# TABLE OF CONTENTS

**RULES AND REGULATIONS OF THE MEDICAL STAFF**  
**INDIAN PATH MEDICAL CENTER**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMISSION AND DISCHARGE OF PATIENT</td>
<td>2 &amp; 3</td>
</tr>
<tr>
<td>MEDICAL RECORDS</td>
<td>3 - 6</td>
</tr>
<tr>
<td>GENERAL CONDUCT OF CARE</td>
<td>6</td>
</tr>
<tr>
<td>CONSULTATIONS</td>
<td>7</td>
</tr>
<tr>
<td>GENERAL RULES REGARDING SURGICAL CARE</td>
<td>7 - 9</td>
</tr>
<tr>
<td>AMBULATORY SERVICES</td>
<td>9 &amp; 10</td>
</tr>
<tr>
<td>EMERGENCY SERVICES</td>
<td>10</td>
</tr>
<tr>
<td>MASS CASUALTY PLAN</td>
<td>10</td>
</tr>
<tr>
<td>SPECIAL CARE UNITS</td>
<td>10</td>
</tr>
</tbody>
</table>
RULES AND REGULATIONS
OF MEDICAL STAFF
OF INDIAN PATH MEDICAL CENTER

A.  Medical Staff Rules and Regulations

1.  Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted in accordance with this Article.  Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in a MSHA Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards.

2.  Rules and Regulations may also be adopted, amended, repealed, or added by the Medical Staff at regular meeting or special meeting called for that purpose, provided that the procedure used in amending the Medical Staff Bylaws is followed.  See 3-7 below:

   (1)  Neither the MEC, the Medical Staff, nor the MSHA Board shall unilaterally amend these Bylaws.

   (2)  Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

   (3)  All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff.  The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.  The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting.  To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

   (4)  The MEC may also present proposed amendments to the voting staff by written ballot or e-mail.  Along with the proposed amendments, the MEC may, in its discretion, provide a written report on them either favorably or unfavorably.  To be adopted, (i) the amendment must be voted on by at least 50% of the voting staff present at the medical staff meeting, and (ii) the amendment must receive a majority of the votes cast.

   (5)  The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed for reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.  The MEC, in consultation with the MSHA Board, shall also have the power to adopt amendments which may be required for regulatory compliance with accrediting and government bodies.

   (6)  All amendments shall be effective only after approval by the MSHA Board.

   (7)  If the MSHA Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the MSHA Board and the officers of the Medical Staff.  Such conference shall be for the purpose of further communicating the MSHA Board’s rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the
recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

B. Screening, Admission and Discharge of Patients

1. The hospital shall accept patients for adult, pediatric, adult critical care, obstetrical and behavioral health for medical and surgical care.

2. Every patient presenting to the emergency room or Family Childbirth Center for medical treatment shall receive a medical screening exam by a member of the Staff or a Qualified Medical Person. Qualified Medical Persons include: Advanced Practice Registered Nurses or Physician Assistants who have been duly appointed as members of the Allied Health Professional Staff; resident physicians; and for medical screening exams performed in the Center for Women’s Health, Registered Nurses employed by the hospital and duly appointed to the Allied Health Professional Staff. Medical screening exams performed by Qualified Medical Persons shall be authenticated by their supervising Staff member as required by their clinical privileges.

3. A patient may be admitted to the hospital only by a physician, dentist or podiatrist who has submitted proper credentials and who has been duly appointed to the membership of the medical staff. All practitioners shall be governed by the official admitting policies of the hospital.

4. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for the necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibilities shall be entered on the order sheet of the medical record.

5. Every patient admitted to the hospital shall have provisional diagnosis or valid reason for admission.

6. Each patient admitted to the hospital shall have routine laboratory work done as required by the licensing and accrediting agencies.

7. Patients for elective operations should be admitted on the day of the scheduled surgery, when applicable.

8. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of others whenever his or her patients might be a source of danger from any cause whatever.

9. For the protection of patients, the medical and nursing staff and the hospital, precautions to be taken in the care of potentially suicidal patients, persons suffering from alcohol and drug abuse include:

   a. Informing the nursing personnel of suicidal potentials so that appropriate safeguards can be undertaken.

   b. Encourage psychiatric consultation.

   c. Consider transferring to Psychiatric Unit.
10. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as defined or identified by the Utilization Review Plan of the hospital or as may be requested by other clinical audit committees. This documentation must contain:

   a. An adequate record for the continued hospitalization. A simple reconfirmation of the patient’s diagnosis is not sufficient.

   b. The estimated period of time the patient will need to remain in the hospital.

   c. Plans for post-hospital care.

