nurse in the Unit shall be advised that the patient will be admitted to the Unit as soon as he or she is discharged from or bypasses the Recovery Room.

In case the operation is being performed at an hour when the Recovery Room is not open, the Intensive Care Unit shall be informed that the patient will be admitted directly from the Operating Room.

It is anticipated that following certain major surgical procedures the patient will be admitted routinely to the Intensive Care Unit. At the time that the surgeon schedules such a case with the Operating Room, he shall indicate that such admission is desired. The Operating Room Supervisor will then inform the Intensive Care Unit and the
Admitting Office that this particular patient will be transferred to the Unit after discharge from the Recovery Room.

In the event that it becomes necessary to admit a patient to the Intensive Care Unit following delivery, the obstetrician shall inform the Intensive Care Unit that such admission is indicated and the Delivery Room nurse shall inform the Admitting Office.

PART D: RECOVERY ROOM SERVICE

During the hours that the Recovery Room is closed, the Intensive Care Unit will provide Recovery Room service as deemed necessary by the surgeon and anesthesiologist. The charge nurse in the Operating Room shall inform the nurse in the Unit of this admission to the Unit as soon as the case is scheduled in the Operating Room.

PART E: TRANSFERS FROM GENERAL & SURGICAL

In case such transfer becomes necessary, the charge nurse in the Intensive Care Unit shall be advised of the pending transfer and given necessary information regarding diagnosis, treatment, and immediate measures that will be necessary upon transfer to the Unit. The charge nurse in the department shall then inform the Admitting Officer of the transfer. Such transfer shall be made only on an emergency basis necessitated by a sudden complication or worsening of the patient's condition.

PART F: CRITERIA FOR REVIEW OF DISCHARGES FROM THE INTENSIVE CARE UNIT

Patients shall be considered appropriate for discharge when their conditions are no longer life-threatening, they no longer require advanced technological and/or pharmacological treatment modalities, and/or they will no longer benefit from intensive medical/nursing care.

(1) Generally, patients shall be considered eligible for discharge from the Intensive Care Unit when the following criteria are achieved:

(a) Respiratory stability as defined by:

1. Does not require mechanical ventilation (exception may be made for chronic ventilator dependent patient);

2. Stable after extubation;

3. Arterial blood gases optimal for patient;

4. Requires pulmonary toilet no more frequently than q2h.

(b) Hemodynamic stability as defined by:
1. Stable vital signs;
2. Does not require titrated vasoactive drugs;
3. Stable cardiac rhythm (optimal for this patient);

(c) Neurological stability as defined as:
1. No longer requires frequent neurological assessment/interventions;

(2) Patients admitted for procedures, treatments or monitoring available only in the Intensive Care Unit shall be eligible for discharge upon their completion.

(3) Patients may not be discharged from the Intensive Care Unit with arterial and/or pulmonary artery catheters in place.

(4) Patients who experience further deterioration of a condition with no apparent hope of recovery and/or who are not to be resuscitated shall be appropriate candidates for discharge from the Intensive Care Unit.

(5) If, at any time, a bed is needed for a more critically ill patient, the physician, at his discretion, may transfer his patient without meeting the discharge criteria.

(6) If the unit is filled to capacity, the medical director of the Intensive Care Unit and/or designee has the authority and responsibility to ask the attending physician of the less critically ill patient to transfer his patient to provide for the critical one. Normally, the charge nurse of the Intensive Care Unit will act on the director's behalf. If no decision can be reached, the charge nurse shall contact the medical director of Intensive Care Unit and his decision shall be final.

(7) In general, patients are not discharged to home from the Intensive Care Unit.

(a) Discharge to home requires a physician's order.

(b) Anyone going home against medical advice will be reviewed according to AMA (Against Medical Advice) policy.

(8) All patient discharges will be subject to the following screens for appropriate patient care under the review of the Critical Care Committee.

(a) Acute Respiratory Insufficiency
1. Stable Arterial Blood Gases x 24 hours (optimal for this patient)
2. No acute respiratory distress x 24 hours
3. Mechanical ventilatory support not needed
4. Pulmonary toilet required no more than q4h
5. Patient is extubated unless required for pulmonary toilet
6. Chest x-ray indicates no deterioration of disease process

(b) Acute Pulmonary Embolism
1. Absence of pain or controlled by oral medication x 24 hours
2. Stable Arterial Blood Gases x 24 hours
3. No acute respiratory distress x 24 hours
4. No acute bleeding as a result of anticoagulation therapy

(c) Shock secondary to any cause
1. Hemodynamic stability without IV medication requiring titration x 24 hours
2. Urinary output > 20cc/hours (if no history of renal failure)
3. Etiology of shock identified and controlled

(d) Hypertensive crisis
1. Blood pressure stability has been demonstrated x 24 hours
2. No continuous IV infusion antihypertensive medication x 12 hours
3. Urinary output > 20cc/hr (if no history of renal failure)
4. No deterioration of neurologic status x 24 hours

(e) Cerebrovascular Accident/Acute Coma states (including cerebral hemorrhages, drug intoxication)
1. No respiratory distress x 24 hours
2. If intubated for airway patency, pulmonary toilet is required no more than q4h

3. Mechanical ventilation is no longer required or can be appropriately maintained on general Medical/Surgical unit per hospital policy

4. Seizure activity controlled: or if not controlled, neurosurgical or neurologist consultation has been obtained and has deemed transfer appropriate.

5. No further deterioration of neurological status x 24 hours

(f) Acute fluid and electrolyte imbalances

1. Absence of life-threatening arrhythmias x 24-48 hours

2. Mechanical ventilation is not required or can be appropriately maintained on a general Medical/Surgical Unit

3. Blood pressure stability has been demonstrated x 24 hours

4. Urinary output > 20cc/hr.

5. No life threatening metabolic abnormalities present

6. No deterioration of sensorium level x 24 hours

(g) Gastrointestinal Bleeding

1. No evidence of active bleeding x 24 hours
   1. Hemoglobin and hematocrit stable x 24 hours

2. Hemodynamically stable as defined above

(h) Post-operative surgical patient

1. No evidence of active bleeding

2. Adequate fluid volume as documented by hemodynamic parameters

3. Mechanical ventilation no longer required (unless chronic ventilator dependent)

4. If intubated for airway patency (or fresh tracheostomy), pulmonary toilet is required no more than q4h.
5. No evidence of uncontrolled or unidentified infection, likely to cause significant deterioration

6. Absence of life-threatening arrhythmias x 24 hours

7. Drainage tubes than can be appropriately managed on general Medical/Surgical Unit
ARTICLE VI

CORONARY CARE UNIT

PART A: CRITERIA FOR REVIEW OF ADMISSIONS TO CORONARY CARE UNIT

(1) The Coronary Care Unit is specifically designed for patients with cardiac disorders. The following diagnostic categories are within the CCU scope of care and serve as guidelines for appropriate patient placement. They also serve as quality screens for Critical Care Committee review.

