

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

## **MEMORIAL HOSPITAL OF SOUTH BEND, INC.**

### **SOUTH BEND, INDIANA**

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# RULES AND REGULATIONS OF THE MEDICAL STAFF

## Table of Contents

A.	ADMISSION AND DISCHARGE OF PATIENTS .....	1
	1. Admissions .....	1
	2. Diagnosis.....	1
	3. Patient Information .....	1
	4. Timely Care .....	1
B.	DISASTER DUTIES .....	2
C.	PHARMACY .....	2
	1. Formulary .....	2
	2. Stop Order.....	2
	3. Generic Substitution .....	2
	4. Meds at Home .....	2
D.	CONSULTATIONS.....	2
	1 Required consultations.....	2
	a. Obstetrics and Gynecology .....	2
	b. Pediatrics .....	3
	c. Psychiatric.....	3
	d. Special Care Unit .....	3
	e. Carotid Angioplasty & Stenting (CAS).....	3
	2. Recommended consultations .....	4
	a. Cases where the diagnosis is obscure or best therapeutic measures in doubt ....	4
	b. Stat consultations .....	4
	c. Routine consultations.....	4
	d. Switchboard cannot take messages regarding consultations .....	4
E.	CODE BLUES .....	4
F.	TB EXPOSURE.....	4
G.	TRANSFER OF PATIENTS .....	4
H.	EMERGENCY CARE AND COVERAGE .....	5
I.	MEDICAL RECORDS .....	6
	1. CONTENT OF THE MEDICAL RECORD .....	6
	a. History and Physical.....	6
	b. Pre-surgical Assessment and Post Procedure Evaluations .....	8
	c. Operative Reports .....	8
	d. Consultation Report .....	9
	e. Reports of Tests and Results .....	9
	f. Physician Progress Notes .....	9
	g. Verbal Orders.....	9
	h. Standing Orders .....	9
	i. Consents .....	10
	j. Discharge Summary.....	10

# RULES AND REGULATIONS OF THE MEDICAL STAFF

## Table of Contents

k.	Final Progress Note .....	10
l.	Discharge Order; Discharge AMA.....	10
m.	Nursing Home Transfer Sheet .....	10
n.	Psychiatric Evaluation .....	10
o.	AJCC T-N-M Staging Form .....	10
p.	Abbreviations .....	10
2.	AUTOPSIES.....	11
3.	AUTHENTICATION.....	11
4.	RECORD COMPLETION GUIDELINES .....	11
5.	RELEASE OF INFORMATION .....	12
J.	ALLIED HEALTH PROFESSIONAL STAFF .....	12
K.	RESIDENTS/MEDICAL STUDENTS .....	12
1.	Residents .....	12
2.	Medical Students.....	13
a.	Sophomore Medical Students .....	13
b.	Junior/Senior Medical Students .....	13
	CERTIFICATION OF ADOPTION AND APPROVAL .....	14



# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

## **A. ADMISSION AND DISCHARGE OF PATIENTS**

### 1. Admissions

The Hospital shall admit patients suffering from all types of diseases, subject to the availability of qualified staff and appropriate facilities, but shall not continue service for patients requiring only prolonged rest or domiciliary care. Only physicians who have submitted proper credentials and have been duly appointed to the Medical Staff, or who have been granted temporary privileges may treat patients.

### 2. Diagnosis

Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated and the consent of the Hospital President or his representative secured. In the case of an emergency, the provisional diagnosis shall be stated at the time of admission.

### 3. Patient Information

Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients or health care workers from those who are a source of danger from any cause whatever, or to assure protection of the patient from self harm. While information regarding communicable disease may have clinical importance to the medical management of patients and should be made available to appropriate personnel who provide health care for the infected patient, such information, like all other health information, must be treated with the highest regard to confidentiality.

### 4. Timely Care

All physicians must assure timely, adequate professional care for their patients in the Hospital by being available or having available, through their office or answering service, an eligible alternate physician with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Should a physician fail to name such an associate, an Officer of the Medical Staff, or Chief of the Department concerned, shall have authority to call any member of the Attending or Conditional Attending Staff to assist as needed in the situation. Failure to provide an alternate physician may lead to suspension from the Medical Staff.

Patients will be seen by their physicians in a timely manner; stable patients will be seen routinely on a daily basis; critically ill patients will be evaluated on a more frequent basis dependent upon the severity of their illness.

Patients admitted to the Adult Special Care Units should be evaluated within 2 hours by an attending physician with Level I privileges or the Chief Resident of the Medicine service, if not examined immediately prior to admission.

