

RULES AND REGULATIONS OF THE MEDICAL STAFF

MEMORIAL HOSPITAL OF SOUTH BEND, INC.

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MEDICAL STAFF RULES AND REGULATIONS

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.	The Consultation Process.....	4
E.	CODE BLUES	4
F.	IMMUNIZATION AND IMMUNITY REQUIREMENTS	4
G.	TRANSFER OF PATIENTS	4
H.	EMERGENCY CARE AND COVERAGE	5
I.	MEDICAL RECORDS	7
1.	CONTENT OF THE MEDICAL RECORD	7
a.	History and Physical	7
(1)	Documenting H&P - Time Frames.....	7
(2)	Timing Requirements - Update Note Required.	7
(3)	Content	7
(4)	H&P From Transferring Hospital	8
(5)	Surgery/Procedure H&P Requirements.....	8
(6)	Outpatient Surgeries/Procedures.....	8
(7)	Dictated H&P or hand written Short Stay H&P.	8
(8)	Action When H&P is not Present.....	8
(9)	Individuals Qualified to Perform H&Ps & Update Notes.....	9
b.	Pre-surgical Assessment and Post Procedure Evaluations	9
c.	Operative Reports.....	9
d.	Consultation Report.....	10
e.	Reports of Tests and Results	10
f.	Physician Progress Notes	10
g.	Verbal Orders.....	10
h.	Standing Orders Protocols	11
i.	Consents	11
j.	Discharge Summary	11
k.	Final Progress Note	11
l.	Discharge Order; Discharge AMA.....	11
m.	Nursing Home Transfer Sheet	11

MEDICAL STAFF RULES AND REGULATIONS

Table of Contents

n.	Psychiatric Evaluation.....	12
o.	AJCC T-N-M Staging Form	12
p.	Abbreviations	12
q.	Transition Orders	12
r.	Copy and Paste Documentation	12
2.	AUTOPSIES.....	12
3.	AUTHENTICATION	12
4.	RECORD COMPLETION GUIDELINES	13
5.	ACCESS TO AND RESPONSIBILITY FOR MEDICAL RECORDS.....	14
J.	ALLIED HEALTH PROFESSIONAL STAFF	14
K.	RESIDENTS/FELLOWS, AND MEDICAL STUDENTS.....	14
1.	Residents	14
2.	Fellows	15
3.	Medical Students	15
a.	Freshmen Medical Students.....	15
b.	Sophomore Medical Students	15
c.	Junior/Senior Medical Students	16
	CERTIFICATION OF ADOPTION AND APPROVAL	17

MEDICAL STAFF RULES AND REGULATIONS

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 Practitioners who have submitted proper credentials and who have been granted 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 as soon as possible after the time of admission.

3. Patient Information

Practitioners admitting private patients shall be held responsible for giving such information as may be necessary to ensure the protection of other patients or health care workers from those who are a source of danger from any cause, and to ensure 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

Practitioners must ensure adequate and timely professional care for their patients by being physically available in the Hospital within a reasonable period of time or by designating a qualified alternate Practitioner with whom prior arrangements have been made. The alternate Practitioner must have Clinical Privileges at this Hospital appropriate for the designating Privilege holder's practice. Should a Practitioner fail to name such an alternate, any Officer of the Medical Staff, or the Chief of the Department concerned, shall have authority to call any Privilege holder to assist as needed in the situation. Failure to provide for an alternate Practitioner may lead to Suspension of Staff Membership and/or Privileges.

Patients will be seen by their Practitioners 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. A Supervising Practitioner may request a Nurse Practitioner or Physician Assistant who has Membership as an Allied Health Professional (AHP) to visit their patients; however, the Supervising Practitioner or a designee Practitioner must visit each patient at least every other day.

Inpatients at Epworth Center will be seen 6 days per week by a psychiatrist or an appropriately credentialed Nurse Practitioner. The attending psychiatrist or the on-call psychiatrist is available 24/7 to meet the needs of the Epworth Center patients.

Patients admitted to the Adult Special Care Units should be evaluated within 2 hours by either a Privilege holder with Level I Privileges or the Chief Resident of the Medicine service, if not examined immediately prior to admission.

Pediatric patients admitted to intensive care status in the Pediatric Intensive Care Unit (PICU) must be examined within 2 hours by the admitting Practitioner or an intensivist, if not examined immediately prior to admission. Pediatric patients admitted to intermediate status need to be examined by a Privilege holder within 12 hours of admission.

