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NORTH OTTAWA COMMUNITY HOSPITAL

RULES AND REGULATIONS

OF THE MEDICAL STAFF

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ARTICLE 1 FUNCTIONS OF THE MEDICAL STAFF

SECTION 1.1 ADMISSION AND DISCHARGE OF PATIENTS

1. Only members of the Active or Associate Medical Staff categories may admit patients to North Ottawa Community Hospital.

2. Each admitted patient must be seen promptly by the admitting/attending physician or his designee, and he/she is responsible for ensuring that the appropriate histories, physicals, orders, special instructions, and an assessment of the patient's condition are completed. "Promptly" is defined as one (1) hour for ICU and eight (8) hours for all other admitted patients. OB admission guidelines, including neonatal guidelines, are covered in the OB/GYN departmental policies. Whenever these responsibilities are transferred to another physician, an order reflecting this must be entered on the order sheet, and the new physician must be notified by the transferring physician. All patients, at all times, must be the responsibility of an Active or Associate staff member.

3. Age-specific admissions are: sixteen (16) and younger are considered Pediatric patients; seventeen (17) and older are adult patients; patients with special needs who are sixteen (16) and older and are currently under a Pediatrician's care will be seen by a Pediatrician.

4. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as reasonably possible after admission.

5. Practitioners admitting emergency patients shall be prepared to justify to the Medical Executive Committee and to the Administration of the Hospital that said emergency was a bona fide emergency. The admitting note must clearly justify this patient being admitted on an emergency basis, and these findings must be recorded in the patient's chart as soon as possible after admission.

6. A patient to be admitted on an emergency basis who does not have a private physician with admitting privileges shall be assigned to the on-call physician from the appropriate department by the emergency physician based on the characteristics of the emergency illness. The Medical Staff member responsible for the patient will provide care for the acute episode for which the patient sought attention.

7. The admitting practitioner shall be held responsible for giving such information as s/he may know to assure the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.

8. Admissions to the Intensive Care Unit shall be within the stated admission and practice privileges of the admitting practitioner. Any controversy over the

validity of such admission shall be referred to the Medical Director of the Intensive Care Unit.

9. It is required by the Medical Executive Committee that all patients be seen at least daily by a physician or physician's assistant. It is recognized that adequate day-to-day care can be provided by the consulting physician, but this is not recognized as the appropriate way to fulfill the responsibility accepted as the role of the attending practitioner.

10. Patients shall be discharged only on the approval of the attending practitioner and consistent with Hospital policies. The attending practitioner is the admitting practitioner unless specifically noted by a transfer of service note or order on the patient's chart. In cases where more than one practitioner group is involved in the care of the patient, the physician who writes the discharge order and progress note is considered the attending or discharging physician at the time of discharge. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record. The patient shall be asked to sign a "Discharge Against Medical Advice" form.

SECTION 1.2 GENERAL CONDUCT OF CARE

1. Consent:

i. A general consent for payment and treatment on a form dictated by the Hospital, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The admitting staff should notify the attending practitioner whenever such consent has not been obtained.

ii. Informed consent must be obtained prior to an invasive procedure situation (see Hospital Informed Consent Policy).

iii. Additional consent forms for specific procedures shall be utilized when appropriate to document informed consent from the patient.

2. Orders:

i. All orders shall be in writing or in an approved electronic form. An order shall be considered to be in writing if dictated to a registered nurse, nurse practitioner, respiratory therapist, physician assistant, medical social worker, CRNA, or other authorized person functioning within his or her sphere of competence, and countersigned with date and time by the ordering or attending physician. Failure to do so shall be brought to the attention of the Medical Practice Committee for appropriate action. The order must be written clearly, legibly, and completely. Orders which are illegible or improperly written or incomplete will not be carried out until clarified. Faxed orders are acceptable if legible and dated/timed/signed by the ordering or attending physician. All telephone orders must be countersigned with date and time by the ordering practitioner or another practitioner who is

responsible for the care of the patient and who is authorized to write orders by hospital policy at the time of the next visit, but not to exceed 30 days following discharge. Verbal orders are acceptable only in emergency situations.

ii. Summary (blanket) orders to resume previous orders are prohibited.

iii. All previous orders, except for consultations, are canceled when the patient goes to surgery. Additional exceptions are listed in Hospital Policies regarding Physician Orders.

