Rules and Regulations of the Medical Staff

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ARTICLE I PREAMBLE

GENERAL STATEMENT: These Rules and Regulations adopt and incorporate by reference the definitions contained in the Medical Staff Bylaws of the Hospital. St. Luke’s Hospital - Miners Campus, Coaldale, PA, is a non-smoking entity. The use of smoking material throughout the hospital building is prohibited.

ADOPTION AND AMENDMENT: Rules and regulations may be adopted or amended at any regular meeting of the Medical Executive Committee or at a special meeting called for such purpose by a vote of qualified and eligible active medical staff members present at the meeting in which a quorum is present and where notice of such proposed rules and regulations, or any amendment thereto, has been given in accordance with the Medical Staff Bylaws. The requirements and procedures regarding the adoption and amendment there to, has been given in accordance with the Medical Staff Bylaws. The adoption of medical staff rules and regulations or any amendment thereto, is subject to, and effective upon, the approval of the Board of Directors.

ARTICLE II APPLICABILITY

These rules and regulation shall apply to all categories of physicians granted privileges at St. Luke’s Hospital - Miners Campus as appropriate to the physician’s privileges. Staff members shall adhere to St. Luke’s Hospital - Miners Campus Rules and Regulations as written in the Bylaws of the institution.

ARTICLE III STATEMENT OF PURPOSE

The hospital is established as a short term general hospital and shall accept patients suffering from acute diseases and conditions, except those that may, from time to time, be designated by the Medical Staff as beyond the clinical capabilities of the hospital, regardless of race, color, creed, sex, national origin, or handicapped conditions.

ARTICLE IV CLINICAL RESPONSIBILITIES

AUTHORITY TO TREAT PATIENTS:
Only a member of the active or courtesy medical staff may admit a patient to the hospital. Patients may be treated only by those physicians, allied health professionals, or medical associates who have been appointed to the medical staff, or have been given specific privileges or scope of care limiting the exercise of their privileges or scope of care to treat patients.
Except in an emergency, no patient shall be admitted until after a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, the attending physician is expected to furnish such data within 24 hours.

**FREQUENCY OF CARE:**

Physicians will visit patients daily and document a progress note every 24 hours to provide quality medical care. Every member of the medical staff with Nursing & Rehabilitation Center patients shall see the patient at least once very 30 days or as clinically indicated and document in the medical record appropriately. The Medical Director of Nursing & Rehabilitation Center shall be authorized to examine any patient and document progress in the medical record if the attending physician does not fulfill the thirty day requirement after due notification to the attending physician.

Repeated failure of availability of the attending physician or his designee can result in loss of medical staff privileges after review of the prevailing circumstances by the Medical Executive Committee.

**ALTERNATE COVERAGE & ON CALL SCHEDULE:**

All members of the Active and Courtesy Medical Staff who admit and attend patients are required to designate an alternate member of the Active or Courtesy Medical Staff who will assume the care of the physician’s patients in case of the physician’s absence.

Members must notify the Nursing Office and/or the Medical Staff Services Office of any absence and designate the physician providing alternate coverage. The physician must assure the availability of the alternate’s care PRIOR to signing out.

The Chain of Command to be utilized is as follows:

1. Alternate Coverage Roster during normal working hours
2. Appropriate Call Schedule evenings & weekends
3. Chief of Department
4. Medical Director

In case of failure to name such an associate or of the unavailability of such an associate, the Chairperson of the Department, the Chief-of-Staff, or the President/CEO, in an emergency, will have the authority to call any member of the Active Staff. Repeated failure of availability of the physician or his designee can result in loss of medical staff privileges after review of the prevailing circumstances by the Medical Executive Committee. Those members of the active staff who wish to accept unassigned patients will designate, in writing, their desire.

Any physician who resigns from the medical staff who has already been scheduled for ED On Call for
the current month in which he resigns shall be required to fulfill the call schedule obligation before the medical staff can accept the resignation.

**DUTIES OF ATTENDING PHYSICIAN:**
All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated by a physician to a duly authorized person, functioning within his/her sphere of competence, or transcribed by a physician's assistant.

Verbal orders (either in person or via telephone) for medications or treatment shall be accepted only under emergent circumstances or when circumstances are considered important for patient care. The order must be signed, dated and timed appropriately by the person writing the order. As per the Department of Health, the responsible physician must countersign, date and time to authenticate such order within 24 hours. Attending physicians may countersign verbal orders from consulting physicians. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action. Telephone orders may be accepted and written, signed with the full name, title, date and time, by the registered nurse.

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for prompt completeness and accuracy of the medical record for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record. Additionally, a note by the physician assuming the care shall also be made on the order sheet of the acceptance of the care of the patient.

All patients admitted to CCU must be seen by the attending physician or alternate, immediately if the patient’s condition is not stable or within 12 hours if the patient’s condition is stable. Attending physicians will visit patients daily and document a progress note at least every 24 hours. Allied Health Professionals are not permitted to manage patients in the CCU.

For clarification of Physician Orders when the primary physician cannot be reached, the chain-of-command is as follows:
1. Alternate Coverage Roster during normal working hours
2. Appropriate Call Schedule evenings & weekends
3. Chief of Department
4. Medical Director

**DUTIES OF DENTIST:**
A dentist with clinical privileges may with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient’s care throughout the hospital stay, including the medical history and physical examination.
Admission: A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the medical staff.

Dentist’s responsibilities are as follow
1. A detailed dental history justifying hospital admission.
2. A detailed description of the examination of the oral cavity and preoperative diagnosis.
3. Preoperative medications.
4. A complete operative report describing the findings and technique. In case of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.
   All tissue, including teeth and fragments, shall be sent to the hospital pathologist for reexamination.
5. Progress notes as are pertinent to the oral condition.
6. A clinical resume.

Physician’s Responsibilities:
1. Medical history pertinent to patient’s general health.
2. A physical examination to determine the patient’s condition prior to anesthesia and surgery.

Discharge: The discharge of the patient shall be on written order of the attending physician of the medical staff or dentist member if the physician so orders.

DUTIES OF PODIATRIST:
A podiatrist with clinical privileges may with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient’s care throughout the hospital stay, including the medical history and physical examination.

Admission: A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician member of the Medical Staff.

Podiatrist’s responsibilities are as follows:
1. A detailed podiatric history justifying admission.
2. Preoperative diagnosis.
3. Preoperative medication.
4. A complete operative report describing the finding and technique.
5. Progress notes as are pertinent.

Physician’s Responsibilities:
1. Medical history pertinent to the patient’s general health
2. A physical examination to determine the patient’s condition prior to anesthesia and surgery.
Discharge: The discharge of the patient shall be on written order of the attending physician of the medical staff or podiatrist member if the physician so orders.

ADMISSIONS:
Only a member of the active or courtesy medical staff may admit a patient to the hospital. The hospital shall admit patients suffering from all types of disease. In the case of any disease subject to isolation under the regulations of the Board of Health, or of the Hospital’s Infection Control Committee, these patients shall be treated in accordance with the policies and procedures defined by the Infection Control Committee.

Patients may be treated only by those physicians who have been appointed to the medical staff or have been given specific privileges limiting the exercise of their privileges to treat patients. All physicians shall be governed by the official admitting policy of the Hospital.

A podiatrist with clinical privileges may, with the concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. This concurring medical staff member shall assume responsibility for the overall aspects of the patient’s care throughout the hospital stay, including the medical history and physical examination.

Except in an emergency, no patient shall be admitted until after a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, the attending physician is expected to furnish such data within 24 hours.

A member of the medical staff shall be responsible for the care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary instructions, and for transmitting reports of the condition of the patient to the referring physician and to the relatives and/or persons responsible for the patient.

There is a physician in the hospital twenty-four (24) hours/day to provide emergency coverage; however, patients presenting themselves to the Emergency Room will be given the opportunity of selecting a physician, in the applicable department or service, to attend to him.

Where no such selection is made, a member from the unassigned call schedule shall be assigned to attend the patient.

The medical staff will observe the hospital admission policy in regard to the classification of patients for admission. The admission clerk will admit patients on the basis of the following order of priorities:

Priority 1 - Emergency Admissions:
Emergency admissions apply to medical conditions or acute trauma such that life limb or the body function of the patient depends on the immediacy of medical treatment. In an emergency admission the condition requires immediate medical attention and any time delay would be harmful to the patient.
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patient does not have to be admitted via the emergency room to be considered an emergency admission. Physicians admitting emergency cases shall be prepared to justify to the Utilization Management Committee of the medical staff and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these finding must be recorded on the patient’s chart within twelve (12) hours. Evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee for appropriate action, which may include loss of Medical Staff privileges.

