

Rules & Regulations

of the

St. Mary Mercy Hospital

Medical Staff

Updated: June 2015

RULES AND REGULATIONS

To implement more specifically the general principles found within the Medical Staff Bylaws, the Medical Staff may adopt Rules and Regulations. These will relate to Medical Staff organizational activities as well as state the standards of practice that are required of each practitioner in the Hospital. Proposed amendments to the Rules and Regulations shall be reviewed by the Bylaws Committee, which shall report thereon to the Medical Executive Committee. If the Medical Executive Committee approves the proposed amendments to the Rules and Regulations, the amendments shall be effective when adopted by the General Staff and Board of Trustees.

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GENERAL RULES AND REGULATIONS

1. Definitions

- 1.1 All capitalized terms that are not defined in these Rules shall have the definition stated in the Medical Staff Bylaws.
- 1.2 "Attending Practitioner" means the Medical Staff member who initiates the admission of a patient and who has primary responsibility for the patient's care during the hospitalization.
- 1.3 "Consulting Practitioner" means a qualified member of the Medical Staff from whom an Attending Practitioner requests consultation with respect to an inpatient. Consulting Practitioners include members of the Departments of Radiology, Pathology and Anesthesiology.
- 1.4 "Covering Practitioner" means a member of the Medical Staff who is designated by either the Attending Practitioner or Consulting Practitioner to provide professional services in their absence. All rights and responsibilities of the Attending or Consulting Practitioner are transferred to the Covering Practitioner during the duration of this designation.
- 1.5 The terms defined in 1.2 through 1.4 may also include practitioners who have been granted temporary privileges at the Hospital.
- 1.6 "Resident Physician" means a physician or podiatrist in training, with a Michigan medical educational limited license, being sponsored by the hospital. All patient care activities are under the supervision of the Attending Practitioner or their designee listed in 1.2 through 1.4.
- 1.7 "Palliative Care" is a medical specialty focused on prevention and relief of pain, stress and other debilitating symptoms of serious complex illness and seeks to provide the best possible quality of life for patients and their families. Non-hospice palliative care is not dependent on prognosis and is offered in conjunction with curative and all other appropriate forms of medical treatment.
- 1.8 "Comfort Care" is hospice-like care, which includes general nursing care and pain and symptom management. All care deemed not to be comfort care will be discontinued. In the event of cardiac or respiratory arrest, the patient will not be resuscitated. Comfort Care may be provided by any physician.
- 1.9 "Hospice Care" is a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six month or less. Hospice involves an interdisciplinary approach to provide medical care, pain management, emotional and spiritual support. The emphasis is on comfort, not cure.
- 1.10 "Non-Beneficial Care" is any clinical circumstance in which the physician and his/her consultants, consistent with the available medical knowledge and community standards of care, conclude that further treatment (except comfort care) cannot, with a reasonable possibility, cure, ameliorate, improve or restore a quality of life that would result in reasonable clinical benefit to the patient.

2. Patient Confidentiality

- 2.1 Confidentiality and privacy of patient's medical and personal information is sacrosanct.
- 2.2 Violation of patient confidentiality may be grounds for immediate suspension of privileges and initiation of Medical Staff corrective action.
- 2.3 A practitioner-patient relationship must be established before a practitioner is entitled to examine the medical record or patient.
- 2.4 Medical record examination may be conducted by Hospital staff when performing approved quality improvement or risk management activities without establishing a treatment relationship; however, privacy and confidentiality must be maintained.
- 2.5 The Medical Staff executed a directive to organize itself as an "Organized Health Care Arrangement" (OHCA) with the Hospital in accordance with the Health Insurance Portability and Accountability Act. As such, the Medical Staff agrees to abide by the terms of the Hospital's Notice of Privacy Practices with respect to protected health information created or received as part of the delivery of health care services at the Hospital.

3. Care Requirements During Hospitalization

- 3.1 The right to admit a patient is exclusive to Medical Staff members. A member of the Medical Staff with admitting privileges may admit a patient to the Hospital. Resident Physicians act under the supervision of the Medical Staff member to facilitate patient admissions on the teaching service.
- 3.2 The Attending Practitioner shall contact the Admitting Office to request admission of a patient. Sufficient information, including a provisional diagnosis, shall be provided by the Attending Practitioner to satisfy Hospital admission policies.
- 3.3 Requests for emergency admissions will receive priority over requests for elective admissions.
- 3.4 All persons admitted to the Hospital shall be under the continuing daily care of a designated Attending Practitioner. The designated Attending Practitioner must see the patient at least once every day while the patient is in the Hospital. (A telephone call/order by the Attending Practitioner does not satisfy the requirement for daily visits.)
 1. All persons admitted to the Hospital teaching service shall be under the continuing daily care of a designated Attending Practitioner and the assigned Resident Physician and/or resident team. The designated Attending Practitioner must see the patient at least once every day while the patient is in the Hospital.

(A telephone call/order by the Attending Practitioner does not satisfy the requirement for daily visits.) The designated Attending Practitioner will maintain daily contact regarding patient care with the assigned Resident Practitioner team.

- 3.5 Inpatients shall be seen by a Practitioner within the following time frames (Note, these are maximum limits, and often a patient should be seen earlier):
 - 3.5.1 Patients in general hospital beds and Cardiac Monitored Units shall be seen by the Attending Practitioner on a timely basis, no later than the morning following admission. The PRISM (Placement Resource Indicator for Systems Management) tool will be used to identify patients for whom early evaluation and intervention is indicated. Adherence to applicable clinical pathways and guidelines for time to initial provider assessment as outlined below is necessary to satisfy the requirements for a timely visit.
 - 3.5.1.1 To provide the safest care, assessment of PRISM 1 patients within two hours of admission is essential. If you admit a PRISM 1 patient prior to 6pm and cannot see them within two hours, please page the house physician to make an initial visit and assessment on your behalf.
 - 3.5.1.2 When you admit a (non-GME) PRISM 1 patient after 6pm, the PA will automatically see them within 2 hours and you are expected to see them before 9am.
 - 3.5.1.3 When you admit a GME PRISM 1 patient after 6pm, the Resident Physician will automatically see them within 2 hours and you are expected to see them before 9am.
 - 3.5.2 Patients in Intensive Care Units shall be seen on a timely basis by a physician (the Attending Practitioner, a Consulting Practitioner or a certified intensivist), no later than the morning following admission.
 - 3.5.3 The time limit stated in 3.5.1 does not apply if a patient is seen by the Attending Practitioner outside the Hospital on the day of admission and is sent to the Hospital by that Practitioner, along with admission note and orders.
 - 3.5.4 All patients on the Resident Practitioner teaching service will be evaluated by the Resident Physician and/or resident team and reviewed with the Attending Practitioner of record.
- 3.6 An Emergency Department patient who requires admission and who is not already under the care of an appropriate Medical Staff member shall be assigned to a Medical Staff member as per Hospital policy and Rule 14.

