MEDICAL STAFF RULES AND REGULATIONS FOR
COMMUNITY HOSPITAL AND FIRST CHOICE OUTPATIENT
SURGERY CENTER

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I. PURPOSE AND USE OF RULES AND REGULATIONS

These Rules and Regulations are intended to establish guidelines for the conduct of and processes relating to practitioners who have applied for and have been granted Medical Staff appointment and/or privileges by the Board for Community Hospital and First Choice Outpatient Surgery Center (hereinafter “FCOSC”).

These Rules and Regulations are intended to inform appointees to the Hospital’s Medical Staff, of the policies, procedures, protocols, rules, regulations, guidelines, and requirements which apply to them. It is each Medical Staff appointee’s sole responsibility to obtain, read, understand, and abide by all bylaws, policies, procedures, rules, regulations, guidelines, and requirements of the Hospital and its Medical Staff.

These Rules and Regulations have been created pursuant to and under the authority of the Medical Staff Bylaws of Community Hospital. The Rules and Regulations outline the mechanisms that the Medical Staff will utilize to accomplish the functions outlined in the Medical Staff Bylaws. In the event of any conflict in the provisions between the Medical Staff Bylaws and the Rules and Regulations, the provisions of the Medical Staff Bylaws shall be controlling. Any definitions in the Medical Staff Bylaws shall apply to these Rules and Regulations.

II. ADMISSION OF PATIENTS

A. Only Medical Staff members in good standing with the appropriate Medical Staff privileges may admit patients to the Hospital. All practitioners shall be governed by the official admitting policy of Community Hospital (hereinafter “Hospital”).

Except in an emergency, a patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. In emergency cases the admitting diagnosis shall be stated as soon as possible. The admitting practitioner is also responsible for providing information, to the best of their knowledge, concerning a patient to be admitted, regarding any source of communicable disease or significant infection, behavioral characteristics that would disturb or endanger others, or the need for protecting the patient from self-harm.

Patients without a primary care physician, who require admission, will be admitted to the Hospitalist Service or to an appropriate on call specialist.

No admission may be denied on the basis of race, color, creed, gender, national origin, gender identity, or ability to pay.
B. Extended Recovery and Observation. Patients may also be placed in Hospital beds as extended recovery or in observation status. Again, no patient shall be denied care based on race, color, creed, gender, national origin, gender identity, or ability to pay.

For patients following surgery or other procedures requiring a period of monitored recovery and who for some reason (uncontrolled pain, persistent nausea and vomiting) are unable to be discharged safely, may be placed as an extended recovery patient in a Hospital bed.

Observation status is used for those patients who:

i. Have a diagnosis likely to respond quickly to limited treatment;

ii. Have a symptom (abdominal pain, chest pain) where the underlying diagnosis is unclear, therefore; require interval reassessment to determine whether inpatient admission is needed; and

iii. Brief stays following outpatient surgery needed to manage a complication.

C. Suicidal Precautions. For the protection of patient, the Medical Staff, nursing personnel, and the Hospital, precautions are to be taken in the care of a potentially suicidal patient.

If there are no appropriate accommodations in the Hospital, the patient shall be referred, if possible, to another institution were suitable facilities are available.

If referral is not available or possible, the patient may be admitted to the intensive care unit (hereinafter “ICU”) of the Hospital where they can be closely observed. If an ICU bed is not available the patient may be placed on the Med/Surg Unit with 1:1 observation in the room by a member of the patient care team.

Any patient known or suspected to be suicidal should have consultation by an appropriate member of the Medical Staff or Allied Health Professional Staff.

III. ADMISSION HISTORY AND PHYSICAL EXAMINATION

A complete and legible admission history and physical examination report shall be performed and charted within 24 hours of admission. The history and physical examination report must include patient identification data, the chief complaint, details of the present illness, relevant past medical history (allergies, medications, and previous surgery and illnesses), social and family history and a review of body systems, as well as a complete physical examination. An osteopathic exam should include a musculoskeletal examination.
A. History and Physical Examination Prepared Prior to Admission. If a qualified member of the Medical Staff has performed a complete history and physical examination within thirty (30) days prior to the patient’s admission to the Hospital, a legible copy of the report may be used in the patient’s Hospital medical record, provided that an interval admission note is recorded that included all additions to the history and any changes in the physical findings subsequent to the original report.

