

MONTROSE MEMORIAL HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS

Table of Contents

General.....	Page 1
Admission and Discharge.....	Page 1
Emergency Services.....	Page 3
Outpatient Services.....	Page 4
Medical Records and Orders.....	Page 5
Surgical Care.....	Page 8
Obstetrical Care.....	Page 10
Newborn Care.....	Page 12
Disaster Plan.....	Page 13
Drugs and Medications.....	Page 13
General Conduct of Care.....	Page 14
Non-Physicians.....	Page 17
Consultations.....	Page 21
Continuing Medical Education.....	Page 21

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GENERAL

1. This document sets forth the Rules and Regulations of the Medical Staff and is subject to the provisions of the Medical Staff Bylaws. The terms defined in the Medical Staff Bylaws shall have the same meanings herein.

2. These Rules and Regulations may be adopted, amended, revised, modified, restated and repealed in the manner set forth in the Bylaws.

ADMISSION AND DISCHARGE

1. All practitioners with authority to admit patients will be governed by the official admitting policy of the Hospital.

2. Patients may be admitted and discharged only on order of the attending practitioner. The Hospital will not be required to accept cases for which facilities for proper care are not available. Patients should not be admitted as a matter of convenience while only undergoing tests or therapy that could be obtained on an outpatient basis. Proper safety precautions shall be taken with respect to patients who are known to be suffering from abuse, alcoholism and mental illness.

3. Patients shall be admitted to the Hospital on the basis of the following order of priorities when there is a shortage of available beds:

- (a) Emergency
- (b) Urgent
- (c) Pre-operative
- (d) Routine

The Utilization Review Committee shall review admissions that do not meet the established criteria if there is need to do so.

4. Except in the case of emergency admissions, no patients will be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, the statement will be recorded as soon as possible. A copy of the emergency service record shall accompany the patient to the nursing unit.

5. In any emergency or non-elective cases in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the nursing service supervisor to ascertain if there is a bed available.

6. Practitioners must be able to justify emergency admissions based on criteria developed by the staff. The history and physical must clearly justify the patient being admitted on an emergency basis, and all findings must be recorded on the patient's medical record as soon as possible after admission.

7. A patient to be admitted on an emergency basis will be given the opportunity to select a member of the active or associate staff to be responsible for the patient while in the Hospital. If a dentist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient. Where no selection is made or where the selected practitioner does not assume responsibility for care of the patient for some reason, the patient shall be assigned to an on-call physician. All members of the Medical Staff and associated call groups will develop a plan to be approved by the Medical Executive Committee continuous 24 hour clinical services for patients who meet their

scope of practice. (See Bylaws Article III, Section 3 "Basic Responsibilities"). For reasons of age, health, or personal circumstances, and with sponsorship by another member of the Active Medical Staff of Montrose Memorial Hospital, a member of the Medical Staff may petition the Executive Committee in writing for temporary or permanent omission from the call schedule for admission of unassigned patients from the Emergency Room. At its discretion, the Executive Committee may recommend that the Board of Trustees grant or deny such an omission. The Board of Trustees may later rescind the omission upon the recommendation of the Executive Committee.

8. A patient will not be transferred within the Hospital without the approval of the attending practitioner. The order of priority for patient transfers shall be as follows: (a) emergency department to appropriate nursing unit; (b) from general care unit to special care unit; (c) from special care unit to general care unit; (d) from temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit; (e) from obstetric care unit to general care unit.

9. Admission and discharges to special care units shall be in accordance with established criteria. Exceptions shall be approved by the unit or service chief.

10. Patients may be discharged from the Hospital on the order of the patient's attending practitioner. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, a notation shall be made in the patient's medical record and Hospital policy will be followed regarding further documentation and action.

11. Practitioners shall use their best efforts to write discharge orders that will allow patients to be discharged from the Hospital by 11:00 a.m. on the day of discharge.

12. In the event of a Hospital patient death, the deceased will be pronounced dead by the attending physician or his/her physician or registered nurse designee within a reasonable time. The attending physician will complete and sign the death certificate. The body will not be released until an entry has been made and signed in the medical record of the deceased by a physician appointee of the staff or the registered nurse designee. Policies with respect to release of dead bodies shall conform to local law.

13. Practitioners shall abide by the Hospital's utilization review plan, including the appropriateness and medical necessity of admissions, continued stay, supportive services, and discharge planning.

14. Patients admitted to the Intensive Care Unit will receive an initial visit by their attending physician immediately prior to or at the time of their admission, regardless of the site of evaluation. Patients admitted to all other areas of the Hospital will receive an initial visit by their attending physician within eight (8) hours of their admission. Exceptions to this rule will be normal vaginal deliveries who must be seen within twelve (12) hours of their admission.

15. Resuscitation will be initiated on all patients when indicated unless a DNR order is documented in the patient's medical record according to the Do Not Resuscitate (DNR) Policy. A DNR order means the patient will not receive cardiopulmonary resuscitation (CPR). The patient or patient's authorized agent must consent to the DNR. All discussions with the patient or authorized agent and the patient's condition must be documented in the record. The DNR order must be written, timed, dated and signed by the physician. Under extraordinary circumstances, a telephone DNR order can be taken by two registered nurse witnesses, providing that full explanatory documentation has previously been recorded in the chart. With the prior knowledge and consent of the patient or the authorized agent of the patient, DNR status will be suspended while the patient is in surgery and post operative recovery unless otherwise addressed in written orders. The Do Not Resuscitate policy of the hospital and medical staff will be followed.