(a) Acute Myocardial Infarction
   1. Chest discomfort compatible with acute coronary insufficiency
   2. ECG changes of either transmural or nontransmural acute M.I.
   3. Elevated cardiac enzymes

(b) Impending or Suspected Myocardial Infarction
   1. Chest discomfort suspicious of acute coronary insufficiency
   2. ECG suggestive of acute ischemic changes

(c) Unstable Angina
   1. Chest pain not controlled by standard dosage of NTG
   2. Angina at rest or nocturnal angina
   3. Increasing frequency, duration, and/or intensity of angina

(d) Cardiopulmonary Arrest
   1. Ventricular asystole
   2. Ventricular fibrillation
   3. Symptomatic ventricular tachycardia
   4. EMD (Electromechanical Dissociation)

(e) Acute Pulmonary Edema
   1. Severe respiratory compromise requiring frequent nursing
assessment/intervention

2. Acute onset of diffuse, moist rales with significant tachypnea, tachycardia, and/or acute diaphoresis

3. Anticipated need for assisted ventilation, hemodynamic monitoring and/or continuous IV medication therapy

(f) Severe Congestive Heart Failure (Associated with Malignant Arrhythmia or Acute Respiratory Distress)

1. Severe respiratory compromise requiring frequent nursing assessment/intervention

2. Continuous IV medication therapy

3. Hemodynamic monitoring

(g) Arrhythmias

1. Nonsustained VT

2. Multifocal PVC's or "R-on-T" phenomenon

3. Symptomatic 2nd degree block, Mobitz type II, 3rd degree block or bradycardia

4. Syncope

5. Rapid atrial fibrillation or atrial tachycardia with an uncontrolled ventricular response

6. Anticipated continuous IV medication or mechanical intervention

(h) Post Angioplasty/Stent/Rotoblation

1. Venous/arterial sheaths in place

2. Frequent nursing assessment/intervention

(i) Post Cardiac Catheterization

1. Venous/arterial sheaths in place

2. Unstable rhythm
3. Chest pain not controlled by SL NTG

4. Hemodynamically unstable

(2) In the event of a direct admission without orders, all patients will have the following:

(a) ECG monitoring

(b) IV to keep vein open

(c) Oxygen

Further orders are to be obtained as soon as possible.

(3) Patients who fall outside the above diagnostic categories, i.e., ICU overflow admissions, may be admitted to the CCU if they are hemodynamically unstable or exhibit signs of respiratory, neurologic or metabolic instability. (See ICU Admission Criteria for definitions.)

(4) The CCU may accept telemetry admissions in the event that no telemetry monitors are available.

PART B: ADMISSIONS

All admissions to the Coronary Care Unit will be made at the request of a physician. In the event of a bed shortage, the Chair of the Cardiology Section will resolve conflicting requests for admission. If the Chair of the Cardiology Section is not available, the Critical Care Committee Chair may act in his/her behalf.

(1) Direct Admissions: A patient may be admitted to the Coronary Care Unit directly from outside the hospital at the request of a physician. The physician will notify the Admissions Department of the nature of the patient's illness and state that admission to the Coronary Care Unit is desired.

(2) Emergency Room: Need for the physician examining the patient will determine admission to the Coronary Care Unit from the Emergency Room. Admission to the Unit will be made directly from the Emergency Room with the proper information being conveyed to the Coronary Care Unit (and subsequently the Admissions Department).

(3) In extenuating circumstances, a patient may be admitted to the Coronary Care Unit without first being examined by a physician.

PART C: TRANSFERS FROM OTHER AREAS OF THE HOSPITAL
In the event the physician feels that a patient has sufficient cardiac complications to require admission to the Coronary Care Unit, the charge nurse in the Unit shall be advised of the pending transfer and given necessary information regarding diagnosis, treatment, and immediate measures that will be necessary upon transfer. The charge nurse at the site of the patient's origin shall then inform the Admissions Department of the transfer.

PART D: CRITERIA FOR REVIEW OF DISCHARGES FROM CORONARY CARE UNIT

(1) In general, patients are eligible for transfer from the Coronary Care Unit when vital signs are stable, no life threatening abnormal lab values are present and there is no evidence of acute hemodynamic or respiratory compromise x 12 hours.

(a) Stable vital signs

Tolerates minimal activity with:

1. No > 30 beat/minute increase in heart rate
2. No > 10 respirations/minute increase
3. No > 30 mm Hg variance in SBP
4. DBP < 100 mm Hg

(b) Hemodynamic stability

1. Does not require titrated vasoactive drugs
2. Absence of invasive monitoring devices
3. Absence of Intra Aortic Balloon Pump
4. Life threatening arrhythmias absent or controlled x 24 hours

(c) Respiratory stability

1. Does not require mechanical ventilation (exception may be made for chronic ventilator dependent patient)
2. Stable after extubation x 12 hours
3. Arterial blood gases optimal for patient
4. Requires pulmonary toilet no > q2h
(2) More specifically, all patient discharges will be subject to the following screens for appropriate patient care under Critical Care Committee review.

(a) Acute Myocardial Infarction

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours
2. Resolving ECG changes
3. Decreasing cardiac enzyme levels
4. Absence of life threatening arrhythmias or arrhythmia controlled by medication x 24 hours
5. No evidence of acute Congestive Heart Failure.

(b) Impending or Suspected Myocardial Infarction

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours
2. Resolution of ischemic ECG changes
3. No evidence of acute MI after 24 hours.

(c) Unstable Angina

1. Absence of chest pain x 24 hours and pain free after conversion to oral/topical medications x 4 hours
2. No evidence of acute MI after 24 hours of observation.

(d) Acute Pulmonary Edema

1. Mechanical ventilation not required
2. Resolution of tachypnea, tachycardia.

(e) Congestive Heart Failure (Associated with Malignant Arrhythmia or Acute Respiratory Distress)

1. Arrhythmias controlled x 24 hours.

(f) Arrhythmias
1. Arrhythmias controlled x 24 hours (Controlled by oral medication x 4 hours when transfer to telemetry bed.)

(g) Post Angioplasty/Stent/Rotoblation

1. Absence of chest pain
2. Removal of venous/arterial sheaths
3. No evidence active bleeding or arrhythmia.

(h) Post Cardiac Catheterization

1. Removal of venous/arterial sheaths
2. Absence of chest pain
3. Arrhythmias controlled x 24 hours

(3) Patients who experience further deterioration of a condition with no apparent hope of recovery and/or who are not to be resuscitated shall be appropriate candidates for discharge from the Coronary Care Unit.

(4) Patients admitted for procedures, treatments or monitoring available only in the Coronary Care Unit shall be eligible for discharge upon their completion.

(5) Patients may not be discharged from the Coronary Care Unit with arterial and/or pulmonary artery catheters in place.

(6) If, at any time, a bed is needed for a more critically ill patient, the physician, at his discretion, may transfer his patient without meeting the discharge criteria.

(7) If the unit is filled to capacity, the Chairman of the Cardiology Section or his designee has the authority and responsibility to ask the attending physician of the less critically ill patient to transfer his patient to provide for the critical one. Normally, the charge nurse of the Coronary Care Unit will act on the Chairman's behalf. If no decision can be reached, the charge nurse shall contact the director and his decision shall be final.

(8) In general, patients are not discharged to home from the CCU

(a) Discharge to home requires a physician's order

(b) Anyone going home against medical advice will be reviewed
according to AMA (Against Medical Advice) policy.

(9) In the event that a patient may require services not provided by BMH, arrangements will be made to transfer patient to another institution upon order of the attending physician. A Coronary Care Unit registered nurse may accompany patient during transport at the request of the attending physician.
ARTICLE VII

DEPARTMENT OF DELIVERY ROOM

PART A: ADMISSION

Obstetrical patients may be admitted on a twenty-four (24) hour basis via the Emergency Room or Admission Office. Nursing personnel shall notify the attending physician when the patient is admitted. No maternity patient shall be denied a bed because of the presence of gynecological patients in the unit. If necessary, gynecological patients shall be transferred to other areas of the Hospital.

PART B: LABOR AND DELIVERY CARE

(1) The physician must be named when a case is scheduled and is responsible for the care of the patient.

(2) When the physician has been informed that a patient is in active labor, it is his responsibility to be present for the delivery.

