BLACK RIVER MEMORIAL HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

Approved by the Board of Directors

_____

Revised
January 26, 2010
April 27, 2010
January 25, 2011
May 28, 2013
May 26, 2015
September 26, 2017
August 27, 2019
June 23, 2020
November 23, 2021

TABLE OF CONTENTS

Page

ARTICLE 1
ADMISSION, CARE AND DISCHARGE OF PATIENTS

1. Black River Memorial Hospital, Inc., including all provider-based clinics, (the "Hospital") shall not deny patients appropriate Hospital care because of the patient's sex, race, religion, color, creed, ancestry, disability, sexual orientation, marital status, gender identity or expression, national origin, age, source of payment, or any other prohibited basis defined by federal or state law.

2. Patients may be admitted to the Hospital only upon the recommendation of a member of the Medical Staff who has been granted admitting Privileges. A physician Member of the Medical Staff shall be notified of each APP admission and shall be involved to the extent the patient has a medical or psychiatric problem that exceeds the APP's scope of practice.

3. A Physician, Dentist or Podiatrist member of the Medical Staff shall be available for consultation regarding the medical care and treatment of each Hospital patient under the primary care of an APP.

4. Each member of the Medical Staff is responsible for the prompt completeness and accuracy of the medical record under that Practitioner's care, for necessary special instructions, and for transmitting reports of the condition of the patient to the patient's primary care provider, if any, and to relatives and support persons of the patient, as permitted by applicable law. Whenever primary responsibility for a given patient is transferred to another Practitioner (whether internal or external), the previously responsible Practitioner will ensure that all information is communicated to the Practitioner assuming the patient's care and the receiving Practitioner shall have access to all information necessary to allow for care and oversight of the patient. Any such transfer of responsibility will be clearly documented in the patient's medical record.

5. If a given patient's needs exceed the capacity or capabilities of the Hospital, arrangements will be made for appropriate transfer or referral to another facility. For patients transferred to another facility from the Hospital's Emergency Department while in an unstable emergency medical condition or otherwise triggering EMTALA, the transfer shall meet all applicable requirements in accordance with the Hospital's EMTALA policy and a transfer form shall be completed.

6. Except in emergencies, all admitting Practitioners shall document a patient's provisional diagnosis or valid reason for admission upon admission as an inpatient to the Hospital. In emergency situations, the attending Practitioner shall furnish such data as soon as possible but no later than twenty-four (24) hours after the patient is admitted.

7. When a Hospital patient is determined or suspected to be a danger to self or others (e.g. suicidal ideation), the Practitioner (or designee) shall determine whether it is appropriate to contact law enforcement and/or the applicable county crisis agency to initiate emergency detention proceedings, transfer to another facility, or facilitate a three-party petition for involuntary commitment. Appropriate precautions (including without limitation special nursing observation) should be taken to protect such patients and others in the Hospital from harm, in accordance with applicable Hospital policies.

8. All Providers shall be familiar with and abide by all facets of the Patient's Bill of Rights as posted in and adopted by the Hospital and with the requirements under the Wisconsin Administrative Code, as further specified in Article 9 below.

9. In the event that a given patient requires services beyond the capacity or capability of the Hospital, the attending Practitioner shall make all reasonable efforts to facilitate an appropriate transition of care to another facility, accommodating patient choice to the extent possible.

10. Patients shall be discharged only pursuant to a written or verbal order of the attending Practitioner. The attending Practitioner may delegate the development and documentation of the discharge summary to another qualified Practitioner who is involved with the care of the patient, as further detailed below. Should a patient leave the Hospital against the advice of the attending Practitioner or otherwise without proper discharge, notation of the incident shall be made in the patient's medical record and, if possible, the proper release form shall be signed by the patient.

11. In the event of a patient death, the requirements outlined in the Death of a Patient Policy shall be followed. An autopsy may be performed in accordance with state law, the Death of a Patient Policy and proper written consent, as applicable. The Hospital shall report deaths to the local coroner or medical examiner to the extent required by state law.

12. When a patient comes to the Hospital seeking emergency evaluation or treatment or appearing to prudent layperson to be experiencing an emergency medical condition (EMC), the Hospital shall provide an appropriate medical screening examination (MSE) to determine whether the patient has an EMC in accordance with EMTALA and Hospital policies. Patients who are having labor symptoms must be screened by a Physician (or a qualified obstetrical RN with appropriate training) to determine and certify whether the patient is in false labor. The MSE must be conducted in a timely manner by a Physician or other qualified medical personnel (QMP) present in the Emergency Department. QMPs may include qualified registered nurses, Advanced Practice Professionals or Allied Health Professionals.

ARTICLE 2
MEDICAL RECORDS

1. Providers are responsible for appropriately documenting all care in each patient's medical record as required by compliance with applicable state and federal law, The Joint Commission (TJC) accreditation standards, and Hospital policy.

