RULES AND REGULATIONS OF THE MEDICAL STAFF

OF

OUR LADY OF LOURDES MEMORIAL HOSPITAL

Revised effective December 20, 2013

A. General Conduct and Responsibility of Medical Staff

1. The Medical Staff acknowledge that the governing body is legally responsible for the quality of patient care services, for the conduct and obligations of the Hospital as an institution and for ensuring compliance with all Federal, State and Local laws.
2. The Medical Staff shall comply with all applicable Federal, State and local laws, including New York State Public Health Law, Mental Hygiene Law, and the Education Law.
3. Members of the Medical Staff must abide by the rules, regulations and bylaws of the Hospital and Medical Staff.
4. Members of the Medical Staff must practice only within the scope of privileges granted by the governing body.
5. All medical staff members shall cooperate fully with the Corporate Compliance Policy of Lourdes Hospital and adhere to all laws, regulations and Guidelines for Ethical Business Behavior applicable to their activities at Lourdes Hospital, the practice of their profession, and their participation in any federal health program. In the event that any medical staff member knows or suspects that he or she or any director, officer, employee or other medical staff appointee has violated applicable laws or regulations, he or she shall immediately report the same to the Hospital's Chief Executive Officer or the Corporate Compliance Officer. Any practitioner who has concerns about the safety of care provided in the hospital may report these concerns to the Joint Commission. The hospital will take no disciplinary action against a practitioner because the practitioner reports safety or quality of care concerns to the Joint Commission. The Joint Commission may be contacted at complaint@jointcommission.org or at 1-800-994-6610.
6. The Medical Staff acknowledges that the Hospital is committed to carrying out its health

care ministry in a manner consistent with the mission of Ascension Health and the vision and values of Lourdes. The Medical Staff agrees that for services they provide at the Hospital, they shall adhere to the Ethical & Religious Directives for Catholic Facilities and to the mission of Lourdes Hospital.

7. The Medical Staff shall be organized and accountable to one governing body for the quality of the medical care provided to all patients.

8. Every patient of the Hospital, whether an inpatient, emergency service patient, or outpatient, shall be provided care that meets generally acceptable standards of professional practice by a practitioner who is a member of the Medical Staff.

9. Patients will be admitted to the Hospital only to the service of a licensed practitioner permitted to admit patients to the Hospital.

10. A physician shall be responsible for the care of each patient with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization.

11. The Medical Staff shall establish objective standards of care and conduct to be followed by all practitioners granted privileges at the Hospital. Those standards shall:

    (a) be consistent with prevailing standards of medical and other licensed health care practitioner standards of practice and conduct; and

    (b) afford patients their rights as patients in accordance with NYS Law.

12. The Medical Staff shall establish mechanisms to monitor the ongoing performance of practitioners granted privileges at the Hospital in delivering patient care, including monitoring of practitioner compliance with bylaws of the Medical Staff and pertinent Hospital policies and procedures.

13. The Medical Staff shall review and, when appropriate, recommend to the governing body, the limitation or suspension of the privileges of practitioners who do not practice in

compliance with the scope of their privileges, Medical Staff bylaws, standards of performance and policies and procedures, and assure that corrective measures are developed and put into place, when necessary.

14. No physician shall be designated to supervise and direct more than six registered physician's assistants or registered specialist's assistants or a combination thereof.

15. Medical Staff members are required to have a mechanism for coverage during any absence to indicate who will cover in their absence. It is a requirement that all covering practitioners must be members of the Lourdes Hospital Medical Staff with clinical privileges. Failure to provide such coverage authorizes the physician covering the service or the chairperson of the Department to assign another member of the Medical Staff to attend patients in need of care.

16. As required by state and federal law and ethical rules, appointees shall not abandon or neglect their patients who are in need of immediate professional care without making reasonable arrangements for the provision of such care by another provider. Discrimination based upon race, ethnicity, gender, religion or ability to pay is prohibited. A physician-patient relationship may be established by an appointee who examines, diagnoses, treats or provides consultation with respect to an Emergency Department patient while the appointee is on call to the Emergency Department. In addition, the relationship may be established by an appointee who has an Emergency Department patient directed to the appointee's practice by the Emergency Department physician for follow-up care, as an alternative to such appointee presenting to the Emergency Department while on emergency call. Therefore, where an appointee has been involved in an Emergency Department patient's care at the Emergency Department, or has agreed to follow up with the patient subsequent to the Emergency Department visit, appointees

shall continue to provide care, consultation and/or treatment to the patient until the condition diagnosed in connection with the Emergency Department visit no longer requires immediate professional care or the Appointee has made reasonable alternative arrangements for the provision of such care.

If an Emergency Department patient has been directed by the Emergency Department to seek follow-up care with the on-call appointee, as an alternative to the appointee presenting to the Emergency Department, then the appointee shall continue to provide necessary follow-up care to the patient as long as the patient has attempted to make arrangements to see the appointee within 30 days following the Emergency Department visit, or as otherwise required under the circumstances by applicable law or ethical rule prohibiting patient abandonment.

17. The Vice President, Medical Affairs and Medical Staff President shall determine whether or not a practitioner who is under an informal or formal plan of correction shall be allowed to serve as a preceptor for another practitioner or as a supervising physician for an allied health care provider until such plan of correction is successfully completed.

18. All orders for treatment shall be entered into the patient's electronic medical record (EMR), or if the practitioner has not been granted electronic health record (EHR) privileges, shall be written legibly, signed, timed, and dated. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within that individual's sphere of competence and signed by the responsible physician. All verbal and telephone orders must be written down and completely read back to the prescriber to verify accuracy, including patient's name and date of birth, name of the drug, including spelling if required, dose, route, frequency, indications, and specific instructions.

Only registered nurses and pharmacists are authorized to accept and transcribe orders for

pharmacologicals, biologicals, and ancillary testing related to these medications; except that respiratory therapists are authorized to accept and transcribe orders for medication relating to respiratory therapy, along with other orders relating to respiratory therapy. Otherwise, diagnostic imaging technologists and sonographers may accept and transcribe orders relating to diagnostic imaging; registered physical therapists may accept and transcribe orders relating to physical therapy; registered occupational therapists may accept orders related to occupational therapy; registered speech therapists may accept orders related to speech therapy; and registered dietitians may accept and transcribe orders relating to nutrition services.

The authorized person receiving the verbal order shall document the ordering practitioner's name in the medical record and indicate the authorized person's own name as the person who received the order. All verbal orders shall be authenticated by the practitioner or another practitioner having responsibility for the care of the patient within 48 hours. Telephone orders for home care patients must be authenticated within 30 days.

19. Standing Orders -

(a) There shall be no standing orders for laboratory tests except as required by law, there shall be a standing order for a PAP smear on all women twenty-one (21) years of age or over unless such a test is medically contraindicated or has been performed within the previous three years.

(b) Each clinical section may adopt other standing orders or written protocols for patient care, drugs or biologicals. These orders or protocols are subject to approval by the Medical Executive Committee and shall apply unless superseded by specific orders written by the attending practitioner.

(c) Standing orders shall be signed by the attending practitioner.

20. Stop Orders:

(a) As required orders (P.R.N., pro re nata) for controlled substances are not valid beyond 72 hours and must be rewritten (reordered) at least every 72 hours. The expiration time is 72 hours after time of order entry into the electronic medical record.

(b) Standing orders or specific controlled substances orders for individual patients to be administered at specified times must be rewritten (reordered) at least every seven (7) days. The expiration time is 168 hours after time of order entry into the EMR.

(c) Orders for antibiotics must be rewritten (reordered) every seven (7) days.

(d) Blood shall be held in reserve only twenty-four (24) hours unless specifically re-ordered. The physician shall be notified before the blood is released.

21. Orders – General Guidelines:

(a) As required orders (P.R.N., pro re nata) medication orders must include a specific time interval and the clinical indication for which the medication is to be administered.

(b) Range orders for dose or frequency will not be accepted.

(c) Orders for medications that must be compounded by the Pharmacy must include the medications, doses, concentrations (when appropriate), and, if appropriate the base solution/substance.

(d) Orders for medications that must be titrated or tapered must include the rate/dose/time period by which the medication is tapered or titrated, frequency of, and indication or parameters for titration.

(e) If medications are to be administered through or via a medical device, the prescriber must specify the type of device to be used (e.g., nebulizer, insulin infusion pump).

(f) Orders for investigational drugs must include name or product identification number, dose, route, frequency, and order(s) for any unique precautions or monitoring that are indicated.

(g) Practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written shall not be carried out until rewritten or understood by the nurse. The use of "Renew", "Repeat" and "Continue orders" are not acceptable. Practitioners entering orders into the medical record are expected to review the alerts and respond appropriately, considering the patient's condition/needs.

22. The attending physician is expected to obtain a consultation when diagnosis or management is in doubt for an unduly long period of time, when complications arise, or when specialized treatments or procedures are contemplated for which the attending physician does not have the necessary clinical privileges.

An example of a circumstance in which a consultation is required includes, but is not limited to, a pregnant woman admitted for a medical condition not related to the pregnancy, in which circumstance a consultation provided by the patient's obstetrician is required.

The attending physician is primarily responsible for requesting and obtaining a consultation from a qualified consultant when indicated. The attending physician shall directly communicate with the consultant (ie provider-to-provider) for all consultations, when attendance is necessary. A mid-level practitioner may complete the initial

consultation assessment, provided that the supervising or collaborating physician examines the patient and follows up with the attending physician within 24 hours. Ordinarily, the attending physician will have established referral relationships with certain consultants, and have customary and established means for making contact with, and a referral to, a particular consultant. However, in circumstances in which the attending physician is for any reason unable to obtain a consultation from a consultant with whom the attending physician has had such a referral relationship, then the attending physician shall take the additional measures necessary to obtain a consultation from another consultant.