PART C: MEDICAL RECORDS

Appropriate medical records must accompany the patient to the Operating Room. Where not feasible, a note of the emergency situation shall be written and signed by the physician. If a C-Section delivery/surgical procedure is performed, the medical record documenting the C-Section delivery/procedure must comply with the Surgical Record requirements stipulated in these Rules and Regulations.

PART D: IDENTIFICATION

Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the Labor & Delivery/Operating Room.

PART E: ATTIRE

Anyone entering the Labor & Delivery/Operating Room must be properly attired. Hair, nose, and mouth shall be properly covered at all times with caps and masks provided by the hospital.

PART F: DELIVERY ROOM ROSTER

A current roster of physicians with a delineation of their obstetrical/gynecological privileges shall be maintained and made available to nursing personnel. An on-call roster shall be established and maintained to ensure that a physician with
obstetrical/gynecological privileges is readily available at all times.
ARTICLE VIII

NURSERY AND CARE OF NEWBORN

PART A: ON-CALL ROSTER

A physician on-call schedule shall be posted in the nursery to provide that a physician is available at all times to come to the Hospital and deal with emergency situations.

PART B: EXAMINATIONS

All newborn infants shall have a complete physical examination by a physician within 24 hours after admission to the Nursery, and the results of the examination shall be recorded in the infant's medical record. A physician shall examine any infant who displays abnormal signs and symptoms at any time as soon as possible or when a physician is requested by a nurse. A physician shall examine every newborn infant on the day before or the day of discharge, and the findings shall be recorded in the infant's medical record.

PART C: HIGH-RISK INFANTS

The physician to be in charge of the infant and the nurse in charge of the Nursery shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants and especially for high-risk infants is to be initiated in the delivery area, with constant observation of newborns for distress.

The physician responsible for the care of the infant shall be informed of any instance of:

1. AN APGAR score of less than 5 points at five minutes or an infant requiring admission to the Neonatal Intensive Care Unit (NICU).
2. Respiratory distress or atelectasis:
3. Generalized cyanosis;
4. Significant jaundice;
5. Blood dyscrasia or anemia;
6. Persistent vomiting;
7. Persistent diarrhea;
8. Delay in voiding or passage of meconium;
9. Neurological abnormalities of any type;
(10) Congenital heart disease;

(11) Any congenital defects that interfere with function or that are disfiguring;

(12) Whenever the diagnosis is obscure;

(13) Staphylococcal infections or other infections;

(14) Dermatitis of any type except for erythema neonatorum toxicum.

PART D: IDENTIFICATION

The identification of each infant and his mother shall be checked again at the time of discharge from the hospital. Infants discharged or transferred to another nursery or hospital shall be identified.

PART E: BIRTH CERTIFICATES

Birth certificates are the responsibility of the attending physician and must be completed within 72 hours of the birth.

PART F: TRANSPORTATION OF INFANTS

Care in the protection of the infant shall be taken when transporting the newborn to the Nursery from Labor & Delivery. Transfer of distressed infants to the Nursery shall be done in such a manner as to minimize heat loss and to ensure adequate oxygenation.

PART G: MEDICAL RECORDS

Every newborn shall be examined at the time of delivery and the following noted on his medical record:

(1) Condition at birth including APGAR score.

(2) Time of sustained respirations.

(3) Any physical abnormalities or pathological states.

(4) Any evidence of distress.

The record of the newborn infant shall accompany the infant from the place of delivery to the Nursery and be immediately available to Nursery personnel. In addition to the information listed above, this record shall also include information concerning prenatal history, course of labor, delivery, drug administration to mother and infant, relevant conditions of the mother, procedures performed on the infant in the LDR/Operating Room, complications of any type, and other facts and observations.
A complete medical record for every newborn should include the following information:

(1) Obstetrical history of mother's previous pregnancies.

(2) Description of complications of pregnancy or delivery.

(3) List of complicating maternal disease.

(4) Drugs taken by the mother during pregnancy, labor, and delivery.

(5) Duration of ruptured membranes.

(6) Maternal antenatal blood serology, rubella titer, blood typing, Rh factors, and, where indicated, a Coombs test for maternal antibodies.

(7) Description of progress of labor including reasons for induction and operative procedures, if any, signed by the attending physician or his authorized delegate.

(8) Anesthesia, analgesia and medications given to mother and infant.

(9) Condition of infant at birth, including the one- and five-minute APGAR Score or its equivalent, resuscitation, time of sustained respirations, details of physical abnormalities, pathological states observed and treatments given before transfer to the Nursery.

(10) Any abnormalities of the placenta and cord vessels.

(11) Date and hour of birth, birth weight and length, and period of gestation.

(12) A written verification of eye prophylaxis.

(13) Report of initial physical examination, including any abnormalities signed by the attending physician or his authorized delegate.

(14) Discharge physical examination, including head circumference and body length, unless previously done; recommendations; and signature of attending physician or his delegate.

(15) A listing of all diagnoses since birth, including discharge diagnosis.

(16) Specific follow-up plans for call of infant.

PART H: NURSING NOTES

Upon admission to a Nursery, nurses shall initiate and maintain records on all infants as
to weight, type and volume of feedings; time of first voiding; time of passage of first stool; number, color, and consistency of stools; and temperature. If abnormalities are suspected or recognized, nurses shall also make notations on respiratory rate, dyspnea, color, cyanosis, jaundice, pallor, lethargy, twitching, motor activity, skin and buttocks, vomiting, condition of the eyes and umbilical cord, and other relevant factors as indicated and warranted by the condition of the infant. Treatments, medication and special procedures ordered by a physician should also be recorded with time, date, and the time and title of the individual who administers them.
ARTICLE IX

MEDICAL RECORDS

PART A: GENERAL RULES

The Hospital initiates and maintains a medical record for every individual assessed or treated. All medical records shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course of treatment and results and promote continuity of care among the health care team. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient under his/her care. Its contents shall be pertinent and current. The medical record shall be completed within 30 days of the patient's discharge. A single attending practitioner shall be identified in the medical record as being responsible for the patient at any given time. Only symbols and abbreviations listed in Appendix A may be used in the medical record.

PART B: MEDICAL RECORD ENTRIES/AUTHENTICATION

Medical Record Entries. An entry in the medical record is any documentation (handwritten or dictated) that is made by any healthcare provider during the patient’s continuum of care. An entry in the medical record shall be made by licensed independent practitioners who have been credentialed by the Medical Staff, licensed and certified nursing personnel, respiratory therapists, physical therapists, speech therapists, occupational therapists, social workers, chaplains, imaging technologists, dieticians, laboratory technicians/technologists, pharmacists, and clinical secretaries. Clinical secretaries may only record entries relating to patient diet, activities, or level of care (acute, observation, or swing bed.)

Authentication. All entries in the record shall be dated, timed, and authenticated by the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry must be individually authenticated. Authentication is the signing of an entry or report after review. The author of each entry must authenticate his or her entry. Original signature, faxed signature, or computer key may accomplish authentication. Computer key and electronic signature is the authentication of an entry utilizing a confidential code that represents or affixes the author’s signature.

Author Identification. Author identification may be verified by reviewing employee signatures contained in the employee’s personnel records in Human Resources or physician signatures contained in the Physician Signature Manual in Information Systems for First Perspective Imaging System.

PART C: COUNTERSIGNATURES OF HOUSESTAFF
All dictation in the record, concerning diagnosis, history and physical, and discharge summary, made by Housestaff shall be reviewed and countersigned as follows:

(1) If the patient has been treated solely by Housestaff, first year Residents shall be reviewed and countersigned by a second or third year Resident.