EMERGENCY SERVICES

1. Members of the staff shall accept responsibility for emergency care in accordance with emergency department policies and procedures.
2. The Emergency Room Medical Director shall have the overall responsibility for emergency care, subject to the authority of the Board.
3. Emergency service policies and procedures shall be approved by the Emergency Room Medical Director, the Emergency Room Committee, the Executive Committee of the staff and the Board.
4. A physician shall be available within approximately 30 minutes for rendering emergency patient care 24 hours per day, seven days a week.
5. On-call physicians and on-call Allied Health Staff must be continuously available to the Emergency Department and must be continuously available by telephone or pager.
6. The patient's private practitioner shall be called in accordance with the emergency department policies and procedures.
7. An appropriate emergency service medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's previous inpatient medical record, if such exists. The emergency service medical record shall include:
 - a) Adequate patient identification;
 - b) Information concerning the time and means of the patient's arrival and by whom;
 - c) Pertinent history of the injury or illness and physical findings including vital signs, details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital and history of allergies;
 - d) Description of significant clinical, laboratory, and x-ray findings;
 - e) Diagnosis, including condition of patient;
 - f) Treatment given and plans for management;
 - g) Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care, patient's condition on discharge or transfer;
 - h) Clinical observations, including results of treatment;
 - i) A patient's leaving against medical advice.
8. An appropriate emergency department record or log shall be kept listing every person who presents himself or is brought to the emergency department for treatment or care and a notation covering treatment or transfer.
9. Each patient's emergency medical record shall be signed by the physician in attendance, who shall be responsible for its clinical accuracy.
10. A copy of the emergency department medical record shall accompany patients being admitted as inpatients.
11. The Emergency Services Committee shall be responsible for monthly patient care evaluation concerning the quality and appropriateness of patient care.

12. Except in cases where transfer to surgery is contraindicated in the judgment of the emergency physician, general anesthesia shall not be administered in the emergency treatment area.

13. The emergency physician shall arrange for an interpretation of x-rays by a radiologist and comparison of initial and final x-ray interpretations. In cases where an x-ray interpretation of the radiologist is different from that initially made by the emergency physician, the radiologist shall notify the emergency physician and/or the patient's private physician as soon as possible, and copies of the radiologist's report shall be made available to the emergency physician and the patient's private physician.

14. Patients with conditions whose definitive care is not within the scope of services provided by the Hospital shall be referred to an appropriate facility when, in the judgment of the attending practitioner, the patient's condition permits such a transfer. No patient shall be arbitrarily transferred, and inquiry shall be made as to acceptance of the patient by the receiving hospital and physician. A copy of pertinent medical records shall accompany the transfer. The Hospital's procedures for patient transfers to other facilities shall be followed.

15. A Medical Screening Examination (MSE) will be performed on any person presenting to the hospital (as defined in the EMTALA policy and Procedure). The categories of practitioners who may perform a MSE are:

- a) Emergency Department Physicians
- b) Credentialed members of the Medical Staff
- c) For obstetrical patients, Registered Nurses competent in the nursing management of the laboring patient and who have received approval by the Obstetrical and Newborn Committee and the Board of Trustees.
- d) For nursery patients, Registered Nurses who are competent in the nursing management of the newborn and have received approval by the Obstetrical and Newborn Committee and the Board of Trustees.
- e) For patients with mental health issues, credentialed Mental Health Screeners

16. The Emergency Room Medical Director shall make certain that emergency department procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.

17. All members of the Active and Associate Medical Staff will cooperate with Hospital Administration and Board of Trustees to provide effective and appropriate coverage of the Emergency Room. Within reasonable safeguards, any physician member of the medical staff should be permitted to do and assist in doing everything reasonably possible to treat a patient in an emergency.

OUTPATIENT SERVICES

1. Requests for Outpatient Services must be made by members of the medical staff or individual mid-level providers who are specifically authorized by a medical staff member to order outpatient procedures in his/her name.

2. Requests for Outpatient Services from licensed providers who are not on the staff may be authorized by any Active Medical Staff member.

3. All requests for diagnostic services will contain a working diagnosis and relevant clinical information needed to aid in the interpretation of the exam.

4. Such outpatient procedures will be conducted only with written request from one of the above providers with specific exceptions in urgent and emergent situations as provided for in departmental policy.

MEDICAL RECORDS AND ORDERS

1. The attending practitioner will be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current for the patient and shall include identification data; chief complaint; medical history, family history and history of the present illness; a summary of patient's psychosocial needs when appropriate, a statement of the conclusions or impressions drawn, a statement of the planned course of action while the patient is in the Hospital; physical examination; diagnostic and therapeutic orders; appropriate informed consents; clinical observations, including results of therapy, progress notes, consultations, nursing notes, laboratory and x-ray and other reports; provisional and final diagnosis; medical or surgical treatment; pathologic findings; reports of procedures, tests and results, including operative reports; discharge summary, condition on discharge and instructions given for further care, such as medications, diet or limitations of activity; and autopsy report, if one is permitted.

2. A complete admission history and physical examination on each patient must be written or dictated and transcribed and recorded on the chart within 24 hours of admission and before surgery or anesthetic is commenced. A Short Form H & P is acceptable for use when moderate sedation is used or the procedure performed is of a minor nature and the patient's recovery period is expected to be of a short duration. Examples may be, but not limited to, ophthalmology cases, colonoscopies, interventional radiological procedures, etc. The short form H & P will consist of evaluation and documentation of allergies, current medications, present and past significant diagnoses, and surgical interventions as well as pre-procedure heart, lung and mental status. In emergency situations in which there is inadequate time to record the history and physical examination before surgery or anesthetic, a brief note, including the preoperative diagnosis, is written in the chart. The History and Physical report should include all pertinent findings resulting from an assessment of all systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the Hospital, a reasonable durable, legible copy of such reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided the reports were recorded by the attending or admitting physician. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must also be recorded. For a surgical H & P, there must be a pre-procedure or progress note on the day of surgery by a physician, operating practitioner, or individual credentialed to administer anesthesia, evaluating the patient's current status for surgery. The H & P Reassessment Form may be used for this pre-procedure note.

3. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written daily on all inpatients.

4. The attending practitioner must read, edit and countersign all orders, the history and physical examination, and pre-operative notes when they have been recorded by an intern, resident physician or physician's assistant, a physician in training, or an accredited Allied Health professional. Orders written by medical students must be countersigned before they are carried out.

5. All clinical entries and summaries in the patient's medical record shall be accurately dated, timed, and authenticated as necessary including H & P's, operative reports, reports of consultants, progress notes, orders, and discharge summaries.

6. Abbreviations from the unapproved abbreviations list may not be used in patient records.

7. The following persons may make entries in medical records of Hospital patients: members of the medical staff, Allied Health Professionals, house staff, medical students (upon request of active staff members), nursing personnel, physician's assistants, dietitians, physical therapists, respiratory therapists, social workers, occupational therapists and pharmacists. The Executive Committee of the staff may authorize other persons or classes of persons to make such entries.

