Pali Momi Medical Center

RULES AND REGULATIONS

Reviewed and Approved May 21, 2025

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PURPOSE

Rules and Regulations cover the major responsibilities of the Medical, Dental and Podiatry Staff and Allied Health Professionals and supplement the Medical Staff Bylaws and Hospital Policies and Procedures. These Rules and Regulations may be amended as stated in the Pali Momi Medical Staff Bylaws.

Medical Staff Rules and Regulations and Policies applying to a particular department or service may be developed by the department or service and shall not become official until approved by the Medical Executive Committee and Board of Directors.

ADMISSION (GENERAL) AND DISCHARGE OF PATIENTS

1. The Hospital shall admit all patients for care and treatment with the exception of emergency or elective obstetrical and critically ill pediatric patients or patients with a primary psychiatric diagnosis that would present a safety or management problem to the hospital staff.

2. Patients may be admitted only by providers of the medical staff with delineated clinical privileges.

3. A provider privileged through the medical staff process (attending provider) shall be responsible for the medical care and treatment of each patient in the hospital. Any patient admitted to the hospital must be seen by the attending provider or his or her designee on a daily basis. The attending provider shall be responsible for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring provider. Whenever these responsibilities are transferred to another provider, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

4. Patients admitted for a primary medical or surgical reason that may require psychosocial intervention shall be offered consultation as ordered by the attending provider.

5. Medical or surgical patients admitted with psychiatric disorders requiring psychiatric or psychological treatment beyond the scope of services offered at Pali Momi Medical Center shall be transferred to an appropriate psychiatric facility as soon as patient's medical or surgical condition can be stabilized and transfer arrangements have been completed.

   All Hospital, Medical Staff and Emergency Department policies governing the procedures for handling of psychiatric patients shall be in compliance with State/Federal laws.

6. The minimum patient age for elective admissions to the Hospital shall be six years of age, unless prior approval has been obtained from the Chief Operating Officer and Chair of the specific Department involved.

   The minimum age of patients undergoing outpatient procedures shall be one year of age, unless prior approval has been obtained by the Chief Operating Officer and Chair of Department of Medicine or Surgery.

7. Patients without an attending provider shall be offered a choice of providers on the medical staff. If such a choice is not exercised, the Chief of Staff or his or her designee shall assign a provider.

8. Emergency Department patients who do not have an attending provider on the Pali Momi Medical Staff will be admitted by the Hospitalist Provider or Call Panel Provider for the relevant medical specialty.

9. Providers admitting patients shall be responsible for giving such information as may be necessary to assure the protection of other patients and staff from patients who are a source of danger for any reason whatsoever.

10. Patients with a known communicable disease may be admitted if the facility can properly care for the patient. The Infection Control Nurse shall be consulted to determine admission eligibility for a patient with a communicable disease.

11. A provisional diagnosis shall be recorded before admission of patients, except in an emergency.

12. All patients admitted to the Hospital shall be under the care of a Provider of the medical staff with appropriate delineated clinical privileges.

13. Members of the Dental Staff may admit patients to the Hospital, if privileges are so granted by the Board of Directors. Patients admitted for dental care shall have a history and comprehensive physical examination recorded by a provider of the medical staff. Dentists are responsible for obtaining the history and physical which pertains to their procedure only.

14. A qualified oral surgeon may obtain a history and perform a physical examination, if he or she is qualified and clinical privilege have been approved by the Board of Directors and the patient is without medical problems.

15. All Federal and State Laws involving abuse of a family member reporting shall be strictly followed.

16. Each provider of the medical staff shall designate another provider of the medical staff with similar clinical privileges who may be called to attend to his or her patients in an emergency or in his or her absence.

17. Except in emergencies, no patient shall be admitted to the hospital until a Terms and Conditions of Service has been completed. A general consent form signed by or on behalf of every patient must be obtained at the time of admission. The admitting officer shall notify the Chief Operating Officer or his or her designee whenever such consent has not been obtained. When so notified, it shall be the provider's obligation to obtain proper consent before the patient is treated.

18. Admissions Priority
    The priority for admissions shall be:

    a. Emergency Admissions
    b. Urgent Admissions
    c. Elective Admissions

19. Admission or transfer by a Provider of a patient from one Department to another shall be by mutual agreement between the Providers involved. No patient shall be transferred or discharged for purposes of effecting a transfer from Pali Momi Medical Center to another health facility unless arrangements have been made in advance for admission to such health facility and transfer agreed upon by that facility, and the person legally responsible for the patient has been notified, or attempts over a 24 hour period have been made and a responsible person cannot be reached.

20. Patients Discharged:

    a. It shall be the responsibility of the attending Provider to discharge patients when medically stable.

    b. Patients may be discharged by the resident only with the approval of the supervising attending.

AUTOPSIES

1. Pali Momi Medical Center does not have an equipped morgue at this facility. Performing of autopsies are, however, readily available by the Hospital Pathologists using other facilities.

2. Providers of the medical staff are encouraged to obtain autopsies on patients whenever possible, although it is strongly recommended that autopsies be performed in the following instances:

    a. All patients without a diagnosis before death or in which a diagnosis is unclear (no change)

b. All intraoperative and postoperative deaths (add - within 48 hours after surgery or an invasive diagnostic procedure)
c. All unanticipated deaths (no change)
d. All deaths incidental to pregnancy (add: or within seven days following delivery)
e. All unexplained deaths (no change)
f. Death occurring while the patient is being treated under a new therapeutic trial regime
g. Death in infants/children with congenital malformations.

3. An autopsy may be performed only with written consent, signed in accordance with state law.

4. In accordance with Pathology Policy, the pathologist performing the autopsy shall communicate with the responsible Provider regarding the request for autopsy. In addition, the responsible Provider shall be notified of the date and time autopsy will be performed.

5. It is anticipated that a provisional anatomic diagnosis shall be recorded in the medical record within 2 working days and the complete report shall be made a part of the medical record within 30 working days for routine cases and within 3 months for complicated cases.

6. The results of autopsies shall be made a part of the overall quality assurance evaluation of medical and surgical management.

CONSENTS

1. Each person who registers for medical treatment or services as an inpatient or outpatient must sign the Terms and Conditions of Service.

