MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF SAINT JOSEPH REGIONAL MEDICAL CENTER

MEDICAL STAFF

RULES AND REGULATIONS

OF

SAINT JOSEPH REGIONAL MEDICAL CENTER MISHAWAKA

AND

SJRMC-PLYMOUTH CAMPUS, INC.

Effective Date

June 8, 2021

1.1.1 TABLE OF CONTENTS

PAGE

PAGE

ARTICLE 1

GENERAL

Section 1. Definitions:

The following definitions apply to terms used in these Rules and Regulations:

(a) "BOARD" means the Board of Trustees of Saint Joseph Regional Medical Center.

(b) CHIEF MEDICAL OFFICER" or "CMO" means the individual appointed by the Board to act as the chief medical officer of the Medical Center.

(c) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(d) "DAYS" means calendar days.

(e) "HOSPITAL-TRAINED DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.") who is trained and experienced in hospital practice.

(f) "MEDICAL CENTER" means Saint Joseph Regional Medical Center, or Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

(g) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Executive Committee of the Medical Staff.

(h) "MEDICAL STAFF" means all physicians, hospital-trained dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

(i) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section chairperson, and committee chair.

(j) "MEMBER" means any physician, hospital-trained dentist, and/or podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Medical Center.

(k) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, or hand delivery.

(l) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as

a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

(m) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(n) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(o) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Medical Center.

(p) "PRESIDENT OF THE MEDICAL STAFF" means the individual elected by the Medical Staff to perform the functions outlined in these Rules and Regulations and the related Medical Staff documents.

(q) "SJRMC" means Saint Joseph Regional Medical Center.

(r) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

1.1.1.1.1 Section 2 – Medical Record Terminology:

The terms “note”, “notation”, “record”, “dictate”, “dictation”, “write”, “in writing”, and “written” include entry of information into the electronic health record. The terms “face sheet”, “order sheet”, “progress note”, and “chart” refer to various equivalent elements of the electronic health record. The terms “sign”, “countersign”, “co-sign” and “signature” refer to either a physical signature or to an electronic signature.

ARTICLE 2

ADMISSION

Section 1. Who May Admit Patients:

(a) A patient may be admitted to the Medical Center only by order of a Medical Staff member who is granted admitting privileges. The attending practitioner shall be responsible for the medical care and treatment of the patient in the Medical Center, including appropriate communication among the individuals involved in the patient's care.

(b) Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 2. Admitting Medical Staff Member's Responsibilities:

(a) All patients admitted to the hospital (including newborns) shall be seen within 24 hours of admission (birth), unless previously seen on the day of admission. In Mishawaka, all patients must be seen in the hospital before discharged or transferred even if the patient is in the hospital less than 24 hours. In Plymouth, all patients must be seen in the hospital before discharged even if the patient is in the hospital less than 24 hours.

(b) Patients will be seen by their physicians in a timely manner; stable patients will be seen routinely on a daily basis; critically ill patients will be evaluated more frequently dependent upon the severity of their illness.

Mishawaka Only:

i. Patients admitted to the ICU and SICU should be evaluated by an attending physician promptly or within a maximum of 2 hours after notification of admission, if not examined immediately prior to admission. If patient being moved to be monitored solely for drug therapy then the patient should be seen within 12 hours like PCU.
ii. Patients admitted to PCU need to be examined by an attending physician promptly or within 12 hours after notification of admission.

Plymouth Only:

i. Patients admitted to the Critical Care Unit (CCU) should be evaluated by an attending physician promptly after notification of admission, if not examined immediately prior to admission. If the attending physician is not physically present at hospital when notified of the admission, physician will be en route to hospital within 15 minutes of notification of admission in order to perform such evaluation. If

patient is being moved to be monitored solely for drug therapy then the patient should be seen within 12 hours.

(c) Any critically ill patient shall be seen promptly after the physician has been notified of an unstable condition. A critically ill patient is defined as one who is unstable as defined by policy. After their initial assessment, all patients shall be seen once in every 24-hour period thereafter.

