1. The regular monthly meeting of the Medical Staff will be held on the second Wednesday of each month at the Hospital. Time to be announced.

2. Patients may be treated only by physicians who have been duly appointed to membership on the Medical Staff and by Allied Health Professionals with practice privileges. All hospitalized patients shall be attended by a member of the Medical Staff and shall be assigned to the service concerned with the treatment of the patient’s disease. The Medical Staff shall be responsible for supervising staff in the provision of care to patients under their care. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of responsibility shall be entered in the medical record.

"Allied Health Professional" – (AHP) means a person holding a license, certification, registration, other legal credentials, or are otherwise trained as required by the State of Colorado, who are eligible to provide specified healthcare services at Mt. San Rafael Hospital under conditions specified in these bylaws.

EMTALA: When a patient presents for emergent care, an initial medical screening examination must occur and may be provided by any privileged physician or allied health Professional. Decision to transfer to a higher level of care is made only after the initial medical screening exam has occurred.

3. The attending practitioner is required to document in the progress notes the need for continued hospitalization after specific periods of stay are identified by the utilization review committee as follows: a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient’s diagnosis is not sufficient; b) the estimated amount of time the patient will need to remain in the hospital; c) Plans for post-hospital care.

4. Except in emergency situations, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission. Physicians, when requesting a consultation from other physicians, will so indicate on the medical record.

5. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from potential sources of danger from any causes whatsoever, or to assure protection of the patient from self-harm. All Medical Staff and Allied Health Professionals will practice according to Hospital’s policies on restraint and seclusion.

6. The Hospital shall admit patients suffering from all types of diseases for which it has the facilities and personnel.

7. A surgical operation shall be performed only on consent of the patient or his legal representative, except in case of emergency, when consent may be waived upon the written, signed statement of the operating surgeon that delay to obtain proper consent would be hazardous to the life or the health of the patient. Patients for general anesthetic
must be detained in the Hospital for a period of no less than two hours to assure complete and satisfactory recovery from anesthesia. Ambulatory surgery patients shall be pre-scheduled following Hospital guidelines and shall be discharged before 12:00 midnight the same day as the surgery except in cases where the physician's assessment indicates that additional hospitalization is required.

8. All orders for medication and treatments shall be in writing. An order shall be considered to be in writing if dictated to a nurse and subsequently signed by the attending physician. Orders dictated over the telephone to the nurse shall be signed by the person to whom dictated with the name of the physician per his own name. Verbal orders shall be signed within 24 hours. The physician's orders for treatment may be received by R.N.'s, and L.P.N.'s. Also, verbal orders may be received by Respiratory Therapy technicians, X-Ray technicians, Laboratory technicians, and Pharmacists in their own respective disciplines only. All orders shall be transferred by the member of the specific discipline to the patient record in order that the patient care can be coordinated by the Nursing Service.

9. As far as possible, the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending physician, they shall be secured and a special charge made to the patient.

10. Consultation with another qualified physician shall be required in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the Medical Staff to see that its members do not fail in the matter of calling consultants as needed. The consultant must be well qualified to give an opinion in the field in which his opinion is sought. Physicians, when requesting a consultation from other physicians, will so indicate by order on the medical record. A consultation is not complete or satisfactory unless it includes an examination of the patient. The consulting physician shall make and sign a record of his findings and recommendations in every case as part of the medical record, but may not write other orders for the patient, unless the request for the consultation clearly indicates that the consulting physician may write orders.

11. Except in an emergency, consultation with another qualified physician shall be required in all curettages or other procedures by which a known or suspected pregnancy may be interrupted prematurely.

12. The patient shall be discharged on an order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

13. In the event of a hospital death, the deceased shall be pronounced dead by a Physician, Allied Health Professional or RN. The body shall not be released until an entry has been
made and signed in the medical record of the deceased by the member of the medical staff. Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible. No autopsy shall be performed without the written consent of a legally responsible relative or representative as per controlling state law. All autopsies shall be performed by a pathologist, or by a physician to whom the duty is delegated.