2. Medical procedures that are complex or invasive require informed consent as defined by Medical Staff Informed Consent policy.

CONSULTATIONS

1. A consultant must be a Provider of the medical staff specializing in the field in which a consultation is requested. Temporary privileges to a Provider who is not granted appropriate clinical privileges may be granted by the Chief Executive Officer or his or her designee after conference with the Chief of Staff under provisions in Section 5 of Article VII of the Medical Staff Bylaws.

2. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

   When operative procedures are involved, the consultation note shall be available prior to surgical procedure (except in an emergency).

3. Consultations are required in the following instances:
   a. Ophthalmology consultation is required for all elective cases of enucleation, evisceration, or penetrating injury to the globe.
   b. Whenever a patient is considered a threat to his-self or others, or grossly impaired, mental health services shall be offered.
   c. Judgment as to the nature of the illness, diagnosis and treatment rests with the Attending Provider responsible for the care of the patient. The Attending Provider is responsible for requesting consultation when indicated.

d. In the management of cases beyond the scope of the Provider's training, experience and/or specialty.

Although not mandatory, it is strongly recommended that consultations be obtained in the following instances:

a. In major surgical cases in which the patient is at high risk.
b. In all cases in which the diagnosis is obscure or when there is doubt as to the best therapeutic measure to be utilized.
c. In any case not progressing satisfactorily.

4. In circumstances of grave urgency where consultation is required by the rules of the Hospital, the Chair of the department involved shall contact the attending provider, and in conjunction with the Chief of Staff, shall have the right to call in a consultant to evaluate the patient.

5. In the event the attending provider's privileges preclude further management of the problem for which consultation was obtained, the consultant will assume full responsibility for the care of the patient, including all treatment, operative and post-operative management (if indicated) in addition to documentation of final summary of all treatment rendered.

6. Consultation Orders
   a. All stat orders for consultations must be arranged personally between ordering Provider and consultant.
   b. Whenever possible, Providers should identify and contact their own consultants.
   c. All orders for consultation given to patient care staff must include who is to be contacted and an appropriate designation of time frame that consultation should be completed.

Reasonable response times are:

Emergency Consult requests:	within 4 hours.
Urgent Consult requests:	within 24 hours.
Routine Consult requests:	within 24 hours; however, if it is not possible, the consulting Provider must arrange an appropriate timeframe with the Provider requesting the consultation, but should not exceed 48 hours.

Consultants must document their impression and recommendation(s) immediately following consultation.

DIETARY

In compliance with policies for Entering and Confirming Diet Orders and for Oral Supplements Order Writing Privileges by Registered Dieticians, nurses and dieticians may write diet orders, but such orders must be countersigned by a Provider with appropriate medical staff membership and clinical privileges.

DISASTER PLANNING

All Providers and members of the Medical and Dental Staff shall be familiar with the Hospital Disaster Plan. Normal hospital procedures shall be superseded upon the implementation of the Hospital Disaster Plan. The Chief Executive Officer (or designee) shall have the sole authority to declare a disaster and to activate the emergency preparedness plan. The Chief of Staff (or designee) and the Chief Nurse Executive or his or her designee shall have the sole authority on all matters regarding patient care within the hospital including triage, admission, discharge, transfer or evacuation of patients.

EMERGENCY MEDICINE

1. The Emergency Department shall be staffed at all times by a physician who has been board certified or is board eligible in emergency medicine as defined in bylaws 3.2.1 (l). All privileges shall be delineated by the Medical Director of Emergency Medicine and approved by the Chair of the Departments of Medicine, Surgery, the Medical Executive Committee and the Board of Directors.

2. The Rules and Regulations governing emergency medicine shall be developed by the emergency medicine staff with representation from nursing services, administration, and other medical staff members, with all policies approved by the Medical Executive Committee and Board of Directors.

3. The emergency department Providers shall not have admitting privileges nor shall they be able to write admitting orders.

4. A medical record shall be kept for every patient receiving emergency care, and incorporated in the patient's hospital record if the patient is admitted. This record shall include but not be limited to:
    a. Patient identification
    b. Time of patient arrival, means of arrival, and by whom transported.
    c. Pertinent history of the injury or illness including details relative to bystander first aid or emergency care given the patient prior to his or her arrival at the hospital.
    d. Description of significant clinical, laboratory and diagnostic imaging findings.
    e. Diagnostic Impressions
    f. Treatment given
    g. Condition of the patient on discharge or transfer
    h. Final disposition, including instructions given to the patient or his or her family, relatives, etc., regarding necessary follow up care.
    i. Notification of attending physician (if on the Pali Momi Medical Staff) or referral of the patient to a private physician on the Pali Momi Medical Staff unless otherwise requested by the patient or physician.
    j. Signature of attending emergency medicine physician.

5. There shall be ongoing quality monitoring of emergency medicine activities to identify areas for improvement and compliance to the medical staff bylaws, rules and regulations by all Providers of the Emergency Department. Findings shall be reported to the chair of the Medicine Peer Review Committee.

6. Emergency Medicine Providers and staff shall participate in the overall Hospital Disaster Plan. The Disaster Plan shall be developed by the Environment of Care Committee and will be based on the hospital's capabilities as well as the capabilities of other emergency facilities in the community.

INFECTION CONTROL

1. Providers and Members of the medical staff shall adhere to all infection control policies as developed by the Infection Control Committee and approved by the Medical Executive Committee and Board of Directors.

2. Body Substance Isolation precautions (as defined by the Centers for Disease Control) shall be adhered to at Pali Momi Medical Center.

3. Personal Protective Equipment shall be worn as follows:

    a. Gloves - must be worn when it is likely that hands will be in contact with body substances (blood, feces, urine, wound drainage, oral secretions, sputum, vomitus, instrumental examinations of oropharynx, invasive procedures, non-intact skin, handling of items or surfaces soiled with blood or body fluids, performing venipuncture, and other vascular access procedures.

    b. Gown (plastic)/Plastic Apron - Must be used in situations where clothing may be soiled with moist body substances.

    c. Masks/Masks with Eye protection - Must be used in situations where eyes or mucous membranes may be splashed with body substances. Masks are worn when the disease may be transmitted by air borne route.

