

**INGHAM REGIONAL MEDICAL CENTER
PROFESSIONAL STAFF**

GENERAL RULES

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GENERAL RULES

ARTICLE I. DEFINITIONS

- 1.1** As used in these Rules, and only when appropriate to the context, the term "***Practitioner***" includes a Nurse Midwife who has delineated Specified Service Authority (limited privileges) to admit patients and manage their care as prescribed in Special Policy For Allied Health Professionals (AHPs) of the Bylaws and appropriate departments' rules and policies. In all other instances, the definitions set forth in the Bylaws shall apply to these Rules.

ARTICLE II. ADMISSION AND DISCHARGE OF PATIENTS

2.1 GENERAL PROVISIONS REGARDING PATIENT ADMISSION

- 2.1-1 The Hospital shall admit all patients for which it is properly equipped to provide care, which shall include the availability of beds.
- 2.1-2 A patient may be admitted to the Hospital only by a Practitioner. All Practitioners shall be governed by the official admitting policy of the Hospital and/or special units, which may from time to time be amended or modified.
- 2.1-3 No patient shall be admitted to the Hospital until a provisional diagnosis or a valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

2.2 PHYSICIAN RESPONSIBILITIES

2.2-1 Care Treatment and Documentation

A Member shall be responsible for the medical care and treatment of each patient in the Hospital, for daily observation of the patient, (except as may otherwise be required by a Special Care Unit consistent with State and Federal regulations), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the patient and/or his relative or legally responsible person and to the referring Practitioner.

2.2-2 Patient Management

- (a) All Practitioners shall assure their patients twenty-four (24) hour coverage while in the Hospital. Should the Practitioner be unavailable, it is his responsibility to make appropriate arrangements with another physician to continue the care for his patients.
- (b) Should a Practitioner fail to name such an alternative Practitioner, the CEO, the Co-Chief(s), or Chairman of the Department or Section concerned shall have authority to call

any Member of the Active Staff with comparable Privileges to assume the care of the patient. The CEO will notify the attending Practitioner.

- (c) If the attending physician transfers the care of a patient to another Practitioner, the attending physician shall indicate on the order sheet the name of the Practitioner who shall be assuming management of the patient.
- (d) All Practitioners shall accept the responsibility to respond to requests for assistance when the quality and/or appropriateness of the care being provided to a particular patient are in question.
- (e) If a Practitioner believes patient care is in jeopardy because of actions or inaction's of another Practitioner, he shall notify the Chairman of the Department of the second Practitioner. If a Chairman is unavailable, he shall notify the Co-Chiefs, Chief Medical Officer, the Vice Chairman of the second Practitioner's Department, or the CEO. Quality concerns shall be referred to the appropriate Professional Staff Department for review.

2.3 EMERGENCY MEDICAL SCREENING, EMERGENCY ADMISSIONS AND ON CALL RESPONSIBILITY

2.3-2 Emergency Medical Screening Obligation Generally

- (a) The Hospital is obligated and shall provide, upon request and within its capabilities, appropriate medical screening examination, stabilizing treatment and/or an appropriate transfer to another medical facility to any individual with an emergency medical condition, regardless of the individual's eligibility for Medicare, in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended.
- (b) The medical screening examination, in accordance with current Hospital policy, may be performed by a physician and/or by such other medical personnel as are delegated by the supervising physician and deemed qualified to determine the presence or absence of an emergency medical condition.
- (c) Any Practitioner with on call responsibilities requested to provide emergency medical treatment must respond in a timely manner, or personally arrange for an appropriate alternative Practitioner to timely provide emergency treatment for patients in the Emergency Department, inpatients requiring emergency specialty consultation or patients in labor. Failure to meet this obligation may result in Emergency Medical Treatment and Active Labor Act (EMTALA) consequences for the Hospital and the offending Practitioner.

2.3-2 On-Call Procedures and Responsibilities for Members

- (a) Consistent with Bylaws Section 4.4, each Active, Adjunct and in certain circumstances Affiliate Professional Staff Member is responsible for on call service as assigned by his Department Chairman.
- (b) When an on call Practitioner is contacted by an attending Department Practitioner or is unable to provide care, it is the on call Practitioner's responsibility to contact another appropriate Practitioner to assume the care, and to inform the Emergency Department

Practitioner or inpatient attending of the arrangement.

- (c) The on call Practitioner, or his designee, is expected to respond within thirty (30) minutes when requested to appear personally.
- (d) If the on call Practitioner and the Emergency Department attending physician or inpatient attending disagree as to the disposition or plan of care of the patient, the on call Practitioner will appear within thirty (30) minutes to personally evaluate the patient.
- (e) If the on call Practitioner cannot fulfill his call responsibilities for any reason, it is his responsibility to find an appropriate alternate and to notify the Emergency Department attending physician or inpatient attending of the alternate(s), coverage dates and times.
- (f) If a Practitioner fails to respond to an on call service request in a timely manner, the behavior will be reported to the Department Chairman of the Member. The Practitioner will be available within two (2) business days of a request to meet with the Chief Medical Officer, Co-Chief(s) of the Professional Staff, or designee when the responsibilities outlined in this protocol are under investigation. If successive infractions of on call coverage occur, the Member may be:
 - (i) referred to the Quality Improvement Committee of his/her Department.
 - (ii) referred to the Professional Staff Executive Committee.
 - (iii) made subject to other disposition according to the disruptive behavior protocol.
- (g) In the event the on call Practitioner disagrees with the conclusion of the Emergency Department attending physician or inpatient attending physician that his presence is immediately required, he shall nevertheless come to the Hospital in accordance with the timeframes outlined in this protocol. He may, however, request Medical Administration to review the case.