3. Autopsy:

i. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent signed in accordance with the law. Provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within sixty (60) days.

ii. Meaningful autopsies shall be those situations in which an autopsy may help explain unknown or unanticipated medical conditions or diagnoses, including those possibly related to environmental or occupational hazards. Also included are cases in which an autopsy may allay concerns of the family and/or public as well as the potential recipients of transplant organs.

iii. All obstetrics, neonatal, and pediatric deaths are to be considered as well as any other unexpected deaths that are unexplained even if waived by the medical examiner.

4. Consultations:

i. Any qualified practitioner with clinical privileges in the Hospital can be called for consultations. In certain situations, specified elsewhere, consultations will be performed by a specialist.

ii. Any attending practitioner who desires a referral or consultation must write an order. The attending practitioner will make it clear in the orders or in a progress note what problem the consultant is to address.

iii. 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, the nurse shall call this to the attention of his superior who in turn may refer the matter to the Director of this area or his designee. If warranted, the Director may bring the matter to the attention of the Vice President of Nursing Services and the Chief of the department wherein the practitioner has clinical privileges. Wherein circumstances justify such action, the Chief of the department may himself/herself request a consultation.

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

v. Consultation should be provided within twenty-four (24) hours of the request. Consultations should be considered to be advice to the attending physician unless otherwise specified.

5. Medications:

i. All drug orders shall include name of the medication, the date and time of the order, the dose, route, and frequency. They will include the indication for PRN's (the indication is not required if the indication is evident based on the type of medication ordered or the patient's diagnosis/disease process).

ii. All drugs and medications administered to patients shall be those listed in the latest edition of the NOCH Formulary or approved by the FDA for prescription use or over-the-counter sale.

6. Restraints:

i. Whenever a patient's condition requires the use of special treatment procedures, such as restraint, see Hospital Restraint policy.

SECTION 1.3 GENERAL RULES REGARDING SURGICAL CARE

1. Surgeons wishing to perform surgery will follow Hospital policies as well as procedures established by the Surgical Services Department and approved by the Surgical Services Committee.

2. For all surgeries and procedures requiring anesthesia services other than life threatening cases, an H&P is required before surgery as explained in the Bylaws. If not recorded, the operation must be postponed or canceled.

3. In a life-threatening emergency, the surgeon staff member should make an admission note regarding the patient's condition prior to induction of anesthesia and start of the operation. The H&P must be completed within twenty-four (24) hours of admission.

4. For procedures requiring anesthesia services, an appropriate H&P may be performed by a Michigan-licensed physician who is not a member of NOCH Medical Staff. The following elements prior to surgery must be recorded by the NOCH Medical Staff Surgeon: a review and update of H&P, pre-procedural diagnosis, impression, and plan pertinent to the scheduled procedure.

5. If the condition of a surgical outpatient warrants admission or placement in observation following a procedure, the patient must be admitted by a physician with admitting privileges at NOCH.

6. Dentist's Responsibilities:

i. A detailed dental history justifying surgical procedure and/or hospital admission.
ii. A detailed description of the examination of the oral cavity and preoperative diagnosis.
iii. A complete operative report describing the finding and technique. In cases of extraction of teeth, a dentist shall clearly state the number of teeth and fragments removed.
iv. Progress notes as are pertinent to the oral condition.
v. Summary statement.
vi. The discharge of the patient on written order of the dentist who is a member of the Medical Staff.

7. Podiatrist's Responsibilities:

i. The podiatrist should do a detailed podiatric history justifying the hospital admission or surgical procedure.
ii. A detailed description of the examination of the foot and ankle, if appropriate, and preoperative diagnosis.
iii. A complete operative report describing findings and techniques.
iv. Progress notes as are pertinent to the foot.
v. Clinical summary statement.
vi. A patient admitted as an inpatient to NOCH for podiatric care is required to receive a consultation by the Hospitalist Service/Attending Medical Staff.

8. Attending Medical Staff Physician's Responsibilities to Practitioners Who Do Not Have Full H&P Privileges:

i. Medical history pertinent to the patient's general health.
ii. Physical examination to determine the patient's condition prior to anesthesia and surgery.
iii. Supervision of the patient's general health status while hospitalized.

9. A signed, informed surgical and anesthesia consent dated within thirty (30) days of the procedure shall be obtained prior to the operative procedure, except in those situations where the patient's life or organ or limb is in immediate jeopardy and suitable signatures cannot be obtained due to the condition of the patient. (See NOCH Informed Consent Policy.) Other consents must be signed, as appropriate, such as for sterilization procedures. All current required consents are available electronically on-line.