- 3.7 A Medical Staff member may arrange to see his or her private patient in the Emergency Department. If the Emergency Department physician determines the patient's condition requires physician services prior to the Staff member's arrival, the Emergency Department physician will provide for appropriate services, but may not admit the patient to the Hospital.
- 3.8 Privileges to admit to the special care units are limited to members of the Departments of Surgery and Maternal-Child and the Division of Internal Medicine.
- 3.9 There shall be no direct admissions to the special care units unless an admitting note and orders of the Attending Practitioner accompany the patient.
- 3.10 Orders for tests and treatments shall be by Computerized Order Entry (CPOE) (except as allowed in Rule 3.12 below).
 - 3.10.1 Resident Physicians may complete orders for tests and treatments under the supervision of the Attending Practitioner. The Resident Physicians' orders do not require co-signatures and will be processed identically to the Attending Practitioners' orders.
 - 3.10.2 Cancer chemotherapy orders will not be done by Resident Physicians.
- 3.11 Electronic signature, certified by Hospital electronic record policy, is permissible.
- 3.12 Verbal orders shall in all instances comply with the following:
 - 3.12.1 The order shall be signed/authenticated prior to discharge by the practitioner who issued the order, except those orders that have special obligations, e.g. restraint orders and drug orders that must be signed within 24 hours.
 - 3.12.2 The name and Hospital identifying number of the practitioner from whom the order was taken will be noted, followed by the name and title of the individual transcribing the order and the date and time the order was accepted (e.g. "phone order-J.L. Smith, M.D. (#1234)-Jane Brown, Speech Therapist-11/21/01- 15:45"). The practitioner who issues a verbal order and the individual who records it shall comply with the Hospital's verbal order "read back" procedures.
 - 3.12.2.1 Resident Physicians will be required to personally place their orders directly into the Electronic Medical Record, except under emergency situations.
 - 3.12.3 The following individuals may record verbal and telephone orders which are related to their respective disciplines and areas of expertise:

- 3.12.3.1 Other Physicians
 - 3.12.3.2 Registered nurse.
 - 3.12.3.3 Pharmacist.
 - 3.12.3.4 Physical therapist.
 - 3.12.3.5 Respiratory therapist.
 - 3.12.3.6 Respiratory therapy technician.
 - 3.12.3.7 Occupational therapist.
 - 3.12.3.8 Speech therapist (SP/audiologists).
 - 3.12.3.9 Dietician.
 - 3.12.3.10 Diagnostic imaging radiology technologist.
 - 3.12.3.11 Laboratory technologist.
 - 3.12.3.12 Others as outlined in Hospital policy.
- 3.12.4 Cancer chemotherapy may not be administered based on a verbal order.
- 3.13 The indication for diagnostic tests for cardiology procedures, nuclear medicine imaging, and radiology diagnostic tests, shall be included in the practitioner's order.
- 3.14 Certain laboratory tests are designated by Hospital policy to require follow-up testing if the results of the initial test are within specified ranges ("reflex testing"). Follow-up testing shall be performed in accordance with that policy.
- 3.15 If a patient is transferred from one level of care to another (e.g. between a nursing unit and surgery, or between a general nursing unit and a special care unit), all orders will be reviewed and reconciled at the time of transfer. If a patient is moved between sites that are of the same level of care (e.g. from one general nursing unit to another), the transfer will not cause orders to terminate.
- 3.15.1 All patients on the Resident Physicians teaching service will have new transfer orders completed by the Resident Physician, under the supervision of the Attending Practitioner.
- 3.16 A designated Attending Practitioner is responsible for the care and treatment of each patient in the Hospital. Whenever this responsibility is transferred to another Medical Staff member, (other than routine temporary evening and weekend coverage arrangements), an order documenting the transfer of responsibility shall be entered in the Cerner Powerchart System.

4. Pre-Admission Testing and Pre-Surgical Requirements

- 4.1 The patient shall be informed that pre-operative laboratory testing is to be done at the Hospital or at a facility defined in Hospital policy as an acceptable source of medical information.
- 4.2 If the Attending Practitioner orders pre-admission testing at the Hospital, he or she shall do so on Hospital-approved forms.
- 4.3 A copy of the results of tests performed outside the Hospital must be available on the patient chart before a procedure begins. Any report from an outside radiologist must accompany the patient.
- 4.4 A formal report signed by an outside radiologist may be acceptable. If an interpretation by a Hospital radiologist is requested, films or digital format must be available for interpretation.
- 4.5 Any testing related to blood banking, e.g. Rh and type and screen, must be performed in the Hospital's laboratory.
- 4.6 A copy of an outside EKG may be submitted provided it clearly identifies the patient's name and the date of the test and includes a signed physician interpretation.
- 4.7 After preoperative testing, a patient who will receive anesthesia shall be directed to an Anesthesiologist who shall interview the patient, review preoperative testing, and may request further studies.
- 4.8 For surgical patients, the results of a complete surgical history and physical examination, including findings justifying the surgical intervention, must be available at the time of surgery. A history and physical performed within 30 days prior to the surgical procedure shall satisfy the requirements of this Section if the responsible practitioner reassesses the patient's medical status on the day of the procedure, confirms the necessity of the surgery and enters an update note (defined in 4.8.1) addressing the patient's current status and any changes in status. The history and physical and the update note will be available in the patient's medical record prior to surgery.
 - 4.8.1 Update Note: Should the patient report no changes to the history and clinical condition since the history and physical was performed, the practitioner could simply enter, "Patient reports no changes" and sign and date the entry as the update.
- 4.9 Valid consent must be obtained and documented in the medical record prior to surgery and administration of anesthesia, in accordance with the Hospital's Informed Consent Policy.

5. Treatment of Unassigned Patients Discharged from the Emergency Department

The Emergency Department will offer the services of an appropriately qualified Medical Staff member to every patient discharged from the Emergency Department or Fast Track Service who does not have an existing relationship with such a practitioner. Medical Staff members will be offered in sequence determined by an on-call list furnished to the Emergency Department by the department chairs, division chiefs and section heads.