Patients admitted to intensive care status in the Pediatric Intensive Care Unit (PICU) must be examined within 2 hours by the attending physician or an intensivist, if not examined immediately prior to admission. Patients admitted to intermediate status need to be examined within 12 hours of admission.

When a physician is on Emergency Department (ED) "staff" call for a given specialty, it is the duty and responsibility of that physician to assure that he/she is immediately available to the ED physician during the scheduled on-call period. The time frame for arrival in the ED by a consulting physician will be determined jointly by the ED physician and the consulting physician and will be based on the acuity of the patient involved. The response time for high acuity patients should be thirty (30) minutes. The response time for trauma (911) patients will be governed by the American College of Surgeons' guidelines. An on-call physician may secure a qualified alternate physician (with at least equivalent Clinical Privileges) to assume call responsibilities in the event that he or she is temporarily unavailable.

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

## **B. DISASTER DUTIES**

Designated physicians shall be assigned disaster duties in the Hospital, and it is their responsibility to report to their assigned stations. No physicians will perform any duties other than those assigned. During a state of emergency, all policies concerning patient care will be a joint responsibility of the Chairman of the Disaster Committee and the Hospital President, and in their absence, the Vice Chairman and alternate in Administration are next in line of authority, respectively. All physicians on the Medical Staff of the Hospital specifically agree to relinquish direction of the professional care of their patients, service and private, to the Chairman of the Disaster Committee in cases of such emergency. Key Hospital personnel shall rehearse the Disaster Plan at least twice a year.

## **C. PHARMACY**

### **1. Formulary**

Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-official Drugs, with the exception of drugs for bonafide clinical investigations. The Institutional Review Board and the Pharmacy and Therapeutics Committee must approve exceptions to this rule.

### **2. Stop Order**

There shall be an automatic stop-order on the following drugs at such times as listed, unless ordered for a longer period of time by specific dates.

Narcotics-----7 days

Antibiotics-----7 days

Anticoagulants-----3 days ((except where prothrombin time exceeds 20 seconds)

I.V. Mainline Admixtures and solutions---3 days

There shall be an automatic cancellation of standing drug orders when a patient undergoes surgery. When a patient returns from surgery, all orders must be re-written.

There shall be an automatic stop order on all orders when a patient is transferred into or out of the Special Care Unit.

### **3. Generic Substitution**

In all cases where a physician orders a drug by trade name, the Pharmacist can dispense the drug by its generic and/or therapeutic equivalency according to the hospital formulary, unless specifically expressed in writing "DO NOT SUBSTITUTE."

### **4. Meds at Home**

The order "Meds as at home" is not accepted as a valid medication order. Such orders must include the names of all medications taken at home to be administered in the Hospital, and doses and frequencies of administration of each medication.

## **D. CONSULTATIONS**

1. Consultations are required in the following situations:

### **a. Obstetrics and Gynecology:**

- Operations for the interruption of pregnancy prior to viability of the fetus shall require consultation with maternal-fetal medicine.
- For "non-specialists" in the field of Obstetrics-Gynecology in the following cases:
  - High risk pregnancy, including, but not limited to breech births, multiple pregnancy, and VBAC
  - Moderate or severe pre-eclampsia or eclampsia.

# RULES AND REGULATIONS OF THE MEDICAL STAFF

- Proposed induction of labor, whether medical or surgical.
  - Hemorrhage.
  - Fetal malposition.
  - Prolonged labor.
  - Cervical incision, version and extraction, craniotomy and embryotomy.
  - Patients under or equal to 32 weeks gestation admitted with preterm labor or premature rupture of membranes.
  - Any operative procedure other than the perineal phase (crowning) of outlet forceps or vacuum extraction, with or without episiotomy.
  - All cases of severe toxemia and sepsis, either puerperal or abortal.
  - Any vaginal birth following cesarean section or other uterine scar.
  - Anesthesia will be notified and available for all breech births, multiple pregnancies, and vaginal deliveries following cesarean section or other uterine scar.
- With a member of the Obstetrical Staff in the management of pregnant patients hospitalized by a physician without obstetrical privileges for medical or non-obstetrical surgical procedures.
- b. Pediatrics:
- For all patients admitted to the Pediatric Intensive Care Unit, the patient's attending physician, jointly with a pediatric intensivist, must determine whether there is a need for consultation by the pediatric intensivist.
  - For "non-specialists" in the field of Pediatrics in cases in which an infant is admitted to the intensive care nursery for reasons other than short-term observation.
- c. Psychiatric:
- Psychiatric consultation is required within 24 hours of admission for all patients who have attempted suicide. If a patient is transferred to Epworth Center for admission within 24 hours, a psychiatric consultation does not need to occur before transfer.
- d. Special Care Unit: The following circumstances indicate those situations in which a consultation is required to ensure optimal patient care. This list may not be all inclusive of presenting symptoms that may require consultation.
- All patients admitted for acute myocardial infarction with complication, including congestive heart failure and/or pulmonary edema associated with hypotension with systolic blood pressure less than 90; urine output of less than 20cc/hour; ongoing unresolved chest pain, must have a cardiology consult.
  - All patients requiring swan-ganz catheters must have a consult with a physician appropriately credentialed.
  - All patients in renal failure, requiring dialysis, must have a nephrology consult.
  - All patients on ventilators more than 48 hours must have a consult with a physician appropriately credentialed.
  - All pregnant patients must have an obstetric consult.
  - All patients with sustained significant cardiac dysrhythmias must have a cardiology consult.
- e. Carotid angioplasty and stenting (CAS): vascular surgery consultation required prior