When the attending physician is unable to obtain a necessary consultation for a patient admitted to the hospital, despite reasonable and diligent efforts to do so, the attending physician may order the consultant who is on call to the Emergency Department to provide the consultation to the inpatient by contacting the on-call consultant directly. It shall be the duty of the on-call consultant to respond to a request to provide an inpatient consultation by the attending physician. However, ordering a consultation from the on-call consultant shall be a last resort only, as necessary to ensure appropriate and timely care to the patient, and after the attending physician has made reasonable efforts to contact and obtain a consultation. Failure to make such reasonable efforts may raise a concern regarding the practitioner's professional conduct, with due consideration given to avoiding delay in providing necessary care. For purposes of this rule, the on-call consultant's obligation to respond to an attending physicians' request, and to assess and treat the patient, shall be governed by the same rules that apply to the on-call consultant's obligations with respect to the Emergency Department under the Emergency Medical Treatment and Active Labor Act ("EMTALA") and associated rules and regulations, as

amended from time to time.

23. Do Not Resuscitate Orders shall be written in accordance with Public Health Law Article 29-B.

24. Patients admitted to the hospital must be seen by the attending physician or designee in a clinically appropriate time frame, but in no case more than 12 hours after admission, except such rule shall not apply to newborns, who must be examined by an appropriately credentialed practitioner in a clinically appropriate time frame, but in no case more than 24 hours after admission.

    The initial visit requirement shall be satisfied by a direct admission to the hospital service if accompanied by a complete history and physical, done on the day of admission, with documentation of chief complaint, history of present illness, past medical/surgical history, family history, social history, review of systems, immunizations, if applicable, medications, allergies, physical examination, impression/assessment and plan of care.

    The history and physical, if performed by a practitioner other than the attending practitioner must be countersigned by the attending practitioner within 24 hours.

    In the case of newborns, the supervising or collaborating physician must perform either the admitting history and physical or the discharge exam.

    Thereafter, patients with acute level of care must be seen at least daily, and patients at an alternate level of care must be seen at least every seven (7) days, by the attending physician or designee and have progress notes written.

25. Medical Staff hereby adopt and shall be subject to the Administrative Policies, titled: Impaired Practitioner and Disruptive Practitioner as if they were fully set forth herein.

26. All on-call physicians are required to respond to the Hospital to evaluate and treat patients upon the request of the Emergency Department and in a timely manner in

accordance with the Administrative Policy titled Duty to Respond.

27. Each Active Staff appointee is expected to attend all regular Medical Staff meetings and applicable department meetings in each year. Failure to attend 50% of the aggregate total of such meetings held during a calendar year will result in the imposition of a fine, the amount of which shall be set from time to time by the Medical Executive Committee, and which shall be payable by the appointee as a part of annual Medical Staff dues for the succeeding year. The President of the Medical Staff or designee may waive the fine on a case by case basis.

28. Outlined below are the expectations that practitioners have of each other as members of our medical staff. These expectations reflect current medical staff bylaws, policies and procedures and organizational policies to bring together the most important issues found in those documents and key concepts reflecting our medical staff's culture and vision. While these expectations will provide a guide for the medical staff in selecting measures of practitioner competency, not every expectation will be directly measured.

Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and at the end of life as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff or appropriate external standards of care as defined by comparative outcome data, medical literature and results of peer review activities.

2. Plan and provide appropriate patient management based on accurate patient information, patient preferences, current indications and available scientific evidence using sound clinical judgment.

3. Assure that each patient is evaluated by a practitioner as defined in the bylaws, rules and regulations and document findings in the medical record at that time.

4. Demonstrate caring and respectful behaviors when interacting with patients and their families.

5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards.

6. Counsel and educate patients and their families.

7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.

8. If applicable, supervise residents, students and allied health professionals to assure patients receive the highest quality of care.

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty and approved by Medical Executive Committee, in selecting the most effective and appropriate approaches to diagnosis and treatment.

2. Maintain ongoing medical education and board certification as appropriate for each specialty.

3. Demonstrate appropriate procedural and cognitive skills as required by the medical staff.

Interpersonal and Communication Skills: Practitioners are expected to demonstrate

interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team as evidenced by the following:

1. Communicate effectively with practitioners, other caregivers, patients and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies.

2. Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and direct practitioner-to-practitioner contact.

3. Maintain medical records consistent with the medical staff bylaws, rules, regulations and policies.

4. Work effectively with others as a member of the health care team.

5. Maintain patient satisfaction with practitioner care.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:

1. Act in a professional, respectful manner at all times and adhere to the Lourdes Hospital Code of Conduct.

2. Respond promptly to requests for patient care needs.

3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers.

4. Participate in emergency call as defined in the bylaws, rules and regulations.

5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.

6. Utilize sensitivity and responsiveness to culture, race, age, gender, and disabilities for patients and staff.

7. Make positive contributions to the medical staff by participating actively in medical staff functions, serving when requested and by responding in a timely manner when input is requested.

Systems Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, and meet national patient safety goals.

2. Follow nationally recognized recommendations regarding infection prevention procedures and precautions when participating in patient care.

3. Ensure timely and continuous care of patients by clear identification of covering practitioners and by availability through appropriate and timely electronic communication systems.

4. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.

5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.

Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self-improvement of patient care.

2. Respond in a constructive manner when contacted regarding concerns about patient care.

3. Use hospital information technology to manage information and access on-line medical information.

4. Facilitate the learning of students, trainees and other health care professionals.

B. Admission/Discharge of Patient

1. Medical Staff shall provide care to patients without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.

2. Medical Staff responsible for the care of a patient shall provide to the patient complete current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. The patient shall be advised of any changes in health status, including harm or injury, the cause for the change and recommended care of treatment. The information shall be made available to an appropriate person on the patient's behalf and documented in the patient's medical record, if the patient is not competent to receive such information.

3. Medical Staff shall provide the necessary information for patients to give informed consent prior to the start of a surgical/invasive procedure, treatment or both. Informed consent shall include as a minimum: the specific procedure or treatment or both, the reasons for it, the reasonable foreseeable risks and benefits involved, and the alternatives for care and treatment, if any, as a reasonable practitioner under similar circumstances would disclose. Documented evidence of such informed consent shall be included in the patient's medical record.
4. Medical Staff shall provide information to the patient necessary for the patient to give informed consent prior to the withholding of medical care and treatment. Documented evidence of such informed consent shall be included in the patient's medical record.
5. Medical Staff shall also document the refusal of treatment by a patient in the medical record and shall adequately inform the patient of the reasonably foreseeable consequence of such refusal.
6. Medical Staff appointees and Medical Associates and Medical Assistants shall comply with all federal and state laws and regulations applicable to the confidentiality of patient information.
7. The responsible admitting practitioner shall be responsible on admission for establishing, in writing, the patient's condition and provisional diagnosis in the patient's medical record.
8. Admitting practitioners shall admit to the Hospital only those patients who require the type of medical service authorized by the Hospital's operating certificate, except in emergent situations.
9. If feasible, the admitting practitioner shall request of each person being admitted, information concerning signs or symptoms of recent exposure to communicable disease.

When indicated the patient shall be isolated and managed in accordance with the Hospital's infection control policies and procedures.

10. Every patient shall have a complete history and physical examination performed by an appropriately credentialed practitioner within seven days before or 24 hours after admission. If recorded in the patient's medical record by an individual other than the attending practitioner, the history and physical examination shall be reviewed and countersigned by the attending practitioner.

    (a) Such examination shall include a screening uterine cytology smear on women 21 years of age and over, unless such test is medically contraindicated or has been performed within the previous three years, and examination of breast, unless medically contraindicated, for all women over 21 years of age. These examinations shall be recorded in the medical record.

    (b) Insofar as it is possible to identify patients who may be susceptible, patients, including infants over six months of age, shall be examined for the presence of sickle cell hemoglobin unless such test has been previously performed and the results recorded in the patient's medical record or otherwise satisfactorily recorded, such as on an identification card.

11. Patients shall be admitted on the basis of the following priorities as supported by provisional diagnosis and/or valid reason(s):

    (a) Emergency

    (b) Urgent

    (c) Elective Pre-Operative

    (d) Routine

12. Areas of restricted bed utilization and assignment of patients shall be as follows:

(a) Maternity

(b) Intensive Care

(c) Nursery

(d) Pediatrics

Patients may be admitted without regard to the above restrictions only after consultation with the Vice President for Medical Affairs, Administrator on-call or President of the Medical Staff.

13. Any patient leaving the Hospital without the order of a practitioner or against the practitioner's or Hospital's advice, shall be requested to sign a release (Against Medical Advice Form). If the patient refuses to observe this request, the responsible nursing staff shall indicate this on the chart and shall have a witness to this fact. The appropriate nursing staff shall notify the Administrator on-call and the attending practitioner.

14. It shall be the responsibility of the attending practitioner, certified nurse midwife, dentist or podiatrist to discharge his/her patient when possible by 11:00 a.m. on the day of discharge, except for extenuating circumstances. If co-existing active medical problems are known to be present, and if the discharge is ordered by the attending dentist or podiatrist, he/she is expected to have discussed the medical appropriateness for discharge with the attending physician. The discharging practitioner (dentist, podiatrist, certified nurse midwife, or physician) is responsible for a summary of the patient's Hospital care and for completion of the chart, unless arrangements have been made for a different practitioner to complete the chart. If so, this should be documented with the discharge orders by the discharging practitioner. The attending physician shall be notified of discharge by the attending nursing unit.

15. Prior to discharge, Medical Staff responsible for the care of a patient must provide an

appropriate discharge plan, to include primary discharge diagnoses, secondary diagnoses, consultations obtained, operations/procedures performed, clinical course, lab and other testing summary, discharge medications, diet/disposition/and follow up plans.

No patient who requires continuing health care services in accordance with such patient discharge plan may be discharged until such services are secured or determined to be reasonably available to the patient.

16. Prior to transferring or discharging any patient, Medical Staff must ensure that they are in compliance with the Hospital's Administrative Policy regarding transfers or discharges.

