

THE MERCY HOSPITAL, INC.

MEDICAL STAFF  
REGULATIONS  
AND  
POLICIES AND  
PROCEDURES

**JUNE 18, 2012**

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## **PART ONE ADMISSION OF PATIENTS**

### **1.1 TYPES OF PATIENTS AND NONDISCRIMINATION**

The Hospital currently accepts patients suffering from most types of diseases requiring inpatient or outpatient hospital services except neonatal and pediatric intensive care services.

Patients are admitted without regard to race, creed, color, sex, sexual preference, disability, age, religion and national origin. Admission of patients is contingent upon the Hospital's current capacity, capability and personnel resources available to care for the patient.

### **1.2 ADMITTING PREROGATIVES AND REQUIREMENTS**

Only a member in good standing of the Active, Senior Active or Courtesy Staff with admitting privileges may admit patients to the Hospital, subject to the relevant sections of the Medical Staff Bylaws, Credentialing Procedures Manual and in Sections 3.4, 3.5 and 3.6 of these Rules and to such other official admitting policies of the Hospital as may be in effect from time to time. Medical Staff Services submits names of members not in good standing to the Patient Registration Department.

Admitting physicians shall:

- a. adhere to Hospital admitting policies and procedures including pre-admission laboratory tests, documentation and scheduling;
- b. assure timely, adequate professional care for his patients in the Hospital by being available or having an alternate Staff member available with whom prior arrangements have been made. The alternate Staff member shall have privileges similar to those held by the physician for whom s/he is covering.

### **1.3 TIME OF ADMISSION - EMERGENCY CASES**

All emergency cases go through ED, if they are new admits-the admitting physician shall, when possible, first contact the Patient Registration Department to ascertain bed availability. Staff members admitting emergency cases shall be prepared to justify the validity of the emergency to Case Management personnel. The history and physical examination should clearly justify an emergency admission and these findings must be recorded in the medical record as soon as possible after admission.

A patient to be admitted on an emergency basis who does not have an attending physician may select any Staff member on the appropriate service. When no such selection is made, a member of the Emergency Department Staff will contact appropriate physician from the on call rotation.

Failure of a Staff member to meet these requirements may result in loss of clinical privileges.

#### **1.3-1 ADMISSION TO ICU**

If there is a question concerning an admission to the ICU the Medical Director of the ICU or his designee shall make the final decision.

## **1.4 ADMISSION INFORMATION**

### **1.4-1 GENERALLY**

A patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the physician requesting the admission. The admitting physician is also responsible for but not limited to providing the following information concerning a patient to be admitted: information as needed by the Admission Office if the case requires pre-certification; information known to the admitting physician regarding the presence of an advance directive executed by the patient; any source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; and need for protecting the patient from self-harm.

### **1.4-2 ADMISSIONS THROUGH THE EMERGENCY DEPARTMENT**

Any patient to be admitted as an emergency shall first be seen by or the case reviewed by the Emergency Department physician unless delay of admission places the patient's life in jeopardy. The Emergency Department record should be signed by the Emergency Department physician. An admission note should be completed at the time of admission and an appropriate history and physical examination must be written and signed by the attending physician within 24 hours of admission. The attending physician must provide bridge orders or regular orders for patient prior to going to any floor. Patients do not go up to ICU/telemetry without orders.

### **1.4-3 ADMISSION STATUS**

Patients requiring nursing and other ancillary services may be placed in a bed in any Hospital department that is designated by the Hospital as having the capacity to care for a patient either as an inpatient or as an outpatient. Inpatients are patients with medical conditions requiring inpatient acute care and generally are intended to stay more than 24 hours. Outpatients may also be placed in a bed and depending on the circumstances are classified as "observation status" as appropriate. Observation status is used when a patient's medical condition is such that s/he requires monitoring and evaluation for a possible inpatient stay. An observation status patient will be reviewed at twenty-three (23) hours in order to determine if the patient's status requires a change to inpatient status. The admitting physician is responsible for providing an order as to the status of the patient at the time of admission based on the individual patient's clinical condition, the procedure(s) performed, and applicable clinical case management criteria as utilized by the Hospital.

### **1.4-4 ADMISSION CATEGORY PRIORITIES**

The Patient Registration Supervisor or designee shall admit patients on the basis of the following priorities:

- (a) Emergent Admissions: Patients that may be admitted at any time when beds are available. The admitting physician is responsible for providing a provisional diagnosis or valid reason for admission as soon as possible after the admission.
- (b) Urgent Admissions: Patients that may be admitted when so designated and justified by the attending Staff member. These may be reviewed by the appropriate committee/individual to determine priority when all such admissions for a specific day cannot be accommodated.
- (c) Pre-Operative Admissions: All patients already scheduled by the attending practitioner for surgery shall be reviewed as necessary by the appropriate committee/individual to determine priority when all such admissions for a specific day cannot be accommodated.
- (d) Elective Admissions: All patients already scheduled for elective admissions involving all services shall be reviewed as necessary by the appropriate committee/individual to determine priority when all such admissions for a specific day cannot be accommodated.

### **1.5 TIMELY VISITATION AFTER PATIENT ADMITTED/TRANSFERRED**

The attending physician or his designee (i.e. another member of the Medical Staff in good standing with the requisite privileges to care for the patient) must see the patient and write or dictate an appropriate history and physical within twenty four (24) hours of Hospital admission. Patients transferred to the ICU should be seen and evaluated in a timely manner, based on the severity of the patient's illness and in all cases the patient must be seen within twenty four (24) hours. At the time of the attending physician's visit, he or his designee should record a note updating the patient's clinical status, stating the rationale for transfer to the ICU and plans for treatment as well as recording admitting ICU orders.

Medication reconciliation must be completed by the attending physician or designee within twenty four (24) hours of admission, upon transfer from or to the, ICU post - operative and at time of discharge.

## **PART TWO ATTENDANCE OF PATIENTS**

### **2.1 ATTENDANCE OF PATIENTS**

Each patient will be attended by the physician of his choice provided said physician is a member of the Medical Staff and has appropriate clinical privileges. The name of the attending physician must be entered officially on the Hospital records. A patient presenting for admission, whether on an emergency or non-emergency basis, who has no personal physician may request any physician who is a member of the Medical Staff and who has appropriate clinical privileges. When no such request is made or when the requested physician chooses not to undertake the care of the patient, the patient will be assigned to an appropriate Staff member according to the Emergency Department on-call roster provided by the applicable Department Chair. This physician shall be the patient's attending physician until discharge or the responsibility has been transferred in writing in the medical record order section to another physician willing to take on such duties.

Should the patient desire to change his physician, the process outlined in Section 3.2 of these Rules and Regulations shall be followed.

### **2.2 PARTICIPATION IN THE ON-CALL ROSTER AND EMTALA RESPONSIBILITIES**

The chair of each clinical department is responsible for arranging for the provision of a listing of members for purposes of on-call coverage for the Hospital's Emergency Department. Unless specifically exempted by the Medical Executive Committee (MEC) and the Board of Trustees, for good cause shown, each member of the Active and Courtesy Staff assigned to the on-call roster agrees that, when he is the designated physician on call, he will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the Hospital referred to the service for which he is providing on-call coverage. If there is a conflict with the published schedule, it is the assigned Staff member's responsibility to locate an appropriate replacement and to notify Medical Staff Services and the Chief of Emergency Medicine or his designee at least 24 hours prior to the scheduled rotation. The on-call physician shall be available to the Emergency Department physician within the period designated by the Hospital's policy which has been approved by the MEC.