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

to procedure.

2. Consultations are recommended in the following situations:
  - a. Except in an emergency, a consultation with another qualified physician is recommended in cases in which according to the judgment of the attending physician the diagnosis is obscure, or the best therapeutic measures are in doubt. Such consultations need only be sought if, after the professional opinion of the physician and consideration of his or her individual experience and training, the physician determines it would be in the best interest of the patient to seek such consultation.
  - b. The attending physician or resident must make all requests for physician consultations, which are "stat" directly to the physician being consulted.
  - c. Routine consultation requests are to be completed within 24 hours. The physician requesting consultation is responsible for ensuring information regarding a patient is provided to the consulting physician. The consultant physician is responsible for providing the appropriate documentation in the medical record regarding his/her involvement with the patient's care.
  - d. The switchboard operators will not be allowed to take messages from anyone regarding consultations.

## **E. CODE BLUES**

Any patient in the hospital whom experiences cardiac/respiratory arrest shall have a Code Blue called and CPR initiated unless the person is identified as a patient with a "No Code Blue" order. Physicians must use best efforts to adhere to the patient's advance directives and wishes regarding resuscitative measures and order "No Code Blue" orders, as appropriate. The Medical Staff will respond to Code Blues in accordance with the Hospital's Code Blue Policy/Procedure. Code Blues will be responded to in a timely manner.

## **F. TB EXPOSURE**

Physicians should provide evidence of current PPD testing and any other immunization status required by the Indiana State Department of Health at the time of initial appointment. Should prevalence data collected on an ongoing basis suggest the need for retesting, physicians are expected to comply with the request within the appropriate time frames.

## **G. TRANSFER OF PATIENTS**

Prior to transferring a patient to another facility or to a community agency, the attending physician shall ensure:

1. Available medical treatment necessary to minimize the risks to the patient (or, for a woman in labor, to the unborn child) is provided before and during transfer.
2. The receiving facility has the facilities and personnel available to treat the patient and has agreed to accept the transfer.
3. Copies of all medical records available at the time of transfer are sent to the receiving facility.
4. With respect to **unstable patients**, the attending physician shall also ensure that the patient is only transferred after **either** the patient requests transfer in writing after being informed of the risks and benefits of the transfer **or** a certification of transfer is completed verifying the medical necessity of the transfer and that the medical benefits of treatment at the receiving facility outweigh the risks of transfer, **and** include in the patient's medical record the name and address of any on-call physician who refused or failed to appear within a reasonable

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

period of time to provide necessary stabilizing treatment.