C. Anesthesia Services

1. Anesthesia services are provided within the Hospital. The Medical Staff in conjunction with the Hospital must develop, implement and keep current effective written policies and procedures regarding staff privileges, the administration of anesthetics, the maintenance of safety controls and the integration of such services with other related services of the Hospital to protect the health and safety of the patients in accordance with generally accepted standards of medical practice and patient care.

2. Anesthesia services shall be directed by a physician who has responsibility for the clinical aspects of organization and delivery of all anesthesia services provided by the Hospital. That physician or another individual qualified by education and experience shall direct administrative aspects of the service.

3. The Medical Staff, in conjunction with the director, shall be responsible for recommending privileges to the governing body for those persons qualified to administer anesthetics, including the procedures each person is qualified to perform and the levels of required supervision as appropriate. Anesthesia shall be administered in accordance with their credentials and privileges by the following:

(a) anesthesiologists;

(b) physicians granted anesthesia privileges;

(c) dentists, oral surgeons, or podiatrists who are qualified to administer anesthesia under State law; or

(d) certified registered nurse anesthetists (CRNA's) under the supervision of an anesthesiologist who is immediately available as needed.

4. The Medical Staff, in conjunction with the director, shall develop and implement anesthesia service policies that clearly outline requirements for orientation and continuing education programs for all staff, and staff compliance with such requirements shall be considered at the time of reappointment or performance evaluation. Such training and continuing education programs shall be established that are relevant to care provided but must, at a minimum, include instruction in safety precautions, equipment usage and inspections, infection control requirements and any patients' rights requirements pertaining to surgical/anesthesia consents.

5. The Medical Staff, in conjunction with the director, shall monitor the quality and appropriateness of anesthesia related patient care and ensure that identified problems are reported to the quality services department and are resolved.

6. Written policies regarding anesthesia procedures shall be developed and implemented which shall clearly delineate pre-anesthesia and post-anesthesia responsibilities. These policies shall include, but not be limited to, the following elements:

(a) Pre-anesthesia physical evaluation shall be performed by an individual qualified to administer anesthesia and recorded in a timely manner prior to surgery.

(b) Routine checks shall be conducted by the anesthetist prior to every administration of anesthesia to ensure the readiness, availability, cleanliness, sterility when

required, and working condition of all equipment used in the administration of anesthetic agents.

(c) All anesthesia care shall be provided in accordance with accepted standards of practice and shall ensure the safety of the patient during the administration, conduct of and emergence from anesthesia. Continuous monitoring is required during the administration of general and regional anesthetics. Such continuous monitoring is not required during the administration of anesthetics administered for analgesia or during the administration of local anesthetics unless medically indicated or otherwise required by specific Hospital policies.

7. An anesthetist shall be continuously present in the operating room throughout the administration and the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care. If there is a documented hazard to the anesthetist which prevents the anesthetist from being continuously present in the operating room, provision must be made for monitoring the patient.

8. All patients must be attended by the anesthetist during the emergence from anesthesia, until they are under the care of qualified post-anesthesia care staff, or longer as necessary to meet the patient's needs.

(a) During the administration and conduct of all anesthesia the patient's oxygenation shall be continuously monitored to ensure adequate oxygen concentration in the inspired gas and the blood through the use of a pulse oximeter or superior equipment. During every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient's breathing system shall be measured by an oxygen analyzer with a low oxygen concentration limit alarm.

(b) All patient's ventilation shall be continuously monitored during the conduct of

anesthesia. During regional anesthesia, monitored anesthesia care and general anesthesia with a mask, the adequacy of ventilation shall be evaluated through the continual observation of the patient's qualitative clinical signs. For every patient receiving general anesthesia with an endotracheal tube, the quantitative carbon dioxide content of expired gases shall be monitored through the use of endtidal carbon dioxide analysis or superior technology. In all cases where ventilation is controlled by a mechanical ventilator, there shall be in continuous use an alarm that is capable of detecting disconnection of any components of the breathing system.

9. The patient's circulatory functions shall be continuously monitored during all anesthetics. This monitoring shall include the continuous display of the patient's electrocardiogram, from the beginnings of anesthesia until preparation to leave the anesthetizing location, and the evaluation of the patient's blood pressure and heart rate at least every five minutes.

10. During every administration of anesthesia, there shall be immediately available a means to continuously measure the patient's temperature.

11. Intraoperative anesthesia records shall document all pertinent events that occur during the induction, maintenance, and emergence from anesthesia. These pertinent events shall include, but not be limited to, the following: intraoperative abnormalities or complications, blood pressure, pulse, dosage and duration of all anesthetic agents, dosage and duration of other drugs and intravenous fluids, and the administration of blood and blood components. The record shall also document the general condition of the patient.

12. With respect to inpatients, a post-anesthetic follow-up evaluation and report by the individual who administered the anesthesia or by an individual qualified to administer

anesthesia, shall be written not less than three or more than 48 hours after surgery and shall note the presence or absence of anesthesia related abnormalities or complications, and shall evaluate the patient for proper anesthesia recovery and shall document the general condition of the patient.

13. With respect to outpatients, a post-anesthesia evaluation for proper anesthesia recovery performed in accordance with policies and procedures approved by the Medical Staff shall be documented for each patient prior to Hospital discharge.

D. Autopsies

1. Medical Staff shall use clinical criteria to determine the need to seek permission to do an autopsy. The criteria shall include the following:

   (a) deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;

   (b) all deaths in which the cause of death is not known with certainty on clinical grounds;

   (c) cases in which autopsy may help to alleviate the concerns of the family or public regarding the death and to provide reassurance to them regarding the same;

   (d) unexpected or unexplained deaths occurring during, or following any dental, medical, or surgical diagnostic procedures or therapies;

   (e) deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards;

   (f) unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;

(g) all obstetric deaths;

(h) all neonatal and pediatric deaths;

(i) deaths resulting from high-risk infections and contagious diseases;

(j) natural deaths that are subject to, but waived by, a forensic medical jurisdiction such as:

(i) persons dead on arrival to the Hospital;

(ii) deaths occurring in the Hospital within 24 hours of admission; and

(iii) deaths in which the patient sustained or apparently sustained an injury while hospitalized.

(k) deaths of patients of any age where it is believed that an autopsy would disclose a known or suspected illness that also may have a bearing on survivors or recipients of transplant organs; and

(l) deaths known or suspected to have resulted from environmental or occupational hazards.

2. Medical Staff shall adhere to applicable New York State law regarding forensic autopsies (coroner cases).

3. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform with State and Local laws.

4. Autopsies shall be performed only by a Hospital pathologist or a physician designated by the Hospital pathologist. Legal consent in writing shall be required before any autopsy is performed unless so ordered by the coroner. All members of the Medical Staff should do

their utmost to obtain permission for an autopsy. Provisional anatomic diagnosis shall be recorded in the medical record within 24 hours. The final autopsy report shall be included as part of the record within 30 days, unless the case is complicated, as defined by Pathology and Laboratory policies, in which case the final autopsy report shall be included as part of the record within 60 days.

E. Critical Care and Special Care Services

1. The direction of each service, unless otherwise specified in this section, shall be provided by a designated member of the Medical Staff who has received special training and has demonstrated competence in the service related to the care provided.
2. The provision of all critical care and special care services shall be in accordance with generally accepted standards of medical practice. Patients admitted to the Intensive Care Unit shall be evaluated by the attending physician in a prompt and clinically appropriate time frame. The Medical Staff in conjunction with the Hospital shall ensure that written policies are developed and implemented for all special care and critical care services.
3. The written policies and procedures shall be reviewed at least annually and revised as necessary and shall include at a minimum the following: infection control protocols, safety practices, admission/discharge protocols and an organized program for monitoring the quality and appropriateness of patient care, with identified problems reported to the Hospital-wide quality assurance program and resolved.

   The written protocols for patient admission to and discharge from a critical care or special care unit shall include:

(a) criteria for priority admissions;

(b) alternatives for providing specialized patient care to those patients who require such care but who, due to lack of space, or other specified reasons such as infection or contagious disease, are not eligible for admission according to unit policy; and

(c) guidelines for the timely transfer and referral of patients who require services that are not provided by the unit.

F. Dental Services

1. The attending oral surgeon or dentist shall be responsible for the admission, management and discharge of dental patients, including all related written documentation.
2. The admission history and physical examination for dental patients shall be completed by an oral surgeon, if so qualified, or by another member of the Medical Staff.
3. Dental patients with medical comorbidities or complications present upon admission or arising during Hospitalization shall be referred to appropriate Medical Staff for consultation and/or management.

G. Diagnostic Imaging

1. Radiologic services shall be provided only on the order of physicians or, consistent with State law, of those other practitioners authorized by the Medical Staff and governing body to order such services.
2. Radiologic procedures requiring the use of contrast media or fluoroscopic interpretation

and control shall be performed with the active participation of a qualified specialist in diagnostic radiology or a physician qualified in a medical specialty related to the radiographic procedure. Emergency equipment and staff trained in its use shall be available for anaphylactic shock reactions from contrast media.

3. Records of radiologic services including interpretations, consultations and therapy shall be filed with the patient's record, and duplicate copies shall be kept in the radiology department/service. All reports of films, scans and other image records shall be referenced in the patient's medical record. All films, scans and other image records shall be retained in the patient's medical record, radiology department/service or in another central location accessible to appropriate staff.
4. Requests by the attending practitioner for X-Ray examination shall contain the clinical indications (ICD 9 code) for the examination which shall be authenticated by the requestor.
5. The radiologist who performs radiology services shall authenticate reports of his or her interpretations.
6. Nuclear medicine services shall meet the needs of the patients in accordance with generally acceptable standards of practice. Nuclear medicine services shall be ordered only by a physician whose Federal or State licensure and staff privileges allow such referrals.
7. The clinical aspect of the organization and delivery of nuclear medicine services shall be directed by a physician who is qualified in nuclear medicine and named in the facility's New York State Health Department or radioactive materials license as authorized to use

radioactive materials in humans. The administrative aspects of these services shall be directed by that physician or another individual qualified for such duties by education and experience.