MEDICAL RECORDS

1. All original medical records, x-rays, and all electronic and printed clinical documents shall be the property of Pali Momi Medical Center and shall not be removed from the hospital, unless by court order subpoena.

2. Releasing of original x-rays will be permitted in accordance with the Imaging Department Policy and Procedure

3. The Medical Records Department shall maintain a medical record on all patients examined or treated at Pali Momi Medical Center consistent with HPH policies and procedures relating to privacy and confidentiality. This record shall be made available to any medical staff or other member of the facility's work force on a "need to know basis."

4. Except as otherwise provided by Hospital Policies and Procedures, non-members of the medical staff using any medical record shall first make written request of the Chief Executive Officer or designee and appropriate Department Chair stating the purpose for which request is made.

5. The medical staff shall be responsible for the proper preparation of a complete, current medical record on all patients seen at Pali Momi Medical Center. This record shall include:

    a. Registration data
    b. History and physical
    c. Consultation report (if any)
    d. Reports of special procedures including operative reports
    e. Emergency room record (if any)
    f. Evidence of appropriate informed consents(if any)
    g. Reports of all procedures, tests and results, including surgical or diagnostic procedures and pathology reports.
    h. Summary at termination of hospitalization which includes the provisional diagnosisor reason for admission, the principal, additional and associated diagnoses, the discharge summary, final summary and final progress note, and, where appropriate, the autopsy report.

6. The medical record exists primarily as a communication tool in patient care and, therefore, every member of the medical staff shall assure that the medical record is immediately available for this purpose, and is legible.

7. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations in the last progress note and/or discharge summary, by the responsible providerat time of discharge.

8. For patients receiving emergency, urgent or immediate care, and no H&P is recorded, the medical record must document the time and means of arrival, the conclusions at termination of treatment, including final disposition and, when applicable, indication that the patient left against medical advice, condition at discharge and instructions for follow-up care.

9. Documentation requirements for medical records:

    a. <u>History and Physical Requirements</u>
    An admission History and Physical examination will be completed and documented within twenty-four (24) hours following admission. For a medical history and physical examination that was completed within 30 days prior to inpatient admission or registration, an update documenting an examination for any changes in the patient's

condition is completed within 24 hours after inpatient admission or prior to surgery, whichever comes first.

In the absence of a written and/or dictated history and physical examination being available prior to surgery, the provider must document a brief handwritten note indicating that heart and lungs have been evaluated and the patient is cleared for surgery.

The H&P will include all pertinent findings resulting from an assessment of the patient. Failure by the provider to complete this requirement within the timeframe specified will result in the Medical Records Department enforcing a temporary suspension of privileges.

Delegation of History and Physical:

The history and physical examination may be delegated to a Physician Assistant, Nurse Practitioner, Resident physician, or medical student under the supervision of, or through appropriate delegation by, a qualified provider who countersigns and retains accountability for the examination.

History and Physical Report Components:

- Medical history, including chief complaint
- Details of the present illness
- Present medications
- Relevant past social and family histories (appropriate to patient's age)
- Review of systems
- Physical examination
- Impression
- Treatment plan (plan of care)

History and Physical Examination: Ambulatory Services

History and physical examination may vary by setting, level of care, treatment or services. Assessment should be sufficient to provide the necessary information to plan for appropriate care of the patient. At a minimum, the report shall include:

- Medical history, including chief complaint
- Details of the present illness
- Present medications
- Physical examination
- Impression
- Treatment plan (plan of care)

A history and physical examination is required for all procedures that involve parenteral sedation services, general anesthesia, or high risk diagnostic or therapeutic intervention.

History and Physical Examination: Imaging Services

The referring provider must complete a history and physical for all patients undergoing angiograms, arteriogram, myelogram and all biopsies receiving parenteral sedation. This excludes lung biopsy or ultrasound/computerized tomography-guided needle biopsies.

The History and Physical shall include a minimum of heart and lung findings and all other pertinent information regarding the overall health status of the patient that would be beneficial to the care of the patient undergoing the radiology procedure.

History and Physical Requirements for Therapeutic Treatment
A history and physical must be completed on patients undergoing therapeutic treatments such as chemotherapy or transfusion for each new or renewed order for treatment.

History and Physical Requirements for Infusion or Transfusion Services
For patients being referred for infusion or transfusion services, an updated H&P shall be submitted no less frequently than every twelve months, or more often if there is a significant change in the patient's health status or test results.

History and Physical – 30 days prior
If a complete history and physical examination has been performed within thirty (30) days prior to the patient's admission to the hospital, a durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and physical, provided these reports were recorded by a privileged provider or member of the medical staff. Assessment of patient's status at the time of admission will be recorded in the progress note to include any change or lack of change in the prior history and physical examination.

History and physical examination performed within thirty (30) days prior to the patient's admission by a practitioner who is not a member of the medical staff may be included in the patient's medical record if it meets the requirements of the hospital and a provider on staff with privileges to perform history and physical examination, reviews and confirms the findings and authenticates the document. Any changes that may have occurred are recorded in the medical record at the time of admission.

Before surgery, the patient's physical examination and medical history, any indicated diagnostic tests and a preoperative diagnosis are completed and recorded in the patient's medical record except in emergencies. If there is no history and physical on record, the procedure will be canceled, unless the attending provider states in writing that such delay would be detrimental to the patient.

b. Progress Notes Requirements
Progress notes sufficient to permit continuity of care and transferability will be recorded at the time of observation. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes will be written daily on all patients including both acute level of care and observation status.

For patients who are below an acute care level, whose condition is stable and who are wait-listed for long-term care facilities, progress notes will be recorded at least once every 30 days.

c. Operative Reports Requirements and Post Operative Note
Operative reports must be written and dictated immediately after and shall include the operative name of the procedure and the name of the licensed independent practitioner and assistant(s), procedures(s) performed and description of the procedure, findings of the procedure, any estimated blood loss, any specimens removed, and postoperative diagnosis. The report is authenticated by the licensed independent practitioner and made available in the medical record as soon as possible after the procedure. Immediately after a procedure is defined as upon completion of the operation or procedure, before the patient is transferred to the next level of care.

High risk procedure reports, which will include all pertinent information as noted above and will be documented or dictated immediately after the procedure. The focus is on procedures, with or without sedation, that place patients at greater than minimal risk.