## **H. EMERGENCY CARE AND COVERAGE**

1. The Medical Staff shall adopt a method of providing medical care in the Emergency Department. When this method consists of a group practice of physicians, the Hospital will enter into an agreement specifying the duties and responsibilities of the Hospital and the group. Clinical privileges shall be granted to members of the Emergency Department in accordance with Article V of the Medical Staff Bylaws.
2. Any person presenting to the hospital, either at the Emergency Department or elsewhere, and requesting treatment or accompanied by another requesting his/her treatment, must be examined by an active member of the Medical Staff, or a member of the Resident Staff under the supervision of a member of the Medical Staff, to determine whether an emergency medical condition exists. Notwithstanding the above, nothing shall prohibit OB Nurses or unsupervised members of the residency program from performing, as qualified medical personnel, labor checks on pregnant women experiencing contractions who present to the Hospital Obstetrics Department. The Hospital shall separately identify any special training or experience required as a prerequisite to being identified as qualified medical personnel. If the individual has an emergency medical condition, the attending physician shall (a) provide or arrange for the provision of such available treatment as may be necessary to stabilize the individual's condition, or (b) if the medical benefits to transfer outweigh the risks and such transfer is medically necessary, arrange for an appropriate transfer. A person is in an emergency medical condition if he/she presents with acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could be reasonably expected to result in: (a) serious jeopardy to the health of the person (or another individual in the case of a psychiatric disturbance) or the person's unborn child, (b) serious impairment to bodily functions; or (c) serious dysfunction of any body organ or part. With respect to a pregnant woman who is having contractions, an emergency medical condition exists if (a) there is inadequate time to effect a safe transfer to another hospital before delivery or (b) the transfer may pose a threat to the health or safety of the woman or unborn child.
3. It is the duty of Attending and Conditional Attending Staff members to provide back-up specialty coverage to the Emergency Department. The Emergency Department call schedule is the responsibility of each Department Chief and is assimilated in the Medical Staff Office in a timely fashion. It is the responsibility of the on call physician to make arrangements for coverage if he or she will not be available on the dates scheduled.
4. When a physician is designated on call, it is the physician's responsibility to provide consultation for care of patients in the Emergency Department for whom he/she is called within the realm of his/her specialty regardless of the patient's financial resources.
5. When a physician is on call to the Emergency Department for a given specialty, it is the duty of and the responsibility of that physician to assure that he/she is immediately available, at least by telephone, to the ED physician for the scheduled on-call period and can arrive at the ED within a reasonable time period. The on-call physician may secure a qualified alternate (same specialty level of training) in the event he or she is temporarily unavailable.
6. When an Emergency Department Physician's proposed disposition of an ED patient does not concur with an attending physician's discharge plan during a telephone consultation, and no mutually agreeable compromise can be met, the attending physician must physically arrive to the ED to evaluate and assume care of the patient. This should occur within a reasonable time period. The attending physician may be represented by a colleague that possesses the same level of knowledge and skills to care for the patient, but it is the attending physician's responsibility to secure the services of that individual. Should the attending physician refuse to attend to this request, the Chief of that physician's department will be notified and assign

# RULES AND REGULATIONS OF THE MEDICAL STAFF

care for the patient. Further review of this case will occur via Departmental investigation and the President of the Medical Staff will be notified.

7. The Medical Staff will provide care for a person with an emergency medical condition in accordance with the Hospital's EMTALA/Patient Transfers Policy.

## I. MEDICAL RECORDS

1. **Content of the Medical Record:** All patient record entries must be legible, complete, dated, timed, and authenticated promptly in written or electronic form by the person responsible for providing or evaluating the service provided. The attending physician shall be held responsible for the preparation of a complete and legible medical record that accurately reflects the patient's condition and care for each individual evaluated or treated as an inpatient, ambulatory care patient, or emergency patient. The record shall include:

### a. History and Physical:

- (1) Documenting H&P – Time Frames

A medical history and physical examination (H&P) must be completed for each patient no more than 30 days before or 24 hours after admission by a physician or other qualified individual who has been granted these privileges by the Medical Staff. Documentation is to be placed in the patient's medical record within 24 hours after admission or prior to surgery.

- (2) Timing Requirements – Update Note Required

When the H&P examination is recorded within the 30 days before admission, the hospital must ensure that an updated medical record entry documenting an examination for any changes in the patient's condition is completed and documented in the patient's medical record within 24 hours after admission or prior to surgery.

- (3) Content

At a minimum, the H&P examination report shall include the following: the chief complaint and details of the present illness, assessment of the patient's past medical, social and family histories, a review of body systems, physical examination, and impression and plan for treatment.

- (4) H&P From Transferring Hospital

If a patient is transferred from another hospital, the H&P from the transferring hospital may be used only if it has been done by a licensed physician or other qualified person and only if it has been done within the above stated conditions. If the H&P is to be used from the transferring hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that any subsequent changes have been documented on the report. If there are no changes, the physician or other qualified person must indicate so and sign the updated note.

- (5) Surgery/Procedure H&P Requirements

Except in emergencies, the patient's H&P, any laboratory and x-ray results, the preoperative diagnosis and a properly executed consent form must be present on the medical record prior to performing any inpatient diagnostic or surgical procedure. By definition, a procedure involves the puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations. The definition excludes peripheral venipuncture and intravenous therapy. If the H&P is not completed prior to surgery, the patient's surgery will be cancelled, unless the surgeon states in writing that

# RULES AND REGULATIONS OF THE MEDICAL STAFF

such a delay would constitute a hazard to the patient. The Emergency Department note cannot be used as an H&P if the patient is admitted through the Emergency Department. The H&P must be obtained by the attending physician.