10. A pre-anesthesia evaluation must be completed and documented by an Anesthesiologist or Certified Registered Nurse Anesthetist within forty eight (48) hours prior to surgery or a procedure requiring anesthesia services.

11. A post-anesthesia evaluation must be completed no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services. Patients are discharged from the recovery area and hospital by a qualified licensed independent practitioner.

12. In certain surgical procedures, it is necessary that a qualified assistant be present and scrubbed. "Qualified assistant" refers to another attending surgeon or a member of the Allied Health Professional Staff who is credentialed for surgery.

13. A brief operative note shall be written, dated, timed, signed, and placed in the medical record immediately upon completion of all procedures, including operating room, laser, outpatient surgical areas, and interventional radiology and pathology procedures. The brief operative note must include identification or description of:

i. The surgeon and assistants
ii. Pre-op and post-op diagnosis
iii. Procedures performed
iv. Specimens removed
v. Blood administered
vi. Any complications
vii. Type of anesthesia administered
viii. Grafts or implants

14. A full operative report shall be documented by the surgeon immediately following surgery for all patients. The documented operative report must record at least:

i. Name and hospital identification number of the patient
ii. Date and times of the surgery
iii. Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision)
iv. Pre-operative and post-operative diagnosis
v. Name of the specific surgical procedure(s) performed
vi. Type of anesthesia administered
vii. Complications
viii. A description of techniques, findings, and tissues removed or altered
ix. Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues),
x. Prosthetic devices, grafts, tissues, transplants, or devices implanted
xi. Specimens removed,
xii. Blood loss,
xiii. Signature of the surgeon with date and time.

15. All tissue and foreign bodies removed during a surgical procedure should be submitted to the Pathology Department for documentation and analysis, except those listed on the Protocol for Surgical Specimens Not Requiring Pathological Evaluation as currently issued by the Pathology Department. The pathologist's authenticated report shall be made a part of the patient's medical records.

SECTION 1.4 MEDICAL RECORDS

1. General Requirements:

The responsible practitioner shall be required to prepare a complete and legible medical record for each patient.

i. The record shall include identification data (see H&P Report Requirements), evidence of informed consent, special reports such as consultations, clinical laboratory and radiology services, and other reports, provisional diagnoses, medical or surgical treatment, operative report, pathological findings, diagnostic and therapeutic orders, progress notes, final diagnoses, condition on discharge, discharge note or discharge clinical summary, and autopsy report when performed.

ii. An admission note must be written in the progress notes when the H&P is not available and in the medical record. This admit note must include pertinent H&P findings and the initial impressions or indication for surgery or admission. Admission notes must be written within 1 hour for ICU patients and within four (4) hours for all other hospitalized patients.

2. Specific Requirements

i. **History and Physical**: An H&P shall be performed by a health care provider acting within the provisions of his license. The admitting Medical Staff member shall sign and/or countersign the H&P examination and preoperative note when they have been recorded by a resident and/or mid-level provider (Physician Assistant/Nurse Practitioner). The H&P report shall include:

- Chief Complaint
- Present Illness
- Allergies
- Past Medical/Surgical History
- Medications
- Family Medical History
- Social History
- Review of Systems
- Physical Examinations
- Initial Impression
- Plan

The H&P report requirements for conscious/moderate sedation shall include the information relevant to the procedure and may be defined in Hospital policies.

ii. **History and Physical Update**: The following must be done and documented if the H&P needs to be updated as required by the H&P requirements of the Bylaws. An update must document any changes in the patient's condition since the most recent H&P.

iii. The original H&P must be attached to the Update Note.

iv. The Update exam must be performed by a member of the Hospital's medical staff or their delegate. Delegated updates must be authenticated, dated, and timed by the supervising medical staff member.

3. Progress Notes: Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability of the patient whenever possible; each of the patient's clinical problems should be clearly identified in the progress notes correlated with specific orders, as well as results of tests and treatment; Progress Notes shall be entered at least daily for inpatients and any patient staying overnight.

4. Symbols and Abbreviations: Clinical symbols and abbreviations may be used only when they have been approved by the Medical Staff under the National Patient Safety Goals. Use of a standard, nationally recognized publication is deemed appropriate for reference to approved abbreviations as defined in Hospital Polic**y**. Symbols and abbreviations may not be used on consent forms. Certain abbreviations (list available) are unacceptable as defined in hospital policy.