When a Practitioner is on Emergency Department (ED) "staff" call (on-call) for a given specialty, it is the duty and responsibility of that Practitioner to ensure 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 an on call consulting Practitioner will be determined jointly by the ED physician and the consulting Practitioner and will be based on the acuity of the patient

MEDICAL STAFF RULES AND REGULATIONS

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 Practitioner may secure a qualified alternate Practitioner (with at least equivalent Clinical Privileges) to assume call responsibilities in the event that he or she is temporarily unavailable.

B. DISASTER DUTIES

When the Emergency Operations Plan (EOP) is activated, Privilege holders will be assigned disaster duties in the Hospital, and it is their responsibility to report to their assigned stations and to perform any assigned duties. During a State of Emergency when the EOP is activated, all policies concerning patient care will be the joint responsibility of the Medical Staff President and the Hospital President or their designees. Key Hospital personnel shall rehearse the Emergency Operations Plan on a routine basis.

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 bona fide 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 for certain medications as recommended by the Pharmacy and Therapeutics Committee and approved by the MEC.

There shall be a review of all orders when a patient undergoes surgery.

There shall be a review of 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 may 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 acceptable as a valid medication order. Such orders must include the names of all medications taken at home to be administered in the Hospital, with 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:
 - High risk pregnancy, including, but not limited to breech births, multiple pregnancy, and VBAC
 - Moderate or severe pre-eclampsia or eclampsia.
 - 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

MEDICAL STAFF RULES AND REGULATIONS

- premature rupture of membranes.
 - Any operative procedure other than the perineal phase (crowning) application 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 with uterine scar from other causation. Patients must be seen by an obstetrician before the end of the second trimester to ensure the patient is a candidate for VBAC. Once the obstetrician agrees to consult, the obstetrician will come in and remain in the Hospital during delivery, or consult the Laborist.
 - Anesthesia will be notified and available for all breech births, multiple pregnancies, and vaginal deliveries following cesarean section or with uterine scar from other causation.
- In the management of pregnant patients hospitalized by a Practitioner without obstetrical Privileges for medical reasons or non-obstetrical surgical procedures.
- b. Pediatrics:
- For all patients admitted to the Pediatric Intensive Care Unit, there will be a 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 recently attempted suicide, patient condition permitting.

Special Care Unit: All patients admitted to the ICU will be evaluated by a critical care specialist on multidisciplinary rounds within 24 hours of admission to the ICU and then subsequently on a daily basis. The critical care specialist will place a note in the chart after rounds. If there are any clinical concerns regarding an ICU patient, the critical care specialist will directly contact the attending physician to collaboratively determine the optimal care of the ICU patient.

- 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, or ongoing chest pain, must have a cardiology consult.
 - All patients with sustained, significant cardiac dysrhythmias must have a cardiology consult.
 - All patients requiring Swan-Ganz catheters must have consultation with an appropriately credentialed Practitioner.
 - 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 an appropriately credentialed Practitioner.
 - All pregnant patients must have an obstetrical consult.
- d. Carotid angioplasty and stenting (CAS): vascular surgery consultation required prior to procedure.

2. The Consultation Process

MEDICAL STAFF RULES AND REGULATIONS

- a. Except in an emergency, a consultation with another qualified Practitioner is recommended in cases where, in the judgment of the admitting Practitioner, the diagnosis is obscure, or the best therapeutic measures are in doubt.
- b. The Practitioner or resident must make all requests for “stat” consultations directly to the Practitioner being consulted.
- c. Routine consultations should be completed within 24 hours. The Practitioner who is requesting consultation is responsible for ensuring that adequate information regarding the patient is provided to the consulting Practitioner. The consulting Practitioner is responsible for entering 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 or consultation requests.

E. CODE BLUE

Any patient in the Hospital who experiences cardiac/respiratory arrest shall have a Code Blue called and CPR initiated unless the patient is identified as a patient with a “No Code Blue” order. Practitioners must use best efforts to adhere to the patient’s advance directives and wishes regarding resuscitative measures and initiate “No Code Blue” orders when they are appropriate. Appropriate Medical Staff Privilege holders will respond in a timely manner to a Code Blue in accordance with the Hospital’s Code Blue Policy/Procedure.

