

Medical Staff

Rules and Regulations

DILEY RIDGE MEDICAL CENTER

A Medical Staff Document

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DEFINITIONS

The definitions set forth in the Medical Staff Bylaws apply to these Rules & Regulations unless otherwise specifically provided herein.

ARTICLE I. ADMISSION

- 1.1 Only those persons for whom the Medical Center has the ability to render care and treatment may be admitted as inpatients. Patients may be admitted to the Medical Center by Practitioners with admitting Privileges at the Medical Center. The charge nurse shall coordinate the admission process. Except in an emergency, a provisional diagnosis or valid reason for admission shall be documented in the medical record by the admitting Practitioner prior to the patient's admission to the Medical Center. In the event of an emergency, the provisional diagnosis or reason for admission shall be recorded as soon as possible but no later than twenty-four (24) hours after admission. In addition to documenting the provisional diagnosis or reason for admission, the admitting Practitioner shall also provide the following information:
- (a) Pre-admission certification or clearance where required.
 - (b) Any source of communicable or significant infection.
 - (c) Behavioral characteristics that would disturb or endanger others.
 - (d) Any reasons for protection of the patient from self harm.
- 1.2 **Exceptions:**
- (a) No patients under the age of 18 years old will be admitted. Any pediatric patient presenting to the Emergency Department will receive an appropriate medical screening examination and be stabilized as necessary. In the event that further treatment or admission is indicated, the patient shall be transferred to an appropriate pediatric facility.
 - (b) Patients must meet the scope of practice criteria for admission.
 - (c) Any patient potentially requiring one on one attention due to a psychiatric condition should be considered for admission to a facility other than Diley Ridge due to current professional capabilities and staffing.
- 1.3 Admission of persons with communicable or infectious diseases shall be subject to applicable Medical Staff/Medical Center policies and procedures.

ARTICLE II. ASSIGNMENT

- 2.1 Every admitted or observation patient will be managed by an attending Practitioner who must have Privileges to practice at the Medical Center.
- 2.2 If the patient has no primary Practitioner, he/she may request the services of a specific Practitioner with Privileges at the Medical Center, or be assigned to a Practitioner with appropriate Privileges who will serve as the attending Practitioner.
- 2.3 Primary responsibility for the patient's care/treatment from admission through discharge shall belong to the attending Practitioner. In complex care cases there may be more than one Practitioner equally sharing responsibility for the patient's care/treatment within agreed upon areas of medical skill or discipline. Nonetheless, the primary responsibility for the patient's care/treatment shall rest with the attending Practitioner until such time as responsibility for the patient is transferred to and accepted by another qualified Practitioner. Transfer orders shall be entered on the order sheet in the patient's medical record by the attending Practitioner and shall document the transfer and acceptance thereof by the receiving Practitioner. No transfer of responsibility shall occur until such order/note is completed and signed, dated and timed.
- 2.4 A Practitioner who refers a patient to another Medical Center Practitioner shall be recognized on the admission record, notified of such admission, and may follow his/her patient to the extent permitted by the referring Practitioner's Privileges.
- 2.5 In the event of an overwhelming volume of patients requiring admission from the Emergency Department (e.g. mass casualty incident, pandemic flu), the Medical Staff President will identify a process to equitably assign patients to all Practitioners with Privileges.

ARTICLE III. ORDERS

- 3.1 All orders shall be in writing and must be legible, complete, authenticated, dated and timed by the ordering Practitioner with the exception that, for the five (5) year period following January 26, 2007, it is acceptable for another Practitioner who is responsible for the care of the patient and authorized to write orders by Medical Center policy in accordance with State law to date, time and authenticate the order of the ordering Practitioner when the ordering Practitioner is unable to do so.
- 3.2 Verbal/telephone orders will be documented in the medical record upon receipt by an individual authorized by law and the Medical Center to accept such orders and shall include the date and time the order was received, the name and signature of the person documenting the order, and the name of the ordering Practitioner. Such orders shall be reviewed, authenticated, countersigned if required, dated and timed by the ordering Practitioner or other authorized Practitioner responsible for the care of the patient within forty-eight (48) hours unless otherwise provided by the Medical Center. Verbal or telephone orders may be accepted by a registered nurse, licensed practical nurse, case manager, radiology technician, pharmacist, respiratory therapist, or dietitian as allowed within their respective scope of practice.
- 3.3 Orders regarding restraints and code status shall be governed by applicable Medical Center policies and procedures as such policies and procedures may change from time to time.
- 3.4 Admission orders shall be written by the admitting Practitioner.

