



An Affiliate of **MERCYONE**SM

Medical Staff Rules and Regulations

Admission and Discharge of Patients

A patient may be admitted to Franklin General Hospital only by or with the concurrence of a provider who has been granted privileges according to the By-Laws. Patients may be treated only by physicians or other advanced health care practitioners that have been duly appointed to membership on the Medical Staff, or given temporary privileges.

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Health System, for the prompt completeness and accuracy of the medical record, and for communicating reports of the condition of the patient to the referring practitioner in accordance to HIPAA, compliance and confidentiality policies. The admitting practitioner may transfer care and treatment of the patient to another Medical Staff member by noting such transfer of responsibility within the medical record.

A patient shall not be admitted to the Health System until a provisional diagnosis or valid reason for admission has been stated, except in the case of an emergency whereby such statement shall be recorded as soon as possible.

Each provider must assure timely and adequate professional care for his/her patients in the Health System by being available, or having available, an eligible provider with whom prior arrangements have been made. The attending provider or his/her designee shall see inpatients at least once per day for acute and observation patients, and at least weekly for skilled care patients. Initial visits will occur within 6 hours of admission.

Patients shall be discharged only on the order of the attending practitioner. The discharge order will include any necessary follow up as well as an accurate list of discharge medications. Should a patient leave the Health System against the advice of the attending practitioner, or without proper discharge, a notation shall be made in the medical record and, if possible, the patient shall sign a release form for leaving against medical advice.

In the event of a Health System death, the deceased shall be pronounced dead by the attending practitioner or a Registered Nurse if the death was expected.

General Rules Regarding Health Information

1. A completed **medical record** will be compiled and maintained electronically, which shall include current and pertinent records including any of the following: the patient's history and physical; consultation, if any; orders; progress notes; discharge summary, operative reports; obstetrical records; autopsy report, if any; interpretation of ancillary studies; clinical laboratory

and radiology services; and pathological findings. All entries are electronically signed, dated and time. The electronic record is the official medical record.

2. A complete **admission history and physical** examination shall be recorded within 24 hours of admission by the attending practitioner. This report should include at least the following: identifying data; medical history of the patient including the following information:
 - a) the chief complaint;
 - b) details of the present illness, including assessment of the patient's emotional, behavioral, and social status;
 - c) relevant past, social and family histories appropriate to the age of the patient;
 - d) review of body systems; and in regard to children and adolescents, an evaluation of the patient's developmental history;
 - e) the physical examination reflects a comprehensive current physical assessment performed within 24 hours of admission; however, if the physical examination has been performed within 30 days prior to admission a copy of this report may be used in the patient's medical record, provided there is an updated interval note to assess the patient's current condition. For non-emergent surgical patients, a complete history and physical must be conducted in accordance with acceptable standards of practice, and the document placed on the medical record, prior to surgery. All or part of the history and physical may be delegated to other practitioners in accordance with State law and Health System policy, but the surgeon must review the history and physical and assume full responsibility.
 - f) the history and physical report shall also include a statement of the course of action planned for this patient.
 - g) the **discharge summary** from acute to skilled nursing (interval history and physical) care may be used for the history and physical if discharge summary is dictated within 24 hours of admission to skilled care.
 - h) when the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be delayed or cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.
3. 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 the specific orders, as well as the results of tests and treatments. Course of action (plan) should also be updated in the progress notes. Progress notes shall be dictated at least daily on all inpatients and observation patients, and weekly on skilled patients.
4. **Operative/procedure reports** shall include a detailed account of findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated within twenty-four (24) hours following procedure. Dictation post

procedure shall include: Patient name and ID number, dates and time of surgery, pre and post-operative/procedure diagnosis, operative surgeon, assistant surgeon, type of anesthesia administered, complications if any, procedure performed, findings, specimens removed and sent to pathology, prosthetic device or implants and approximate blood loss.

5. **Consultations** shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations.
6. **Discharge Summary (Recapitulation)**. The discharge summary serves as a recapitulation of the patient's stay, and shall concisely summarize the reason for hospitalization, final diagnoses, the significant findings, the procedure performed and treatment rendered, the condition of the patient on discharge, follow-up instructions, including medications, diet and activity. Completion is required within 30 days of discharge. A final progress note may be substituted for the summary in the case of patients with problems of a minor nature who require less than 48 hours of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical delivery, outpatient procedures or ambulatory surgery patients
7. The patient's medical record shall be **completed** within 30 days of discharge.
8. **Consent**. Written consent of the patient is required for the release of medical information to persons not otherwise authorized to receive this information. A "consent for treatment" form, signed by or on behalf of every patient admitted to the Health System, must be obtained at the time of admission. In addition to obtaining the patient's general consent for treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure, and anesthesia consent when appropriate should be obtained. Documentation in the medical record shall include that risks, benefits, and reasonable alternatives have been discussed with the patient (or legal decision maker).
9. **Records**. Records may not be removed from the Health System's jurisdiction in the absence of a Court Order, subpoena or Statute. All records are the property of the Health System.
10. **Orders**. All orders for treatment, diagnostic studies, and procedures are provided by those who have the authority as permitted by their license, clinical privileges, and/or their scope of practice or job description.

Surgical Service

The Surgery Service is comprised of those providers and Allied Health Professionals who have clinical privileges in the general area of surgery. The Surgery Service shall be responsible for maintaining the quality of the surgical practice.

The Medical Director of Surgery shall be appointed annually by the Chief of the Medical Staff.

Privileges

Surgical privileges will be reviewed for recommendation by the Credentials Committee based on qualifications, including the provider having sufficient training for the type of operation performed. A current privilege file is available to the surgical staff. Credentials policies are followed. Proctoring policies are followed when indicated.

Pre-Procedure Time Out

Prior to the start of every surgical procedure, there shall be a mandatory "time out" during which there is verification of the correct person, site, procedure, and fire risk. No operation shall commence until all team members are in agreement.

Pathology Examinations

All tissues removed during operations shall be sent to the Health System specified pathologist who shall make such examinations as they consider necessary to arrive at a pathologic diagnosis with written and signed report sent to operating surgeon.

Emergency Service

EMTALA

Providers comply with the Emergency Medical Treatment and Labor Act (EMTALA) and follow the EMTALA guidelines.

ER Provider Call

The Medical Staff shall adopt a method of providing medical coverage in the emergency room. This shall be in accordance with the Health System's basic plan for provision of services, including the delineation of clinical privileges for all providers who render emergency care. Response is required within 30 minutes of being called by the ER. An MD or DO, is always on call to back up Mid – level Providers.

Disaster Preparedness / Mass Casualties

The Health System's plan for disasters and mass casualties shall be followed.

Autopsies

The medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The Health System's policies for consent for autopsies, forms, and notification of the attending provider shall be followed.