(d) Each patient shall be the responsibility of the attending Medical Staff member. The attending Medical Staff member shall be responsible for the medical care and treatment of the patient while in the Medical Center, including daily physician rounding with appropriate daily documentation, prompt and accurate completion of the medical record, necessary patient instructions, and transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient.

i. SJRMC Mishawaka only: The supervising/collaborating Medical Staff member or designee may request a Nurse Practitioner or Physician Assistant who has been granted privileges as an Allied Health Professional (AHP) to visit patients of their supervising/collaborating Medical Staff member in place of the supervising/collaborating Medical Staff member; however, the Medical Staff member or designee shall review all patient encounters daily and see all patients at least every other day.

ii. SJRMC Plymouth only: When there is more than one Practitioner involved in the care of a patient who is being admitted, or when there is a lack of agreement as to which Practitioner will be the attending Practitioner of record, the attending Practitioner of record will be the Practitioner whose specialty concerns is the principal reason for admission. If the principal reason for admission is for surgery, the surgeon is to be the attending practitioner. Surgeons are required to see all major and minor surgery post op patients post op day 1 for their post-surgery follow-up visit if they are not discharged on post op day 1. Patient care can be transferred to another Medical Staff member with the same or similar clinical privileges for the principal reason for admission if coverage is needed. Patient care can be transferred to a primary care specialist Medical Staff member if the surgical episode of care is complete after post op day 1 visit if this is considered minor surgery. Exceptions include patients in the critical care unit at Plymouth Medical Center where the intensivist becomes the attending if there are co-morbidities.

(e) The admitting Medical Staff member (or designated office employee) shall notify the administrative supervisor at Plymouth or nursing supervisor at SJRMC of each admission and shall provide all required information regarding the admission prior to sending the patient to the Medical Center.

(f) Whenever the Medical Staff member's responsibilities are transferred to another Medical Staff member, an order covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record. This order, by itself, will not usually constitute an adequate transfer of care. As with all physician consultations, direct physician-to-physician communication is the preferred method of information transfer. The practitioner shall be responsible for verifying the Medical Staff member's acceptance of the transfer and for giving verbal report of the patient's condition, current plan of care, significant changes in health status and any other information vital to the efficient care of the patient to the receiving physician.

(g) The admitting Medical Staff member shall provide the Medical Center with any information concerning the patient that is necessary to protect the patient, other patients or Medical Center personnel from infection, disease or other harm, and to protect the patient from self-harm.

Section 3. Care of Unassigned Patients:

In the case where a patient who is evaluated by the emergency department requires Medical Center admission and does not have an attending physician with clinical privileges at the Medical Center, or has not requested that a specific member of the Medical Staff with the appropriate clinical privileges assume his or her care, the patient shall be assigned to the appropriate on-call Medical Staff member.

Section 4. Alternate Coverage:

(a) Each Medical Staff member shall provide professional care for his/her patients in the Medical Center by being available or making arrangements with an alternate Medical Staff member who has appropriate clinical privileges at the Medical Center to care for the patients.

(b) If an attending physician or that physician's designated call group is going to be unavailable to care for a patient, the attending physician shall document on the order sheet of the chart the name of the alternate Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability.

Section 5. Transfer of Patients to Another Facility:

(a) Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel. When the Medical Center does not provide the services required by a patient or for any reason the Medical Center cannot admit a particular patient who requires inpatient care, the Medical Center and/or the attending physician shall assist the patient in making arrangements for care at another facility so as not to

jeopardize the health and safety of the patient. Such transfer shall not occur until the patient's condition has been sufficiently evaluated and it has been determined by the attending physician that the patient's medical condition is stable enough for transport and that the benefits available at the receiving medical facility outweigh any risk associated with transport.

(b) A patient may be transferred to another medical facility at his/her request or at the request of the patient's representative if the patient is judged incapable of making such decision. Such a transfer request can only be granted after the attending physician determines that the patient's medical condition is stable enough for transport and that the transport shall not adversely affect the patient's condition or jeopardize the patient's health.

(c) If the patient is to be transferred to another medical facility, the attending physician shall enter all pertinent information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has agreed to accept the patient.

(d) If the patient is transferred to another medical facility, the Medical Center and/or attending Medical Staff member shall provide a copy of the patient's medical record to the receiving facility.

Section 6. Continued Hospitalization:

(a) The attending Medical Staff member shall be required to document daily the need for continued hospitalization. The attending Medical Staff member's documentation must contain:

(1) an adequate written or dictated record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(b) Upon request of the MEC, or its designee, the attending Medical Staff member must provide written justification of the necessity for continued hospitalization for any patient who has been in the Medical Center for the specified period of time documented in the Utilization Plan, and shall include an estimate of the number of additional days of stay, the reason for continued stay, and plans for post-hospitalization care. This report must be submitted within twenty-four (24) hours of the request. Failure to comply with this requirement may result in action by the MEC.

(c) If the MEC or its designee decides that continued hospitalization is not medically necessary, written notification must be given, no later than two (2) days after the determination, to the Medical Center, the patient, and the attending Medical Staff member.