(6) Outpatient Surgeries/Procedures

An H&P is also required for all outpatient surgeries and procedures with the following exceptions: CT scans and MRIs, diagnostic lumbar punctures, epidural steroid injections, paracentesis, thoracentesis, joint aspirations or injections, facet injection, EEG studies, outpatient tube thoracostomy, central line placement, fine needle aspiration, drainage tube exchanges or injections, needle aspirations/biopsy of superficial organs (i.e., thyroid, breast), nasogastric tube placement, urodynamic studies, and laser treatments of the eye and skin. Any procedure that employs the use of moderate sedation must follow that policy and, therefore, requires an H&P to be present.

For outpatient pediatric dental procedures performed by dentists, the "Pre-anesthesia Evaluation Form" will be accepted as the H&P and qualify for these surgeries.

(7) Other Requirements

(a) A dictated H&P or hand-written Short Stay H&P will be accepted as meeting the requirement for an H&P prior to surgery.

(b) Any other document thought to be the physician's or other qualified provider's H&P is to be reviewed for presence of required content before assuming it meets the requirements of an H&P. Components which must be present include chief complaint, history, physical exam (which at least includes reference to heart, lungs, and neuro or mental status), impression, and plan.

(c) Action when H&P not present: If it appears a patient will be going to surgery without an H&P which meets the above requirements, or the H & P is greater than 30 days old, the following steps shall be taken:

(d) Upon preparation for surgery, the RN determines the presence of an H&P. If not present to meet all of the above, the RN notifies the surgeon.

(e) If the H&P is not on the chart within 30 minutes of the scheduled surgery and the surgeon has not indicated the H&P will be written prior to surgery, the nurse shall page one of the following to assist in resolution of the H&P:

Exec. Dir., Surgical Services	pager 675-4328d
VP, Chief Nurse	pager 236-6765d
VP, Medical Staff	pager 280-9888d
Administrator on Call	pager 284-0183d
Administrative Supervisor	pager 753d

(f) Surgery staff may not take the patient to surgery until approved by one of the above persons.

(g) Individuals qualified to perform H&Ps include:

# RULES AND REGULATIONS OF THE MEDICAL STAFF

- Licensed physician
- Oral Surgeons who are members of the Medical Staff with H&P examination privileges.
- Dentists are responsible for the part of their patients' H&P examinations related to dentistry. For dental admissions, the full H&P examination must be completed by a licensed physician or other qualified person. The examination needs to be performed and documented no more than 30 days prior to the procedure. Any H&P older than 30 days will not be accepted and the procedure cannot be done. The Pre-Anesthesia Evaluation form will qualify as the H&P for surgeries performed by pediatric dentists and the H&P update note will be completed by the anesthesiologist as documented on the Pre-Anesthesia Evaluation form.
- Podiatrists who are privileged to perform H&P examination on their patients including examination and documentation of cardio-respiratory status. Podiatrists are responsible for the Update Note when the H&P Examination is over 24 hours old but within 30 days of admission prior to surgery.

- b. **PRE-SURGICAL ASSESSMENT AND POST PROCEDURE EVALUATIONS:** Any patient for whom moderate or deep sedation is contemplated must receive a pre-sedation or pre-anesthesia assessment.

The pre-anesthesia evaluation of the patient will be documented in the patient's medical record by an individual qualified to administer anesthesia. This will include pertinent information relative to the choice of anesthesia, the surgical or obstetrical procedure anticipated, and the ASA risk classification. Except in extreme emergency cases, this evaluation should be recorded prior to the patient's transfer to the anesthesia and operative area and before preoperative medication has been administered.

The patient must be re-evaluated immediately prior to moderate or deep sedation use and before anesthesia induction.

The post-anesthesia follow-up note must be written in the medical record within 48 hours after the inpatient surgery.

In operative procedures where laterality exists, the surgical or procedure site will be verified for laterality in accordance with the Memorial Hospital Policy and Procedure "Surgical Site Verification Policy."

- c. **OPERATIVE REPORTS:** An operative report shall be dictated within 24 hours following the operative procedure.

The operative report shall contain a description of the findings, technical procedures used, specimens removed, preoperative and postoperative diagnoses, estimated blood loss, and the name of the primary surgeon and any assistants.

When the operative report is not placed in the medical record immediately after surgery, for example when there is a transcription delay, an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend the patient. The progress note is to include the name of the procedure, name of the primary surgeon and assistants, findings, preoperative and postoperative diagnoses, specimens removed, estimated blood

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

loss, and complications, if any.

The use of preprinted or pre-taped material is unacceptable.