2. All clinical entries in the patient's medical record shall be complete, and accurately dated, timed, and authenticated by the individual making the entry and shall include that individual's title. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations is kept on file in all patient care units and in Health Information Management department.

3. To the extent required by applicable state and federal law, TJC standards, and/or Hospital policy, a Physician member of the Medical Staff shall review and co-sign entries in a patient medical record by Advanced Practice Professionals. Verbal orders will be appropriately authenticated within a reasonable time frame.

4. **Medical Record Content.**

   a. Each patient's medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. Where applicable, the medical record shall include patient identification data (including name, address, date of birth, sex, and name of any legally authorized representative); the legal status of any patient receiving behavioral health care services; the patient's language and communication needs; the reason(s) for care, treatment, and services; a concise statement of complaints, including chief complaint and the date(s) of onset; personal history; family history; medical history and existing medical conditions, medication administration record or list of medications (including current medications); allergies to food and medications; social history; physical examination; conclusions and impressions drawn from the patient's medical history and physical, including all positive and negative findings resulting from an inventory of systems; special reports such as consultations, clinical laboratory and radiology services, EKG, respiratory therapy, diagnostic and physical

therapy and others; original and provisional diagnoses; all diagnostic and therapeutic orders; any access site for medication, administration devices used, and rate of administration; any adverse drug reaction; operative reports; pathological reports, progress notes; clinical observations relevant to the care, treatment and services and the patient's response thereto; results of diagnostic and therapeutic tests and procedures; final diagnoses; significant findings; discharge diagnosis; discharge summary; discharge planning evaluation and instructions provided to the patient; any medications dispensed or prescribed on discharge; autopsy report when performed; authorizations for treatment; patient informed consent forms; emergency room treatment if admitted through emergency; treatment goals; a plan of care; advance directives (if any); records of communication with the patient (e.g. telephone calls); any patient-generated information; and anatomical gift information (as appropriate).

b. All records of newborn patients include: a record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth, a record of physical examinations, a progress sheet recording medicines and treatments, tissue reports, consultation notes, weights, feedings and temperatures. In the case of a fetal death, the weight and length of the fetus shall be recorded on the delivery record. Upon admission to labor and delivery or upon testing, the mother's status of the following diseases (during the current pregnancy) shall be documented in the newborn's record after delivery: HIV, Hepatitis B, Group B Streptococcus (GBS), and syphilis.

c. The medical record of a patient who receives urgent or immediate care, treatment, and services shall also contain the following: the time and means of arrival; indication that the patient left against medical advice(if applicable); conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services; a copy of any information made available to subsequent providers (if any).

5. **History and Physical Examinations.**

a. A complete admission history and physical examination ("H&P") shall be recorded no more than thirty (30) days prior to admission or registration nor longer than twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The content of the H&P report may vary based on the setting, level of care, treatment, or service, but shall at a minimum include those elements pertinent to the chief complaint, or presenting problem: the history of the present illness; relevant past medical, surgical, social and family history; medications, and allergies; vital signs, pain assessment and review of systems; physical examination; mental status; diagnostic impression/assessment; treatment plan and goals; and any additional elements necessary for the safe and effective treatment of the patient.

b. When an H&P is completed within thirty (30) days before admission or registration, an updated examination of the patient must be completed and documented within twenty-four (24) hours after admission or registration, but prior to a surgery or procedure requiring anesthesia services. Such update shall include a reference to the previous H&P and, as necessary, provision of required information that is otherwise absent or incomplete; a description of the patient’s condition and course of care since the H&P was performed; and, regardless of whether any changes or updated information are necessary, the signature of the Physician or other Practitioner, time, and date on any document with updated or revised information as an attestation that it is current.

c. The H&P, and any updates thereto, must be completed and documented by a Physician member of the Medical Staff, except that a H&P that is completed prior to admission or registration may be completed by a Practitioner who is not privileged by the Hospital if an update is completed and documented by a Physician who is credentialed and privileged

by the Hospital. In addition, all or part of the H&P, and any updates thereto, may be delegated to other qualified Advanced Practice Professionals in accordance with state and federal law, but a Physician with Privileges at the Hospital must review, sign, and date the H&P and/or update and assume full responsibility for the H&P and/or update. All pre-operative history and physicals must be signed by the surgeon.

d. Patients registered for ambulatory or other outpatient surgeries and procedures requiring anesthesia services shall have an H&P. Such H&P or updates thereto shall meet the requirements of an inpatient H&P and shall be recorded in the medical record within the same timeframes.

e. Except in an emergency situation, an appropriate H&P shall be performed and recorded in the medical record of every patient before an operative or invasive procedure. Failure to do so may result in cancellation of the scheduled surgery. H&Ps prior to operative or invasive procedures must include all items listed in Article 2, paragraph 5.a. above, as well as indications for the procedure, evaluation of the operative site as appropriate, examination of the heart and lungs by auscultation and assessment of mental status. In emergency situations, when a delay may constitute a danger to the health and safety of the patient and there is inadequate time to record the H&P prior to surgery, a progress note may be placed in the patient's medical record. The progress note shall include the preoperative diagnosis, description of any known drug allergies and other clinical findings pertinent to the safety of the patient during surgery including information such as pulmonary status, cardiovascular status, BP, vital signs, etc.

f. In circumstances where the H&P examination has been conducted but the documentation is not present in the chart, or in emergency situations where a complete H&P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, blood pressure, vital signs, etc.