Section 7. Qualified Medical Personnel for Medical Screening

(a) When an individual, by himself or herself or with another person, comes to the Emergency Department, and a request is made on the individual's behalf for a medical examination or treatment, the Hospital must provide for an appropriate Medical Screening Examination within the capability of the Hospital's Emergency Department, including ancillary services routinely available to the Emergency Department, to determine whether an Emergency Medical Condition exists, or with respect to a pregnant woman having contractions, whether the woman is in Labor.

(b) Medical Screening Examinations must be performed by individuals who are:
a. Determined qualified by Hospital Medical Staff Rules and Regulations which are approved by the Hospital's Board of Trustees, and
b. Functioning within the scope of their license and are in compliance with state law.

(c) Medical Executive Committee approved Qualified Medical Personnel include:
a. Mishawaka Medical Center:
    i. Residents
    ii. Emergency Medicine Nurse Practitioners and Physician Assistants
    iii. Midwives
b. Plymouth Medical Center:
    i. Obstetric Registered Nurse

(d) If a physician is not physically present at the time a patient is transferred, a Qualified Medical Personnel shall sign a certification, after consultation with a physician, and physician agrees with the certification and subsequently countersigns the certification.

ARTICLE 3

MEDICAL ORDERS

Section 1. General Requirements:

(a) To improve patient safety SJRMC expects physicians to enter their orders using computerized physician order entry. Only under special circumstances will verbal, telephone, or written orders be accepted. Special circumstances as defined in Article 3 Section 3.a.

(b) Orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written shall not be carried out until they are clarified by the ordering Medical Staff member and are understood by the appropriate health care provider.

(b) The use of the terms "renew," "repeat," "resume," and "continue" with respect to previous orders is not acceptable.

(c) Orders for "daily" tests shall state the number of days and shall be reviewed by the attending Medical Staff member at the expiration of said days unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format that it was originally recorded if it is to be continued.

(d) Orders for all medications and treatments for all patients shall be under the supervision of the attending physician and shall be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

(e) All orders must be reviewed and updated when a patient is transferred from one level of care to another.

(f) When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped must be rewritten.

Section 2. Who May Write Orders:

(a) Medical Staff members and allied health professionals shall have the authority to write orders only as permitted by their licenses and by the clinical privileges or scope of practice and as specified in hospital policy.

(b) All orders must be entered in the patient's record, dated, timed, and authenticated by the responsible practitioner.

Section 3. Verbal Orders:

(a) A verbal order (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is impractical for such order to be given in writing by the responsible practitioner. Special Circumstances in which Verbal or Telephone orders will be accepted:

i. During procedures including, but not limited to, intra-operative and intra-partum orders as well as orders given during cardiac catheterization or interventional radiology procedures;
ii. During emergent patient care or at any time when patient safety would be compromised, and;
iii. When the physician is unable to access the computer physician order entry system in a timely fashion.

(b) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the medical record of the patient. The individual accepting the verbal order shall read the complete order back to the ordering practitioner for verification and shall note in the medical record that read-back of the order occurred.

(c) A verbal order shall include the date, time, and full signature and title of the person to whom the verbal order has been given and shall be authenticated by the prescribing Medical Staff member within forty-eight (48) hours unless a read back and verify process is utilized as follows:

i. Hospital policy provide for a read back and verify process for verbal orders which required that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct, and
ii. The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified

Where the above read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.

If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge..

(d) Acceptance of a verbal order is limited as defined in hospital policy.

ARTICLE 4

MEDICAL RECORDS

Section 1. General Rules:

(a) A medical record shall be maintained for each patient who is evaluated or treated as an inpatient, outpatient, or emergency patient. The attending Medical Staff member shall be responsible for the preparation of a complete, accurate, and legible medical record for each patient under his/her care.

(b) The contents of the record shall be pertinent and current. A single attending physician shall be identified in the medical record as being responsible for the patient at any given time.

(c) Documentation of communications, secure messaging and other relevant exchanges during an episode of care via mobile device. An increased use of mobile devices for communication, monitoring of care and ordering of treatment necessitate a vigilant method of incorporating those exchanges within the health record to ensure a complete, accurate and accessible record of care and treatment. Providers should make every effort to include documentation of relevant conversations, secure email exchanges, video conferences; events related to remote monitoring of patient's and other health information conducted via mobile device.