14. All surgical operations performed shall be fully described and signed by the operating surgeon. Prior to surgery, the physician who has primary care of the patient will transfer that patient to the surgeon. Operative reports will be dictated immediately after the surgical procedure. All post-operative orders and progress notes will be written by the surgeon performing the surgery immediately following the procedure. When it is necessary that the admitting physician follow the patient for other reasons, he may write such orders pertaining to other conditions, subject to the authorization of the responsible surgeon. When, in the opinion of the operating surgeon, the condition of the patient is such, he may then be transferred back to the original physician by written order. Physicians transferring patients from one service to another must assure that all necessary progress notes, especially on a transfer from medical to surgical, are in the hands of the operating physician prior to surgery.

15. The physician in charge of the patient is responsible for seeing that all tissue removed in an operation is sent to the pathologist who shall make such examination as he may consider necessary to arrive at a pathological diagnosis and he shall sign his report.

16. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultations, clinical laboratory, x-rays and others, provisional diagnosis, treatment, progress notes, final diagnosis, summary on discharge, follow-up, and autopsy report when available. No medical record shall be filed until it is complete. If a patient is re-admitted within 30 days, an interval note may suffice in lieu of a history. If positive pregnancy test is obtained, no dilation or curettage shall occur without ultrasonic evidence of either a missed abortion or blighted ovum. This ultrasonic consultation shall occur among the Radiologist, the ordering physician and another physician qualified in obstetrics.

17. Discharge Summary/Final Progress Note
A dictated discharge summary is required for all inpatient stays over 48 hours, all inpatient surgical cases, and for all deaths regardless of length of stay. A final progress note is acceptable for: 1) inpatient stays under 48 hours; 2) observation; 3) outpatient surgery who rollover to observation; 4) normal newborn; and 5) uncomplicated obstetric cases. The final progress note shall be completed and signed by the attending physician within 14 days of discharge. The final progress note shall include principal diagnosis (which is the reason after the study the patient sought hospital care) and complications and co-
morbidities (CCs), the clinical condition of the patient on discharge (not in terms of “improved” or “doing well”) and other secondary procedures when indicated. The newborn discharge examination may serve as final progress note:

18. Each physician’s patient in the acute care setting will be assessed and a progress note shall be written daily. Progress notes shall be written at least once a week for patients in non-acute care inpatient areas of the hospital campus and at least once every 30 days or whenever the patient condition changes in the Skilled Nursing Facility.

19. Physician orders should not contain any of the prohibited abbreviations.

20. Orders for Outpatient diagnostics and rehabilitative services to patients form non-privileged / non member providers may be accepted provided that such order received for services is within the scope of licensure of that practitioner. Verification of the practitioner licensure status will occur at time of registration as per policy.

   a. Criteria that ordering provider must meet:
      1. Responsible for the care of the patient-provider / patient relationship established – under the care of (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State Law or a State’s regulatory mechanism to include Allied Health Professionals (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of their license. (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform, (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices. (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by a x-ray to exist, (vi) A clinical psychologist.
      2. Licensed in the state or practice under state law
      3. Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order applicable outpatient services.

21. All records are the property of Mount San Rafael Hospital and shall not be removed from the Hospital unless a subpoena is presented to the Medical Record Librarian or the Administrator. In case of re-admission of a patient, all previous records shall be available
for the use of the attending physician. This shall apply whether the patient be service or pay, and whether he/she is attended by the same physician or another.

22. Free access to all medical records of all patients shall be afforded to staff physicians in good standing consistent with preserving the confidentiality of personal information concerning the patients. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the institution.

23. The Medical Staff is responsible for endotracheal intubations and arterial punctures for arterial blood gas analysis and may assign qualified personnel to perform these tests. The designation of qualified personnel will come under the direction of anesthesia and respiratory services in cooperation with the attending physician.

24. Every member of the Medical Staff must have written certification from an approved institution or organization of cardiopulmonary resuscitation training as outlined by the American Heart Association.

25. Do Not Resuscitate orders may be suspended when patients go to surgery and for a period of time following the surgery as defined by the surgeon and anesthesiologists after discussion with the patient and family.

26. All previous orders are discontinued when patients go to surgery.

ADOPTED by the Medical Staff of Mt. San Rafael Hospital of Trinidad, Colorado.

[Signature]
Chief of Medical Staff

09/28/2015
Date

APPROVED by the Governing Board of Mt. San Rafael Hospital of Trinidad, Colorado.

[Signature]
President of the Board

9/29/15
Date

[Signature]
Secretary of the Board

9/29/2015
Date