8. The qualifications, training, functions and responsibilities of all nuclear medicine personnel shall be specified by the clinical service director in accordance with applicable regulations and approved by the Medical Staff and the Hospital.

H. Disasters

Disasters shall be handled in accordance with the Hospital's written plan for Internal and External Disasters. All physicians in such an event shall be assigned to posts by the medical director or his/her designee.

1. In the event of a disaster in which additional beds are needed, the President of the Medical Staff or a designee shall request physicians to discharge such patients as could reasonably be discharged or, if necessary, shall order the discharge of such patients.
2. The plan for Internal and External Disasters shall be rehearsed at least as frequently as recommended by the Joint Commission on Accreditation of HealthCare Organizations and as required by law.

I. Emergency Services

1. The Medical Staff shall develop and implement written policies and procedures approved by the governing body that shall specify:

   (a) The responsibility of the emergency services Medical Staff is to evaluate, initially

manage and treat, or admit or recommend admission, or transfer patients to another facility that can provide definitive treatment;

(b) The organizational structure of the emergency service, including the specification of authority and accountability for services; and

(c) Explicit prohibition on transfer of patients based on their ability or inability to pay for services.

2. The emergency service shall be directed by a licensed and currently registered physician who is board-certified or board-admissible for a period not to exceed five years after the physician first attained board admissibility, in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advanced trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS.

3. The emergency service Medical Staff, in conjunction with the discharge planning program of the Hospital, shall establish and implement written criteria and guidelines specifying the circumstances, the actions to be taken, and the appropriate contact agencies and individuals to accomplish adequate discharge planning for persons in need of post emergency treatment or services but not in need of inpatient Hospital care.

4. There shall be a medical record that meets the medical record requirements of New York State laws for every patient seen in the emergency service. Medical records shall be integrated or cross-referenced with the inpatient and outpatient medical records system to assure the timely availability of previous patient care information and shall contain the

pre-hospital care report or equivalent report for patients who arrive by ambulance.

5. Staffing. The following requirements are applicable to the Hospital's emergency services:

(a) Emergency service physician services shall meet the following requirements:

(i) The emergency services attending physician shall meet the minimum qualifications set forth in either clause (b) or (c) of this subparagraph.

(b) The emergency services attending physician shall be a licensed and currently registered physician who is board-certified in emergency medicine, surgery, internal medicine, pediatrics or family practice and who is currently certified in advance trauma life support (ATLS) or has training and experience equivalent to ATLS. Such physician shall also have successfully completed a course in advanced cardiac life support (ACLS) or have had training and experience equivalent to ACLS. A licensed and currently registered physician who is board-admissible in one of these specialty areas and is currently certified in ATLS or who has training and experience equivalent to ATLS and has successfully completed a course in ACLS or has had training and experience equivalent to ACLS, may be designated as attending physician for a period not to exceed five years after the physician has first attained board admissibility. Physicians who are board-certified or admissible, for a period not to exceed five years after the physician first attained board admissibility, in other specialty areas may be designated as attending physicians for patients requiring their expertise.

(c) The emergency services attending physician shall be a physician who:

(i) is licensed and currently registered;

(ii) has successfully completed one year of postgraduate training;

(iii) has, within the past five years, accumulated 7,000 documented patient contact hours or hours of teaching medical students, physicians in-training, or physicians in emergency medicine. Up to 3,500 hours of documented experience in Hospital-based settings or other settings in the specialties of internal medicine, family practice, surgery or pediatrics may be substituted for the required hours of emergency medicine experience on an hour-for-hour basis;

(iv) has acquired in each of the last three years, an average of 50 hours or more per year of continuing medical education pertinent to emergency medicine or to the specialties of practice which contributed to meeting the 7,000 hours requirement specified in subclause (iii) of this clause;

(v) is currently certified in ATLS or has training and experience equivalent to ATLS; and

(vi) has successfully completed a course in advanced cardiac life support (ACLS) or has had training and experience equivalent to ACLS.

6. There shall be at least one emergency service attending physician on duty 24 hours a day, seven days a week.

7. Other Medical Staff practitioner services provided in the emergency service shall be in accordance with the privileges granted the individual.

8. Every medical-surgical specialty on the Hospital's Medical Staff which is organized as a

department or clinical service and where practitioner staffing is sufficient, shall have a schedule to provide coverage to the emergency service by attending physicians in a timely manner, 24 hours a day, seven days a week, in accordance with patient needs. A nurse practitioner or physician assistant, who has a scope of practice at Lourdes Hospital, and who is under the supervision of an on-call physician appointee, may provide evaluation of an emergency medical condition in the emergency department in place of the on-call physician appointee, unless in the judgment of the ED physician or the patient's attending physician, the on-call physician appointee should evaluate the patient. Such a substitution requires subsequent communication among the on-call physician, emergency department physician and nurse practitioner/physician assistant in regard to appropriate stabilizing treatment and other disposition in the emergency department. The on-call physician must co-sign the record within 24 hours of the patient's visit to the emergency department.

9. Registered physician's assistants and nurse practitioners:

   (a) Patient care services provided by registered physician's assistants shall be in accordance with section 405.4 of the New York Code of Rules and Regulations.

   (b) Patient care services provided by certified nurse practitioners shall be in collaboration with a licensed physician whose professional privileges include approval to work in the emergency service and in accordance with written practice protocols for these services.

   (c) The registered physician's assistants and the nurse practitioners shall have current ACLS certification or the equivalent and shall have training and experience in

trauma management equivalent to ATLS.

10. The emergency service Medical Staff shall assure that all persons arriving at the emergency service for treatment receive emergency health care that meets generally accepted standards of medical care.

11. Every person arriving at the emergency service for care shall be promptly examined, diagnosed and appropriately treated in accordance with triage policies and protocols adopted by the emergency service and approved by the Hospital. All patient care services shall be provided under the direction and control of the emergency services director or attending physician. In no event shall a patient be discharged unless evaluated and treated as necessary by an appropriately privileged physician, physician's assistant, or nurse practitioner.

12. Emergency service Medical Staff shall develop and implement standard descriptions of patients in need of specialized emergency care and have triage protocols. Patients in need of specialized emergency care shall include, but not be limited to:

    (a) trauma patients and multiple injury patients;

    (b) burn patients with burns ranging from moderate uncomplicated to major burns as determined by use of generally acceptable methods for estimating total body surface area;

    (c) high risk maternity patients or neonates or pediatric patients in need of intensive care;

    (d) head injured or spinal cord injured patients;

    (e) acute psychiatric patients;

(f) replantation patients; and

(g) dialysis patients.

13. Emergency services Medical Staff shall verbally request ambulance dispatcher services to divert patients with life threatening conditions to other hospitals only when the chief executive officer or designee appointed in writing, determines that acceptance of an additional critical patient would endanger the life of that patient or another patient. Request for diversion shall be documented in writing and, if warranted, renewed at the beginning of each shift.

14. Patients shall be transferred to another hospital only when:

(a) the patient's condition is stable or being managed;

(b) the attending practitioner has authorized the transfer; and

(c) administration of the receiving hospital is informed and can provide the necessary resources to care for the patient; or

(d) when pursuant to paragraph (12) of this subdivision, the patient is in need of specialized emergency care at a hospital designated to receive and provide definitive care for such patients.

15. Quality improvement activities of the emergency service shall be integrated with the Hospital-wide quality improvement program and shall include review of:

(a) arrangements for medical control and direction of pre-hospital emergency medical services;

(b) provisions for triage of persons in need of specialized emergency care to hospitals designated as capable of treating those patients;

(c) emergency care provided to Hospital patients, to be conducted at least four times a year, and to include pre-hospital care providers, emergency services personnel and emergency service physicians; and

(d) adequacy of staff training and continuing education.

J. Food and Dietetic Services

1. There shall be a systematic record of diets and menus, consistent with the physician's orders which meet the needs of the patients.
2. Therapeutic diets shall be prescribed by the practitioner or practitioners responsible for the care of the patients.

K. Housestaff

1. Policies regarding Housestaff Supervision, Attending Physician Responsibilities on Teaching Services, Housestaff Responsibilities on Teaching Services, and Housestaff Procedure Credentialing Policy are maintained by the Vice President of Medical Affairs and Medical Education.
2. Housestaff have no independent activity at the Hospital. All activity must be supervised by an attending physician who has full Medical Staff privileges at Lourdes Hospital.
3. Level of supervision is determined by the Housestaff Procedure Credentialing Policy.
4. Any entry into the patient medical record, e.g. history and physical examination, progress notes, orders, must be countersigned by the attending physician within 24 hours.

L. Institutional Review Board (IRB) Review

Medical Staff agrees to follow IRB review guidelines and regulations established by the Department of Health and Human Services (DHHS), National Institutes of Health (NIH), Office for the Protection from Research Risks (OPRR) and the Food and Drug Administration (FDA).

This includes the following:

1. emergency use of a test article (under FDA criteria) in a systematic investigation designed to develop or contribute to general knowledge;
2. all compassionate drug program protocols;
3. Community Clinical Oncology Program (CCOP) protocols which plan, accrue, and actively treat subjects on protocol;
4. Cooperative Oncology Group(COG) protocols which plan, accrue, and actively treat subjects on protocol;
5. drug studies requested by pharmaceutical companies, whether in inpatient or primary care settings; and
6. any and all research.

M. Laboratory Services

1. The Hospital shall ensure that all laboratory services are conducted under the supervision of a director who holds a certificate of qualification issued by the New York State Department of Health.
2. The laboratory director shall:

(a) provide technical supervision of all laboratory services, regardless of site;

(b) assure that all tests, examinations and procedures are properly performed, recorded and reported;

(c) assure that all tests for Hospital patients are ordered by a practitioner so authorized by the Hospital;

(d) assure that appropriate signatures are on all cytology and histopathology reports and that all reports are filed with the patient's medical record and duplicate copies kept in a manner which permits ready identification and accessibility;

(e) assure that the laboratory staff:

(i) have appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;

(ii) are sufficient in number for the scope and complexity of the services provided; and

(iii) receive inservice training appropriate to the type and complexity of the laboratory services offered; and

(f) assure that there is a documented quality control program in effect for all laboratory services and in conjunction with the Hospital-wide quality assurance program.