6. **Operative Reports.**

a. Operative reports shall include the name and identification number of the patient, the date and times of the surgery; name of surgeon(s) and assistant(s) who performed surgical tasks (even when performed under supervision); the name of the specific surgical procedure(s) performed, a description of the specific significant surgical tasks conducted by Providers other than the primary surgeon (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, and altering tissues); type of anesthesia administered; complications, if any; a description of the findings, surgical techniques and any tissue or specimen removed; pre and post-operative diagnosis; estimated blood loss; and prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

b. Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient’s current medical record.

c. If the full operative report is not included in the medical record promptly after the surgery, a brief operative note must be documented by the surgeon before the patient is transferred to the next level of care. The brief note must, at a minimum, identify the procedure, the primary surgeon and his/her assistants, any significant findings, any complications, estimated blood loss, any specimens removed and the postoperative diagnosis.

d. In addition to the operative report, an operating room register shall be maintained including at a minimum the patient's name, identification number, the date of the operation, the total operation time, the name of the surgeon and/ or assistants, the names of nursing personnel including scrub and circulating, the type of anesthesia used and the name of the person administering it, the operation performed, the pre-operative and post-operative diagnosis, and the patient's age.

7. **Consultations By Specialists.** Where a consultant (e.g. specialist) is requested and/ or evaluates or treats the patient, the request and evaluation or treatment must be documented in the patient's medical record including pertinent findings on examination of the patient, and the consultant's opinion and recommendation. A limited statement such as "I concur" does not constitute an acceptable report of consultations. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

8. **Obstetrical Records.** A maternal obstetrical record will include documentation of prenatal care. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission. The obstetrical record shall include at a minimum: prenatal H&P findings; the labor and delivery record, including anesthesia; upon admission for labor and delivery, the mother's HIV, Hepatitis B, Group B Streptococcus (GBS), and Syphilis status or results of the tests for same; the Physician's progress record; the Physician's order sheet; a medicine and treatment sheet, including nurses' notes; any lab and x-ray reports; any medical consultant's notes; and an estimate of blood loss. A physical newborn exam shall be performed and documented as soon as possible, and no later than twenty-four (24) hours after delivery.

9. **Emergency Department Records.** All Emergency Department encounters must be fully documented in the patient's medical record. The documentation of any such encounter must include all information required by EMTALA in accordance with the Hospital's EMTALA policy, including but not limited to:

   a. Information concerning the time of the patient's arrival, means of arrival, by whom the patient was transported, and the time of Physician notification;

   b. Documentation of the medical screening examination;

   c. Whether or not the patient had an emergency medical condition (and the specifics regarding any such condition);

   d. Any stabilizing treatment rendered; and

   e. Any resolution of the condition or appropriate transfer to another facility in accordance with EMTALA and Hospital policy.

10. **Progress Notes.** Pertinent progress notes shall be recorded at the time of observation indicating all material developments in the patient's condition, changes to the plan of care, and any other information necessary to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems shall be clearly identified in the tests and treatment. Progress notes shall be recorded for each patient encounter.

11. **Final Diagnosis.** Final diagnoses shall be recorded in full and dated, timed, and authenticated by the responsible Physician at the time of discharge for all patients if possible.

12. **Discharge Summaries For Inpatients.**

a. The Hospital shall comply with the discharge planning requirements for all inpatients including a process that focuses on the specific patient's goals and treatment preferences, includes the patient and any involved caregivers as active partners in the planning for post-discharge care, and includes parameters for:

i. Ensuring that patients have the right to access their own medical records upon oral or written request, in the form and format requested by the individual (including electronically, if readily producible in that format) and within a reasonable time frame.

ii. Allowing for timely arrangement of post-hospital care prior to discharge;

iii. Evaluating the likely need for, availability of, and patient access to non-health care services and community-based care providers; and

iv. Providing patients and their caregivers with assistance selecting a post-acute care providers including, where necessary, relevant data on quality and resource use measures relevant to the patient's goals of care and treatment preferences.

b. The attending Practitioner who admitted the patient (or designee) will ensure that the patient has an adequate discharge summary documented in his or her medical record. Discharge summaries must include at a minimum(to the extent applicable): reason for admission/admitting diagnosis; any pertinent secondary diagnoses; diagnostic studies performed during the hospitalization; medications; significant findings; care, treatment and services rendered; operative and other invasive procedures performed; brief review of the H&P; condition of patient at discharge; disposition; final diagnosis; diet, activity, medications, and provisions of follow-up care, including but not limited to any post-inpatient appointments scheduled, how post-inpatient patient care needs are to be met and plans for post-inpatient care; and any other specific instructions or information provided to the patient and/or caregivers. For newborn patients, discharge summaries must be accompanied by appropriate references to maternal inpatient and follow-up care. For swing bed patients, the discharge summary shall specify the post-discharge residential plans..

c. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All discharge summaries must be dated, timed, and authenticated by the responsible Practitioner. Patients admitted to dental or podiatry service must comply with additional requirements specified in these Rules and Regulations, the Medical Staff Bylaws or other Medical Staff or Hospital policy.

d. Discharge summaries for nursing home patients must be completed on the date of discharge whenever possible, and as soon as possible thereafter. When a patient is transferred to a different level of care within the Hospital (e.g. swing bed status), a transfer summary / discharge summary is created

13. **Additional Requirements For Swing Bed Patients.**

a. Patients may be admitted to swing bed status only upon a signed order of a Physician. Additionally, a Physician must complete and sign a certification certifying the need for post-acute services upon admission to swing bed status or as soon thereafter as reasonable and practical. Such admission orders and certifications shall be completed in accordance with applicable Hospital policy and documented in the patient's medical record.

b. All swing bed patients shall receive a comprehensive assessment within fourteen (14) days after admission. The comprehensive assessment shall include, without limitation, the following information: identification and demographic information; customary routines; cognitive patterns; communication; vision needs; mood and behavior patterns; psychosocial well-being; physical functioning and structural problems; continence; disease diagnoses and health conditions; dental and nutritional status; skin condition; activity pursuit; medications; special treatments and procedures; discharge planning; documentation of summary information regarding the additional assessment performed; and documentation of patient's participation in assessment.

c. The medical record for a swing bed patient must include acute care discharge orders changing the patient's status to swing bed, appropriate progress notes, a discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the Hospital or transfers to another hospital or CAH with swing bed approval.

d. The discharge summary from swing bed status shall be completed by the admitting Physician. A Physician may delegate the responsibility to complete the discharge summary to another Physician or Advanced Practice Professional with appropriate cosignature as required by law or Hospital policy. The swing bed discharge summary shall include:

i. The reason for transfer, discharge, or referral;

ii. A recap of the patient's swing bed stay including but not limited to diagnoses, course of illness, treatment provided, pertinent lab, radiology and consultation results, diet, medication orders, and orders for the patient's immediate care;

iii. Referrals provided to the patient, the referring Practitioner's name, and the name of the Practitioner who has agreed to be responsible for the patient's medical care and treatment, if this person is someone other than the referring Practitioner;

iv. A final summary of the patient's status including the items enumerated in the comprehensive assessment pursuant to (in these rules), and without limitation to the extent not duplicative, any medical findings and diagnoses including, without limitation, a summary of the care, treatment, and services provided and progress reached toward goals;

v. Information about the patient's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation;

vi. Nursing information that is useful in the patient's care;

vii. Any advance directives;

viii. Instructions given to the patient before discharge;

ix. Attempts to meet the patient's needs;

x. Reconciliation of the patient's pre-discharge medications with the patient's post-discharge medications (both prescribed and over-the-counter); and

xi. Post-discharge plan of care that is developed with input from both the patient and (with the patient's authorization) any person who will be assisting the patient in

adjusting to the patient's new living environment. The post-discharge plan of care must indicate where the patient plans to reside, any arrangements that have been made for follow-up care, and post-discharge medical and non-medical services.

14. **Completion of Patient Medical Records.** All medical records are to be completed within thirty (30) days after the patient's discharge. Any Provider who has not completed their entries in the chart within the thirty (30) days shall receive notice from the Medical Record Committee on the thirty-seventh (37th) day. Any Provider who has not completed his/her charts within seven (7) days of receiving such notice may be subject to potential discipline, up to and including initiating corrective action.

15. **Confidentiality and Access.**

a. The Hospital, all Providers and other personnel shall abide by all confidentiality requirements applicable to medical records and their contents including the applicable HIPAA policies.

b. A patient's request for access to his or her medical record will be accommodated as quickly as possible and within the parameters of applicable policy. For non-patient, access, health care records may be accessed as permitted by the Hospital's HIPAA Privacy and Security Policies. In addition, Medical Staff members may access patient health care records for research purposes if the research has been appropriately approved by an Institutional Review Board and the Hospital and the patients whose records are to be accessed have signed an authorization or the Institutional Review Board has granted a waiver of the authorization requirement.

c. Medical records may only be disclosed only to the extent permitted by state and federal confidentiality laws. Any original paper records shall not be removed from Hospital premises except where legally required or with the consent of the CEO.

16. **Protocols and Standing Orders.** Protocols and standing orders may be developed by the full Medical Staff in accordance with the Medication Ordering and Transcribing Policy.

