

HENDRICKS REGIONAL HEALTH

MEDICAL STAFF RULES AND REGULATIONS

DEFINITIONS

- 1.1 "Hospital" shall mean Hendricks Regional Health, Danville and Brownsburg, Indiana, and other facilities owned by the Hospital and which operate under the Hospital's Indiana license.
- 1.2 "Board of Trustees" or "Board" shall mean the Board of Trustees of the Hospital.
- 1.3 "Chief Executive Officer" or "CEO" means the individual appointed and selected by the Board to act on its behalf in the overall administrative management of the Hospital.
- 1.4 "Chief Medical Officer" or "CMO" means the individual appointed and selected by the CEO to oversee the medico-administrative affairs of the Hospital.
- 1.5 "Medical Staff" shall mean the formal organization of all Physicians who are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services in the Hospital.
- 1.6 "Medical Executive Committee" or "MEC" means that group of Active members of the Medical Staff chosen to represent and coordinate all activities and policies of the Medical Staff and its subdivisions.
- 1.7 "Physician" means an individual holding a M.D. or D.O. degree and who has been issued an unlimited current license to practice medicine in the State of Indiana.
- 1.8 "Provider" means an individual holding a M.D., D.O. degree or an advanced practice degree (i.e. Nurse Practitioner, Certified Nurse Anesthetist, or Physician Assistant) and who has been issued a current license to practice medicine in the State of Indiana.
- 1.9 "Allied Health Professional" or "AHP" means a licensed health care professional other than a licensed Physician. Allied Health Professionals can be further subdivided into "Independent Allied Health Professionals" ("IAHP") and "Dependent Allied Health Professionals" ("DAHP"). Independent Allied Health Professionals have an unrestricted Indiana license to render clinical care in their specialty. Dependent Allied Health Professionals may or may not be licensed and function under the direct supervision of

an appropriately licensed independent Practitioner who has Privileges to provide care in the Hospital. Allied Health Professionals do not have voting rights.
- 1.10 "Practitioner" means, unless otherwise expressly provided, any Physician applying for or exercising Clinical Privileges or providing other diagnostic, therapeutic, teaching or research services in the Hospital; or an Independent Allied Health Professional (IAHP) applying for or exercising specific clinical responsibilities or providing other diagnostic, therapeutic, teaching or research services in the Hospital as outlined by the AHP Professional Policy and Credentialing Manual.
 - 1.10.1 "Clinical Privileges" or "Privileges" means the rights granted to a Practitioner to provide those diagnostic, therapeutic, medical, surgical, dental, or podiatric services specifically delineated to him/her.
 - 1.10.2 "Access to Hospital Services" means access by non-staff health care professionals to Hospital diagnostic, therapeutic and teaching services that are permitted under Indiana law. Appropriate services will be provided to patients presenting with written orders by appropriately licensed Non-staff Health Care Professionals.
- 1.11 "Non-staff Health Care Professionals" are licensed independent Practitioners allowed to order procedures and treatments and receive the results of the evaluations to the extent permitted by law who are not members of the Medical or Allied Health Staff.

- 1.12 “Service Chief” is a Physician who serves as the Chief of Medicine or Chief of Surgery. The Chief of Surgery is the Surgery Committee Chair. The Chief of Medicine is the Medicine/ICU Chair.
- 1.13 "Prerogative" means a participatory right granted, by virtue of Staff category or otherwise, to a Staff member or Allied Health Professional, and exercisable subject to the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.
- 1.14 "Medical Staff Year" means the period from January 1 to December 31.
- 1.15 "Ex Officio" means services as an appointee of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
- 1.16 "Special Notice" means notification sent by certified or registered mail, return receipt requested, email with returned receipt requested, or by hand delivery or by courier service designed for overnight or same day delivery.
- 1.17 "Oral Surgeon" means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery.
- 1.18 "Peer Review Committee" shall mean the Board , the MEC, Clinical Review Committee, Physician Relations Committee, and/or any other committee of the Medical Staff which recommends or takes actions based on the competence or professional conduct of an individual Provider and which affects or may affect the Clinical Privileges or membership on the Medical Staff of any Provider, including any recommendation or decision whether the Provider may have Clinical Privileges with respect to or membership in the Medical Staff of the Hospital, the scope or conditions of such Privileges or membership, or any changes or modifications in such privileges or membership.
- 1.19 "Quorum" shall mean: Service Committees - presence of 3 or more active members of the medical staff. Physician Relations, Bylaws and Medical Executive Committee – presence of 3 or more voting members. General Medical Staff meetings - presence of at least 25 Active Category members of the medical staff.
- 1.20 “Peer Review Information” shall mean: information obtained for the purpose of (i) evaluating the qualifications of, (ii) the patient care rendered by, or (iii) the merits of a complaint against a Practitioner which is based on their competence or professional conduct which affects or could adversely affect the health or welfare of a patient(s).

Refer to Addendum I – Category Chart

Article 1 ADMISSION OF PATIENTS

1.1 Admission of Patients Responsibilities

- 1.1-1 Shall be scheduled by the Registration department.
- 1.1-2 Prior to inpatient admission, a provisional diagnosis will be given to the house supervisor or placed in electronic health record (EHR).
- 1.1-3 Outpatient surgery patients admitted will require an admitting diagnosis and an admitting order.
- 1.1-4 Collaborate with Transitions of Care (TOC) to determine appropriate admission status (inpatient, observation, or outpatient in bed).
- 1.1-5 Medical Staff member will be responsible for communicating to the House Supervisor information concerning a patient to be admitted regarding:
 - (a) Preadmission certification or clearance where required (elective admission).
 - (b) A source of communicable disease or significant infection.
 - (c) Behavioral characteristics that would disturb or endanger others.
 - (d) Any reason for protection of the patient from self-harm.