6. Autopsy

- 6.1 All autopsies shall be performed by a Hospital pathologist in accordance with Pathology Department policy, unless the Medical Examiner elects to perform the autopsy.
- 6.2 Requests for an autopsy of an individual who did not expire at the Hospital are reviewed by a pathologist and performed at the pathologist's discretion. There may be a charge for this service. In all cases, the decision to perform or deny autopsy rests with the responsible pathologist. (Please see Department Policy.)
- 6.3 An autopsy shall be performed only with the written consent of the legal custodian of the body and party responsible for its disposal. (Please see Department Policy.)
- 6.4 The Attending Practitioner and Resident team providing care shall be notified by telephone when the autopsy is to be performed.
- 6.5 Criteria for requesting an autopsy (unless the case is a Medical Examiner's case).
 - 6.5.1 Unanticipated death.
 - 6.5.2 Death occurring while the patient was treated under an experimental regimen.
 - 6.5.3 Death occurring intra-operative or intra-procedure
 - 6.5.4 Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
 - 6.5.5 Death incident to pregnancy or within seven days following delivery.
 - 6.5.6 Death where the cause is sufficiently obscure to delay completion of the death certificate.
 - 6.5.7 All deaths on the behavioral medicine service.

7. Medical Examiner Cases Defined

The following cases shall be reported to the Medical Examiner's Office in accordance with Pathology Department Policy:

- 7.1 Deaths by violence, or with injuries acquired through violence (shooting, stabbing, hanging, beating, poisoning, etc.)
- 7.2 Deaths by accident, or with injuries acquired in an accident (industrial, auto, burns, falls, drowning, etc.)
- 7.3 Sudden and unexplained deaths of persons in apparent good health.
- 7.4 Deaths occurring without medical attendance by a physician within 48 hours, unless a reasonable natural cause of death can be certified.
- 7.5 Prisoners (dying while in custody or dying from injuries sustained while in custody).
- 7.6 Deaths under suspicious, unusual or unexplained circumstances. (All individuals who are admitted to a hospital unconscious, and remain unconscious until death are considered in this category.)
- 7.7 Deaths resulting from or associated with any therapeutic procedure. Deaths during any anesthesia shall be reported to the Medical Examiner. The body may not be removed until after notice is given to and removal of the body authorized by the Medical Examiner.

8. Communications

- 8.1 Medical Staff members and Resident Physicians may be paged via the Hospital's designated paging system and/or policy.
- 8.2 A Medical Staff member's residence phone number shall be released only to authorized personnel.

9. Consent Forms

Informed consent shall be obtained and documented in the patient's medical record in accordance with the Hospital's Informed Consent Policy.

10. Consultation

- 10.1 If the patient is a poor risk, the diagnosis is obscure, or there is doubt as to the best therapeutic measures to be utilized, consultation is advised.
- 10.2 Urgent and emergency consults should be ordered via direct communication between the Attending Practitioner and the Consulting Practitioner. The Attending Practitioner will indicate the purpose of the consult and the required time frame for completion of the consult. The Consulting Practitioner should personally report the results of the consult to the Attending Practitioner in urgent or emergent cases.

10.2.1 Resident Physicians may communicate with Consulting Practitioners under the supervision of the Attending Practitioner.

10.3 The unit staff may contact the Consulting Practitioner when non-urgent consults are ordered by the Attending Practitioner. The Attending Practitioner will indicate the purpose of the consult in his/her documentation. The Consulting Practitioner will complete non-urgent consults within twenty-four (24) hours of receiving the request, unless the Attending Practitioner specifically makes an exception.

10.3.1 All orders for consultation placed by the Resident Physician will be called to the Consulting Practitioner by the Resident.

11. Coverage

11.1 When a Medical Staff member will be unavailable to care for patients, he/she will arrange for the services of a Covering Practitioner who is of the same or related specialty.

11.2 If, in an emergency, the Attending Practitioner of an inpatient cannot be contacted, the Chair of the Department or the Vice President of Medical Affairs are authorized to call another Medical Staff member to care for the patient pending the Attending Practitioner's arrival.

11.2.1 Resident Teaching Service patients are covered by a resident team member 24/7/365. All required duty hours are monitored. A monthly call schedule is published by the Department of Medical Education. If during an emergency, the teaching attending physician is unavailable, the program director may assign another teaching attending physician.

12. Death Certificates

12.1 For deaths in a hospital, Section 2843 of Act 368 of 1978 requires that the death certificate be completed and signed by the Attending Physician no later than 48 hours after death. To ensure compliance, SMMH requires that the attending physician fill out and sign the medical certificate of death within 24 hours after death. In the absence of the attending physician and in the absence of a physician representing the attending, medical certification must be provided as follows:

- For deaths pronounced within a hospital, by the Chief of Staff, Chief Medical Officer or Pathologist after reviewing pertinent records.
- For deaths pronounced in the Emergency Department, by the Patient's Personal Physician or by the County Medical Examiner.
- For deaths pronounced outside the hospital, by the County Medical Examiner.

12.2 Definition:

- Patient's Personal Physician: The Physician identified by the Patient or Family as the physician providing the bulk of patient care.

12.3 Hospital Deaths:

- 12.3.1 The death certificate is the responsibility of the attending staff member and/or designee at the time of death and must be completed by designating the cause of death and signing.
- 12.3.2 Before certifying a cause of death, the certifier should determine that the death is not reportable to, or will not be certified by, the medical examiner or coroner and that there is not a more suitable certifier available to verify the cause of death (see section 12.5: Situations requiring a call to the Medical Examiner for Investigation).
- 12.3.3 If the attending physician is unavailable (vacation, off), the physician taking clinical call for that physician or physician practice is responsible for completing and signing the death certificate.
- 12.3.4 If the attending physician fails to complete and sign the death certificate correctly within 24 hours after death, the Department Chair will be notified and is responsible for further follow-up.
- 12.3.5 If there is a dispute as to whom the attending physician is or which department is responsible, the Department Chairs of each involved department will be notified to determine responsibility and assure completion of the death certificate.
- 12.3.6 If the death certificate has not been correctly completed within 48 hours after death, the Chief of Staff and/or Chief Medical Officer will be contacted to assure completion.