ARTICLE IV. CONSENTS

Consent forms shall be completed pursuant to Medical Center policy. Practitioners are responsible, prior to the treatment/procedure, for obtaining the patient's informed consent. If a designee of the Practitioner documents consent on the standard Medical Center form, the Practitioner's progress note must reflect discussion with the patient and/or the patient's legal representative concerning the risks, benefits, expected outcomes and alternatives to the recommended treatment/procedure. Any questions addressed by the Practitioner shall also be documented.

ARTICLE V. DISCHARGE

- 5.1 Patients shall be discharged only on the order of a Practitioner. The responsible Practitioner shall discharge the patient in accordance with the provisions set forth herein and any applicable Medical Center/Medical Staff policies, as such policies may change from time to time.
- 5.2 Patients who demand discharge against medical advice shall be asked to sign a release form. In the event a patient refuses to sign the release form, or leaves the Medical Center against medical advice or without a proper discharge, such facts shall be noted in the patient's medical record.
- 5.3 At the time of discharge, or as soon thereafter as practical, but in no event later than thirty (30) days following the patient's discharge, the medical record shall be completed.
- 5.4 No discharge will be considered valid without a final diagnosis.

ARTICLE VI. CONSULTATIONS

6.1 **Required Consultations**

The requirements for consultation with a qualified Practitioner, except in emergencies, shall be accomplished in accordance with the rules and regulations of the applicable Department.

6.2 **Responsibility**

6.2-1 The patient's attending Practitioner has the responsibility to request a consultation as he/she deems appropriate.

6.2-2 The Department Chair is empowered to intervene and request that a consultation be sought upon appropriate indication.

6.2-3 The following procedure shall be followed unless the Department has more stringent requirements.

(a) Consultation requests will be designated by the attending Practitioner as "urgent" or "routine."

(b) The consultant will evaluate patients requiring "urgent" consultation on the same day that the consult request is written.

(c) A routine consultation shall be performed within twenty-four (24) hours of the time that the consulting Practitioner is notified of the consultation request.

6.2-4 If consultation is required in a service or specialty that is unavailable at the Medical Center, the attending Practitioner has the responsibility to arrange for such specialty consultation with a Practitioner at another healthcare facility.

6.3 **Consultation Records**

6.3-1 When requesting consultation, the attending Practitioner shall be required to indicate in writing the reason for such request.

6.3-2 In all cases, a consultant shall document his/her findings, conclusions and recommendations in the patient's medical record. Such entries must be authenticated, dated, and timed.

ARTICLE VII. MEDICAL RECORDS

7.1 Medical Record Contents And Documentation Requirements

7.1-1 Record Completion

- (a) Each Practitioner is expected to maintain an adequate, current medical record for each patient.
- (b) The attending Practitioner shall be responsible for the preparation of a complete, accurate, and legible medical record for each patient.
- (c) Medical records shall be completed within thirty (30) days following discharge regardless of patient type.
- (d) A complete medical record is defined as one that has all entries/dictation completed, timed, dated and authenticated.
- (e) No record is to be placed in permanent file until all entries have been completed, timed, dated and signed.
- (f) In the event a medical record remains incomplete by reason of death, resignation, or inability of a Practitioner to complete the record, the Site Administrator may request the Department Chair to consider the circumstances and approve the record for filing via placement of a signed memorandum in the medical record describing the situation.