- d. **CONSULTATION REPORT:** A consultation shall be requested on the written order of the attending physician. 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. This report shall be made a part of the patient's medical record.
- e. **REPORTS OF TESTS AND RESULTS:** All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record.
- f. **PHYSICIAN PROGRESS NOTES:** Progress notes should give a pertinent chronological report of the patient's progress and reflect any change in condition and the results of treatment. Progress notes are to be written daily, except for patients admitted to Hospice status, in which case they should be written every third day or when there is a change in the patient's condition.
- g. **VERBAL ORDERS:** Verbal orders (including telephone orders) shall originate only from a member of the Medical or Dental Staff, a resident physician, or allied health practitioner authorized to write orders and must be dated, timed, and authenticated promptly. Verbal orders may be accepted and transcribed by a Registered Nurse, Graduate Professional Nurse, Practical Nurse, Senior Medical Student, Registered Pharmacist, Respiratory Therapist, Radiologic Technologist and Medical Technologist; and, within their areas of respective specialties, Occupational Therapist, Physical Therapist, Perfusionist, Licensed Psychologist, Clinical Neuropsychologist, Certified Speech Pathologist, Certified Audiologist, or Memorial Hospital employed paramedics.

The Manager of Admitting and/or his or her designated delegates, may accept and transcribe Verbal Orders for diagnostic tests only. A Dietitian may accept and transcribe Verbal Orders for diet orders/changes only. Nursing extender staff may accept orders for Diet, Discharge, diagnostic tests, and non-invasive therapeutic procedures. (They may not accept orders for invasive therapeutic procedures nor medications.) Nursing extender staff include Unit Clerks, Patient Care Clerks, Care Extenders, Critical Care Techs, and Social Workers as it pertains to discharge planning. All Verbal Orders for treatment shall note the name of the practitioner giving the order and the person relaying the order, and be dated, timed, and signed by the authorized person to whom it was dictated.

Recorded Verbal Orders are read back to the person giving or relaying the order by the person who records it on the record. If an individual other than the individual giving the verbal orders authenticates such orders, then such individual must be of the same discipline as the individual giving the verbal orders. Verbal Orders which have been read back, i.e., repeated and verified, are recorded as R&V on the order sheet. These orders are dated, timed, and authenticated (signed) by the person giving the order within 30 days of discharge. In unusual situations for which the verbal read back is not possible, and R&V is not recorded, the verbal order is signed within 48 hours or receipt of the order.

- h. **STANDING ORDERS:** Standing orders shall be formulated by joint action of the Medical Staff and the Hospital President or his representative, and may be changed only in the same manner. These standing orders shall be initiated by the attending physician and be followed insofar as proper treatment of the patient will allow, unless and until specific orders are written for and signed by the attending physician.

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

- i. **CONSENTS:** Before obtaining informed consent, the risks, benefits, and potential complications associated with a procedure are discussed with the patient and family. Alternative options are discussed. The possibility of the need for transfusion of blood or blood components and the risk of and alternatives to transfusion are discussed as well when appropriate. Except in an emergency, the physician performing the procedure shall obtain the patient's informed consent as appropriate for relevant diagnostic and treatment procedures. All surgical consent forms will be completed and signed by the patient (or legally qualified representative) and physician prior to the time of surgery; otherwise the surgery shall be cancelled, unless the attending surgeon states in writing that such a delay would constitute a hazard to the patient.
  
- j. **DISCHARGE SUMMARY:** A Discharge Summary is required for all patients staying in the hospital 48 hours or more and on any patient (inpatient or outpatient) who expires. A discharge summary shall contain the reason for admission, procedures performed, treatment rendered, the condition of the patient upon discharge and instructions relating to physical activity, medication, diet, and follow-up care. The discharge summary will also include the principal diagnosis, secondary diagnoses, procedures performed, any infections and/or complications occurring during hospitalization, and the physician's signature.  
  
The admitting physician will be responsible for the discharge summary unless the patient has been formally accepted by another physician in transfer, in which case the discharge summary will be prepared by that physician. Nurse Practitioners and Physician Assistants may dictate discharge summaries. Other individuals may be allowed to dictate discharge summaries as approved by the Credentials Committee.
  
- k. **FINAL PROGRESS NOTE:** A final progress note may be substituted for a discharge summary in the case of patients who require less than 48 hours of hospitalization (and in the case of normal newborns, uncomplicated obstetrical deliveries, cesarean sections and obstetrical patients undergoing a tubal ligation). The final note includes the outcome of the hospitalization, case disposition, instructions given to the patient and/or family, the final diagnosis and any secondary diagnoses and/or complications. If the final progress note is not written at the time of discharge, the final progress note will be required to be dictated for entry into the electronic medical record.
  