12.4 Emergency Department Deaths

- 12.4.1 The completion of the death certificate for patients that expire in the Emergency Department is the responsibility of the expired patient's personal physician. The Emergency Department will notify the expired patient's personal physician at the time of death and document in the medical record the name of the patient's personal physician who must complete the death certificate. The patient's personal physician must complete the death certificate by designating the cause of death and signing.

- 12.4.2 Before certifying a cause of death, the certifier should determine that the death is not reportable to, or will not be certified by, the County Medical Examiner or coroner and that there is not a more suitable certifier available to verify the cause of death (see section 12.5: Situations requiring a call to the Medical Examiner for Investigation).
- 12.4.3 If the patient's personal physician is unavailable (vacation, off) or the patient's personal physician is not identified, then the County Medical Examiner is responsible for completing and signing the death certificate.
- 12.4.4 If the primary care physician, who agreed to complete the death certificate, fails to complete and sign the death certificate correctly within 24 hours after death, the Medical Examiner will be notified and is responsible for further follow-up.
- 12.4.5 If there is a dispute as to whom the patient's personal physician is, the County Medical Examiner will be notified to determine responsibility and assure completion of the death certificate.
- 12.4.6 If the death certificate has not been correctly completed within 48 hours after death, the County Medical Examiner will be contacted to assure completion.

12.5 Situations requiring a call to the Medical Examiner for Investigation

- 12.5.1 All violent deaths (due to injury), including suicides and suspected suicides, motor vehicle, motorcycle, and pedestrian fatalities, industrial accidents, domestic accidents, accidents occurring in public places, and any death in which injury is felt to have been a contributory factor to the death.
- 12.5.2 Any death caused by or contributed to by drug and/or chemical overdose or poisoning.
- 12.5.3 Any sudden death of an individual, baby, child, or adult, in apparently good health (unexplained, unexpected, and/or sudden death).
- 12.5.4 All deaths of hospitalized prisoners, regardless of cause and/or manner of death.
- 12.5.5 All deaths occurring during diagnostic or therapeutic procedures, including intraoperative deaths or deaths under general or local anesthesia, as well as any deaths in which a diagnostic or therapeutic procedure is believed to have contributed to the death, even if the death occurs post-operatively or post-procedurally (i.e., death occurring from complications of such procedures).

12.5.6 Any deaths occurring at the workplace, including deaths due to injury, toxicity, and/or sudden unexpected deaths.

12.5.7 Any in-hospital deaths occurring under suspicious or unusual circumstances; specifically, this applies to deaths in which the manner of death is in question (suicide vs. accident, homicide vs. accident, etc.).

12.5.8 Any deaths occurring on a psychiatric unit.

12.5.9 Any deaths in which neglect is a possible causal or contributory factor.

13. Discharge

13.1 Patients shall be discharged only on order of the Attending Practitioner. The discharge order shall be entered on the day of discharge.

13.2 Discharge time is before 11:00 a.m.

13.3 Discharge from the outpatient area following surgery shall be the responsibility of the practitioner who performed the outpatient operative procedure or an anesthesiologist.

13.4 Resident Physicians may place discharge orders under supervision of the Attending Practitioner. All patients on the Resident Teaching Service will have a discharge summary completed by the resident team.

14. Emergency Department Call

14.1 Medical Staff members are required to accept emergency call in a rotation schedule if requested by the Department Chair. An exception may be made by the Department Chair for extenuating circumstances.

14.2 An Emergency Department patient who does not have a treatment relationship with a member of the Medical Staff in the applicable specialty and who requires inpatient admission at the Hospital or requires services in the Emergency Department other than those provided by the Emergency Department physician, shall be assigned to the Medical Staff member listed on the call schedule of the respective department or specialty, based upon the time the patient requires consultation.

14.3 If the practitioner assigned to the emergency call schedule fails to or cannot respond in a timely manner, the Chair of the appropriate department is notified. The Chair shall arrange coverage by either referring the problem to the appropriate division chief or section head for prompt resolution, assigning another member of the department to treat the patient, or treating the patient himself.

- 14.4 An on-call practitioner's failure, without just cause, to respond in a timely manner to a request from the Emergency Department shall subject the practitioner to sanctions.
- 14.5 The Emergency Department physician will determine what type of services the patient requires and which department/division/section on-call list to consult. Patients presenting with abdominal pain or active GI bleeding will be first presented to the general surgeon on call. Patients with multi-system trauma will be admitted by the general surgeon on call.

15. Professional Liability Insurance

- 15.1 Each Medical Staff member shall maintain professional liability insurance in an amount specified by the Board of Trustees.
- 15.2 Subject to the approval of the Board of Trustees, the insurance requirement may be waived.

16. Library

- 16.1 The library shall provide a lending service and an inter-library loan service to Medical Staff members, nurses, technologists, Resident Physicians, and students.
- 16.2 The Hospital library shall be open for use Monday through Friday from 8:00 a.m. to 4:00 p.m. On request, it shall be opened when needed. Resident Physicians will have 24/7/365 access to the library.
- 16.3 Designated reference texts shall not be taken out of the library.
- 16.4 Books shall be signed out for seven (7) days, and may be renewed.
- 16.5 Periodicals and journals may be signed out overnight.
- 16.6 Audio-visual aids may be signed out by pre-arrangement.
- 16.7 All periodicals and journals that are bound shall be kept for such periods as determined by the librarian.

17. Medical Record

- 17.1 The medical record is confidential. The patient, the patient's legally designated representatives, and those practitioners who have a treatment relationship with the patient may have access to the record in accordance with Hospital policy. The record is also available to Hospital and Medical Administration for quality improvement purposes, with attention to maintaining the confidentiality and privacy of patient materials.