B. History and Physical Examination from Prior Admission. When a patient is readmitted to this Hospital within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available. If the patient is admitted for a new or different disease process, then another complete history and physical examination shall be competed and placed on the chart.

C. Preoperative Documentation of History and Physical Exam. A relevant history and physical examination is required on each patient having surgery. Except in an emergency, certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until a legible history and physical examination is on the chart. In cases of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient’s condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency surgery has been completed. Appropriate advance laboratory and other diagnostic tests must be performed and documented in the medical record prior to induction of anesthesia for any elective surgery. An update to the history and physical examination is required for any history and physical completed prior to the day of surgery.

D. Preoperative Anesthesia Evaluation. The anesthesiologist or other licensed independent professional responsible for the patient’s anesthesia care must conduct and document in the record a preanesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient classification, and orders for preoperative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient’s transfer to the operating room and before preoperative medication has been administered.
IV. TRANSFER OF PATIENTS

When, in the opinion of the attending physician, the Hospital does not have the resources or ability to care for the needs of the patient, or if the patient’s condition requires care outside of the service line of the Hospital, or if the patient or their legal guardian requests a transfer, the patient may be transferred to an appropriate facility with the capacity to care for the particular patient.

A. These transfers shall be arranged by the attending physician, or a designee, speaking directly to the accepting physician at the receiving institution and documenting the acceptance of the receiving institution and the accepting physician.

B. Transfer of a patient to another facility shall include the following:
   a. A written order;
   b. Completion of a COBRA form; and
   c. A dictated or written discharge summary/transfer note, which shall contain the original reason for admission, an outline of the Hospital course including treatments rendered, a summary of important diagnostic results, a provisional diagnosis, and reason for transfer.

V. DISCHARGE OF PATIENTS

Patients shall be discharged only upon order of the attending practitioner or his designee. After a discharge order is written, all orders will continue for a period of twelve (12) hours maximum. The attending practitioner is responsible for recording a progress note in the chart, completing the medical reconciliation form, and dictating a discharge summary in a timely fashion not to exceed 7 days.

A. Discharge of a minor patient. Any individual who cannot legally consent to their own care shall be discharged only to the custody of their parents, legal guardian, person standing in loco parentis, or as directed by the parent, guardian, or court of competent jurisdiction. If the parent or guardian direct that discharge be made otherwise, the person must state same in writing, and a statement must be made as part of the patient’s medical record.

B. Leaving against medical advice. Should a patient leave the Hospital against the advice of the attending practitioner or without proper discharge, the attending
practitioner shall be notified and the patient will be asked to sign an
acknowledgement form indicating that they understand that they are leaving
against medical advice. A notation of the incident must be made in the patient’s
medical record. If the patient refuses to sign the acknowledgment form,
appropriate documentation regarding same shall be made in the medical record.

C. Death. In the event of a Hospital death, the deceased shall be pronounced dead by
a practitioner within a reasonable period of time after the death has been
discovered. In the event the practitioner can’t pronounce the patient in person, the
practitioner may request that the registered nurse verify and document in the
patient record:

a. No pulse;
b. No respiration; and
c. No heart sounds; and
d. Fixed and dilated pupils.

The nurse will also document that the practitioner was notified of date and time
the patient was pronounced dead.

1. Autopsy. Every member of the Medical Staff is encouraged to secure an
autopsy whenever appropriate. Proper consent for an autopsy shall be in
accordance with Hospital policy and applicable state and local law. All
autopsies shall be performed by a Hospital pathologist, or by his qualified
designee.

2. Reportable deaths. Reporting of deaths to the Medical Examiner’s Office
shall be carried out when required by and in conformance with local and
state statutes.

VI. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

A member of the Medical Staff shall be responsible for the medical care and treatment of each
patient in the Hospital and FCOSC, for the prompt completeness, accuracy, and legibility of
those portions of the medical record for which he/she is responsible, for necessary special
instructions, and for transmitting reports of the condition of the patient to the referring
practitioner, if any, and to relatives of the patient.

A. Transfer of responsibility of care. When primary responsibility for a patient’s
care is transferred from the admitting or current attending practitioner to another
Medical Staff member, a note covering the transfer of responsibility and
acceptance of the same must be entered on the order sheet and notation made in the progress notes.