1.2 Admitting Prerogatives

- 1.2-1 Only an Active Medical Staff in good standing who has been granted appropriate clinical privileges may admit patients to the Hospital.
- 1.2-2 The Medical Staff member who is responsible for the care of the patient must be identified and verified by Registration.

1.3 Timely Visitations After the Patient is Admitted

The attending Physician must evaluate all patients admitted to the Hospital within a clinically reasonable amount of time, **based on acuity**, not to exceed 24 hours. Likewise, a consulting Physician must see a patient within a clinically reasonable amount of time, based upon acuity, not to exceed 24 hours.

Article II ASSIGNMENT AND ATTENDANCE OF PATIENT

2.1 Assignment to Service

All patients are assigned to a service. Physicians designated to be On-Call for the Emergency Department must be continuously and immediately available to consult on Emergency patients. If requested to do so by the Emergency Physician, the On-Call Physician must present to the Hospital within a timely manner to provide stabilizing care to the patient at issue. Where appropriate, the On-Call Physician may also be requested to assist in coordinating such patients transfer to another facility consistent with the requirements of the Emergency Medicine Trauma and Labor Act (EMTALA).

In compliance with EMTALA, any On-Call Physician who refuses or fails to respond as described will be listed in the patient's permanent record and may be subject to corrective action. Should the On-Call Physician and the Emergency Physician's determination conflict in assessing the patients need for emergency care or the presence of an emergency medical condition, they must work collaboratively with appropriate services as needed to be certain patient disposition is both appropriate and timely.

2.2 Attendance of Patients

Generally, treatment of self, immediate family, or others with whom there is a close emotional attachment should be limited to care for illness or conditions in which the diagnostic, therapeutic or procedural approaches are low-risk and brief in nature.

In treatment of self, immediate family, relative, or others with whom there is a close emotional attachment, access and use of the electronic medical record is not considered a HIPAA violation. Non-professional activity will be referred to the Clinical Review Committee.

Where a close emotional attachment exists, the Chief Medical Officer (“CMO”), Ethics Committee Chair and Service Chair should be consulted to provide guidance.

In the case of emergency services in which another qualified Physician is not readily available, it is acceptable for any Provider to provide any and all necessary stabilizing and/or life-saving care as defined in Section 5.5-1 of the Medical Staff Bylaws.

2.3 Participation on the On-Call Roster

Physicians granted clinical privileges may be required to provide on call services commensurate with their clinical activity. Physicians that have offices within Hendricks County and that are members of the Active Medical Staff may be expected to provide a disproportionate share of On-Call coverage (rather than *pro rata*). However, in situations in which reasonable coverage cannot be obtained utilizing only Active staff, affiliate members of staff may be required to provide coverage regardless of primary office location if their clinical activity is such that public perception is their services are routinely available in the community. Call responsibilities for Physicians who rarely provide services in the community or do not routinely admit patients to the Hospital will be determined on a case-by-case basis during the initial credentialing process by the Medical Executive Subcommittee on Call Coverage described below. Their clinical activity will be monitored and evaluated no less than every two years at the time of reappointment.

2.4 MEC Subcommittee On Call Coverage

The Medical Executive Subcommittee On-Call Coverage shall include the chief of the Medical Staff, CMO, and other Medical Executive staff members as appropriate. The Medical Executive Subcommittee on Call Coverage has been delegated authority for evaluating issues related to on call coverage. That responsibility extends to assessment of available specialties and making recommendations for call assignments based on the needs of the Hendricks County community. The subcommittee also evaluates the reasonableness of gaps in the call schedule and monitors growth of specialty groups and clinical activity in the community. During the credentialing process, when call is not initially assigned to newly appointed Practitioners, monitoring of clinical activity will be ongoing with re- evaluation of call responsibilities and call assignments made as warranted.

Unless specifically exempted by the Medical Executive Committee (“MEC”) through the process outlined in the Bylaws, Section 3.3 B, a member of the Medical Staff exercising any privileges agrees that, when they are the designated Physician on call, they will accept responsibility during the time specified by the published schedule for providing care or counsel to any patient referred to the service for which they are providing on call coverage. For medical or surgical practices that establish their own On-Call schedule, the Physicians are required to provide the Hospital operator with the name of the actual

Physician responsible for On-Call coverage at the Hospital at least seven (7) days in advance of the rotation. All Physicians are expected to furnish the operator with up-to-date contact information. If a given specialty fails to submit a call schedule for a given month or if the schedule submitted leaves gaps that are historically different from what is

reasonable and customary for that service, then the CMO, in consultation with the Chief of Staff and the appropriate Service Chair, will develop and distribute the specialty call schedule for that given month. Each group is then responsible for supplying the individual Physician's name that will cover each period delineated on the call schedule.

The major medical and surgical services are generally expected to provide continuous On-Call coverage for the Hospital system.

When conditions develop that may result in gaps in the On-Call schedule, the involved Physician (s) is required to notify the CMO in advance. If there is a conflict with the published schedule that results in a gap in coverage, it is the Medical Staff member's responsibility to notify the applicable service chairperson and the emergency room director at least forty-eight (48) hours prior to the scheduled rotation. The Medical Executive Subcommittee On Call Coverage will evaluate the reasonableness of the gap, and a report will be presented for review and approval at the next MEC meeting.

The call schedule may not refer to a Physician group but must instead delineate a specific Physician who is responsible to fulfill the call requirement. If an answering service is utilized as a step in contacting the Physician, it is still necessary to define the Physician.