2.3-3 Responsibilities of Departments

- (a) Each Department Chairman is responsible for assignment of on call duties. He must ensure that all specialties and sub-specialties in his Department are covered by an on call Practitioner and his Department's Members fulfill their obligations.
- (b) The on call schedule will be provided to the Emergency Department and the CEO or his designee in no less than one-month increments.

2.3-4 Responsibilities of the Emergency Department

- (a) All pertinent information pertaining to the patient must be available to the on call Practitioner for evaluation. The information shall be faxed to the office of the on call Practitioner for appropriate outpatient follow up when indicated.

2.3-5 Process for Reporting And Investigation of On Call Protocol Violations

- (a) If a Professional Staff Member fails to respond to an on call service request in a timely manner, this will be reported immediately to his Department Chairman or, if he is not available, Medical Administration will arrange for evaluation and/or care of the patient.
- (b) The Emergency Department attending physician or inpatient attending physician will immediately notify Risk Management or the on call administrator if:
 - (i) An on call Practitioner refuses to timely come in; and
 - (ii) A substitute Practitioner cannot be found; and
 - (iii) The patient is or may be transferred to another facility as a result of this.
- (c) If patient care was provided by another Practitioner because the on call Practitioner failed to respond, the Emergency Department attending physician or inpatient attending physician will notify Risk Management the next business day.
- (d) Risk Management and Compliance, in conjunction with Medical Administration, will investigate any occurrence related to a potential or actual violation of the on call protocol in a timely manner when EMTALA rules appear to be infringed.
- (e) Violations of the on call protocol will be referred to the physician's Departmental Quality Improvement Committee. The committee's disposition of the issue will be done in accordance with the provisions of the Professional Staff Bylaws, Appendices, Rules and Policies.

2.3-6 Patients who are admitted on an emergency basis and do not have an established relationship with a Practitioner will be assigned to the care of a Member on call. The Chairman of each Department shall provide a schedule for such assignments to the Department of Emergency Medicine and to the CEO.

2.4 PATIENT TRANSFERS

2.4-1 Internal Patient Transfers

Transfer priorities shall be:

- (a) The emergency patient to an appropriate inpatient bed;
- (b) To a special care unit from another inpatient area if unit admission criteria are met or by approval of the special care unit director; or
- (c) From a special care unit to a general care unit whenever level of necessary care does not meet unit criteria.

2.4-2 Transfers from one Hospital campus to another shall be considered internal patient transfers but shall only be made if the patient is stable or the perceived benefits of the transfer outweigh the apparent risks of transfer.

2.4-3 In transferring patients (to/from service areas), the approval of the responsible Practitioner will be

obtained whenever possible. When there is a conflict regarding patient placement, consultation shall take place between the appropriate Practitioner, Administration, and Nursing personnel.

2.4-4 Patients will be discharged from acute care units and admitted to Medical Rehabilitation and Geropsychiatry. Likewise, patients will be discharged from Medical Rehabilitation and Geropsychiatry, and admitted to the acute care units.

2.4-5 External Patient Transfers

- (a) The attending Practitioner is responsible for transfer arrangements to another hospital and/or Practitioner. These transfers should be made in compliance with Hospital policies.
- (b) Arrangements for transfers to extended care facilities or nursing homes will be completed by the Hospital personnel in conjunction with the attending Practitioner.

2.5 SPECIAL PROVISIONS FOR PATIENT CONDITIONS OF A PSYCHIATRIC NATURE

2.5-1 The admitting Practitioner shall be held responsible for obtaining and providing such information as may be necessary to minimize risk to the patient from self harm and to minimize risk to others whenever the patient might be a source of danger for any reason.

2.5-2 For the protection of patients, the medical and nursing staffs, other employees, and the Hospital, the following principles are to be met in the case of the potentially suicidal patient regardless of placement in the Hospital.

- (a) Any patient known or suspected to be suicidal in intent shall be admitted to appropriate accommodations in the Hospital. In the event such accommodations are not available, the patient should ordinarily be transferred to another facility with available appropriate accommodations.
- (b) Any patient known or suspected to be suicidal or who has recently attempted suicide shall be seen by a Member of the Department of Psychiatry within twenty-four (24) hours.

Exception: For pediatric consultations in cases of overdose or suicide, if a child psychiatrist is unavailable, an AHP credentialed child psychologist may be called to accomplish the consultation while the patient is in the Hospital. A consultation note with specific reference to future management shall be written/dictated.

2.5-3 Any Practitioner may admit a patient to the inpatient psychiatric units; however, all patient admissions must be approved for appropriateness as soon as possible by the Medical Director(s) of the psychiatric units.

2.5-4 The management of all patients admitted to the psychiatric units shall be consistent with requirements of the Michigan Department of Mental Health and the Policies and Procedures established for patients admitted to the psychiatric units and approved by the Professional Staff.