Upon request of the Utilization Review Committee or other clinical audit committee, the attending practitioner must provide additional written justification of the necessity of the continued hospitalization including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

11. The patient shall be discharged only on written 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 on the patient’s medical record. If possible, when the patient elects to leave the hospital without concurrence with this attending physician, the patient shall sign a release from liability statement.

12. At the time of discharge, the attending physician, dentist or podiatrist shall see that the record is as complete as possible and state final diagnosis, or a provisional diagnosis pending receipt of essential reports that have not been received at the time of discharge.

13. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his or her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances wherein the patient’s course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

14. It shall be the duty of all staff members to be actively interested in securing meaningful autopsies, whenever possible. An autopsy may be performed only with the consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist or by a practitioner delegated this responsibility.

C. Medical Records

1. The attending practitioner shall be responsible for the preparation of a complete legible medical record with each patient. Its contents shall be pertinent, current, and the record shall include identification data; chief complaint; past history; family history; history of present illness; physical examination; provisional diagnosis; medical or surgical treatments; progress notes; final diagnosis; conditional discharge; summary of discharge note; follow-up. Special reports such as consultation, clinical laboratory and radiology services, operative report; pathological findings; autopsy report, when performed shall be the responsibility of the consultant or service.
2. A history and physical shall be recorded in the medical record within twenty-four (24) hours of admission but always prior to the performance of a surgical procedure with the exception of emergencies. The history and physical examination shall be the responsibility of the attending physician or Tennessee certified Oral and Maxillofacial surgeon. A medical history and physical is required for all outpatient procedures that require moderate sedation (conscious sedation) or deep sedation/analgesia, and include relevant history of the present illness or injury significant past history, allergies, review of systems, physical exam including heart, lungs, affected area, and patient’s general condition.

   a. The report of the physical examination shall reflect a comprehensive current physical assessment. If a complete physical examination has been performed previously and is validated within thirty (30) days prior to admission, such as in the attending practitioner’s office, a durable, legible copy of this report may be used in the patient’s hospital medical record, provided there is physician documentation stating the following and signed within 24 hours of admission:

      • H&P still current
      • That appropriateness of assessment was completed on admission confirming that the necessity for the procedure or care is still present; and,
      • That the patient’s condition has not changed since the last H&P was originally completed.

   b. If the history and physical exam is performed by other than a physician or oral maxillofacial surgeon, the findings, conclusions, and assessment of risk must be signed by the physician or oral maxillofacial surgeon prior to major diagnostic or therapeutic invention or within 24 hours, whichever occurs first.

c. When history and physical examination are not on the chart before the patient is to undergo surgery or have any potentially hazardous diagnostic procedure, the operation or procedure shall be cancelled unless it is stated in writing on the chart that such a delay would be detrimental to the patient’s health and essential positive findings are recorded.

3. Where the history and physical examination have not been done before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending practitioner states in writing that such delay would be detrimental to the patient.

4. The attending physician shall sign the history, physical examination and pre-operative note when they have been recorded by a duly appointed intern or resident in his or her charge.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient’s clinical problems shall be clearly identified in the progress notes and correlated with specific order, as well as results of tests and treatment. The attending practitioner shall write a progress note at least daily while the patient is admitted to the acute hospital care setting. The Skilled Nursing Unit patients require progress notes as indicated.

6. Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written or dictated immediately or as soon as practical following surgery and a copy forwarded to the attending physician. A brief operative note shall be included in the progress notes indicating the exact procedure performed, how tolerated, and
whether complications, before the patient leaves the recovery room. The operative report is to be subsequently signed by the surgeon and made a part of the patient’s current medical record.

7. All clinical entries in the patient’s medical record shall be accurately dated, timed, and authenticated. The responsible practitioner shall sign, time and date all verbal orders within 48 hours.

8. The discharge summary shall be written and dictated on all medical records of patients hospitalized over 48 hours. A written summary only will suffice for patients hospitalized less than 48 hours. In all instances the content of the medical record shall be sufficient to justify the diagnosis, warrant the treatment and end result. All summaries shall be signed by the responsible practitioner.

9. Written consent of the patient is required for the release of medical information to persons not otherwise authorized to receive this information.

10. Records may be removed from the hospital’s jurisdiction in safekeeping only in accordance with a court order, subpoena, statute, or written permission of the Administrator. In the case of readmission of a patient, all previous records shall be made available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for supervision of the practitioner of a period to be determined by the Medical Executive Committee of the Medical Staff.

