MEDICAL STAFF
RULES AND REGULATIONS

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MEDICAL STAFF RULES & REGULATIONS

Preamble: All mid-level providers shall abide by rules and regulations pertaining to physicians, except if specifically excluded.

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The hospital shall accept patients for care and treatment without regard for race, religion or ability to pay.

2. A patient may be admitted to hospital only by a member of the Medical Staff who has admitting privileges. All physicians shall be governed by the official admitting policy of the hospital.

3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for communicating necessary special instructions, and for transmitting reports on the condition of the patient to the referring physician and to relatives of the patient. **Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.**

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

5. In any emergency case in which it appears that the patient will have to be admitted to a hospital, whenever possible first contact the appropriate personnel to ascertain an available bed.

6. When a patient must be admitted on an emergency basis and does not have a private physician, a member of the active or associate staff on duty in the service will be assigned to the patient, on a rotation basis, where possible.

7. Each physician must assure timely, adequate professional care for his patients in the hospital by being available or, in his absence, having available through his office an eligible alternate physician, or physicians, with whom prior arrangements have been made to cover both in house patients and potential emergency room patients. Physicians providing coverage must possess clinical privileges equivalent to the absent staff member. An exception shall be made for uncomplicated post operative care when, in the surgeon's absence, the patient's private physician may assume coverage. Failure of an attending physician to meet these requirements shall result in loss of clinical privileges. **A physician who will be out of town for over twenty-four hours should, on the order sheet of the chart of each of his patients, indicate in writing the name of the physician who will be assuming responsibility for the care of the patient during his absence.**

8. Patients will be admitted under the following descriptions as defined in the U.R. Policy:

   (a) Inpatient Admissions
   (b) Observation Admissions
   (c) Swing Bed
   (d) Hospice/Respite

9. Patient Transfers

   (a) Emergency Department to appropriate patient bed;

   (b) From Intensive Care Unit to appropriate care area;

   (c) From temporary placement in an appropriate geographic or a clinical service area to the appropriate area for that patient.

10. The admitting physician shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

11. The attending physician is required to document a diagnosis on admission.

12. Patients shall be discharged only on the order of the attending provider. Should a patient leave the hospital against the advice of the attending provider, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

13. Should it be necessary to attend the patient of any physician in an emergency, the institution is free to call in any member of the Medical Staff after a reasonable effort has been made to locate the attending physician.

14. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death.

15. Staff members should attempt to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with State law. All autopsies shall be performed in accordance with the Autopsy Policy of the Hospital.

16. Medical specialists, who are solo-practitioners and cannot obtain equivalent coverage of their specialty on-staff during their absence, must have a clear mechanism for care of their practice when they are not available. Such coverage shall include: 1) notification of Administration of their planned absence, and 2) provisions for ED patients and in-patients must be made in advance. Unless otherwise stated, such coverage for their ED patients will involve referral of such patients to an alternative facility of the patient's choice. Patients already hospitalized must have care arranged with another physician on-staff, if appropriate, or transfer must be arranged to another facility prior to their departure.

B. MEDICAL RECORDS

1. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services; and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition of discharge; summary or discharge note (clinical resume) to include discharge instructions; and autopsy report when performed.

2. History and Physicals (H&P's) will be completed as outlined below. This report should include all pertinent findings resulting from an assessment of body systems. If a complete history has been recorded and a physical examination performed prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of physical examination, provided these reports were recorded by a member of the medical staff, by an un-credentialed resident, physician assistant, or certified nurse practitioner. This history and physical must have been completed within the last 30 days prior to admission. In such instances, an interval admission note that includes additions to the history and any subsequent changes in the physical findings must always be recorded.

   (a) Inpatient and Observation Admissions need a full "completed H&P" no more than 30 days before or 24 hours after admission.

   (b) Any surgery admission needs a "completed H&P" placed in the chart before surgery or a procedure requiring anesthesia is performed (in compliance with above stipulations).

(c) When an H&P is completed 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 placed in the patient's medical record within 24 hours after admission but in all cases involving surgery or a procedure requiring anesthesia services, prior to the surgery or procedure. The examination must be conducted by a practitioner who is credentialed and privileged by the hospital's medical staff to perform an H & P.