An operative or high risk procedure progress note is to be entered in the medical record immediately after the procedure. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and assistant(s), procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. Failure by the physician to meet the requirements for completion will result in the Medical Records Department enforcing a temporary suspension of privileges.

d. Consultation Report Requirements

Consultation report shall contain a written or dictated opinion of the examination in the patient's medical record. When operative procedures are involved, the consultation note will be recorded prior to the operation except in emergency situations.

The attending provider is primarily responsible for documenting the request for a consultation, when indicated, and calling in a qualified consultant.

e. Discharge Summary Requirements

A discharge summary shall be written or dictated on all medical records of patients hospitalized. All require a discharge summary. The discharge summary must be completed and available no later than 15 days post discharge.

The discharge summary shall include:

- Reason for hospitalization
- Final diagnosis
- Significant findings
- Procedures, tests and results
- Treatment rendered
- Discharge medications
- Condition and disposition of the patient on discharge
- Instructions to the patient and/or family
- Complications, if any

On observation patients, the provider must enter a note documenting why the patient was on observation status and the criteria for discharge.

f. Cancer Staging

The provider must document staging of newly diagnosed cancer in the patient's medical record. If cancer staging is not documented by the attending provider, the medical record shall be considered incomplete.

g. Residents: Residents in training providing patient care in all areas Services provided by residents are always under the supervision and responsibility of the attending physician. An attending physician could be any full time University faculty, clinical faculty or private attending physician who has approved privileges at Pali Momi Medical Center. Residents are authorized to write patient care orders. This does not prohibit a member of the Medical Staff from writing orders. In all hospital areas, responsibility for the quality of care, proper supervision, review of chart notes, and review of orders written by residents is the responsibility of the attending physician. Only the following performed by residents must be authenticated by countersignatures by attending practitioners in accordance to timelines described in Section 19. Suspensions for incomplete medical records:

a. Medical History and Physical Examination (If the required medical history and physical examination is independently completed by the attending practitioner, attending practitioner countersignature of the medical history and physical examination performed by the resident will not be required.)
b. Admission Orders and Notes
c. Transfer Orders
d. Operative or high-risk procedure
e. Discharge Summary or Final Progress Note

9. When an inpatient must be referred to another health care facility for special tests or treatment, only copies of the pertinent medical record data will be sent with the patient upon transfer to another facility.

10. In case of readmission of a patient, all previous records will be available for the use of the attending provider. This applies whether the patient is attended by the same provider or by another.

11. All entries in the medical record shall be dated, timed and signed. Once entered into the record, all parts of the patient's chart are part of Hospital property and must not be destroyed or altered in any way. If an entry is found to be incorrect, an addendum note may be made referencing the incorrect entry.

12. Individuals, other than members of the medical staff, authorized to document in the medical record are multidisciplinary team members,Allied Health Professionals, and resident physicians involved in the care of the patient.

13. Unapproved abbreviations as defined by the hospital shall not be used and applies to all orders and other medication related documentation when handwritten, entered as free text into a computer, or on pre-printed forms.

14. The Medical Records Committee may recommend to the Medical Executive Committee that an incomplete medical record be filed in the event the attending provider involved is deceased, has his or her hospital privileges permanently suspended or has moved out of the state, is no longer a practicing provider or for other reasons rendering the provider involved incapable of completing the medical record.

15. Providers may send and receive Facsimile (FAX) medical record documents. Information transmitted via facsimile will be considered as the intended original document and is acceptable for inclusion into the medical record.

16. <u>Inpatient Medical Records</u>:
The inpatient record will include, if applicable:
    a. Identification data;
    b. Complaint or reason for admission;
    c. Personal history, including allergies;
    d. Family history;
    e. History of present illness;
    f. Physical examination;
    g. Treatment plan;
    h. Consultation report;
    i. Provisional diagnosis;
    j. Medical and surgical treatment;
    k. Operative report
    l. Anesthesia record;
    m. Informed consent;

n. Pathological findings;
o. Progress notes;
p. Final diagnosis;
q. Condition on discharge;
r. Discharge summary;
s. Autopsy report;
t. Provider's orders;
u. Ancillary reports (i.e. lab, radiology, nuclear medicine, EKG, EEG).
v. Current medications

17. Provider Verbal/Telephone Orders (refer to "Orders" section)
Orders shall normally be entered by the provider in the electronic medical record; verbal orders should be given rarely and only on an emergent or urgent basis.

Verbal or telephone orders or telephonic reporting of critical test results require verification of the complete order or test result by having the person receiving the information record and "read back" the complete order or test result.

Verbal or telephone orders shall be recorded with date and time and shall include the names of the individuals who gave, received and implemented the order.

a. Medication Orders

Pali Momi Medical Center shall minimize the use of verbal and telephone medication orders. Verbal or telephone orders for medications shall be given only by a provider and shall be accepted only by a licensed nurse, physician assistant, pharmacist or physician. Registered respiratory therapists and certified respiratory therapists may receive and transcribe provider's verbal orders for drugs directly related to the provision of respiratory care.

Orders for medication shall include*: (refer to "Pharmacy" section)*

- Name of medication
- Dose and dosage form
- Strength
- Route of administration
- Dosage regimen (frequency)

b. Blanket Orders

Orders which are written as "resume preoperative orders", "continue previous medications", or "discharge on current medications", are **NOT** acceptable. The process for medication reconciliation shall apply as defined by hospital policy.

c. Restraint Orders

All verbal or telephone orders for restraints will be countersigned by a provider within twenty-four (24) hours of initiation of the restraint. Continued use of restraint beyond the first twenty-four (24) hours requires authorization by a licensed independent practitioner renewing the original order or issuing a new order if restraint continues to be clinically justified. Such renewal or new order is issued no less often than once each calendar day and is based on the licensed independent practitioner's examination of the patient. Restraint orders will only be accepted by a Registered Nurse.