8. The attending practitioner shall complete the medical record at the time of the patient's discharge, including progress notes, final diagnosis and discharge summary except that where this is not possible, because the physician is required under these circumstances to write a final progress note and final diagnosis in the record at the time of discharge or a note as to who is responsible for this documentation.

9. Responsibility for performance of History and Physical examinations on surgical patients shall be that of the attending or admitting physician. When a history and physical examination is not written or dictated and transcribed and recorded on the chart prior to conducting urgent, non-emergent operative and other invasive procedures, the procedure shall be cancelled. In instances of emergencies where there is inadequate time to record the history and physical examination, it is the responsibility of the surgeon to record a brief note including the pre-operative diagnosis.

10. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee or other appropriate medical staff committee.

11. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.

12. A discharge summary shall be dictated on all medical records of patients hospitalized over 24 hours (including those patients who have died or are transferred regardless of length of stay) except normal newborns. A final progress note is substituted for the discharge summary only for those patients who require a hospitalization of less than 24 hours and whose problems and interventions are of a minor nature. Examples of problems and interventions of a minor nature will include, but are not limited to the following: jaundice with a bilirubin of less than 18, outpatient observation of a patient needing to stay for nausea and vomiting or to rule out a more significant problem, post operative temperature that resolves within 24 hours or non-specific pain. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be signed by the responsible practitioner.

13. A practitioner will be considered delinquent in completion of his/her medical records if a record is missing a dictated report 15 days after the patient is discharged. A practitioner is also considered delinquent if reports or orders have not been authenticated within 30 days after the patient is discharged. A practitioner will automatically be suspended in the form of withdrawal of his/her admitting privileges five days after he/she is given a warning of delinquency for failure to complete medical records. In the case of physicians assigned to the service of anesthesiology, the suspension will be in the form of withdrawal of his/her privileges to give or provide an anesthetic. In the case of physicians assigned to emergency services, the suspension will be in the form of suspension of privileges to treat or examine patients. The suspension shall continue until the medical records are completed, unless the practitioner provides a justifiable excuse to the Chief of Staff. If the medical record is incomplete five days after the warning is given, a written notice shall be sent to the physician, notifying him/her that his/her admitting or other privileges shall be suspended immediately and that he/she shall remain suspended until all of his/her delinquent records have been completed, unless there are known extenuating circumstances. If the medical records are not thereafter completed within five days, all clinical privileges of the practitioner shall be suspended. The Chief of Staff, admitting office, operating supervisor, emergency room supervisor, nursing, radiology and pathology directors shall be notified of this action by the Director of Medical Records. Reinstatement of privileges will be automatic upon completion of records, and the Director of Medical Records shall inform the admitting office. The Medical Records Department will be responsible for analyzing medical records for the purpose of administering this rule.

14. In compliance with State and Federal Statutes and Regulations, written consent of the patient shall be required for release of medical information to persons not otherwise authorized to receive such information. No one other than authorized persons shall have access to or information from the medical records without the written permission of the patient, in which case the written permission shall be attached to the record. However, information may be obtained from medical records in compliance with state law. Medical information for the purpose of establishing the patient's claim or hospitalization insurance or other third party payment or reimbursement will be provided only as a matter of routine to the insurance company or payer after the consent of the patient has been

obtained (unless consent is not required) and will be provided only on the currently acceptable insurance or payer form.

15. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken or removed from the Hospital. All original x-ray films are the property of the Hospital and shall not be removed. In any case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This will apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee.

16. Free access to all medical records of all patients will be afforded to members of the staff for bona fide study and research, gathering relevant statistical information, use in quality assurance activities and other appropriate analysis consistent with preserving the confidentiality of personal information concerning the individual patients. Former members of the staff will be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the Hospital.

17. All orders for treatment and diagnostics must be in writing. A verbal or telephone order shall be considered in writing if dictated to an authorized person, entered into the medical record and signed by that person, along with the name of the ordering physician, date and time order received. A verbal order will be authenticated within 48 hours after the time the order was made unless a read-back and verify process is followed. If a read-back and verify process is followed, the order may be authenticated within 30 days after the date the order was made. The following disciplines are authorized to accept verbal and telephone orders:

- a. registered nurse: all patient treatment and diagnostic orders;
- b. licensed practical nurse: all patient treatment orders except telephone no cor orders;
- c. medical technologist/phlebotomist: outpatient lab orders only;
- d. radiology technologist: x-ray, nuclear medicine, CT scan, ultrasound, MRI, and associated prep orders only;
- e. physical/occupational/speech therapists: therapy orders
- f. respiratory therapist: cardiopulmonary and EEG orders;
- g. pharmacist: all medication orders;
- h. clinical dietitian: diets, labs, nutritional assessment interventions, nutrition support regimens, and education.
- i. case manager: discharge, admit, and status change orders.
- j. ICU Assistant: telemetry orders exclusive of medications

18. Standing orders may be formulated by individual members of the active staff and placed on file at the Hospital following their approval by the appropriate service committee and the Executive Committee. These orders must be recorded on the patient's medical record and signed by the attending practitioner. Standing orders shall not, however, replace or cancel those written for the specific patient. Standing orders shall be reviewed at least annually and revised as necessary.

19. Narcotics, sedatives, antibiotics, steroids, and anticoagulant drugs that are ordered without time limitation of dosage shall be automatically discontinued according to specifications by the specific committee as approved by the staff. The attending staff member will be notified when the drug is discontinued. If the order expires in the night, it shall be continued, and it shall be called to the attention of the staff member the next morning.

20. When adding to or changing orders, physicians are to inform the nursing staff, assuring such additions and/or changes are not omitted or misinterpreted.

21. Practitioners shall be responsible for obtaining the patient's informed consent. Consent shall document explanation of benefits and potential complications associated with the procedure(s) discussed with the patient before obtaining informed consent. It will also document alternative options and, if appropriate, the need for and risk of blood transfusions and available alternatives. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by hospital policy or by law. Both the patient (or guardian) and the practitioner shall sign the consent form affirming that the practitioner has personally informed the patient. Space shall be provided on the form for the practitioner to document treatment explanation to the patient and to document that the patient (or guardian) understood and agreed to the proposed treatment.