- 17.1.1 A copy of the Hospital medical record, or portions thereof, shall be sent to any practitioner and medical facility responsible for subsequent medical care of the patient.
- 17.2 The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among health care providers.
- 17.3 The content of the medical record shall be sufficiently detailed and organized to enable practitioners to provide continuing care to the patient, determine what the patient's condition was at a specific time, and to review the procedures performed and the patient's response to treatment. All records accompanying the patient to Hospital shall be part of the permanent medical record.
- 17.4 The Medical Records Department shall, in cooperation with the Medical Staff, declare the source of truth for each component of the medical record. In this declaration, permanent, legal, and reproducible files may be variously stored as paper or electronic media. It remains the obligation of the Medical Records Department to be able to produce the source of truth. This provision allows for electronic signature, co-signature, and authentication of orders, results and electronic documents.
- 17.5 The Attending Practitioner shall be responsible for completion of the medical record, which shall include:
 - 17.5.1 Identification data.
 - 17.5.2 Admitting history and physical examination.
 - 17.5.2.1 Complete, reflecting all pertinent information related to:
 - (a) Chief complaint, present illness.
 - (b) Past medical history including current medications and allergies.
 - (c) Past social and family history.
 - (d) Review of systems.
 - (e) Comprehensive physical examination.
 - (f) Provisional diagnosis.
 - (g) Plan of action.
 - 17.5.2.2 **(A)** All Inpatients shall have an appropriate history and physical examination performed and recorded by a

physician (except as otherwise provided in 17.5.2.7 and 17.5.2.8 below) within 24 hours of admission. In the absence of a recorded history and physical by the Attending Practitioner, an appropriate consultation that meets both documentation and timeliness requirements, will satisfy external regulatory requirements for a history and physical within 24 hours, however, the attending practitioner is still required to perform a history and physical.

(i) Resident Physicians will complete an appropriate history and physical on all patients admitted to the Resident Teaching Service. The Attending Practitioner will co-sign all resident documentation including the history and physical.

(B) All Outpatients (outpatient procedures & observation stays) shall have an appropriate history and physical examination performed and recorded by a physician (except as otherwise provided in 17.5.2.7 and 17.5.2.8 below) within 30 days of the procedure and a history and physical update must be performed within 24 hours of the procedure. **The update must be recorded prior to the performance of the procedure.** In the absence of a recorded history and physical by the Attending Practitioner, an appropriate consultation that meets both documentation and timeliness requirements will satisfy external regulatory requirements for a history and physical within 24 hours, however, the Attending Practitioner is still required to perform a history and physical.

Outpatient history and physical examination shall include:

- (a) chief complaint, present illness.
- (b) past medical history including current medications and allergies.
- (c) pertinent social and family history
- (d) review of systems relevant to procedure.
- (e) focused physical examination relevant to procedure.
- (f) impression.
- (g) plan of action.

17.5.2.3 A history and physical performed within 30 days prior to admission shall satisfy the requirements of this Section if the responsible practitioner reassesses the patient's medical status (including performing a physical examination) within 24 hours after admission, confirms the necessity of the admission, and writes an update note (defined in 4.8.1) addressing the patient's current status and any changes in status. If a patient is readmitted within 30 days of discharge for the same or a related problem, an interval history and physical documenting any changes in the patient's condition may be used in lieu of a comprehensive new history and physical.

The history and physical and the update note must be present in the patient's medical record within 24 hours after admission.

17.5.2.4 In the case of outpatient procedures, the history and physical examination shall be recorded before the surgery (as per 4.8).

17.5.2.5 Procedures requiring history and physical examination:

1. All procedures performed in the OR
2. All endoscopy procedures.
3. Interventional radiology procedures when conscious sedation is used.
4. Cardiac cath procedures.
5. Other procedures requiring conscious sedation. (All procedures performed under local anesthetic will not require history and physical).

17.5.2.6 In the case of short stay and observation cases (such as, repeat admissions for blood transfusion, chemotherapy, bladder installations, and intravenous antibiotic therapy) appropriate interval documentation shall be recorded in the Hospital record regarding the health status of the patient and material changes since the patient's last Hospital episode.

All Resident Teaching Service short stay and observation cases will have documentation provided by the Resident Physician and co-signed by the Attending Practitioner.

17.5.2.7 Qualified oral-maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examination on those patients, if they have

such privileges, and may assess the medical risks of the proposed surgical and or other invasive procedures(s).

17.5.2.8 Practitioners who are not members of the Medical Staff and have been delegated authority to care for the patients of their supervising physicians, and who have been granted privileges to do so through the Allied Health Credentialing process, may enter orders, complete reports such as History & Physician or Discharge Summary without the supervising physician's co-signature.

17.5.2.9 Nurse Practitioners who are not members of the Medical Staff and who are granted privileges to perform the medical history and physician examination, daily rounds, enter progress notes, orders and discharge summaries, shall document same, and their findings, conclusions and assessment of risk shall be confirmed and countersigned by a qualified physician member of the Medical Staff before major diagnostic or therapeutic intervention or within twenty-four (24) hours, whichever occurs first.

17.5.3 Diagnostic and therapeutic orders.

17.5.4 Special reports.

17.5.5 Consultations.

17.5.5.1 Relevant history and physical findings.

17.5.5.2 Impression.

17.5.5.3 Recommendations.

17.5.5.4 Report includes date, time of entry and signature.

17.5.6 Clinical laboratory, radiology, nuclear medicine and other diagnostic results.

17.5.7 Evidence of informed consent or acknowledgement of informed consent, if applicable, in accordance with the Hospital's Informed Consent Policy.

17.5.8 Treatment.

17.5.9 Pathology reports.

- 17.5.9.1 The only laboratory reports permitted in the patient's record shall be:
 - (a) Those produced by the Departments of Pathology.
 - (b) Those produced by sources approved by the Hospital's Department of Pathology.
- 17.5.10 Staging form, if required for malignancies.
- 17.5.11 Immediate Operative/Invasive Procedure Note
 - 17.5.11.1 Recorded immediately after surgery.
 - 17.5.11.2 Names of primary surgeon and assistants.
 - 17.5.11.3 Type of Anesthesia
 - 17.5.11.4 Complications, even if none
 - 17.5.11.5 Preoperative diagnosis, post-operative diagnosis, name of procedure.
 - 17.5.11.6 Brief description of findings, techniques, specimens removed, estimated blood loss even if zero (0), implants and grafts (if applicable) and patient's condition following surgery.
 - 17.5.11.7 Date, time of entry and signature of surgeon.
- 17.5.12 Operative/Invasive Procedure Report.
 - 17.5.12.1 Recorded within 24 hours of surgery.
 - 17.5.12.2 Names of primary surgeon and assistants.
 - 17.5.12.3 Type of Anesthesia
 - 17.5.12.4 Complications, even if none
 - 17.5.12.5 Preoperative diagnosis, post-operative diagnosis, name(s) and description(s) of each procedure.
 - 17.5.12.6 Description of findings, techniques, specimens removed, estimated blood loss even if zero (0)), implants and grafts (if applicable) and patient's condition following surgery.
 - 17.5.12.7 Date, time of entry and signature of surgeon.