2.5-5 Certain special treatment procedures for psychiatric patients require specific documentation and/or consultation as delineated below:

- (a) *Restraint/Seclusion*
 - (i) Hospital policy shall specify the time within which an order must be obtained after each use of restraint or seclusion and the maximum time for the use of either intervention.
 - (ii) Hospital policy shall address periodic observation of patients for whom restraint or seclusion is employed, including a maximum time between observations. Physician orders shall not specify a length of time between observations that is greater than that specified in Hospital policy.
- (b) *Electroconvulsive Therapy*
Prior to the administration of electroconvulsive therapy or other forms of convulsive therapy to adults or adolescents, the concurrence of two psychiatrists, who shall examine and consult with the physician responsible for the patient and make the appropriate documentation in the record, is required. In the event of children, at least one (1) consulting psychiatrist must be a child psychiatrist.
- (c) *Behavior Modification Techniques*
Specific documentation justifying the use of aversive conditioning in emotional, mental, or behavioral disorders is required.
- (d) *Treatment for Children and Adolescents*
All special treatment procedures for children and adolescents require a consultation by a child psychiatrist.

2.6 **ADMISSION TO SPECIALIZED CARE UNITS**

- 2.6-1 Rules for the operation of specialized units, included, but not limited to, the special care units, shall be formulated by the appropriate committees of the Professional Staff with such rules subject to approval of the PSEC.

This rule as stated above is applicable, but not limited to the following special care units:

- (a) *Critical Care Units*
- (b) *Geropsychiatric Unit*
- (c) *Medical Rehabilitation Unit*
- (d) *Step-Down Units*

- 2.6-2 Only patients meeting the respective admission/continued-stay criteria as approved by the Professional Staff for designated special care areas may be admitted to such specified units.

- 2.6-3 If questions as to appropriateness of an admission to or transfer from a special care unit should arise, the Medical Director or other designated individual as defined in the unit's respective criteria will be consulted. The admitting Practitioner will be consulted whenever possible, but the Medical Director or other designated person shall have discretionary authority to transfer the patient if deemed appropriate. If, for some reason, the Medical Director or his designee cannot be

consulted, the Department Chairman of the Practitioner or his appropriate representative, or Co-Chief(s) may administratively validate a transfer.

2.7 ADMISSION TO PROVIDER BASED CARE UNITS

2.7-1 Rules for the operation of provider based care units shall be formulated by the appropriate committees of the Professional Staff with such rules subject to approval of the PSEC.

This rule as stated above is applicable, but not limited to the following provider based care units:
ESRD Center

2.7-2 Only patients meeting the respective admission criteria as approved by the Professional Staff for designated provider based care areas may be admitted to such specified units.

2.7-3 If questions as to appropriateness of an admission to or transfer from a provider base care unit should arise, the Medical Director or other designated individual as defined in the unit's respective criteria will be consulted. The admitting Practitioner will be consulted whenever possible, but the Medical Director or other designated person shall have discretionary authority to transfer the patient if deemed appropriate. If, for some reason, the Medical Director or his designee cannot be consulted, the Department Chairman of the Practitioner or his appropriate representative, or Co-Chief(s) may administratively validate a transfer.

2.8 DOCUMENTATION OF CONTINUED HOSPITALIZATION

2.8-1 An attending physician is required to document on a daily basis the continuing care of the patient from direct personal observation of the patient. This documentation should contain at a minimum:

- (a) Information reflecting the patient's current condition and the continuing plan of care;
- (b) Indication of any changes which may alter the estimated length of stay, if applicable;
- (c) Indication that discharge planning (if applicable) is being coordinated; and
- (d) Date, time, and signature of the physician making the observation.

EXCEPTION: Special Care Units or Provider Based Care Units may develop other guidelines consistent with State and Federal regulations and accreditation requirements. Failure to develop other guidelines shall mean the specific Special Care Units or Provider Based Care Units is to be governed by this section.

2.8-2 Upon request of the committee charged with the utilization review function, the attending Practitioner must provide additional written information justifying continued hospitalization as indicated following review of the record. Failure to comply with this policy will be brought to the attention of the PSEC for appropriate action.

2.9 DISCHARGE OF PATIENTS

2.9-1 Patients shall be discharged only upon order of a Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner or without proper discharge, the events should be documented according to Hospital policy and procedure. At a minimum, a notation of the incident

shall be made in the medical record indicating the patient was advised against leaving the Hospital and the reasons therefor.

- 2.9-2 It shall be the responsibility of the attending Practitioner or designee to discharge his patients as expediently as possible.
- 2.9-3 Practitioners should initiate discharge planning as soon as possible after admission.
- 2.9-4 Discharge of Dental and Podiatric patients shall be governed by Sections 5.2 and 5.3 of these Rules.

2.10 RELEASE OF DECEASED PATIENTS

In the event of an in-hospital death, the deceased shall be pronounced by the attending Practitioner or his designee within a reasonable time. The body shall not be released until an appropriate entry has been made in the record by the Practitioner or designee who pronounced death. Notification of the family and disposition of the body shall be made in compliance with Hospital policy.

2.11 AUTOPSIES

An autopsy may be performed only with written consent of the next of kin or legal guardian, except in cases involving the Medical Examiner where consent is established by law. All autopsies shall be performed by the Hospital's Pathology Department unless otherwise directed by the Medical Examiner. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours, and the complete findings shall be made a part of the record within sixty (60) calendar days except for toxicology reports.