7.1-2 General Contents: The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. All entries in the patient's medical record must be complete, legible, accurate, timed, dated, and authenticated. Each patient record shall include, if applicable:

- (a) Identification data
- (b) Complaint/symptoms
- (c) Personal history
- (d) Family history
- (e) History of present illness, including any emergency care, treatment and services provided prior to arrival, if any
- (f) Physical examination
- (g) Conclusions or impressions drawn from the medical history and physical exam including initial/admitting diagnosis, diagnostic impressions or conditions

- (h) Reasons for admission for care, treatment and services
- (i) Any findings of assessments/reassessments
- (j) Any allergies to food or medications
- (k) Any diagnoses or conditions established during the patient's course of care, treatment and services
- (l) Any observations relevant to care, treatment and services
- (m) The patient's response to care, treatment and services
- (n) Goals of treatment and treatment plans/plans of care and revisions thereto, including evidence of advance directives
- (o) Any progress notes, nursing notes and other information necessary to monitor the patient's condition (*e.g.* vital signs, etc.)
- (p) Informed consent
- (q) Pre- and post-sedation notes, including pre-sedation assessment
- (r) Invasive procedure report entered into electronic medical record (EMR) immediately post-procedure
- (s) All orders
- (t) Special reports and results of diagnostic and therapeutic tests and procedures
- (u) Consultations
- (v) Clinical laboratory results
- (w) X-ray reports
- (x) Pathologic report
- (y) Other test results
- (z) Documentation of hospital acquired infections
- (aa) All relevant final principal and secondary diagnoses, complications and procedures performed which are written without use of symbols and abbreviations
- (bb) Conclusions at termination of Medical Center treatment

- (cc) Discharge instructions to the patient and family
- (dd) Medications ordered/prescribed and administered, including the strength, dose and route
- (ee) Any access site for medication, administration devices used, and rate of administration
- (ff) Any adverse drug or anesthesia reactions
- (gg) Discharge diagnosis, plan and planning evaluation
- (hh) Discharge summary, final note or transfer summary including reason for Medical Center admission, significant findings, procedures performed and treatment rendered, the patient's condition at discharge and patient discharge disposition
- (ii) Any medications dispensed or prescribed on discharge

7.1-3 History and Physical Examination

- (a) The medical history and physical examination (H&P) shall be completed, documented and present in the medical record no more than thirty (30) days before, or twenty-four (24) hours after admission or registration but prior to surgery or a procedure requiring anesthesia services.
- (b) In the event of an emergency surgical situation, the responsible Practitioner must document the emergency and record a progress or admission note describing a brief history, appropriate physical findings and the preoperative diagnosis in the medical record before surgery or the procedure requiring anesthesia services. In such event, the history and physical must be completed as soon as possible after surgery or the procedure requiring anesthesia services, but in no event later than twenty-four (24) hours after admission or registration.
- (c) An updated examination of the patient, including any changes in the patient's condition, shall be completed, documented and present in the medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the history and physical is completed within thirty (30) days before admission or registration. If the history and physical examination is less than thirty (30) days old, an H&P update note is required describing any change in status, new diagnosis, new medications, allergies etc., or a statement indicating no changes exist since prior evaluation. The H&P update note must be signed, dated and timed and present in the medical record as required above.

- (d) A history and physical greater than thirty (30) days old may not be used in the medical record.
- (e) The history and physical, and the updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician, an oral maxillofacial surgeon, or other qualified licensed individual who has been granted Privileges to do so in accordance with State law and Medical Center policy.
- (f) The history and physical, and any updates thereto, shall be authenticated (and, if applicable, validated and countersigned), dated, timed and made a part of the patient's medical record within the time frames set forth herein.
- (g) With the exception of emergency situations, when the history and physical is not completed and documented in the patient's medical record before surgery or a procedure requiring anesthesia services, the operation or procedure will not proceed.
- (h) The long form or dictated history and physical is required to be completed for all inpatients and shall contain:
- Chief complaint
 - Details of present illness or condition including, when appropriate, assessment of patient's emotional and behavioral status
 - Past medical or surgical history
 - Medications and allergies
 - Relevant social history appropriate to patient's age
 - Clinically relevant family history
 - Inventory of body systems
 - Physical examination
 - Diagnostic results, if available
 - Diagnosis/problem list with initial plan of care
- (i) A short form history and physical is required to be completed for all outpatient, ambulatory and observation patients; provided, however, that in the event of admission a long form or dictated history and physical shall be completed pursuant to Section 7.1-3 (h). The short version H&P shall contain:
- Chief complaint
 - Details of present illness or condition including, when appropriate, assessment of patient's emotional and behavioral status
 - Past medical or surgical history
 - Medications and allergies
 - Relevant family and social history appropriate to the patient's age
 - Physical examination
 - Diagnostic results, if available