3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, **the procedure shall be canceled, unless the attending physician states in writing that such delay would be detrimental to the patient.**

4. The attending physician shall authenticate the history, physical examination and pre-operative note within 24 hours of admission when they have been recorded outside the hospital by an un-credentialed resident, a physician assistant, or certified nurse practitioner.

5. Pertinent progress note shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

6. Operative reports shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, pre and postoperative diagnosis, estimated blood loss, and complications. Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. Whenever this is not possible, a progress note is entered immediately.

7. Consultations are required whenever the patient requires services that the attending physician is not privileged to render. The attending physician must state the reason for consultation. 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 recommendation. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

8. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record

transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

9. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

10. Unapproved symbols and abbreviations shall not be used by the Medical Staff. An official record of unapproved abbreviations will be maintained in hospital policy and available electronically. If the abbreviations are on the unapproved list they cannot be used if handwritten.

11. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations. This will be deemed equally as important as the actual discharge order.

12. A discharge summary or clinical resume shall be written or dictated on all medical records of patients hospitalized over forty-eight hours except for normal obstetrical deliveries and normal newborn infants. The content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

13. Medical records cannot be removed from the hospital.

14. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research consistent with preserving the confidentiality of the personal information concerning the individual patients. All such projects shall be approved by the Medical Staff before records can be studied. Subject to the discretion of the President and CEO, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. All medical records access must be in compliance with HIPAA regulations and Preston Memorial Hospital's *Notice of Privacy Policy*.

15. A physician's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the physician.

16. A medical record shall not be considered complete until it is completed by the responsible physician.

17. Medical Records are to be completed within 30 days after discharge. Physicians are encouraged to have final diagnoses on the chart at the time of discharge. The following notification and disciplinary procedure will be used:

(a) The physician will receive a written notice if charts are not completed at two weeks and at three weeks after discharge.

(b) The physician will get another written warning, with a copy to the President and CEO, between day 26 and 29 of a chart being deemed incomplete.

(c) At 30 days after discharge if the chart is incomplete, the physician will receive written notice, with a copy to the President and CEO, and the physician will lose inpatient admitting privileges until the chart is completed.

History and physicals are to be completed within 24 hours and Operating Room (OR) reports are to be completed immediately. If a physician has more than three late history and physicals per quarter or more than three late OR reports per quarter he will get a written notice. With the fourth occurrence the physician will get a written notice, with a copy to the President and CEO, and the physician will lose inpatient admitting privileges until the history and physical or report is completed.

17. Standing orders shall be formulated by conference between the Medical Staff and the Patient Care Policy Committee. These orders shall be followed insofar as proper treatment of the patient will allow and when specific orders are not written by the attending physician they shall constitute the orders of treatment.

18. The following criteria must be met by the physician when utilizing experimental drugs:

(a) Investigational drugs shall be used only under the direct supervision of the principal investigator or his approved designee who shall be a member of the Medical Staff and who shall assume the burden of serving the necessary consent.

(b) When nurses are called upon to administer investigational drugs, they shall have available to them basic information concerning such drugs - including dosage forms, strengths available, actions and uses, side effects, symptoms of toxicity, etc. The Pharmacy shall maintain essential information on the investigational drugs which can be made available to the authorized personnel.

(c) The Pharmacy will be the storage area for the investigational drugs, and it will provide for the proper labeling and dispensing in accordance with the investigator's written orders.

19. Any qualified physician with clinical privileges in this hospital may be called for consultation within his area of expertise.

20. The attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending physician to attend or examine his patient, except in an emergency.

21. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of his or her supervisor who in turn may refer the matter to the Chief Nursing Officer. If warranted, the Chief Nursing Officer may bring the matter to the attention of the Chairman of the committee wherein the physician has clinical privileges or the Chief of Staff. When circumstances are such as to justify such action, the Chairman of the committee or the Chief of Staff may himself request a consultation.

C. GENERAL CONDUCT OF CARE

1. All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the responsible physician or appropriate member of the house staff. All telephoned orders and faxed orders shall be signed by the appropriately authorized person who dictated with the name of the physician per his or her own name. The responsible physician shall authenticate such inpatient, swing bed, observation, or Emergency Department orders within twenty four (24) hours, and failure to do so shall be brought to the attention of the Medical Staff for appropriate action. Outpatient clinic and diagnostic orders must be signed no later than the next time the practitioner is present to do so. Telephone or faxed orders by physicians outside of the facility may be authenticated by faxed signature.