F. IMMUNIZATION AND IMMUNITY REQUIREMENTS

All Practitioners, at the time of initial appointment or grant of Privileges, will comply with the same infection-related immunization/screening requirements that are required of Memorial Hospital employees. Annual influenza immunization is required of all Practitioners except those with a bona fide medical contraindication. Practitioners are expected to comply within an appropriate time frame should prevalence data collected on an ongoing basis suggest the need for resumption of Tuberculosis testing. Practitioners with Telemedicine Privileges only, and Members who hold no Clinical Privileges, are exempt from the requirements of this Section, but otherwise, lack of compliance will result in Automatic Suspension of Privileges.

G. TRANSFER OF PATIENTS

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

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 Practitioner 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. The name and address of any on-call Practitioner who refused or failed to appear within a reasonable period of time to provide necessary stabilizing treatment shall be entered in the patient’s medical record.

H. EMERGENCY CARE AND COVERAGE

1. The Medical Staff shall adopt a method of providing medical care in each distinct Emergency Care Center (ECC) of Memorial Hospital, including the Emergency Care Centers at 615 North Michigan Street, South Bend (South Bend ER) and 3220 Beacon Parkway, Granger (Granger ER). When this method consists of a group practice of physicians, the Hospital will enter into

MEDICAL STAFF RULES AND REGULATIONS

agreements specifying the duties and responsibilities of the Hospital and the group(s). Requests for Emergency Department Clinical Privileges shall specify the distinct practice location and delineate specific privileges for which the eligible practitioner is intending to practice. Clinical Privileges shall be granted to members of the Emergency Department in accordance with the Medical Staff Bylaws and Related Manuals.

2. Any person presenting to the hospital, either at the Emergency Care Centers or elsewhere, and requesting treatment or accompanied by another requesting his/her treatment, must be examined by a Physician who is a Medical Staff Privilege Holder, or by a member of the Resident Staff under the supervision of a Physician who is a Medical Staff Privilege Holder or by an appropriately Credentialed and Privileged Nurse Practitioner or Physician Assistant under the supervision of an Emergency Medicine Medical Staff Privilege Holder, to determine whether an Emergency Medical Condition exists. If the individual has an Emergency Medical Condition, the attending Practitioner shall (a) provide or arrange for the provision of such available treatment as may be necessary to stabilize the individual's condition, or (b) arrange for an appropriate transfer if the medical benefits of transfer outweigh the risks and such transfer is medically necessary. A person has 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. Notwithstanding the above, nothing shall prohibit OB Nurses or unsupervised members of the Residency Staff 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.
3. Medical Staff Members and Privilege holders have the obligation to provide specialty back-up coverage to the Emergency Care Centers. Each Department Chief is responsible for producing a Departmental call schedule which must be delivered to the Medical Staff Office in a timely fashion. It is the responsibility of each on-call Practitioner to make arrangements for coverage if he or she will be unavailable for the scheduled time.
4. When a Practitioner has been scheduled to provide specialty back-up coverage, it is that Practitioner's responsibility to provide consultation for care of patients in the Emergency Care Centers for whom he/she is called within the realm of his/her specialty regardless of the patient's financial resources.
5. When a Practitioner is scheduled to provide specialty back-up coverage, it is the duty of and the responsibility of that Practitioner to ensure that he/she is immediately available, at least for telephone consultation, to the Emergency Care Center physician for the scheduled on-call period and can arrive at the South Bend ER within a reasonable time period. The on-call Practitioner may secure a qualified alternate (same specialty level of training) in the event he or she is temporarily unavailable.
6. When, during a telephone consultation, an Emergency Care Center Physician's proposed disposition of an ED patient is inconsistent with a consulting Practitioner's treatment plan, and no mutually agreeable compromise can be met, the following will occur:
 - a. At the South Bend ER location:
The consulting Practitioner must physically arrive to the Emergency Care Center to evaluate and assume care of the patient. This should occur within a reasonable time

MEDICAL STAFF RULES AND REGULATIONS

period. The consulting Practitioner may be represented by an alternate who possesses at least the same level of knowledge and skills, but it is the consulting Practitioner's responsibility to secure the services of that individual. Should the consulting Practitioner refuse to fulfill this responsibility, the Chief of the Consulting Practitioner's Department will be notified and will assign care for the patient. The case will be reviewed by the Practitioner's Department and the Department of Emergency Medicine, and the Medical Staff President will be notified.

b. At the Granger ER location:

The on-call Practitioner or (designated alternate) must physically arrive in a timely manner to the Beacon Granger Hospital Emergency Care Center to evaluate and assume the care of the patient with an emergency medical condition whenever requested by the emergency physician (or his/her designee). If however, the on-call Practitioner (or designed alternate) and the emergency physician agree that the patient requires specialized capabilities at the Memorial Hospital main campus that are not otherwise available at the Granger campus, then the patient may be transported to the Memorial Hospital main campus, in which case the on-call practitioner (or designed alternate) will timely present to the Memorial Hospital main campus to receive, evaluate, and as necessary stabilize the patient after transport. Examples may include (but are not limited to): anesthesia care, procedures which require specialized equipment such a surgery, bronchoscopy, endoscopy, etc.