Toxicology reports must be on the chart within six (6) months. The results of autopsies shall be used as a source of clinical information for quality assessment/improvement purposes. Members of the Professional Staff are strongly encouraged to obtain an autopsy in cases of deaths in the Surgical Suites, deaths within twenty-four (24) hours of surgery/invasive procedures, any unexpected death, and any death where the cause of death is unknown

2.12 MEDICAL EXAMINER CASES

The Medical Examiner must be notified of a patient death which by law is classified as reportable. Reportable deaths include the following types:

- (a) All deaths by violence, whether accidental or purposeful, self-inflicted, or caused by another person. The passage of time between the injury and death does not alter the reporting requirement;
- (b) Sudden, unexpected deaths of persons believed to be in good health where no history of major medical problems or progressive disease can be determined; and
- (c) Any other death where no definitive causes can be determined.

The Nursing Supervisor on duty shall coordinate notice to the Medical Examiner's office on reportable cases. All Medical Examiner cases shall be released from the Hospital only on the authority of the Medical Examiner.

ARTICLE III. MEDICAL RECORDS

3.1 CONTENTS OF THE MEDICAL RECORD

3.1-1 The attending Practitioner shall be responsible for the preparation of a complete, current, accurate, pertinent, and legible permanent medical record for each of his patients.

- a) In the event of a Member's death or other situations where the Member may be unable to provide care to patients, where associates of the Member exist as Members of the Staff, the associates are requested to assist in completing medical records and assumption of the care of any inpatients, as qualified. Otherwise, the appropriate Department and/or Committee Chairman and/or a Co-Chief of the Professional Staff shall assume such responsibilities.

3.1-2 This medical record shall contain:

- (a) *Identification data;*
- (b) *Medical history;*
- (c) *Physical examination;*
- (d) *Diagnostic and therapeutic orders;*
- (e) *Evidence of appropriate informed consent* that shall include a description of the procedure, benefits and risk to include the patient's (or guardian's), proceduralist's and physician's signature.
- (f) *Clinical observations, including results of therapy;*
- (g) *Reports of procedures, operations, tests, and results thereof;*
- (h) *Consultation reports when applicable;*
- (i) *Autopsy report when appropriate;*
- (j) *Detailed discharge instructions; and*
- (k) *A discharge summary at termination of hospitalization to include principal diagnoses, secondary diagnoses if appropriate, and prognostics.*

NOTE: The format in which this information is recorded may vary among units especially on the Special Care Units.

3.1-3 All entries in the patient's medical record shall be accurately dated, timed, and signed by the writer.

3.2 HISTORY AND PHYSICAL REQUIREMENT AND CONTENTS

3.2-1 An admission medical history and physical examination shall be recorded within twenty-four (24) hours. Each Professional Staff Department will determine specific content requirements based upon its scope of practice, but all records should include:

- (a) *Identifying Data*
Patient's name, record number and name of the primary care physician.
- (b) *Presenting Complaint and History of Present Illness*
A thorough review of the involved (or potentially involved) system(s), relevant life-style, occupational or exposure risk factors and family history.
- (c) *Past Medical and Surgical History*
- (d) *Allergies*

- (e) Medications
- (f) *Social History and Habits*
A brief review of the patient's occupational status, living situation and stressors and any data relevant to cultural/spiritual needs of the patient. Habits, which may impact negatively on the patient's immediate course, should be listed.
- (g) *Review of Systems*
If a condition other than the primary admitting condition is found or suspected which might impact on the patient's immediate course, a complete review of the involved system(s) should be recorded. All patients undergoing an invasive procedure who have a history of significant medical problems shall have a review of the involved system(s) recorded.
- (h) *Immunization status*
(Required for all pediatric patients.)
- (i) *Required components for special populations include:*
 - (i) *Pediatric patients*
Developmental age, weight, length/height and head circumference.
 - (ii) *Patients undergoing any invasive procedure*
Mental status.
 - (iii) *All osteopathic physicians shall record a musculoskeletal examination*
In accordance with the American Osteopathic Association accreditation requirements. If a musculoskeletal examination is contraindicated the reason shall be recorded.
- (j) *Assessment and Plan*
A statement of the active and relevant diagnoses and a plan of evaluation and treatment including appropriateness of setting for care rendered.
 - (i) For pediatric patients consideration of educational/daily activity needs must be documented.
 - (ii) For patients who are victims of alleged or suspected abuse or neglect:
 - (iii) The assessment is conducted with the consent of the patient or parent or legal guardian or as otherwise provided by law.
 - (iv) The assessment is conducted in accordance with the organization's responsibility for the collection, retention, and the safeguarding of evidentiary material released by the patient.
 - (v) The assessment includes, as legally required, the notification and release of information to the proper authorities.

3.2-2 If a completed history has been obtained and a physical examination performed within seven (7)

calendar days prior to admission by a Member, a durable, legible copy of these reports may be used in the patient's hospital medical record **provided** there is an update to the history and physical documented in the record within twenty-four (24) hours of admission. The admission history and physical may also serve as a preoperative history and physical for any surgical procedure performed during the admission.

3.2-3 When a patient is readmitted within seven (7) calendar days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original is readily available to the physician.

3.2-4 If the admitting Practitioner later transfers the patient to the care of another Practitioner, the admitting Practitioner shall remain responsible for the history and physical and a mandatory admitting progress note.

3.2-5 Obstetrical Patients:

Properly executed prenatal forms, which have been approved by the Hospital, may be used in lieu of a history and physical progress note provided that the form is submitted to the Obstetrical Department prior to delivery. The attending physician shall still be responsible for the completion of an interval history and physical within twenty-four (24) hours after admission.