2. The physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Renew" and "Continue" orders are not acceptable.

3. All previous orders are canceled when patients go for General or Regional surgery and special monitoring units. Patients requiring local anesthesia do not require canceling of previous orders.

4. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, Physician's Desk Reference, American Hospital Formulary Service, or A.M.A. Drug Evaluations.

5. The Guidelines for the Peer Review Process of Medical Records and Problems/Potential Problems are as follows:

a. The identified case is directly routed to the Quality Improvement Services Director.

b. The Quality Improvement Services Director prepares the "Peer Review Worksheet" and forwards the worksheet and information to the Chief of Staff or his designee.

c. The reviewing physician reviews the information, investigates the case and makes a determination:

1. No problem is identified and the form is returned to the QIS Director who notifies the physician about the report.

2. A potential problem is identified and the form is returned to the QIS Director who will share the information with the Chief of Staff. The Chief of Staff will discuss the problem with the physician. Any educational intervention, if needed, will be recorded.

3. If a potential problem recurs the Chief of Staff may refer cases to the Credentials Committee for further review.

4. When a significant problem is identified, the form is returned to the QIS Director who will refer the case to the Credentials Committee. The physician will have the opportunity for an interview. Before the interview, the physician shall be informed of the charges against him and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedure rules provided in these bylaws with respect to hearing shall apply thereto. If a reduction of privileges is considered the procedural rules under Article VIII (Corrective Action) need to be followed.

d. The QIS Director will file these forms in a Performance Improvement file separate from the physician's credentials.

e. The Credentials Committee will review the physician performance review files every two years at the time of credentialing.

f. An outside consultant may be used to review cases.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Scheduling Operations:

(a) Priority

First priority - The highest priority for scheduling goes to a patient in an emergency or life threatening situation;

Second priority - Those patients scheduled in sequence of the original schedule receive second priority after emergency types.

(b) Scheduling periods - Scheduling is done by the operating room staff during normal hours of operation of the surgical suites, and by the nursing supervisor other times.

(c) Assignment of priority - Non-emergency cases receive priority by the sequence of original scheduling.

2. Emergency operations - Emergency operations are scheduled by the Operating Room Staff and when necessary after 3:00 p.m. by the Nursing Supervisor.

3. Requirements prior to anesthesia and operation:

a. Identification of patient - The patient is identified by the circulating nurse and the Anesthetist by answering to his spoken name and checking his arm bracelet. Two patient identifiers are used – name and date of birth.

b. Surgeons are to be in the operating room suite before the induction of anesthesia and in the Hospital before the patient is brought to the operating room. No room remains empty awaiting scheduled cases longer than 30 minutes if other surgeons are waiting to do cases.

c. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be delayed. In any emergency, the physician shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

4. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

5. Tissues removed at the operation shall be sent to the hospital pathologist, with noted exceptions. His authenticated report shall be made a part of the patient's medical record. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but are not necessarily limited to, the following:

(a) Specimens such as cataract, orthopedic appliance, foreign body and hernia sacs;

(b) Foreign bodies (for example: bullets) that for legal reasons are given directly in the chain of custody of law enforcement representatives;

(c) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant;

(d) Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and

(e) Teeth, provided the number, including fragments, is recorded in the medical record.

E. EMERGENCY DEPARTMENT

1. The emergency services will have 24 hour Emergency Department physician coverage by physicians in the hospital at all times while on duty. These physicians are subject to the duties and responsibilities of other members of the hospital staff as listed in Section 3 of Article III of the bylaws. They are to maintain up to date requirements in advanced cardiac life support. They are to be available for inpatient emergencies.

   All physicians in the Emergency Department must comply with EMTALA regulations (Hospital policy "Emergency Medical Treatment & Active Labor (EMTALA").

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

   (a) Adequate patient identification;

   (b) Information concerning the time of the patient's arrival, means of arrival and by whom transported;

   (c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;

   (d) Description of significant clinical, laboratory and radiology findings;

   (e) Diagnosis;

   (f) Treatment given;

(g) Condition of the patient on discharge or transfer; and

(h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy.

There shall be a monthly review of Emergency Department medical records by the Outpatient Committee to evaluate quality of emergency medical care. Reports shall be submitted to the Medical Staff.as required.

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by the Safety Committee.