Physicians are permitted to provide simultaneous call coverage at more than one institution when on- call for Hospital. Elective procedures and surgeries may be scheduled when on- call; however, the Physician is expected to respond to the ED in the appropriate time frame, unless they are Actively involved in a case at the time of contact.

In the event that the On-Call Physician is unavailable (due to events beyond their control or is performing a surgery or procedure), the emergency Physicians will contact other appropriate Physicians to provide stabilizing care until the On-Call Physician becomes available. In the event that another member of the specific specialty is not available, the Physician with the competencies that most closely reflect the patient's needs would be contacted for aid.

Physicians can take call for the Hospital system. Advanced Practice Nurses and Physician Assistants can take call that aligns with their delineation of privileges.

2.5 Unassigned Patients

An unassigned patient:

- (a) reports no ongoing relationship with a Provider on the Medical Staff, and
- (b) makes no request for a specific Provider.

The following special situations also exist:

- (a) A patient may also be considered unassigned if they have a relationship only with a medical or surgical specialist whose area of specialization is not germane to the present indication for admission or observation.
- (b) A patient may be considered unassigned if their relationship with a member of the Medical Staff has been permanently severed regardless of the amount of time that has elapsed since the prior contact. This situation can exist regardless of whether it was the patient or the Physician who ended the prior association.

The policy delineated above is to be followed by the Emergency Department and Immediate Care Center Physicians when determining whom to contact regarding admission or observation patients. Should an exception become necessary, the ED or Immediate Care Providers will notify the admitting Physician.

If the admitting Physician notices an error, they may transfer the patient to the more appropriate Provider before assessing the patient provided that:

- (a) There is adequate time allowed for the new attending to assess the patient before a violation of the Medical Staff Rules and Regulations would occur, and
- (b) The patient does not require urgent or emergent attendance by the attending of record. Furthermore, such a transfer of responsibility must occur after direct communication and *agreement* between the Physicians.

Article III GENERAL RESPONSIBILITY AND CONDUCT OF CARE

3.1 Generally

A Medical Staff Practitioner shall be responsible for the ongoing medical care and treatment of each Hospital patient, for the prompt completeness and accuracy of those portions of the medical record for which they are responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner, if any, and to coordinate treatment with other Practitioners involved in the patient's care. Such coordination includes communications with the patient or relatives of the patient as may be appropriate and will be recorded in EHR (ACHC 31.00.03)

Emergency/stat pages should be responded to as soon as possible, urgent pages within 15 minutes and routine pages within 30 minutes. Primary responsibility for these matters belongs to the attending Provider except when transfer of responsibility is affected pursuant to Section 3.2.

3.2 Transfer of Responsibility

When primary responsibility for a patient's care is transferred from the admitting or current attending Provider to another service, a note covering the transfer of responsibility and acceptance of the same must be entered in the medical record. This transfer of responsibility can occur only after direct contact between the admitting or current attending Provider and explicit acceptance by the other service.

A transfer of responsibility must occur when a Provider will not be physically able to present to the patient's bedside in a timely manner. Specifically, the primary service may NOT utilize tele-medicine in lieu of finding appropriate coverage during their absence or inability to respond to the Hospital in a timely fashion.

3.3 Alternate Coverage

Each Provider must ensure timely, adequate, professional care for their patients in the Hospital by being available or designating a qualified Provider with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient. In the absence of such designation, the chief executive officer, the chief medical officer, the chief of the Medical Staff or the applicable service chair has the authority to call any member of the staff with the requisite clinical privileges to care for the patient.

3.4 Oral Surgeons, Dentists, Podiatrists, and Allied Health Professionals

Oral Surgeons, Dentists, Podiatrists, and Independent Allied Health Professionals may treat patients under the conditions provided in Sections 5.3 and 5.4 of the Medical Staff Bylaws.

Each oral surgeon, dentist, podiatrist, and allied health professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services they provide to the patient. More specifically, oral surgeons, dentists and podiatrist members of the staff are responsible for the following:

- (a) A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;

- (b) A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- (c) A complete operative report, describing the findings, technique, specimens removed, and postoperative diagnosis;
- (d) Progress notes as are pertinent to the dental/podiatric condition;
- (e) Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge;
- (f) Final discharge or after visit summary (AVS) note.

3.5 Policy Concerning Immediate Questions of Care

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or questions the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the attending Physician. If the matter is not resolved between the nurse or other health care provider and the Physician, the matter may be referred to the individual's supervisor who may in turn refer the matter to the service chair and/or Hospital administrative staff.

3.6 Consultations

3.6-1 Responsibility

The attending Provider is personally responsible for obtaining an urgent consultation from a qualified Physician, as indicated or when required pursuant to the guidelines in section 3.6-2 below. The attending Physician will personally contact the consultant to communicate pertinent patient information necessary for the consultation. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending Physician.

3.6-2 Guidelines for Obtaining Consultations

Unless the attending Physician's expertise is in the area of the patient's problem, consultation with a qualified Physician or their associates within 24 hours is required in the following cases:

- (a) Consultations are required as established in the Rules and Regulations of the specific service and where requested by the patient or legally responsible member of the patient's family.
- (b) Where diagnosis is obscure, or where doubt exists as to the best therapeutic measures to be taken, including cases where the disorder or complications are not in the field of the attending Physician's practice.
- (c) A consultation may be required for patients who are not good surgical or anesthetic risks.

3.6-3 Qualifications of Consultant

Any qualified Practitioner may be consulted for opinion regardless of their staff category assignment.

A consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges to manage hospitalized patients.