18. Suspensions for Incomplete Medical Records:
All medical records shall be completed within fourteen (14) days following patient discharge from the hospital.

a. The medical record shall be made available to the responsible provider for completion after discharge. If the medical record remains incomplete or unsigned for seven (7) days after it is made available, a notice informing the provider of incomplete records will be sent by regular mail.

b. If provider has not completed the medical record within six (6) days following notice, the provider or provider office shall be notified by phone call of impending suspension one (1) day prior to suspension.

c. If the provider fails to comply within seven (7) days after notice, the provider's admitting (or consulting) privileges will automatically be suspended for noncompliance. Provider shall be notified of suspension by certified mail. Suspension will be lifted as soon as the records are complete.

d. The medical record committee, medical staff office, guest registration, operative services and executive office shall be notified immediately of all automatic suspensions. They shall be notified as soon as such suspensions are lifted.

e. During the period of suspension, the provider:
- May continue to care for patients already in the hospital.
- May perform all previously scheduled procedures up to 72 hours (3 days) following date of suspension. No surgery may be performed after 72 hours.
- May not schedule elective inpatient or outpatient surgical cases.
- Shall maintain ER call responsibility.
- May admit only patients deemed emergent. Emergent admissions while physicians are on suspension shall be transferred to the care of another provider with current, unrestricted privileges at Pali Momi until such time as the suspension is cleared.
- Must sign dictated reports no later than 30 days after discharge or providing outpatient services.
- Providers who have had a single suspension over 10 days, or 3 suspensions within twelve months, will be reported to the Medical Executive Committee. A maximum of 3 formal notifications to the Medical Executive Committee within a practitioner's credentialing cycle, or a single suspension greater than 30 days, shall result in the automatic termination of membership without the right to hearing or further review, unless a factual dispute exists.

CREDENTIAL FILE STANDARDS

1. All applicants for membership to the Medical, Dental, Podiatry, and Allied Health Professional Staffs shall submit an application for membership. Documentation of the following will be necessary in order to process the application:

    a. Current license to practice medicine in the State of Hawaii
    b. Education and training to substantiate privileges requested. All applicants shall have had training in an approved (specialty) post-graduate training program or documented and verifiable experience commensurate with the privileges granted.
    c. Current competency
    d. Current liability insurance in the amounts determined by the Board of Directors unless waived by the Board of Directors.
    e. Voluntary or involuntary loss, suspension, limitation or reduction of clinical privileges or staff membership at another facility
    f. Previous or current challenges or voluntary relinquishment of a medical license or DEA Certificate from any and all States.
    g. Involvement in a professional liability action including current or past settlements, judgments and claims.
    h. Any past or present treatments or diagnoses for psychological, mental illness, alcohol or drug dependency during the past five years.
    i. Physicians and Dental Staff members must submit in writing on the prescribed Alternate Physician Coverage Form, the name of another Medical Staff Member to provide backup coverage in their absence (this does not include Emergency Department or House Physicians).

2. All applicants for medical staff membership who are granted temporary privileges must comply with the observation requirements. Temporary privileges shall be granted in accordance with Medical Staff Bylaws, 7.5 through 7.5.4.

3. Initial appointments are for a period of not more than two years (24 months), with the first year being provisional. The new member shall be responsible for completing their FPPE requirements as well as successfully accomplishing their duties and responsibilities as assigned by their Department's Chair. Reappointments are for a period of not more than two years (24 months).

4. Members of the Medical Staff are assigned to either the Department of Surgery or the Department of Medicine, based on their medical or surgical specialty.

5. Membership access to Credentials Committee Files:

    a. A Medical, Dental and Podiatry Staff or Allied Health Professional shall be granted access to his or her own credentials committee file under the following provisions:

        (i) The provider shall notify the Chief of Staff or his or her designee at least 14 days in advance. The provider may review and receive a copy of those documents provided by or addressed personally to him/her. A summary of all other information including peer review committee findings, letters of reference, proctoring reports, complaints, etc. shall be provided to the provider in writing by the Chief of Staff or his or her designee (at the time the provider reviews his or her credentials committee file). Such summary shall disclose the substance, but not the source of the information summarized. The review by the provider shall take place in the medical staff office during normal working hours with an officer or designee of the medical staff present.

        (ii) When a provider has reviewed his or her file as provided above, he or she may address to the Chief of Staff a written request for correction or deletion of information in his or her

credentials committee file. Such request shall include a statement of the basis for the action requested.

The Chief of Staff shall review such a request within ten (10) days and shall recommend to the Medical Executive Committee whether or not to make the correction or deletion as requested. The member shall be notified in writing of the decision of the Medical Executive Committee. A provider shall have the right to add to his or her own credentials committee file, upon written request to the Medical Executive Committee, a statement responding to any information contained in their credentials committee file.

7. . Any patient admitted for care shall be admitted by a staff provider, who has admitting privileges and agrees to accept the patient. The provider member shall be responsible for the medical care of the patient.

8. Physicians who wish to participate on the Interpretation Panels, developed for the reading of ECG, ECHO, Neurodiagnostic Panels, must comply with credentialing and panel guidelines established by the Medical Staff.

APPROVED MALPRACTICE FINANCIAL RESPONSIBILITY

1. All providers shall be required to provide documentation of approved and appropriate malpractice financial responsibility as defined below and consistent with those clinical privileges.

   Professional liability insurance coverage issued by a commercial insurance company, indemnity plan or risk retention group licensed to do business in any state in the United States in the amounts of at least $1,000,000 per occurrence and $3,000,000 in annual aggregate. A certificate of insurance must be provided.

SUPERVISION OF MEDICAL STUDENTS AND RESIDENTS

All medical students and residents must comply with all medical staff bylaws, rules and regulations and hospital policies and procedures. Residents must be properly supervised by an appropriately credentialed member of the Pali Momi Medical Center Medical Staff. Policies and requirements specific to resident supervision can be found in the Residents/Medical Students Policy and the House Staff Guidelines.
Fourth-year medical students, sub-interns, on an approved rotation are authorized to write orders, etc. and must e authenticated by countersignature by supervising physician prior to being carried out.

OBSERVATION AND PROCTORING

1. In accordance with the medical staff bylaws, all new members to the medical staff and members requesting a modification or additional clinical privileges shall require observation specific to those privileges which they have requested and have been approved by the Board of Directors.

2. Under certain circumstances, the observation requirement may be waived based on the approved medical staff criteria,at the discretion of the Credentials Committee in conjunction with the Department chair. One such circumstances includes but is not limited to having been previously privileged at the medical center for the same privileges being requested.
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3. The performance of all members of the medical staff shall be evaluated on an ongoing basis as part of the quality assurance program at Pali Momi Medical Center and reappraised at time of reappointment.