3.2-6 All or part of the history and physical may be delegated to other practitioners, in accordance with State Law and hospital policy, but the Physician must sign, date and time the history and physical and as applicable, the update note and assume full responsibility for its contents. For example, a Nurse Practitioner or Physician Assistant may perform the history and physical, and the update assessment and note, but both must be co-signed by the attending/covering Physician.

3.3 HISTORY AND PHYSICAL ON CHART PRIOR TO SURGERY

The medical history and physical examination shall be on the chart before performance of a surgical operation, invasive procedure or procedure requiring anesthesia consistent with anesthesia guidelines. Failure to so record may result in cancellation of the operative procedure unless the attending Practitioner states in writing that such delay would be dangerous to the patient. The Nursing Supervisor on duty shall notify the Chairman of the Department or Section Chairman of the operating Practitioner, or his designee, which shall have the authority to cancel a procedure under these circumstances.

3.4 DATE AND SIGNATURE REQUIREMENT FOR ATTENDING PHYSICIAN

The attending Practitioner shall date, sign, and/or countersign the history, physical examination, operative report, consultation, and discharge summary when they have been recorded by a member of the House Staff, which includes but is not limited to, medical students, interns, residents, and fellows or when recorded by those AHPs who have been granted the authority to record entries in the medical record. Medical record entries made or dictated by a member of the House Staff or an AHP shall be signed by such person.

Exception: Entries made by Dentists or Podiatrists shall be governed by Sections 5.2 and 5.3 of these Rules and by the Bylaws.

3.5 PROGRESS NOTES

Bylaws Committee Approved 12/05/05
Joint Conference Approved 12/12/2005
PSEC Approved 1/23/2006
Quarterly Professional Staff Approved 1/24/2006
Board of Trustees Approved 2/21/2006

Print Date: 2/19/2007

Progress notes shall be recorded, dated, timed, and signed by all attending Practitioners or an appropriately credentialed AHP at least daily. The mandatory admitting progress note should state the chief complaint, the symptoms and physical findings that led to a working diagnosis, the expected therapy, and possible consultation. There should be a pertinent chronological report of the patient's hospital course including significant physical changes, new signs and symptoms, complications, consultations, treatment, and results of that treatment. Each of the patient's clinical problems should be clearly identified.

Pertinent progress notes may also be made by others so authorized to make entries in the medical record, such as medical students, interns, residents, and AHPs who have been granted such privileges. The attending physician is responsible for authenticating such entries where applicable. Recording of progress notes by such persons does not relieve the attending Practitioner of his responsibilities under Section 3.1.

3.6 OPERATIVE AND PROCEDURE REPORTS

Operative and procedure reports should be dictated or written by the operating Practitioner or House Staff under the direction of the operating Practitioner in the medical record immediately after surgery and shall include a detailed description of the procedure, the findings, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. All operative reports, including outpatient surgery procedures, shall be dictated within twenty-four (24) hours of the procedure and signed as soon as possible following transcription. All such reports shall be made a part of the current medical record.

3.7 CONSULTATION REPORTS

Consultations shall show evidence of the consultant's review of the patient's current medical record and prior records, if relevant; pertinent findings on examination of the patient; his opinion based on review and examination; and his recommendations. This report shall be made a part of the patient's medical record. The recommendations of the consultant shall be entered on the chart immediately upon completion of the consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified in the record, be recorded prior to the operation. The consultant shall sign the consultation report and record the date and time of the consultation.

3.8 USE OF SYMBOLS/ABBREVIATIONS IN MEDICAL RECORD

Symbols/abbreviations should not be used in the final diagnosis or on the face sheet of the patient's record. The use of symbols/abbreviations is discouraged in any documentation related to patient care, treatment, or orders except for those abbreviations established by the Medical Records Committee and placed in the Medical Record Department's glossary.

3.9 DISCHARGE SUMMARY

Except as provided below, a discharge summary shall be written or dictated on all patients hospitalized. The content of this summary shall describe the hospital stay including any complications that developed, condition on discharge (whether there was a resolution of the admission diagnosis and chief complaint), determination of whether the diagnosis and treatment were justified or whether a diagnosis could not be established, the disposition of the case, and termination of the physician's responsibility. The summary shall be sufficient to justify the diagnosis, warrant the treatment rendered, indicate the end result, assess condition of patient on discharge, and, if applicable, postoperative instructions to the patient including the recommended time for a return visit and to whom. All summaries shall be signed by the responsible Member and made a part of the medical record of that patient.

A final progress note can take the place of a discharge summary for patients who stay less than twenty-four (24) hours and for normal, uncomplicated obstetrical cases and newborns. The final progress note must contain all elements of a discharge summary.

3.10 ACCESS TO MEDICAL RECORDS/INFORMATION

- 3.10-1 The medical record is the property of the Hospital and is maintained for the benefit of the patient, the Professional Staff and the Hospital.
- 3.10-2 The release of medical records and access to medical records shall be governed by Hospital policy. Medical records generally cannot be released to persons, physicians or outside organizations other than the patient unless the patient or his legal representative has provided written authorization for the release of medical information to persons not otherwise authorized to receive this information. Generally, the original medical records may be removed from the Hospital's jurisdiction only with a court order, subpoena (accompanied by written authorization from the patient or legal representative), or State or Federal statute.
- 3.10-3 In the case of readmission of a patient, previous relevant records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same attending physician or another.
- 3.10-4 Access to the medical records of all patients shall be afforded to Members for bona fide study and research consistent with preserving the confidentiality or personal information concerning individual patients. Subject to the discretion of the CEO, former Members of the Professional Staff may be permitted access to information from the medical records of patients they attended while a Member.
- 3.10-5 Unauthorized removal of records from the Hospital is grounds for suspension of the Practitioner, including health care providers who are under the supervision of a Member. The PSEC shall determine the period of suspension.