17.5.13 Progress notes.

17.5.13.1 Daily recording.

17.5.13.2 Admitting progress note.

17.5.13.3 Reflect the patient's condition and clinical progress.

17.5.13.4 Reflect changes in condition and diagnostic and therapeutic plan.

17.5.13.5 Describe patient's response to medical and surgical treatment.

17.5.13.6 Abnormal test results and complications described.

17.5.13.7 Note on the day of surgery or delivery describing findings.

17.5.13.8 All notes include date, time of entry and signature.

All patients on the Resident Teaching Service will have daily appropriate progress notes reflecting patient care discussions with the teaching service Attending Practitioner and co-signature by the Attending Practitioner.

17.5.14 Final diagnosis: the discharging practitioner shall record the final diagnosis in a final progress note or the discharge summary by the day of discharge.

17.5.14.1 Resident Physicians will complete the final diagnosis in a final progress note or the discharge summary by the day of discharge for those patients on the teaching service under supervision of the Attending Practitioner.

17.5.15 Discharge-hospitalization summary.

17.5.15.1 Reflects events of the hospital stay and conclusions at termination of hospitalization.

(a) Reason for hospitalization.

(b) Essential physical findings.

(c) Diagnostic tests of significance/procedure(s) performed.

(d) Clinical course.

- (e) Patient's response to therapy.
- (f) Condition at discharge.
- (g) Discharge instructions: diet, medications, physical activity, limitations, follow-up plans, and completed discharge instruction sheet.
- (h) Resident Physicians will complete a detailed discharge summary for all patients on the teaching service on the day of discharge. The attending physician will co-sign.

17.5.15.2 A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than forty-eight (48) hours of hospitalization, normal newborn infants, and uncomplicated obstetric deliveries. The final progress note shall include any instructions given to the patient and/or family.

17.5.15.3 In the event of death, a summation statement shall be added to the record either as a final progress note or as a separate discharge summary. The final note shall indicate the reason for admission, the findings and course in the Hospital, and the events leading to death.

17.5.15.4 When an autopsy is performed, provisional anatomic diagnosis shall be recorded in the medical record within three days of the autopsy. The complete protocol shall be made part of the record within sixty (60) days, unless the Medical Staff establishes exceptions for special studies.

17.5.16 Discharge planning.

17.5.17 All authorizations for release of information.

The Attending Practitioner, Consulting Practitioner(s), House Physicians and others with clinical privileges may make entries in the medical record. All entries in the medical record shall include date, time of entry and signature

All Resident Physician entries into the medical record will be co-signed by the Attending Practitioner. For electronic records, the resident shall electronically forward all documentation to the Attending Practitioner for verification.

17.6 Each practitioner shall sign the medical record entries which are the responsibility of that practitioner. When non-Medical Staff members have been approved for duties such as taking medical histories, performing physical examinations and writing orders, the Attending Practitioner shall authenticate such information.

- 17.7 Before a chart has been completed and placed in the permanent files, a charting error may be corrected only by means allowed by the current electronic health record system.
- 17.7.1 After a document has been signed and finalized the only appropriate way to correct a document in the patient's record is through the completion of an addendum.
- 17.8 A medical record shall be considered complete when the following required documents have been electronically added or transcribed, dated, signed and timed by the responsible practitioner and inserted into the medical record:
- 17.8.1 Clinical discharge summary or final progress note.
- 17.8.2 Dictated reports.
- 17.8.3 If the responsible practitioner has died or is unavailable due to illness, charts shall be filed in the condition in which they were at the time of the event.
- 17.9 All original medical records are the property of the Hospital and shall not be removed from the building except under court order, subpoena or statute. Written consent of patient or the patient's legal representative shall be required for release of copies of medical information, except as otherwise permitted or required by law.
- 17.10 The medical record of discharged patients shall be accurate, legible and completed within a period of time that in no event exceeds thirty (30) days following discharge.
- 17.10.1 If a record remains incomplete fourteen (14) days after discharge, the responsible practitioner will be notified of the deficiency and given two weeks to complete the record.
- 17.10.2 It is the responsibility of the practitioner to complete all records prior to vacation or leave of absence.
- 17.10.3 The Medical Records Committee Chair should be notified of any extenuating circumstances preventing the practitioner from completing his/her records.
- 17.10.4 The suspension of clinical privileges will occur for delinquent records that are 30 days or more past the discharge date.
- 17.10.5 Deficient history and physical report will be subject to No Admit/Boarding List if not completed within 24 hours of admission.

17.10.6 Deficient operative report will be subject to No Admit/Boarding List if not completed with 24 hours of procedure.

17.10.7 All Delinquent Medical Records will be managed per the SMMH Delinquent Record Policy.

18. Meeting Procedures

Medical Staff and committee meetings shall be conducted in conformance with *Robert's Rules of Order*, to the extent not inconsistent with the Medical Staff Bylaws or these Rules.

19. Restraint Policy

Please see Hospital Restraint/Seclusion Policy and Soft Wrist Restraints Policy.

20. Vacation or Other Absence

A practitioner who will be unavailable to care for his/her patients shall notify the Medical Staff Office in advance of the dates he/she will be unavailable and the arrangements made for coverage of his/her practice and hospitalized patients, including the name(s) of the Covering Practitioner(s).

21. Non-Beneficial Care

21.1 It is the policy of St. Mary Mercy Hospital to promote careful communication and clear guidelines that respect the inherent dignity of the patient and support the recommendation of a physician not to provide medically non-beneficial care.

21.2 Treatment decisions should be based on the patient's overall best interest as determined by weighing relative benefits and burdens to the patient. Ideally, the patient, family, or patient advocate does this. The authority to make the determination of non-beneficial treatment rests with the patient's physician who holds the primary ethical and legal responsibility for the patient's welfare.

21.3 If the patient's family and/or patient advocate persist in requesting continuation of active treatments, the attending physician may refer the case to the Ethics Committee or Palliative Care as appropriate. Neither the physician nor the hospital is required to provide care/treatment that is not medically indicated and has been judged to be of no benefit for the patient. Therefore, as outlined in the Non-Beneficial Treatment Policy (Hospital Policy 339), the patient will be treated as comfort care.

21.4 If the patient's family and/or patient advocate refuses to come in or discuss the plan of care for their loved one, a certified letter will be sent to the patient advocate stating that the current care being provided to their loved one is no longer medically indicated and that unless they contact the hospital in the

specified time, the non-beneficial care will be discontinued and comfort care will be provided for their loved one.

22. Patient's Code Status

(See Hospital Policy #301 for additional information.)