(2) If a member of the Medical Staff is the attending physician and coverage has been provided by Housestaff, the records shall be reviewed and countersigned by the attending physician.

(3) If a Resident is on rotation with a member of the Medical Staff for a specialty and dictates a consultation, the record shall be reviewed and countersigned by the member of the Medical Staff.

PART D: CONTENTS

A complete medical record shall include information to justify admission and continued hospitalization, support the diagnosis and describe the patient’s progress and response to medications and services. All medical records for inpatients hospitalized for more than forty-eight (48) hours must document the following, as appropriate:

(1) Identification Data;
(2) Evidence of a physical examination, including a health history, performed no more than seven (7) days prior to admission or within twenty-four 24 hours after admission;
(3) Admitting diagnosis;
(4) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;
(5) Documentation of clinical observations, including results of therapy, complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia;
(6) Properly executed informed consent forms for procedures and treatments specified by the Medical Staff or by Federal or State law if applicable, to require written patient consent;
(7) All practitioners’ orders, nursing notes, nursing plan of care, reports of treatment, medication records, radiology and laboratory reports, vital signs and other entries by health care providers that contain information necessary to monitor the patient’s condition;
(8) Progress notes;
(9) Operative note;
(10) Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatments, anesthesia records and any other diagnostic or therapeutic procedures and their results;
(11) Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. The physician must authenticate the discharge summary. A final progress note may be substituted for the discharge summary in the
case of a normal newborn infant and uncomplicated obstetric delivery. The final progress note should include any instructions given to the patient and family;
(12) Final diagnosis with completion of medical records within thirty (30) days following discharge.

A short stay record form may be used for inpatients hospitalized for less than forty-eight (48) hours, observation patients, ambulatory care patients and ambulatory surgery patients. The short stay medical record shall include, but not be limited to the following information:

1. Identification data;
2. Medical history and description of the patient’s condition and pertinent physical findings;
3. Diagnostic and therapeutic orders;
4. Care based on identified standards of care and standards of practice;
5. Data necessary to support the diagnosis and treatment provided, including clinical observations, results of therapy and anesthesia;
6. Operative note;
7. Final progress note, including instructions to the patient and family with discharge diagnosis and disposition of patient;
8. Authentication by the physician and other responsible personnel in attendance.

Outpatient records shall include, but not be limited to the following information:

1. Identification data;
2. Diagnostic and therapeutic orders;
3. Description of treatment given, procedures performed and documentation of patient responses to intervention, if applicable;
4. Results of diagnostic tests and examinations done, if applicable.

For patients receiving continuing ambulatory care services, the medical record contains a summary list noting known significant medical diagnoses and conditions, known significant operative and invasive procedures, know adverse and allergic drug reactions; and medications known to be prescribed for or used by the patient. The summary list is initiated for each patient by the third visit and maintained thereafter.

Emergency Service records shall include, but not be limited to the following information:

1. Identification data;
2. Time of arrival, means of arrival, time treatment was initiated, and time examined by physician, if applicable;
3. Pertinent history of illness or injury, description of the illness or injury, and examination, including vital signs;
4. Diagnostic and therapeutic orders;
5. Description of treatment given or prescribed clinical observations including the
(6) Authentication by the practitioner or licensed health professional who rendered treatment or prescribed for the patient in accordance with hospital policy;
(7) Instruction given to patient on release, prescribed follow-up care, signature of patient or responsible individual and name of individual providing instructions;
(8) Diagnostic impression and condition on discharge documented by the practitioner, disposition of the patient and time of discharge;
(9) Copy of transfer form, if patient is transferred to the inpatient service of another hospital. If care is not furnished to a patient or if the patient is referred elsewhere, the reasons for such action shall be recorded.
(10) The medical record shall note when a patient receiving emergency, urgent, or immediate care left against medical advice.

PART E: HISTORY AND PHYSICAL

A history and physical examination shall be performed and recorded within 24 hours of admission by a physician appointee to the Medical Staff, a member of the House Staff, or a nurse practitioner with appropriate clinical privileges. This report shall reflect a current physical assessment. If the history and physical examination is performed by a nurse practitioner, the history and physical examination shall be co-signed by the admitting physician. If a physical examination has been performed within 30 days prior to admission (or within seven (7) days prior to admission for patients who are insured through the Medicare Program), a durable, legible copy of this report may be used in the patient's Hospital medical record, providing these reports are recorded by a physician appointee to the Medical Staff, a member of the House Staff or a nurse practitioner with appropriate clinical privileges and there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. Obstetrical records should include prenatal information.

When a patient is readmitted within 30 days for the same diagnosis, an interval history and physical examination and readmission note reflecting any subsequent changes may be used in the medical record, provided the original information is readily available. The short form for the history and physical examination may be used for non-inpatient admissions.

The medical record shall document a current physical examination prior to the performance of inpatient surgery. Relevant history of the illness or injury and physical findings shall be documented prior to the performance of outpatient surgery.

PART F: PROGRESS NOTES

Progress notes made by practitioners should give a pertinent chronological report of the patient's course in the Hospital. Progress notes shall be legible, recorded at the time of observation, and shall contain sufficient content to ensure continuity of care if the patient is transferred. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as
results of tests and treatment. Progress notes shall be written at least daily on all inpatients.

Pertinent progress notes may also be made by other personnel specified by the Hospital.

PART G: CONSULTATION REPORTS

Each consultation report should contain a written opinion and recommendation by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record. A limited statement such as, "I concur" does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

PART H: DISCHARGE SUMMARIES

All relevant diagnoses established by the time of discharge, as well as all operative procedures performed, should be recorded, using acceptable disease and operative terminology that includes topography and etiology as appropriate.

A clinical discharge summary shall be included in the medical records of all patients except those who require less than a 48-hour period of hospitalization, normal newborn infants and uncomplicated obstetrical deliveries. A final progress note may be substituted for the discharge summary for these patients, which should include condition at discharge, discharge instructions, and follow-up care.

The discharge summary shall be dictated and/or recorded by a physician appointee to the Medical Staff, a member of the House Staff or a nurse practitioner with appropriate clinical privileges. If the discharge summary is dictated and/or recorded by a nurse practitioner, the discharge summary shall be co-signed by a physician appointee to the Medical Staff. The discharge summary shall include the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient or family, as pertinent. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. When preprinted instructions are given to the patient or family, the record should so indicate. All summaries shall be authenticated by the attending physician or dentist.

PART I: POSSESSION AND ACCESS

The legal medical record is considered to be the electronic medical record that resides in the optical imaging system. All medical records are the property of the Hospital and shall not be taken from the premises of the Hospital by appointees to the Medical Staff. Medical records may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from the Hospital is grounds for suspension from the Medical Staff and shall require that
the matter be turned over to the Executive Committee for appropriate action. All medical records must be available for retrieval by the Medical Records Department upon completion of services or discharge of the patient from the hospital.

Upon written approval of the Chief Executive Officer, or his designee, access to the medical records of all patients shall be afforded to appointees to the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the Chief Executive Officer, former staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patient's medical records is forbidden without written approval of the Chief Executive Officer.

Written consent of the patient or other person authorized by law to consent to the release of medical information is required for release of medical information to those not otherwise authorized to receive this information.

PART J: CHART COMPLETION POLICY

(1) Definitions:

(a) **Deficient**: Any medical record that contains a deficiency that is in the date range of zero to thirty (0-30) days post-discharge.

(b) **Delinquent**: Any medical record that contains a delinquency that is thirty-one (31) days or greater post-discharge.

(2) Medical Records Procedure: The practitioner shall be responsible for completing all charts thirty (30) days post-discharge.