After triage is completed, the Emergency Department physician or a mid-level provider will provide a medical screening examination for all individuals seeking emergency services. Prior to any individual being triaged to another outpatient setting, the mid-level provider must discuss this referral with the Emergency Department Physician. A registered nurse may provide triage screening on patients presenting from outpatient clinics for intravenous therapy, palliative medications, vaccine administration, or scheduled lab tests. If a nurse finds a condition such as increased pain, fever, abnormal vital signs, or new patient complaints, the physician will be notified and a medical screening examination will be performed.

A patient must be stabilized, within the capabilities of the staff and facilities of the hospital, prior to discharge or transfer.

F. SPECIAL CARE UNITS

Physicians who admit patients to the intensive care unit (ICU) shall maintain certification in Advanced Cardiac Life Support or complete at least 12 Category I CME credits covering acute cardiac care and resuscitation every two years. This requirement will not be needed for surgical cases admitted to the ICU for a non-cardiac problem.

G. MEDICAL STAFF MEETINGS

Medical Staff meetings will be held on the second Thursday of every month unless otherwise indicated.

H. VERBAL ORDERS

Verbal and Telephone orders will be accepted by the following licensed or registered health care professional in the area of their training and professional expertise as specified in their job description:

Registered Professional Nurse (RN)
Licensed Pharmacist
Licensed Physical Therapist (PT)
Licensed Certified Respiratory Therapist (LRTC)
Licensed Registered Respiratory Therapist (LRRT)
Licensed Practical Nurse (LPN)
Registered Radiology Technologist (RRT)
Licensed Point of Care Technicians (POCT)
Licensed Medical Laboratory Technician (MLT)
Licensed Medical Technologist (MT)
Medical Assistants (MA) in outpatient clinics

The receiver of the verbal or telephone order is to read back the order(s) in its entirety to the practitioner, including the patient identification information, before the acceptance of the order is considered complete and can be implemented. Whenever possible, the receiver of the order is to write it down, then read it back and receive confirmation from the LIP. Any Verbal or Telephone order that includes patient treatment modalities **must be signed by physician within 24 hours**, unless he demonstrates just cause for his absence; i.e.: medical or family emergency, scheduled vacation, or weekend or holiday group coverage. Outpatient orders must be signed no later than the next time the practitioner is present to do so. Telephone or faxed orders by physicians outside of the facility may be authenticated by faxed signature.

X-ray and laboratory staff, who have been properly inserviced and proven competent, may take verbal or telephone orders for diagnostic testing that do not emergently affect patient care.

I. SUPERVISING RESIDENTS

Physicians in an approved residency program, who have appropriate agreements between their training program and this hospital, as well as their supervising physician, may practice here under the supervision of a credentialed attending physician.

Their practice is limited by the attending physician's privileges and may include examining patients, writing notes, and writing orders that have to be co-signed within24 hours by the supervising physician.

They may perform procedures with the supervising physician.

J. SUPERVISING STUDENTS

Health Care Professional Students in an approved training program, who have appropriate agreements between their contracting agent and this hospital may train here under the supervision of an Attending Physician/CNM/Advanced Practice Registered Nurses. Their practice is limited by the privileges of the Attending Physician/CNM/Advanced Practice Registered Nurses and may include examining patients and writing supplemental notes, (which do not replace the Attending Physician/CNM/Advanced Practice Registered Nurse's notes). The notes are to be co-signed by the Attending Physician/CNM/Advanced Practice Registered Nurse. The Health Care Professional Students may perform procedures with the supervising Physician/CNM/Advanced Practice Registered Nurse.

K. "NO CODE" POLICY

The physician documents in the progress notes that this order has been given, why it was judged to be appropriate, and specifically with whom (the patient and/or family) it has been discussed and at what time.

A written consent must be obtained from the patient or his legally-authorized surrogate.

Medical and nursing staff will continue to provide the usual standard of medical and nursing care to the patient, and endeavor to make them as comfortable as possible.

L. AMENDMENT

These rules and regulations may be amended at any regular meeting of the Medical Staff at which a quorum is present, and such amendment shall become effective when approved by the Board of Directors. The Chief of Staff will be responsible for getting amendments recorded into print.

M. ADOPTION

These rules and regulations shall become effective when adopted by the Medical Staff at a regular meeting and approved by the Board of Directors.

Recommended by the Medical Staff

Frederick A. Conley, MD, Chief of Staff

Approved by the Board of Directors

Ronald L. Crites, Chairman
Board of Directors