- Diagnosis/problem list with initial plan of care
- (j) If the history and physical exam is completed by a designee of the admitting Practitioner, the admitting Practitioner must review, validate and countersign the documentation. Designees include, but are not limited to:
- Advanced Practice Nurses
 - Physician Assistants

7.1-4 Informed Consent

- (a) Documentation of informed consent will be placed in the medical record prior to the procedure or treatment.
- (b) Informed consent consists of:
- The nature and purpose of the procedure
 - What the procedure is expected to accomplish
 - Reasonably known risks, benefits and alternatives
 - Likelihood of success
 - Who will perform the procedure
 - Discussion regarding patient questions
- (c) Informed consent is required for all procedures listed in the Medical Center informed consent policy, as such policy may be changed from time to time.

7.1-5 Orders (See Article III)

7.1-6 Operative/High-Risk Procedure Note and Report

Operative and other high-risk procedure reports shall be written or dictated in the medical record immediately following completion of the operative or other high risk procedure and before the patient is transferred to the next level of care. Such reports shall be dated, timed and signed by the surgeon or Practitioner performing the procedure. The operative or other high-risk procedure report shall include the following information: the name(s) of the Practitioner(s) who performed the procedure and his/her assistant(s); the name of the procedure performed; a description of the procedure/techniques; findings of the procedure; any estimated blood loss; any specimen(s)/tissues removed or altered; and the postoperative diagnosis. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note shall include: the name(s) of the primary surgeon(s) and his/her assistant(s); procedure performed and a description of each procedure finding; estimated blood loss, specimens removed; and postoperative diagnosis.

7.1-7 Anesthesia Documentation. To the extent anesthesia services are provided, such services shall be provided in accordance with the procedures set forth in applicable Medical Staff/Medical Center policies, as such policies may be changed from time to time.

7.1-8 Progress Notes

- (a) Progress notes shall be written daily by the attending Practitioner on all patients at the time of examination/observation to give a chronological report of the patient's course in the Medical Center.
- (b) Progress notes must be legible, authenticated, dated, and timed by the author.
- (c) Progress notes will be documented in the EMR unless unavailable. In such event written notes will be scanned into the EMR when the system is functioning again.
- (d) Progress notes shall include, whenever applicable and without limitation, review of the medical record, significant clinical changes in the patient, new signs and symptoms, complications, consultations, and changes in treatment. Clinical problems should be clearly identified and correlated with specific test/treatment orders and results. Progress notes should be sufficient to permit continuity of care and transfer of the patient, if necessary.

7.1-9 Discharge Summary/Final Note

- (a) The discharge summary written or dictated for patients hospitalized greater than twenty-four (24) hours contains:
 - The reason for hospitalization
 - Significant findings
 - Procedures performed
 - Care, treatment and services rendered
 - The patient's condition and disposition at discharge
 - Information/instructions provided to the patient and/or family
 - Provisions for follow-up care
- (b) A final progress note may be substituted for the discharge summary for those patients with problems and interventions of a minor nature who require a twenty-four (24) hour stay or less. The final progress note must clearly summarize the patient's hospital course and include relevant discharge instructions.
- (c) When preprinted discharge instructions are given to the patient and/or family/legal representative, the record should so indicate.

- (d) In lieu of a final progress note, Practitioners caring for observation patients may choose to dictate an observation history and physical/summary note, which shall include the required medical history and physical examination information and the required elements of a final progress note in one document.
- (e) All discharge summaries, final progress notes, or observation summaries will be completed in the EMR, unless the system is unavailable. In such event any handwritten documentation will be scanned into the EMR when the system is functioning again.

7.1-10 Death Summary

- (a) In the event of death, a dictated death summary is required. This summation should include:
 - Reason for admission
 - Findings and course in the hospital
 - Events leading to death
 - Time and date of death
 - Procedures performed
 - Care treatment and services provided
 - Cause of death, if known
 - Information provided to the family/legal representative
 - Disposition of the body

7.1-11 Birth Certificates

- (a) Completed birth certificates are to be signed at the time of birth or within 72 hours by the responsible Practitioner.

7.2 Authentication

- 7.2-1 Authentication means to establish authorship by written signature, identifiable initials or computer key.
- 7.2-2 All entries in the medical record must be signed by the person making the entry with an authorized signature facsimile (written signature, computer entry).
- 7.2-3 Computer signature must be used with personal signature password protection.
- 7.2-4 Inappropriate use of passwords or use of signature stamps violates the Medical Staff Policies and Procedures and Practitioners may be subject to corrective action by the Medical Executive Committee.