B. Alternate coverage. Each practitioner must assure timely adequate professional care for their patients in the Hospital by being available 24/7 or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient. Each member of the Medical Staff, who will be unavailable, must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his absence. In the absence of such designation, the Department Chair, the President of the Medical Staff or the Chief Medical Officer has the authority to call any member of the staff with the requisite clinical privileges to provide and direct the appropriate medical care for the patient. Failure of an attending practitioner to meet these requirements may result in loss of Medical Staff membership or other disciplinary action as the MEC deems appropriate.

C. Dual responsibility for care of patients of dentists and podiatrists. The admission of a patient for podiatric or dental services shall be conducted in accordance with the requirements stated in the Medical Staff Bylaws, Hospital policies FCOSC policies, and federal and state statutes.

1. Responsibilities of the podiatrist or dentist are to:
   a. Provide a detailed podiatric or dental history to support Hospital and FCOSC care;
   b. Provide a detailed description of the podiatric or dental examination including when indicated, diagnosis anticipated treatment and prognosis;
   c. Provide a complete operative report as well as a written post-procedure note;
   d. Write orders for services and medications as they relate to the podiatric or dental care rendered; and
   e. Write progress notes and final summary as they relate to the podiatric or dental care rendered.

2. Responsibilities of the Medical Staff Member providing general medical care to the podiatric or dental patient shall perform the following functions:
a. Admit the patient;
b. Perform a medical history and physical examination;
c. Provide for overall care of the patient’s general health during the hospital stay as appropriate;
d. Write orders for services and medications for the general care of the patient as appropriate; and
e. Discharge the patient.

3. Podiatrists, who can document training in physical diagnosis, may perform a medical history and physical examination on ASA Class 1 and 2 patients.

4. ASA Class 3 and 4 patients must be managed as in 1 and 2 above.

VII. INPATIENT MEDICAL RECORDS

A. General Guidelines. The attending Practitioner or other Medical and Hospital Staff members, as applicable, shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include:

1. Identification data, including date and time of admission;
2. Admission diagnosis;
3. Description and history of present complaint and/or illness;
4. Personal and family medical histories;
5. Physical examination report;
6. Appropriate orders;
7. Special reports (such as laboratory, radiology, EKG, EEG);
8. Progress notes and other clinical observations, such as therapy and interventions, or surgery;
9. Consultation notes;
10. Pathological findings/reports;
11. Final diagnosis, secondary diagnosis, and complications;
12. Conditions on discharge and discharge instructions including medicine reconciliation forms;
13. Autopsy report, when appropriate.

B. History and Physical Examination. A complete and legible history and physical examination must be recorded in the chart after admission of the patient. See Section III. Admission History and Physical Examination.

An abbreviated report of the history and physical examination may be used for patient admitted for minor surgical procedures. The Medical Staff determines
what non-inpatient services require a medical history and physical exam and the extent of the history and physical.

C. Progress Notes. Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and assessment of continued need for inpatient care. Final responsibility for an accurate description in the medical record of the patient’s progress rests with the attending practitioner. Whenever possible, each of the patient’s clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of test and treatment. Progress notes by the attending practitioner or his designee, must be written at least daily. Progress notes written by a physician-directed AHP must be countersigned within 24 hours and supplemented every 24 hours by the responsible supervising practitioner.

1. Operative Notes. Complete reports of all operations/procedures performed shall be dictated immediately following the operation by the operating physician and become part of the patient’s medical record. If the dictated report is not immediately transcribed after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend to the patient. Operative reports must include the name of the primary surgeon and assistants, type of anesthesia, findings, technical procedures used, specimens removed, pre and post operative diagnosis, and specimens removed.

2. Discharge Summary. A discharge summary must be dictated/recorded for all patients admitted to the Hospital. The content of the discharge summary shall be sufficient to justify the diagnosis and treatment and shall state the condition of the patient at the time of discharge and directions for follow-up care as well as any other instructions to the patient.

3. Entries. The Medical Staff promotes legible physician handwriting in order to avoid potential medical errors resulting from misinterpretation of written entries that are illegible. Every medical record entry shall be timed, dated, its author identified, and authenticated. Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee (hereinafter “MEC”). An official list of approved abbreviations shall be kept on file in the Health Records Information Services Department and at each nursing station. No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation, or other inability or unavailability of the responsible practitioner to complete the record, the MEC shall consider the circumstances and may enter such reasons in the record and order it filed. Authentication means to establish
authorship by written signature, electronic signature, or identifiable initials. All charts must be completed and properly signed within 30 days.