Refusal of any physician who is on call to provide treatment under the policies established by the Hospital and under these Rules and Regulations shall result in a report filed with the Chief Executive Officer and corrective action may be taken as



outlined in the Collegial Intervention, Peer Review and Fair Hearing and Appellate Review Manual.

Every physician providing care for patients in the Emergency Department shall be required to respond as defined in the Hospital's EMTALA policy.

In accordance with the Hospital's EMTALA Policies, the Hospital will maintain a list of on-call physicians, including specialists and sub-specialists, that are available for duty to screen, examine, and treat patients with potential emergency medical conditions. Only individual names, and not physician group names, are acceptable for inclusion on the on-call list.

### **2.3 CONTINUED HOSPITALIZATION**

In the event a termination of Medicare or other insurance benefits is pending as a result of an assertion that the patient's clinical condition does not justify continued hospitalization, the attending Staff member will document in the progress notes of his patient's medical record the need for continued hospitalization. This documentation should contain:

- (a) An adequate written statement of the reason for the continued hospitalization; and
- (b) The estimated period of time the patient will need to remain in the Hospital.

### **2.4 CARE OF OBSTETRICAL PATIENTS**

If a female patient presents to the Emergency Department who is at least at 20 weeks gestation with complaints of abdominal pain, or in labor, she will be transferred to the Family Life Center for the performance of an assessment, monitoring and a medical screening examination.

Whenever an obstetrical patient undergoes surgery under general or spinal anesthesia, there will be a current comprehensive history and physical examination in the medical record prior to anesthesia/surgery.

<b>PART THREE GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE</b>
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### **3.1 GENERALLY**

A physician, oral surgeon, dentist or podiatrist member of the Medical Staff or a Health Professional shall be responsible for:

- (a) the medical, dental or podiatric care and treatment of each patient in the Hospital as applicable;
- (b) the prompt completion and accuracy of those portions of the medical record for which he is responsible;
- (c) necessary special instructions; and
- (d) transmitting reports of the condition of the patient to the referring physician.

Primary physician responsibility for these matters belongs to the attending physician except when transfer of responsibility takes place as noted below.

### **3.2 TRANSFER OF RESPONSIBILITY**

- a. Transfers of patients from one service to another shall be made only after consultation with the recipient Staff member or service and his agreement to accept the patient. Once transferred, the responsibility for orders, progress notes, discharge summary and completion of the front sheet and medical record rests with the recipient service

- b. All transfers shall be implemented by physician order. The transfer and accepting physician should discuss the case at the time of or prior to the transfer.

### **3.3 ALTERNATE COVERAGE**

Each physician must assure timely, adequate professional care for his patients in the Hospital by being available or designating a member of the Medical Staff, or similarly qualified physician who has appropriate temporary privileges. Each member of the Staff who will be out of town or unavailable in case of emergency must identify to the Hospital a qualified physician who will assume responsibility for the care of the patient during his absence. Failure of an attending physician to meet these requirements may result in loss of Staff appointment or such other disciplinary action as deemed appropriate by the Medical Executive Committee. If the alternate physician is actively seeking appointment, he must request and receive temporary privileges. If the alternate is unavailable, the applicable Department Chair or the Medical Staff President has the authority to assign any member of the staff with the requisite clinical privileges.

### **3.4 ORAL SURGEONS**

An oral surgeon who has successfully completed an accredited postgraduate/ residency program in oral/maxillofacial surgery and who demonstrates current competence in performing a complete history and physical examination may be granted the privileges to do so and to assess the medical risks of the proposed procedure to the patient. Consultations will be obtained when appropriate. A physician member of the Medical Staff must be responsible for the care of any medical problem that may be identified at admission or that may arise during hospitalization. This physician will have the responsibility for the overall medical care of the patient and any surgical procedure(s) performed must be with his knowledge and concurrence. When significant medical abnormality is present, the final decision concerning whether to proceed with the surgery or not must be agreed upon by the oral surgeon and the physician consultant. The Chair of the Department of Surgery will decide the issue in case of dispute. Except in the event of an emergency, the responsible physician shall be identified prior to admission of the patient for surgery to be performed by an oral surgeon member of the staff.

### **3.5 DENTISTS**

A physician member of the Medical Staff must perform a medical appraisal on a dental patient and document such in the medical record. The physician and the dentist/podiatrist must assess the risk and effect of any proposed procedure on the total health status of the patient. When significant abnormality is present, the final decision on whether to proceed must be determined by the dentist/podiatrist and the physician. In the case of dispute, the Chair of the Department of Surgery will decide the issue. In all instances, a physician member of the Medical Staff must be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization.

The dentist is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he provides to the patient. More specifically, the dentist/podiatrist is responsible for the following:

- (a) A detailed dental history and description of the dental problem documenting the need for hospitalization and any surgery;
- (b) A detailed description of the examination of the oral cavity/ foot and a preoperative diagnosis;
- (c) A complete operative report, describing the findings, technique, specimens removed, and the postoperative diagnosis.
- (d) Progress notes as are pertinent to the dental condition;

- (e) Pertinent instructions relative to the dental condition for the patient and/or significant other at the time of discharge;
- (f) Making appropriate transfer of responsibility or coverage arrangements for the patient's dental care as necessary and required under Sections 3.2 and 3.3 of these Rules and Regulations;
- (g) Clinical resume or final summary note; and
- (h) Writing the discharge order for the patient

### **3.6 PODIATRISTS**

The following rules and regulations shall apply to patients admitted who require podiatry are:

#### **3.6-1 History and Physicals**

Patients who require podiatric care shall receive the same basic medical appraisal, history and physical examination as all patients who are admitted to the Hospital. This appraisal, history and physical examination may be performed by either a physician or podiatrist.

The history and physical examination for patients undergoing a procedure under local sedation shall be performed by a podiatrist. A podiatrist may also perform the history and physical examination for all podiatry Class 1 and 2 anesthesia cases (as defined by the National Standards for Anesthesiologists). The admission history and physical examination shall assess the medical risks of any podiatric procedure for the patient.

Podiatrists are responsible for the part of the patient's history and physical examination that relates to his or her specialty in podiatry.

#### **3.6-2 Discharge of Patients Requiring Podiatry Care**

The discharge of such patients shall be on written order of the podiatry member of the Medical Staff.

### **3.7 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE**

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient by a particular practitioner or feels that appropriate consultation is needed and has not been obtained, such individual is encouraged to bring the matter to the attention of the practitioner. If resolution cannot be obtained, the health care professional may refer the matter to his supervisor and then to the chair of the clinical department or designee. The Department Chair or designee shall take such action, stop the process, as well as ~~or~~ follow the process outlined in the Chain of Command policy.

### **3.8 CONSULTATIONS**

#### **3.8-1 RESPONSIBILITY**

The good conduct of medical practice includes the proper and timely use of consultation. The attending physician is responsible for ordering a consultation from a qualified Staff member when indicated or required. In an urgent or emergent situation, the attending physician is responsible for direct oral communication with the consultant. In all cases, it is desirable that the referring physician communicate directly with the consultant prior to the consultation.

#### **3.8-2 GUIDELINES FOR REQUESTING CONSULTATIONS**

Guidelines for calling consultations are as follows:

- (a) When the rules of any clinical unit, including any intensive or special care units, of the staff require it;

- (b) When required by state law;
- (c) When requested by the patient or family;
- (d) When consultation should be obtained in complex cases where there is diagnostic uncertainty or when treatment involves procedures for which the attending is not privileged;
- (e) When there is doubt as to the choice of therapeutic measures to be utilized;
- (f) When the patient exhibits severe psychiatric symptoms;
- (g) When curettage or other procedures by which a known or suspected pregnancy may be interrupted is anticipated;
- (h) When a second opinion is needed for determination of brain death.