1) Twenty-one (21) days post-discharge - Chair of Medical Records Committee sends a letter to all members whose charts have not been completed within twenty-one (21) days post-discharge. Purpose of letter is to formally request that the member complete the deficient records within the 31 day time period and outline the consequences for failure to complete the medical records within the specified time period.

2) Thirty-one (31) days post-discharge – Chair of Medical Record/Utilization Review Committee provides notice via fax or e-mail to all members whose charts are delinquent. Purpose of the notice is to formally advise the member of automatic relinquishment of their clinical privileges if the member does not complete the delinquent records within five (5) days after delivery of said notice via fax or e-mail.

3) Five (5) days after delivery of the notice referenced in the immediately preceding section 2) above if the member has not completed all delinquent medical records - Chair of the Executive Committee sends the member a
registered letter i) notifying the member of automatic relinquishment of their clinical privileges effective immediately which relinquishment shall remain in effect until completion of all delinquent medical records, and ii) advising member of their obligation to provide continuous physician coverage for their patients during the time period of automatic relinquishment of their clinical privileges. The Chair of Executive Committee shall notify the Credentials Office, Patient Access Department, Nursing Services and Surgical Services of the automatic relinquishment of the member’s clinical privileges.

PART K: LEGIBLE HANDWRITING POLICY

For purposes of patient safety and quality care, each member of the Medical Staff shall use legible handwriting in the medical record. The Health Information Management Department will conduct random audits of handwriting legibility in the medical record and will forward to the Executive Committee of the Medical Staff handwriting samples which it deems illegible. The Executive Committee of the Medical Staff will then review the handwriting samples forwarded to it by the Health Information Department and make a determination, within its sole discretion, as to whether the handwriting in the medical record is legible or illegible.

If the Executive Committee of the Medical Staff determines the handwriting in the medical record to be illegible, then the Chair of the Executive Committee shall send a registered letter to all members whose handwriting in the medical record is deemed illegible notifying them that: i) if this is the member’s first registered letter received under this policy or more than six (6) months have elapsed since the member received a registered letter under this policy, then the member will be advised that it is strongly suggested that he/she implement handwriting tool(s) recommended by the Health Information Department and that in the event the member should receive a second registered letter under this policy within a six (6) month time period that the member shall have fourteen (14) days from receipt of the second registered letter in which to provide proof of implementation of a handwriting tool(s) recommended by the Health Information Department to the Chair of the Executive Committee or such failure to do so will result in automatic relinquishment of their clinical privileges; or ii) if this is the member’s second registered letter received under this policy within a six (6) month period, then the member will be advised that he/she shall have fourteen (14) days from receipt of the second registered letter in which to provide proof of implementation of a handwriting tool(s) recommended by the Health Information Management Department to the Chair of the Executive Committee or such failure to do so will result in automatic relinquishment of their clinical privileges effective immediately which relinquishment shall remain in effect until proof of implementation of a handwriting tool(s) recommended by the Health Information Management Department has been received by the Chair of Executive Committee. The Chair of Executive Committee shall notify the Credentials Office, Patient Access Department, Nursing Services and Surgical Services of the automatic
relinquishment of the member’s clinical privileges.

For purposes of this policy, the registered letter will be deemed to have been received by the member on the third day following its deposit in the mail addressed to the member.

ARTICLE X

INFORMED CONSENT

PART A: TREATMENTS/PROCEDURES WHICH REQUIRE INFORMED CONSENT

It is the policy of BMH to obtain a signed “Consent for Treatment” at the time of admission and to obtain specific informed consent for the following:

(1) Any treatment or procedure which is non-routine or which presents significant risk;
(2) Operative and invasive procedures;
(3) Treatments or procedures for which written consent is required by law;
(4) Administration of anesthesia;
(5) Administration of blood and blood products;
(6) Any test to determine the presence of HIV antibodies.

DEFINITIONS

(1) Informed Consent means consent obtained from the patient (or someone authorized to give consent on the patient's behalf), after being provided a clear explanation of the proposed treatment or procedure.

The explanation includes:

- potential benefits and drawbacks;
- potential problems related to recuperation;
- the likelihood of success;
- the possible results of non-treatment;
- any significant alternatives.

The patient, and when appropriate, the family, is also informed of:

- the name of the physician or other practitioner who has primary responsibility for the patient’s care;
- the identity and professional status of individuals responsible for authorizing and performing procedures and treatments;
- any professional relationship to another health care provider or institution that might
• their relationship to educational institutions involved in patient’s care; and
• any business relationships between individuals treating the patient, or between the organization and any other health care, service, or educational institutions involved in the patient’s care.

(2) Emergency means a situation which presents an immediate threat to the life or a serious impairment to the health of the patient and any delay caused by an attempt to obtain consent could jeopardize the life or health of the patient.

(3) Invasive procedure. A procedure involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties and implantations and excluding routine venipuncture, intravenous therapy and routine physical examinations.

PART B: RESPONSIBILITY FOR OBTAINING INFORMED CONSENT

Except in an emergency, it is the responsibility of the licensed independent practitioner to obtain the informed consent of the patient to proposed treatments or procedures prior to initiation of the treatment or procedure.

(1) The surgeon shall obtain the patient’s informed consent to any surgical procedure undertaken by him/her or under his/her supervision, including ambulatory surgery.

(2) The anesthesiologist shall obtain the patient’s informed consent to the administration of anesthesia administered by him/her or under his/her supervision.

(3) The licensed independent practitioner who will perform the treatment or procedure shall obtain the patient’s informed consent to the treatment or procedure.

Members of the Medical Staff may not delegate the duty to obtain informed consent to BMH staff members except in the following circumstance:

• In the event of an occupational bloodborne pathogen exposure to a “healthcare provider,” BMH employees may obtain informed consent from the source patient and/or the healthcare provider for any tests to determine the presence of HIV antibodies.

In all other circumstances, BMH personnel may aid in procuring signed consent forms as a matter of courtesy to the members of the Medical Staff. However, their role is ministerial in this regard. The responsibility of obtaining informed consent is the responsibility of members of the Medical Staff. If the patient has questions concerning the treatment or procedure or is unsure of his/her decision, BMH personnel shall refer the patient to the appropriate member of the Medical
Staff for additional explanation.

PART C: WRITTEN CONSENT

Except in an emergency, no treatment or procedure for which informed consent must be obtained will be performed unless a completed consent form is in the patient’s chart. In an emergency, the nature of the emergency circumstances shall be fully explained in the patient’s chart by the responsible practitioner.

Consents are to be signed and witnessed by an adult. An adult is defined as an individual eighteen (18) years of age or older. An individual not an adult is referred to as a “minor.”

A minor may give consent for his/her healthcare if:

- He or she is emancipated;
- He or she is at least fourteen (14) years of age, is not dependent on a parent for support, is living apart from his parents or from an individual in loco parentis (in place of a parent) and is managing his or her affairs;
- He or she is or has been married;
- He or she is in the military service of the United States;
- He or she is authorized to consent to their own healthcare by any other statute (as in the case of treatment for venereal disease).

If the minor is not authorized to consent to his or her healthcare, the consent may be given by:

- A judicially appointed guardian or judicially appointed health care representative;
- If there is no judicially appointed guardian or health care representative, then a parent or individual in loco parentis;
- If there is no judicially appointed guardian or health care representative or no parent or individual in loco parentis, then an adult sibling of the minor.

If an adult is incapable of giving consent and does not have an appointed health care representative or the health care representative is unavailable or declines to act, consent may be given by:

- A judicially appointed guardian or health care representative;
- If there is no judicially appointed guardian or health care representative, consent may be given by:
  (1) Spouse;
  (2) Parent;
  (3) Adult child, or
  (4) Adult sibling
of the individual in that order.