11. 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 hospital.

12. A practitioner’s routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient’s record, dated, timed, and signed by the practitioner.

13. To provide timely and accurate communications regarding patient care and comply with Medicare and JCAHO standards of completing medical records within 30 days of discharge or an outpatient date of service, the following delinquent medical record cycle exists to require physicians to complete medical records on predetermined intervals or automatically relinquish hospital admitting and scheduling privileges at all MSHA facilities. The cycle begins when the medical record is actually available for physician completion. The physician is notified in advance of all incomplete records and due dates.

Records incomplete greater than 30 days from the date of discharge are considered delinquent.

Reports of incomplete and delinquent records will be generated each week. Delinquencies will be sent to the appropriate physician.

Physicians are encouraged to attend to the completion of records on a weekly basis due to the volume and the cycle of weekly reporting. Although by definition medical records incomplete greater than 30 days from the date of discharge are considered delinquent, Physicians will have 30 days from the date the record is allocated to their responsibility to get the record completed. Failure to complete the record within 30 days from the date of allocation will result in automatic relinquishment of their scheduling and admitting privileges.

If a physician is going on vacation, it is his/her responsibility to have their record completion up to date, and to notify Medical Records. The Medical Record staff will enter the dates of vacation in the
profile, which places the physician on a “Physician Hold.” The hold time is the number of days the physician will be on vacation.

Patient care is not to be compromised by a physician’s suspension; therefore, if suspended, the physician can provide care to any patient that is in-house or has already been scheduled for surgery at the time of the suspension. The physician cannot admit any NEW patients nor schedule any NEW procedures.

Physicians with delinquent charts or physicians who fail to complete delinquent charts within 30 days from the allocation date are subject to automatic relinquishment of admitting and scheduling privileges. Automatic relinquishment of privileges is through the authority of the Chairman of the Medical Staff or the Chief Executive Officer of the hospital or his designee.

Copies of the suspension notice will be distributed every Wednesday to Admitting, Surgery, Cardiac Labs, and any other area that may schedule patients. Medical Records staff will promptly notify these areas once suspension is no longer valid.

Copies of the suspension will also be sent to the Medical Staff Office and will be used for reappointment decisions.

D. The General Conduct of Care

1. A general consent form signed by or on behalf of every patient who enters the hospital must be obtained at the time of admission. The admitting officers should notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner’s obligation to obtain proper consent before the patient is treated in the hospital.

2. All orders for treatment shall be in writing or entered into the hospital computer system to be valid. An order shall be considered to be in writing if dictated to an individual licensed in the field of nursing. Respiratory therapy orders may be dictated to a certified respiratory therapist or registered respiratory therapist; physical therapy orders may be dictated to a registered physical therapist; occupational therapy orders may be dictated to a registered occupational therapists; speech therapy orders may be dictated to a certified speech language pathologist; dietary orders may be dictated to a registered dietetic technician; radiology orders may be dictated to a registered radiological technologists; pharmaceutical orders may be dictated to a registered pharmacist; clinical pharmacists may initiate pharmaceutical orders based on utilization of approved clinical protocols/guidelines for which they have been consulted.

The appropriate authorized personnel, to whom the order was dictated, must sign and include the name of the ordering practitioner. Any practitioner participating in the care of the patient may sign all verbal orders. Signatures are required within 48 hours.

3. A physician’s verbal or written order is obtained for each use of restraint or seclusion outside of protocols approved by the Medical Executive Committee. The order must be time specific, not to exceed a period of twenty-four hours. After the initial order, the patient must be reassessed by a practitioner to determine the necessity for continuation of restraint/seclusion.

4. The practitioner’s orders must be written clearly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.
5. All previous orders are cancelled when patients go to surgery.

6. All drugs and medications administered to patients shall be listed in the latest edition of the United States Pharmacopoeia, the National Formulary, the American Hospital Association Formulary Service, or the AMA Drug Evaluations. Exceptions to the rule shall be well justified.

7. Narcotics, sedatives, antibiotics and anticoagulant drugs that are ordered without the time limitation shall be automatically discontinued after 72 hours. Drugs should not be discontinued without notifying the physician. If the order expires in the night, it should be called to the attention of the attending physician the following morning.

E. Consultations

1. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within the area of expertise.