When a consultation is required under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable Department Chair, the physician director of a special unit; the Medical Staff President or the Senior Vice President, Medical Affairs. If the attending physician disagrees with the necessity for consultation, the matter shall be brought immediately to the next supervisory level. If the matter is sufficiently important, it shall be referred to the MEC through the Medical Staff President.

### **3.8-3 QUALIFICATIONS OF CONSULTANT**

Any qualified physician may be called as a consultant regardless of his Staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

Consultant physicians are expected to respond to requests in a timely manner by seeing the patient and discussing the patient with the referring physician or his covering physician within twenty-four (24) hours of the consultation request, unless otherwise requested by the attending physician or otherwise clinically indicated.

If a consultant who is not a member of the Medical Staff is to provide direct treatment or orders, s/he must apply for and receive temporary privileges pursuant to Part Five Section K of the Credentials Procedures Manual.

### **3.8-4 DOCUMENTATION**

- a) Consultation Request: When requesting consultation, the attending physician must provide a summary of the patient's condition in the medical record and indicate, in writing, on the record the reason for the request.
- b) Consultant's Report: Immediately after seeing the patient, the consultant must make, date and sign a report of his findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record. When operative procedures are involved, a consultation note shall, except in emergency situations as verified on the record, be recorded prior to the operation.
- c) Attending Physician's Response to Consultant's Opinion: In cases of elective consultation when the attending physician elects not to substantially follow the advice of the consultant, he shall record in the progress notes his reasons for electing not to follow the consultant's advice and/or seek the opinion of a second consultant. In cases of required consultation when the attending physician does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the applicable Department Chair, Senior Vice President Medical Affairs or Medical

Staff President for final advice. If the attending physician obtains the opinion of a second consultant and does not agree with it either, he shall again refer the matter to the applicable Department Chair.

### **3.9 MASS CASUALTY ASSIGNMENTS**

There shall be a plan for the care of patients at the time of any major disaster (also referred to as the Emergency Response Plan) which shall be developed by a committee consisting of designated Medical Staff representatives (by the Medical Staff President and Chief Executive Officer of the Hospital) and the Vice President of Patient Care Services, or designee, the Nurse Manager of the Emergency Department, and appropriate representatives from Hospital departments and administration.

Physicians shall be assigned posts and it is their responsibility to report to their assigned stations. Once a major emergency has been declared physicians shall be assigned posts as directed by the hospital incident commander or their designee. The Chief Executive Officer and the Senior Vice President of Medical Affairs of the Hospital shall be the next in line of authority respectively.

### **3.10 USE OF RESTRAINTS**

All restraints, as defined by the Hospital wide policy and procedure on Restraints, must have a written physician's order. For each use of restraint there must be a "time limited order", and must include a justification for the use of the restraint documented in the patient's medical record. A restraint order which is not time limited will not be accepted. Further clarification is available in the Hospital's Operational Restraint Policy and the relevant unit policy to which the patient has been admitted.

### **3.11 QUALIFIED PERSONNEL TO PERFORM INITIAL MEDICAL SCREENING**

As required by the Federal Emergency Medical Treatment and Labor Act (EMTALA) and in accordance with the Mercy Hospital "EMTALA Policies and Procedures for Screening, Stabilization and Transfer of Individuals" (referred to below as the "EMTALA Policies"), Mercy Hospital will provide a medical screening examination by a physician or "Qualified Medical Person" (defined below) to (i) an individual who comes to one of the Hospital's dedicated emergency departments and (ii) requests, or has a request made on his or her behalf for, such an examination to determine if the individual has an emergency medical condition, regardless of the ability of such individual to pay.

The medical screening examination will be conducted by an individual who is determined qualified by these rules and regulations and who, as appropriate in accordance with 42 C.F. R. § 482.55, is supervised by a qualified member of the medical staff.

A Qualified Medical Person ("QMP") means an individual, other than a licensed physician, who is licensed or certified in one of the following professional categories and who has demonstrated to the satisfaction of his or her Department Chair current competence in the performance of a medical screening examination. Mercy Hospital designates the following categories of personnel, in addition to physicians, to be qualified to perform the medical screening examination within the Hospital's dedicated emergency departments, including but not limited to the Emergency Department, Labor and Delivery and Psychiatry:

- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Licensed Clinical Social Workers, licensed mental health counselors and certified nurse specialists who are each deemed qualified by the Chair of the Department of

- Psychiatry to perform a medical screening examination to evaluate the status of a patient presenting with psychiatric symptoms.
- Registered nurses who are deemed qualified by the Chair of the Department of Obstetrics and Gynecology to perform a medical screening examination to evaluate labor.

Although the above listed categories of professionals have been approved by the Hospital's Board of Trustees as qualified to administer one or more types of medical screening examination (and, in consultation with a physician, when appropriate, to complete/sign a certification for transfer), individual practitioners within those categories shall be approved to administer medical screening examinations as part of the individual credentialing/clinical privilege delineation process at the Hospital.

<b>PART FOUR TRANSFER OF PATIENTS</b>
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#### **4.1 INTERNAL TRANSFER**

Internal patient transfer priorities are as follows:

- (a) Emergency patient to an appropriate patient bed;
- (b) From CCU to general or intermediate care area;
- (c) From obstetric patient care area to general care area
- (d) From intermediate care to general care; or
- (e) When patients are transferred internally from a temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

No patient shall be transferred within the Hospital without the approval of the attending practitioner with the exception of a harmful or infectious patient who requires immediate relocation to protect him/herself or others or in the case of an emergency transfer from a specialty unit to the floor or vice versa. In the latter case, the attending physician will be notified as soon as possible after the transfer

#### **4.2 TRANSFER OF SERVICE**

When a patient is transferred from one in-Hospital service to another, documentation in the medical record in the form of a transfer note from one service to another is encouraged. The receiving service attending physician or designee is also encouraged to enter an acceptance note in the medical record.

Formal transfer is not required for diagnostic procedures, such as endoscopy, biopsies, etc. but a consultative and/or operative note is required on all such cases.

Patients undergoing major surgery will be transferred to the Surgical Service. This transfer will be implemented by an order from the attending physician and countersigned by the surgeon accepting the transfer.

Transfer of patients to the geriatric psychiatry and acute rehabilitation units require a formal discharge.

#### **4.3 TRANSFER TO ANOTHER FACILITY**

Transfers to other facilities for diagnostic or therapeutic procedures not available in the Hospital may be implemented provided the patient's clinical condition warrants safe transport.

##### **4.3-1 GENERAL REQUIREMENTS**

All patient transfers must be in compliance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) as defined in the Hospital wide Operations policy. It is the Hospital's policy to provide a medical screening exam for emergency medical conditions and women in labor and provide stabilizing treatment prior to appropriate transfer (if required). The Hospital will not delay provision of an appropriate medical screening examination or further medical examination and/or treatment to stabilize the medical condition in order to inquire about the individual's method of payment or insurance status. A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient including the reason for transfer, name of receiving facility, the appropriate staff and equipment to accompany the patient for safe transport, name of accepting practitioner, status of patient's clinical condition and signature of the attending practitioner or his designee, effectuating the transfer.