- l. **DISCHARGE ORDER; DISCHARGE AMA:** Patients shall be discharged only by verbal or written order of the attending physician. Should a patient leave the hospital against medical advice, the attending physician or other appropriate person shall document all efforts taken to apprise the patient of the risks associated with such a departure.
  
- m. **NURSING HOME TRANSFER SHEET:** The Nursing Home Transfer Sheet shall be completed at least 24 hours prior to the patient's transfer to allow appropriate arrangements to be made by the Social Services Department for the patient's transfer.
  
- n. **PSYCHIATRIC EVALUATION:** A Comprehensive Psychiatric Evaluation must be completed by the psychiatrist, or nurse practitioner under the direction of the psychiatrist, within 24 hours of admission and be present on the Medical Record within 24 hours of admission.
  
- o. **AJCC T-N-M STAGING FORM:** A site-specific TNM Staging Form shall be included in the medical record of all appropriate newly-diagnosed cancer patients. The form will be completed by the surgeon if a definitive surgery was performed, or by the attending physician.

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

- p. **ABBREVIATIONS:** Symbols and abbreviations may be used in the medical record unless the abbreviation is on the "Do Not Use" list of abbreviations. Abbreviations that are allowed must be understood within the context of the material written.

## **2. AUTOPSIES:**

It shall be the duty of all Medical Staff members to attempt to secure meaningful autopsies whenever possible, but at least with respect to all cases of unusual deaths and of medical-legal and educational interest. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist, or by a physician delegated this responsibility. Provisional anatomical diagnoses shall be recorded on the medical record within 72 hours and the complete protocol shall be made part of the record within 60 days. The attending physician shall be notified of the time of the autopsy directly by the pathologist whenever possible. If direct physician-to-physician communication cannot occur, the attending will be notified of the autopsy time by the Pathology Office.

It is highly recommended that any intra-operative death shall have an autopsy unless specifically refused by the family.

## **3. AUTHENTICATION:**

The parts of the medical record that are the responsibility of the practitioner must be legible, complete, dated, timed, and authenticated promptly in written or electronic form by the practitioner.

Authentication of Nurse Practitioner and Physician Assistant documentation: The supervising physician must co-sign all Orders, H&Ps, and Discharge Summaries within 24 hours of the documentation by the Nurse Practitioner or Physician Assistant. Progress Notes do not need to be co-signed.

## **4. RECORD COMPLETION GUIDELINES:**

The medical records of patients shall be complete within a period of time that will in no event exceed thirty (30) days following discharge from inpatient or outpatient care. Any record not complete within this period of time will be considered delinquent.

If a medical record is not complete at the time of discharge, the following procedure will be followed:

1. Following discharge, medical records will be reviewed by the Medical Record Department and deficiencies will be identified and assigned to the responsible physician.
2. Each Tuesday, physicians will be notified by postcard of any records that will be considered delinquent if not complete by the second Monday following notification. Documentation queries sent to physicians and not responded to are considered incomplete and will be included in the delinquent record count. If all available records have not been completed by 8:00 a.m. on this date, the responsible physician's privileges shall be automatically suspended, including admitting and consultation privileges.
3. No admissions, consultations, surgeries or other elective procedures will be scheduled after the date the physician's privileges have been temporarily suspended. Admitting privileges include scheduled, elective or direct admissions. Emergency admissions are excluded. Upon completion of all incomplete/delinquent medical records, rescheduling of any canceled procedures or admissions will be

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

necessary. In the case of physicians currently treating inpatients, the physician will be allowed to treat the patient until the patient is discharged.

4. Each Monday, a list of physicians whose privileges have been suspended will be distributed by the Medical Record Department to all appropriate Hospital departments. Upon completion of records, the Medical Record Department will notify all involved departments that the physician has completed all his/her medical records and his/her admitting privileges are reinstated immediately.
5. Exceptions to the above may be granted by the President of the Medical Staff.
6. After six (6) automatic suspensions during any 12-month period, the Medical Staff Office will be notified by the Medical Record Department and the physician's membership and privileges shall be automatically terminated based upon this non-clinical, administrative factor. At this point, the physician must complete all available medical records, reapply for medical staff membership and privileges, and pay the current application fee.

## **5. RELEASE OF INFORMATION:**

All medical records are the property of the hospital and may be removed only by court order, subpoena or statute. A physician who is a member of Memorial's Medical Staff and is currently treating the patient, may have access to copies of the patient's previous medical records. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient be attended by the same physician or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the physician for a period to be determined by the Executive Committee of the Medical Staff.