2. Except in an emergency, consultation with another qualified physician is required in the following situations:
   a. On psychiatric patients who must be transferred to the state psychiatric facility as prescribed by state law.
   b. Cases in which in the judgment of the attending physician:
      1) The patient is not a good risk for operation or treatment.
      2) The diagnosis is obscure after ordinary diagnostic procedures have been completed.
      3) There is a doubt as to the choice of therapeutic measures to be utilized.
   c. In unusually complicated situations where specific skills of other practitioners may be needed.
   d. When requested by the patient or his/her family.

3. A satisfactory consultation shall show evidence of a review of the patient’s record by a consultant, pertinent findings on examination of the patient, consultant’s opinion and recommendations. This report shall be made a part of the patient’s record.

4. When operative procedures are involved, the consultation note shall, except in emergency situations, so verified in medical record, be reported prior to the operation.

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

6. It is the duty of the hospital staff through its President and Executive Committee to make certain that members of the medical staff not fail in the matter of calling for consultations, when need.

F. General Rules Regarding Surgical Care

1. Surgeons must be in the operating room and ready to commence operation at the time scheduled. In no case will the operating room be held longer than 15 minutes after the time scheduled.
2. Except in severe emergencies, the pre-operative diagnosis and required laboratory tests must be reported prior to any surgical procedure. If not reported, the operation shall be cancelled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient’s condition prior to induction of anesthesia and start of surgery.

3. A patient admitted for dental care is a dual responsibility involving the dentists and a physician member of the medical staff who is to assume responsibility for the medical aspects of the cases.

   a. Dentists’ Responsibilities:

      1) A detailed dental history justifying hospital admission;

      2) A pre-operative diagnosis;

      3) Assure that the history and physical examination and laboratory work is completed in accordance with the Medical Staff Bylaws prior to surgery.

      3a. The history and physical examination may be performed by and oral surgeon for his or her own patients. This may be done only where the oral surgeon has been specifically credentials to perform history and physical examinations. The awarding of clinical privileges for oral surgeons in the area of history and physical examination will be made on an individual basis in accordance with the credentialing process outlined in these Bylaws. The awarding history and physical will be made only where it is deemed appropriate and where educational back- ground, training and experience demonstrates suitable clinical competence of the individual oral surgeon in this area.

      4) A complete operative report describing the findings and techniques.

      5) In case of extraction of teeth the dentist shall clearly state the anatomic number of each tooth or fragment to tooth removed, either in the operative report, progress notes or dental record.

      6) Progress notes as pertinent to the patient’s condition.

      7) Discharge summary. The discharge of the patient shall be on the written order sheet of the dentist member of the medical staff.

   b. Physician’s Responsibility:

      1) Medical history pertinent to that patient’s general health, if not provide in accordance with 3a above.

      2) A physical examination to determine the patient’s condition prior to surgery by the anesthesiologists (i.e., pre-anesthetic work-up).

      3) Supervision of the patient’s general health while hospitalized.

4. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and a physician member of the medical staff who is to assume responsibility for the medical aspects of the case.

   a. Podiatrist’s Responsibilities:

      1) A detailed podiatry history justifying hospital admission;
2) A pre-operative diagnosis;

3) Assure that the history and physical examination and laboratory work are completed in accordance with the Medical Staff Bylaws prior to surgery;

4) A complete operative report describing the findings and techniques;

5) Progress notes as pertinent to the patient’s conditions;

6) Discharge summary. The discharge of the patient shall be on the written order sheet of the podiatrist member of the medical staff.

b. Physician’s Responsibility:

1) Medical history pertinent to that patient’s general health;
2) A physical examination to determine the patient’s condition prior to surgery;
3) Supervision of the patient’s general health while hospitalized.

5. Written, signed, and informed surgical consent shall be obtained, prior to the operative procedure except in those situations wherein the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained, from parents, guardian or next of kin, these circumstances should be fully explained on a patient’s medical record. A consultation in such instances may be desirable before emergency operative procedures are undertaken, if time permits. Refer to Policy #PC-600-114 – “Informed Consent.”

6. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic follow-up of patient’s condition.

7. In any surgical procedure with unusual hazard to life, if possible, there should be a qualified assistant present and scrubbed.

All tissues removed at the operation, except (at the discretion of the physician, dentist or podiatrist) introcular lenses, teeth, toenails, nasal cartilage, recurrent renal stones, orthopedic tissue, excess eyelid skin, foreskin of males one year old or under, placenta removed at Cesarean Section and vaginal delivery, tissue removed at the time of cosmetic abdominoplasty, and normal tissue removed to facilitate surgical exposure shall be sent to the hospital pathologist, who shall make such examination as he may consider necessary to arrive at tissue diagnosis. His report shall be made a part of the patient’s medical record and he shall sign this report.