4. Established providers who wish to perform new procedures must assist in the development of new credentialing guidelines, must document their training and competency to perform these procedures, and obtain approval by the Chairpersons of the Department, Medical Executive Committee and the Board of Directors.

5. Observation General Requirements:
A minimum of five cases (unless specified) are required and must include cases involving at least two of the most specialized procedures requested. The reports shall be completed by the observer/proctor and forwarded to the medical staff office. The chair of the department or designee shall forward a recommendation for approval or continued observation to the Credentials Committee.

Non-Invasive Procedures:
The department chairperson and/or designee shall perform retrospective review of cases involving the performance of non-invasive procedures (i.e. overall medical management and treatment plan, documentation, etc.) by a member of the medical staff who is under observation. The reviewer's findings shall be evaluated by the Credentials Committee who shall make a recommendation to continue or remove observation status.

Invasive Procedures:
A qualified member of the medical staff, with full unrestricted privileges in the specific specialty, shall provide direct observation of invasive procedures and complete an Observation Report form for each procedure observed. The department chair and/or designee shall forward to the Credentials Committee a recommendation based on an evaluation of the observation reports. The Credentials Committee shall make a recommendation to continue or remove observation status.

Providers in good standing with full unrestricted privileges at a HPH sister facility may fulfill this observation requirement with retrospective chart reviews of their initial procedures at Pali Momi Medical Center in lieu of direct observations. The Credentials Committee will determine the method of initial provider focused professional performance evaluation.

Anesthesiology Requirements:
The first five procedures shall be observed, which include a minimum of 3 general procedures and 2 regional procedures. It is required that two general procedures and one regional procedure must be performed at Pali Momi Medical Center. Observation reports from other facilities may be accepted for one general and one regional procedure.

6. Observation shall be required for IV sedation procedures if observation for general procedures have not been completed.

Applicant Responsibilities:

a. In accordance with the medical staff bylaws, all new members to the medical staff and members requesting a modification of privileges or additional clinical privileges shall require observation specific to those privileges which they have requested and have been approved by the Board of Directors.

b. The specific procedures to be observed shall be determined by the department chairperson in which privileges have been requested. As a guideline, major

procedures which require a high degree of skill should be included as observed cases.

c. The provider being observed shall be responsible for obtaining a qualified observer from the Observer Panel, which will be provided to the applicant.

In the event that an observer cannot be obtained, the applicant shall contact the chairperson of the department (via the medical staff office) for assistance and/or resolution.

d. Providers shall not be observed by anyone who has a professional or financial relationship with the applicant; however, a waiver may be granted by the Credentials Committee for certain contract groups including, but not limited to, Anesthesiology, Pathology, Radiology, Emergency Room, and Hospitalist services. Providers who are related shall not be allowed to serve as an observer for each other.

e. All providers on observation shall be held responsible for obtaining at least two different observers for elective cases.

A minimum of five cases are required and must include cases involving at least two of the most specialized procedures requested. The proctoring reports shall be completed by the observer and forwarded to the medical staff office. The chairperson of the department in conjunction with the Peer Review Committee shall forward a recommendation for approval or continued observation to the Credentials Committee.

f. The provider being observed is to arrange for his or her own observer. Cases requiring observation shall be scheduled at a time convenient with the observer. The date and time of the case must be verified with the observer prior to scheduling.

g. Applicants who are new graduates from an accredited school of medicine and who have not been in active practice in Hawaii for a period to two years shall be required to provide specific documentation to perform privileges requested, number of cases performed, along with results of observation reports. Unless current, documented verification of competency is received from another hospital in which applicant is performing the privileges requested, observation of invasive procedures shall be required.

h. Observation Reports from another facility on the island of Oahu, may be acceptable but only if the observer is someone within the same specialty as the provider being observed. A maximum of two cases performed and observed at another facility may be considered.

Observer's Responsibilities:

a. It shall be the responsibility of all active staff members who enjoy full unrestricted privileges at Pali Momi Medical Center to serve as an observer in their specialty. Courtesy Staff members with unrestricted privileges may be required to serve as observers in order to accommodate a particular specialty in which there are no active staff members.

b. An observer shall not assist in the operation which he/she is observing.

c. Observers may not function as assistants nor are they to charge for their monitoring.

d. Surgical procedures must be observed beginning with the initial incision and may be concluded at the start of closure of incision.

ORDERS

1. Orders shall be written only by qualified members of the Medical, Dental and Podiatric Staff and residents. An Allied Health Professional credentialed through the medical staff process may write orders, but only to the extent established for him or her by the department to which he or she is assigned, but not beyond the scope of his or her license, certificate or other legal credential.

2. All patient care orders must be entered as per CPOE Medical Staff Policy.

3. Verbal orders may be given to other professional staff members only if the order does not infringe upon the guidelines of the Nurse Practice Act and are related to the professional's particular field only, i.e., physical therapist, pharmacist, radiology technician, respiratory therapist, laboratory technician, EKG/EEG technician, dietitian, nuclear medicine technologist, dialysis therapist, speech pathologist, audiologist, and medical social worker.

   Face-to-face verbal orders will only be allowed in emergencies or conditions in which the provider does not have immediate access to the medical record (e.g., provider performing a procedure or chart is not available). Face-to-face verbal orders given in an emergency must be authenticated within 48 hours by the prescribing provider or another provider responsible for the care of the patient.

4. All verbal orders for prescription drugs shall be given only by a provider and shall be accepted only by a licensed registered nurse, pharmacist, respiratory therapist or another provider. Orders shall normally be entered by the provider in the electronic medical record; verbal orders should be given rarely and only on an emergent or urgent basis. All verbal telephone orders for controlled substances, investigational drugs, I.V. solutions, injectables, renewals and initiation changes, or termination of therapeutic modalities shall be authenticated within 24 hours by the prescribing provider or another provider responsible for the care of the patient, even if the order did not originate with him or her.

5. All orders for Therapeutic and Diagnostic Cardiology Procedures must include documentation of reason (or indication) for performing the procedure. Cardiology Diagnostic Procedures may not be performed until this information is provided by the ordering provider. Members of the health care team who have authority to accept these orders shall obtain this information from the provider at the time the order is given. Orders shall not be carried out until the indication for procedure is provided (exception: emergencies).