ARTICLE 3
SURGICAL CARE

1. **Informed Consent.**

a. Except in emergencies, a surgical procedure or other interventional treatment shall be performed only with the written informed consent of the patient or the patient's legally authorized representative following a discussion with the Provider performing the procedure (or qualified designee). The informed consent form and related discussion shall include a description of the procedure to be performed and the patient or legal representative's acknowledgement of the understanding of the same; the name of the Practitioner(s) performing the procedure(s) or important aspects of the procedure(s), as well as the name(s) and specific significant surgical tasks that will be conducted by the Practitioner(s) other than the primary surgeon; a description of the risks, benefits and side effects of the proposed procedure and the possible alternatives to the procedure,(s) including not having the procedure completed; the likelihood of the patient achieving his/her goals; and potential problems that may arise during recuperation; and the signatures of the patient, or legally authorized representative, professional person witnessing the consent, and the person who explained the procedure(s) (which shall be the Practitioner performing the procedure whenever possible). Documentation of the

consent discussion must be included in the patient's medical record, along with informed consent forms where applicable.

b. In emergency situations where failure to treat a patient will result in risk to the patient's life or limb and where the patient is a minor (under the age of 18) or where the patient has been determined to lack decisional capacity, the Hospital shall attempt to locate a legal representative or pursue the appointment of a guardian or the attainment of a court order, if time permits. However, in the absence of an authorized decision maker or court order, the Hospital staff shall proceed with treatment necessary to resolve the emergency medical condition, and shall consult with the patient thereafter to the extent practicable. In all such circumstances, the decision making process and all attempts made to locate or pursue a legal representative must be fully documented in the patient's medical record.

2. Additional required documentation prior to surgery, except in emergencies, includes the following: pre-operative diagnosis/indications/symptoms for the procedure; report regarding the pre-anesthesia evaluation; current medications and dosages; allergies, including medication reactions; existing co-morbid conditions; mental status; and required laboratory tests. In an emergency, the Practitioner shall make a note regarding the patient's condition prior to induction of anesthesia. A pre-operative H&P shall be performed in accordance with the H&P requirements outlined in these Rules and the Medical Staff Bylaws.

3. **Pre- And Post-Anesthesia Evaluations.**

a. The anesthesiologist or anesthetist shall maintain a complete anesthesia record and include evidence of pre-anesthesia evaluation, pre-anesthesia discussion with the patient (or legally authorized surrogate, if a given patient lacks decisional capacity) regarding anesthesia to be used and any risks, allergies or potential issues with the same, the patient's (or legally authorized representative's) consent to proceed with the anesthesia, and post-anesthetic follow-up of the patient's condition. The pre-anesthetic evaluation shall be completed and recorded prior to surgery, except in emergencies and then as soon as practicable.

b. The post-anesthesia examination shall include (at a minimum) the patient's cardiopulmonary status, level of consciousness, any follow-up care and/or observations, and any complications occurring during post-anesthesia recovery. The post-anesthetia examination shall be completed and recorded after surgery, but in all cases prior to discharge from surgery and anesthesia services, by the individual who administered the anesthesia or qualified anesthesiologist or Certified Registered Nurse Anesthetist.

4. **Dental and Podiatric Care**. A patient admitted for dental or podiatric inpatient care is under the care of both the Dentist or Podiatrist and a Physician member of the Medical Staff.

a. Dentists' responsibilities include: a detailed dental history justifying the Hospital admission; a detailed description of the examination of the oral cavity and a preoperative diagnosis; a complete operative report including all of the elements of the surgical operative report described in Article 2, paragraph 6 above; in cases of extraction of teeth, the number of teeth and fragments removed; progress notes as are pertinent to the oral condition; a clinical résumé or summary statement. Dentists shall ensure appropriate pathological examination of all tissues removed. The discharge of the patient shall be on the order of the Dentist or the Physician member of the Medical Staff.

b. Podiatrists' responsibilities include: a detailed podiatric history justifying the Hospital admission; a detailed description of the examination of the foot and preoperative diagnosis; a complete operative report including all of the elements of the surgical operative report above; appropriate pathological examination of tissue removed; progress notes as are pertinent to the pedal condition and clinical résumé or summary statement.

The discharge of the patient shall be on the order of the Podiatrist or the Physician member of the Medical Staff.

c. Physicians' responsibilities with regard to dental or podiatric patients include: a medical history pertinent to the patient's general health; a physical examination to determine the patient's condition prior to anesthesia and surgery; supervision of the patient's general health status while hospitalized. The discharge of the patient shall be on written order of the Dentist or Podiatrist, as applicable, or the Physician member of the Medical Staff.

5. The operating surgeon, Dentist or Podiatrist shall be responsible for ordering appropriate examination of tissues removed during a procedure. The authenticated pathological diagnosis and report shall be incorporated in the medical record and reported to the operating surgeon, Dentist or Podiatrist.