Priority 2 - Urgent Admission:
Urgent admissions involve medical conditions or acute trauma such that medical attention, while not immediately essential, should be provided very early in order to prevent possible loss or impairment of life, limb, or body function. This group includes those cases where very early medical evaluation or treatment is considered the patient must have the next available bed.

Priority 3 - Elective:
Elective admissions refer to those patients designated as scheduled or routine admissions. The group includes those cases where there is no urgency for immediate or very early medical evaluation or treatment because the possibility of serious consequences resulting from lack of medical attention is small.

Critical Care Unit Admission:

Group I: Patients with acute myocardial infarction or those patients who present with symptoms history. Respiratory problems that may be life threatening.

Group II: Patients with complex medical or surgical problems that in their totality may represent or progress to life threatening.

Group III: Patients in acute pulmonary edema or shock.

If any questions as to the validity or priority of admission to or discharge from CCU should arise, that decision is to be made through consultation with the Director of CCU to determine appropriateness of triage.

Any patients admitted to CCU for PACU recovery from surgery must be admitted as “Admit to CCU for PACU Recovery Only” with discharge according to established protocol.

Patients will not be admitted to CCU unless evaluated by the Emergency Department.
All patients admitted to CCU must be seen by the attending physician or alternate, immediately, if the patient’s condition is not stable or within 12 hours if the patient’s condition is stable.
Attending physicians will visit patients daily and document a progress note at least every 24 hours.

Any patient who is known or suspected to be suicidal in intent, who is emotionally ill or who becomes
emotionally ill while in the hospital, or who suffer the results of alcoholism or chemical abuse must be stabilized and transferred to an appropriate facility.

The attending physician is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Management Committee of the medical staff. Documentation must contain the information as required by the Hospital’s Utilization Management Review Plan as follows:

1. An adequate record of the reason for continued hospitalization.
2. A simple reconfirmation of the patient’s diagnosis is not sufficient.
3. The estimated period of time the patient will need to remain in the hospital.
4. Treatment plan for the hospitalization care.

**MEDICAL ORDERS:**

**General Requirements:** Orders must be written clearly, legibly and completely including date and time. Orders that are illegible or improperly written will not be carried out until they are rewritten and are understood by the nurse. The use of "renew", "repeat", and "continue" orders is not acceptable. All previous orders including standing drug orders are canceled when patient goes to surgery. The surgeon or attending physician must rewrite post-operative orders.

**Read Back Policy:** The nurse will write orders and then read it back to the physician. This is in compliance the Read Back Policy as required by the Telephone/Verbal Order Policy #130 in the Administrative Policy & Procedure Manual.

**CCU Orders:** All orders will be completely rewritten when a patient is transferred from one service to another or when medication or treatment is to be resumed after automatic stop orders has been employed.

**Who May Write Orders:** Physician, Dentist, Podiatrist, or medical staff appointees, to include Physician Assistants and Certified Registered Nurse Practitioners, shall have the authority to write orders as permitted by their clinical privileges or scope of practice. All orders must be entered in the patient’s record. All entries must be dated, timed, and signed.

**Verbal Orders:**

All verbal orders received orally or via telephone for medications and treatments shall be accepted only under urgent circumstances when it is impractical for the orders to be given in written manner by the responsible practitioner. All verbal orders shall be taken by privileged personnel and shall be written in the physician order section of the patient’s medical record.

Verbal orders for acute care patients must be countersigned, dated, and timed within 24 hours by the ordering physician or fellow licensed independent practitioner authorized by the attending physician; permitting the fellow licensed independent practitioner is knowledgeable of the patient’s condition.
Attending physicians may countersign verbal orders from consulting physicians. Verbal medication orders for residents of the Nursing & Rehabilitation Center must be countersigned, dated, and timed within 48 hours; care and treatment orders must be countersigned, dated, and timed within 7 days. All verbal orders for residents of the Nursing & Rehabilitation Center must be signed in the designated timeframe by the ordering physician or fellow licensed independent practitioner authorized by the attending physician; permitting the licensed independent practitioner is knowledgeable of the patient’s condition.

Acceptance of a verbal order is limited to only the following personnel with noted restrictions:

1. Physician, Dentist, or Podiatrist with clinical privileges at this facility
2. Registered Nurse;
3. Pharmacist who may accept verbal orders pertaining to drugs;
4. Physical Therapist who may accept verbal orders pertaining to physical therapy regiments;
5. Respiratory Therapist who may accept verbal orders pertaining to respiratory therapy treatments;
6. Imaging technologist may accept verbal orders pertaining to imaging
7. Physician Assistant or Certified Registered Nurse Practitioners

The ordering practitioner should countersign, date and time the verbal order within 24 hours.

Nurse Practitioner and Physician Assistants

- May function within their defined scope of practice denoted by specific privileging
- Works under the director of a physician licensed to practice medicine in the PA Commonwealth
- The supervising physician shall countersign the patient record within a reasonable time not to exceed 10 days

Orders for Specific Procedures: All requests for x-ray and EKG examinations shall contain a statement of the reason for the examination. An order for a serial electrocardiogram must specify both the desire and frequency and the duration of the series. This rule does not apply to orders written for patients while in CCU. When report and study have arrived on the patient’s floor, they shall be entered in the patient’s chart immediately.

Orders for Therapy: All orders for therapy shall be entered in the patient’s record and signed by the physician.

Orders for Therapeutic Diets: Therapeutic diets are prescribed by the attending physician in written order on the patient’s chart. Orders for diets must be specific in accordance with the officially approved policy or manual of the Pharmacy & Therapeutics Committee.

Orders for Restraints:

Physician orders for physical restraints and or seclusion will be governed by the St Luke's
Hospital "physical restraint policy" as outlined in the St. Luke's Nursing Procedure Manual.

Abbreviations: Only abbreviations, signs and symbols as attached to these Rules and Regulations shall be used in the medical record. No abbreviations, signs or symbols may be used in recording the patient’s final diagnosis or any unusual complications.

CONSULTATIONS:

Duty to Consult: It is the duty of the hospital staff, through the Chief of Service and the Executive Committee, to see that members of the staff do not fail in the matter of consultants as needed. The attending physician is responsible for writing an order for a consultant. Urgent or Stat consults should be seen within a reasonable amount of time as agreed upon by both the attending and consulting medical staff members. Direct communication is required between the requesting physician and the consultant.

For routine consults, the patient should be seen within 48 hours unless another timeframe is agreed upon by both the attending and consulting medical staff members.

The attending physician is primarily responsible for requesting consultation when indicated.

**Except in an emergency, consultation is required in the following situations:

1. When the patient is not a good risk for operation or treatment.
2. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed
3. Where there is doubt as to the choice of therapeutic measures to be utilized
4. In unusually complicated situations where specific skills or other physicians may be needed.
5. In instances in which the patient exhibits severe psychiatric systems.
6. When requested by the patient or his/her family.

Direct communication is required between the physician extender and the requesting physician if the physician extender wishes to change an existing physician order.

Administrator’s Responsibility: In circumstances of grave urgency or where consultation is required by the rule of the Hospital, the Administrator has, at all times, the right to call a consultant or consultants after conference with the Chief of Staff or available members of the medical staff.

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who, in turn may refer the matter to the VP/Patient Services. If warranted, the VP/Patient Services may bring the matter to the attention of the Chief of Service, wherein the physician has clinical privileges, and the Hospital Administrator. If the Chief of Service is not available, the Chief of Staff shall be contacted in that order of priority.

Stat Consults: Requests for a stat or emergency consultation are to be placed by telephone or personal contact by the requesting physician to the consultant. In the absence of the consultant, transfer shall be considered in the patient’s best interest.

Response: The physician responsible for ordering a consultation must document the reason for the consultation in the patient’s medical record. The requested consultant is required to see acute care patients and emergent consults requested for residents of the Nursing & Rehabilitation Center within 24 hours from the time he/she is notified. If the consultant is unable to respond within 24 hours, the requesting physician may discuss the case with the consulting physician via the telephone; thereafter,
detailed documentation of the discussion must be recorded in the patient’s medical record by the
requesting physician. Non-emergent consults requested for resident of the Nursing & Rehabilitation
Center shall be completed within 2 weeks.