Objective: as part of the admission process, every patient over the age of 18, with the exception of the Behavioral Medicine patients, will have his/her code status determined and documented and will be asked if he/she has an Advance Directive.

22.1 In the Behavioral Medicine Department (MHU/CDU) every patient is treated as a full code. If a patient has a pre-existing medical condition (i.e. terminal illness) and/or an Advance Directive in place, and has chosen a code status other than Full Code on another medical unit, the psychiatrist may approve to honor it if it is determined that the patient is not actively suicidal. If the patient attempts self-harm or suicide while in treatment here, the patient will be treated as a full code.

22.2 Types of Code Status:

22.2.1 Full Code: No limit on life sustaining treatments.

22.2.2 DNAR/No CPR/No Code: The patient will be treated as medically indicated. The patient will receive no resuscitation or CPR if cardiac or respiratory arrest occurs.

22.2.3 Comfort Care: The patient will receive pain and symptom management, no new treatments will be initiated, and all care deemed not to be Comfort Care will be discontinued. In the event of cardiac or respiratory arrest, the patient will not be resuscitated.

22.3 Requirements

22.3.1 Full Code status will be documented in the Electronic Medical Record (EMR). No paper form is required. If no decision is made by the patient/advocate and there is no Advance Directive, the patient will be treated as a full code.

22.3.2 DNAR and Comfort Care require the signature of the patient/patient advocate and the nurse. The physician or Resident Physician will enter a DNAR order in the EMR and the nurse will check the EMR signature box on the Code Status form (NS148). Resident Physicians may address the patient's code status and document the results under the supervision of the Attending Practitioner.

22.3.3 If the attending physician is not present when the Code Status form is signed, the nurse will contact the physician to obtain a verbal order for DNAR or comfort care. The order will be entered in the EMR and will be signed by the physician/resident within the prescribed timeline.

22.4 Process

- 22.4.1 Competent patients or their patient advocate requesting a DNAR or Comfort Care code status will sign the Patient Decision Regarding Code Status form (NS #148), which is witnessed by the nurse.
- 22.4.2 If the patient is unable to make a decision and the patient advocate is unable to come to the hospital to sign the Code Status form, a phone consent will be accepted and documented in the EMR and on the Code Status form.
- 22.4.3 The family or DPOA may leave the code status decision to the attending physician. The physician will discuss his/her recommendation with the patient's family or DPOA and will document on the Code Status form that he/she is following the patient's wishes and that the family/DPOA agrees with his/her recommendation. If the code status is DNAR or Comfort Care, the family/DPOA will sign the Code Status form.
- 22.4.4 If the Code Status form is signed by an Emergency Room Physician, that documentation will serve as the physician order for the entire patient stay unless the patient/patient advocate or Attending Physician changes the code status. The admitting nurse will execute a department order in the EMR listing the EC Physician as the physician who ordered the DNAR code status.
- 22.4.5 The nurse will place a purple band on the patient's wrist to designate the DNAR status and place the Code Status form in the plastic folder near the front of the patient's chart.
- 22.4.6 The physician will discuss changes in the patient's condition that would impact a change in the code status with the patient and/or patient advocate. If the code status is changed from DNAR or Comfort Care to Full Code, a horizontal line will be made on the Code Status form, the code status will be changed in the EMR and the purple band will be removed. If the change is from Full Code to DNAR or Comfort Care, a Code Status form will be completed and a purple band will be placed on the patient.
- 22.4.7 The physician/resident may request the assistance of the Palliative Care Team, Ethics Committee or Spiritual Care to help the patient or patient's family make a decision about code status or plan of care.
- 22.4.8 For a Palliative Care Consult, a physician order is required for the Palliative Care team to visit the patient. The Palliative Care team consists of a Palliative Care physician, nurse and social worker.

A patient or patient's family may request Hospice Care. The patient or patient's family will be given a list of hospice agencies that have contracted with the hospital to provide this service. To transfer the care of the patient to the hospice selected by the patient or patient's family, the attending physician must initiate a physician order in the electronic medical record and the patient or patient's family must sign a consent form for the hospice agency to manage his/her care. The patient is usually transferred to the hospice care area of the hospital.

23. Withdrawing Life Support

Objective: The life support systems of the terminally ill patient may be removed by the physician when the physician has determined that the criteria for withdrawing life support have been met. Brain death may be applicable.

Process: The physician will discuss with the patient or patient representative the consequences of removing the life support equipment and if they consent to this removal NS #149 (Consent for Withdrawal of Life Support Equipment) will be signed by the patient/patient representative, physician and witness. The Attending Practitioner will directly authorize all Resident Physician orders for withdrawing life support.

Brain Death Criteria

23.1 The following abnormalities shall be documented by two full determinations: (first exam) followed by an additional full determination (second exam) at least six hours later (with a confirmatory isoelectric EEG) or at least twelve hours later (without a confirmatory EEG). The physician participating in each exam must either be a neurologist, neurosurgeon or intensivist. The second exam may be conducted by the physician who conducted the first exam or by his/her designee. No physician attending a proposed organ recipient or member of the transplant team may participate in either exam or certify a patient's brain death.

23.2 Criteria/elements of a physical examination for brain death:

- 23.2.1 Coma (absence of spontaneous movement with and without painful stimuli)
- 23.2.2 Absence of evidence of coma secondary to central nervous system depressant drugs
- 23.2.3 Absence of hypothermia (i.e., temperature less than 90 degrees F or 32.2 degrees C)
- 23.2.4 Absence of spontaneous breathing movements for three minutes without ventilator assistance (in absence of hypocarbia and neuromuscular blockage). Record PaCO₂; must be 40 mm Hg or greater or an increase by 15 mm Hg.

- 23.2.5 Pupils must be dilated and fixed
 - 23.2.6 Absence of corneal reflexes
 - 23.2.7 Absence of ocular response to head turning (so called doll's eyes movement)
 - 23.2.8 Absence of gag and cough reflexes and lower airway stimulation
 - 23.2.9 Absence of reflex eye movements on vestibular stimulation by caloric testing
 - 23.2.10 Absence of ciliospinal reflexes.
 - 23.2.11 Additional tests, such as EEG, angiogram, and/or brain scan may be performed at the discretion of the participating physician
- 23.3 Physician Responsibility for Certification of Brain Death

The staff neurologist, neurosurgeon or intensivist who completes the second examination must sign the certification of brain death. If the patient meets the above criteria, the patient's attending physician shall first pronounce the patient dead, inform the family, and then withdraw all support measures unless the patient is an organ donor in which case life support measures will be disconnected after organ procurement. Satisfaction of the brain death criteria must be documented in the patient's medical record.