6. All orders for radiological services (e.g. x-rays) shall contain the reason for the examination. The requesting medical staff member or other practitioner authorized to request radiological services is responsible for providing this information.

7. Providers shall document in the medical record the reason for ordering blood transfusions.

8. Physicians or physician designees shall be responsible for ordering TPN.

9. Stop orders will be followed in accordance with current Automatic Stop Order policy.

10. Orders to withhold or withdraw treatment shall be written only by the attending provider or provider other than a resident physician, designated by the attending provider.

Nursing Staff may accept verbal and telephone orders for change of code status if there is documentation that prior to accepting the order, the attending physician or physician other than a resident physician, designated by the attending physician has spoken to the patient or significant other regarding this change in code status and agreement has been acknowledged between patient or significant other and attending physician or physician other than a resident physician, designated by the attending physician.

11. Patients at Pali Momi Medical Center shall not receive medications unless they are properly labeled and dispensed by the Pharmacy Department, or ordered and signed by the provider.

PHARMACY

1. Only drugs listed on the Hospital Formulary shall be stocked by the Pharmacy. Additions or deletions must be approved by the Pharmacy and Therapeutics Committee. *See "Medication Formulary" and "Pharmacy and Therapeutics Committee" policies and procedures.*

2. Each drug shall be identified immediately prior to administration and each patient receiving a drug shall be identified immediately prior to administering the drug. *See the "Medication Administration" policy and procedure.*

3. Administration of medications shall be in accordance with all State and Federal Laws and Regulations, Medical Staff Rules and Regulations, and Department of Nursing, Pharmacy, Imaging, Respiratory Care and other Departmental policies and procedures for staff who are authorized to administer medications. Those administering medications shall be responsible for documentation of administration according to laws, regulations and policies and procedures.

4. Medication errors and drug reactions shall be reported immediately to the attending and prescribing provider. Occurrence reports shall be documented in the on-line reporting system.

5. All medication orders must be reviewed when a patient is transferred to a different level of care. Transfers including moving to or from the Special Care Units, or to or from the OR, or any other level of care transfer. See "prescribing Medications, General Practices" for the policy and procedure governing medication orders.

6. All requests to temporarily "hold" medications must include a period of time orders are to be held. Failure to provide this information shall result in discontinuance of order. A new order will need to be written. *See "prescribing Medications, General Practices" for the policy and procedure governing medication orders.*

7. Medications brought into the Hospital by a patient or by other persons, shall be returned to a family member or other designee of the patient and removed from the hospital unless there is an order to administer the medications to the patient while in the hospital. If there is no designee to take custody of the medications, the medications will be sent to the pharmacy for storage during the patient's stay as per hospital policy.

8. The Hospital shall maintain a formulary and will supply drugs according to the provider's order using generic or therapeutic equivalents as approved by the medical staff through the Pharmacy and Therapeutics Committee and by hospital policy.

9. Stop orders will be followed in accordance with current Automatic Stop Order policy which governs automatic stop order periods for medications.

10. Drugs which have not been approved by the Food and Drug Administration or by the Pharmacy and Therapeutics Committee shall not be ordinarily used in the Hospital. See “Medication Formulary” and “Medications: Proper Storage, Distribution and Control of Investigational Drugs” for policies and procedures governing non FDA approved substances.

QUALITY MANAGEMENT

1. All members of the medical, dental and allied health professional staff shall participate in the overall Quality Management Plan at Pali Momi Medical Center including utilization review and risk management functions.

2. The Medical Executive Committee shall have the overall responsibility of evaluating, monitoring, reporting and submitting appropriate recommendations regarding all medical staff activities to the Board of Directors.

3. Members of the active medical staff and other staff categories as deemed necessary, shall participate in one or more of the Medical Staff and/or Hospital committees.

4. Quality Council Purpose, Description and Responsibilities

    a. To maintain a hospital-wide mechanism to continuously improve patient care outcomes by fostering communication and coordination between disciplines to improve the patient care system.

    b. The Quality Council is a hospital committee composed of medical staff and key members of the hospital’s administration and departments/services. This committee will be accountable for overseeing the performance improvement activities of the medical center. The committee will also serve as an educational resource to medical and hospital staff. The committee reports to the Medical Executive Committee.

    c. The Council is composed of 12 representatives; 5 from the medical staff leadership; 5 from hospital administrative leadership to include the Chief Medical Officer; a Member of the Board of Directors and the Director of Quality Management. Other representation shall be requested as deemed necessary by the Council. Meetings are held bi-monthly or more frequently as deemed necessary by the chair of the committee.

SIGNATURE AUTHENTICITY

1. Signature stamps shall not be used at Pali Momi Medical Center.

2. Electronic signatures may be used when appropriate. Authorized users shall be responsible for the authenticity of the reports and the exclusive use of their electronic signatures.

SURGICAL RULES

1. Except in an emergency, prior to surgery, the following documentation is required:

a. The preoperative diagnosis, indication for surgery, type of surgery contemplated, history and physical examination, necessary consultations, indicated laboratory and radiology examinations shall be recorded on the chart before the patient is transported to the Operating Room.

   No routine or required preoperative laboratory testing is required. Selective laboratory testing should be based upon the medical history and physical examination in advance of surgery, allowing for follow-up consultation or further testing; benefit/risk analysis of tests considering patient status, age, and sensitivity/specificity of tests.

   Guidelines are Selective Preoperative Testing are available in the Surgery Policies, but are not intended to replace individual medical judgment. Testing may be expanded or contracted according to individual judgment.

   All preoperative testing shall be performed within thirty (30) days of surgical procedure with results available by time of surgery. All exceptions to this rule must be approved by both the anesthesia provider and surgeon. Additional diagnostic and/or laboratory testing for all patients undergoing regional or general anesthesia may be ordered at the discretion of the anesthesia provider or surgeon.

b. In the absence of a dictated history and physical being available prior to surgery, the provider must document a brief handwritten note indicating that heart and lungs have been evaluated and patient is cleared for surgery.

c. Signed and witnessed consent form for the proposed operation in accordance with hospital Informed Consent policy.

d. An operative note including the name of the surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis must be written in the progress notes immediately following surgery. In the event that a patient will by-pass the PACU, the postoperative note must be documented prior to the patient leaving the operating room.