4. Ownership and Release of Records. All original patient medical records, including x-ray images, pathological specimens, and slides are the property of the Hospital and may be removed only in accordance with approved departmental policy, court order, subpoena, statute, or with permission of the CEO. Copies of the patient’s medical record shall only be released upon presentation of appropriate authorization and fees for duplication and according to policies of Health Records Information Services. A patient may, upon written request have access to all information contained in their medical record, unless access is specifically restricted by the attending practitioner for medical reasons or is prohibited by law.

D. Utilization Management. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Management policy in this Hospital.

E. Consultations. Shall be sought by the patient’s attending physician when the best interest of the patient’s care will be served.

1. Requesting a consultation:

   a. All consultation requests shall include the reason/purpose of the consult;
   b. All consults will be regarded as “consult and treat”, unless specifically stated otherwise in the orders;
   c. All consults will be regarded as “routine” and will be completed within 24 hours unless they are deemed URGENT by the requesting physician; and
   d. All requests for consultation require direct communication between the requesting physician and the consulting physician.

2. Performing a consultation:

   a. All routine consults shall be performed within 24 hours;
   b. The time frame for performing urgent consults will be determined through direct communication with the requesting physician;
   c. Following evaluation of the patient, there shall be a legible consultation note placed in the chart which is dated, timed, and signed, and shall include: impression, recommendations,
statement of planned follow-up and treatment or a statement of signing off the case;

d. Dictation of a full consultation note is required; and
e. Upon completion of a consultation, the consultant must communicate directly with the referring physician and there must be absolute clarity between the consultant and the attending physician as to the management of the case.

F. Orders. All orders shall be by electronic order entry or in writing that is clear, legible, and appropriately dated, timed, and signed. Any order that is illegible, improperly written, or not consistent with standard medical care will not be carried out until the order is rewritten or clarified in the mind of the nurse or individual carrying out the order.

1. Verbal orders may be accepted according to Hospital and FCOSC policy, only in the case of an emergent situation when patient care would suffer should the practitioner stop and take time to write the order. The order shall be written as follows: “read back verbal order” to assure complete understanding of the order. Verbal orders must be signed, dated and timed, as well as countersigned by the appropriate provider within 48 hours.

2. Telephone orders may be accepted according to Hospital policy, following “read back telephone order” to assure complete understanding of the order. Telephone orders must be signed, dated, timed, and countersigned by the appropriate provider within 48 hours.

3. Protocols may be used as standing order sets when approved by the department chair or physician director of a unit of the Hospital, and the MEC, and in consultation with the nursing service. Protocols must be reviewed annually and revised as necessary.

4. Allied Health professionals (hereinafter known as “AHP”) may write orders only to the extent specified by State law and consistent with the scope of services defined for them. Any authorized order by an AHP must be countersigned by the responsible supervising practitioner within 30 days.

5. All signatures by AHP’s and students must be dated, time, and countersigned by supervising physician per Medical Records policy.
6. Automatic cancellation of orders occurs when a patient is taken to surgery or transferred to another level of service. Under such circumstances a complete new set of orders is required to be completed.

7. Special Orders:

a. Patient’s own medication. Should a patient bring their own medication to the Hospital, it first must be taken to the pharmacy for identification and approval and used according to Hospital policy.

b. Self – medication by patients is normally not permissible. Any exception must be in compliance with Hospital policy and on order of the patient’s physician.

VIII. FORMULARY AND INVESTIGATIONAL DRUGS

A. Formulary Drugs. The hospital formulary lists drugs available for ordering from stock. Each member of the Medical Staff assents to the use of the formulary as approved by the Pharmacy and Therapeutics Committee. The formulary will be reviewed on an annual basis. All drugs and medications administered to patients, with the exception of drugs for bona fide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations. Exceptions to this rule shall not be made without reasonable documentation of the need and approval of the appropriate formally constituted Medical Staff body.

On orders written by physicians for drugs not in stock in the Pharmacy, generic or therapeutic equivalents will be dispensed in accordance with the hospital drug list. If the physician does not want an equivalent dispensed he must write “do not substitute” by the item on the drug order.