All such transports will be effected in, as determined by the Beacon Granger Hospital physician, a medically safe and appropriate manner, through qualified personnel and transportation equipment, including the use of medically appropriate life support measures, consistent with the pertinent obligations of EMTALA. Prior to transport to the Memorial Hospital main campus, consideration shall also be given to any facility(s) (other than Memorial Hospital main campus) that may be more appropriate to receive the patient. Hereto any such transfer shall be facilitated in a manner consistent with the pertinent obligations of EMTLA.

Nothing herein precludes the emergency physician at the Beacon Granger Hospital Emergency Care Center from requesting, in his or her discretion, a telemedicine consultation (as opposed to an in-person consultation) with an on-call practitioner or eligible practitioner. However, when requested by the emergency physician to physically present to the Emergency Care Center, the on-call practitioner must timely do so.

Should the on-call Practitioner fail or refuse to fulfill his/her responsibilities pursuant to this provision, the case will be handled per the *Emergency Department On-Call Responsibilities* policy (Section 10), including that the Chief of the Consulting Practitioner's Department will be notified and will assign care for the patient. The case will be reviewed by the Practitioner's Department and the Department of Emergency Medicine, and the Medical Staff President 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.
8. When there is more than one Practitioner involved in the care of a patient who is being admitted, or when there is a lack of agreement as to which Practitioner will be the admitting Practitioner of record, the admitting Practitioner of record will be the Practitioner whose specialty concerns the principal reason for admission.
9. Responsibilities of the Emergency Care Center:
 - a. At the South Bend ER location:

The emergency physician is not responsible for inpatient care, only for care while

MEDICAL STAFF RULES AND REGULATIONS

the patient is physically present in the ECC, prior to the assignment of an admitting Practitioner. The admitting Practitioner is responsible for the care of the patient after they have accepted responsibility for admission, regardless of the patient's physical location within the Hospital. For patients who have ongoing needs, especially in the case of an emergency, prior to moving to the inpatient unit, the emergency physician will continue to reasonably provide and facilitate care of the patient in support of the admitting Practitioner.

b. At the Granger ER location:

The emergency physician is not responsible for ongoing inpatient care. The emergency physician will care for patients in the inpatient setting when urgent medical needs require intervention and another qualified medical provider is not available. Medical Staff Members are able to care for patients at the Granger facility in accordance with their privileges, but are not required to do so unless they have entered into an agreement with the hospital to provide such services. The Hospital will arrange for care of patients admitted or in observation status at the Granger location unless a Medical Staff Member chooses to care for assigned patients at the Granger location. If appropriate care cannot be arranged at the Granger facility, the patient will be transferred to another facility.

I. MEDICAL RECORDS

1. Content of the Medical Record: All patient record entries must be legible, complete, dated, timed, and promptly authenticated in written or electronic form by the responsible provider. For each patient who is treated as an inpatient, an ambulatory care patient, or an emergency patient, the admitting Practitioner shall be held responsible for the preparation of a complete and legible medical record including an H&P and a Discharge Summary or Final Progress Note that accurately reflects the patient's care and condition.

a. History and Physical:

(1) Documenting H&P – Time Frames

A medical history and physical examination (H&P) must be completed and documented no more than 30 days before and no more than 24 hours after admission or registration, but prior to surgery or any procedure requiring anesthesia services. The H&P must be completed and documented by a Qualified Individual who has been granted H&P Privileges by the Medical Staff.

(2) Timing Requirements – Update Note Required

When the H&P is recorded within the 30 days before admission or registration, an update examination noting any changes in the patient's condition must be completed and documented as an Update Note in the patient's medical record within 24 hours after admission but prior to surgery or any procedure requiring anesthesia services.

(3) Content

At a minimum, the H&P shall include the following: the chief complaint and details of the present illness, an assessment of the patient's past medical, social and family histories, a review of body systems, a physical examination (including at a minimum, cardiac assessment, respiratory assessment, and assessment of any other relevant system pertinent to the admission or procedure), and an impression and the plan for treatment.