22. A written operative note shall be entered in the medical record immediately after surgery with the findings of surgery, the procedure performed, the specimen(s) removed, the anesthetic technique, the post-operative diagnosis, any complications, and the name of the primary surgeon and any assistants. A detailed operative report shall be dictated (or written) no later than twenty-four (24) hours following the time and date of the operation. Upon discovery that the operative report dictation is delinquent, a telephone call will be made to the physician (or to the office staff if he or she is unavailable) specifically stating that an operative report is delinquent and the name and date of birth of the patient. The surgeon will then have an additional twenty-four (24) hours to complete the dictation. If the dictation is not completed within that 24-hour grace period, the surgeon will be notified that his or her surgical privileges for performing elective surgeries have been suspended until the dictation has been completed. Exceptions will be made for any emergency surgeries or any inpatients who have already been scheduled for surgery.

23. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

24. In all cases when the patient is admitted for surgery, the surgeon shall be assigned the responsibility of dictating the Discharge Summary. In all other cases the physician who discharges the patient will be responsible for the Discharge Summary. The physician who discharges the patient may request that another physician take the responsibility for the Discharge Summary by writing an order to the effect at the same time the discharge order is written. However, the physician who discharged the patient has ultimate responsibility for the Discharge Summary.

SURGICAL CARE

1. A history and physical examination, the preoperative diagnosis, appropriate consents, and consultations, when requested, must be recorded on the patient's medical record prior to any surgical procedure. In an emergency situation where there is inadequate time to record the history and physical, a brief note is required, including the preoperative diagnosis, and indicating the patient's condition prior to surgery and anesthesia, and that the patient's condition is deemed to be satisfactory for the planned surgery. In all cases other than emergencies, preparation for surgery, including pre-medication, shall not be performed until proper entries are recorded in the patient's medical record. If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time. Patients will be notified on the reasons for delay.

2. Written, signed, informed surgical consent shall be obtained prior to the operative procedure, except in those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving minor or unconscious patients in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. The informed consent shall have been obtained within 60 days prior to the procedure, shall be signed by the patient or legal guardian and signed, dated and timed by the physician. For consents older than 60 days the patient will be required to re-sign, date, and time the original consent.

3. Patients who are admitted to the Hospital more than seven days prior to major surgery shall have a new physical examination recorded or daily progress note updating their condition prior to surgery. It shall include at least the heart, lungs and other vital signs by the attending practitioner, the operating surgeon, or the anesthesiologist. Proper notes shall be made in the progress notes as to the findings. The operating surgeon shall be responsible for such physical examination having been completed prior to surgery.

4. If, in the opinion of the operating surgeon, there is in any surgical procedure an unusual hazard to life, and in all major surgery areas as defined by the Executive Committee, there shall be present and scrubbed, as first assistant, a qualified physician. In all other cases the operating surgeon shall be responsible for the selection of an appropriate and qualified assistant(s). To qualify and perform as a non-physician surgical assistant, the following requirements must be met:

- (a) Shall be employed by a member of the medical staff to assist on appropriate surgeries.
- (b) Will perform his/her duties under the direct supervision of the operating physician.
- (c) Will be credentialed as an Allied Health Professional according to the Medical Staff Bylaws.
- (d) The employing physician must provide evidence of professional liability coverage for the non-physician assistant.

5. The rules for scheduling of elective or non-emergency surgery will be as follows:

- (a) The schedule is available for posting of cases at all times.
- (b) The following information is required in order to post a case:
 - (1) The patient's full name
 - (2) Age
 - (3) Sex
 - (4) Planned surgical procedure
 - (5) Type of anesthesia
 - (6) Operating surgeon
 - (7) Time and name of person posting the case
 - (8) Assisting surgeon
- (c) The order of cases will be based on the time of the cases posted, available operating room personnel, room cleaning, etc., as determined by the operating room supervisor. Emergency cases shall be given priority.
- (d) If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or if they do not interfere with the normal operating room schedule.

6. The anesthesia provider is responsible for writing a pre-anesthetic note in the medical record prior to the patient's transfer to the operating area and before pre-operative medication has been administered. This note shall indicate a choice of anesthesia, the surgical or obstetrical procedure anticipated, and the patient's prior anesthetic history. The anesthesiologist is responsible for writing a post-anesthetic note after the patient has completed post-anesthesia recovery care which includes at least a description of the presence or absence of anesthesia-related complications. Each anesthesia entry shall be dated, timed, signed and authenticated by the responsible practitioner.

7. The anesthesia provider shall maintain a complete anesthesia record which includes evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

8. The attending surgeon shall ensure that all surgical specimens removed during surgery will be submitted for pathological examination. The medical staff, in consultation with the pathologist, shall decide on exceptions to sending specimens removed during a surgical procedure to the laboratory.

The pathologist's report shall be made a part of the patient's medical record. Each specimen shall be accompanied by necessary information including the pre-operative diagnosis, description of tissue and brief pertinent clinical data which the surgeon will complete or cause to be completed. The attending surgeon shall complete or cause to be completed the proper form available to describe each operation. His/her report shall be made a part of the patient's medical record.

9. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The progress note will contain the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.

10. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chief of Surgery.

11. A staff appointee who is classified in a preceptorship or supervisory status for specified surgery privileges must have present his/her preceptor or qualified assistant for these specified surgery procedures.

12. Surgeons must be in the Operating Room and ready to commence the operation at the time scheduled, and, in no case, will the Operating Room be held longer than fifteen (15) minutes after the time scheduled. The anesthesiologist shall be ready to administer the anesthesia fifteen (15) minutes before the time the operation is scheduled.

OBSTETRICAL CARE

1. Labor - First Stage

(a) Admission of Patient

Patients will be admitted and interviewed per hospital policy. Informed consent for the delivery shall be obtained on the patient's arrival. If it appears that labor is progressing rapidly or delivery is imminent, the patient should be taken to the OB department at once, prepared, and the attending physician will be called to come for the delivery. If the patient's labor does not appear to be progressing rapidly, she will be admitted and assessed per Hospital policy, and the physician will be notified.

(b) Orders

Physician should write all specific orders. This should include those for enemas and local preparation, analgesics, sedatives, fluids, oxytocics or anesthesia, if not appearing on the approved standing orders. No patient in the labor room should receive anything more than ice chips except on specific order of a physician. Verbal orders may be carried out and should be written thereafter. Routine ante-partum and post-partum standing orders must be dated and signed by the practitioner.