The individual’s religious superior if the individual is a member of a religious order.

Telephone consents may be obtained if time does not permit obtaining a prior written consent. The telephone consent must be witnessed by two adults, either hospital employees or physicians, and documented in the medical record. Telephone consents must be followed up with written consent from the individual giving consent.
ARTICLE XI

ABORTION

"Abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.

Abortions may not be performed at IU Health Ball Memorial Hospital unless the abortion is necessary to prevent a Substantial impairment of the life or physical health of the pregnant woman.

A physician performing an abortion at IU Health Ball Memorial Hospital is responsible for assuring compliance with any and all legal requirements concerning abortions prior to performing the procedure.

ARTICLE XII

PHARMACY SERVICES

PART A: GENERAL RULES

All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia National Formulary," "American Hospital Formulary Service," or "AMA Drug Evaluations" with the exception of drugs for bona fide clinical investigations. Investigational drugs may be used as part of a study previously approved by the Institutional Review Board (IRB). Investigational drug studies must be registered with the Department of Pharmacy Services and dispensed through the Department of Pharmacy Services. The entire protocol must be given to the Department of Pharmacy Services. The Department of Pharmacy Services shall not obtain, stock, or dispense non-FDA approved alternative products.

A pharmacist may prepare intravenous solutions with additives, dilute, dried, or concentrated injectables, or prepare unit dose medications for administration by an appropriately qualified individual. Each drug dose shall be recorded in the medical record of the patient and properly signed after the drugs have been administered.

PART B: SELF-ADMINISTRATION; PATIENT'S OWN DRUGS

Self-administration of drugs by patients may be permitted as prescribed in writing by the attending practitioner. Patients’ personal medications from home may be used only if the medication is not stocked in the pharmacy and cannot be obtained in a timely manner. Under these circumstances, the practitioner who prescribed the medication must write a complete order for the administration of the patient’s personal medication. Patient’s personal IV Hyperalimentation bags or other IV admixtures may not be used during the patient’s hospitalization. Medications brought to the hospital by patients shall be sent home or shall be stored in the pharmacy and returned to the patient upon discharge.
PART C: MEDICATION ERRORS; ADVERSE REACTIONS

Any significant medication errors and apparent adverse drug reactions shall be reported as soon as possible to the practitioner who ordered the drug. Any entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the medical record of the patient. Any adverse drug reaction shall be documented in the patient's chart. Notification of all drug sensitivities, including any apparent adverse reactions, shall be sent to the Department of Pharmacy Services. All medication errors and adverse drug reactions shall be documented through the appropriate reporting system.

PART D: HOSPITAL FORMULARY SYSTEM

The Hospital shall maintain a formulary system whereby the Medical Staff, working through the Pharmacy and Therapeutics Committee, evaluates, appraises, and selects those medical agents for use in patient care. The Hospital formulary shall be reviewed and revised by the Pharmacy and Therapeutics Committee to reflect current clinical judgment. With some exceptions, as determined by the Pharmacy & Therapeutics Committee, generically equivalent drug products will be substituted as necessary. The practitioner who prescribed the medication shall not be notified of the substitution.

PART E: AUTOMATIC THERAPEUTIC SUBSTITUTION

With the approval of the Pharmacy & Therapeutics Committee, the Pharmacy Services Department may substitute therapeutically equivalent products. Specific drug and dose substitutions will be reviewed by the P & T Committee. When a substitutable drug is Ordered, the pharmacist will write the order for the approved drug and dose and indicate that the substitution was made in accordance with P & T Committee guidelines.

PART F: MEDICATION ORDERS

Medication orders must be written completely with drug, dose, route of administration, frequency and duration (if applicable) noted on the order. Diagnosis/indication for use may be included but is not required. To avoid errors, leading decimals (e.g., .5 mg) and trailing zeros (e.g., 5.0 mg) should not be used when writing drug dosages. Illegible, unclear, or questionable drug orders will result in an intervention by a pharmacist.

Medication orders for patients transferring in or out of ICU, CCU, and CRU are to be rewritten at the time of transfer. Any medications that are not reordered will be discontinued.
ARTICLE XIII

DISCHARGE

PART A: WHO MAY DISCHARGE

Patients shall be discharged only on a written order of the attending physician or dentist. Should a patient leave the Hospital against the advice of the attending physician or dentist, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient shall be asked to sign the Hospital's release form.

PART B: DISCHARGE PLANNING

Discharge Planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge Planning shall include, but need not be limited to, the following:

- Appropriate referral and transfer plans.
- Methods to facilitate the provision of follow-up care.
- Information to be given to the patient or his family or other persons involved in caring for the patient on matters such as the patient's condition; his health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complications. This information should be provided by the attending physician, dentist or designated ancillary department.

Patients transferring from the hospital to a skilled nursing facility for the first time or after a stay at home with a readmission to the hospital, must be referred to the Social Work/Discharge Planning Department to facilitate compliance with state and federal pre-admission guidelines before transfer.

Patients requiring a referral to a home health agency for the first time or a re-referral after discontinuation of home health services must be referred to the Social Work/Discharge Planning Department to facilitate compliance with the federal statute requiring that all patients are advised of eligible home health providers before a referral is made.

PART C: TRANSFER OF PATIENTS

Patients shall be transferred to other medical facilities in accordance with the guidelines established in the Comprehensive Omnibus Reconciliation Act (COBRA). The transferring Medical Staff member shall document compliance with COBRA requirements and such documents shall become part of the medical record.
PART D: DISCHARGE OF MINORS & INCOMPETENT PATIENTS

A patient who is unable, by reason of his minority or other incompetency, to consent to his own care or treatment shall be discharged only to his parent, his guardian or another responsible party as determined by the Hospital, unless the Hospital is otherwise directed in writing by the parent, guardian or court order. If such direction is received by the Hospital, the writing or order shall be made a part of the permanent medical record of the patient.

PART E: AUTOPSIES: DISPOSITION OF BODY

The remains of any deceased patient including a fetal death or a neonatal death shall not be subjected to disposition until death has been officially pronounced by a Medical Staff appointee or House Staff member. Disposition shall be arranged with the consent of the parent, surviving spouse, legal guardian, or responsible person.

It shall be the duty of all Medical Staff appointees or House staff to secure consent to autopsies whenever possible. An autopsy may be performed only with proper consent in accordance with state law. All autopsies shall be performed by a pathologist or by his designee. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete protocol shall be made a part of the medical record within 30 days.

ARTICLE XIV

GENERAL RULES REGARDING PRACTICE IN THE HOSPITAL

PART A: REPORTS

It shall be the responsibility of each physician or dentist to report to the Chairman of the Executive Committee any conduct, acts or omissions by appointees to the Medical Staff of which he is aware which he, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional ethics.

PART B: DISASTER PLAN

Each appointee to the Medical Staff except Honorary and Courtesy Staff members shall be responsible for familiarizing him/herself with the Hospital’s Mass Casualty Disaster Plan. The members of the Medical Staff shall participate as requested in periodic disaster “drills” to test the effectiveness of the Hospital and community’s emergency preparedness plans.

PART C: CARE OF SERVICE (CHARITY) PATIENTS
(1) Patients may be referred to "Service" by any physician or dentist on the Medical Staff admitting such cases to the Hospital.

(2) The referring physician or dentist will write an admitting note on the patient's chart, which will include original orders for treatment and also will indicate that the patient is referred to the service physician for further treatment.

(3) The service physician or service physician team will remain actively involved with each service patient until the patient is discharged.