#### **4.3-2 DEMANDED BY EMERGENCY OR CRITICALLY ILL PATIENT**

A transfer demanded by an emergency or critically ill patient or his family or legal guardian is not permitted until a physician has explained to the patient or family or legal guardian the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport as defined by the Hospital's policy on EMTALA compliance. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

#### **4.3-3 PATIENT REQUEST FOR SHORT TERM PASS (Leave of Absence)**

Day or night short term pass of patients to their homes or other outside facility for personal reasons while still an inpatient of the Hospital will not be permitted except in unusual and extenuating circumstances with the recommendation of the attending Staff member, involvement of the designated case manager, and approval of the Chief Executive Officer or designee, and the signing by the patient of a statement absolving the attending Staff member and Hospital of any liability during his temporary absence.

#### **4.4 TRANSFER TO SUBACUTE LEVEL FACILITY**

A patient should be transferred to a subacute or skilled nursing facility only upon the order of the attending physician or designee who shall dictate a transfer summary to include current patient status, assessment and medications. The attending physician or designee shall complete the designated transfer form.

### **PART FIVE DISCHARGE OF PATIENTS**

#### **5.1 DISCHARGE PLANNING**

In collaboration with the multidisciplinary team, the case management nurse, the attending practitioner shall make arrangements as early as possible after admission for anticipated discharge needs and post discharge care of patients who will likely require aftercare.

#### **5.2 REQUIRED ORDER**

A patient may be discharged only on the order of the attending practitioner and in compliance with discharge criteria. Documentation of the order must be in the patient's record. The face sheet of the patient's medical record will be completed by the attending Staff member and shall include a final diagnosis recorded according to

standard nomenclature. Day (ambulatory) surgery patients shall be discharged in accordance with approved criteria.

### **5.3 DISCHARGE PROCEDURES**

The attending practitioner is responsible for discharging his patients according to the patient discharge and EMTALA policies established by the Hospital.

### **5.4 LEAVING AGAINST MEDICAL ADVICE**

If a patient desires to leave the Hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient or legally responsible individual shall be requested to sign the appropriate release form indicating that he realizes he is leaving against medical advice. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident, with any reason given, must be made in the patient's medical record. A patient leaving the Hospital on his own accord without signing the AMA release form shall be considered to be officially discharged.

### **5.5 DISCHARGE OF MINOR OR INCOMPETENT PATIENT**

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction.

## **PART SIX ORDERS**

### **6.1 GENERAL REQUIREMENTS**

All orders for treatment or diagnostic tests must be written clearly, legibly and completely, dated and timed, and signed by the practitioner responsible for them or his designated covering physician. An order shall be considered to be in writing if given verbally and confirmed by read back, and signed by the responsible Staff member within 48 hours.

Orders which are illegible or improperly written will not be carried out until rewritten or clarified with the originating prescriber or covering physician responsible for carrying them out. Orders for diagnostic tests, which necessitate the administration of test substances or medications, will be considered to include the order for this administration providing a policy is in place which identifies the medications to be used. All initial orders must include documentation of any medication allergies.

All orders must be rewritten. The use of the terms "renew," "repeat," and "continue orders" are not acceptable.

### **6.2 STANDING ORDERS**

The Department Chair or the medical director of the unit in consultation with other appropriate representatives of the Medical Staff, the Senior Vice President, Medical Affairs, and appropriate representatives of Patient Care Services and other Hospital departments may formulate standing orders for any Department or other clinical unit. A member of the Medical Staff may formulate additional orders for his own use, subject to the approval of the applicable Department Chair and approval by the Medical Executive Committee.

Standing orders shall be listed on a "Physician's Order" sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. All standing orders and routine procedures within a Department must be reviewed by the originator,



department and Medical Executive Committee at least annually for confirmation or change with re-issuance of orders indicated by signature and date. The Pharmacy and Therapeutics Committee must approve any standing orders referencing medication. The Hospital's Forms Committee must endorse and recommend to the Medical Executive Committee all standing orders that will be included in the medical record. Failure to respond within a reasonable period of time to a request from the Department Chair to review standing orders or routine procedures will automatically suspend the order.

### **6.3 PATIENT CARE PROTOCOLS**

Patient care protocols formulated as provided in the Hospital Wide Policy and Procedure Manual may be implemented in the care of a patient where such protocols are known to all those involved in the care of the patient and all agree on their implementation for the patient. The Pharmacy and Therapeutics Committee must approve any protocols referencing medication and all Patient Care Protocols need Medical Executive Committee approval.

### **6.4 TELEPHONE ORDERS – See attached Verbal and Telephone Order Policy**

### **6.5 ORDERS BY HEALTH PROFESSIONALS**

An health professional (HP) may write orders only to the extent, if any, specified in applicable Hospital and Medical Staff policies. The attending or responsible practitioner must countersign orders by a Health Professional within a timely fashion as required by state or federal statute or regulation.

### **6.6 AUTOMATIC CANCELLATION OF ORDERS**

All previous orders are automatically discontinued when the patient is transferred to and from a critical care unit or surgery. Orders must be reviewed and either continued or changed at the time of transfer from the ICU

### **6.7 STOP ORDERS**

#### **6.7-1 DRUGS/TREATMENTS COVERED AND MAXIMUM DURATION**

The period of automatic stop orders will be as follows:

- (a) Controlled substances in Class II shall be renewed every seven (7) days;
- (b) All medication orders are discontinued when a patient is transferred to the Operating Room;
- (c) All medication orders are discontinued when the practitioner orders the medications "held".

This documentation shall be reviewed as part of the quality assessment/ performance improvement process. For each medication, the administration times or the interval between doses must be clearly stated in the order.

### **6.8 PATIENT'S OWN MEDICATIONS AND SELF-ADMINISTRATION**

The use of patient's own medication is generally discouraged. However, if the use of patient's own medication or self-administration of medications by a patient is medically necessary, a specific written order by the authorized prescribing practitioner is required for either. The order must contain the patient's name and location, date of the order, name and dosage of the drug, directions and signature of the prescriber. Medications brought into the Hospital by a patient (or a practitioner for a patient) may not be administered unless the Hospital pharmacist, has validated the identification and integrity and acceptability of these medications. The medication should be identified as to drug strength, route and frequency of administration. The medication must be stored in the pharmacy and dispensed in units of use.

## **6.9 DO NOT RESUSCITATE AND SIMILAR TYPE ORDERS**

The Hospital's policies covering advance directives, do not resuscitate, withholding and withdrawal of life supportive therapy, refusal of treatment and related or similar matters shall be followed. All "No Code" orders must be in writing and signed by the attending physician. Verbal "No Code" orders are acceptable if witnessed by two nurses and documented and signed by a physician in a timely manner.

Policy specifics are included in the Hospital's general administrative policy manual. Once a Do Not Resuscitate order is properly entered into the patient's medical record, it is the operative order until it is withdrawn or cancelled. In the event that a patient goes to surgery, the Do Not Resuscitate order may be cancelled provided there is documentation in the patient's medical record that the attending practitioner, anesthesiologist and patient (if the patient has the capacity to make health care decisions) or the patient's health care agent, family or legal guardian (if the patient is determined to be legally incompetent) have discussed the procedure and the risks involved and, the patient (if the patient has the capacity to make health care decisions) agrees to undergo the surgical procedure and rescind the DNR order. If a Do Not Resuscitate Order has been cancelled prior to surgery, the Practitioner must again write a Do Not Resuscitate Order on the order sheet in the patient's medical record for it to be effective.

## **6.10 FORMULARY AND INVESTIGATIONAL DRUGS**

### **6.10-1 FORMULARY**

A formal process exists whereby the Pharmacy and Therapeutics Committee selects from the drugs available, those that are considered to produce the best balance of efficacy, safety and cost. The Formulary of Approved Drugs lists by generic name those agents selected for stocking in the pharmacy. All Formulary agents administered to patients shall be either FDA approved or those listed in the latest edition of the United States Pharmacopoeia, the National Formulary, the New and Non-Official Remedies, the American Hospital Formulary Service or the AMA Drug Evaluations. Each member of the medical staff assents to the use of the Formulary system.