3.11 FINAL DISPOSITION OF MEDICAL RECORD

A medical record shall not be permanently filed until it is completed by the responsible Member or is filed as incomplete by order of the Chief Medical Officer.

3.12 COMPLETION OF MEDICAL RECORDS

All medical records shall be completed within thirty (30) calendar days of patient discharge. Any records not completed by the thirty-first (31st) calendar day after patient discharge are considered "delinquent".

The staff privileges of a Professional Staff Member who fails to complete his documentation within thirty (30) calendar days shall automatically be suspended. This means all admitting, consulting and operative Privileges will be withheld until the charts are completed.

Documentation delegated to an Intern, Resident Physician, or Physician Assistant is also the responsibility of the Member. The Member will be suspended if such documentation is not completed within thirty (30) calendar days of patient discharge.

Medical Records shall forward notices of medical record deficiencies to physicians. These notices shall detail each deficiency and its age. The oldest charts will be at the top of the notice. Intern, Resident Physician, and Physician Assistant documentation will be assigned to the Member. Interns, Resident Physicians, and Physician Assistants will not receive separate notification.

A Member will be suspended if this notice contains any medical record deficiencies that have aged thirty-one (31) calendar days. Suspension shall occur on a weekly basis. Suspension memorandums shall be distributed on the same day the notice of medical record deficiencies is distributed to physicians.

If a Member remains on suspension two (2) weeks in a row and/or is on suspension five (5) times during a two (2) year calendar period, the Medical Record Administrator will notify the CEO and PSEC. The physician will then be required to attend a PSEC meeting to discuss his reasons for the delinquency. Special assessments and/or fees may be assigned to the Member by the PSEC.

A Member's failure to complete delinquent records by the deadline imposed by the PSEC shall be considered the same as recommendation to revoke Membership made pursuant to the Resolution Processes Appendix of the Bylaws, reported to the Board pursuant to Resolution Processes Appendix and entitle the Member to such review procedures as are applicable in the Review Procedures Plan.

ARTICLE IV. GENERAL CONDUCT OF CARE

4.1 PATIENT CONSENT FOR TREATMENT

4.1-1 Patient consent for medical treatment shall be governed by the Hospital's written policies and procedures for the authorization of medical treatment and these Rules.

4.1-2 A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission.

4.1-3 Informed consent must be obtained for all invasive procedures, high-risk therapies/drugs, and experimental treatments, except that such consent may be implied in a bona fide emergency or described in surgical consent below. Professional Staff Departmental/Section Rules shall delineate what activities constitute high-risk therapies/drugs as they pertain to their specialty. It is the physician's responsibility to specifically inform and document in the medical record, via a progress note and/or consent form provided by Hospital, his discussion with the patient of the diagnosis, nature and purpose of the care/procedure to be provided, the risks/consequences of care/procedure, feasible alternatives, and the prognosis if no treatment is rendered.

4.1-4 Surgical Consent

An informed consent for surgery shall be a part of the patient's chart before surgery is performed. It must be dated, timed, and signed by the patient and the Practitioner informant. In those situations wherein the patient's life or permanent well-being is in jeopardy and delay in treatment would add to that jeopardy and suitable signatures cannot be obtained due to the condition of the patient, the written and signed informed surgical consent need not be on the record prior to surgery. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record.

In circumstances where a second operation will be required during the patient's stay in the Hospital, a second consent specifically worded shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

4.2 WRITTEN AND VERBAL ORDERS

4.2-1 All orders for treatment shall be in writing and shall be signed, dated, and timed by the Practitioner making them. A verbal order shall be considered to be in writing if dictated by a Practitioner to a duly authorized person functioning within his or her sphere of competence and signed by the responsible Practitioner or appropriate member of the House Staff.

Verbal orders should be used infrequently and used as necessary to meet the care needs of the patient when the Practitioner is unable to write the order. All orders dictated over the telephone or given verbally shall be dated, timed and signed by the person to whom dictated with the name of the Practitioner noted before the writer's name. All orders for treatment shall be in writing and shall be signed, dated and timed, by the Practitioner making them the next time the patient is visited or documents information in the patient's record, or within forty-eight (48) hours, whichever is sooner. When the Practitioner who dictated the verbal order is not able to authenticate the order (e.g. the Practitioner who dictated the order is "off-duty") a covering Practitioner should co-sign the order for the Practitioner. A verbal order can only be counter-signed, dated and timed by an appropriate Attending Physician.