(4) Service assignments for those departments other than internal medicine will be made by the President from lists submitted to him by the chairman of each department. Any disagreements regarding service assignments shall be settled at the department level.

ARTICLE XV

SEXUAL HARASSMENT POLICY

IU Health Ball Memorial Hospital and the Medical Staff are committed to providing a work environment which is free from unlawful discrimination. In keeping with this commitment, no physician, dentist, medical assistant or medical associate shall engage in unlawful discrimination, including sexual harassment.

(1) Sexual harassment includes, but is not limited to, unwelcome or unsolicited sexual advances, requests for sexual factors and other verbal or physical conduct of a sexual nature when:

(a) Submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment;

(b) Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual (i.e., hiring, firing, promotion, demotion, compensation, benefits, working conditions); or

(c) Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

(2) Sexual harassment does not refer to occasional compliments of a socially acceptable nature. It refers to behavior that is not welcome, that is personally offensive, that debilitates morale, and therefore, interferes with work effectiveness. Examples of prohibited conduct include, but are not limited to:

(a) Demanding sexual favors in exchange for favorable reviews, assignments, promotions, continued employment or promises of the same;
(b) Continued or repeated sexual jokes, language, epithets, flirtation, advances or propositions;

(c) Verbal abuse of a sexual nature;

(d) Graphic verbal commentary about an individual's body, sexual prowess or sexual deficiencies, including social life;

(e) Sexually degrading or vulgar words to describe an individual;

(f) Leering, whistling, touching, pinching, brushing the body, assault, coerced sexual acts or suggestive, insulting or obscene comments or gestures;

(g) The display in the workplace of sexually suggestive objects, pictures, posters or cartoons;

(h) Name calling, relating stories, gossip, comments or jokes that may be derogatory toward a particular sex;

(i) The display of sexually suggestive graffiti;

(j) Retaliation against Hospital employees for complaining about such behavior;

(k) Asking questions about sexual conduct or sexual orientation or preferences; and

(l) Harassment consistently targeted at only one sex, even if the content of the verbal abuse is not sexual.

(3) Any Hospital employee or medical staff member who believes he or she has been unlawfully discriminated against, including sexual harassment, by a physician, dentist, medical assistance or medical associate should promptly report the facts of the incident or incidents and the names of the persons involved directly to a supervisor, the Chairman of the Medical Staff, Chairman of the Executive Committee, Chairman of any Clinical Department, Chairman of any committee, the Chief Executive Officer or the Chairman of the Board. All claims will be investigated and appropriate corrective action will be taken. In the event a physician, dentist, medical assistant or medical associate engages in unlawful discrimination, including sexual harassment, which has been substantiated, corrective action will be taken which may include revocation of staff appointment. Any disciplinary action in excess of counseling and monitoring shall be in compliance with Article VII, Part D of the Medical Staff Bylaws.

(4) Retaliation is prohibited against Hospital employees and/or medical staff members who bring charges of unlawful discrimination, including sexual harassment, or those who assist in investigating charges.
ARTICLE XVI

DISRUPTIVE PHYSICIAN PROGRAM

It is the policy of IU Health Ball Memorial Hospital that all Medical Staff members are to exhibit the highest professional ethics and to conduct themselves in a manner which is in keeping with those ethics as well as with the Bylaws and policies of the hospital and the Bylaws, Rules and Regulations of the Medical Staff. Medical Staff members are further expected to work harmoniously with others in order to preserve the orderly operation of the hospital and the Medical Staff organization. All conflicts caused by the failure to abide by such expectations shall be resolved in the following manner:

(1) **First Level Resolution:** When possible, conflicts shall be settled to the satisfaction of complainant and involved physician on an interpersonal basis. Supervisory personnel and/or other physicians may assist at this level through informal mediation.

(2) **Second Level Resolution:** When interpersonal resolution is not possible, the chairman of the department in which the involved physician practices shall be notified. The department chair shall then attempt to settle the dispute to the satisfaction of the complainant and the involved physician through information mediation. The incident may be brought to the attention of the department chairman by supervisory personnel, directly by the affected individual, or by witnesses.

(3) **Third Level Resolution:** An incident that cannot be resolved at the department chairman or lower level shall come to the Executive Committee for action. The Executive Committee shall conduct an investigation and make all appropriate recommendations in accordance with Article XII of the Bylaws of the Medical Staff of Indiana University Health Ball Memorial Hospital, Inc.

Second Level and Third Level Resolutions shall be reported by the supervisory personnel or the department chair to the Medical Staff Executive Committee. The Executive Committee, at its discretion, may track these incidents and may order that a copy of the record of the dispute and its resolution be placed in the involved physician’s credentials file.

A physician with adverse behavior actions in their physician file may, after five (5) years of good behavior, request that the Executive committee review the file, and at the discretion of the Executive Committee, purge said report of actions.

ARTICLE XVII

CONTINUING MEDICAL EDUCATION
To be eligible for appointment or reappointment, the Medical Staff candidate must show evidence to the Medical Staff, through its offices, of earning fifty (50) hours of AMA approved Category I continuing medical education credits during the preceding two (2) years. Exceptions to this requirement are stipulated below:

**Board Certification/Re-certification**
Practitioners who become Board-certified or Re-certified during a reappointment cycle will be considered to have met all CME requirements for that and the subsequent reappointment cycle.

**Residency/Fellowship**
Practitioners who have completed an ACGME approved residency or a fellowship during a reappointment cycle will be considered to have met all CME requirements for that and the subsequent reappointment cycle.

**New Members**
Practitioners who have joined the Medical Staff within six (6) months of a reappointment date are exempted from the CME requirements for that reappointment cycle.

For new Medical Staff appointees who were appointed to the staff greater than six (6) months but less than two (2) years prior to reappointment, the CME requirement will be prorated to the duration of the appointment.

The Executive Committee may grant limited extensions on an individual basis for extenuating circumstances.
ARTICLE XVIII

DRUG SCREENING

For completion of an application to the BMH Medical Staff, the applicant is required to submit to a substance screening procedure. The Credentials Committee shall determine the scope and methods of the screening process.

ARTICLE XVIV

STATE AND FEDERAL NARCOTIC LICENSE

All Medical Staff Members are required to maintain a continuous valid state and federal narcotic license except those physicians who by nature of their practice may be excused from this requirement by the Credentials Committee.

ARTICLE XX

IMPAIRED MEMBERS OF THE MEDICAL STAFF

The primary purpose of this policy is to protect patients. However, its secondary function is to provide a means to identify impaired clinicians and direct them toward treatment and rehabilitation while maintaining the confidentiality of the peer review process. This policy provides for a logical series of steps in the assessment of the clinician involved, with the safeguard of multiple opportunities for peer review before a determination is made that a clinician is truly impaired. The universal application of this policy should ensure fair and equitable treatment for all clinicians.

PART A: ACUTE IMPAIRMENT

If a member of the Medical Staff, executive officer of the hospital or a house officer has a reasonable concern that a member of the Medical Staff is acutely impaired, then that concern must be communicated to the Administrator-on-Call to request that the administrator come immediately to the hospital. If the Administrator-on-Call finds that cause exists to believe that the member of the Medical Staff is acutely impaired, then the administrator shall contact a member of the Executive Committee of the Medical Staff (hereinafter “designated superior”) and request that the designated superior come immediately to the hospital. The following procedures will be followed:

(1) For purposes of Part A, a member of the Medical Staff is “acutely impaired” if the quality of his or her patient care is severely reduced from the usual and ordinary level of care.