Essentials of Consultation: A satisfactory consultation includes examination of the patient and the
record. A written opinion, signed by the consultant, must be included in the medical record. When
operative procedures are involved, the consultation note, except in an emergency, shall be written prior
to the operation.

INTERPRETATION OF STUDIES - CARDIOVASCULAR LAB:
Assigned Patients: The test/procedure for ASSIGNED PATIENTS will be read within 24 hours of the
performance of the test/procedure. The responsibility of monitoring this time limit is the obligation of
the physician receiving that referral. After 24 hours the test/procedure will be referred to the next
reader of the unassigned patients for that day, if the physician on the ASSIGNED pool is delinquent
more than two times, the physician will be dropped from the pool.

Unassigned Patients: The test/procedure for UNASSIGNED PATIENTS will be read within 24 hours of
the performance of the test/procedure. The reading is to be performed by the physician designated to
read Unassigned Patients on that day. If the assigned physician does not read interpretation within 24
hours, the next assigned physician will interpret the procedure.

Rules for Assignment:
1. Physician Groups shall be considered as one slot when the unassigned schedule is prepared.
2. Solo Physicians shall be considered as one slot.
3. For any procedure/test where only one physician or physician group meet the
criteria developed, the minimum time period shall be waived.

DISCHARGE:
Who May Discharge: Patients shall be discharged only on an order of the attending physician. Should
a patient leave the hospital against the advice of the attending physician or without proper discharge,
the patient shall be requested to sign a form of release from responsibility. A notation of the incident
shall be made in the patient’s medical record. If the patient refuses to sign a release, the attending
physician must document the circumstances. Patients are to be discharged, where possible, by
10:00 AM.

Discharge Planning: Discharge Planning shall be an integral part of the hospitalization of each patient
and shall commence as soon as possible after admission. When hospital personnel determine no
discharge planning is necessary in a particular case, the conclusion shall be noted on the medical record
of the patient.

Discharge planning shall include, but need not be limited to, the following:
1. Appropriate referral and transfer plans
2. Methods to facilitate the provision of follow-up care.
3. Information to be given to the patient or his designated family representative or other persons involved in caring for the patient on matters such as the patient’s condition; his health care needs; the amount of activity he should engage, in; any necessary medical regimens including drugs, diet or other forms of therapy; sources of additional help from other agencies; and procedure to follow in case of complications.
4. The attending physician shall authorize this information.
5. Notification to Case Management of the patient’s intended discharge at least 24 hours prior to the intended discharge. This is necessary so the Case Managers can make appropriate arrangements for the patients if services are needed after discharge.

TRANSFER FROM EMERGENCY DEPARTMENT:
Circumstances for Transfer: A patient may be transferred from St. Luke’s Hospital – Miners Campus Emergency Department to another hospital only under the following circumstances:

1. Following the determination that transfer is anticipated, the Emergency Department physician determines that such a transfer in no way presents a threat to the patient’s welfare. The private attending physician should be consulted that such transfer is anticipated.

2. If the emergency department physician determines that such a transfer presents a threat to the patient’s welfare, the private attending physician must physically examine the patient in the Emergency Department and must write an order for transfer. If the attending private physician refuses to see the patient, the patient, if able may:
   a) Select another physician, or
   b) Be assigned to the appropriate physician who is on unassigned call.

3. Provided the recipient hospital has agreed to accept the transfer.

The transfer of patients shall comply with The Emergency Medical Treatment and Active Labor Act (EMTALA) requirements as identified in the policy of the hospital. Patients with unstable conditions will continue to receive stabilizing treatment within the capabilities of the physician and the emergency departments while arrangements are made for transfer to another facility.

Basis for Transfer: No patient with an unstabilized emergency medical condition shall be transferred unless one of the following reasons for transfer exists:

1. Patient may be transferred if the patient or his representative requests the transfer to another facility in writing after being fully and accurately informed of the hospital’s obligation to provide stabilizing treatment and the patient is informed of the medical risks and benefits of transfer.

2. Physician certifies that the benefits outweigh the risks. The patient may be transferred if the examining physician verifies, in writing that based upon information available at the time of transfer, the medical benefits reasonably expected from the
provision of appropriate medical treatment at another facility outweigh the increased risks of the unborn child.

Document Consent or Refusal to Consent: When the physician has verified that the benefits of transfer outweigh the risks of transfer, the patient’s consent to transfer may be implied unless the patient or his representative specifically objects to and refuses the transfer.

If patient or his representative refuses the transfer, he shall be informed of the risks and the benefits. If, after being informed of the risks and benefits to the patient, he continues to refuse the transfer, the Emergency Services Personnel shall obtain the informed refusal in writing.

Responsibility: The transferring physician is responsible for arranging for a physician at the receiving hospital to provide appropriate care for the patient.

TRANSFER FROM NURSING UNIT:
Transfer from any other clinical area of St. Luke’s Hospital - Miners Campus will be the responsibility of the attending physician and he shall assume full responsibility for the patient’s welfare during the transfer. A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to ensure continuity of care will accompany the patient.

WITHHOLDING OF RESUSCITATIVE SERVICES:
It shall be the policy of the medical and administrative staff at St. Luke’s Hospital - Miners Campus to provide a protocol whereby life-sustaining procedures may be withheld in situations where death relevant to it will be as outlined in the Hospital Policy & Procedure Manual. In formulating this policy, the medical staff and administration have conformed to generally accepted medical standards to promote communication with the patient and/or family to ensure that physicians adhere to uniform procedures in determining when orders not to resuscitate may be appropriately entered, and in documenting such orders.

DEATH/AUTOPSY:
In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable period of time. The attending physician will complete and document the death certificate. 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.

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed with consent obtained in accordance with state law. All autopsies shall be performed by the hospital pathologist or by his designee. The report of the autopsy will be made part of the medical record with provisional diagnosis provided within three days and final diagnosis within 60 days.
Indications for autopsy are as follows:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;
2. All deaths in which the cause of death is not known with certainty on clinical grounds;
3. Cases in which autopsy may help to allay the concerns of the family or public regarding the death and to improve reassurance to them regarding the same;
4. Unexpected or unexplained deaths occurring or following any dental, medical, or surgical diagnostic procedures or therapies;
5. Death of patients who have participated in clinical trials (protocols) approved by institutional review boards;
6. Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction;
7. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction such as persons dead on arrival to hospitals, deaths occurring in hospitals within 24 hours of admission, and deaths in which the patient sustained or apparently sustained an injury while hospitalized;
8. Deaths resulting from high-risk infectious and contagious diseases;
9. All obstetric deaths;
10. All neonatal and pediatric deaths.

ARTICLE V PHARMACY GUIDELINES:

Registry: A current registry of the name and narcotic number of all staff personnel authorized to prescribe for patients served by the hospital shall be maintained by the pharmacist in charge of the hospital pharmacy. No physician shall prescribe for patients unless registered.

Hospital Formulary: All drugs and medications administered to patients shall be listed in the hospital formulary. Non-formulary, FDA approved drugs and medications may be administered at the discretion of the attending physician and must be referred to the Pharmacy and Therapeutic Committee for evaluation as to justification for use.

Time Period for Orders: All pre-existing orders are canceled when the patient is transferred into or out of CCU or after surgery. New orders will be required postoperatively or post to or from CCU transfer. All other orders are valid for the limited time period for time indicated by current pharmacy policy under the direction of the Pharmacy & Therapeutic Committee and are available from the Pharmacist. It is the responsibility of the physician to see that the orders are renewed. Nursing will not administer a drug for which the order has expired. It is the responsibility of the nurse to notify the physician prior to the discontinuance of these medications. The pharmacy will provide a listing daily with the cost exchange that will give a 48-hour and a second 24-hour notice of automatic stop orders. All medication orders are automatically cancelled when a patient undergoes surgery.
Stop Orders: Stop Orders are not in effect when:
1. The order indicates an exact number of doses to be administered.
2. An exact period of time for the medication is specified.
3. The attending physician reorders the medication.
4. Telephone or verbal orders may be accepted and written, signed by the full name and title of the Registered Nurse or Physician Assistant. The attending physician must countersign the order within a twenty-four (24) hour period.

Miscellaneous Guidelines:
1. Drugs shall not be discontinued without notifying the physician.
2. All surgical patients’ medications must be discontinued prior to surgery and reordered by the physician after surgery.
3. The use of "renew" or "continue" or "resume" is not acceptable. If any oral medications are to be given prior to surgery, these must be specifically ordered and written by the physician.
4. Narcotics, sedatives, antibiotics, and anti-coagulant drug orders are subject to
5. Established time limitations and must be rewritten in full.