### **6.10-2 NON-FORMULARY MEDICATIONS**

Any medication that does not appear in the formulary is considered a non-formulary (NF) medication. When a NF drug is requested a practitioner must complete and submit a non-formulary one time use request form to the pharmacy. A pharmacist will inform the prescribing practitioner of those formulary agents which are similar or preferred by the Pharmacy and Therapeutics Committee. If medically necessary the Pharmacy will obtain a small supply of the drug for that particular patient unless the Pharmacy and Therapeutics Committee has approved a therapeutic substitution and it is available.

### **6.10-3 SUBSTITUTION POLICIES**

The Pharmacy is authorized by virtue of the Formulary System to substitute an FDA approved, equivalent generic drug any time a trade name drug is ordered. The Pharmacy and Therapeutics Committee is authorized to approve therapeutic substitutions. The specific instances in which this therapeutic substitution may be performed are detailed in the Formulary of Approved Drugs.

## **6.11 RESTRICTION OF SPECIFIC DRUGS**

The Pharmacy and Therapeutics Committee may restrict the use of a specific drug or class of drugs, either entirely or for use only in stated conditions, for use by specific specialties or for use only on consent of the department chair or other designated

physician or the physician chair of Infection Control or Pharmacy and Therapeutics Committees or the Pharmacy Director.

**6.12 MEDICATION-FOOD INTERACTION MONITORING**

Potential medication-food interactions shall be monitored and managed through a multi-disciplinary effort (i.e., physician, pharmacist, nurse, and dietitian) designed to educate patients and minimize the effects of these incompatibilities. Patient education, including that provided at the time of discharge, shall be documented in the medical record.

**6.13 USE OF RANGE ORDERS ARE NOT ACCEPTED**

Range orders for medications are not accepted.

**6.14 MEDICATION ADMINISTRATION**

All individuals administering medications shall adhere to the requirements for the safe administration of medications, set forth in the current Comprehensive Accreditation Manual for Hospitals, published by the Joint Commission.

**6.15 DISCHARGE MEDICATIONS**

When medications are prescribed for a patient at time of discharge, the patient will be informed of important aspects of the medication, its proper use, side effects and storage requirements, and potential significant adverse drug-food interaction(s). The responsible physician must document the discharge medications being prescribed including the dosage, frequency and duration for time limited medications. The individual responsible for providing the medication to the patient must record in the patient's medical record that the patient received and understood the information concerning the discharge medications.

<p style="text-align: center;"><b>PART SEVEN HEALTH INFORMATION</b></p>
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**7.1 REQUIRED CONTENT**

The attending practitioner, other Medical Staff members, other clinical staff and health professionals, involved in the care of the patient in a collaborative effort, shall be responsible for the preparation of a complete and legible medical record for all inpatients and outpatients. All entries in the medical record must be dated and timed and the record's content shall be pertinent; i.e. facilitate -legal issues; support treatment continuity of care; support the physician and/or Hospital in medico provided; provide appropriate documentation for performance improvement purposes; be accurate, legible, timely and current. The record shall include but not be limited to:

- (a) Name, address, date of birth and legal representative
- (b) Legal status
- (c) Any prior emergency care
- (d) Findings of assessment
- (e) History and Physical, including impressions and plans
- (f) Diagnosis or diagnostic impression
- (g) Reasons for admission or treatment
- (h) Goals of treatment & treatment plan
- (l) Evidence of known advance directives

- (j) Evidence of informed consent if required by Hospital policy
- (k) Diagnostic/therapeutic orders, if any
- (l) Diagnostic/therapeutic procedures and test results
- (m) Operative and other invasive procedures performed, using acceptable terminology, including etiology (if appropriate)
- (n) Progress notes
- (o) Reassessments/revisions of the treatment plan
- (p) Clinical observations
- (q) Response to care
- (r) Consultation reports (if appropriate)
- (s) All medications ordered or prescribed for inpatients or ambulatory patients including indication(s) for use of each PRN medication.
- (t) Every dose administered and any adverse reactions
- (u) All relevant diagnoses established during course of care
- (v) Referrals/communications to external or internal care providers or community agencies
- (w) Conclusions at end of hospitalization
- (x) Discharge instructions
- (y) Clinical resumes and discharge summaries, or final progress note, or transfer summary, autopsy report (if available)
- (z) For patients receiving ongoing ambulatory care, the medical record must contain a list of significant diagnoses, conditions, procedures, drug allergies, and medications. This list must be initiated and maintained by the third ambulatory visit and maintained in all subsequent visits.
- (aa) For patients receiving emergency care, the medical record must contain: time and means of arrival. If a patient refuses to sign an AMA form or if the patient leaves without being seen, this should be documented in the medical record as patient "refuses to sign".

## **7.2 HISTORY AND PHYSICAL EXAMINATION AND ADMISSION NOTE**

### **7.2-1 GENERALLY**

A complete history and physical examination, assessment and plan of treatment shall be recorded for all inpatient and outpatient admissions within twenty-four (24) hours of the surgery. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to a patient's admission, a durable legible copy of such a report may be used in the patient's Hospital medical record in lieu of the admission or pre-procedure history and physical examination provided this report was recorded by a member of the medical staff and an interval note written within twenty-four (24) hours of admission is included and notes any change in health status or medication, as well as a brief physical exam documenting any changes. A complete history contains at a minimum:

- Clinical appropriate evaluation of the chief complaint;
- Present illness;
- Past medical and surgical history including medications and allergies;
- Review of systems, family history and social history.

A complete physical examination includes, at a minimum:

- Clinically appropriate evaluation of the vital signs;
- Head and neck;
- Lungs;
- Heart;
- Abdomen;
- Extremities;

- Neurological status and
- The involved specific organ system or body part.

### **7.2-2 AMBULATORY PATIENTS**

A brief history and physical examination, assessment and plan of treatment shall be recorded for all moderate-risk ambulatory procedures on otherwise healthy patients (ASA classification 1 and 2) twenty four (24) hours prior to the procedure. These moderate-risk procedures shall include all those done with conscious/moderate sedation, diagnostic and therapeutic invasive vascular procedures, needle biopsy of an intra-abdominal or intra-thoracic organ. Other low-risk diagnostic or therapeutic procedures do not require a history or physical examination. A history and physical examination shall be considered current if completed within twenty four (24) hours of the procedure. If a history and a physical examination has been performed within thirty (30) days prior to a patient's admission, a durable legible copy of such a report may be used in the patient's Hospital medical record however, an interval note, written within twenty four (24) hours prior to the procedure shall include any change in health status or medication, as well as a physical examination documenting any changes shall be recorded. A history, in this instance, shall consist, at a minimum of:

- Clinically appropriate evaluation of the chief complaint;
- Present illness and past medical and surgical history including medications and allergies.

A physical examination in this instance shall include, at a minimum:

- Clinically appropriate evaluation of vital signs;
- Lungs;
- Heart;
- And the involved specific organ system or body part.

### **7.2-3 For Patients at Providence Hospital (Behavioral Health):**

**Methadone Maintenance Treatment Program (MMTP)** – The history, physical examination and admission note must be completed by the physician or licensed independent practitioner within twenty four (24) hours. Progress notes must be made as clinically indicated, the closing note must be written within thirty (30) days of discharge.