4.2-2 The initiation of no code orders or discontinuation of life support measures shall be governed by Hospital policies. Verbal orders for a no code may be taken over the phone by a duly authorized person functioning within his sphere of competence in the following situations:

- (a) There is prior documentation in the chart that a discussion has previously occurred between the patient and/or his family and/or his legal representative and the Practitioner; or
- (b) The patient is a private patient of the attending Practitioner and a pre-admission discussion has taken place; or
- (c) The patient has an advance directive reflecting patient's desires to be a no code. Such a verbal no code order shall reflect prior discussions and/or the language in the advance directive whichever takes legal precedence. The verbal no code order will remain in effect for twenty-four (24) hours by which time substantiating documentation must be in the medical record. That documentation shall be:
 - (i) A copy of the advance directive, or
 - (ii) A copy of no code documentation from another acute care or skilled nursing facility, or
 - (iii) Documentation by the Practitioner of prior discussions with the patient and/or his family and/or his legal representative.

The phone order must be signed within twenty-four (24) hours. All no code orders must be reaffirmed by signed order within time frames established by Hospital Policies and

Procedures.

- 4.2-3 Orders that cannot be verbally dictated will be delineated by the PSEC and available on each Nursing unit.
- 4.2-4 Specific AHPs may write and give verbal orders to the extent designated in the credentialing process and in compliance with stated restrictions or restrictions dictated by Federal or State law.
- 4.2-5 Persons Able to Accept and Transcribe Verbal Orders

Duly licensed ancillary health care professionals employed by the Hospital and AHPs credentialed by the Hospital may accept and transcribe into the medical record verbal orders issued by a qualified Practitioner. Such verbal orders must be limited in scope to the AHPs specific licensed discipline and/or his credentialed privilege.

Ancillary health care personnel may accept specialty-related verbal orders from physicians in accordance with established departmental and Hospital policies.

4.3 FORM OF WRITTEN ORDERS/RE-WRITTEN ORDERS

Practitioner orders must be written clearly, legibly and completely. Illegible or improperly written orders will not be administered until re-written or understood by the appropriate personnel.

4.4 CONTROL OF DRUG ADMINISTRATION

- 4.4-1 All drugs and medications administered to patients shall be those listed in the Hospital Formulary, or formulary of any entity with which the Hospital has contracted for pharmacy services, or any FDA update/advance notice.

Exception: Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of the FDA, subject to the authorization by the Hospital's Institutional Review Board.

- 4.4-2 Automatic Expiration of Orders

- (a) An automatic expiration date shall be observed for all inpatient medication orders unless:
 - (i) The order indicates a specific number of doses to be administered.
 - (ii) An exact period of time for the medication is specified.
 - (iii) The prescriber reorders the medication.
 - (iv) The Professional Staff and the Pharmacy and Therapeutics Committee shall establish time periods for the classes of pharmaceuticals.
 - (v) The prescriber shall be notified at least twenty-four (24) hours prior to the designated expiration time at which time the order to continue or discontinue will be obtained.

- (b) All previous medication orders shall be automatically canceled and new orders written when any patient goes to surgery unless:
 - (i) The procedure is diagnostic.
 - (ii) No anesthesia or local anesthesia only, is required.
 - (iii) Performed in the surgical suite because of the availability of necessary equipment or personnel elsewhere

4.5 CONSULTATIONS

4.5-1 The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Any qualified Member credentialed with appropriate clinical Privileges can be called for consultation. Requests for consultations and participation in management shall be recorded on the physician's order sheet. Content of the Consultation Report is governed by Section 3.7 of these Rules.

4.5-2 Consultation is required in the following situations:

- (a) When the patient is critically ill and the clinical condition of the patient is outside the privileges and area of expertise of the attending Practitioner.
- (b) When the patient is not a good risk for operation or treatment contemplated.
- (c) When the diagnosis is obscure after ordinary diagnostic procedures have been completed.

4.5-3 Except in an emergency, consultation is encouraged in the following situations:

- (a) Where there is significant doubt as to the choice of therapeutic measures to be utilized.
- (b) In unusually complicated situations where specific skills of other Practitioners may be needed.
- (c) When evidence of a major psychiatric disorder is revealed in a patient who is admitted for conditions non-psychiatric in nature, a psychiatric consultation is strongly recommended.

4.5-4 Form of Consultations

The attending Practitioner shall clearly indicate one of the following categories of consultation:

- (a) *Consultation Only*
Denotes a request for consultation on a single-visit basis with appropriate documentation. The consultant would not have authority to write orders or administer therapy.
- (b) *Consultation and Concurrent Care*
Asks for continued assistance and joint coverage of the patient by the attending physician and consultant, in addition to the documented consultation. Both the attending

Practitioner and the consultant may write orders; however, the overall chart responsibility remains with the attending physician.

(c) *Consultation and Complete Referral*

Asks for a consultation and transfer of the patient to the service of the consultant. The attending Practitioner may no longer write orders for the patient.

4.6 SUPERVISION OF HOUSE STAFF

House Staff are supervised by attending physicians in all aspects of patient care.

4.6-1 Policies are maintained by the Medical Education Committee which outline supervision requirements.

4.6-2 The Director of Medical Education and Residency/Training Program Directors monitor and ensure appropriate supervision.

ARTICLE V. GENERAL RULES REGARDING SURGICAL CARE

5.1 AUTOMATIC CANCELLATION OF SURGICAL PROCEDURE

Except in life-threatening emergencies, the pre-operative diagnosis, required laboratory tests, informed consent and history and physical must be recorded on the patient's medical record prior to any surgical procedure. Failure to so record may result in cancellation of the procedure unless the attending physician states in writing that such delay would be unreasonably dangerous to the patient. The Nursing Supervisor on duty shall notify the Chairman of the Department or Section Chairman of the operating Practitioner, or his designee, who shall have the authority to cancel a procedure under these circumstances.