ARTICLE VI SURGICAL GUIDELINES

PROCEDURAL SEDATION:

DEFINITION:
Minimal sedation (anxiolysis)
A drug-induced state which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

Moderate sedation analgesia (“conscious sedation”)
A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep sedation analgesia
A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia
Consists of general anesthesia and spinal or major regional anesthesia. It does not include local
anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

GOAL:
The goal of these standards and policies is to provide uniform care throughout St. Luke’s Miners Memorial Hospital for patients receiving pharmacological sedation and/or analgesia during diagnostic, therapeutic, or minor surgical procedures, hereafter referred to as “conscious sedation”.

These standards take effect when patients received conscious sedation whenever the physician, dentist, CRNA, CRNP, or licensed independent practitioner who is responsible for the overall conduct of conscious sedation (i.e., the person responsible for the medication order) is NOT a specialist in Anesthesiology and either a. or b. apply:

1. It is the intent, expectation, or it can be reasonable anticipated, that the drug(s) to be administered will (or can) result in a substantive impairment in the patient’s level of consciousness and/or protective airway reflexes, and/or spontaneous ventilation, and/or cardiovascular status, and/or a sedation score > 2 will result (see Table 1).

2. The patient is considered to have a pre-procedure ASA class of > 4, even when there is no intent or expectation that the sedatives or analgesics to be administered will result in a sedation score >2.

In all instances, orders for administration of medications for procedural sedation-analgesia must be provided by a physician, dentist, CRNA, CRNP, or licensed independent practitioner (“Physician”).

1. Such individuals must have specific competency for prescription of medications for conscious sedation, which have been assessed and documented by the Department and reviewed by the Anesthesiology Section Director.

2. Privileges for prescribing conscious sedation are to be based on demonstrated competencies in areas related to sedation and management of complications.

3. The “Physician” must be immediately available throughout the procedure to diagnose, treat and otherwise attend to any and all conscious sedation complications.

4. The responsible “Physician” must be physically present in the hospital throughout the procedure and until recovery from conscious sedation is assured.

In all instances patients who receive conscious sedation must be monitored and assessed by an individual whose principal role is patient safety and monitoring (“Monitor”).
1. Such individuals must have specific competency for monitoring and assessing patients during conscious sedation, which has been assessed and documented by their clinical Department and reviewed by Anesthesiology Section.

2. Competency standards for prescribing conscious sedation are to be based on demonstrated capability in areas related to pharmacological sedation and management of complications.

3. The “Monitor” must be in continuous physical proximity with the patient at all times during the procedure with unrestricted visual and physical access.

4. Conscious sedation standards do not apply to the following circumstances:

5. Patients who receive sedation and/or analgesia that is not administered for a specific diagnostic, therapeutic, or minor surgical procedure. Examples include management of acute or chronic pain, anxiety, psychiatry disease, or insomnia.

6. Patients undergoing procedures while physically present in a critical care unit (ICCU). This exception is made on the assumption that the cardio-pulmonary status of all patients in critic care units is completely characterized and continually monitored and personnel with advanced airway and cardio-vascular management skills are always immediately available.
   a) However, critical care patients who leave ICCU for diagnostic or therapeutic procedures and receive pharmacological conscious sedation do fall under these standards.

7. All patients who are assessed as ASA class 4 or 5 (defined below) are to be considered for an Anesthesia consultation whenever conscious sedation is planned.

<table>
<thead>
<tr>
<th>TABLE 1 – American Society of Anesthesiologists (ASA) Physical Status Classification System</th>
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Emergency status: In addition to indicating underlying ASA status (1-5), any patient undergoing an emergency procedure is indicated by the suffix “E”. For example, a fundamentally healthy patient undergoing an emergency procedure is classified as 1-E. If the patient is undergoing an elective procedure, the “E” designation is not used.

INFORMED CONSENT:
Responsibilities of Attending Physician: In Pennsylvania, the duty to apprise a patient of the nature of the procedure, risks and alternatives under the Informed Consent Doctrine is limited to the physician actually performing the procedure for which consent is being obtained. The duty to obtain a patient’s informed consent does not extend to any other individual or the hospital. However, if the hospital knows or should know that a procedure is about to be performed without the patient’s informed consent and fails to prevent this from happening, the hospital may be held liable. Therefore, St. Luke’s Hospital - Miners Campus requires written documentation of the patient’s informed consent contained within the patient’s medical record prior to the performance of the procedure or treatment.

The physician performing the procedure or treatment shall obtain informed consent from the patient or the patient’s Health Care Agent or, if none designated, Health Care Representative, as appropriate. Except in emergencies, a physician/AP owes a duty to obtain consent prior to conducting the following procedures:

- performing surgery, including the related administration of anesthesia;
- administering radiation or chemotherapy;
- administering a blood transfusion;
- inserting a surgical device or appliance;
- administering an experimental medication, using an experimental device or using an approved medication or a device in an experimental manner; and
- Any procedure that requires general anesthesia or conscious sedation.

Consent from a patient who has already been sedated in preparation for the proposed operation or procedure is invalid.

Prior to obtaining a patient’s informed consent, the responsible physician must fully explain the nature of the proposed procedure, the risks and consequences of this procedure, the alternative courses of treatment and their risks and consequences and the risks and consequences of refusing the recommended diagnostic or treatment procedure. If, after this explanation, the patient gives his informed consent, this informed consent must be documented on the appropriate consent form.

Documentation: If at the time the pre-op checklist is completed and reviewed there is no documentation of the patient’s informed consent to the procedure, the individual
completing or requiring this checklist must immediately contact the physician performing the surgery and advise the physician that there is no documentation of the patient’s informed consent on the chart. This contact with the physician must be documented on the chart. No patient shall be sedated in preparation for a procedure until his or her informed consent is properly documented on the chart.

Validity of Consent Form: The Consent to Procedure or Surgery form, including but not limited to blood transfusion shall be deemed valid for the length of the admission unless revoked by the applicable health care decision maker. In the outpatient setting, blood consents shall be deemed valid for up to one year, unless consent is revoked sooner by the patient or applicable surrogate.

Release of Patient: No patient shall be released from a nursing station for transfer to the surgical suite for surgery and anesthesia unless the patient’s chart contains a Surgical/Anesthesia consent form signed by the patient or his/her legal representative, and the surgeon–Informed consent must be obtained prior to the patient being sedated.

Life-Threatening Emergencies: A life-threatening emergency case, when suitable signatures cannot be obtained due to the condition of the patient, a consultation may be desirable before surgery is undertaken. A brief explanatory note on the chart is required.

**DIAGNOSTIC TESTING:**

Documentation: Except in severe emergencies, the preoperative diagnosis and required diagnostic tests must be recorded on the patients’ medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In an emergency or life-threatening situation, the medical physician shall make at least a comprehensive note regarding the patient’s condition prior to the induction of anesthesia and start of surgery.

Required Testing: The following diagnostic studies are required for transfer to the Surgical Services are a for all patients regardless of admission status, requiring general or regional anesthesia and should be obtained within 5 days prior to surgery.

1. CBC
2. SMA 6 (Electrolytes, FBS, BUN)
3. EKG (on patients >35 years of age prior to general anesthesia at discretion of anesthesiologist)

Outpatient surgery requiring only local anesthesia can be performed after obtaining surgical consent order. Diagnostic studies may be required per the condition of the patient as decided by the attending physician or surgeon.

For women admitted for surgery and of childbearing age: A pregnancy test shall be performed at the discretion of the Anesthesiologist, Surgeon, or Primary Attending Physician if, at the time of patient’s H&P examination, there may be any question of pregnancy. If H&P exam documents that there is No possible pregnancy, testing is not necessary) (10/02)
SURGICAL SCHEDULING:
The Surgical Services Manager or her designee has the authority for scheduling the procedures and for altering the schedule to accommodate emergencies that arise during the progress of the regular schedule. All cases must be scheduled with the Surgical Services Manager. Cases after 1500 hours are scheduled with the Nurse Supervisor and are temporary until approved by the Surgical Services Manager. The Surgical Services Manager has the authority to cancel or delay a case if the preoperative requirements are not complete. Scheduling is according to the Modified Block Schedule Policy indicated below and must include the name of patient, procedure, surgeon, status (in- or outpatient) and recommended anesthetic agent.