(c) Monitoring (Fetal)

Monitoring will be conducted per Hospital policy on the order of the attending physician.

(d) Oxytocic Agents

Oxytocic drugs are recommended to be used in the following manner:

1. Intravenous oxytocin may be initiated by an RN having completed pitocin inservice and with the physician available according to hospital policy;
2. Intravenous oxytocin for induction of labor shall be administered by piggyback;
3. Availability of nursing staff should be considered when scheduling elective inductions. Elective inductions may be scheduled by calling the labor and delivery nurse; and

4. The reason for induction labor shall be stated in the history or progress notes.
2. Delivery - Second Stage
 - (a) Delivery Room Technique

Patients shall be attended, and emergency deliveries performed per hospital policy.
 - (b) Anesthesia

Qualified practitioners may use local infiltration, paracervical block, epidurals; spinal anesthesia, pudendal block, or self administered penthrane (observed). Practitioners performing regional anesthesia (saddle block, epidurals, or spinals) must show proof of adequate training.

All patients who are going to undergo caudal, spinal, saddle block or epidural anesthesia should have an IV started prior to the administration of the anesthesia.
 - (c) Forceps Delivery and/or Vacuum/Obstetrical Vacuum Delivery Kit shall be performed and classified per Hospital policy.
3. Placenta - Third Stage

Expulsion of the placenta shall be handled per Hospital policy.
4. Immediate Post-Partum Care and General Post Partum Care

The patient's removal from the delivery table, attendance, vital signs, and assessment shall be conducted per Hospital policy, as well as the routine post-partum care. Post-partum discharge instructions are to be documented on the discharge form and signed by the patient and doctor or RN at discharge, per Hospital policy.
5. History and Physical

Patients having Caesarean sections or post-partum tubal ligations shall have an updated history and physical examination. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall suffice.
6. Sterilization

Sterilization for the sole purpose of sterilization for either male or female patients may be done at the discretion of the attending physician with the informed consent of the patient being sterilized.
7. Cancellation of Previous Orders

All previous orders are cancelled after Caesarean section or post-partum tubal ligation.
8. Dilatation and Curettage

Dilatation and curettage will not be performed unless the medical record reflects one of the following:

 - (a) inevitable abortion;
 - (b) negative pregnancy test;

(c) procedure done for dysfunctional uterine bleeding.

9. The current obstetrical records shall include a complete prenatal record. All obstetrical medical records shall have complete prenatal histories, physical examinations and discharge summary. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital, shall be up-to-date and shall include findings since the time of the last visit.

NEWBORN CARE

1. Newborn Profile

Shall be filled out partly in labor and delivery along with the flow sheet and taken to the nursery with the infant for the nursery personnel to do their assessment and admitting procedure.

2. Orders

Routine newborn orders are used for all infants on admission unless specific orders have been written by the attending physician. All orders must be signed and dated by the delivering or attending physician who is taking care of the newborn.

3. Physical Examinations

Initial (within 24 hours of delivery) discharge physical examinations are to be done and noted on the initial profile newborn form and discharge form, and signed and dated by the physician.

4. PKU Tests

PKU tests shall be done on all newborns prior to discharge. Should parents refuse testing for their infant, the benefits will be explained and the parents will be asked to sign a waiver.

5. Immediate Care of the Newborn

The physician should assume complete responsibility for the immediate post-delivery care of the infant unless he/she has requested that another physician assume care.

The physician should assume responsibility for establishing respiration and examining the baby.

If significant problems requiring the physician's undivided attention (e.g. Caesarean section or retained placenta or excessive bleeding) can be anticipated, or if the baby's condition is in doubt (e.g. prematurity, erythroblastosis, difficult vaginal delivery, or twins) a second physician qualified in infant resuscitation should be present to care for the infant, as well as Respiratory Therapy or the Anesthesiologist from the operating room, per Hospital policy.

6. Identification of the Newborn

Identification of the newborn shall be conducted per Hospital policy.

DISASTER PLAN

1. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be reviewed and approved by the Administrator, the staff and the Board.

2. The disaster plan should make provision within the Hospital for:

- a. Availability of adequate basic utilities and supplies, including water, food, and essential medical and supportive materials;
- b. An efficient system of notifying and assigning personnel;
- c. Unified medical command under the direction of the Chief of Staff or his designated substitute;
- d. Conversion of all usable space into clearly defined areas for triage, patient observation and immediate care;
- e. Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;
- f. A special disaster medical record, such as an appropriately designated tag, that accompanies the casualty as he/she is moved;
- g. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy;
- h. Maintaining security in order to monitor relatives and curious persons; and
- i. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual.

3. All physicians may be assigned to posts, and it is their responsibility to report to their assigned stations. The Physician Disaster Coordinator and the Administrator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the Physician Disaster Coordinator or the Administrator during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Physician Disaster Coordinator and the Administrator. In their absence, the Chief of Staff and alternate in Administration are next in line of authority, respectively.

4. The disaster plan will be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills will be made.

DRUGS AND MEDICATIONS

1. All medications brought into the Hospital by a patient must be sent to the Pharmacy for proper identification. The pharmacist will verify the fact that the medications brought in by the patient are in fact those that the practitioner has prescribed or permitted. Any such medications shall be administered as directed by the attending physician.

2. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principle involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

3. All antibiotics, narcotics, hypnotics, steroids, sedatives, and oxytoxics will carry an automatic seven day stop order. If the practitioner desires to continue these medications, he/she must reorder them at the end of this period. The attending practitioner or his/her designee shall be notified by the responsible nurse when drugs are due for an automatic stop order.

4. I.V. anticoagulants should only be written for a twenty-four (24) hour period unless otherwise specified. The physician will be notified for continuing orders after the initial (24) hours.

5. Certain medications may be administered only by a physician or under his direct supervision when given by the I.V. push method. These medications include:

- (a) Those medications for which no "FDA Approved" indication for direct I.V. administration, i.e.: I.V. push, is stated in the official package insert unless such medication has been specifically exempted from this restriction by the Executive Committee;
- (b) Those medications having "FDA Approved" indication for direct I. V. push administration but which have been restricted from such administration by the Executive Committee. A list of the latter drugs shall be maintained in the policy manuals of nursing services and the department of pharmacy.