3.6-4 Documentation

- (a) Consultation Request: When requesting consultation, the attending Provider must indicate in the medical record the medical necessity and/or reason for the request and the extent and involvement in the care of the patient expected from the consultant, e.g., "for consultation only," "for consultation, orders, and follow-up regarding a particular problem."
- (b) Consultant's Report: The consultant must make and sign a report of their findings, opinions and recommendations that reflect an actual examination of the patient and the medical record. Such a report shall become a part of the patient's medical record.
- (c) Attending Physician Response to Consultant's Opinion: In cases of elective consultation when the attending Physician elects not to follow the advice of the consultant, they shall either seek the opinion of a second consultant or record in the progress notes their reasons for electing not to follow the consultant's advice.

In cases of required consultation when the attending Physician does not agree with the consultant, they shall either seek the opinion of a second consultant or refer the matter to the applicable service chair for final advice. If the attending Physician obtains the opinion of a second consultant and does not agree with it either, they shall again refer the matter to the applicable service chair.

3.7 Radiologic Interpretation

A board certified or board eligible radiologist member of the Medical Staff shall perform or otherwise supervise the performing of and render interpretations of all radiologic examinations and other procedures resulting in a permanently diagnostic recorded image at Hospital, except echocardiography, diagnostic and interventional cardiac procedures, dental radiography, peripheral vascular angiography, and interventional procedures, which may also be performed and interpreted by appropriately trained members of the Medical Staff who have requested and been granted such privileges.

The use of ultrasound for bedside procedures outside of Radiology for guiding procedures (e.g., central line placement, regional blocks, etc.) or for screening evaluation in the emergency department and/or obstetrics department will not be a diagnostic read.

3.8 Medical Residents

Any medical resident physician granted privileges will be required to be supervised by a board certified or board eligible member of the Medical Staff in their specialty. Medical residents may not supervise the performance of any allied health professionals, i.e., CRNA's.

Article IV Transfer of Patients

4.1 Transfer of Responsibility

4.1.1 General Requirements

A patient shall be transferred to another medical care facility only upon the order of the attending Physician, only after arrangements have been made for admission to the other facility, including consent to receive the patient and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

4.1.2 Demanded by a Patient

A transfer demanded by a patient or their designated caregiver is not permitted

until a Physician has explained to the patient or his family or their designated caregiver the seriousness of the condition and generally not until a Physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form and general requirements (4.1.1 above) is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

Article V Discharge of Patients

5.1 Required Order

A patient may be discharged only on the order of the attending Physician. In the event of a disaster when the attending Physician or designee may not be accessible or is no longer able to provide discharge information, the service chair / designee will assume responsibility for assessing patients for discharge and providing discharge orders and documentation. To facilitate the transition of care between Providers, it is essential that the discharge summary document is available to the next provider, at a minimum, by the time of the patient's next appointment. Thus, a concise discharge summary, from the attending Provider, must be completed on each patient within 48 hours of patient discharge. This document should include, at minimum, the principal diagnosis, secondary diagnoses, co-morbidities, complications, procedures, and pending tests/diagnostics.

5.2 Leaving Against Medical Advice

If a patient desires to leave the Hospital against the advice of the attending Physician or without proper discharge, the attending Physician shall be notified, and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending Physician or without proper discharge, a notation of the incident must be made in the patient's medical record. A patient leaving against medical advice must be advised of all material risks of their action but should not be threatened that leaving will result in the denial of future health care.

5.3 Discharge of Minor Patient

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, they shall state in writing, and the statement must be made a part of the patient's medical record.

Article VI Orders

6.1 General Requirements

All orders for treatment or diagnostic tests, not entered electronically, must be written clearly, legibly, and completely and signed, dated, and timed by the Practitioner responsible for them.

Orders which are entered improperly or not understood by nursing staff will not be carried out until re-entered or appropriately understood by the nurse or other clinical staff.

Orders for diagnostic tests, which necessitate the administration of test substances or medications will be considered to include the order for this administration. All orders shall include the date, time, and signature of the prescribing Provider. Outpatient tests ordered will require a diagnosis of medical necessity for each test. Screening examinations must be

designated as such on the order. Outpatient test results shall be reviewed by the ordering Provider within a reasonable amount of time, as noted in section 7.13-5, with appropriate follow-up action noted in the outpatient record.

6.1-1 Infusion Center Orders

Orders for medication administration and blood/blood products may be placed electronically or faxed to the department or sent in with the patient. The orders shall include the date, time, and signature of the prescribing Provider and the patient's name and diagnosis on the order.

Orders will be accepted from credentialed Providers formally affiliated with the Hospital Medical Staff/Independent Allied Health Staff. Orders from Providers who are not affiliated will be accepted only if a credentialed Medical Staff Provider co-signs the orders. Should the affiliated patient require additional orders, the HRH Provider would be responsible for care.

6.1-2 Orders for Therapy and/or Intervention by HRH Providers to Non-Staff Health Care Professionals

When an HRH provider orders therapy and/or intervention to be completed outside of HRH, the HRH Provider must indicate if a specific protocol is to be used or if the treatment plan will be delegated to the non-staff health care professional.

(a) If the specific protocol to be used is not recognized by the non-staff health care professional, then the HRH Provider order should include the following:

- (1) Individualized goals for the patient
- (2) Type, frequency, and likely duration of services

(b) If the treatment plan is delegated to the non-staff health care professional:

- (1) The orders will include the evaluation, development and implementation of the treatment plan and be within the scope of licensure and training of the non-staff health care professionals.

Regardless of whether the order is for a specific protocol or for delegations of the evaluation and treatment plan, the HRH Provider retains responsibility of care provided to the patient and can continue/discontinue such interventions at any time.