3. Tissue pathology services shall be provided by and under the direction of a pathologist possessing a certificate of qualification issued by the New York State Department of Health. The Medical Staff and the pathologist shall identify which tissue specimens require a macroscopic examination only and which tissue specimens require both

macroscopic and microscopic examinations. Policies and procedures pertaining to the receipt and holding of tissue specimens shall be developed and implemented and shall, at a minimum, include the following:

(a) a pathologist shall be responsible for verifying the receipt of tissues for examinations;

(b) a plan is established in the absence of a pathologist for sending all tissues requiring examination to a qualified pathologist outside the Hospital; and

(c) provisions for maintaining a tissue file in the Hospital.

4. Requests by the attending practitioner for laboratory testing shall contain the clinical indications (ICD 9 code) for the examination which shall be authenticated by the requestor.

5. Laboratory PRN standing orders must be renewed after six months. The patient is responsible for contacting the physician to request a renewal if appropriate.

N. Maternity and Newborn Services

1. The medical record for each maternity patient admitted to the maternity service shall be maintained in accordance with Section O of this Manual and also shall include the following:

(a) a copy or abstract of the prenatal record, if existing, including a maternal history and physical examination as well as results of maternal and fetal risk assessment and ongoing assessments of fetal growth and development and maternal health;

(b) the prenatal record, which may be a legible copy of the attending physician's

office record transferred to the Hospital before admission, however, an interval admission note must be written that includes pertinent additions to the history and subsequent changes in the physical findings. Hepatitis B surface antigen must be part of the prenatal testing;

(c) the results of a current physical examination performed by a member of the Medical Staff or by a certified midwife granted privileges to perform such examination; and

(d) labor and birth information and postpartum assessment.

2. The medical record for each newborn shall be cross-referenced with the mother's medical record and contain the following additional information:

(a) newborn physical assessment, including APGAR scores, presence or absence of three cord vessels, description of maternal-newborn interaction, ability to feed, eye prophylaxis, vital signs and accommodation to extrauterine life; and

(b) orders for newborn screening tests.

3. As a condition of continuing Medical Staff membership, Medical Staff members must provide to maternity patients under their care prenatal care, prebooking arrangements, testing, timely transfer of records and other necessary services.

4. The Hospital shall assure that each prebooked woman receives a written description of available options for labor, delivery and postpartum services. The attending practitioner shall:

(a) advise the woman of options for treatment, care and technological support that are expected to be available at the time of labor and delivery together with the

advantages and disadvantages of each option;

(b) answer fully any questions the woman may have regarding the options available; and

(c) obtain from the woman her informed choice of mode of treatment, care and technological support that are expected to be necessary.

5. The Medical Staff shall, in conjunction with the Hospital and the nursing staff, monitor the quality and appropriateness of patient care and ensure that identified problems are reported to the quality services department together with recommendations for corrective action.

6. Women in need of medical care and services pertaining to pregnancy, delivery and the puerperal period shall be admitted to the maternity and newborn service.

(a) Each patient shall be attended by a licensed and currently registered obstetrician, family practitioner or certified nurse-midwife.

(b) A patient may not be sent home without an appropriate medical screening examination and the prior knowledge and approval of her attending physician or certified nurse-midwife.

7. Evaluation of the patient's condition and need for special care services shall be conducted in accordance with standardized risk assessment criteria based on generally accepted standards of practice which shall be adopted in writing and implemented uniformly throughout the maternity service.

8. Medical Staff in conjunction with the Hospital shall develop and implement written policies and procedures that indicate the areas of responsibility of both medical and

nursing personnel for normal and emergency deliveries. These policies and procedures should be reviewed yearly and made available to all staff. There also shall be written policies for the care of pregnant patients when all antepartum and postpartum beds are occupied.

9. Chemical induction or augmentation of labor may be initiated only after an attending practitioner has evaluated the woman, determined that induction or augmentation is medically necessary for the woman or fetus, recorded the indication, and established a prospective plan of management acceptable to the woman. Induction of labor with oxytocics may be performed only under the direction of an obstetrician with current privileges at Lourdes Hospital. If the attending practitioner initiating the procedure does not have privileges to perform Cesarean deliveries, a physician who has such privileges shall be contacted directly prior to infusion of the oxytocic agent, or other substance used to induce or augment labor, and a determination made that he or she shall be available within 30 minutes of determination of the need to perform a Cesarean delivery.

10. The attending (or covering) practitioner shall initiate, when appropriate, the infusion of the oxytocic agent, or other substance used to induce or augment labor, and remain with the woman for a period of time sufficient to ensure that the drug is well tolerated and has caused no adverse reactions. During the entire time of the infusion of the oxytocic agent, or other substance used to induce or augment labor, the attending (or covering) practitioner shall be available within 10 minutes to manage any complications that may arise.

11. No attempt shall be made to delay birth of infant by physical restraint or anesthesia.

12. The medical record shall be updated to note whenever the woman's choice of the following cannot be honored due to medical contraindications:

    (a) position for labor;

    (b) use of drugs or technological support devices; or

    (c) mode of treatment and care.

    Standing orders for drugs or technological support devices may only be implemented after the nature and consequences of the intervention have been explained to the woman, and the woman agrees to such implementation.

13. The anesthetist shall be informed in advance if complications with the delivery are anticipated.

14. The maternity and newborn service and the Medical Staff shall designate in writing those situations which require consultation with and/or transfer of responsibility from a certified nurse-midwife or a family practice physician to an obstetrician.

15. The practitioner who delivers the baby shall be responsible for the immediate post delivery care of the newborn until another qualified person assumes this duty. At all times, the newborn shall be under the service of a licensed physician or certified nurse-midwife and shall be under the care of a registered professional nurse.

16. Routine medical evaluation of the neonate's status shall have been conducted or arranged after 24 hours of life, such evaluation to include newborn screening for the following: phenylketonuria, branched chain ketonuria, homocystinuria, histidinemia, galactosemia, adenosine deaminase deficiency, homozygous sickle cell disease, and hypothyroidism.

17. Members of the Departments of OB/GYN and Family Practice and medical

associates/medical assistants providing obstetrical care to patients are required to have current certification in Neonatal Advanced Life Support.

18. Members of the Department of Pediatrics providing care to newborn patients are required to have current certification in either Neonatal Advanced Life Support or Pediatric Advanced Life Support.

O. Medical Records

1. The attending physician shall be responsible for the preparation of a complete, legible medical record for each patient.

2. Members of the Medical Staff shall be responsible for completing their respective portion of the medical records within 30 days following discharge or visit date. Failure to complete records in a timely manner will result in suspension and possible revocation of Medical Staff appointment and clinical privileges in accordance with the Credentialing Policy.

3. Medical records shall be legible, accurately documented, properly filed, accessible and retained according to current State regulations.

4. Original medical records, or information from the record~~s~~ shall only be released to Medical Staff physicians participating in the care of the patient. Any additional release of patient information will be based on the current Health Information Management Services Release of Information policy.

5. Medical records may be used for research purposes with the appropriate patient consent and IRB approval. The original medical record may not be removed from the Hospital.

6. Patient evaluations, documentation of care, and orders shall be promptly recorded in the

patient's medical record. All entries shall be authenticated and dated. Authentication may include signature, written initials or electronic verification. Verbal orders must be authenticated within 48 hours.

7. All records shall document, as appropriate, at least the following:

(a) Evidence of a history and physical examination, including documentation of chief complaint, history of present illness, past history (medical and surgical), family history, social history, review of systems, immunizations (where applicable), medications, allergies, physical examination, impression/assessment, and plan of care, performed by a member of the Lourdes Hospital Medical Staff: 1) in the case of an admitted patient, no more than 30 days prior to admission (with significant changes recorded at the time of admission) or within 24 hours after admission; or 2) in the case of outpatient surgery or invasive medical procedure (excluding emergency procedures), no more than 30 days prior to the outpatient surgery or invasive medical procedure, with an update note recorded at the time of the procedure.

The update note documenting the reassessment of the history and physical examination shall include the following, as necessary:

(1) A physical examination of the patient to update any components of the patient's current medical status that may have changes since the prior history and physical examination or to address any areas where more current data is needed. The note should document and address as necessary the patient's current status and/or changes to the patient's status,

regardless of whether there are any changes. Any changes in the patient's health status or any pre-existing conditions must be clearly documented and evaluated. If there is no change to the patient status, "no change" should be documented in the patient's record and signed by the practitioner performing the examination update.

(2) In the case of outpatient surgery or invasive medical procedure, the current record must document/address any contraindication to surgery and/or anesthesia. The information documented should confirm that the necessity for the procedure or care is still present, and that the history and physical examination is still current, appropriate to the patient and to the admission/surgery.

All history and physical examination records, including updates, must be included in the patient's medical record:

(1) in the case of an admitted patient, within 24 hours after admission;

(2) in the case of outpatient surgery or invasive medical procedure, prior to surgery or procedure.

(b) Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient;

(c) Documentation of all complications, Hospital acquired infections, and unfavorable reactions to drugs and anesthesia;

(d) All practitioners' diagnostic and therapeutic orders, nursing documentation, care plans, reports of treatment, medication records, vital signs, diagnostic imaging,

laboratory reports, and other information necessary to monitor the patients condition;

(e) Properly executed consent forms for procedures and treatments; and

(f) Discharge summary including admitting diagnosis, principal diagnosis, secondary diagnosis, all procedures, treatment, course in the Hospital, disposition including provisions for follow up care and instructions to the patient.

8. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability.

9. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This information shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations that are so verified on the record. Consultations shall be performed only by a member of the Lourdes Hospital Medical Staff.