(d) Only those abbreviations, signs, and symbols authorized by the Medical Center shall be used in the medical record per hospital policy. No abbreviations, signs or symbols shall be used to record a patient's final diagnoses, any unusual complications, or discharge orders. An official record of approved abbreviations shall be kept on file in the Health Information Management Department. The Medical Center shall also maintain a list of abbreviations that are not acceptable for use.

(e) All routine medical orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and shall be dated and signed by the attending physician or other appropriate practitioner.

(f) The following requirements shall be enforced by the MEC or its designee:

i. histories and physicals must be documented on the chart within twenty-four (24) hours following admission of the patient; a brief written note identifying the patient’s admitting diagnoses and plan of care may be made at the time of the attending physician’s initial evaluation;

ii. Short Stay H&Ps and Final Progress Notes may be dictated or handwritten. All other H&Ps should be documented within 24 hours

after admission of the patient, and an adequate admission note may be written at the same time.

iii. all consultations shall contain the date and time of the consultation and shall be documented on the patient's chart within twenty-four (24) hours of the consultation in accordance with Article 5 of these Rules and Regulations;

iv. all surgical procedures performed shall be fully described by the operating surgeon who shall record information immediately after the procedure as required by Section 7 of this Article; and

v. when an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, and the complete protocol shall be made part of the record within thirty (30) days unless exceptions for special studies are authorized by the MEC.

Section 2. Authentication:

(a) Authentication means the author or responsible individual has reviewed the clinical content of the order and validated an entry in the medical record by a unique identifier such as a number or computer key, a full signature, written initials if full signature appears on the same page.

(b) All entries in the medical record shall be dated, timed and authenticated by the person making the entry.

Section 3. Contents:

(a) A complete medical record shall include:

(1) identification data, including the patient's name, gender, address, date of birth, and the name of any legally authorized representative, and, if the patient is receiving behavioral health care services, the record shall state the legal status of the patient;

(2) medical history, including:

(i) the chief complaint,

(ii) admitting diagnosis

(iii) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status,

(iv) relevant past, social and family histories,

(v) relevant menstrual and obstetrical history in females,

(vi) an inventory by body systems, and

(vii) drug and food sensitivities/allergic history,

(3) report of a physical examination, including but not limited to vital signs, heart, lungs, neuro and mental status, head, chest, abdomen and extremities;

(4) statement of diagnosis or impressions;

(5) diagnostic and therapeutic orders;

(6) evidence of informed consent when required by hospital policy;

(7) clinical observations;

(8) progress notes;

(9) operative notes;

(10) results of consultative evaluations;

(11) nursing notes, plan of care, and entries of other providers;

(12) reports related to pathology, clinical laboratory, radiology, nuclear medicine, anesthesia, and/or other diagnostic or therapeutic procedures;

(13) documentation of complications or adverse reactions to drugs or anesthesia;

(14) dosages of medications ordered or prescribed, including those prescribed or dispensed upon discharge;

(15) patient's language and communication needs;

(16) evidence of known advance directives;

(17) records of communication with the patient regarding care, treatment, and services;

(18) discharge summary; and

(19) final diagnosis.

(b) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the Health Information Management Committee. All new forms proposed for use in the medical record shall be submitted to the Health Information Management Committee for approval (or rejection). Approved changes shall not be made until the mechanics of standardization have been accomplished. The Health Information Management Committee will forward all medical record forms relating to physician documentation to MEC for endorsement.

(c) The medical record should be maintained intact at all times. Once information has been filed in the record, it should not be removed for any reason.

Section 4. Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the Medical Center. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

(b) Progress note documentation shall include, but need not be limited to, the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(2) any complications, new symptoms or additional diagnoses for which the patient is to be evaluated or treated;

(3) plans for additional workups, consultations, or definitive treatment(s); and

(4) discharge planning.

If the patient's condition is stable and unchanged, a statement documenting that status shall be adequate.

(c) Progress notes can be written by Medical Staff members and allied health professionals as permitted by their clinical privileges or scope of practice and as specified in hospital policy, as applicable.

(d) Physician progress notes shall be written at least daily for all patients who have been admitted to the Medical Center.

Section 5. Surgical Records:

Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery, or the surgical procedure may be subject to cancellation:

(a) verification of the patient's identity, the procedure to be performed, and the site of surgery;

(b) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(c) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(d) provisional diagnosis;

(e) laboratory test results, if applicable (including those obtained from sources outside of the Medical Center);

(f) consultation reports;

(g) consent form signed by the surgeon and the patient or the patient's legal representative, and an anesthesia consent form signed by the patient or the patient's legal representative and the attending anesthesiologist or anesthetist;

(h) x-ray reports, if applicable (including those obtained from sources outside of the Medical Center); and

(i) other ancillary reports, if applicable.