B. Investigational Drugs. Use of investigative drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Board and the Medical Executive Committee. Investigational drugs shall be used only under the direct supervision of the principal investigator. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to:

1. Untoward symptoms;
2. Special precautions in administration;
3. Proper labeling of the container;
4. Proper storage of the drug;

5. Methods of recording doses when indicated; and

6. Method of collection and recording specimens of urine and/or other specimens.

IX. CONSENTS

Each patient's medical record must contain evidence of the patient's or his legal representative's general consent for treatment during hospitalization. Except in emergencies, a surgical operation shall be performed only with the informed and written consent of the patient or his legal representative.

A. Informed Consent.

1. When required. The performing practitioner is responsible for obtaining the patient's or his legal representative's informed consent for the procedures and treatments listed below:

   a. Anesthesia;
   b. Surgical and other invasive and special procedures (as specified by policy);
   c. Use of experimental drugs;
   d. Organ donation;
   e. Radiation or oncologic chemotherapy;
   f. Autopsy;
   g. Photography;
   h. Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form. This requirement includes all fathers and significant others present during the birth of a child in the hospital.

B. Documentation Required. The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

   a. Patient identity;
   b. Date when patient informed and date when patient signed the form, if different;
   c. Nature of the procedure or treatment proposed to be rendered;
   d. Name(s) of the individual(s) who will perform the procedure or administer the treatment;
   e. Authorization for any required anesthesia;
f. Indication that the risks and complications of the procedure or treatment and of the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment;

g. Authorization for disposition of any tissue or body parts as indicated according to established Hospital policy;

h. Name of the practitioner who informs the patient and obtains the consent.

C. Signatures. An informed consent must be signed by the patient, or on the patient's behalf, by the patient's authorized representative, and witnessed by a legally competent third party.

D. Emergencies. If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section II. Admission of Patients without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record. Two physicians shall document the medical advisability of proceeding without informed consent.

X. INFECTION CONTROL

A. Cultures. Suspected clinically significant infections of the skin or surgical incisions may be cultured for organism and sensitivity to the organism. Suspected infection of other organs by communicable organisms shall be cultured when practical. Cultures shall be ordered by the physician in charge of the case. The infection control nurse shall call suspected cases of infection to the attention of the attending physician. If the attending physician refuses to order a culture in such cases, this information shall be given to the chairman of the Infection Control Committee who shall then consult with the attending physician and make the final decision concerning ordering a culture.

B. Patients with Infectious / Communicable Disease. Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending physician and consistent with Center for Disease Control (CDC) principles as outlined in the Infection Control Manual of Community Hospital. The infection control nurse may call cases which may need isolation to the attention of the attending physician. If the attending physician refuses to order isolation, this information shall be given to the chairman of the Infection Control Committee who will consult with the chairman of the department involved. Said chairman shall consult with the attending physician and make the final decision concerning isolation of the case for the protection of Hospital employees and other patients.
Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, but especially in the case of patients who have communicable diseases, or to assure protection of the patient from self harm. Cases in dispute shall be referred to the Infection Control Officer for resolution.

C. Reporting of Infections / Communicable Diseases. All cases of infection and communicable disease must be reported to the Infection Control Committee or the Infection Control nursing representative, by the attending physician, or by a Hospital staff member when the attending physician has not reported the infection to the Infection Control Committee. Those infections found in special services units must also be reported to the physician in charge of the unit. Those infections found in other areas of the Hospital should be reported to the applicable department chairman. Every staff member should also report promptly to the Infection Control Committee infections which develop after discharge and which may be Hospital-acquired.

D. General Authority. The Infection Control Committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

XI. GENERAL RULES FOR INTENSIVE CARE UNIT

The Intensive Care Unit (ICU) shall have a Medical Director so designated for the unit by the Medicine Committee and approved by the MEC. The responsibilities of the Medical Director shall include availability to answer questions concerning care or policy, addressing care that appears to deviate from the accepted standards of care or best practice, and participating in the process to meet the ongoing educational needs of the unit.