6.2 Pre-Printed Orders, Order Sets and Standing Orders/Protocols

Pre-printed orders shall be considered as a specific order by the Provider for that patient and shall be followed in the absence of other specific orders by the Provider, insofar as the proper treatment of the patient will allow. Order sets, standing orders, and protocols will be reviewed on a regular basis as outlined in the Administrative Manual Order and Order Management. This review will be completed by Practitioners in the relevant service. Pre-printed orders, order sets, and standing orders/protocols must be reviewed for each individual patient such that all orders are considered medically necessary for each patient.

6.3 Electronic Orders and Communications

6.3-1 Voice Transcription and Note Generation Technology

The Hospital provides speech to text technology for use of Practitioners. Account use will be monitored and is subject change due to inactivity as referenced in information systems identity management and access control policy.

The Hospital makes available technology for ambient listening and notes

generation. No other ambient listening/scribe or note generation technology is to be used during patient care at the Hospital, except those approved by the Hospital in the information systems identity management and access control policy.

6.3-2 Electronic Prescribing of Controlled Substance

Electronic prescribing of controlled substances (EPCS) is the process for electronically transmitting controlled substance prescriptions to a pharmacy. It is necessary to install and maintain the Imprivata ID app on your personal cell phone and meet with an enrollment supervisor to enroll your phone for use with EPCS. The initial enrollment must be completed in person with your practice coordinator or a member of the Information Systems informatics team. When purchasing or replacing a phone this enrollment process must be repeated.

6.3-3 Electronic Telehealth Encounters

Telehealth services are available to virtually interact with a patient without an in-person encounter. The Epic telehealth system is provided by the Hospital for use by the Practitioner. No other virtual platform such as is to be utilized, except for those that are approved by the Hospital for use during Epic downtimes.

Practitioners providing patient care services provided to patients present in another state must ensure that they are following that state's requirements for telemedicine including licensure and malpractice regulations.

6.3-4 Secure Messaging

Secured communication by messaging is available using Epic Secure Chat. Patient information can be communicated using this method in compliance with HIPAA rules. Limited verbal orders may be placed using Secure Chat as outlined in 6.4-2. No other messaging platform (e.g. iMessage, SMS) is to be used for patient care, except for those allowed by the Hospital during Epic downtimes. Reference Administrative Manual Secure Messaging Policy.

6.4 Verbal Orders – Refer to Order & Order Management Policy

6.4-1 By Whom and Circumstances

Telephone orders will be accepted only from the responsible Practitioner or Practitioner's designee provided the designee is a credentialed Practitioner with equivalent privileges. In general, verbal and telephone orders are to be avoided except when no other practical method exists to provide the order. Under no circumstances are verbal or telephone orders to be used to circumvent the use of computerized Practitioner order entry (CPOE).

Telephone or other verbal orders may be taken only by a , Practitioner, a registered nurse and a licensed practical nurse, except that the following personnel may take verbal orders for medication, treatment, and/or procedures within their respective areas of practice and which they will prepare, deliver, or perform: Registered pharmacist, certified respiratory therapist, radiology technician, certified registered nurse anesthetist, occupational therapist, speech pathologist, physical therapist, registered dietitian, registered nurse, licensed practical nurse, certified Physician assistant, paramedic, social worker, advanced practice registered nurse, cardiovascular technologist, exercise physiologist, radiologic technologist, registered polysomnographic technologist, medical assistant in ambulatory practice , certified medical assistant in ambulatory practice, medical students, CRNA students, and scribes.

6.4-2 Orders by Secure Messaging

Secure communication by text is available currently by using Epic Secure Chat. Limited ordering by secure text is permitted. Limit orders by secure messaging to simple, single orders. The following types of orders are allowable by secure text:

- Change in bed status
- Diet orders
- Nursing placement of tube (NG, Foley)

The following orders are not allowable by Secure Chat or other messaging:

- Medications
- Blood products
- Order sets

6.4-3 Documentation

All verbal orders shall be transcribed in the proper place in the electronic health record, shall include the date, time, name, and signature of the person transcribing the order and the name of the Practitioner, and shall be co-signed by a Practitioner within 24 hours. Telephone orders that are received and read back will be authenticated as outlined in the **Administrative Manual Order and Order Management**.

6.5 Orders by Providers

Providers may write orders only to the extent, if any, specified in the position description and consistent with the scope of services individually defined for them as outlined in the Administrative Manual Order and Order Management

6.6 Medication Review

6.6-1 Review Process: In order to ensure that proper and complete therapeutic regimens are carried out, the total dosage and total period of time for certain drugs or treatments will be monitored. Pharmacy will review the following drugs on a daily basis: DEA class II medications, sedatives, anticoagulants, and antibiotics. Other medications and treatments will be reviewed as appropriate.

6.6-2 Notification: The applicable unit (nursing/pharmacy/respiratory therapy) will notify the prescribing Practitioner with recommendations for discontinuation of a medication or treatment.

6.7 Blood Transfusions and Intravenous Infusions

Blood transfusions and intravenous infusions must be started by a Practitioner responsible for the patient's care or by a registered nurse. Administer per Nursing Blood & Blood Product Policy.

6.8 Special Orders

6.8-1 Patient's Own Medications and Self-Administration

Medications brought into the Hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending Provider to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing Provider.