**Acute Residential Treatment (ART)** – The history and admission note must be made within twenty-four (24) hours of admission. The physical examination must be completed and recorded within fourteen (14) days of admission. Progress notes must be made by the physician or licensed independent practitioner at least once per week. The discharge summary must be written as noted in Section 7.9-1, the same as inpatient requirements.

**Outpatient Substance Abuse Treatment** – No physician or licensed independent practitioner is necessarily involved in this treatment, an attempt is to be made to obtain a copy of the most recent physical examination from the primary care practitioner, if not obtainable, then the patient is to be referred to a primary care provider. There is no progress note requirement. The discharge summary must be written as noted in Section 7.9-1, the same as inpatient requirements.

**Detox** – The history, physical examination and admission note must be completed within twenty –four (24) hours. Progress notes must be made as clinically indicated. The discharge summary must be written as noted in Section 7.9-1. the same as inpatient requirements.

## **7.3 PREOPERATIVE DOCUMENTATION**

### **7.3-1 HISTORY AND PHYSICAL EXAMINATION**

A relevant history and physical examination is required on each patient having surgery. Except in an emergency, so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and required laboratory tests have been recorded in the medical record. Elective inpatient or outpatient surgery (to be performed under other than local anesthesia) will be cancelled or delayed until an appropriate history and physical examination is recorded in the medical record.

In cases of emergency, the responsible practitioner shall, prior to induction of anesthesia and start of the procedure, make at least a comprehensive note regarding the patient's condition stating the basic nature of the proposed surgery/ procedure and the condition for which it is to be done, the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient. The history and physical examination shall be recorded immediately after the emergency surgery has been completed. All cases in which the requirements of this section are not met shall be acted upon in accordance with this section and section 7.12 of these Rules and Regulations.

### **7.3-2 CLINICAL LABORATORY TESTS AND X-RAYS**

Appropriate advance lab tests, EKGs, and x-rays must be performed within guidelines developed by the Department of Surgery for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia. Reports from laboratories outside the Hospital may be acceptable provided the laboratory is appropriately accredited, and the test is recent enough to be pertinent. Examinations or procedures (radiologic or pathologic) performed outside the Hospital may be submitted to the appropriate Hospital Department for review at the discretion of the operating surgeon.

### **7.3-3 ANESTHESIA EVALUATION**

A pre-anesthesia evaluation of the patient by an anesthesiologist must be conducted and documented in the medical record and shall include: pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, the patient's allergies, previous medications, smoking or alcohol use history, ASA patient status classification, orders for preoperative medication and the anticipated location for post anesthesia recover. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered. The anesthesiologist responsible for the patient's anesthesia care must also conduct and document in the record a re-assessment just prior to induction and a post-anesthesia follow-up of the inpatient's condition within forty-eight (48) hours. All practitioners providing anesthesia shall adhere to the "Standards for Basic Intra Operative Monitoring" established by the American Society of Anesthesiologists.

## **7.4 DOCUMENTATION OF ORDERS**

Orders for treatment and diagnostic tests shall be documented in the medical record as set forth in Part Six of these Rules and Regulations.

## **7.5 PROGRESS NOTES**

### **7.5-1 GENERALLY**

Pertinent progress notes must be recorded at the time of observation on all inpatients, outpatients, and observation patients to permit continuity of care and transferability, including a brief admission note to be recorded at the time of admission. Progress notes shall be written at least daily by the attending practitioner or designee.

Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Progress notes should provide a chronological report of the patient's course in the Hospital and should reflect any change in the condition and the results of treatment. Whenever possible, each of the patient's active clinical problems must be clearly identified in the progress notes and correlated with specific orders, with reasons for instituting various tests or treatment given and results of tests and treatments recorded.

Progress notes written by a health professional must be countersigned by the responsible supervising practitioner as required by state or federal statute or regulation.

#### **7.5-2 ADVANCE DIRECTIVE**

The medical record must contain documentation which justifies the effectuation of an advance directive.

### **7.6 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS**

#### **7.6-1 OPERATIVE AND SPECIAL PROCEDURE REPORTS**

Operative reports should be written or dictated immediately following surgery and before the patient is transferred to the next level of care. These should include at least the name of the primary surgeon and assistants, preoperative and postoperative diagnoses, a detailed account of findings at surgery, details of surgical technique, specimens removed, any complications and the condition of the patient at the termination of the procedure as well as estimated blood loss. If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then a comprehensive operative progress note should be entered in the record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This note should contain, at a minimum, primary surgeon and assistants, findings, technical procedures performed, specimens removed, postoperative diagnosis and estimated blood loss.

#### **7.6-2 TISSUE EXAMINATION AND REPORTS**

All tissues and artifacts removed during a procedure, except those specifically excluded by joint policy approved by the MEC and of the Departments of Surgery and Pathology shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the Hospital's Department of Pathology. All objects of a criminal nature should be placed in a specimen container, given to a nurse who will forward to the investigating officer. If the object is something that caused injury, but is not a part of a criminal act (e.g. a nail, a piece of glass or metal) removal must be documented in the medical record. If the object cannot be identified, or if there is question regarding the identification, then the object should be sent to the Department of Pathology. The specimen(s) must be accompanied by a form completed, signed and dated by the operating practitioner or his designee in the OR indicating any pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. An authenticated report of the pathologist's examination shall be made a part of the medical record.

### **7.7 OBSTETRICAL RECORD**

The current obstetrical record must include a complete prenatal record. The prenatal records must include results of the following laboratory tests: Complete blood count, serological test for syphilis, blood type and Rh, rubella screen, cervical cytology, urinalysis, screen for Rh, Hepatitis B antigen screening, and irregular antibodies. The prenatal record may be a durable, legible copy of the attending physician's office or clinic record transferred to the Hospital before admission; but an interval admission note, either handwritten in the progress notes or on the designated form, that includes pertinent

additions to the history and any subsequent changes in the physical findings, must be signed and dated by the responsible practitioner.

In the case of Caesarian sections, prenatal notes may be used to fulfill the past history, family history and social history requirements of the complete history and physical examination.

## 7.8 OBSERVATION STATUS

An admission note describing the clinical history and physical findings, ancillary testing results, the reason for observation and the plan for diagnosis and/or therapy should be recorded by the attending physician at the time of admission to observation status. The physician's progress notes should document the treatment course. A discharge note must be written or dictated which indicates the patient's diagnosis, treatment, condition on discharge, instruction and follow-up care needed.

## 7.9 ENTRIES AT CONCLUSION OF HOSPITALIZATION

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure and any additional procedures must be recorded in full at the time of discharge, without the use of symbols or abbreviations, and must be dated and signed by the attending practitioner. The attending practitioner has the responsibility for the accuracy of this information. The following definitions are applicable to the terms used herein:

- Principal Diagnosis: The condition established, after study, to be the chief reason for the admission of the patient to the Hospital for care.

Secondary Diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

- Co-morbidities - (if applicable): A condition that co-existed at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day (for about 75% of the patients).
- Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of Hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.
- Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
- Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

The physician is responsible for completing the applicable sections of the state mandated forms used when the patient requires practitioner assisted level of care.

### 7.9-1 DISCHARGE DOCUMENTATION

- (a) In General: A discharge summary must be recorded for all patients whose length of stay exceeds forty-eight (48) hours, all deaths and complicated cases. A transfer summary must be in the medical record prior to a patient being transferred



to another healthcare facility. The summary must concisely recapitulate the reason for hospitalization, the significant findings including complications, the procedures performed and treatment rendered, the condition of the patient on discharge stated in a manner allowing specific, measurable comparison with the condition on admission, discharge instructions, and principal and secondary diagnoses.