Only registered nurses who have completed orientation and a review of the I.V. push technique may administer nonrestricted drugs by the I. V. push method.

Upon the transfer of a patient to Surgery or the Special Care Unit, all medication orders will be discontinued with new orders developed upon transfer.

6. All medications not mentioned in #3 or #4 above, unless ordered for a specific number of doses or for a specific number of days, shall carry an automatic stop order of 21 days.

7. The Medical Staff will adopt a Formulary. Staff members will use drugs listed in the Hospital Formulary, except in bona fide emergencies. Exception to this rule shall be presented to the Pharmacy and Therapeutics Committee.

GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at time of the admission. The admitting personnel should notify the attending practitioner whenever such consent has not been obtained and the attending practitioner shall make an entry in the medical record explaining the reason the consent was not obtainable. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

2. Practitioners shall be responsible for obtaining the patient's informed consent. When consent is not obtainable, the reason shall be entered in the patient's medical record. The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by Hospital policy or by law. Both the patient and the practitioner shall sign the consent form affirming that the practitioner has personally informed the patient. Space shall be provided on the form for the practitioner to document treatment explanation to the patient and to document that the patient understood and agreed to the proposed treatment. The informed consent shall have been obtained within 60 days of the procedure, shall be signed by the patient or legal guardian and signed, dated and timed by the physician. For consents older than 60 days, the patient will be required to re-sign, date, and time the original consent.

3. Blood which has been cross-matched and is being held for a patient will be held for forty-eight (48) hours at which time the order for the blood will be cancelled unless reordered for another forty-eight (48) hours. Blood will not be released without notifying the appropriate practitioner.

4. Oxygen and respiratory therapy will be administered according to the joint decision of the practitioner and the Respiratory Therapist. The Respiratory Therapist will review charts of all patients admitted to the Hospital, having orders for Respiratory Therapy consultation, evaluating each and making recommendations according to standard protocol. Suggested treatment plan will be submitted by the Respiratory Therapist and the physician will respond to the suggestion in writing or by verbal orders within twenty-four (24) hours. When the Respiratory Therapist, according to standard protocol, feels the treatment may be discontinued the practitioner will be so notified. Treatment will be discontinued only by order of the physician.

5. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who in turn may refer the matter to the Director of the Clinical Service. If warranted, the Director of the Clinical Service may bring the matter to the attention of the attending practitioner, the Administrator, or the Chief of Staff. Where circumstances are such as to justify such action, the Chief of Staff may, himself, request a consultation.

If, in the nurses opinion, an inpatient is in need of immediate attention by his/her physician, and the physician refuses to attend, the nurse is to contact the Chief of Service and Administration to facilitate patient care in a timely manner.

6. Consultation request forms for radiology and pathology shall be filled out completely. The attending practitioner is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes by a nurse.

7. All requests for medical imaging services must include information from the requesting practitioner justifying the need for the examination(s) requested.

8. Women in childbearing ages should be screened for possibility of pregnancy before examinations requiring radiation. A menstrual history will suffice in most cases, but additional testing for pregnancy may be necessary in selected cases.

9. No members of the medical staff shall be permitted to administer radioisotopes or perform fluoroscopic x-ray examinations unless specifically approved through the credentialing process of the medical staff.

10. The attending physician shall be responsible for documenting daily patient visits. The physician must be available for urgent patient care issues within a reasonable period of time. Each physician shall establish a reliable means of emergency contact.

11. The Infection Control Committee, through its chairman, or practicing members, has the authority to institute any appropriate control measures or studies when it reasonably feels that danger to patients, visitors, or personnel exists.

12. (a) The medical staff, with other appropriate hospital staff develops and uses criteria that identifies deaths in which an autopsy should be performed.

Noting all death cases are possible sources of unexpected information, medical staff policy requires request of autopsy permission in all cases in which autopsy is indicated. Autopsy is indicated in at least the following circumstances:

- (a.1) Death in which the admission diagnosis suggests death was not expected;
- (a.2) Patients below age fifty (50), unless the probable etiology has been well documented during life;
- (a.3) Patients on therapeutic protocols in which autopsy data may be used to assess results of therapy;

- (a.4) Cases with a major unanswered question. Example: Is the infiltrate in a patient with cancer due to pneumonia, chemotherapy or radiation-induced fibrosis, or carcinoma?
- (a.5) Deaths within forty-eight (48) hours of a surgical or invasive procedure (including radiology);
- (a.6) Deaths associated with drug reaction;
- (a.7) Deaths associated with adverse events.
- (b) Findings from autopsies are used as a source of information in Quality Improvement and as indicated in infection control activities.
- (c) When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within three (3) days, and the complete protocol is made a part of the record within sixty (60) days, unless exception for special studies are authorized by the Chief of Staff.
- (d) Documentation of the effort to procure the autopsy, in the progress notes is required.

13. A physician appointee of the staff shall be responsible for the medical care of each patient in the Hospital. The governing body assumes overall responsibility for physician coverage for all patients. This responsibility includes the requirements for physician coverage at all times, as outlined in these Rules and Regulations. The attending practitioner shall be responsible for the treatment and the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient, if appropriate, to the referring practitioner. Whenever these responsibilities are transferred to another practitioner, the transferring physician shall confirm the acceptance of the patient by the receiving physician, and a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. A progress note summarizing the patient's condition and treatment shall be made and the practitioner transferring his/her responsibility shall notify the other practitioner within twelve (12) hours of admission to ensure that the acceptance of responsibility is clearly understood. Notification may take the form of a written order on the patient's chart, delegating the responsibility to the attending nurse; or by personal telephone call to the attending physician by the admitting physician. In the case of a patient requiring admission who has no practitioner, he/she shall be assigned to a practitioner on call, or to the patient's choice of practitioner, with that practitioner's agreement to accept the patient.

14. Each member of the staff who does not reside in the immediate vicinity shall name a member of the medical staff who is nearby, and accepts the responsibility, who may be called to attend patient emergencies until he/she arrives. When neither can arrive quickly enough, an on-call physician shall be called for emergency treatment until the patient is stable and/or the attending physician arrives.

15. The Utilization Review and Quality Assurance Plans of the Hospital, as approved by the Medical Staff and Board of Trustees, shall be adhered to by all attending practitioners.