(2) The Indiana State Medical Association (ISMA) has published a list of symptoms that may indicate impairment. The list is attached. No one symptom is singularly diagnostic of any one illness. A combination of these symptoms likely signifies an impaired physician.
(3) The Medical Staff member involved will be informed of these procedures by the member of the Medical Staff, executive officer of the hospital or house officer – whichever individual contacted the Administrator-on-Call. The Medical Staff member will be informed that this is hospital procedure. The Medical Staff member will be requested to wait until the arrival of the Administrator-on-Call and designated superior, if the situation so requires. If the administrator and designated superior determine that cause exists to believe that the Medical Staff member in question may be acutely impaired, then a urine drug screen and blood alcohol level will be obtained. Chain of custody procedure will be followed in the collection of urine. If the administrator and the designated superior do not agree that the Medical Staff member may be impaired, then no testing shall occur. However, a Medical Staff member may always request that such testing be done to demonstrate the absence of drugs or alcohol.

(4) The refusal of a member of the Medical Staff to wait as provided in Paragraph 3 above, or delay or refusal to provide a sample in response to a request for a urine drug screen and/or blood alcohol level are grounds for an immediate precautionary suspension of clinical privileges. The Medical Staff member shall be requested to immediately cease patient care and the matter will be referred to the “Committee” authorized under the Medical Staff Bylaws for consideration of precautionary suspension of clinical privileges.

(5) Consent by a member of the Medical Staff to the release of urine or blood test results consistent with the execution of this policy and any other purposes required by the Medical Staff Bylaws shall be presumed in any instance where the testing is conducted in accordance with this policy. Should the urine screen and/or blood alcohol level be positive for a controlled substance or alcohol (defined as greater than .02 mg percent) or the designated superior determines the Medical Staff member to be otherwise psychiatrically or physically impaired, the Medical Staff member in question will be required to cease patient care immediately. The designated superior shall arrange for immediate care of the clinician’s patients.

(6) If the urine screen and/or blood alcohol are positive, as defined in Paragraph 5 above, or the designated superior believes the Medical Staff member is otherwise psychiatrically or physically impaired, the designated superior shall report that information to the Physician Health and Well-Being Committee (“PHWBC”) and to members of the “Committee” authorized under the Medical Staff Bylaws to impose precautionary suspensions of clinical privileges. All information shall be provided to the PHWBC for immediate review within two (2) business days after the results of the testing and other procedures are completed. The Medical Staff member in question shall be apprised of this procedure. Within thirty (30) days after the referral of this matter to the PHWBC, it shall act to recommend to the Executive Committee whether this incident merits referral to the ISMA Physician Assistance Program (PAP), or provide a statement of the reasons why more time is needed.

(7) All incidents or concerns reported under this policy and which require review by the
(8) If a referral is made by the Executive Committee to the ISMA PAP, the ISMA PAP, in conjunction with the PHWBC will evaluate and investigate the complaint. A course of action will be developed by the ISMA PAP and the PHWBC and the Executive Committee will be notified. Options include, but are not limited to the following:

(a) If an initial report lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be investigated.

(b) If the reports prove substantial and the Medical Staff member is recommended to undergo an appropriate evaluation by a facility or a physician Medical Staff member approved by ISMA PAP, the Medical Staff member must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendations is presumed by the Medical Staff member entering into an evaluation contract with the ISMA PAP.

(9) If treatment is recommended, the Medical Staff member will sign a contractual agreement with the ISMA PAP. This agreement will be effective for at least five (5) years.

(10) The contract will cover, but is not limited to the following areas:

(a) Weekly random urine drug screens, if appropriate to the impairment;
(b) Attendance at weekly Alcoholics/Narcotics Anonymous meetings, if appropriate to the impairment;
(c) Attendance at Caduceus meetings, a support group for physicians, if appropriate to the impairment;
(d) Monthly meetings with an approved advocate;
(e) Continued therapy, if recommended by the treating physician;
(f) Other items appropriate to the impairment/;
(g) Approval to send regular reports to the appropriate hospital personnel documenting contract compliance.

(11) Failure to comply with requests for evaluation or the terms of the contract, including refusal to provide a blood or urine specimen if directed to do so, will result in a report to the Executive Committee of the Medical Staff, the Governing Board of the hospital, and may result in a report to the Indiana Medical Licensing Board.

PART B: IMPAIRED PHYSICIANS
If any member of the Medical Staff, hospital personnel, patient or the patient’s family has a reasonable concern that a member of the Medical Staff is impaired, the following procedures will be followed:

1. For purposes of Part B, a Medical Staff member is “impaired” if the quality of his or her patient care is reduced from the usual and ordinary level of care.

2. The Indiana State Medical Association (ISMA) has published a list of symptoms that may indicate impairment. This list is attached. No one symptom is singularly diagnostic of any one illness. A combination of these symptoms likely signifies an impaired physician.

3. A written report of the specific concerns and behaviors shall be provided to the PHWBC. The anonymity of the individual providing the report shall be maintained. The PHWBC may invite the Medical Staff member to discuss the concerns and behaviors, but is not obligated to do so.

4. If the report clearly suggests impairment, the PHWBC will recommend to the Executive Committee that the ISMA PAP become involved.

5. The ISMA PAP, in conjunction with the PHWBC, will evaluate and investigate the complaint. A course of action will be developed by the ISMA PAP and the PHWBC and the Executive Committee will be notified. Options include, but are not limited to the following:

   a. If an initial report lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be investigated.

   b. If the reports prove substantial and the Medical Staff member is recommended to undergo an appropriate evaluation by a facility or physician approved by the ISMA PAP, the Medical Staff member must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendations is presumed by the Medical Staff member entering into an evaluation contract with the ISMA PAP.

6. If treatment is recommended, the Medical Staff member will sign a contractual agreement with the ISMA PAP. The contractual agreement will be effective for at least five years.

7. The contract will cover, but is not limited to the following:

   a. Weekly random drug urine screens, if appropriate to the impairment;

   b. Attendance at weekly Alcoholics/Narcotics Anonymous meetings, if appropriate to the impairment;

   c. Attendance at Caduceus meetings, a support group for physicians, if appropriate to the impairment;
(d) Monthly meetings with an approved advocate;
(e) Continued therapy if recommended by the treating physician;
(f) Other items appropriate to the impairment;
(g) Approval to send regular reports to the appropriate hospital personnel documenting contract compliance.

(8) Failure to comply with requests for evaluation of the terms of the contract will result in a report to the Executive Committee of the Medical Staff, the governing board of the hospital and may result in a report to the Indiana Medical Licensing Board.

Article XXI

AUTHORITY FOR FINES / FEES

The Medical Executive Committee has the authority, among other options, to assess reasonable assessments and/or fines on members of the Medical Staff for failure to comply with requirements of the Medical Staff Bylaws, Rules and Regulations and Hospital Policies.

Article XXII

CHEMICAL DEPENDENCY TREATMENT

Chemical Dependency treatment is now considered an outpatient process and provided through outpatient programs.

Patients needing acute detoxification may be cared for in acute care but once stabilized, should be referred to an appropriate outpatient chemical dependency program.

Article XXIII

UNRESOLVED PATIENT CARE AND SAFETY CONCERNS

When a member of the medical staff has concerns about patient care or safety in the hospital, the member should contact hospital administration.

If the concerns cannot be resolved through the hospital, the member may contact, without disciplinary or retaliatory actions, regulatory or accreditation agencies such as the Indiana State Department of Health, Joint Commission or CMS (Center for Medicare/Medicaid Services).

ARTICLE XXIII

ADOPTION

These Rules and Regulations are adopted and made effective October 26, 2000, superseding and replacing any and all previous Medical Staff Rules and Regulations

ADOPTED by the Board on October 26, 2000.
Appendix

Revision History

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<td>Article IX, Part J:</td>
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