Block Time Availability:
Monday: 2 rooms, mornings only
Wednesday: 2 rooms, mornings only
Thursday: 1 room, mornings only
Friday: 2 rooms, mornings only

All other scheduling for available rooms will be scheduled on a “first-come, first-served” basis. This practice will be reviewed along with block allocation biannually.

Blocks will be released on the following schedule:
Ophthalmology - 5 days prior; Others - 11 AM 2 days prior

Block Start Time: The time posted on the schedule indicates that all members of the team are in place for the procedure to begin and/or for the anesthetic agent to be administered. Physicians are expected to start at the beginning of their block start time even if they are not able to fill the entire block. Any physician who is 10 minutes late for any case more than 5 times in a quarter will be discussed at the next quarterly scheduled meeting of the Department of Surgery. Possible action will be restriction of 7:30 AM or preferred start times. The hospital commits to start cases on time and to staff the assigned blocks as long as utilization of the block is at least 60%.

Scheduling hours are Monday through Friday from 7 AM to 3 PM. This will be evaluated quarterly and adjustment made based on calls made outside this time (via voice mail for after hour scheduling). Notification of scheduling request can be made outside of these hours by calling the after hours scheduling voice mail number. After 3 PM, next day scheduling will be accomplished by the house supervisor. The OR will provide the next possible time on the house supervisor’s copy of the next day’s schedule.

When a physician has an emergency case that will bump another physician, it is the responsibility of the bumping surgeon to discuss the matter with the physician who will be bumped. When requested, nursing personnel will communicate the request to the surgeon to be bumped. Nursing CANNOT be responsible for the end decision. The Chief of Surgery will settle conflicts.

Block Utilization Reports will be distributed quarterly. Utilization of block time will be maintained at 60% or the allocation will be reviewed for possible reallocation. Allocations will be adjusted twice each year.
All procedures must be scheduled with a start time that will ensure a completion time of 3 PM. The operative schedule indicates the time at which the procedure is expected to begin. The timing is such that the Surgical Services personnel are prepared to receive the patient and to begin the procedure shortly after their arrival.

Cases are scheduled on a first come - first scheduled basis. Surgeons should schedule their cases as far in advance as possible. This will help to ensure day and time they wish. Caseload may have to be split if added at the last minute. Because add-ons to the surgery schedule result in delays in surgery, it is required that any physician who wishes to add cases to the schedule, which will affect other previously scheduled cases, must contact the other physician regarding this change. This issue will be addressed physician-to-physician and is not the responsibility of the Surgical Services Manager.

First procedure of the day will begin at 7:30 AM. All surgeons are expected to be on time. Surgeons having the first procedure of the day must be ready by 7:35 AM. The primary surgeon must be on hand, scrubbed, and ready to operate at the scheduled time. (The scheduled time is the time the operation is to begin not the time the scrubbing and preparations are to start). Under no circumstances will a room be held longer than fifteen (15) minutes past the scheduled time unless the surgeon notifies the Surgical Services Manager and arrangements are made.

All major procedures must be completed by 2 PM when possible. No major elective cases will be scheduled after 1 PM. All cases that may result in overtime will be referred to the Chief of Surgery for review to determine appropriateness of scheduling at that time. All non-emergency cases to be scheduled after 1 PM are to be referred to the Chief-of-Surgery for approval before scheduled.

Outpatients receiving general or sedation anesthesia will be done as first cases on the schedule as often as possible. This DOES NOT mean they will bump previously scheduled cases. If necessary, the schedule will begin at 7 AM.

After 3 PM anesthesiology will notify the surgeon about their patients that may still be in the SDS Unit. It is the surgeon’s responsibility to discharge his own patients. The medical physician performing the medical clearance on patients for dental and podiatric services will be responsible for those cases.

If the surgeon wishes the presence of the pathologist for a frozen section examination of tissue or of the radiologist for specific radiographs during surgery, he shall do so at the time of scheduling the procedure.

Endoscopy Room will follow the same rules as all other OR Rooms.

If a question arises in reference to the patient emergency status, the Chief of Surgery is the final arbitrator.

Acute emergencies may take precedence over previously approved surgery schedules. All concerned should be consulted to include the Surgical Services Manager, previously scheduled physicians, and
anesthesiology.

**MISCELLANEOUS SURGICAL GUIDELINES:**

Preadmission History & Physical: Preadmission history and physical examination shall be valid if obtained 30 days prior to admission provided that an appropriate assessment was completed on admission and documented in the medical record confirming that the necessity for the procedure is still present and that the patient’s condition has not changed since the H&P was originally completed.

Other Studies: Other evaluation studies, including lab work, are to be performed within 30 days prior to surgery.

Preoperative Checklist: A preoperative checklist for both inpatients and outpatients will be placed on all charts of patients having surgery or diagnostic procedures done which require general or regional anesthesia.

Surgical 1st Assist: The operating surgeon shall obtain qualified assistant at all major operations.

Tissue Producing Surgery: All tissues or foreign material removed during surgery shall be sent to the hospital Pathologist who shall make such examination, as he may consider necessary to arrive at a diagnosis. His authenticated report shall be made part of the patient’s medical record.

Required Medical Operative Risk Assessment: Except in an emergency, consultation with a member of the consulting or active medical staff is required in all major cases in which the patient is not a good risk, in which the diagnosis is obscure, and all pacemaker insertions. The consultation note is to be recorded prior to the operation. Nursing staff is instructed not to send the patient to the Surgical Services area until the consultation is recorded.

Observers: Observers shall be permitted in the Surgical Suite only with the consent of the surgeon, patient, and administration, and it is to be obtained in advance.

Consent Form: Surgical and Anesthesia Consents can be obtained in the holding area in the Surgical Services Area. Informed consent must be obtained prior to the patient being sedated.

Anesthesia: The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up with appropriate documentation in the medical record of routine work-up relative to choice of anesthesia for the surgical procedure. Except in extreme emergency cases, this evaluation shall be recorded and signed by the anesthesiologist prior to patient’s transfer to the Operating Room area and before preoperative medication is administered. Recording of post-anesthesia visits, at least on written note (additional notes if required) describing presence or absence of anesthesia-related complications, shall be documented in patient’s record.

Preoperative & Postoperative Note: It is the responsibility of the attending surgeon, either in the progress note or in the form of a consultation, to have a preoperative note in the chart. It is also required that a postoperative note be contained in the progress notes of medical record.
Operative Note: The surgeon must complete the handwritten operative note immediately after the completion of the surgical procedure. The operative note must be completed in its entirety. An operative report describing in detail the reason for the operation, the preoperative diagnosis, postoperative diagnosis, findings and the procedure performed must be dictated immediately after completion of the surgical procedure.

SAME DAY SURGERY:
The Same Day Surgery unit shall have written policies and procedures specifying the scope of patient care rendered. Such policies must be approved by the medical staff and the governing body through its designated mechanism and shall be reviewed and revised as necessary.

Scope of Services: The scope of services provided shall be defined in writing. There shall be written guidelines for the event of an emergency situation. Provisions shall be made for back-up services by other departments in case of emergency or complications.

Medical Direction: The Chief of Surgery shall provide medical direction of the SDS unit. The Chief of Surgery shall have the authority and responsibility of assuring that established policies are carried out and that a review of the quality, safety, and appropriateness of the SDS unit is performed.

Clinical Personnel: There shall be a sufficient number of qualified personnel under competent medical supervision. These personnel shall include a registered nurse. Additional personnel are to be designated, as necessary, to insure that the needs of the patient are fulfilled.

Medical Record: The medical record shall include:
   a) History and physical sheet;
   b) Physician order sheet;
   c) Progress note sheet;
   d) Nurses record sheet;
   e) Surgical Consent (signed by surgeon)
   f) Anesthesia Consent (general anesthesia only, signed by anesthesiologist)
   g) Conclusion and disposition sheet.

Medical Operative Risk Assessment: In those instances where Medical Operative Risk Assessment has been obtained by physicians who are not members of the medical staff of St. Luke’s Hospital - Miners Campus should a medical problem arise, the anesthesiologist has the choice of a physician to care for the patient. These records are to be kept within the Health Information Management department upon discharge of the patient.

Medical Operative Risk Assessment of patients must be documented prior to preoperative medications being given. Oral assessment must be written and signed by the physician. Medical Operative Risk Assessment by telephone is acceptable only when witnessed by two (2) nurses and must be countersigned by the physician within 24 hours.

Preadmission Testing/Preoperative Care: Pre-admission testing and patient arrival to the unit prior to surgery are to be in accordance with the written policy of the unit. Anesthesia evaluation is to be under
the direction of the anesthesiologist. The anesthesiologist will be responsible for preoperative visits, medications, anesthesia record, and assistance during surgery, and postoperative visits.