## **J. ALLIED HEALTH PROFESSIONAL STAFF**

Non-practitioner personnel supervised and employed by a Medical Staff member must conform to the following requirements while engaged in designated activities within the Hospital:

- Medical Staff member shall submit a request for his non-practitioner personnel to assist in the hospital. This request shall specify the duties the practitioner expects his employee to perform.
- Medical Staff member shall submit written credentials of adequate training or certification in the area of which services are to be rendered, to the President for approval by the proper medical department and the Executive Committee of the Medical Staff.
- Medical Staff member shall assume complete responsibility for his personnel's actions, including professional liability, and shall submit a signed document substantiating this responsibility.
- The practitioner's personnel shall be permitted to provide services within their scope of practice as authorized by the Board of Trustees of Memorial Hospital.
- The practitioner's personnel shall not be permitted to function independently.

## **K. RESIDENTS/MEDICAL STUDENTS**

### **1. Residents**

Residents are not members of the medical staff and have no independent privileges within Memorial Hospital. Residents may participate in the care of patients at Memorial Hospital only with the agreement of the attending physician. While residents may write orders and progress notes in patient charts, attending physicians retain responsibility for the care of patients seen by residents and must review the care of these patients at least daily.

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

Specifically, the Resident has the privilege of performing all the functions of an attending physician, but under supervision. Histories, physicals, discharge summaries and discharge orders shall be counter-signed by the attending physician. The face sheet of inpatient hospital charts and the medical record of patients seen in the Emergency Department shall also be counter-signed.

Residents may perform procedures in Memorial Hospital under the direct supervision of attending physicians. Residents may only perform procedures for which the patient's attending physician has privileges. Residents may perform minor procedures without direct supervision only with the agreement of the attending physician. Minor procedures are those which are minimally invasive with a low risk of complications, including those procedures typical taught in medical school or delegated to non-physicians in the hospital. Examples include starting peripheral intravenous lines and inserting urinary bladder catheters.

Residents may perform circumcisions without direct supervision after they have successfully completed five procedures under direct supervision. This supervision can be provided by attending physicians or by other residents who have met the requirements to perform the procedure without direct supervision.

Residents may perform lumbar punctures without direct supervision after they have successfully completed three procedures under direct supervision. This supervision can be provided by attending physicians or by other residents who have met the requirements to perform the procedure without direct supervision.

Residents may perform other procedures without direct supervision only if the attending physician has directly observed the resident successfully performing the procedure and the attending physician approves, or if the residency program has documentation of successful completion of the procedure in the past.

As physicians, residents may act in the best interest of patients in emergency situations, subject to subsequent review by the attending physician and the usual quality assurance measures of the medical staff of Memorial Hospital.

Residents not following the above guidelines are subject to the disciplinary policies of the residency program. The above guidelines apply to residents in all years of training.

Attending physicians or their designees AND a representative of the residency program's faculty are available for consultation at all times to ensure that questions arising from hospital staff members about the conduct of residents with respect to this policy can be answered promptly.

## **2. Medical Students**

All medical students at Memorial Hospital are in good standing with their Medical School and are covered by appropriate malpractice insurance.

### **a. Freshmen Medical Students**

The freshmen students engaged in the summer HME program at Memorial Hospital are under the direct supervision of Medical Staff physicians who have verbally agreed to have the students with them. The Department of Medical Education is responsible for developing and assigning the clinical activities for the students.

### **b. Sophomore Medical Students**

The sophomore students engaged in the Physical Diagnosis Course at Memorial Hospital are under the direct supervision of a Medical Staff physician who is a member of the faculty of Indiana University. The course director is responsible for

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

developing and assigning the clinical activities for the student.

c. **Junior/Senior Medical Students**

The junior/senior students may write or dictate histories and physicals, progress notes, and discharge summaries. They may also write orders after first conferring with a Resident or the attending physician. All orders written by students require a verbal or written approval by the attending physician, consultant, or Resident before the order may be carried out. Special procedures by the students, such as spinal taps, paracenteses, etc., will be supervised by a Resident, attending physician, or consultant.

The above guidelines are to be transmitted to all hospital areas involved before each educational experience of the student is initiated.

# **RULES AND REGULATIONS OF THE MEDICAL STAFF**

## **MEDICAL STAFF RULES AND REGULATIONS CERTIFICATION OF ADOPTION AND APPROVAL**

Adopted by the Medical Staff

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President of the Medical Staff  
Memorial Hospital of South Bend, Inc.

June 5, 2000  
Date

Approved by the Board of Trustees

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Chairman, Board of Trustees  
Memorial Hospital of South Bend, Inc.

June 22, 2000  
Date