A. Admission and Discharge of Patients. Admission to the ICU shall be by physician order and consistent with the Admission and Discharge Policy for the ICU, which includes patients who are critically ill, who may be benefited by the specialized nursing care and advanced physiologic monitoring, and/or equipment available in the ICU unit. Admissions may also include “step-down patients” and pediatric patients up to 12 years of age. Patients are discharged at the discretion of the attending physician or consultant.

B. History and Physical examination. All patients admitted to the ICU shall be evaluated immediately prior to admission or within two hours after admission to the unit, at which time a complete and legible history and physical exam shall be completed.
C. Progress Notes and Consultations. It is the responsibility of the admitting physician to record progress notes clearly delineating the condition of the patient, the working diagnosis, and the treatment plan for the patient. These notes should be recorded at least daily and more frequently as the condition of the patient dictates. It is also the responsibility of the admitting physician to seek consultation from the appropriate specialists according to the ICU policies. An order for consultation should designate whether the consultation is for evaluation and advise or evaluate and treat.

XII. GENERAL RULES FOR THE OPERATING AND RECOVERY ROOMS

Because of the complexity of the surgical services there shall be a representative committee of various physician members of the Department of Surgery, as well as physician representatives from anesthesia, representatives from other disciplines, as appropriate, and the directors of PACU and Surgery. Other attendees may include the CEO, CMO, CNO, and other invitees as deemed appropriate. This Surgical Department Committee shall be chaired by the Chairman of the Department of Surgery. The Surgical Department Committee shall meet nine times per year to review the functions within the procedure center and the inpatient and outpatient surgical areas including FSOCS, review and recommend policies germane to the safe and efficient function of surgical services, and review and maintain outstanding quality.

A. Only a member of the Medical Staff with the appropriate clinical privileges may care for patients in the operating, recovery, procedure rooms, or at FCOSC. Only patients undergoing surgical procedures that comply with the requirements of the Community Hospital Surgical Services policies as amended from time to time, may be admitted for care.

B. History and Physical examination must be completed by the surgeon and the anesthesiologist or their designee, for each patient in accordance with Section III of these Rules and Regulations.

C. A written surgical consent shall be obtained prior to the operative procedure, except in a documented life threatening emergency. The consent must be dated, timed, and authenticated both by the patient and the surgeon in accordance with Section IX of these Rules and Regulations.

D. Patient identification must be accomplished in the preoperative/preprocedure area as well as confirmation of the type of procedure anticipated and the correct site of the procedure. Site marking must be accomplished according to the Site Marking policy.

E. “Time Out” immediately prior to the initiation of surgery must occur in the operating room confirming: a) the right patient; b) the operation/procedure to be performed; c) the right site/side/level; d) the proper equipment is available; and e) antibiotics were given.
F. Assistants at surgery shall be qualified and properly credentialed. They may include, but not be limited to, assistant surgeons, RN first assists, trained surgical scrubs, and other Allied Health Professionals.

G. Scheduling of surgical cases shall be through the Surgery Scheduling Office. Scheduling may set into predesignated block times in accordance with the Block Scheduling policy or into open surgical times. During the hours that the scheduling office is closed, such as nights, weekends and holidays, cases may be scheduled with the house supervisor. The following information shall be provided:
   a. Name age and sex of the patient;
   b. Pre-operative diagnosis and anticipated procedure/surgery;
   c. Name(s) of assistant(s);
   d. Special preps, instruments, procedures, service or material or equipment required;
   e. Anticipated length of procedure; and
   f. If frozen section is expected.

H. The Recovery Room is used to care for and observe anesthetized patients until they react and vital signs are stable. Recovery shall occur in Stage 1 Recovery, Stage 2 Recovery, and Extended Recovery. The operating surgeon and/or anesthesiologist is responsible for all postoperative orders and protocols for patient care and patient status monitoring. Anesthesia is responsible for the discharge order and signing of the discharge order from the Recovery Room. An anesthetic post recovery note shall be written after the patient is awake, recovered and aware.

I. A complete operative report describing the findings and technique shall be placed in the medical record according to Article VII C 1 of these rules and regulations.

J. Care of patients of dentists and podiatrists shall follow the responsibilities outlined in Section VI C of these rules and regulations.

XIII. GENERAL RULES FOR EMERGENCY SERVICES

Community Hospital is committed to providing emergency services 24 hours/day, 7 days/week, and 365 days/year within its scope of services. Emergency patients who require services beyond the scope of the Hospital must be stabilized and referred to an appropriate institution as soon as possible.