- (b) Exceptions: A final progress note may be substituted for the discharge summary in the case of the following categories of patients: (1) those with problems of a minor nature who require less than 48 hours of hospitalization; (2) normal newborn infants; (3) patients having uncomplicated vaginal deliveries. The content must include: diagnosis, procedures, condition on discharge, medications, instructions to patient and family and discharge disposition.
- (c) In those instances when an autopsy is performed, provisional anatomic diagnoses will be recorded in the medical record and the complete protocol shall be made part of the record as soon as possible, but not later than 60 days, unless otherwise required by state law.

#### **7.9-2 INSTRUCTIONS TO PATIENT**

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care.

#### **7.10 AUTHENTICATION**

Each clinical entry in the patient's record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, written initials, or electronic authentication.

A record shall be considered incomplete until all necessary (as defined in department policies and procedures) physician entries are authenticated.

Any practitioner who authenticates another practitioner's order or who cosigns a history, physical examination, or other medical record entry for another practitioner or another individual authorized to make such entry has the legal responsibility for the order or the information bearing his authentication.

#### **7.11 MEDICAL RECORD COMPLETION REQUIREMENTS AND ENFORCEMENT POLICIES**

All portions of a patient's medical record must be prepared within the time frames provided in these Rules and Regulations. All portions of the medical record of a hospitalized patient should be complete at the time of discharge except when there are pending reports, transcriptions and associated authentication, or at the maximum within thirty (30) days after the patient's discharge.

Except as otherwise specified in these Rules, the sanctions for failure to prepare a portion of the record of a patient in a timely fashion are suspension of the practitioner's clinical privileges, of the right to admit patients, to consult with respect to patients and to schedule and perform surgery/other invasive procedures, and of voting and office-holding prerogatives until all of his delinquent records are completed.

A medical record shall not be permanently filed until the responsible attending Staff member completes it or it is ordered filed by the Director of Health Information Management (HIM). Medical records are considered delinquent if they are incomplete thirty (30) or more days after discharge. Physicians shall be notified of all incomplete records weekly. A letter listing physicians' incomplete records will be faxed every Monday to that physician's office. If a holiday falls on a Monday, these notices are sent on the next

workday. Such list will be effective at noon on the day of distribution. If a physician has notified HIM that he will be on vacation, the counting of delinquent days is suspended until he has returned.

All physicians with records that are at a delinquent status will receive a certified letter that informs them of their effective date of suspension, allowing ten days to complete the delinquent records. The HIM department will send out the certified letters on Monday afternoon.

All practitioners with suspensions for delinquent medical records of four weeks or more in a calendar year will be placed on a one-year conditional reappointment. If no suspension for delinquent medical records occurs during the one-year conditional reappointment, the practitioner will be reappointed to the medical staff the two year cycle.

If during the one year conditional reappointment period there is a suspension for delinquent medical records of less than one week cumulative, mandatory weekly or biweekly scheduled visits to the Health Information Management Department will be prescribed. If an unexcused absence for a medical record visit occurs during the conditional reappointment, the individual will be terminated or not reappointed to the medical staff at the end of the conditional period.

If during the one year provisional reappointment period, there is a suspension for delinquent medical records of more than one week cumulative, the practitioner will automatically relinquish privileges for thirty (30) days. A second occurrence will result in termination of the practitioner's clinical privileges.

The Patient Registration Department, Departments of Nursing and Surgery, laboratories and other notified departments are expected to enforce the suspension. It is the responsibility of the practitioner to designate an appropriate practitioner for coverage of any new admissions, consults or procedures. In the absence of such a designation, the situation will be handled as defined. The practitioner will remain on enforced suspension until completion of overdue medical records.

A record of each suspension imposed shall be made part of the practitioner's credentials file after verification with the applicable Department Chair and the Director of Health Information Management.

#### **7.12 USE OF SYMBOLS AND ABBREVIATIONS**

The use of symbols and abbreviations is discouraged in the medical record. Medication orders that include use of any of the unapproved list of abbreviations prohibited by The Joint Commission standards will not be accepted by Pharmacy for processing until clarified and re-written. Those abbreviations noted as "Unapproved" by the Medical Staff shall not be used. Final diagnoses and complications shall always be recorded without the use of symbols and abbreviations. Symbols and abbreviations may only be used after they have been approved by the MEC. An official record of unapproved abbreviations shall be maintained by the Pharmacy Department and posted on the Hospital's intranet site and at all nursing stations.

#### **7.13 ERRORS**

If an error is made on an entry in the medical record, a single-line shall be drawn through it, and the correct entry written in along with the date and authentication of the practitioner. The error is not to be obliterated or erased, but will be identified as an error.

#### **7.14 FILING OF INCOMPLETE RECORDS**

In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Director of Health Information Management shall consider the circumstances and may enter such reasons in the record and order it filed.

No medical staff member shall be permitted or requested, for any reason, to complete a medical record on a patient unfamiliar to him/her, regardless of the status of the practitioner who is responsible for completing the record. Any practitioner who is removed per the Bylaws and these Rules and Regulations for delinquent records or who resigns from the medical staff without adequately completing all medical records will not be allowed to reapply for staff membership until such records are satisfactorily completed.

#### **7.15 OWNERSHIP AND REMOVAL OF RECORDS**

All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the Hospital and the information contained therein is the property of the patient and may be removed only in accordance with Hospital policy. The patient has the right to request inspection of the record and to obtain a copy of the record. Unauthorized removal of a medical record or any portion thereof from the Hospital is grounds for disciplinary action, including immediate and permanent revocation of Staff appointment and clinical privileges, as determined by the MEC and Board of Trustees.

#### **7.16 ACCESS TO RECORDS**

##### **7.16-1 BY PATIENT**

Patients, Hospital personnel, and medical staff members may have access to information contained in the medical record per Hospital policy.

##### **7.16-2 ON READMISSION**

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner. This shall apply whether the patient is attended by the same practitioner or another.

##### **7.16-3 TO FORMER MEDICAL STAFF MEMBERS**

Subject to Hospital policy, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the Hospital.

### **PART EIGHT CONSENTS**

#### **8.1 GENERAL**

Patients have the legal right to consent to or refuse treatment. Practitioners performing procedures or administering treatments are responsible for explaining the risks, benefits and alternatives of such treatment. The process of informed consent or informed refusal should be documented in the medical record in accordance with the Hospital's Informed Consent Policy.

### **PART NINE SPECIAL UNITS AND PROGRAMS**

#### **9.1 DESIGNATION**

Special units and programs include, but are not limited to, the following:

- (a) Intensive and Intermediate Care Units
- (b) Labor and Delivery

- (c) Newborn Nursery
- (d) Day-Surgery Program
- (e) Operating Room
- (f) Post Anesthesia Care Unit (PACU)
- (g) Emergency Department
- (h) Outpatient Department
- (l) Rehabilitation
- (j) General Psychiatric

## 9.2 POLICIES

The policies of the various units and programs related to clinical care and practice are to be reviewed and are subject to the approval of the MEC and the Board of Directors.

## PART TEN SURGICAL REQUIREMENTS

### 10.1 ASSISTANTS AT SURGERY

The primary operating surgeon, working within the guidelines of the policies of the Surgery Department, will be responsible for having a qualified assistant available. Patients should be informed of the identity of all operating surgeons and assistants.

### 10.2 CURETTAGE

No curettage or other such procedures leading to termination of pregnancy shall be done except in accordance with the most recent version of "Ethical and Religious Directives for Catholic Health Care Facilities and amendments thereto.