Section 6. Operative Notes and Reports:

(1) A pre-operative note which contains the patient's age, gender, pre-operative diagnosis and recommended surgery or high risk procedure requiring sedation/anesthesia, the risks of the surgery, the choice of anesthesia, a pertinent drug history and any allergies shall be documented in the medical record before the surgery is to be performed.

(2) Reports of pre-operative work-up appropriate to the patient's history and condition, as determined and documented by the attending Medical Staff member, surgeon or anesthetist, shall be part of the medical record prior to the performance of any surgical procedure or high risk procedure requiring sedation/anesthesia.

(3) A history and physical shall be performed for each patient and documented in the medical record prior to any surgical or high risk procedure, including any

procedure to be performed as "same day surgery" under sedation/anesthesia. In any emergency, the attending Medical Staff member shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

(4) A detailed operative report for any surgical or high risk procedure requiring sedation/anesthesia shall be documented. The detailed operative note shall contain:

(1) a description of the surgery and related findings;

(2) the technical procedures performed;

(3) the specimens removed;

(4) the pre and post-operative diagnosis;

(5) the complications encountered;

(6) the names of the primary surgeon and any and all assistants including the significant surgical tasks that were conducted by the assistants; and

(7) the type of anesthesia used;

(8) estimated blood loss; and

(9) prosthetic devices, grafts, tissues, or devices implanted, if any

(5) When a detailed operative report is not placed in the medical record (such as a dictation that has not been immediately transcribed) immediately after a surgical or high risk procedure requiring sedation/anesthesia, a note which includes the following shall be entered immediately:

(1) name of primary surgeon and assistants;

(2) description of procedure;

(3) findings;

(4) technical procedures performed;

(5) specimens removed;

(6) post-operative diagnosis; and

(7) estimated blood loss.

Section 7. Anesthesia and Sedation Rules and Records:

(a) A pre-anesthesia or pre-sedation evaluation shall be documented in the medical record of all patients undergoing surgery, anesthesia, or moderate or deep sedation. The evaluation shall include an assessment of the anesthesia risks, anesthesia, drug and allergy history, any potential anesthesia problems identified, and the patient's condition prior to anesthesia induction. The pre-anesthesia or pre-sedation physical evaluation shall be recorded in the medical record within forty-eight (48) hours prior to the surgery or the administration of anesthesia or sedation.

(b) An individual qualified to administer anesthesia shall review the patient's condition immediately prior to induction of anesthesia or moderate to deep sedation and shall check equipment, drugs and gas supply. A record shall be maintained of all events taking place during the induction and maintenance of, and the emergence from, anesthesia and sedation, including:

(1) the dosage, route, time of administration and duration of all anesthetic agents;

(2) other drugs, intravenous fluids, blood or blood products;

(3) the technique(s) used;

(3) unusual events during the anesthesia period; and

(4) the status of the patient at the conclusion of anesthesia;

(5) continuous recording of patient status noting blood pressure, heart and respiration rate, and

(6) oxygen flow rate;

(c) A post-anesthesia evaluation shall be documented in the medical record of all patients who have undergone surgery, anesthesia, or deep sedation. The post-anesthesia evaluation should begin in post anesthesia recovery but may be completed after the patient is moved to another location or for same day surgery after patient is discharged by the individual who administered the anesthesia, no more than forty-eight (48) hours following the procedure. The post-anesthesia evaluation note shall include:

(1) the patient's physiological and mental status and pain level immediately following the procedure, including the patient's vital signs (pulse and blood pressure, temperature, respiratory rate), cardiopulmonary status,

level of consciousness, airway patency and oxygen saturation and nausea and vomiting;

(2) intravenous fluids administered, including blood and blood products;

(3) all drugs administered;

(4) post-anesthesia visits by the anesthesiologist or anesthetist;

(5) any unusual events or post-operative complications, including any blood transfusion reactions, and the management of those events; and

(6) any follow-up care and/or observations.

(d) Post-operative documentation records the patient's discharge from the post-sedation or post-anesthesia care area by the responsible licensed independent practitioner or physician according to discharge criteria and the record indicates the name of the individual responsible for discharge.

(e) When surgical or anesthesia services are performed on an outpatient basis, the patient shall be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions shall be reviewed with the patient or the individual responsible for the patient.

Section 8. Pathology Reports and Disposition of Surgical Specimens:

(a) All specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnoses. Refer to medical staff policy for exempted tissues.