6. Only authorized personnel shall be allowed in the operation room during surgery in accordance with the Observation of Surgery Policy.

7. All surgical policies and procedures as outlined in these Rules and Regulations except when indicated by term "inpatient" shall apply to ambulatory surgery patients or other outpatients as applicable.

8. Sterile procedure and universal precautions shall be observed at all times for all surgical procedures.

9. Any anesthesia in gas form must not be flammable.

ARTICLE 4
OBSTETRICAL CARE

1. **Personnel.**

a. The duties and responsibilities of all personnel serving patients within the obstetrical area shall be defined in policies and procedure related specifically to the obstetrical area. Contents of these policies and procedures shall be developed by a multidisciplinary committee of the Medical Staff including representatives from the nursing service and Hospital administration.

b. A registered nurse shall be responsible for the admission assessment of the maternity patient in labor and continuing assessment and support of the mother and fetus

c. A registered nurse shall be responsible for the admission assessment of the newborn infant and continuing assessment until the newborn infant is stabilized in accordance with applicable clinical standards and policies.

d. A qualified anesthesia Practitioner shall be available at all times to provide emergency care to maternity patients.

2. **Transfer.**

a. Hospital shall have available personnel and equipment necessary for the transfer of patients.

b. All transfers of perinatal and neonatal patients, including inter-Hospital transfer and transfers to another hospital, shall be in accordance with applicable written policies and procedures.

3. **Delivery.**

a. Delivery rooms shall be used only for delivery and operating procedures related to deliveries unless otherwise permitted by a written safety risk assessment that facilitates safe delivery of care.

b. Equipment for neonatal stabilization and resuscitation shall be available during delivery.

4. **Security.**

a. All Providers and other Hospital personnel shall comply with applicable Hospital policies that address infant identification and security.

b. An infant may be discharged only to a parent who has lawful custody of the infant or to an individual who is legally authorized to receive the infant. If the infant is discharged to a legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents. Providers and/or Hospital staff shall record the identity of the legally authorized individual to whom the infant is discharged

5. **Labor-Inducing Medications.**

a. Only a Physician may order the administration of a labor-inducing medication.

b. A registered nurse shall be present when administration of a labor-inducing medication is initiated and shall remain immediately available to monitor maternal and fetal well-being. A registered nurse may discontinue the labor--inducing medication in accordance with applicable policies if circumstances warrant discontinuation and no standing orders by a physician are in place authorizing their discontinuation.

c. A registered nurse shall closely monitor and document the administration of a labor-inducing medication. Monitoring shall include monitoring of the fetus and monitoring of uterine contraction during administration of a labor-inducing medication.

d. The Physician who prescribed the labor-inducing medication, (or another Physician), shall be readily available during its administration so that, if needed, the Physician arrives at the patient's bedside within 30 minutes after being notified.

6. A separate room apart from the newborn nursery shall be provided when circumcisions are performed according to religious rites. A Physician, PA or registered nurse shall be present during the performance of the religious rite. Aseptic techniques shall be used when an infant is circumcised.

7. Orders are to be signed by the appropriate Provider as soon as possible. Pre-established orders must be revised or reviewed each year by the OB-Newborn Committee with appropriate pharmaceutical consultation and input.

8. Patient affiliates and family members may be present in the delivery room only in accordance with current OB-Newborn policy.

ARTICLE 5
EMERGENCY SERVICES

1. The Hospital employs and/or contracts with Physicians or other qualified Practitioners to provide medical coverage in the emergency department ("ED") on a twenty-four (24) hour a day, seven (7) day a week basis. The Physician or other qualified Practitioner who is scheduled to work a given shift in the ED shall be on the premises at all times during that shift. The emergency services shall be provided under the direction of a qualified and credentialed member of the Active Medical Staff, in accordance with established qualifications for that position ("ED Medical Director.").

2. The ED Medical Director or his/her designee shall be responsible for assuring medical coverage for the ED in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) using Hospital-employed or contracted Practitioners. Responsibilities of ED Practitioners and on-call Physicians are set forth in the Hospital's Responsibilities for the Care of Patients policy.

3. The Hospital maintains an Emergency Operations Plan ("EOP") in compliance with 42 CFR s. 485.625 based on a facility-based and community-based risk assessment using an all-hazards approach. The EOP is developed by a committee which includes at least one (1) member of the Medical Staff, the ED manager or his/her designee, and a representative from Hospital administration. The EOP will include strategies for addressing emergency events and tailored to the patient population specifying the services that the Hospital has the ability to provide in an emergency and including delegation of authority and succession plans and a process for collaboration with authorities to facilitate an integrated response during a disaster. The specifics of this program may be found in the Hospital policy under Emergency Operations Plan. The Plan is reviewed and updated at least every two (2) years. All members of the Hospital Medical Staff and Advanced Practice Professionals agree to function according to the Hospital's EOP and shall participate in all rehearsals, if possible, as the Hospital administration deems necessary. Each Medical Staff member and Advanced Practice Professional shall supply the Hospital with a correct telephone number where that person may be reached in the event the Hospital's disaster/ emergency operations plan is implemented.