24. Tissue Specimens Removed In-House

- 24.1 All surgical pathology specimens removed from patients within the Hospital premises shall be sent to the Hospital pathologist who shall proceed with examination as necessary to arrive at a pathological diagnosis.
- 24.2 Appropriate clinical history and diagnosis will be provided with these specimens.
- 24.3 Pathology Department policies may specify categories of specimens which are exempt from routine microscopic examination and will receive a report of gross examination only.
- 24.4 In addition to the specimens referred to in 23.3, other categories of specimens may be exempted from the requirement of submission to the Department of Pathology, provided an alternative extra-laboratory procedure is followed to document removal and disposition of the specimen.
- 24.5 Current lists of specimens subject to 23.3 and 23.4 are available from the Pathology Department. Additions to the lists must receive written approval of the specific clinical department's chair and the Chair of the Department of Pathology, subject to review by the Vice President of Medical Affairs.

25. Cancellation of Laboratory Test Orders

An order for laboratory testing is valid for a maximum of 72 hours. If the specimen is not collected within 72 hours, the order is cancelled and a new order is required if the test is still deemed necessary. Exceptions to this rule include determinations of glucose levels, protimes (PTs) and activated partial thromboplastin times (PTTs). Notification will occur by cancellation messages in the Hospital Information System.

26. Department Policies

- 26.1 Department policies must be consistent with, and adopted in accordance with, the Medical Staff Bylaws and these Rules.
- 26.2 The department chair, a department committee, or member(s) of the department may propose revisions to department policies. Such revisions shall be effective when approved by the voting members of the department and the Medical Executive Committee.

27. Pharmacy Medication Rules

- 27.1 The Hospital uses a formulary system for drugs, which is continuously updated by the Pharmacy, Therapeutics & Transfusion Committee, is available on the SMMH Intranet under Pharmacy Department. The Formulary lists all formulary drugs by generic and common trade names according to therapeutic use as designated by the American Hospital Formulary Classification System. Requests forms for an addition to the Formulary can be obtained from the Pharmacy Department.
- 27.2 Since all available trade/brand names of a specific drug entity cannot be carried as stock, generic substitution shall be practiced by the Pharmacy Department. Generic substitutes are chosen according to their efficacy, safety and cost.
- 27.3 Since the Formulary contains a finite number of drugs, the Pharmacy may substitute a therapeutically equivalent medication. These therapeutic substitutes are chosen from a list approved by the Pharmacy, Therapeutics & Transfusion Committee and the Medical Executive Committee.
- 27.4 If a non-formulary drug is requested for a specific patient, a Form 26 (located at all Nursing stations) must be filled out completely by the prescribing practitioner and accompany the order to the Pharmacy. Since these drugs are not routinely carried as stock, a delay in obtaining them may be experienced.
- 27.5 All new medications shall have the initial dose administered at the next scheduled Hospital administration time unless an alternate time is specified in the medication order.

- 27.6 If a dose is to be given before the next scheduled time, or any additional doses are to be given that day, the request must be stated explicitly on the order.
- 27.7 Standard medication administration times will be followed per Pharmacy Policy #332 Orders – Standard Administration Times.
- 27.8 I.V. orders shall be written in full, specifying solution, volume, additives, flow rate and duration.
- 27.9 All orders for intravenous fluids containing **additives** will be honored for 24 hrs only, unless otherwise specified as Daily, Continuous, or Keep Open. Orders for **non-additive** intravenous fluids will be honored until discontinued by the prescribing practitioner.
- 27.10 All routine orders for keep-open intravenous solutions will run for 24 hours, continuously, at a rate of 20 ml/hour per port unless otherwise specified by the prescribing practitioner.
- 27.11 Parenteral oncology medications shall be administered by an oncology-trained nurse in a designated area of the Hospital. If a patient cannot be transferred to the designated area, parenteral chemotherapy may be administered elsewhere in the Hospital by an oncology-trained nurse. An exception to this policy is use of methotrexate for ectopic pregnancy, which may be administered by the prescribing practitioner at any location within the Hospital.
- 27.12 All verbal or telephone orders for medications shall be signed by the ordering physician within 24 hours.
- 27.13 Each section of the physician order form shall include the date, time and signature of the prescribing practitioner.
- 27.14 Orders for "PRN" medications, where more than one dose is intended to be administered, shall include a time interval to indicate how frequently the doses may be administered.
- 27.15 When it is desirable to administer a medication within approximately one hour, the word "STAT" should be specified on the order. Such medications shall be delivered with the next scheduled Pharmacy run. If it is an emergency situation and imperative for the patient to receive a medication within minutes, the word "STAT" should be specified on the order. Such medications shall be delivered by the Pharmacy immediately.
- 27.16 Orders for "PRN" medications must be written to include the symptom or indication for use (e.g. PRN pain, PRN fever) unless there is only one possible use for the medication (e.g. Dulcolax-for constipation).
- 27.17 Use of range orders should be minimized whenever possible. Range orders deemed essential to the care of the patient are permissible (eg 25-50mg every 3 to

4 hrs prn pain) and will be carried out as follows: The patient initially will receive the **least** amount of medication using the **longest** dosing interval in the range.

28. Seasonal Influenza Vaccination Requirement

- 28.1 All Active and Provisional members of the Medical Staff must obtain the seasonal influenza vaccine.
- 28.2 If a physician cannot be immunized due to a documented medical or religious reason they are required to submit an exemption form stating the reasons, and include a physician's note for medical issues.
- 28.3 Physicians must submit proof that that vaccine was received. Some form of written proof must be turned in to the Medical Staff Office.
- 28.4 Physicians who come on staff between the deadline indicated for receipt of the seasonal flu vaccine and March 31st of the following year must also provide written proof to the Medical Staff Office within one month of initial appointment. Physicians appointed to the Medical Staff after March 31st would follow the normal annual procedure.
- 28.5 If the flu vaccine is not received by the date specified in the communication provided regarding the annual requirement, the member will be notified via certified mail that clinical privileges will be suspended by the Medical Executive Committee until the vaccine is obtained or an exemption form is submitted and will not be allowed to board cases, admit patients, or have access to the physician lounge or the hospital. The suspension will not be reportable to the National Practitioner Data Bank.