(b) The pathologist shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra-operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within twenty-four (24) hours of completion, if possible.

(c) Foreign bodies and objects may be referred to the Medical Center pathologist at the option of the attending surgeon.

(d) The disposition of surgical specimens shall be recorded in the operative record immediately following surgery and authenticated by the surgeon.

Section 9. Medical Information from Other Hospitals or Health Care Facilities:

Upon written authorization, if possible from the patient, the Health Information Management Department shall transmit information to other hospitals or health care facilities requesting data concerning the patient's previous admissions, name, birth date, and dates of previous hospitalization. Similarly, the Health Information Management Department or clinical department, upon written authorization, if possible from the patient, may request information from other hospitals or health care facilities concerning the patient.

Section 10. Discharge Summaries:

(a) A documented clinical discharge summary shall be included in the medical records of all patients except:

(1) those with minor problems who require less than a forty-eight (48) hour period of hospitalization;

(2) normal newborn infants; and

(3) uncomplicated obstetrical deliveries.

A progress note, which includes any instructions given to the patient or the patient's representative, may be substituted for the discharge summary of these patients.

(c) The discharge summary shall include:

(1) Final diagnosis

(2) the reason for hospitalization;

(3) any complications;

(4) the procedures performed and treatment rendered;

(5) the condition and disposition of the patient at discharge; and

(6) any specific, pertinent instructions given to the patient or the patient's representative, including instructions for follow-up care;

(d) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission.

(e) When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate and a copy of the preprinted instruction sheet used should be on file.

(f) All discharge summaries shall be authenticated by the attending Medical Staff member.

Section 11. Delinquent Medical Records:

(a) It is the responsibility of each Medical Staff member to prepare and complete medical records in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Medical Center. Specific requirements and timeframes are detailed in medical staff policy.

(b) No Medical Staff member or other individual shall be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

Section 12. Possession, Access and Release:

(a) Medical records shall be used and disclosed only in accordance with the regulations implementing the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 ("the HIPAA Privacy Rule") and the Medical Center's corresponding privacy policies.

(b) All medical records are the property of the Medical Center and shall not be taken from the confines of the Medical Center. Medical records may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with the HIPAA Privacy Rule and the Medical Center's privacy policies. When such a removal is mandated, every reasonable attempt shall be made to notify the attending Medical Staff member. Unauthorized removal of a medical record from the Medical Center by a Medical Staff member shall constitute grounds for a professional review action.

(c) No patient record shall be removed from the Health Information Management Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the President of the Medical Center or a designee for the "health care operations" of the Medical Center, as that term is defined by the HIPAA Privacy Rule.

(d) Members of the Medical Staff may access medical records for research purposes only if they obtain an authorization form from the patient that

complies with the HIPAA Privacy Rule. However, an authorization form is not required in the following instances:

(1) an Institutional Review Board (IRB) or Privacy Board has determined that patient authorization is not required, pursuant to the procedures set forth in 45 C.F.R. § 164.512(i)(2);

(2) access to the medical record is necessary to prepare a research protocol, the medical record will not be copied or removed from the Medical Center, and the information sought is necessary for the research; or

(3) access to the medical record is solely for research on decedents, and the information sought is necessary to that research.

(e) Subject to the approval of the President, former Medical Staff members may access information from the medical records of their patients if necessary for treatment, payment purposes or for medical malpractice action review. Such access shall cover all periods during which former Medical Staff members attended their patients in the Medical Center.

(f) Any record taken out of the Health Information Management Department for the purpose of patient readmission shall be returned with the current record by the charge nurse on the unit upon discharge of the patient.

Section 13. Filing of Medical Record:

A medical record shall not be permanently filed until it is completed by the attending Medical Staff member or is ordered filed by the appropriate Medical Staff committee.

ARTICLE 5

CONSULTATIONS

Section 1. General:

(a) Any individual with clinical privileges at this Medical Center may be requested to provide a consultation within his or her area of expertise.

(b) The attending Medical Staff member shall be responsible for requesting a consultation when indicated.

(c) Requests for a consultation shall be entered in the patient's medical record. For non-Stat and non-Urgent consults, the physician could write for the consult in the patient's medical record to include 1) reason for the consult, 2) level of participation, 3) priority, 4) additional instructions/comments and 5) physician notified, and 6) contact number in case consultant needs to contact him/her. If the history and physical are not part of the patient's medical record and the documentation has not been completed, it shall be the responsibility of the Medical Staff member requesting the consultation to provide this information to the consultant.