G. Anesthesia Services:

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel to support these activities. In addition, anesthesiology involves perioperative consultation, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the care of critically ill patients. This care is personally provided by or directed by the anesthesiologist.
1. The Hospital provides anesthesia services in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

2. Anesthesia Services is organized under the direction of a Director who is a qualified doctor of medicine (MD) or a doctor of osteopathy (DO) who is appointed by the Medical Executive Committee.

3. The hospital’s governing body approves, after considering the medical staff’s recommendations, Medical Staff Rules and Regulations establishing criteria for the qualifications for the Director of Anesthesia Services. Such criteria must be consistent with state laws and acceptable standards of practice.

4. The head of Anesthesia Services has the authority and responsibility for directing the administration of all anesthesia services, including anesthesia and analgesia, throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided).

5. Responsibility for evaluating the quality and appropriateness of the anesthesia patient care as part of the hospital’s QAPI (Quality Assessment/Performance Improvement) program.

**Director of Anesthesia Services Job Description:**

Physician will meet the following criteria:

1. Successfully completed a training program in anesthesiology accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or equivalent organization.

2. Permanent certification by the American Board of Anesthesiology (ABA) or current recertification within the time interval required by the ABA.

3. Compliance with the ABA Maintenance of Certification in Anesthesiology Program (MOCA)

4. Be a member of the Medical Staff in good standing including compliance with the MSHA Code of Conduct and with all bylaws.

5. Have active privileges in Procedural Sedation.

6. Hold a current, full and unrestricted license to practice medicine in the state, territory, or commonwealth of the United States or in the District of Columbia where the hospital or facility is located.

7. Hold a current, unrestricted DEA registration (schedules II-IV) and have no history of revocation of DEA registration (schedules II-IV) within the past five years.

8. Be in compliance with relevant state and institutional requirements for CME with at least 50 percent of CME hours in the primary specialty of practice.

9. Demonstrate competence in advanced life support.

10. Agree in writing to abide by the ASA “Guidelines for the Ethical Practice of Anesthesiology.”
H. **Ambulatory Services**

1. The medical staff shall adopt a method of providing medical coverage in the ambulatory services area. All ambulatory services are to be rendered after arrangement has been reached between the patient and his/her private physician for care. The Executive Committee of the medical staff has the overall responsibility for the quality of ambulatory care.

2. An appropriate medical record shall be kept for every patient receiving ambulatory care.

3. Each patient’s medical record shall be signed by the medical staff member in attendance that is responsible for its clinical accuracy.

4. There shall be a periodic review of ambulatory room medical records by the Medical Record Committee to evaluate the quality of ambulatory room medical care. Pertinent reports shall be presented to the Executive Committee.

I. **Emergency Services**

1. The role of the medical staff relating to the provision of emergency services shall be to provide or see to the provision of appropriate care.

2. The emergency room will be staffed 24 hours per day with properly credentialed emergency room physicians who are members of the medical staff. All patients will be evaluated by a physician upon arrival in the emergency room.

3. Non-emergency room physician members of the medical staff shall primarily serve as attending physicians to their private patients. The emergency room will notify the physician of their patient’s arrivals.

4. The medical staff must provide a call roster for specialized back-up coverage where indicated.

5. An appropriate medical record shall be kept for every patient receiving emergency care.

6. Each patient’s medical record shall be signed by the medical staff member in attendance that is responsible for its clinical accuracy.

7. There shall be a periodic review of emergency room medical records by the Medical Record Committee to evaluate the quality of emergency room medical care. Pertinent reports shall be presented to the Executive committee.

J. **Mass Casualty Plan**

1. There shall be a plan for the provision of medical care of mass casualties at the time of any disaster based upon the hospital’s capabilities in conjunction with other emergency facilities in the community.

K. **Special Care Units**

1. Procedures governing special care units within this hospital shall be developed by specifically assigned committees and shall be approved by the Executive Committee of the Medical Staff.
Such procedure manuals shall govern the operation of the various special care units and shall, after approval by the Executive Committee be appended to these rules and regulations.

Adopted by the Medical Staff:

November 17, 2014
(Date)
Cheryl Stanski, MD
President of the Medical Staff
Indian Path Medical Center

Approved by the MSHA Board:

December 12, 2014
(Date)
Barbara Allen
Chair, MSHA Board of Directors