11. Discharge summaries will be dictated by the time of discharge.

12. For all operative and high risk procedures, a written report describing techniques, findings, complications, tissues removed or altered and the general condition of the patient shall be placed in the record immediately following surgery and signed by the surgeon. An operative report shall be dictated as soon as practical following the procedure, but in no event not to exceed 24 hours, and contain: pre and post operative diagnosis, procedures performed, findings, specimens removed

13. Symbols and abbreviations may be used only when they have been approved by the Utilization Management Committee. An approved abbreviation list shall be available on the Lourdes Intranet.

14. Medical records, including all test results and films, are the property of the Hospital and shall not be removed without the consent of the chief executive officer or his or her designee.

15. A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the Utilization Management Committee and Medical Executive Committee. A letter verifying permission to permanently file the record will be signed by the Director of Health Information Management Services and the President of the Medical Staff.

16. A physician's standard orders, when applicable to a given patient, shall be reproduced in detail on the order sheet, dated and signed by the physician. All physician's written standing orders shall be received by the Director of Health Information Management Services and reviewed and approved by the appropriate Medical Staff committee.

17. In accordance with New York State Code 405 regulations, medical students, in the course of their educational curriculum, may take patient histories, perform complete physical examinations and enter findings in the medical record of the patient with the approval of the patient's attending physician. All medical student entries must be countersigned within twenty-four hours by an appropriately privileged physician. Also, medical students may be assigned and directed to provide additional patient care services under the direct, in person, supervision of an attending physician or authorized post graduate

trainee. Specific identified procedures may be performed by medical students under the general supervision of an attending physician provided that the Medical Staff and the medical school, affirm in writing, each individual student's competence to perform such procedures.

18. Certificates of Live Births are to be filed within five days. The delivering practitioner will sign the prepared certificate as soon as possible within this time frame.

19. Certificates of Fetal Deaths are to be filed within 72 hours.

20. Certificates of Death are to be completed by the attending physician or nurse practitioner in a timely fashion.

21. Co-signature requirements for nurse practitioners, physician assistants, and radiology assistants shall be as follows:

    (a) Inpatients and Patients Admitted for Outpatient Surgery or Procedure:

        (1) Co-signature by the collaborating physician shall be required for histories and physicals, and within 24 hours, for an initial consult.

        (2) Co-signature by the collaborating physician shall not be required for orders, progress/procedure notes, and discharge summaries/notes.

    (b) Ambulatory Office and Emergency Department:

        There are no co-signature requirements for ambulatory office or emergency department visits.

    (c) Pre-operative History and Physical

        A nurse practitioner or physician assistant may perform a pre-operative history and physical if the below conditions are met:

(1) The history and physical form is co-signed by the collaborating/ supervising physician. If the physician is unwilling to sign the form, then the physician will be responsible for performing the exam.

(2) Pre-op histories and physicals, performed by a nurse practitioner or physician assistant, shall stand as sufficient when assessment concludes as ASA Class I or Class II. ASA Class III and higher require a history and physical by an appropriately credentialed member of the Lourdes Medical Staff.

P. Outpatient Services

Outpatient services, including ambulatory care services and extension clinics, shall be provided in a manner which safely and effectively meets the needs of the patients.

1. The Hospital-based ambulatory surgery service shall be directed by a physician found qualified by the governing body to perform such duties.
2. The governing body and the Medical Staff shall develop, maintain and periodically review a list of surgical procedures which may be performed in the service. The Medical Staff shall assure that procedures performed in the service conform with generally accepted standards of professional practice, in accordance with the competencies of the medical and professional staff who have privileges in the Hospital-based ambulatory surgery service, and are appropriate in the facilities and consistent with the equipment available. The Medical Staff shall, based upon its review of individual Medical Staff qualifications, recommend to the governing body specific surgical procedures which each

practitioner is qualified to perform in the Hospital-based ambulatory surgery service.

3. The Medical Staff shall approve all Hospital-based ambulatory surgery written policies. The policies must provide a mechanism to assure that complications of surgery or anesthesia, which occur before and after discharge, are identified and documented in the patient's medical record.

4. The Hospital-based ambulatory surgery service shall have an organized system of quality assurance approved by the Medical Staff and the governing body which undertakes investigations into operative results of surgical procedures performed on the service and maintains statistics on operative failures and complications.

5. Prior to surgery, each patient shall have a timely history and physical examination, appropriate to the patient's physical condition and the surgical procedures to be performed, which shall be recorded in the patient's medical record.

6. Each post surgery patient shall be observed for postoperative complications for an adequate time period as determined by the attending practitioner and the anesthesiologist. The services shall have written policies for Hospital admission of patients whose postoperative status prevents discharge and necessitates inpatient admission.

7. Detailed verbal instructions understandable to the patient, confirmed by written instructions, and approved by the Medical Staff of the Hospital-based ambulatory surgery service shall be provided to each patient at discharge, to include at least the following:

   (a) information about complications that may arise;

   (b) telephone number(s) to be used by the patient should complications or questions arise;

(c) directions for medications prescribed, if any;

(d) date, time and location of follow-up visit or return visit; and

(e) designated place to go for treatment in the event of emergency.

Q. Performance Improvement

1. Medical Staff shall participate in carrying out the Plan for Improving Organizational Performance as approved by the Medical Executive Committee and the Board of Directors, or such other plan as may govern peer review activities, and shall participate in and monitor quality assurance activities.

2. Medical Staff shall review the care provided by the Medical Staff and other health care practitioners, including but not limited to:

(a) peer review activities; and

(b) morbidity and mortality reviews.

R. Pharmaceutical Services

1. The Hospital shall provide pharmaceutical services that are available at all times on the premises to meet the needs of the patients.

2. The pharmacy shall be responsible, in conjunction with the Medical Staff, for ensuring the health and safety of patients through the organization, management and operation of the service in accordance with accepted professional principles and the proper selection, storage, preparation, distribution, use, control, disposal and accountability of drugs and

pharmaceuticals.

3. The director in conjunction with designated members of the Medical Staff, shall ensure that:

   (a) information relating to drug interactions, drug therapies, side effects, toxicology, dosage, indications for use, and routes of administration is available to the professional staff;

   (b) a formulary is established to meet the needs of the patients for use in the Hospital to assure quality pharmaceuticals at reasonable costs; this formulary is reviewed at least annually and updated as necessary;

   (c) standards are established concerning the use and control of investigational drugs and research in the use of recognized drugs;

   (d) clinical data are evaluated concerning new drugs or preparations requested for use in the Hospital; and

   (e) the list of floor stock medication is reviewed and recommendations are made concerning drugs to be stocked on the nursing unit floors and by other services.

4. All abuses and losses of controlled substances shall be reported to the director, and to the Medical Staff, as appropriate, in accordance with applicable Federal and State laws.

5. The hospital has a policy of using approved formulary equivalents in place of name brand pharmaceuticals as a cost-effective measure. The pharmacy will, from time to time, seek permission of each Medical Staff member to use the formulary equivalents for all of the member's pharmacy orders unless indicated otherwise by the member on a particular order.

S. Radiation Oncology

1. A radiation oncology service shall be directed by a board certified radiation oncologist.

2. A radiation oncology service shall have on staff:

   (a) one full-time New York State licensed radiation therapist for every MEV unit; and

   (b) a full-time registered professional nurse with appropriate education and experience.

3. A facility with a radiation oncology service shall have on staff or through formal arrangements:

   (a) a board admissible or board certified medical oncologist, hematologist or other specialist who devotes at least 80 percent of his/her practice to medical oncology and who treats not fewer than 175 oncology patients per year; and

   (b) a radiological physicist who will be involved in treatment, planning and dosimetry as well as calibration of the equipment, and who holds a degree in physics and who is either certified or admissible for certification by the American Board of Radiology or the American Board of Health Physicists; or

   (c) a person holding a degree in physics and having full-time radiation therapy experience; or

   (d) a physicist in training or a dosimetrist supervised by a part-time radiological physicist.

4. The radiation oncology service shall be part of a multidisciplinary approach to the management of cancer patients, involving a variety of specialists in a joint treatment

program, either through formal arrangement or in the facility.

5. Each patient shall have a treatment plan in his/her medical records.

T. Rehabilitation Services

1. Rehabilitation services shall be ordered by the attending physician or authorized practitioner(s) and provided in accordance with a written multidisciplinary treatment plan which is based upon a functional assessment and evaluation performed and documented by a professional who is qualified under the provisions of the New York State Education Law, and shall include the diagnosis or diagnoses, precautions and contraindications, and goals of the prescribed therapy.

2. Medical Staff shall work in conjunction with nursing staff and rehabilitation service staff to ensure the identification of patients and delivery of appropriate services.

   (a) The multidisciplinary treatment plan shall identify patient needs, establish realistic and measurable goals and identify specific therapeutic interventions by type, amount and frequency needed to maintain, restore and/or promote the patient's functioning and health, within stated time frames for achievement.

   (b) The multidisciplinary treatment plan shall be prepared by rehabilitation service staff with the involvement of the practitioner who ordered the services, the nursing staff, as well as the patient and the family to the extent possible.

   (c) The patient's progress and response to treatment shall be assessed on a timely and regular basis, in accordance with Hospital policies and procedures, and documented in the patient's medical record.

(d) Multidisciplinary treatment plans and goals shall be revised as appropriate in accordance with the assessment of the patient's progress and the results of treatment.

3. Rehabilitation therapy staff shall work with the attending practitioner, the nursing staff, other health care providers and agencies as well as the patient and the family, to the extent possible, to assure that all appropriate discharge planning arrangements have been made prior to discharge to meet the patient's identified needs.

U. Respiratory Care Services

1. Respiratory care services shall be provided in a manner which assures the safe and effective operation and management of staff and services necessary to provide respiratory care to Hospital patients at all times.

2. The services shall be directed by a physician who shall be responsible for the clinical aspects of organization and delivery of all respiratory care services. The physician, or another individual qualified by training and experience, shall direct administrative aspects of the service. The service shall have effective and current written policies and procedures regarding staff assignments, the administration of medication, diluents and oxygen, the maintenance of safety controls and the integration of such services with other related services of the Hospital.