(d) Request for consultation would be direct physician-to-physician communication through a phone call or other direct communication for all consultations unless communication between the providers has been established on that patient prior to the consultation. It is also acceptable to have an advance practice clinician to the physician provide this communication or receive this communication as the representative of the physician.

(e) In circumstances of grave urgency, or where consultation is required by these Rules and Regulations or imposed by the MEC, the Board, the President, the CMO, or the President of the Medical Staff, the appropriate clinical department chairperson shall at all times have the right to call in a consultant or consultants.

Section 2. Required Consultations:

(a) As determined by available resources of the hospital, consultations are required for complicated situations that require specific skills of other practitioners; or

(b) Mandatory Consultations:

i. Mishawaka Only: Due to the highly specialized nature of Critical Care Medicine and the potential complexities involved in the care of the critically ill patient, all patients designated for admission to, or transfer into the Medical Intensive Care Unit shall require a mandatory Critical Care consultation. This consultation shall be obtained with the Medical Director of the Medical ICU, or his/her designee. The consult will be obtained immediately upon admission or transfer to the Medical ICU and should be facilitated by direct communication from the Attending/Admitting physician/provider, physician/provider in attendance at the time of transfer of the patient, or the Emergency Department physician/provider.

   This requirement applies to all adult and pediatric patients, with the exception of purely cardiac patients with no significant medical co-morbidities, who meet the designated status criteria for Medical Intensive Care services. This requirement will not apply to Surgical ICU patients, or to patients occupying Intensive Care Unit beds but not meeting the criteria for the Medical ICU admission/transfer.

   Plymouth Only: Due to the highly specialized nature of Critical Care Medicine and the potential complexities involved in the care of the critically ill patient, all patients designated for admission to, or transfer into the CCU shall require a mandatory Critical Care consultation. The consult will be obtained immediately upon admission or transfer to the CCU and should be facilitated by direct communication from the Attending/Admitting physician/provider, physician/provider in attendance at the time of transfer of the patient, or the Emergency Department physician/provider. This requirement applies to all adult patients, with the exception of purely cardiac patients with no significant medical co-morbidities, who meet the designated status criteria for the Critical Care Unit. This requirement will not apply to Surgical CCUL patients, or to patients occupying Critical Care Unit beds but not meeting the criteria for the CCU unit as consistent with patients remaining in the CCU unit for hospital convenience.

ii. When, as a result of peer review activities, a consultation requirement is imposed by the MEC or the Board, pursuant to the Medical Staff Credentials Policy, the required consultation shall not be rendered by an associate or partner of the attending Medical Staff member.

iii. Failure to obtain required consultations may result in a further professional review action pursuant to the Medical Staff Credentials Policy.

Section 3. Contents of Consultation Report:

(a) Each consultation report shall be completed in a timely manner and shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," shall not constitute an acceptable consultation report. The consultation report shall be made a part of the patient's medical record.

(b) Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the surgical procedure. The consultation report shall contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the signature of the consultant.

ARTICLE 6

CRITICAL CARE UNITS

Section 1. Who May Be Admitted:

(a) Patient admission to the adult Critical Care Units - Progressive Care Unit (PCU SJRMC), Critical Care Unit (CCU-Plymouth), Intensive Care Unit (ICU-SJRMC), Surgical Intensive Care Unit (SICU-SJRMC), and Cardiac Interventional Unit (CIU-SJRMC) shall be in accordance with admission criteria established by the Critical Care Committee (SJRMC).

(b) Patient admission to the Neonatal Intensive Care Unit (NICU) shall be in accordance with admission criteria established for the NICU.

Section 2. Admissions and Transfers:

(a) Arrangements for admissions to these units shall be made at the request of the attending Medical Staff member. Written orders shall accompany the patient, or, in an emergency, the attending Medical Staff member may telephone orders to the charge nurse of the unit. In the event of a bed shortage, conflicting requests for admission shall be resolved by the director of the unit.

i. **Direct Admissions:** Patients may be admitted to the unit directly from their homes at the request of the attending Medical Staff member. The Medical Staff member requesting such admission shall notify the administrative supervisor at Plymouth or nursing supervisor at SJRMC of each admission and shall provide all required information regarding the admission prior to sending the patient to the Medical Center.

ii. **Emergency Room:** The need for admission to the CCU from the emergency room shall be determined by the physician examining the patient in the emergency room.

(a) The seriousness of a patient's condition shall be the primary criteria for admission to the unit.