(4) H&P From Transferring Hospital

If a patient is transferred from another hospital, the H&P from the transferring hospital will satisfy the H&P requirement only if it has been completed by a licensed Practitioner or other qualified person who has Memorial Medical Staff H&P Privileges and only if it has been completed within the timeline

MEDICAL STAFF RULES AND REGULATIONS

required for any H&P. If the H&P is to be used from the transferring hospital, a durable, legible copy of the report must be entered into the patient's medical record, and any subsequent changes must be documented in the medical record. If there are no changes, the Practitioner or other Qualified Individual must indicate so in an Update 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 in the medical record prior to performing any inpatient diagnostic or surgical procedure. By definition, a procedure involves 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 such a delay would constitute a hazard to the patient. The Emergency Department note cannot be used as an H&P unless it satisfies all the requirements for being a valid H&P.

(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 puncture, epidural steroid injection, paracentesis, thoracentesis, joint aspiration or injection, facet injection, EEG studies, outpatient tube thoracostomy, central line placement, fine needle aspiration, drainage tube exchange or injection, needle aspiration/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 the Moderate Sedation Policy which requires an H&P to be present.

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

(7) 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.

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

(a) During preparation for surgery, the RN documents the presence of an H&P. If it is not present or fails to meet the requirements for an H&P, the RN notifies the surgeon.

(b) 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 completed prior to surgery, the nurse will page the Executive Director of Surgical Services or the VP of Medical Staff Affairs to assist in resolution of the situation.

(c) Surgery staff may not take the patient to surgery without approval from one of the above.

(9) Individuals qualified to perform H&Ps and Update Notes include:

(a) Licensed physician with appropriate Privileges

MEDICAL STAFF RULES AND REGULATIONS

- (b) Oral Surgeons who have been granted H&P Privileges.
- (c) Podiatrists who have been granted H&P Privileges including examination and documentation of cardio-respiratory status.
- (d) Dentists are responsible for the part of their patient's H&P related to dentistry. For dental admissions, the full H&P must be completed by a licensed physician or other Qualified Individual. The examination needs to be performed and documented no more than 30 days prior to the procedure. An H&P older than 30 days will not be acceptable and the procedure cannot be done. The Pre-Anesthesia Evaluation as documented by the anesthesiologist will qualify as the H&P or as the H&P Update Note for surgeries performed by pediatric dentists.
- (e) Physician Assistants or Advanced Practice Nurses who have been granted H&P Privileges.

- 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 operative area and before preoperative medication has been administered.

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

The post-anesthesia follow-up note must be entered in the medical record within 48 hours after 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 entered in the medical record immediately after surgery, for example when there is a transcription delay, an Operative Progress Note is to be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend the patient. This 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 loss, and complications, if any. Circumcision procedure notes will contain the date, time, type of clamp used, estimate of blood loss, type of anesthetic used, complications, and the performing physician signature.

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

- d. **CONSULTATION REPORT:** A consultation may be requested by any Practitioner who is involved in the care of a patient. Consultation reports 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, and shall be made a part

MEDICAL STAFF RULES AND REGULATIONS

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 entered at least daily, except for patients admitted to Hospice status, in which case they should be entered every third day and when there is a change in the patient's condition.
- g. **VERBAL ORDERS:** Verbal orders (including telephone orders) shall originate only from a Practitioner who holds appropriate Privileges, a resident physician, or an Allied Health Practitioner authorized to write orders and must be dated, timed, and promptly authenticated in written or electronic format by the ordering provider. Registered Dietitian Nutritionist may manage and modify diets, supplements and tube feedings when ordered by provider and within their scope of practice. Verbal orders may be accepted and transcribed by a Registered Nurse, Graduate Professional Nurse, Practical Nurse, Genetics Counselor, Registered Dietitian Nutritionist, Registered Pharmacist, Respiratory Therapist, Radiologic Technologist, or Medical Technologist; and, within their area of respective practice, Occupational Therapist, Physical Therapist, Perfusionist, Licensed Psychologist, Clinical Neuropsychologist, Certified Speech Pathologist, Certified Audiologist, or Memorial Hospital employed paramedic. Medical Students who are under the direction of a Medical Staff Privilege holder may record orders prescribed by the Privilege holder or Resident, but these orders must be countersigned by the Privilege holder or Resident before they are carried out as Medical Students are not licensed.