16. Policies and procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized treatment, disposal of specimens, when determined and published by authorized committees or the appropriate services of the staff and approved by its Executive Committee, the Medical Staff, and the Board of Trustees, shall be adhered to by all attending practitioners and said practitioners are responsible for remaining abreast of all current directives.

17. Non-resident Staff Member: A non-resident medical staff member shall not perform surgery, perform obstetrical deliveries, or accept primary care responsibilities in the intensive care unit in the Hospital unless he/she has made arrangements with a member of the Active Staff to be immediately and continuously available to attend the patient until the patient is discharged from the Hospital. Such Active Staff member shall have the surgical privileges for the particular surgery, and shall have intimate knowledge of the particular case. Such Active Staff member shall assume responsibility for the patient and by so acting shall represent competency to perform in post surgical care. He/she shall be named at the time of admission and his/her written consent shall be attached to the patient's medical record before said surgery or delivery is performed.

NON-PHYSICIANS

1. Dentists

A patient admitted for dental care is primarily the responsibility of the dentist. Prior to arrival at the hospital for elective surgery, the dentist shall seek preoperative consultation, including an appropriate history and physical examination, from an MD/DO/APN or PA licensed in the State of Colorado. The dentist will also have in place (per the intended Practice Plan) an arrangement with a credentialed medical staff member to identify and manage medical conditions, and that physician shall share the responsibility for the patient's care.

Responsibilities of the dentist shall include:

- A dental history justifying hospital admission
- A detailed description of the examination of the oral cavity and a pre-operative diagnosis
- The dentist is responsible for the oral and dental care
- Progress notes as are pertinent to the oral/dental condition
- A complete operative report describing the findings and procedures used
- Discharge Summary as required by the Bylaws and Rules and Regulations
- Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
- Dental Staff members shall have thirty (30) hours of documented postgraduate education annually.

2. Allied Health Professionals:

a. Independent –

i. Podiatrists

A patient admitted for podiatric care is primarily the responsibility of the podiatrist. Prior to arrival at the hospital for elective surgery, the podiatrist shall seek preoperative consultation, including an appropriate history and physical examination, from a credentialed medical staff member to identify and manage any prior medical conditions, and that physician shall share the responsibility for the patient's care.

Responsibilities of the podiatrist include:

- A podiatric history justifying hospital admission
- A detailed description of the examination of the feet and a pre-operative diagnosis
- The podiatrist is responsible for the podiatric care of the feet with surgery limited to the forefoot and toes
- Progress notes as are pertinent to the podiatric condition
- A complete operative report describing the findings and procedures used
- Discharge Summary as required by the Bylaws and Rules and Regulations
- Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
- Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal

b. Dependent Professionals (designated) – Dependent professionals will work in collaboration with a similarly privileged physician member of the Montrose Memorial Hospital Active or Provisional Medical Staff.

i. Nurse Practitioners - A nurse practitioner may provide patient care only if he/she has been credentialed as a member of the Allied Health Staff and then may exercise only those specified patient services approved by the Board. There will be in force a collaborative agreement with a similarly privileged physician member of the Montrose Memorial Hospital Active or Provisional Medical Staff. The Nurse Practitioner shall meet the following conditions:

- Must practice in accordance with the approved Montrose Memorial Hospital Nurse Practitioner Clinical Practice Guidelines
- Shall work in collaboration with a physician who holds the privileges that reflect the patient care responsibilities of the nurse practitioner
- The collaborating physician will review the nurse practitioner's entries in the medical record for quality and appropriateness of care and sign the record in a timely manner
- Must be licensed by the State of Colorado and registered with the Advanced Practice Registry of the Board of Nursing
- Must be certified by American Nurses Credentialing Center
- May perform inpatient history and physical examinations on established patients and clinic outpatients in collaboration with the attending physician
- May order laboratory and diagnostic imaging procedures, medications and treatments in collaboration with the attending physician
- May write patient care orders in collaboration with the attending physician, excluding patients in the ICU
- May make hospital rounds in collaboration with the attending physician
- May not perform consultations within the hospital
- Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
- Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal

ii. Physician Assistants – A physician's assistant may provide patient care only if he/she has been credentialed as a member of the Allied Health Staff and then may exercise only those specified patient services approved by the Board. The Physician's Assistant shall meet the following conditions:

- Must practice in accordance with the approved Montrose Memorial Hospital Physician Assistant Clinical Practice Guidelines
- Shall be supervised by a physician who holds the privileges that reflect the patient care responsibilities of the physician assistant
- Physician supervisor will review the physician assistant's entries in the medical record for quality and appropriateness of care and sign the record in a timely manner
- Must be licensed by the State of Colorado
- Must be certified by the National Commission on Certification of Physician Assistants, Inc.
- May perform inpatient history and physical examinations on established patients and clinic outpatients under physician supervision
- May order laboratory and diagnostic imaging procedures, medications and treatments under physician supervision
- May write patient care orders under physician supervision, with the exception of patients in the ICU
- May make hospital rounds under physician supervision
- May not perform consultations within the hospital
- Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage

- Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal
- iii. Certified Registered Nurse Anesthetists – A certified registered nurse anesthetist may provide patient care only if he/she has been credentialed as a member of the Allied Health Staff and then, may exercise only those specific patient services approved by the Board. There will be in force a collaborative agreement with a similarly privileged physician member of the Montrose Memorial Hospital Active or Provisional Medical Staff. The CRNA shall meet the following conditions:
- Will practice in collaboration with an anesthesiologist as described in the Collaborative Practice Agreement.
 - Practice will be limited to the administration of anesthesia services; this does not include treatment for chronic pain.
 - Criteria used for screening and review of anesthesia performance will be the same for the CRNA allied health staff as it is for the anesthesiology medical staff members.
 - When the CRNA is administering anesthesia, the surgeon and/or surgical assistant must be a credentialed member of the Montrose Memorial Hospital medical staff.
 - Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
 - Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal
- iv. Certified Nurse Midwives - A certified nurse midwife may provide patient care only if he/she has been credentialed as a member of the Allied Health Staff and then may exercise only those specified patient services approved by the Board. There will be in force a collaborative agreement with a similarly privileged physician member of the Montrose Memorial Hospital Active or Provisional Medical Staff. The Certified Nurse Midwives shall meet the following eligibility requirements:
- Will practice in collaboration with the Medical Director of the Montrose Memorial Hospital Nurse Midwifery Department as described in the Medical Director Agreement, Montrose Memorial Hospital Nurse Midwifery Department.
 - Must practice in accordance with the approved Montrose Memorial Hospital Nurse Midwife Services Clinical Practice Guidelines
 - Must be licensed by the State of Colorado and registered with the Advanced Registry of the Board of Nursing
 - Must be certified by the American College of Nurse Midwives
 - May perform inpatient history and physical examinations on established patients and clinic outpatients in collaboration with the Medical Director.
 - May order laboratory and diagnostic imaging procedures, medications and treatments in collaboration with the Medical Director.
 - May write patient care orders in collaboration with the Medical Director, with the exception of patients in the ICU
 - May make hospital rounds in collaboration with the Medical Director
 - May not perform consultations within the hospital
 - Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
 - Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal

v. Certified Oncology Nurse Practitioners – A certified oncology nurse practitioner may provide patient care only if he/she has been credentialed as a member of the Allied Health Staff and then may exercise only those specified patient services approved by the Board. There will be in force a collaborative agreement with a similarly privileged physician member of the Montrose Memorial Hospital Active or Provisional Medical Staff. The Certified Oncology Nurse Practitioner shall meet the following conditions:

- Must practice under the approved Montrose Memorial Hospital Oncology Nurse Practitioner Clinical Practice Guidelines
- Shall work in collaboration with a physician who holds the privileges that reflect the patient care responsibilities of the certified oncology nurse practitioner
- Collaborating physician will review the certified oncology nurse practitioner's entries in the medical record for quality and appropriateness of care and sign the record in a timely manner
- Must be licensed by the State of Colorado and registered with the Advanced Practice Registry of the Board of Nursing
- Must be certified by the American Nurses Credentialing Center
- May perform history and physical examinations on established patients in collaboration with the attending physician
- May order laboratory and diagnostic imaging procedures, medications and treatments in collaboration with the attending physician
- May write patient care orders in collaboration with the attending physician, excluding patients in the ICU
- May make hospital rounds in collaboration with the attending physician
- May not perform consultations within the hospital
- Must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage
- Must provide documentation of fifty (50) hours of continuing education per year or 100 hours upon renewal

c. Dependent Professionals (not otherwise designated) – Allied Health Professionals and specialists employed by the Hospital, independently contracting with the hospital, or employed by members of the Medical Staff – including, but not limited to, physical therapists, speech therapists, respiratory therapists, counselors, surgical first assistants, ophthalmic surgery technicians, neuromonitoring technicians, lithotripsy technicians, dental surgery technicians, autotransfusionists, and transurethral microwave thermotherapy technicians, etc. shall meet the following conditions:

- Must practice under the supervision of the attending physician requesting (or ordering) services
- Must be a graduate of an accredited/appropriate educational or training program in his/her discipline
- Must be licensed by the State of Colorado and/or certified by a certifying board, as appropriate and applicable
- Must practice within the scope of his/her license/certification/training and education
- Must have qualifications, training/education, certification and/or licensure verified prior to practicing at Montrose Memorial Hospital.
- It is recognized that hospital employees are covered by the Montrose Memorial Hospital professional liability insurance. All others must provide verification of professional liability insurance, minimum \$1,000,000 each occurrence and \$3,000,000 total coverage, and maintain this coverage while practicing at Montrose Memorial Hospital.

CONSULTATIONS

1. General
Consultations shall be requested, except in extreme emergencies, under the following conditions:
 - (a) When the patient is not a good risk for operation or treatment;
 - (b) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - (c) Where there is doubt as to the choice of therapeutic measures to be utilized;
 - (d) In unusually complicated situations where specific skills of other practitioners may be needed;
 - (e) In any instances in which the patient exhibits severe psychiatric symptoms;
 - (f) Major surgical cases in which the patient is not a good risk or in which the diagnosis or indications for surgery are in doubt;
 - (g) When requested by the patient or his/her family;
 - (h) When required by the policy of a special care unit;
 - (i) Psychiatric consultation and treatment should be recommended to all patients who have attempted suicide or have taken a chemical overdose. That such services were at least recommended must be documented in the patient's medical record.

2. It is the responsibility of the requesting physician to personally contact the consulting physician and write an order for consultation with a written concurrent progress note documenting the reason for the consult. The practitioner responsible for the care of the patient shall be responsible for judgments as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment. The following levels of consultation are defined as:

Level I – request for a second opinion without co-management
Level II – care is co-managed
Level III – transfer of care to the consulting physician

3. Performance of Consultations

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so stated in the record, be recorded prior to the operation. Any qualified practitioner with clinical privileges in the Hospital may be called for consultation. The consultant must be qualified to give an opinion in the field in which his/her opinion and consultation is sought. The practitioner responsible for the care of the patient shall be responsible for judgments as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment.

4. It is the responsibility of the requesting physician to personally contact the consulting physician or write an order for consultation with a written concurrent progress note documenting the reason for consultation.

CONTINUING MEDICAL EDUCATION

1. One Hundred (100) hours of postgraduate education are required for physicians every two (2) years, with a minimum of forty (40) hours being acquired each year. During each two year period, twenty (20) hours of the required one hundred hours must be acquired outside Montrose Memorial Hospital. Attendance at the Montrose Fall Clinics is acceptable as "outside Montrose Memorial Hospital". Post graduate education may include clinical conferences, teaching conferences, and any other Category I accredited medical meetings at which attendance can be documented. The following Category I hours will be accepted towards the required education requirements:

- 25 hours for medically related degree as per the guidelines of the AMA Physician Recognition Award
- 25 hours for Board Certification/recertification
- 10 hours for published article
- 2 hours for lecture presentation (up to 10 hours annually)

These educational requirements are established for all Active, Associate, and Courtesy physician staff members. Dental staff members shall have thirty (30) hours of documented postgraduate education annually.

2. All members of the staff are encouraged to participate in basic cardiopulmonary resuscitation training.
3. Each practitioner or other person with clinical privileges shall participate in the Hospital's continuing education programs and in other continuing education activities that relate to the privileges granted.
4. Continuing medical education programs will be based at least in part on the findings in the quality assurance program.
5. ACLS certification is strongly recommended for physicians working in high risk areas such as the operating room, emergency room, special care unit, and obstetrics.