3. Respiratory care services shall be provided in a manner which assures the achievement and maintenance of generally accepted standards of professional medical practice and patient care.

4. Respiratory care services shall only be provided upon the orders of members of the Medical Staff. The orders for respiratory care services shall specify the type, frequency and duration of treatment, and, as appropriate, the type and dose of medication, the type of diluent, and the oxygen concentration.

V. Surgical Services

1. If surgery is provided, the service shall be provided in a manner which protects the health and safety of the patients in accordance with generally accepted standards of medical practice.
2. The surgical service shall be directed by a physician who shall be responsible for the clinical aspects of organization and delivery of all inpatient and ambulatory surgical services provided to Hospital patients. That physician or another individual qualified by training and experience shall direct administrative aspects of the service.
3. Surgical privileges shall be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service shall maintain a roster of practitioners specifying the surgical privileges of each practitioner.
4. In accordance with written policies and procedures developed and implemented by the Medical Staff and approved by the governing body, in any procedure presenting unusual hazard to life based on the individual patient risk factors and complexity of the procedure, there shall be present and scrubbed as first assistant a physician designated by the Medical Staff and the governing body as being qualified to assist in major surgery.

5. All Medical Staff shall comply with all applicable safety precautions, equipment usage and inspections, infection control requirements, cardiopulmonary resuscitation and patient rights requirements pertaining to surgical/anesthesia consents.

6. There shall be a complete history and physical work-up in the chart of every patient prior to any surgery except emergency surgery. Each record shall document a review of the patient's overall condition and health status prior to any surgery including the identification of any potential surgical problems and cardiac problems. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient. Such reports shall be signed to attest to the adequacy and currency of the history and physical or countersigned by the attending surgeon, prior to surgery.

7. When the history and physical examination by a physician member of the staff is not adequately recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the attending practitioner states in writing that such delay would be detrimental to the patient's health.

8. A written, signed, informed, surgical consent by the patient or the patient's legal representative shall be obtained prior to the operative procedures except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. Such consent shall include identification of the practitioner(s) performing the surgical procedure. In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on

the patient's medical record. The anesthesiologist shall not begin the administration of anesthesia until such consent is assured except in extreme emergency.

9. For all operative and high risk procedures, a written report describing techniques, findings, complications, tissues removed or altered and the general condition of the patient shall be placed in the record immediately following surgery and signed by the surgeon. An operative report shall be dictated as soon as practical following the procedure, but in no event not to exceed 24 hours, and contain: pre and post operative diagnosis, procedures performed, findings, specimens removed.

10. Findings of any pathology reports shall be recorded in the patient's medical record and a procedure established and implemented for reporting unusual findings to the patient's attending practitioner or surgeon.

11. All infections of clean surgical cases shall be recorded and reported to the infection control officer. A procedure shall be developed and implemented for the investigation of such cases.

12. All previous order(s) shall be canceled when patients go to surgery under general anesthesia.

13. All tissues removed at the operation shall be sent to a Hospital pathologist who shall make such examination as may be considered necessary to arrive at a tissue diagnosis. This authenticated report shall be made a part of the patient's medical record.

W. Participation in Organized Health Care Arrangement under HIPAA

1. All members of the Medical Staff shall participate with the Hospital in the Hospital's

Organized Health Care Arrangement ("OHCA"), as permitted under patient privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder (“HIPAA”), and as described in the OHCA’s Joint Notice of Privacy Practices. As participants in the OHCA, each member of the Medical Staff shall abide by the Hospital’s privacy policies and the terms of the Joint Notice of Privacy Practices with respect to patient information created or received by such member while exercising privileges at the Hospital’s facilities, or otherwise created or received by, or maintained at, the Hospital.

2. Each member of the Medical Staff shall comply with applicable state and federal laws, rule and regulations, as well as hospital policies and procedures, including but not limited to patient confidentiality and privacy laws, regulations, policies and procedures.

3. Each member of the Medical Staff or other participant in the OHCA shall indemnify and hold other OHCA participants, including the Hospital, its directors, officers, employees, agents and representatives, harmless from and against any claims, losses, damages, verdicts, judgments, actions, fines, penalties or injuries arising as a result of any act or omission of such member or OHCA participant that is in violation of HIPAA, the Joint Notice of Privacy Practices or the Hospital's privacy policies.

4. Any failure by a member of the Medical Staff to comply with the provisions of HIPAA or other privacy laws, the terms of Joint Notice of Privacy Practices or the Hospital's privacy policies, shall be considered an event raising a concern regarding such members conduct, and as such shall be subject to the disciplinary provisions of the Credentialing Policy and the Fair Hearing Policy.

X. General Terms and Conditions

1. When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairman, may delegate performance of the function to one or more designees.

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Originally Approved by the Board of Directors on July 31, 1998

Rules and Regulations Amendments

1. Amendment to *D. Autopsies, #4, pg. 16* to amend time frame for completion of final autopsy report from 90 days to 60 days.
   Approved by the Medical Executive Committee, August 18, 1998
   Approved by the Board of Directors, August 28, 1998

2. Amendment to A. *General Conduct and Responsibility of Medical Staff* to add a new #5, *pg 2,* regarding medical staff cooperation with the Corporate Compliance Policy of Lourdes Hospital.
   Approved by the Medical Executive Committee, March 16, 1999
   Approved by the Board of Directors, March 26, 1999

3. Amendment to *D. Autopsies, #4, pg 16* to add reference to Pathology and Laboratory policies to define a complicated case.
   Approved by the Medical Executive Committee, March 16, 1999
   Approved by the Board of Directors, March 26, 1999

4. Amendment to *O. Medical Records, #7, (a), pg 35 and #9, pg 35* to add the provision that the patient history and physical examination and consultations must be performed by a member of the Lourdes Hospital Medical Staff.
   Approved by the Medical Executive Committee, August 19, 1999
   Approved by the Board of Directors, August 27, 1999

5. Amendment to *A. General Conduct and Responsibility of Medical Staff, #15* to specify that Medical Staff members are required to have a mechanism for coverage and to specify that all covering practitioners must be members of the Lourdes Hospital Medical Staff with clinical privileges.
   Approved by the Medical Executive Committee, July 18, 2000
   Approved by the Board of Directors, July 28, 2000

6. Amendment to *A. General Conduct and Responsibility of Medical Staff, #6* to change Daughters of Charity National Health System to Ascension Health.
   Approved by the Medical Executive Committee, October 17, 2000
   Approved by the Board of Directors, October 27, 2000

7. Amendment to *N. Maternity, #1* to correct reference to Medical Records section as Section O, rather than Section M.
   Approved by the Medical Executive Committee, October 17, 2000
   Approved by the Board of Directors, October 27, 2000

8. Amendment to *O. Medical Records, #12* to revise wording to state that report of procedures should be dictated within 24 hours, rather than in a timely fashion.
   Approved by the Medical Executive Committee, October 17, 2000
   Approved by the Board of Directors, October 27, 2000

9. Amendment to *E. Critical Care and Special Care Services, #2* to add wording that patients admitted to the ICU are evaluated by the attending physician in a prompt and clinically appropriate time frame.
Approved by the Medical Executive Committee, December 12, 2000
Approved by the Board of Directors, January 26, 2001

10. Amendment to *A. General Conduct and Responsibility of Medical Staff, #17* to delete the paragraph that allows the provision that if a practitioner does not sign, date or time an order within the required time period that there be a presumption of authentication if it is evident from the medical record that the practitioner had physically seen the patient within the 24 hour time period.
Approved by the Medical Executive Committee, December 12, 2000
Approved by the Board of Directors, January 26, 2001

11. Review of Medical Staff Rules and Regulations:
Bylaws Committee: January 5, 2001
Medical Executive Committee: April 17, 2001

12. Amendment to *A. General Conduct and Responsibility of Medical Staff, #17* to revise the requirement for the timeframe for authentication of telephone orders (for other than controlled substances) from "not to exceed 24 hours" to "as soon as possible." The provision to allow a covering physician to authenticate a telephone order was deleted. The timeframe for authentication of telephone orders for controlled substances was revised from "within 24 hours" to "in no event more than 48 hours".
Approved by Medical Executive Committee, May 15, 2001
Approved by Board of Directors, May 25, 2001

13. Amendment to *O. Medical Records, #6* to change the timeframe for authentication of telephone orders from "within 24 hours" to "as soon as possible".
Approved by Medical Executive Committee, May 15, 2001
Approved by Board of Directors, May 25, 2001

14. Addition to *R. Pharmaceutical Services,* a new # 5, regarding policy of use of approved formulary equivalents with approval by individual medical staff member.
Approved by Medical Executive Committee, May 15, 2001
Approved by Board of Directors, May 25, 2001

15. Addition to *A. General Conduct and Responsibility of Medical Staff,* a new #26, to institute a meeting attendance requirement for members of the Active Staff.
Approved by Medical Executive Committee, August 21, 2001
Approved by Board of Directors, August 31, 2001

16. Amendment to *O. Medical Records,* #7 (a) to revise the requirements for what should be included in the history and physical examination.
Approved by Medical Executive Committee, August 21, 2001
Approved by Board of Directors, August 31, 2001

17. Amendment to *Q. Performance Improvement,* #1 to include Medical Staff participation in the hospital's Plan for Improving Organizational Performance, other peer review and monitoring activities.
Approved by Medical Executive Committee, August 21, 2001
Approved by Board of Directors, August 31, 2001

18. Amendment to *A. General Conduct and Responsibility of the Medical Staff,* #21 revisions to the consultation section.
Approved by Medical Executive Committee, September 18, 2001
Approved by Board of Directors, September 21, 2001

19. Amendment to *N. Maternity and Newborn Services,* #1(c) to include that a certified midwife may perform a physical exam.
Approved by Medical Executive Committee, September 18, 2001
Approved by Board of Directors, September 21, 2001