4. The EOP shall provide for assignments of specific Providers (or others) during an emergency or disaster in the Hospital (or elsewhere as appropriate) and for the maintenance of all patient care equipment in safe operating condition during any emergency or disaster.

ARTICLE 6
GENERAL CONDUCT OF CARE

1. **General Consent for Admission and Treatment.** A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission, authorizing general care to be provided as well as any necessary disclosures of information.

2. **Consultations.**

   a. Any qualified Provider may be asked to consult on a patient within his/her area of expertise.

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

   c. Any Hospital staff having reason to question the safety or appropriateness of care being provided (or withheld) from a patient should follow the process specified in the Chain of Command for Questioning Patient Care Management policy.

3. **Orders.**

a. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.D. Drug Evaluations. Investigational drugs (that is, those drugs not approved by the Food and Drug Administration (FDA) but having the status of an investigational new drug as recognized by the FDA) may be administered in the Hospital but must be in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all applicable regulations of the FDA.

b. Telephone and verbal orders may be given when the Practitioner l is unable to personally enter or write the order. Only the categories of staff identified in the Hospital Orders Management Policy shall be authorized to receive and record verbal orders from Practitioners. The person transcribing the verbal or telephone order must record in the appropriate location in the patient's medical record the name of the person giving the order, the title of the person giving the order, and the order. The person transcribing the verbal order shall verify the order by writing down and then reading back the complete order to the prescribing Practitioner, who shall confirm the information. The order must be signed, timed, and dated by the person transcribing the order at the time of acceptance. The ordering Practitioner must sign, date, and time all telephone or verbal orders as soon as possible after the fact.

c. Critical test results that are reported verbally or by telephone shall be written down or entered into the medical record, including the name of the ordering Practitioner, and must be dated, timed and signed by the individual receiving the test result. The complete test result shall then be read back to the individual who communicated the test results, who shall confirm the information.

d. Orders that are unclear, illegible or conflicting will be clarified by the responsible Practitioner before such orders are acted upon.

e. After consultation with the attending Practitioner, automatic stop orders (ASOs) will be issued for preoperative medication orders upon the patient going to surgery, unless the surgeon or attending Practitioner specifies otherwise.

4. Patients with an acute need for detoxification services may be admitted to the Hospital for such services in accordance with applicable Hospital policy. Follow-up care will be provided through available services.

5. Practitioners shall make daily rounds on all patients. Swing bed patients shall be seen by a Physician at least once a week. In the event a Physician plans to be absent, the Practitioner shall assign that person's patients temporarily to another Practitioner. Such assignment shall be entered on the order sheet.

6. There shall be policies and procedures regarding no resuscitation/no code situations.

7. There shall be appropriate reviews of medical records by the appropriate Medical Staff committee to evaluate the adequacy of care with pertinent reports submitted to the Medical Executive Committee.

8. All Medical Staff members shall maintain the high level of practice as set forth directly and indirectly in the Bylaws and procedural policies of the Medical Staff. In an effort to maintain these high levels of practice, all appointees to the Medical Staff shall cooperate with individuals responsible for the monitoring mechanisms as set forth in the Medical Staff Bylaws and procedural policies.

9. Medical Staff members shall not engage in prohibited fee-splitting, kickback, or referral arrangements.

10. All Medical Staff members will comply with state and federal laws regarding screening for infectious diseases.

11. All Medical Staff members will observe recognized infection prevention protocols, including but not limited to standard precautions and the wearing of appropriate personal protective equipment.

12. Where necessary to protect a patient from immediate harm to self or others by the use of restraints or seclusion, the restraints or seclusion will only be used in the least restrictive form and only in accordance with applicable Hospital policy, which shall be consistent with applicable accreditation and regulatory requirements. Standing orders, as-needed orders, or order sets for restraints or seclusion shall not be used.

ARTICLE 7
MEDICAL EDUCATION

1. The administration shall select an individual to coordinate students, including medical, nurse practitioner (NP) and physician assistant (PA) students; interns; and residents who are utilizing the Hospital as a practice site. Each Practitioner overseeing a student is individually responsible for that particular student.

2. Before a medical student, intern, or resident may begin practicing within the Hospital, the Hospital will confirm that the student, intern, or resident is enrolled in an accredited medical school, PA or advanced nursing program, or residency program, as applicable, and verify with the school or program each student's, intern's or resident's qualifications, e.g., year in medical school or residency program. Subject to legal limitations, the Hospital has the authority to reject or remove any medical student, intern, or resident from practice within the Hospital at any time and for any reason, including supervisory capabilities.

3. Students, interns, and residents are not members of the Medical Staff and do not hold Privileges at the Hospital. As such, they are not entitled to the fair hearing rights outlined in the Medical Staff Bylaws. Students, interns, and residents are not employees of the Hospital.