Discharge Planning: The Discharge Plan shall also be in accordance with the written policy of the unit. The patient must be discharged by their physician. General anesthesia patients will have to remain in PACU for at least one hour and will not be discharged from the unit without the anesthesiologist’s order. The patient is to receive written instructions as to follow-up upon discharge. Verbal or telephone discharge by the physician is accepted if the discharge criteria from the SDS Unit as listed on the Discharge Summary sheet are met.

ARTICLE VII PHYSICAL THERAPY GUIDELINES

It is the policy of the Physical Therapy Department to administer health care in the form of therapeutic exercise, physical agents, and functional training.

Scope of Care: Physical therapy services are provided under a written or verbal plan of care initiated by the attending physician. All verbal orders must be forwarded in writing and on the chart within 24 hours. These services may be developed through consultation with appropriate therapist and nursing services. All treatments provided by qualified personnel under the supervision of licensed physical therapists are ordered by licensed physicians, dentists, and podiatrists. When the prescribed treatment is questionable, the referring physician is consulted. It is the policy to provide the patient with the highest quality of care at all times.

Medical Record: In reference to patient records, records for each patient referred to a rehabilitation program/service shall include at least the following data:

1. The diagnosis and problem list, and plan of care pertinent to the rehabilitation process.
2. Precautions necessitated by the patient’s general medical condition or by other factors.
3. The short term and long term goals of the treatment program, as well as the patient’s stated goals.
4. A statement regarding the frequency of review, when it is desired more often than monthly, of the patient’s progress within each rehabilitation program/service providing treatment to the patient.
5. A copy of each patient’s initial evaluation and progress note will be faxed, mailed, or hand delivered to the physician at least monthly, as well as at each physician follow-up meeting.

ARTICLE VIII RESPIRATORY THERAPY GUIDELINES

There shall be written policies and procedures specifying the scope and conduct of patient care to be rendered in the provision of respiratory care services. Such policies and procedures must be approved by the medical staff through its designated mechanisms and shall be reviewed at least annually, revised as necessary, dated to indicate the time of the last review, and enforced.
Scope of Care: The scope of the diagnostic and therapeutic respiratory care services provided to inpatients, outpatients, and home-care patients shall be defined in writing. Pulmonary function studies and blood gas analysis capability shall be appropriate for the level of respiratory care services provided and shall be readily available to meet the needs of the patient.

Medical Direction: Medical direction of the respiratory department/service shall be provided by a physician member of the Active Medical Staff who has special interest and knowledge in the diagnosis, treatment, and assessment of respiratory problems. Whenever possible, this physician shall be qualified by special training and/or experience in the management of acute and chronic respiratory problems. The physician director shall designate a qualified physician member of the Active Medical Staff to act in his absence. The physician director or his qualified designee shall be available to provide any required respiratory care consultation, particularly on patients receiving continuous ventilator or oxygenation support. The physician director shall have the authority and responsibility for assuring that established policies are carried out; that overall direction in the provision of respiratory care services in the inpatient, outpatient, and home-care setting is provided, and that a review of the quality, safety, and appropriateness of respiratory care service is performed.

Clinical Personnel: Respiratory care services shall be provided by a sufficient number of qualified personnel under competent medical direction. When the scope of the services warrants it, respiratory care services shall be supervised by a technical director who is registered or certified by the National Board of Respiratory Therapy, Inc., or has the equivalent education, training, and/or experience.

The technical director’s duties shall include responsibility for assuring the supervision of respiratory personnel in the performance of respiratory therapy and any designated related laboratory procedures, the care, maintenance and disinfection or sterilization of all ventilator equipment, accessories and, as required, supplies and the maintenance of appropriate records and reports. Additional responsibilities may be designated to the technical director by the physician providing medical direction for the respiratory care services.

Other qualified respiratory care personnel shall provide respiratory care services commensurate with their documented training, experience, and competence. Such personnel may include registered respiratory therapists or certified respiratory therapy technicians, or individuals with the documented equivalence in education, training and/or experience, qualified cardiopulmonary technologists, and appropriately trained licensed nurses. This does not preclude the provision of respiratory care personnel.

Prescription for Respiratory Care: The prescription for respiratory care shall specify the type, frequency, and duration of treatment, and, as appropriate, the type and dose of medication, the type of diluent, and the oxygen concentration.

Medical Record: A written record of the prescription and any related respiratory consultation shall be maintained in the respiratory care department files, shall be incorporated into the patient medical record, and shall include the diagnosis. When feasible, the goals or objectives of the respiratory therapy should also be stated in the medical record. All respiratory care services provided to a patient shall be
Rules and Regulations of the Medical Staff

documented in the patient’s medical record, including type of therapy, date and time of administration, effects of therapy and any adverse reactions. The responsible physician shall document in the patient’s medical record a timely pertinent clinical evaluation of the overall results of respiratory therapy.

Discharge Plan: Prior to discharge of the patient, instructions appropriate to the respiratory problem should be given in all relevant aspects of pulmonary care. This may include instruction to the patient or the patient’s family on postural drainage, therapeutic percussion, and other measures. The need for long-term oxygen therapy should be adequately documented in the medical records of patients discharged on such therapy. When appropriate, such need should be based on arterial blood gas results at rest and/or exercise.

Quality Review: The physician director of the respiratory care department shall be responsible for assuring that a review of the appropriateness and effectiveness of such services is accomplished in a timely manner including respiratory care provided to inpatients and, where applicable, to outpatients. The review shall be performed at least quarterly and shall involve the use of the medical record and the use of pre-established criteria, including indications for use, effectiveness of treatment, and adverse effects requiring discontinuance of treatment. The review shall include input from the medical staff and personnel of the respiratory care department and may be performed as part of any overall hospital patient care evaluation program. Particular attention shall be given to evaluation of the necessity for those respiratory care services having the highest utilization rate. The quality and appropriateness of respiratory care services provided by outside sources shall be included in the review on the same regular basis.

ARTICLE IX MEDICAL RECORD GUIDELINES

General Charting Guidelines: The attending physician shall be responsible for preparing and maintaining a complete and LEGIBLE medical record for each patient evaluated and/or treated in the inpatient, outpatient or emergency unit. Its contents shall be pertinent and current.

Medical Record: This record shall include identification data, complaint, age, mental status, personal history, family history, history of present illness, past history, physical examination, special reports such as consultations, clinical laboratory and radiology services and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, plan of care, final diagnosis, condition on discharge, summary or discharge note, and autopsy report.

History & Physical Examination: A complete admission history and physical examination shall be recorded and placed in the patient’s medical record within 24 hours of admission for every patient receiving inpatient services; history and physical examinations for nursing & rehabilitation facility patients must be recorded and placed in the patient’s record within 72 hours of admission.

If a patient has had a complete history and physical examination performed by a practitioner granted the privilege to do so no more than 30 days before the patient’s current date of admission to the hospital, a reasonable, durable and legible copy of this report may be used to satisfy the admission history and
physical examination requirement permitting that an update to the patient’s condition since it was last assessed is documented within the report within 24 hours of admission unless the patient is having surgery or other procedure that places the patient at risk or involves the use of sedation or anesthesia within the first 24 hours in which case there must be an update to the patient’s condition prior to the start of surgery.

History and physical reports for all **inpatients** shall include chief complaint, history of present illness, relevant past medical and surgical history, social and family history, allergies, list of current medications, review of systems, physical examination, impression and statement on the course of action planned for the episode of care.

**Outpatient** history and physical reports shall include a chief complaint, history of present illness, relevant past medical and surgical history, allergies, list of current medications, social and family history, relevant review of systems, relevant physical examination, impression and statement on the course of action planned for the episode of care.

When the history and physical examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled except in the case of an emergency. In an emergency, when there is not time to record the patient’s complete history and physical examination, a progress note describing a brief history, appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery.

History and physical examinations performed, as permitted by state law and policy, by individuals who are not licensed independent practitioners must be countersigned by the physician accountable for the patient’s medical history and physical examination within 10 days.

**Plan of Care:** Plan of Care must be part of H&P or admission note and must be documented within 24 hours. When the Physician Assistant completes the H&P, the PA will refer to the Plan of Care as documented by the attending physician in the admission note. The plan of care shall define the course of action the physician intends to follow to further diagnose and treat the patient. The plan shall be reviewed and updated as appropriate. Clinical Pathways shall be recognized as an acceptable equivalent.