5. Operative Documentation: The brief operative note and full operative note shall be part of the patient's medical record following all procedures for outpatients and inpatients. The brief operative note shall be written, dated, timed and signed and placed in Medical Records immediately upon completion of all procedures.

6. Consultation Reports: Consultation reports shall show evidence of review of the patient's record by the consultant, pertinent examination of the patient, and the consultant's impression and recommendation. This report shall be legible, signed, dated, timed and part of the patient's permanent medical record. Except in emergency situations that are verified in the record, consultation reports will be recorded, dated, timed and signed.

7. Clinical Entries: All entries in the patient's medical record shall be accurately dated, timed, and authenticated by written signature, identifiable initials, or computer key. The use of rubber stamp signatures is not acceptable.

8. Final Diagnoses: The final diagnoses should be recorded, dated, timed and signed at the time of discharge. The final progress note should include the condition of the patient at discharge. When preprinted discharge instructions are given to the patient or his legally qualified representative, the original shall be filed within the medical record.

9. **Discharge Summary:** A discharge summary shall be written or documented for all patient stays greater than forty-eight (48) hours and on all patients who die within the first forty-eight (48) hours of admission. For those patients who do not meet the criteria, a discharge summary is not required. If no discharge summary is written, the chart must have a handwritten discharge note briefly describing the diagnoses, the course of management, condition of discharge, outcome of hospitalization, the case disposition, and any provisions for follow-up care.

Discharge summaries should include the following information:

- Identification data – patient name, attending physician, surgeon, consultant, admission/discharge dates, indication
- Chief complaint/reason for hospitalization
- Provisional diagnosis
- Treatment given or operation/procedures performed
- Hospital course (include pertinent laboratory data only)
- Complications, if any
- Discharge instruction (include diet, activity, medications, provisions for follow-up)
- Condition on discharge
- Discharge diagnoses
- Case disposition

In all instances, the content of the medical record should be sufficient to justify the diagnoses, treatment, and end result. All summaries shall have date and time of completion and be authenticated by the attending practitioner.

SECTION 1.5 COMPLETION OF A MEDICAL RECORD

Significant clinical events, including the H&P examination, shall be documented as soon as reasonably possible after their occurrence. The records of discharged patients shall be completed within a period of time that will in no event exceed ten (10) days following discharge. A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including any required clinical summary or final progress note, and when all final diagnoses and any complications are recorded, without use of symbols or unapproved abbreviations. Practitioners are responsible for the completion of all documentation and notes. A longer period will be allowed for those physicians who have notified Medical Records of a vacation or illness which is one (1) week in length or longer. Completeness implies the transcription of any documented record is signed with date and time and inserted into the medical records.

Electronically signed reports must be completed (signed) within twenty-four (24) hours of transcription or availability for uncomplicated pathology and radiology reports.

SECTION 1.6 COMPLETION OF MEDICAL RECORDS FOLLOWING DISCHARGE

All patient medical records must be completed within ten (10) days after the date of discharge of the patient. A practitioner who has incomplete records that are incomplete

fourteen (14) days from discharge will be notified by email, fax or letter. After twenty-one (21) days the practitioner with an incomplete record will be notified that he will lose his admitting, consulting, and scheduled surgery, ED on-call, surgery assisting, and provision of professional services with the hospital privileges for elective admissions after thirty (30) days of a delinquent record. Such loss of privileges shall be automatically imposed after notice of delinquency is communicated to the Practitioner. Such loss of privileges will be considered a voluntary relinquishment of privileges. Exceptions will be situations in which the physician is out of town or on medical leave. If out of town, it is recommended that the physician notify the Health Information Management Department of his planned absence.

After voluntary relinquishment of privileges pursuant to this paragraph, the practitioner may continue to care for current patients in the hospital under his care. The Practitioner may not admit patients directly or under another practitioner's name, except that the practitioner may admit patients or perform procedures in life threatening situations.

A physician may be required to appear before the Medical Practice Committee to explain his inability to complete his medical records requirements if his delinquent records exceed six (6) weeks or for recurring delinquencies. The Hospital may report to the National Practitioner Databank Voluntary Relinquishment of Privileges beyond thirty (30) days in accordance with regulations.

ARTICLE 2 AMENDMENT

The Rules and Regulations will be formulated, amended, and modified as set forth in the NOCH Medical Staff Bylaws.