4. Under all circumstances, the students, interns, or residents shall be introduced to the Medical Staff, Hospital staff, and to the patients in such a manner that his/her role as a student, intern, or resident is clear. All such individuals are required to wear an appropriate nametag.

5. Students, interns, and residents may not assume call responsibilities for members of the Medical Staff.

6. **Students.** The following requirements shall apply to Students:

    a. All students shall function under the supervision of a Practitioner and will be ultimately evaluated by a Practitioner in the particular specialty that the student is pursuing.

    b. Because students are not licensed, the medical record must reflect active participation and supervision by the attending Practitioner or another Practitioner responsible for the patient's care.

    c. Where a student acts as a scribe in creating an order for a given patient, the patient's attending Practitioner or other Practitioner responsible for the patient's care shall countersign the order prior to the execution of the order.

d. A student place an order (except those involving medications) at the request of or with the approval of) the attending Practitioner, who will counter-sign the order as soon as possible.

e. E/M Service Documentation. Students may document services in the medical record. However, the attending Practitioner or other Practitioner responsible for the patient's care must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision-making. The Practitioner must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather then re-documenting the work.

7. **PG-1 & 2.** The following requirements shall apply to residents in Post Graduate years 1 & 2 (PG-1 & 2):

a. All PG-1 & 2 residents function under the supervision of an Active Staff member. Because PG-1 & 2 residents are not fully licensed, the medical record must reflect active participation and supervision by the attending Physician.

b. All patient orders written by PG-1 & 2 residents must be countersigned by the attending Physician or another Physician responsible for the patient's care prior to the execution of such order.

c. All H&Ps, face sheets, discharge summaries, and operative reports prepared by PG-1 & 2 residents must be countersigned by the attending Physician or another Physician responsible for the patient's care.

8. **PG-3 And Above.** The following requirements shall apply to residents in Post Graduate years 3 and above (PG-3 and above):

a. All PG-3 and above function under the supervision of an Active Staff member.

b. All H&Ps, face sheets, discharge summaries, and operative reports prepared by residents PG-3 and above must be countersigned by the attending Physician or another Physician responsible for the patient's care.

c. Residents PG-3 and above may write orders and there is no requirement for a countersignature, as long as the attending Physician documents participation in the patient's care by countersigning the daily progress note or writing his or her own note.

9. The documentation of discharge summaries, operative or procedure reports and final diagnoses shall be the responsibility of the attending Practitioner. These can be either dictated or written into the progress notes by the intern or resident, but shall be reviewed and countersigned by the attending Practitioner, who is ultimately responsible for the documentation.

10. All students, interns, and residents shall abide by the ethical principles of the medical profession, as well as the Hospital's Medical Staff Bylaws, procedural policies, and Rules and Regulations. Students, interns and residents shall receive a copy of the Medical Staff Bylaws and the Rules & Regulations when they begin their practice at the Hospital.

ARTICLE 8
PATIENT RIGHTS

The Hospital shall ensure that all patients have the following rights (in accordance with Wisconsin Admin. Code s. DHS 124.06):

1. Not to be denied appropriate care due to race, creed, color, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment responsible for the documentation.

2. To be treated with consideration, respect, and recognition of the patient's individuality and personal needs, including privacy in treatment.

3. Confidentiality of medical records in accordance with Hospital policy.

4. Access to the patient's medical record as permitted by law (by patient or representative).

5. Patient knowledge of who has overall responsibility for the patient's care.

6. Appropriate information about illness, course of treatment and prognosis.

7. Opportunity to participate in planning for care and treatment.

8. Copy of appropriate Hospital policies on patient rights and responsibilities.

9. Except in emergencies, consent is obtained before treatment.

10. Right to refuse as permitted by law, with understanding of the medical consequences of the refusal.

11. Informed consent prior to research.

12. Not transferred (except in emergencies) without full explanation, continuing care plans, and acceptance by the receiving institution.

13. Right to examine and have any bill explained and information (upon request) regarding financial assistance.

14. Patient obligation to comply with rules, cooperate in treatment, provide accurate medical history, be respectful of other patients, staff, and property, and provide relevant information related to payment of charges.

15. Information regarding policies and procedures relating to compliants including address for filing complaints with the Department of Health Services.

16. Right to designate visitors

17. Rights specified under Wisconsin law for mental illness, developmental disability alcohol abuse or drug abuse.

ARTICLE 9
ADOPTION AND AMENDMENT

These Rules and Regulations shall be adopted and amended in accordance with the procedures for adopting and amending the Medical Staff Bylaws as the same is set forth in the Medical Staff Bylaws.

ADOPTED BY the Active Medical Staff on November 3, 2021

Carol Martin, MD, Chief of Staff

Neil Cox, MD, Secretary, Medical Staff

ADOPTED BY the Board of Directors on November 23, 2021

Mary Beth White-Jacobs, Secretary, Board of Directors