**Progress Notes:** Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever, 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 shall be written daily on all patients. In all instances, progress notes should be legible and describe, but not be limited to, the status of the patient, the patient’s complaints, reasons for testing, interpretation of results of tests, and intended course of action. Progress Notes should be written no less than daily on all patients.

**Operative Notes:** Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique, post operative diagnosis, and specimen removed. The surgeon must complete the handwritten operative note immediately after the completion of the surgical procedure. The operative note must be completed in its entirety. A postoperative progress notes must be documented in the patient’s medical record upon completion of surgery, prior to the patient’s transfer to the next level of care. The note should include at
minimum comparable operative report information. These elements include; name of primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis as well as estimated blood loss. Operative reports shall be written or dictated immediately following surgery for outpatients and inpatients and authenticated promptly by the surgeon and made a part of the patient’s current medical record as soon as possible. A postoperative progress note must be documented in the chart.

Consultations: Consultations shall show evidence of a review of the patient’s medical record by the consultant, pertinent findings on examination of the patient, the consultant’s opinion and recommending actions and documented accordingly. This report shall be made a part of the patient’s record. A limited statement, such as, “I concur” does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation noted shall, except in emergency situations so verified on the record, be recorded prior to the operation.

Authentication of Clinical Entries: All clinical entries in the patient’s medical record shall be accurately dated, timed, and signed. Authentication may include signatures, written initials, electronic signature or computer entry.

Abbreviations: Symbols and abbreviations may be used only when the medical staff has approved them. An official list of approved abbreviations shall be kept on file in Medical Records and shall be reviewed annually by the Medical Records Committee. All persons who document on a health record are encouraged to not use abbreviations when documenting in the medical record. The St. Luke’s Hospital and Health Network does not support the use of these abbreviations: QD -every day; QOD - every other day; ug – micrograms; U, IU or MU Unit; Leading zero (always); Trailing zero (never); MS - morphine sulfate; MSO4 - morphine sulfate; MgSO4 - magnesium sulfate.

Final Diagnosis: Final diagnosis shall be recorded in full without the use of symbols or abbreviations and dated and signed by the responsible physician at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

Discharge Summary: A discharge summary shall be written or dictated on all medical records of inpatients, observation patients, or skilled nursing facility patients within 24 hours of discharge. For these, a final summation progress note shall be sufficient. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The Discharge Summary shall include all information related to the care of the patient, and must include the patient’s medications ordered on discharge. The responsible physician shall authenticate all summaries.

Completion of Medical Record: A medical record shall not be permanently filed until the responsible physician completes it. The patient’s medical record shall be completed at time of discharge and will include progress notes, final diagnosis, and discharge summary.

Incomplete Medical Record: All medical records must be completed within twenty five (25) days of the patient’s discharge from the hospital. It is the responsibility of each member of the Medical Staff to complete their portion of the medical record. Records not completed within this twenty five (25) day
period will be reported as delinquent.

All physicians and non-physician practitioners will be notified of their incomplete medical records weekly. Any physician or non-physician practitioner with more than 3 delinquencies on the monthly Medical Record Delinquency report will be reported to the Medical Executive Committee for consideration of disciplinary action which can include suspension.

Any physician or non-physician practitioner with more than 25 delinquent records on the monthly Medical Record Delinquency report for two consecutive months will be reported directly to the Medical Director for consideration of immediate disciplinary action which may include suspension. Report will follow to the Medical Executive Committee.

When the decision to suspend a physician or non-physician practitioner is enacted, the suspended practitioner will not be permitted to report to work for regularly scheduled hours in any department, schedule procedures, perform consults, admit, or assign patients to observation, or accept a transfer of a case unless authorized by the President of the hospital or the Medical Director. Existing admissions will not be affected by the suspension.

All suspensions will be reported to the Medical Executive Committee on a monthly basis for consideration of additional disciplinary action and renewal of privileges.

ARTICLE X PRIVILEGES OF INFORMATION AND RELEASE

All information on medical records is held to be privileged communication and is not to be released outside to parties or institutions without written permission of the patient, except in cases of subpoena, court order, or statute, in accordance with the law. All records are the property of the Hospital and shall not be released except by subpoena, court order, state and federal statute. In the case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another physician. Unauthorized removal of charts from the Hospital is grounds for suspension of the physician for a period to be determined by the Executive Committee of the Medical Staff. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All projects shall be approved by the Medical Executive Committee of the Medical Staff before records can be studied. 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. Medical Staff access to patient medical records shall coincide with HIPAA regulations.
ARTICLE XI MEDICAL COVERAGE OF EMERGENCY ROOM

Medical coverage in the Emergency Services Department is furnished by St. Luke’s Physician Group. Physicians being provided must be credentialed in the usual manner of credentialing before staff approval. ED Physicians are credentialed to provide services in the Emergency Department only. ED Physicians will only respond to situations in Acute Care and Nursing & Rehabilitation Center that involve cardiopulmonary arrest and require the presence of a physician to direct resuscitation. (1/03)

Monitoring of physician services is the responsibility of the Emergency Services Section Director with reports sent to the Medical Executive Committee via quality assurance reviews. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multi-specialty committee of the medical staff including representatives from nursing service and hospital administration. It shall be approved by the medical staff and by the governing body.

ARTICLE XII DISASTERS

All physicians shall be assigned to posts and it is their responsibility to report to their assigned stations. The chief of the clinical services in the hospital and administrator of the hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another, or evacuation from the hospital premises, the chief of the clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the department chairman and administrator of the hospital.

ARTICLE XIII MEDICAL STAFF FILES

Responsibility: All requests for medical staff files and/or records shall be made to and recorded and approved by the medical staff services coordinator according to the medical staff bylaws. The medical staff services coordinator will refer requests requiring further consideration to the chief of staff and/or legal counsel whenever necessary. Removal or copying will be upon permission of the chief of staff and/or as specified in this policy. The medical staff services coordinator and officers of the medical staff shall be responsible for preserving the confidentiality of the records in accordance with this policy.

Members of the medical staff recognize the importance of preserving confidentiality of all information obtained in connection with responsibilities as medical staff members.

Access by persons performing official hospital or medical staff functions are defined as follows:

1. Medical staff officers
2. Medical staff services coordinator
3. Department chairman
4. Section directors
5. Medical staff committee members
6. Consultants
7. Medical Director
8. Chief Executive Officer: The CEO or his designee shall have access to the information contained in a physician’s credentials and/or peer review file.

Access by medical staff members will be processed as follows:
1. Credentials and Peer Review Files: Review of the file can only be carried out by the individual physician in the presence of the medical staff services coordinator or his designee. The physician shall have a right to copies of documents submitted by him. A request form will be signed by the requesting physician and the chief of staff authorizing each request.
   a) Examples:
      b) Application and reapplication
      c) Delineation of privileges forms
      d) Licensure
      e) Malpractice Insurance
      f) DEA Registration
      g) Correspondence from him or addressed to him.

Committee/Department Records: Review may be carried out by all committee or department members of their respective committees or department minutes and correspondence after these documents have been approved by the chairman of the department or committee. Copying and distribution of minutes and/or correspondence will be at the discretion of the department chairman and/or chief of staff. All committee members are copied for distribution to the Medical Executive Committee after approval.

Access by persons or organization outside the hospital system will be processed as follows:
1. Credentialing or Peer Review at Other Hospitals: Routine written requests for information will be completed by the department chairman, chief of staff, medical director, CEO, in-house departments if requested in these specialties, or the medical staff services coordinator. All request must be accompanied by written authorization for release of information from the involved physician prior to completion of such request.

2. Other Requests: All requests must be submitted in writing and reasons for the request provided. These requests by persons or organizations outside of the hospital for information contained in the medical staff files and/or committee/department minutes will be reviewed by the medical staff services coordinator and completed at the discretion of the chief of staff.

3. Subpoenas: All subpoenas of medical staff files/records shall be referred to the chief of staff and legal counsel prior to responding to the order.

Filing: All medical staff credential files and records are maintained in a locked file cabinet in a secure and locked area as follows:
1. Physician Credential Files: Physician credential files shall contain all credentialing information and other miscellaneous correspondence directly related to the individual physician.
2. Physician Peer Review Files: A Peer Review file is maintained in a separate file in a locked and secured area. Physicians will be notified of information recommended to be placed in their files and given the opportunity to review or dispute such information in accordance with medical staff bylaws.
3. Minutes: All minutes will be filed upon completion and final approval by the chairmen of the respective committee/department along with attached supporting documentation and filed with the MEC Minutes in the Office of Medical Staff Services.
4. Correspondence: All correspondence will be filed as completed and maintained in chronological order within a binder in the Office of Medical Staff Services with any correspondence relative to department/committee meetings attached to minutes and filed accordingly.