6.8-2 Code Status Orders

All patients require classification of their code status on admission to the

Hospital. Patients are considered All Resuscitative Efforts unless otherwise stipulated by a provider order or documentation of a valid Indiana POST form with “no resuscitative efforts” checked. The following code status categories are used:

- (a) All Resuscitative Efforts (Full Code)
- (b) DNR/DNI
- (c) Intubation for respiratory failure only (no CPR/ACLS)

All Code Status other than All Resuscitative Efforts must be ordered by a Provider. If given verbally to a nurse, the order must be witnessed by two nurses at the time it is given and should be carefully documented and co-signed as soon as possible.

6.8-3 Restraint Orders

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint can be a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient condition. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff member or others and must be discontinued at the earliest possible time. A thorough comprehensive RN assessment of the patient will be completed to include a determination of nonviolent/non-self-destructive behavior or violent/self-destructive behavior. Violent or self-destructive behavior is identified as behavior that jeopardizes the immediate safety of the patient, staff, or others.

- (a) Orders: The use of each restraint or seclusion episode must be in accordance with the order of a Provider who is responsible for the care of the patient and authorized to order restraint or seclusion by Hospital policy in accordance with Indiana Law. Order for restraint or seclusion must never be written as a standing order or on an as-needed basis (PRN).
- (b) Orders for restraint and/or seclusion should follow the guidelines outlined in the Administrative Manual Restraint and/or Seclusion Policy.
- (c) Violent restraint orders and the face-to-face evaluation must be entered by the Provider.

6.9 Formulary and Investigational Drugs

6.9-1 Formulary

The Hospital formulary lists drugs available for ordering. Each Medical Staff Practitioner with prescriptive authority assents to the use of the formulary. The Hospital formulary is managed by the pharmacy with the approval of the Medical Staff. Non-formulary medications can be requested, reference policy Pharmacy Department Formulary. Certain generic and therapeutic equivalent medications will be automatically substituted based on guidelines approved by the Medical Staff.

6.9-2 Investigational Drugs

All clinical research and use of investigational drugs will be in accordance with the Administrative Manual Institutional Review Board (IRB).

Article VII. Medical Records

7.1 Required Content

The credentialed Practitioner, authorized students, and residents involved in the care of the patient shall be responsible for the preparation of and legible content of the record for each patient. The record's content shall be pertinent, accurate, legible, timely, and current. The record shall include:

- (a) Identification Data
- (b) Personal and family medical histories
- (c) Description and history of present complaint(s) and/or illness
- (d) Physical examination report
- (e) Diagnostic and therapeutic orders
- (f) Evidence of appropriate informed consent, as needed
- (g) Treatment provided
- (h) Progress notes and other clinical observations, including results of therapy
- (i) Special reports, when applicable (such as, clinical laboratory, radiology, radiotherapy, EEG, EKG, pre- and post-anesthesia, operative, and other diagnostic and therapeutic procedures, etc.)
- (j) Pathological findings
- (k) Final diagnosis without the use of symbols or abbreviations
- (l) Condition on discharge, including instructions, if any, to the patient or significant other on post-Hospital care
- (m) Autopsy report, when available

7.1-1 Signatures

A complete written or electronic signature shall consist of a minimum of the first initial of the first name, the full last name, and earned degree or license. The written signature shall be the same as their signed name on the signature card obtained at the time of initial credentialing.

Within electronic documentation and CPOE, the signature shall be affixed by the use of a private password that complies with all regulatory requirements. This password shall be kept confidential by the Practitioner and will not be shared for any reason.

7.2 History and Physical Examination

7.2-1 Generally

All patients admitted to Hospital require a Physician's evaluation for the initial History and Physical (H&P). A complete history and physical examination must be recorded in the chart within 24 hours after admission of the patient. The H & P must include:

- Chief Complaint
- History Present Illness
- Relevant past medical, social and family history
- Emotional behavioral and social status when appropriate

- Pertinent findings from a review of systems
- Physical Examination
- Assessment and Plan

For radiology procedures, the Radiologist will complete a focused (short form) history and physical. The focused history and physical will include:

- Reason for visit
- Review of systems (relevant to area of procedure)
- Sedation note
- Discharge medication reconciliation

7.2-2 Use of Reports Prepared Prior to Current Admission

- External to Hospital: If a qualified Medical Staff member has obtained a complete history or has performed a complete physical examination within seven (7) days prior to the patient's admission to the Hospital, a durable, legible copy of the report may be used in the patient's Hospital medical record, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report.
- On Prior Admission: When a patient is readmitted to this Hospital within thirty (30) days, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.
- Following completion of history and physical if no changes, members of the Medical Staff may document "No change in the History and Physical" followed by signature, date, and time.

7.3 Preoperative Documentation

7.3-1 History and Physical Examination

A relevant history and physical examination is required on each patient having surgery as outlined in the Surgery Rules and Regulations.

If not recorded, the Operating Room Director or anesthesiologist responsible for the patient's anesthesia care shall not allow the surgery to proceed.

In case of emergency, as certified in writing by the operating Physician, the responsible Provider shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be completed immediately after the emergency procedure has been done.

7.3-2 Preoperative Anesthesia Evaluation

The anesthesiologist (or other Providers responsible for the patient's anesthesia care) must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

The anesthesiologist (or other Providers responsible for the patient's anesthesia care) must conduct and document in the record a post-operative status of the patient as evaluated on admission to and discharge from the post-anesthesia recovery area. The documentation includes a record of vital signs and level of consciousness; intravenous fluids administered, including blood and blood products; all drugs administered; post-anesthesia visits; and any unusual events or postoperative complications and the management of those events.

7.4 Progress Notes

7.4-1 General

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the Practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes must be written by the attending service every calendar day.

7.5 Operative, Special Procedure, and Tissue Reports

7.5-1 Operative and Special Procedure Reports

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing Provider and any assistants. The Medical Staff Provider must enter an operative note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any Provider who is required to attend to the patient. The complete report must be documented within twenty-four (24) hours following the procedure.