A. Medical staff coverage of the Emergency Department shall be provided by physicians who are board certified in emergency medicine, in the process of certification, or have demonstrated experience as an Emergency Department
physician. Back up specialty coverage is provided according to on-call schedules of specialist members of the Medical Staff.

B. A medical screening exam shall be performed on all patients presenting to the hospital Emergency Department. This medical screening exam may be performed by the Emergency Department physician, a qualified nurse practitioner, or physician assistant who is qualified and supervised by the attendant Emergency Department physician.

In the case of urgent care centers, this medical screening exam may be performed by the attending physician, a qualified nurse practitioner, or a qualified and supervised physician assistant.

C. Community Hospital is designated as a Level IV Trauma Center by the Colorado State Trauma System; therefore, trauma patients are cared for by ATLS certified physicians in accordance with the Colorado State Trauma System guidelines.

D. Transfer of patients to another facility shall follow Section IV of these Rules and Regulations.

E. Patients discharged from the Emergency Department shall be given written instructions regarding their follow-up care. A copy of the discharge instructions shall be signed, acknowledging receipt and understanding of the instructions, and shall become part of the patient’s medical record.

F. The policies set forth in Section V, B, shall be followed should a patient leave the Emergency Department against medical advice.

G. An accurate, legible, and complete medical record shall be maintained for each patient seen and shall be incorporated into the patient’s permanent medical record.

The medical record shall contain:

a. Identification data;

b. Chief complaint and history of injury or illness;

c. Pertinent past medical, surgical, and family history;

d. Diagnostic and therapeutic orders;

e. Description of the Emergency Department visit including treatment and; response to treatment as well as consultations; and

f. Condition on discharge/transfer as well as follow up instructions.

XIV. MASS CASUALTY PLAN

A. Disaster Plan. Physicians will function as described in the Hospital Emergency Incident Command System (HEICS). In case of evacuation of patients from one section of the Hospital to another, or evacuation from the Hospital premises, the Chief of Staff will, during the disaster, be consulted as necessary. Community
Hospital utilizes the HEICS for internal and external disaster needs as necessary. Physician participation in such activities is a requirement for all members of the Medical Staff.

All policies concerning patient care will be the joint responsibility of the Chief of Staff, Medical Director and the President / CEO of the Hospital. In their absence, the Vice-Chief of Staff and the alternate in Administration of the Hospital are next in line of authority respectively. All physicians on the Medical Staff of the Hospital specifically agree to relinquish direction of the professional care of their patients to the Chief of Staff in case of such emergency. This plan for the care of mass casualties should be rehearsed at least twice a year by key Hospital personnel.

B. Emergency Assistance. Each Medical Staff member shall assist another staff member in an emergency, an emergency being defined as a condition endangering life, limb, or causing undue suffering.

XV. ADMINISTRATIVE FUNCTIONS

A. Unusual Occurrences. Accidents or unusual occurrences involving any patient shall be reported to the attending physician immediately and/or Risk Management.

B. Complaints. Any formal complaint by a member of the Medical Staff concerning another Medical Staff member relative to actions under the jurisdiction of the Medical Staff shall be submitted in writing to the Chief Medical Officer, MEC, and President / CEO respectively.

XVI. ADOPTION AND AMENDMENT

These Rules and Regulations may be amended or repealed in whole or in part by a majority vote of the MEC, the Medical Staff, and the Board of Trustees. These Rules and Regulations were recommended by the MEC and approved by the Board of Trustees.

MEDICAL STAFF RULES AND REGULATIONS FOR COMMUNITY HOSPITAL AND FIRST CHOICE OUTPATIENT SURGERY CENTER

Date: November 13, 2012

Sara Gaglione, M.D.
Chief of Staff

Date: February 7, 2013

Medical Staff
<table>
<thead>
<tr>
<th>Date:</th>
<th>Board of Trustees</th>
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<tbody>
<tr>
<td>February 27, 2013</td>
<td>Board of Trustees</td>
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<tr>
<td>March 12, 2013</td>
<td>Sara Gaglione, M.D.</td>
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<td>Medical Executive Committee</td>
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<td>Chief of Staff</td>
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<tr>
<td>July 25, 2013</td>
<td>Medical Staff</td>
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<td>Board of Trustees</td>
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