Computer Access: Employees of Medical Staff Services are designated as having access to medical staff files/records contained in the Medical Staff Information System computer system. Release of this information will be kept in accordance with above guidelines. Computer disks, backup files, etc, are kept in a locked storage area.

ARTICLE XIV  GENERAL PRINCIPLES OF PATIENT, PRACTITIONER AND HOSPITAL RELATIONSHIPS

1. St. Luke’s Hospital, its Medical Staff, and its Employees will give considerate and respectful care to all patients without discrimination as to race, color, sex, sexual preference, religion, national origin, or ability of payment.

2. The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his/her behalf. He/she has the right to know, by name, the physician responsible for coordinating his/her care, the names of all other physicians directly participating in his/her care, and the names and functions of the health care persons having direct contact with the patient.

3. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives or possible complications, the patient has the right to information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.
4. The patient may refuse any drugs, treatment, or procedure to the extent permitted by law and will be informed by his/her physician of the medical consequences of his/her action. The patient shall be responsible for his/her actions if he/she refuses treatment or does not follow his/her physician’s instructions. The patient is responsible for following hospital rules and regulations affecting patient care and conduct.

5. The patient has by law a right to privacy. This means that his/her medical care program including case discussion, consultation, examination and treatment are confidential and should not be divulged to those not directly involved in his/her care or those involved in the monitoring of its quality without the patient’s permission. This also means that he/she may refuse to talk with or see anyone not officially connected with the hospital or persons officially connected with the hospital but who are not officially connected with his/her care.

6. All communications and records pertaining to a patient’s care should be treated as confidential except as otherwise provided by law or third-party contractual arrangements.

7. The hospital and its employees will endeavor to make responsible response, within their capacity, to patient’s reasonable request for service. The patient’s physician will provide evaluation service, and/or referral as indicated by the urgency of each case. When medically permissible, a patient may be transferred to another facility only after he/she or his/her next of kin or other legal representative has received complete information and explanation concerning the need for and the alternatives to such transfer. No transfer shall be made unless the facility to which the patient is to be transferred has notified the physician and the hospital that it will accept the patient for transfer.

8. The hospital will not engage in or perform clinical investigation affecting a patient’s care or treatment without his/her consent or in event the patient is unable to give informed consent a legally responsible representative. The patient or legally responsible person may at any time refuse to continue in any such program to which he/she has previously given informed consent.

9. The patient shall have access, upon request, to all information contained in his/her medical records, unless access is specifically restricted by the attending physician for medical reasons or is prohibited by law.

10. The patient who does not speak English should have access, when possible, to an interpreter.

11. The patient has the right to obtain consultation with another physician at his/her request.

12. Patient Accounts and Social Work and Discharge Management will provide the patient with full information and counseling on the availability of known financial resources for his/her health care.

13. The patient will be informed upon discharge, by his/her physician, of his/her continuing health care requirements following discharge and the means for meeting them.
14. Patients are entitled to prompt, courteous service. Any patient not receiving such service is asked to report the facts to the Hospital Administration. It will appreciate having such information as well as suggestions for improvement of service.

15. The hospital has adopted procedures to ensure effective and fair investigation of violations of patients' rights and to ensure their enforcement. These procedures include:
   a. Formal written complaints shall be addressed to the President, St. Luke’s Hospital Miners Campus, 360 West Ruddle Street, Coaldale, PA 18218
   b. Formal written complaints are recorded and investigated.
   c. Complaint records and case dispositions are kept for two years and made available to the Pennsylvania Department of Health on request.
   d. Investigation and resolution, when possible, for formal complaints shall be timely; and
   e. Disciplinary and remedial education procedures will be initiated for members of the hospital and medical staff who consistently cause patient relationship problems.
   f. A response, in writing, will be sent to the individual making the complaint.

ARTICLE XV MEDICAL STAFF DISRUPTIVE PHYSICIAN GUIDELINES

Definition: Disruptive conduct by a physician is behavior which adversely impacts on the quality of patient care and includes: verbal and/or physical abuse of colleagues, hospital personnel or patients, sexual harassment, and threatening or intimidating behavior exhibited during interactions with colleagues or hospital personnel, or patients.

Process:
   1. All complaints against members of the medical staff must be handled by the medical staff.
   2. Any medical staff member, employee or agent of the hospital, or patient may file a complaint against a physician regarding disruptive conduct.
   3. Complaints will be submitted to the medical staff president or department chair wherein the physician holds privileges who will notify the Medical Director or equivalent. If complaints are submitted directly to the Hospital President, he/she will notify the medical staff president.
   4. Complaints must be in writing and must include documentation of the disruptive conduct, which will include:
      a. the date and time of the behavior in question;
      b. the circumstances which precipitated the situation;
      c. whether the behavior involved a patient and, if so, the patient’s name;
      d. a description of the behavior limited to factual, objective and observed acts as much as possible;
      e. the consequences, if any, of the disruptive behavior as it relates to patient care and/or hospital operations; and
      f. a record of any action taken to remedy the situation including date, time, place,
action, and name(s) of those intervening.
g. corroboration by another individual if possible.

5. The medical staff president, in collaboration with the chair of the department wherein the physician holds privileges, will conduct an investigation which will include, but not be limited to, an interview with the involved physician.

6. Single minor incidents of disruptive conduct, warranting a discussion with the involved physician, will be handled by the medical staff president. A single copy of the incident and decision documentation will be kept and placed in the physician’s confidential credentials file. The physician should have an opportunity to present a written response to the charges placed in that physician’s file. The physician should be entitled to review his file periodically until documentation is removed. If no further incidents are reported within two years, the documentation will be removed from the physician’s file and destroyed.

7. If there appears to be a pattern of disruptive behavior or if the behavior in question suggests impairment (medical, psychological, or substance abuse problem), the medical staff president will contact the Medical Executive Committee. The Medical Executive Committee may arrange for the physician to be evaluated by a professional with appropriate expertise to determine whether the physician is impaired.*

8. If the physician refuses to be evaluated, the Medical Executive Committee will then determine the need to report to the State Board of Medicine or the State Board of Osteopathic Medicine.

9. If the involved physician is determined not to be impaired, the president of the medical staff will meet with the physician to discuss the inappropriate behavior, emphasizing that if the behavior continues, more formal action will be taken (i.e., initiation of the disciplinary process as delineated in the Medical Staff By-Laws). This meeting will be documented and a follow-up letter to the physician, which will be part of the physician’s permanent record, will emphasize that the physician is expected to behave professionally and cooperatively. One copy only of the letter to the physician will be kept and placed in the physician’s confidential credentials file.

10. Additional incidents within two years will result in initiation of a corrective action proceeding pursuant to the Medical Staff By-Laws. When patient safety is in jeopardy, summary suspension procedures, as outlined in the Medical Staff By-Laws, may be indicated pending this process.

* The Physician’s Health Programs of the Educational and Scientific Trust of the Pennsylvania Medical Society is a resource available to hospitals and physicians regarding impairment.
Informal, confidential consultative services may be obtained without necessitating a formal referral. The address and phone numbers are as follows:

Physicians' Health Programs  
777 East Park Drive, P.O. Box 8820  
Harrisburg, PA 17105-8820  
Direct Line: (717) 558-7750  
Message Line: (717) 558-7817  
Toll Free Line: 1-800-228-7823

ARTICLE XVI COMPLAINT POLICY

1. Physician complaints are to be evaluated by the Chief of the Department involved or the Medical Director. Complaints arising outside of the hospital not involving hospital referral or care should be referred to the individual physician involved.

2. Complaints involving the hospital should be evaluated for quality of care issues as well as physician disruptive behavior issues. If the complaint falls within the scope of these parameters, it should be referred to the appropriate management as outlined in the Rules and Regulations and By-Laws. For complaints arising outside of these parameters, the complaint should be passed onto the physician involved and discussion with the physician and the Chief of the Department or President the Medical Staff is strongly advised but not required. Such complaints arising within the hospital may be evaluated and taken into consideration during the process of re-credentialing.

Reviewed and Revised 8/2008  
Reviewed and Revised 10/2010  
Reviewed and Revised 4/2011  
Reviewed and Revised 4/2012