The Manager of Admitting and/or his or her designated representative may accept and transcribe Verbal Orders for diagnostic tests 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 or medications.) Nursing extender staff includes Unit Clerks, Patient Care Clerks, Care Extenders, and Critical Care Techs. Social Workers may accept verbal orders as it pertains to discharge planning. All Verbal Orders shall document the name of the Practitioner or other qualified person giving the order and the person recording the order, and shall be dated, timed, and signed by the authorized person to whom the order was dictated.

Recorded Verbal Orders shall be read back to the person giving or relaying the order by the person who records it on the record. Verbal Orders which have been read back, i.e., repeated and verified, are recorded as R&V on the order sheet or in the electronic record. These orders are dated, timed, and authenticated (signed) by the person giving the order within 30 days of discharge. For the unusual situation in which verbal read back is not possible, and R&V is not recorded, the verbal order shall be authenticated by the qualified person who issued the order within 48 hours after the order is recorded.

- h. **STANDING ORDERS PROTOCOLS:** Standing Orders Protocols 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 Protocols shall be initiated by a Practitioner who is involved in the care of the patient. Standing Order Protocols such as the Hypoglycemia Protocol shall have all drugs and biological entered in the electronic record as communication type "Protocol needs signed" or on paper records as "Protocol order of (name of provider) for (name of receiving patient)" and must include the date and time. Depending on the urgency of the situation, the Protocol Order may be entered in the medical record after the actual administration per CMS guidelines.

MEDICAL STAFF RULES AND REGULATIONS

- i. **CONSENTS:** Before obtaining informed consent, the risks, benefits, and potential complications associated with a procedure will be discussed with the patient and family. Alternative options will be presented. The possibility of the need for transfusion of blood or blood components and the risk of and alternatives to transfusion will be 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 Practitioner prior to the time of surgery. In the absence of a Surgical Consent, the surgery will be cancelled, unless the attending surgeon states and documents 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 for any patient (inpatient or outpatient) who expires. A Discharge Summary shall contain the reason for admission, procedures performed; care, treatment, and services provided; condition of the patient on discharge, and the disposition as well as information provided to the patient and family and the provisions for follow-up care. The Discharge Summary will also include the principal diagnosis, secondary diagnoses, any infections and/or complications occurring during hospitalization, and the Practitioner's signature.

The admitting Practitioner will be responsible for the Discharge Summary unless the patient has been formally accepted by another Practitioner in transfer, in which case the Discharge Summary will be prepared by that Practitioner. Nurse Practitioners and Physician Assistants may dictate Discharge Summaries if they have been granted Privileges to do so. Other individuals may be allowed to dictate Discharge Summaries as approved by the Credentials Committee and the MEC.

- 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 Progress 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.

- l. **DISCHARGE ORDER; DISCHARGE AMA:** Patients shall be discharged by verbal or written order of the attending Practitioner or a resident who is associated with the case. Should a patient leave the hospital against medical advice, the attending Practitioner 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:** Nursing Home Transfer Information shall be completed in the medical record at least 24 hours prior to the patient's transfer to allow appropriate arrangements to be made by the Social Services Department.

- n. **PSYCHIATRIC EVALUATION:** A Comprehensive Psychiatric Evaluation must be completed and documented by the psychiatrist, or the nurse practitioner under the direction of the psychiatrist, within 24 hours of admission for Behavioral Health admissions.

- o. **AJCC T-N-M STAGING FORM:** A site-specific TNM Staging Form shall be included in the medical record of newly-diagnosed cancer patients when appropriate. The Form will be completed by the surgeon if a definitive surgery was performed, or otherwise by the attending Practitioner.

MEDICAL STAFF RULES AND REGULATIONS

- 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 easily understood within the context of the material. A medical abbreviation on-line reference is available under “Medical Library” on the Memorial Hospital intranet to assist in interpretation of abbreviations
- q. **TRANSITION ORDERS:** Transition Orders are those orders written by an emergency physician as a means to facilitate the safe transition of the patient from the ECC to the inpatient setting, until formal admitting/observation orders are written by the responsible admitting Practitioner or designee. Transition Orders are skeletal by nature and only cover basic patient maintenance, not inpatient evaluation, diagnosis and treatment. Transition Orders are written at the discretion of the emergency physician, based on the patient’s condition. If an emergency physician writes Transition Orders for a patient going to a Special Care Unit, those orders must be replaced by admission orders within two (2) hours of being initiated. For all other patients, Transition Orders must be replaced by admission orders within eight (8) hours of being initiated.
- r. **COPY AND PASTE DOCUMENTATION:** The writer of each document is responsible for all of the content of that document, and must ensure that any material copied into that record accurately reflects the care provided during that episode of care. CLONING of documentation is not allowed. Cloning occurs when an entire note is a copy of a previous note except for the date of service.