20. Amendments to *N. Maternity and Newborn Services,* #'s 9 and 10, to make consistent with hospital policy regarding practitioners authorized to initiate chemical induction or augmentation of labor.
Approved by Medical Executive Committee, September 18, 2001
Approved by Board of Directors, September 21, 2001

21. Amendments to *A. General Conduct and Responsibility of Medical Staff,* # 17, to state that orders for treatment shall be signed and dated, and to specify that *registered* nurses, *pharmacists, and respiratory therapists* are authorized to accept and transcribe verbal orders for medication.
Approved by Medical Executive Committee, November 19, 2002
Approved by Board of Directors, December 6, 2002

22. Addition of a new section *W. Participation in Organized Health Care Arrangement under HIPAA* which requires the participation of all members of the Medical Staff with the Hospital in the Hospital's Organized Health Care Arrangement.
Approved by Medical Executive Committee, March 18, 2003
Approved by Board of Directors, March 28, 2003

23. Amendment to A. *General Conduct and Responsibility of Medical Staff,* #24 to correctly state the name of the two referenced administrative policies.
Approved by Medical Executive Committee, June 17, 2003
Approved by Board of Directors, June 27, 2003

24. Amendment to O. Medical Records, 2. to make consistent with Medical Staff Credentialing Policy regarding failure to complete medical records.
Approved by Medical Executive Committee, September 16, 2003
Approved by Board of Directors, September 26, 2003

25. Amendment to A. General Conduct and Responsibility of Medical Staff, 21. to include a requirement for consultants on-call to the Emergency Department to provide an inpatient consultation if requested by the patient's attending physician.
Approved by Medical Executive Committee, February 17, 2004

Approved by Board of Directors, February 27, 2004

26. Amendment to O. Medical Records, 7. to define the time frame for completion of a history and physical examination for admitted patients and patients undergoing outpatient procedures.
Approved by Medical Executive Committee, February 17, 2004
Approved by Board of Directors, February 27, 2004

27. Amendment to O. Medical Records, 7. to re-define and clarify the time frame for completion of a history and physical examination for admitted patients and patients undergoing outpatient procedures.
Approved by Medical Executive Committee, June 15, 2004
Approved by Board of Directors, June 25, 2004

28. Amendment to S. Radiation Oncology, to delete 6, which required that only physicians employed by Lourdes Hospital could be granted radiation oncology privileges.
Approved by Medical Executive Committee, June 15, 2004
Approved by Board of Directors, June 25, 2004

29. Amendment to O. Medical Records, addition of a new 21., to include co-signature requirements for nurse practitioners and physician assistants for inpatients and for patients admitted for outpatient surgery.
Approved by Medical Executive Committee, September 21, 2004
Approved by Board of Directors, September 27, 2004

30. Amendment to A. General Conduct and Responsibility of Medical Staff, #23, to require that patients admitted to the hospital must be seen by the attending physician or designee in a clinically appropriate time frame, but in no case, not to exceed 12 hours.
Approved by Medical Executive Committee, December 14, 2004
Approved by Board of Directors, January 28, 2005

31. Amendment to A. General Conduct and Responsibility of Medical Staff, #23, to state that newborns must be examined no more than 24 hours after admission.
Approved by Medical Executive Committee, April 18, 2006
Approved by Board of Directors, April 28, 2006

32. Amendment to B. Admission/Discharge of Patient, #6 to reword regarding confidentiality of patient information.
Approved by Medical Executive Committee, April 18, 2006
Approved by Board of Directors, April 28, 2006

33. Amendment to A. General Conduct and Responsibility of Medical Staff, add a new #16 (and renumbered subsequent paragraphs accordingly), which includes wording regarding a medical staff member's responsibility to provide follow-up care to patients when acting as the on-call physician to the Emergency Department.
Approved by Medical Executive Committee, May 16, 2006
Approved by Board of Directors, May 26, 2006

34. Amendment to A. General Conduct and Responsibility of Medical Staff, #22, wording to allow a mid-level practitioner to complete the initial consultation assessment, provided that the supervising/collaborating physician examines the patient and follows up with the attending physician within 24 hours.
Approved by Medical Executive Committee, November 21, 2006
Approved by Board of Directors, December 1, 2006

35. Amendment to I. Emergency Services, *#8*, to include the provision that a nurse practitioner or physician assistant, who is on staff at Lourdes, may provide evaluation of an emergency medical condition in the emergency department, in place of the on-call physician.
Approved by Medical Executive Committee, January 16, 2007
Approved by Board of Directors, January 26, 2007

36. Amendment to A. General Conduct and Responsibility of the Medical Staff #18 to revise to read that orders for treatment shall be in writing, signed, timed, and dated, and allows a covering practitioner to sign a verbal order.
Approved by Medical Executive Committee, June 19, 2007
Approved by Board of Directors, June 29, 2007

37. Amendment to O. Medical Records #7 to revise time frame in which history and physical must be performed.
Approved by Medical Executive Committee, July 17, 2007
Approved by Board of Directors, July 20, 2007

38. Amendment to A. 17 to allow a practitioner who is under a plan of correction to serve as a preceptor for another practitioner or as a supervising physician for an allied health practitioner if approved by the Vice President, Medical Affairs and Medical Staff President.
Approved by Medical Executive Committee, August 21, 2007
Approved by Board of Directors, August 31, 2007

39. Amendment to O. 7. to revise to wording that a history and physical is required for any outpatient surgery or invasive medical procedure.
Approved by Medical Executive Committee, October 16, 2007
Approved by Board of Directors, October 26, 2007

40. Amendment to A. 22 to require the attending physician to directly communicate with the consultant (ie physician-to-physician) for all consultations, when attendance is necessary.
Approved by Medical Executive Committee, June 17, 2008
Approved by Board of Directors, June 27, 2008

41. Amendment to A. 27 to add that the president of the Medical Staff or designee may waive the fine on a case by case basis.
Approved by Medical Executive Committee, July 15, 2008
Approved by Board of Directors, July 25, 2008

42. Amendment to A. 5. to add that any practitioner may contact the Joint Commission to report a safety or quality concern.
Approved by Medical Executive Committee, July 15, 2008

Approved by Board of Directors, July 25, 2008

43. Amendment to A. 22. to clarify that communication for consultations shall be provider-to-provider, rather than physician-to-physician.
Approved by Medical Executive Committee, October 21, 20008
Approved by Board of Directors, October 31, 2008

44. Amendment to O. 12 (Medical Records) and V. 9 (Surgical Services) to be consistent in wording regarding reports of operation.
Approved by Medical Executive Committee, February 16, 2010
Approved by Board of Directors, February 26, 2010.

45. Addition of a new X, General Terms and Conditions.
Approved by Medical Executive Committee, April 20, 2010
Approved by Board of Directors, June 25, 2010

46. Amendment to A. 24. to allow initial visit requirement to be satisfied by a direct admission to the hospital service if accompanied by a complete history and physical done on the day of admission.
Approved by Medical Executive Committee, July 20, 2010
Approved by Board of Directors, July 30, 2010

47. Amendment to A. 24 to require that for newborns, the supervising or collaborating physician must perform either the admitting history and physical or the discharge exam.
Approved by Medical Executive Committee, July 20, 2010
Approved by Board of Directors, July 30, 2010

48. Amendments to A. 18 to: (1) reflect the transition to the electronic health record; (2) include a requirement for read-back of all verbal and telephone orders; (3) update wording from the term "medication" to "pharmacologicals, biologicals, and ancillary testing related to these medications"; (4) update wording of the groups of professionals who are authorized to accept and transcribe orders; (5) require that telephone orders for home care patients must be authenticated within 30 days.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

49. Amendment to A. 19, Standing Orders, to update the language to include written protocols for drugs or biologicals, and to change the word "physician" to "practitioner".
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

50. Amendment to A. 20, Stop Orders, to update the language to be in compliance with CMS requirements, specifically that PRN orders for controlled substances are not valid beyond 72 hours, and that standing orders or specific controlled substances orders for individual patients must be rewritten at least every 7 days.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

51. Amendment to A., to add a new paragraph 21 – Orders – General Guidelines.
Approved by Medical Executive Committee May 14, 2013

Approved by Board of Directors, May 17, 2013

52. Amendment to O. 6. to change the word “phone” to “verbal” and to include the time frame for authentication.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

53. Amendments to O. 13 and O. 15 to change the name from the “Peer Review Committee” to the “Utilization Management Committee”, and to state that the abbreviation list is available on the Lourdes Intranet.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

54. Amendment to O. 20 to allow nurse practitioners to sign death certificates, as allowed by New York State Public Health Law.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

55. Amendment to O. 21, addition of a new paragraph (c) to <u>not</u> require orders placed by a physician assistant to be co-signed by the supervising physician.
Approved by Medical Executive Committee May 14, 2013
Approved by Board of Directors, May 17, 2013

56. Amendment to O.21, revision to change the co-signature requirements for physician assistants for inpatients to make them the same as the co-signature requirements for nurse practitioners, and adds radiology assistants to the provision; and makes one minor wording change
Approved by Medical Executive Committee, August 13, 2013
Approved by Board of Directors, August 16, 2013

57. Amendment to A. 15, to delete the requirement that when patient care responsibilities are transferred to another practitioner, a note covering the transfer of responsibility is entered in the medical record, as a note is not written for patients covered by the hospitalists and groups.
Approved by Medical Executive Committee, August 13, 2013
Approved by Board of Directors, August 16, 2013

58. Amendment to B. 15, revision to delete the word “written” to reflect transition to electronic health record.
Approved by Medical Executive Committee, August 13, 2013
Approved by Board of Directors, August 16, 2013

59. Amendment to A. 24, revision to clarify direct admission H&P requirements, and to make consistent with B. 10.
Approved by Medical Executive Committee, December 10, 2013
Approved by Board of Directors, December 20, 2013

60. Addition to A., a new 28, “Expectations of Attending Practitioners Granted Privileges at Our Lady of Lourdes Memorial Hospital”.
Approved by Medical Executive Committee, December 10, 2013

Approved by Board of Directors, December 20, 2013