7.5-2 Tissue and Examination Reports

All tissues, foreign bodies, artifacts and prostheses removed during a procedure will be subject to the Pathology Department Policy for Defining Specimens for Pathology Examination.

7.5-3 Pre-Procedure Review of External Histo-Pathologic Diagnosis

When a patient enters this Hospital to undergo a definitive therapeutic procedure based on histo-pathologic diagnosis made elsewhere; the Medical Staff member must provide a report which substantiates the indications for surgery. This report will become a part of the medical record.

7.6 Obstetrical Record

The current obstetrical record will include a complete prenatal record if available. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

7.7 Entries at Conclusion of Hospitalization

7.7-1 Discharge Summary

In General: A discharge summary must be recorded for all patients within 48 hours of patient discharge. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on

admission.

7.7-2 Instructions to Patient

The discharge process is intended to provide patients with adequate information and necessary resources to improve or maintain their health during the post-Hospital period and to prevent adverse events and unnecessary re-hospitalization. Thus, the attending Provider, and any/all consultants will work collaboratively with Hospital staff to assure that patients receive all the information required on the discharge instructions sheet(s) and checklist. All information provided to the patient must be legible and free from medical or other abbreviations.

7.8 Authentication

All clinical entries in the patient's medical record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, electronic signature (stamped signatures are not acceptable on any medical record). Facsimile of original written or electronic signatures are acceptable.

7.9 Use of Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved symbols and abbreviations is available at each nursing station and in the Health Information Management Department.

7.10 Filing

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation, or other unavailability of the responsible Provider to complete the record, the MEC shall consider the circumstances and may enter such reasons in the record and order it filed. Refusal of a Physician to complete a medical record may be grounds for peer review action under the Corrective Action/Fair Hearing Plan.

7.11 Ownership and Removal of Records

All patient medical records, including, but not limited to, X-ray films, pathological specimens and slides are the property of the Hospital only as prescribed by law. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof from the Hospital are grounds for disciplinary action.

7.12 Access to Records

7.12-1 By Patient

A patient, may, upon written request have access to all information contained in their medical record, unless access is specifically restricted by the attending Provider for medical reasons or is prohibited by law.

7.12-2 For Statistical Purposes and Required Activities

Patient medical records shall also be made available to authorized Hospital personnel, Medical Staff members or others with an official, Hospital approved interest for the following purposes:

- (a) Automated data processing of designated information
- (b) Activities concerned with assessing the quality, appropriateness, and efficiency of patient care

- (c) Clinical unit/support service review of work performance
- (d) Official surveys for Hospital compliance with accreditation, regulatory, and licensing standards
- (e) Approved educational programs and research studies

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.12-3 Patient Consent Required Under Other Circumstances

Written consent of the patient or their legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or by law to receive this information.

7.13 Incomplete Charts

All Practitioners are required to complete their medical records within the time frame stipulated in the Medical Staff Rules and Regulations, to support a medicolegal sound medical record and to assist in meeting completion requirements of the various regulatory agencies of which HRH is accredited.

7.13-1 Chart Completion Requirements

Chart completion requirements are as follows:

- (a) History and physical exam completed within 24 hours of admission. History and physical exam is required to be on the chart prior to surgery.
- (b) Operative note/delivery summary completed within 24 hours of surgery/delivery.
- (c) All Queries responded to within 7 days.
- (d) Discharge summary must be completed within 48 hours of discharge.

7.13-2 Inpatient, Same Day Care, and Observation Patient:

- (a) Health Information Management will analyze and enter charts incomplete within two to four working days after discharge. Incomplete discharge summaries will be entered the first (1st) working day following discharge. The date available to the Providers will be the date entered incomplete—not the patient's discharge date.
- (b) Providers will be responsible for adhering to the requirements set forth above for completion of all medical records.

7.13-3 Variation from Acceptable Practice Patterns for the Inpatient, Same Day Care and Observation Patient:

- (a) Delinquent Record criteria:
 - (1) H&P—delinquent 24 hours after admission.
 - (2) Note: H&P is required prior to surgery.
 - (3) Operative note delinquent 24 hours following the surgery.
 - (4) Delivery summary delinquent 24 hours after delivery.
 - (5) All queries delinquent after 7 days.
 - (6) Discharge summary is delinquent at 48 hours.

- (7) Other medical records requiring signatures must be completed within 7 days.

- (b) Monitoring Body

Audits will be performed weekly. The MEC shall monitor the completion of medical records and implement any corrective action deemed necessary through the Clinical Review Committee (CRC). Quarterly QI reports will be sent to Quality Steering Committee with the regular Medical Record Reporting data.

7.13.4 Repercussions for Delinquent Inpatient Medical Records:

- (a) Administrative Suspension

- (1) A letter from Health Information Management will notify Medical Staff Practitioners of any outstanding medical records greater than or equal to 15 days.
- (2) At 30 days, a certified letter will be sent from the CMO to the Practitioner noting the Practitioners delineated clinical privileges are suspended until all Medical Records are completed.

- (b) Failure to write or dictate reports that have a 24-hour deadline for completion will be reported to the MEC. Recurring non-compliance will be addressed under the Corrective Action/Fair Hearing Plan.