2. **AUTOPSIES:**

It is the duty of all Medical Staff Members and Privilege holders to attempt to secure meaningful autopsies whenever possible, but at least in cases of unusual or unexpected deaths and in cases 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. A provisional anatomical diagnosis shall be recorded on the medical record within 72 hours and the complete autopsy report shall be made part of the record within 60 days. The attending Practitioner will be notified of the time of the autopsy directly by the pathologist whenever possible. If direct Pathologist to Practitioner communication cannot occur, the attending Practitioner will be notified of the autopsy time by the Pathology Office.

It is highly recommended that any intra-operative death 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 by the Practitioner. Authentication of medical record entries may include handwritten signatures, electronic signatures, or facsimiles of original written or electronic signatures. Stamped signatures are not acceptable on any medical record.

The Supervising Practitioner must co-sign H&PS and Discharge Summaries entered by an Advanced Practice Nurse or Physician Assistant within 30 days of discharge.

4. **RECORD COMPLETION GUIDELINES:**

Any medical record missing an H&P by 24 hours after admission, or missing an H&P prior to surgery, or missing an Operative Report by 24 hours after surgery, will be considered incomplete at 7 days after the original required time of completion. The Practitioner will be notified of the incomplete record and will have 7 days from the date of notification to complete the record. Failure to complete the record within 7 days after notification will result in the record becoming Delinquent and will result in Automatic Suspension with Privilege restrictions as described below.

MEDICAL STAFF RULES AND REGULATIONS

Medical records shall be completed within a period of time that will in no event exceed fourteen (14) days following discharge from inpatient or outpatient care. Any record not complete within this period of time will be considered Delinquent.

Following discharge, medical records will be reviewed by the Medical Record Department and deficiencies will be identified and assigned to the responsible Practitioner.

Each Tuesday, Practitioners will be notified of any records that will be considered Delinquent if not complete by the second Monday following notification. Documentation queries sent to Practitioners 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 the second Monday after Tuesday notification, the responsible Practitioner's Privileges and Membership will be Automatically Suspended, and if the records remain not completed by 8:00 a.m. on the subsequent Monday after this second Monday, another Automatic Suspension will accrue, and will continue to accrue every Monday until the records are completed. In order for privileges to be re-instated, all available incomplete records in the practitioner's In Box must be completed regardless of the age of deficiencies.

Each Monday, a list of Practitioners on Automatic Suspension will be distributed by the Medical Record Department to all appropriate Hospital departments. Upon completion of all Delinquent records, the Medical Record Department will notify all involved departments that the Practitioner has completed all Delinquent medical records and the Automatic Suspension has terminated with immediate restoration of all Privileges.

No scheduled, elective, or direct admissions, consultations, surgeries or other elective procedures will be scheduled after the date the Practitioner is placed on Automatic Suspension because of delinquent medical records. Emergency admissions are allowed. Upon completion of all Delinquent medical records and subsequent termination of the Automatic Suspension, rescheduling of any canceled procedures or admissions will be necessary. Practitioners currently treating inpatients will be allowed to continue attending those patients until they are discharged.

Exceptions to the above requirements of this "Record Completion Guidelines" section may be granted by the Medical Staff President.

Practitioners who are on vacation or are not practicing due to illness or other personal reasons will be temporarily exempt from Automatic Suspension because of incomplete or Delinquent medical records until after they resume practice, Upon resuming practice they will be given notification of any Delinquent records with Automatic Suspension if the records are not completed by 7 days after such notification.

When a Practitioner is Automatically Suspended for Delinquent medical records for the seventh (7th) time during any 12 month period, the Practitioner will be required to complete all available medical records and pay a fee of \$300 to the Medical Staff before the Automatic Suspension can be terminated.

After payment of the \$300 fee is received in the Medical Staff Office, the Practitioner must complete all available incomplete records regardless of age within 7 days of receipt of the payment. If all available incomplete records are not completed within these 7 days, an additional fee of \$250 for this episode of incomplete records will be assessed. If any incomplete records still remain incomplete, the fee will be \$250 weekly.

Notification of each weekly fee assessment will be made to the Practitioner by Certified Mail.