(b) Specific admission and transfer requirements are detailed in hospital policy.

(c) Physician responsibilities pertinent to the admission and transfer of patients are outlined by the Critical Care Committee in hospital policies.

ARTICLE 7

DISCHARGE

Section 1. Who May Discharge:

Patients shall be discharged only upon an order of the attending Medical Staff member. Should a patient leave the Medical Center against the advice of the attending member, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Medical Center's release form.

Section 2. Discharge Planning:

Specific discharge planning requirements are detailed in hospital policy

ARTICLE 8

MISCELLANEOUS

Section 1. Disaster Plan:

The Hospital will maintain a current Disaster Plan to include emergency management planning requirements.

Section 2. Reports:

It shall be the responsibility of each Medical Staff member to report, in writing and confidentially, to the President of the Medical Staff (and/or the President of the Hospital) any conduct, acts, or omissions by other Medical Staff members, which are believed to be detrimental to the health or safety of patients or to the proper functioning of the Medical Center, or which violate professional ethics.

Section 3. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff members shall not discuss with any other individuals the confidential business or discussions that occur within the confines of any official staff meetings or any meetings of Medical Staff committees or departments.

(b) Written attendance records shall be maintained for all meetings of the Medical Staff, and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee.

Section 4. Research Activities:

(a) Participation in research projects by Medical Staff members is encouraged and shall be in accordance with the Medical Center's research policy.

(b) The results of all research projects, clinical, statistical, or otherwise, and all publications written or provided by Medical Staff members using the name of this Medical Center, must be submitted to the President for approval prior to any publication.

Section 5. Orientation of New Medical Staff Members:

All new members of the medical staff shall be provided with an orientation.

Section 6. Treatment of Family Members:

(a) No member of the Medical Staff shall admit or treat a member of his or her immediate family, including spouse, parent, child, or sibling, unless otherwise approved by the President of the Medical Staff, the CMO, or the Chairperson of the relevant department. This prohibition is not applicable to in-laws or other relatives.

(b) An exception to this prohibition will be made if the patient's disease is so rare or exceptional and the physician is considered an expert in the field.

ARTICLE 9

AMENDMENTS

(a) The Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the Medical Center, and shall act as an aid to evaluating performance under, and compliance with, these standards. The Rules and Regulations shall have the same force and effect as the Medical Staff Bylaws and the other Medical Staff documents.

(b) The Rules and Regulations may be amended at any regular or special MEC meeting where (i) at least two-thirds (2/3) of the voting members are present, and (ii) the amendment receives a by majority vote of the MEC members present and voting at the meeting where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least fourteen (14) days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 10

ADOPTION

These rules and regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, policies, manuals or Medical Center policies pertaining to the subject matter thereof.

Discussion Draft April 11, 2007
Facility Specific Bylaws/MEC Final Draft February 12, 2008
System-Wide Task Force Final Revisions February 13, 2008
SJRMC-South Bend Medical Executive Committee Final March 3, 2008
Board of Directors South Bend and Mishawaka March 31, 2008
SJRMC-Plymouth Medical Executive Committee April 21, 2008
SJRMC-Plymouth Board of Directors June 9, 2008

Saint Joseph Regional Medical Center Mishawaka

Adopted by the Medical Staff:	March 3, 2008 December 7, 2009 September 13, 2010 April 11, 2011 February 3, 2014 May 5, 2014 June 6, 2016 November 5, 2018 February 4, 2019 March 1, 2021
Approved by the Board:	March 31, 2008 June 24, 2008 (Board Resolution) December 21, 2009 September 20, 2010 April 25, 2011 February 25, 2014 May 21, 2014 July 28, 2016 November 27, 2018 February 26, 2019 March 30, 2021
Revised Effective Date:	April 1, 2008 July 1, 2008 January 1, 2010

October 1, 2010
April 25, 2011
February 25, 2014
May 21, 2014
July 28, 2016
November 27, 2018
February 26, 2019
March 30, 2021

Saint Joseph Regional Medical Center-Plymouth Campus, Inc.

Adopted by the Medical Staff:	April 21, 2008 August 23, 2010 (MEC) April 18, 2011 May 9, 2014 January 23, 2017 February 18, 2019 March 16, 2021
Approved by the Board:	June 9, 2008 September 14, 2010 May 24, 2011 May 21, 2014 February 21, 2017 February 20, 2019 June 8, 2021
Revised Effective Date:	June 9, 2008 October 1, 2010 June 14, 2011 May 21, 2014 February 21, 2017 February 20, 2019 June 8, 2021