2. Surgeons must be in the operating room and ready to commence surgery at time surgery is scheduled. Anesthesia shall not be started until the surgeon is present in the hospital and is immediately available and has identified the patient. The operating room will not be held longer than 20 minutes past the scheduled time. Such cases shall either be canceled or deferred to the end of the day's surgery schedule.

3. The Attending Practitioner performing an invasive procedure shall provide and sign a preoperative note which shall include the indication for the procedure, the pre-op diagnosis, the planned procedure including specific site and informed consent

4. Procedures performed without anesthesia providers - local and/or sedation.

   Certain procedures are scheduled and performed, without anesthesia providers within the surgical suite. These are procedures performed on patients, who have been deemed medically stable and appropriate by surgeons. The following represents current procedures, which fall into this category:

   - Temporal artery biopsy
   - Myringotomy on adults
   - Excision, cyst

- Excision, ganglion
- Incision and Drainage
- Orthopedic procedures, minor (e.g., carpal tunnel, removal of finger spur)
- Excision, minor mass (e.g., mass of hand, mass of neck, mass of face)
- Biopsy, minor (e.g., breast biopsy, neck biopsy, back biopsy)
- Cosmetic procedures, minor (e.g., small flap, scar revision, otoplasty)

5. The anesthesia provider shall maintain a signed, pre-anesthesia record which shall include the pre-operative diagnosis, the planned procedure including the specified site, the planned anesthesia and informed consent, and a post anesthesia follow-up note of the patient's condition.

Pre-anesthesia Evaluation

A pre-anesthesia evaluation shall be performed by a physician qualified to administer sedation for each patient who receives general, regional or monitored anesthesia. The pre-anesthesia evaluation must be performed and documented within 48 hours prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia for any inpatient or outpatient surgery or procedure requiring anesthesia services.

The pre-anesthesia evaluation shall be documented and include, at a minimum:

- Medical history, including anesthesia, drug and allergy history
- Interview and examination of the patient
- American Society of Anesthesiologists classification
- Any potential anesthesia problems
- Additional pre-anesthesia evaluation, based on patient condition
- Plan for anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient or patient's representative of the risks and benefits of the delivery of anesthesia.

Post-anesthesia Evaluation

A post-anesthesia evaluation is required any time general, regional or monitor anesthesia has been administered to the patient and completed and documented by an individual qualified to administer anesthesia. The evaluation must be documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation must occur in the PACU/ICU or another designated recovery location and shall not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation.

The post-anesthesia evaluation shall be documented and include, at a minimum, an assessment of:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation
- Cardiovascular function, including pulse rate and blood pressure
- Mental status
- Temperature
- Pain assessment
- Nausea and vomiting
- Post-operative hydration

6 PRIOR to performing any definitive surgical procedures, all tissue slides shall be reviewed by a pathologist at Pali Momi Medical Center, confirming diagnosis made by a laboratory other than that at Pali Momi Medical Center.

7. Surgical Procedures shall not be performed on obstetrical patients that are greater than 20 week gestational age, unless there is an immediate risk to the mother's life (exception ITOP).

8. ITOPS (vacuum and aspiration) shall not be performed on patients at Pali Momi Medical Center after the 13th week of pregnancy. Any exceptions to this rule must have prior approval by the Chief of Surgery and Hospital Administration.

9. All tissues removed from a surgical operation shall be sent to the hospital pathologist who shall make such examination as may be necessary to arrive at a tissue diagnosis. *(*reference Tissue Policy)*

   Although it is recommended that all tissues and/or foreign bodies removed be sent to the Pathologist for a minimum gross examination, at the discretion of the surgeon, the following may be exempt from undergoing a pathological examination, if the surgeon provides appropriate documentation in the medical record:

   a. Specimens that by their nature or condition do not permit productive examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure.

   b. Foreign bodies, (e.g. bullets) that, for legal reasons, are given directly to the chain of custody to law enforcement representatives;

   c. Specimens known to rarely, if ever, show pathologic change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant;

   d. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;

   e. Teeth, provided anatomic name or anatomic number of each tooth, or fragment of each tooth, is recorded in the medical record;

   f. Revision of scars, non-plastic surgical procedure;

   g. Port-a-catheters

10. A signed Pathology Report shall be made a part of the medical record.

11. Upon approval by the pathologist, specimens removed from a surgical procedure which are deemed non-infectious and/or are not involved in any legal implications may be given to the patient, upon their request.

12. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

13. All local, state and federal laws governing surgical procedures which may result in sterilization of a patient must be obeyed.

14. An operative procedure, regardless of whether performed in the Operating Room, Outpatient Department, X-ray or elsewhere, cancels all previous orders. Complete orders for the care of the patient must be rewritten after such procedure.

15. Visitors in the Operating Room shall be restricted to include only those people who are directly involved in the surgical care of the patient, as well as medical students and other health professional affiliates associated with Pali Momi Medical Center.

    Any other request to observe a surgical procedure must have the approval of the patient, the surgeon, the anesthesiologist, the Chair of the Department of Surgery and the nurse in charge of the Operating Room.

16. Suggested Guidelines involving DNR orders for patients undergoing invasive procedures are:

    Providers performing invasive procedures shall document in the medical record, the following information involving code status during the perioperative period:

    a. Any changes in code status have been discussed with the patient, family and/or significant others.

    b. The results of this discussion specific to maintaining or changing the code status during the perioperative period are documented in the medical record as a means of communication with other involved members of the health care team, i.e. anesthesia provider, patient care services staff, etc.

    c. The provider performing the invasive procedure shall determine on each individual case, the definition of the perioperative period, including when the DNR would be re-instituted. Suggested guidelines of the perioperative period are from the induction of anesthesia until the patient is discharged from PACU.

VISITATION POLICY

Only members of the health care team directly involved with a patient's care shall be present in the room when an invasive procedure is being performed, i.e., operating room, ambulatory care, cardiac catheterization lab. Members of the Medical Staff who wish to have other persons present, must request permission at the time procedure is scheduled and obtain written approval from the chair of the assigned department or designee and a representative from Hospital Administration.