5. **ACCESS TO AND RESPONSIBILITY FOR MEDICAL RECORDS:**

All medical records are the property of the hospital and may be removed only by court order, subpoena or statute. A Practitioner who is a Memorial Medical Staff Privilege holder and who is currently treating a patient may have access to copies of the patient's previous medical records. In the case of readmission of a patient, all previous records will be available for the

MEDICAL STAFF RULES AND REGULATIONS

use of the attending Practitioner. This will apply whether the patient is attended by the same Practitioner or by another. Unauthorized removal of medical records from the Hospital is grounds for Corrective Action.

J. **ALLIED HEALTH PROFESSIONAL STAFF**

AHP personnel who are supervised and employed by a Medical Staff Privilege holder must conform to the following requirements while engaged in designated activities within the Hospital:

- The supervising Medical Staff Privilege holder shall submit a request for his AHP personnel to assist in the hospital. This request shall specify the duties the Practitioner expects his employee to perform.
- The supervising Medical Staff Privilege holder shall submit written credentials of adequate training or certification by the AHP in the field where services are to be rendered, to the Medical Staff Office for consideration by the appropriate Medical Staff Department and the MEC.
- The supervising Medical Staff Privilege holder shall assume complete responsibility for actions of his AHP personnel, including professional liability, and shall submit a signed document substantiating this responsibility.
- AHP personnel shall be permitted to provide services within their scope of practice as authorized by the Board of Trustees of Memorial Hospital.
- AHP personnel shall not be permitted to function independently.

K. **RESIDENTS/FELLOWS, AND 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 a supervising Practitioner. While residents may write orders and progress notes in patient charts, supervising Practitioners retain responsibility for the care of patients seen by residents and must review the care of these patients at least daily.

Specifically, a Resident may function much as of an attending Practitioner, but under supervision. H&Ps, Final Progress Notes, and Discharge Summaries shall be counter-signed by a supervising Practitioner.

Residents may perform procedures in Memorial Hospital under the direct supervision of a supervising Practitioner and residents may only perform procedures for which the supervising Practitioner has privileges. Residents may perform minor procedures without direct supervision only with the agreement of the supervising Practitioner. 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 Practitioners with circumcision Privileges 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 LP Privileged Practitioners 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 supervising Practitioner has directly observed the resident successfully performing the procedure and the supervising Practitioner approves, or if the residency program has documentation of

MEDICAL STAFF RULES AND REGULATIONS

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 a supervising Practitioner and the usual Medical Staff quality assurance measures at the 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.

Supervising Practitioners 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. **Fellows**

Fellows may be Active Members of the Medical Staff who are enrolled in a post-residency training program through the Memorial Family Medicine Residency Program. They may admit, care for, and discharge patients as permitted by their Clinical Privileges. In addition, Fellows may also participate in training activities under the supervision of a Memorial Hospital Medical Staff Privilege Holder while learning procedures and medical skills for which they do not currently hold Privileges. Fellows in all of their training activities are under the supervision of the graduate medical education faculty, all of whom are Members of the Medical Staff who have been granted appropriate Clinical Privileges for the specific training activity. The rights, obligations, and instructional and disciplinary procedures for Fellows are delineated in the Policy and Procedure Manual of the Residency Program. Supervising Practitioners or their designees AND a representative of the residency program faculty are available for consultation at all times to ensure that questions arising from Hospital staff members about the conduct of Fellows with respect to this policy can be promptly answered.

3. **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**

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

b. **Sophomore Medical Students**

Sophomore students engaged in the Physical Diagnosis Course at Memorial Hospital are under the direct supervision of a Medical Staff Privilege holder who is a faculty member of the Indiana University School of Medicine. The course director is responsible for developing and assigning the clinical activities for these students.

c. **Junior/Senior Medical Students**

Junior and senior medical students may write or dictate H&Ps, Progress Notes, and Discharge Summaries. They may also write orders after first conferring with a Resident, the admitting Practitioner, or a consultant. All orders written by students require written approval by the admitting Practitioner, consultant, or resident before the order may be carried out. Special procedures by students, such as spinal tap, paracentesis, etc., will be supervised by a resident, admitting Practitioner, or consultant.

The above guidelines are to be transmitted to all involved hospital clinical units before each educational experience for a student is initiated.

MEDICAL STAFF RULES AND REGULATIONS

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff
April 9, 2012

Approved by the Board of Trustees
April 26, 2012