7.13.5 Delinquent Outpatient Medical Records

- (a) Definition:

- (1) An incomplete medical record includes either of the following which are 7 or more days old (i) incomplete notes, (ii) unsigned notes or (iii) unreviewed labs and imaging in a provider EPIC inbasket. A Providers notes are not complete unless the documentation supports the level of billing. Provider records submitted which are not substantially complete, as determined by the CMO (or their designee) shall be deemed incomplete and subject to repercussions for delinquent medical records.
- (2) Delinquent outpatient medical records are a breach of a Provider's employment agreement to provide specific, accurate, and timely medical records. This also constitutes a failure to comply with Hospital and Medical Staff policies and procedures. Failure to meet such obligations may, in the discretion of the Hospital, in accordance with Section 7.13.5(C), result in disciplinary action up to and including termination of the employment agreement.
- (3) If a provider is on PTO the preceding Monday through Friday, a grace period of 48 hours will be granted to complete delinquent charts.

- (b) Audits:

- (1) Audits will be performed weekly. Delinquent outpatient medical records, as defined in Section 7.13.5(A), are subject to repercussions described in Section 7.13.5(C).

- (c) Process and Repercussions for Delinquent Medical Records:
 - (1) The process and associated repercussions shall not constitute adverse action nor trigger rights under the Corrective Action/Fair Hearing Plan except as otherwise stated herein. Upon review or investigation of a violation of this section, each instance described below could result in disciplinary action up to and including termination of employment.
 - (i) First instance: the provider must submit an action plan to their director(s) the following Monday. The action plan should indicate how the provider will prevent further delinquent records.
 - (ii) Second instance: the provider must appear before the Outpatient CRC for review. This shall not represent adverse action, nor does it activate rights under the Medical Staff Fair Hearing Plan, except as otherwise noted herein.
 - (iii) Third instances: the provider must appear before the Outpatient CRC chairperson, along with the CMO and/or their designee(s), to determine the appropriate next steps.

Article VIII CONSENTS

8.1 General

Each patient's medical record must contain evidence of the patient's or his legal representative's general consent for treatment during hospitalization.

8.2 Informed Consent

8.2-1 When Required

The performing Provider is responsible for obtaining the patient's or his legal representative's informed consent for the procedures and treatments listed below:

- (a) Anesthesia;
- (b) Surgical and other invasive and special procedures;
- (c) Use of experimental drugs;
- (d) Organ donation;
- (e) Radiation and chemotherapy;
- (f) Autopsy;
- (g) Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form;
- (h) Blood transfusion;
- (i) Transfer to another facility

8.2-2 Documentation Required

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

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

8.2-3 Signatures

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

8.2-4 Emergencies

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2.1 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record:

- (a) Emergency/Life Threatening - In an emergency, involving threat to life, a Practitioner needs no consent to perform any treatment necessary which they are qualified to perform.
- (b) Urgent/Not Life Threatening - If the Practitioner feels that failure to treat may have adverse consequences, they may proceed without a legally executed consent, provided an effort has been made to notify the responsible person to arrange consent.

8.2-5 Verbal and Telephone Consent

Verbal and/or telephone consent obtained by the Practitioner is valid upon informing the patient or the patient's legal representative of the plan of treatment.

(a) Verbal Consent

Verbal consent may be accepted in cases when the patient, or legal representative, cannot sign due to a physical or literacy incapacity, provided the reason for verbal consent and the witness's name is documented.

(b) Telephone Consent

Telephone consent may be accepted when distance, timing, or lack of availability of legal representative is a bona fide problem and the Provider deems the necessity of treatment is such that significant delay

could cause harm. Telephone consent must be witnessed and documented, as such.

(c) Witnesses

Witnesses to verbal or telephone consent shall be professional nursing personnel, supervising management personnel and/or administrative position personnel who are knowledgeable about the legal requirements covering informed consent.

APPROVED BY: MEC on 06/08/2026

ADOPTED BY: The Medical Staff on 05/26/2026

APPROVED BY: The Board of Trustees of Hendricks Regional Health on 06/15/2026

Addendum I:

<i>Medical Staff</i>		<i>Allied Health Professionals</i>	
Active	Affiliate	Independent	Dependent
Physician, MD or DO	Oral Surgeon, DMD Dentist, DDS Podiatrist, DPM	Advanced Practice Registered Nurse Audiologist Certified Registered Nurse Anesthetist Certified Nurse Midwife Clinical Nurse Specialists Licensed Clinical Psychologist Occupational Therapist Optometrist Physician Assistant Physical Therapist Registered Dietitian Nutritionist	Certified Neurological Intraoperative Monitor Dental Assistants Medical Assistants Rounding Nurses Scrub Nurses Surgical Technicians Individual Basis as determined by Medical Executive Committee
Privileges, Eligibility & Responsibilities*			
Admit privileges Hospital Wide Call Coverage Leadership Positions (Medical Staff Committee Chair or Service Chief) Medical Staff Committee participation Voting Rights Corrective Action/Fair Hearing	Attending, but not admitting privileges Medical Staff Committee Participation Voting Rights Corrective Action/Fair Hearing	Advanced Practice Providers may attend to patients, but not admit Outpatient Call Coverage Medical Staff Committee participation	
Attend 50% of General Medical Staff Meetings	Attend 50% of General Medical Staff Meetings	Advanced Practice Providers (CRNA, NP, PA) attend 50% of General Medical Staff Meetings	
<i>*All categories are held to the Medical Staff Bylaws, Medical Staff Rules & Regulations, and Credentialing Manual. Privileges, Eligibility & Responsibilities are subject to individual Practitioner delineation of privileges.</i> <u>Provider:</u> Defined as both Active and Affiliate Medical Staff and Advanced Practice Registered Nurses, Physician Assistants and Certified Registered Nurse Anesthetists. Attend 50% of General Medical Staff Meetings. <u>Practitioner:</u> Defined as both Active and Affiliate Medical Staff and all Independent Allied Health Professionals.			