7.3 **Confidentiality**

7.3-1 A Practitioner's access to patient information is limited to necessary use in the treatment of patients, scientific study, or peer review activities.

7.3-2 All Practitioners are required to maintain the confidentiality of patient information and abide by all relevant local, state and federal laws related to the confidentiality and security of patient information.

7.3-3 No patient information may be disclosed except in accordance with the Medical Center's policy concerning the confidentiality and release of medical records/patient information, as such policy may change from time to time.

7.3-4 Improper use or disclosure of patient information shall be grounds for corrective action pursuant to the Medical Staff Bylaws.

7.4 **Failure to Complete Medical Records.** Records must be completed according to Medical Staff Policies, Medical Center policies, and regulatory requirements.

7.5 **Symbols and Abbreviations.** Symbols and abbreviations may be used in a patient's medical record only when they have been approved by the Medical Staff. An official record of approved and prohibited abbreviations shall be kept on file in Medical Records.

7.6 **Final Diagnosis.** The final diagnosis shall be recorded in full without the use of symbols or abbreviations, dated, timed and authenticated by the attending Practitioner at the time each patient is discharged. The attending Practitioner has the responsibility for establishing the final diagnosis.

7.7 **Emergency Department Records.** Emergency Department documentation must be written or dictated prior to the Practitioner leaving the Medical Center following the Emergency Department Patient Encounter.

7.8 **Pathology.** Specimens removed during a surgical procedure shall be handled in accordance with applicable Medical Center policy, as such policy may change from time to time

7.9 **On-Call Coverage.** On call coverage shall be required consistent with the Medical Center's on call policy, as such policy may be changed from time to time.

7.10 **Medication Usage.** Medication usage shall be subject to Medical Center Pharmacy policies, as such policies may change from time to time.

ARTICLE VIII. UTILIZATION

8.1 Regulatory and payor requirements pertaining to patient care shall be observed.

8.1-1 Designation of Patient Type

A Practitioner shall determine the patient type for all Medical Center hospitalized patients by written order at the time of admission. If it is determined that an outpatient or observation patient requires an inpatient admission, the patient's status shall be changed by Practitioner order documented in the medical record.

8.1-2 Admission Note

Requirements for an admission note are as specified in these Rules & Regulations.

8.1-3 Progress Notes

Requirements for progress notes are as specified in these Rules & Regulations.

8.1-4 Failure to Comply

Pursuant to the Medical Staff Bylaws, failure to comply with Medical Staff/Medical Center policies regarding completion of medical records may result in corrective action.

AUTOPSIES

8.2 Autopsies

The Medical Staff shall attempt to secure autopsies in all cases of unusual deaths and of medical, legal and educational interest. The mechanism for obtaining and documenting permission to perform an autopsy, and the system for notifying the Medical Staff, specifically the attending Practitioner, when an autopsy is to be performed is set forth in applicable Medical Center policy, as such policy may change from time to time.

8.2-1 Autopsies should be considered at least in the following circumstances:

- (a) Death under age 50
- (b) Death within 48 hours of a surgical or invasive procedure
- (c) Death associated with drug reaction
- (d) Death associated with an unexpected outcome
- (e) Death within 48 hours of admission
- (f) All deaths in the Emergency Department
- (g) Death in an outpatient setting when the known diagnosis would not be expected to result in death

8.2-2 If an autopsy is considered, documentation must be provided concerning:

- (a) Attempts to secure permission
- (b) Mechanism for securing permission
- (c) System for notifying the Practitioner when performed

8.2-3 Deaths requiring autopsy will be referred to the Fairfield County Coroner. All other autopsies will be referred to Fairfield Medical Center or an appropriate facility as determined by the Medical Center.

8.3 Certificates

8.3-1 Death certificates shall be signed by the responsible Physician within forty-eight (48) hours or by the coroner, if applicable. (Ohio Revised Code 3705.16)

8.3-2 Birth certificates shall be signed by the Physician in attendance at the time of the birth or within seventy-two (72) hours. (Ohio Revised Code 3705.09)