### 10.3 HISTORY AND PHYSICAL EXAMINATION

Per Section 7.3-1 of these Rules, the Same Day Surgery Admitting Nurse or Circulating Nurse shall review each patient's chart scheduled for an operative elective procedure to ensure that an appropriate history and physical is present on the chart prior to the procedure beginning.

### 10.4 SURGERY SCHEDULING

Surgeons must be in the operating room and ready to commence the operation within fifteen (15) minutes of the scheduled time or the case may be rescheduled after all other scheduled surgeries have taken place.

### 10.5 PRESENCE OF NON-STAFF IN THE OPERATING ROOM

Only employees of Mercy Hospital or members of its Medical Staff or its nursing personnel, CRNA's employed by the Department of Anesthesia, Health Professional staff, or other authorized categories of students enrolled in educational programs shall be present during invasive procedures, unless otherwise authorized as provided in Hospital Operations Policy.

Sales and technical representatives associated with devices utilized during the procedure may be present to provide technical support. Patients shall be informed of all sales and technical representatives who will be present during the procedure. At no time will these individuals be allowed to directly participate in the invasive procedure, touch the patient or enter into the sterile field.

#### 10.5.1 ANESTHESIA PRESENCE IN THE OPERATING ROOM

The conduct of anesthesia is the responsibility of the attending anesthesiologist. The attending anesthesiologist will either personally deliver the anesthetic to the patient or will

supervise the preparation of the patient and the conduct of anesthesia by the appropriate nurse anesthetist. The attending anesthesiologist will be immediately available to conduct the anesthesia, supervise the nurse anesthetist or assist the surgeon and/or the surgeon's assistants in the event of problems or emergencies. There will be either an anesthesiologist or nurse anesthetist in the operating room at all times for the entire period that the patient is in the operating room.

It is the responsibility of the attending anesthesiologist to be in the operating room at the time of induction, at the critical times during the procedure as designated by the attending anesthesiologist or nurse anesthetists and at the time of the termination of anesthetic. If the attending anesthesiologist does not appear at the times identified above, at the request of the nurse anesthetist, the circulating nurse will have the attending anesthesiologist paged. If the attending anesthesiologist does not appear within a reasonable amount of time, the nurse anesthetist may continue the operation so long as the attending anesthesiologist's absence does not represent a danger to the patient. In the absence of such a danger to the patient, the surgeon and nurses are expected to continue to treat the patient and cooperate in the performance of the operation in the best interests of the patient. The absence of the attending anesthesiologist shall be reported by the circulating nurse through the use of an incident report and shall be forwarded to the Chief of the Department, the Senior Vice President of Medical Affairs, the Vice President of Patient Care Services, the Director of Surgical Services and the Director of Quality/Risk Management Department. The matter shall be properly investigated by the Chief of the Department and reported to the Executive Committee within thirty (30) days. Appropriate disciplinary measures may be instituted upon recommendation of the Senior Vice President of Medical Affairs if it is determined that the attending anesthesiologist violated these regulations. Any disciplinary action contemplated must be initiated consistent with the Focused Review Plan of the Medical Staff and the Collegial Intervention, Peer Review and Hearing and Appellate Review Manual.

#### **10.6 UNIVERSAL PROTOCOL TIME OUT**

Prior to any invasive/surgical procedure the chart must contain the following: informed consent, history & physical (for any procedure requiring moderate sedation or general anesthesia) and all appropriate test results.

In the pre-procedure/pre-operative area and prior to the start of any invasive/surgical procedure, confirmation of correct site, procedure and patient will be completed and documented.

Site marking must be completed by the physician performing the procedure prior to the patient entering the procedure/surgical area. All sites are required to be marked with the exception of those defined in the Universal Protocol Policy.

The physician must actively participate in the time-out process in collaboration with the surgical/treatment team. Pre-operative/pre-procedural verification and "time-out" will be performed for all cases, except in an emergency.

The physician name will be documented on the time out form as part of the team members present.

<b>PART ELEVEN HOSPITAL DEATHS</b>
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#### **11.1 HOSPITAL DEATHS**

### **11.1-1 PRONOUNCEMENT**

In the event of a death, the deceased shall be pronounced dead by the attending physician or his designee, a duly licensed physician in accordance with Massachusetts state law. The body may not be released from the Hospital until an entry has been made and signed in the deceased's medical record by the individual pronouncing.

### **11.1-2 DEATH CERTIFICATE**

The attending physician or his designee is required to complete in black ink the appropriate and pertinent sections of the death certificate following the guidelines on the back of the death certificate.

Release or removal of the body, reporting of deaths, and issuance of the death certificate are to be carried out in accordance with current Hospital policy and Massachusetts law.

### **11.1-3 NOTIFICATION OF NEXT OF KIN**

Notification of next of kin will be followed in accordance with Hospital policy.

## **PART TWELVE INFECTION CONTROL**

### **12.1 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES**

Any patients with a suspected infectious or communicable disease will be placed on appropriate precautions in accordance with the provisions of the Hospital's Infection Control policies. The infection control personnel may call cases which may need isolation to the attention of the attending practitioner.

### **12.2 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES**

All cases of reportable infectious diseases shall be reported in accordance with the provisions of the Hospital's Infection Control policy to the infection control department and as required by Massachusetts state law, for pertinent review by the Infection Control Committee. Perceived disease outbreaks will be assessed in accordance with the provisions of Infection Control Policy.

Every Staff member shall report promptly to the infection control surveillance individual, any post-discharge infections which develop after discharge and which may have been hospital-acquired.

### **12.3 GENERAL AUTHORITY**

The Infection Control Committee has the authority to institute appropriate infection control measures or studies at its discretion.

## **PART THIRTEEN MEDICAL STAFF DUES AND ASSESSMENTS**

### **13.1 MEDICAL STAFF DUES**

Members of the Medical Staff shall pay dues in accordance with the requirement of Article III of the Bylaws. The amount of dues shall be recommended by the secretary-treasurer of the staff and approved by the Medical Executive Committee. The identified amount shall be presented to the Medical Staff for approval at the Annual Meeting of the Medical Staff. Payment of dues is a mandatory requirement for continuing Medical Staff membership and is due by July 1 of each year. Any member who has not paid annual dues in full by the identified due date shall be subject to disciplinary action by the Medical Executive Committee. A practitioner whose staff membership or clinical

privileges are suspended or terminated for failure to pay dues, fees or assessments, shall not have access to the Fair Hearing and Appellate procedures.

### **13.2 ASSESSMENTS**

Special assessments and fees for processing applications for Medical Staff membership may be adopted after recommendation of the Medical Executive Committee and approval by the Board.

<p style="text-align: center;"><b>PART FOURTEEN REVIEW AND AMENDMENT</b></p>
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These General Rules and Regulations of the Medical Staff shall be reviewed at least every two (2) years by the Bylaws Committee, and may be reviewed more frequently when deemed necessary by the appropriate Medical Staff or Hospital authorities. Suggestions for changes in the Rules and Regulations shall be referred to the Bylaws Committee which shall present its recommendations in timely fashion to the MEC.

These Rules and Regulations may be amended or repealed, in whole or in part, or new ones proposed by the affirmative vote of a majority of the MEC present at a regular or special meeting at which a quorum is present. Amendments or new Rules and Regulations shall become effective upon the affirmative vote of the Board of Trustees. Any changes in the MEC's recommendations proposed by the Board of Trustees shall first be submitted to the MEC for its recommendations, including 30 working days for response, and any response timely made shall be carefully considered by the Board of Trustees prior to its action on the proposed amendments or new Rules and Regulations.