5.2 CARE OF GENERAL DENTAL PATIENTS

The responsibility of the care of dental patients co-admitted by a Dentist and physician Member shall be in accordance with the Bylaws, Section 5.5-5, and in accordance with the Rules of the Department of Surgery. Basic responsibilities are as noted.

5.2-1 Dentist's Responsibilities

The admitting Dentist is responsible for the following:

- (a) A detailed dental history justifying hospital admission.
- (b) A detailed description of the examination of the oral cavity and pre-operative diagnosis.
- (c) A complete operative report, describing the findings, technique, and a description of any discarded, surgically removed specimen, i.e. teeth, fragments.
- (d) Progress notes as are pertinent to the oral condition.
- (e) Discharge or summary statement.
- (f) Notification upon scheduling of admission as to the physician who will co-manage the patient.
- (g) Obtaining an informed consent (refer to Section 4.1) from patient or legally responsible person.

5.2-2 Physician's Responsibilities

The physician undertaking the co-management of a general dental patient is responsible for:

- (a) Medical history pertinent to the patient's general health.
- (b) A physical examination to determine the patient's condition prior to anesthesia and surgery.
- (c) Supervision of the patient's general health status while hospitalized.

5.2-3 Discharge of Dental Patients

The general dental patient shall be co-discharged by the Dentist and the physician Member responsible for the medical management of the patient.

5.3 CARE OF PODIATRIC PATIENTS

The responsibility for the care of Podiatric patients shall be in accordance with the Bylaws and Rules of the Department of Orthopedic Surgery. Basic responsibilities are as noted.

5.3-1 Podiatrist's Responsibilities

The admitting Podiatrist is responsible for the following:

- (a) A general history detailing the Podiatric problem and justifying the hospital admission.
- (b) A detailed description of the examination of the feet and pre-operative diagnosis.
- (c) A complete operative report, describing the findings and technique, and description of any surgically removed specimen which may be discarded in accordance with Professional Staff policy.
- (d) Progress notes as are pertinent to the podiatric condition.
- (e) Discharge summary or summary statement prior to discharge.
- (f) Notification upon scheduling of admission as to the physician who shall co-manage the patient if any.
- (g) Obtaining an informed consent (refer to Section 4.1) from the patient or legally responsible person if any.
- (h) If there is no co-management by a physician, the Podiatrist assumes the duties as described in Section 5.2-2 and 5.3-2 of these Rules.

5.3-2 Physician's Responsibilities

- (a) Medical history pertinent to the patient's general health.
- (b) A physical examination to determine the patient's condition prior to anesthesia and surgery.
- (c) Supervision of the patient's general health status while hospitalized.

ARTICLE VI. EMERGENCY SERVICES

6.1 PHYSICIAN STAFFING

The Emergency Department shall be staffed by a qualified Member at all times. Supervision and direction of the care rendered in the Department shall be the responsibility of the Chairman of the Department of Emergency Medicine.

6.2 MEDICAL RECORD FOR EMERGENCY PATIENTS

6.2-1 An appropriate medical record shall be kept for every patient receiving emergency service. 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 physical, laboratory, and radiological findings.
- (e) Diagnosis.
- (f) Treatment given.
- (g) Condition of the patient on admission, discharge, or transfer.
- (h) Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.
- (i) Evidence of general and informed consent when applicable as stated in Section 4.1 above. If the patient's condition is life threatening, the patient's consent is not required for care and treatment; however, the physician must document evidence of the life threatening nature of the patient's condition.
- (j) Completed transfer paperwork pursuant to Hospital policies and State and Federal laws if the patient is transferred to another health care facility.

6.2-2 Each patient's medical record shall be signed, legible, and completed within twenty-four (24) hours of patient's discharge from the Emergency Department by the Practitioner in attendance that is responsible for its clinical accuracy.

6.3 DISASTER PLANNING

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. The composition of a disaster planning committee and the details of the plan shall be defined in the Disaster Plan.

ARTICLE VII. PROVISIONS FOR USE OF ANESTHETIC AGENTS

7.1 USE OF LEVEL I MEDICATIONS

Qualified Practitioners shall be permitted to administer anesthetic agents for Level I procedures. Level I Privileges shall be defined as the performance of local infiltration anesthesia, topical application, and minor nerve blocks.

7.2 USE OF LEVEL II ANESTHESIA MEDICATIONS

7.2-1 Definition

Level II anesthesia medications are those which, under specific conditions, are routinely used to render a patient insensible to pain and emotional stress during surgery or other invasive procedure and which may result in the loss of a patient's protective reflexes. Level II anesthesia is limited to major regional anesthesia and/or intravenous analgesia. These medications include the use of the following medications administered by any route:

- (a) *Narcotics (Opioids)*
- (b) *Specified barbiturates (Emergency Department only)*
- (c) *Benzodiazepines*
- (d) *Dissociative Agents (Emergency Department only)*
- (e) *Propofol*
- (f) *Chloral Hydrate (Emergency Department and Pediatrics only)*

7.2-2 Designated Areas/Facility Support

The following areas within the Hospital are recognized locations where Level II anesthesia medications are routinely used for the purposes herein defined:

- (a) *Surgery - Main Operative Suites*
- (b) *Surgery - Arthroscopic Surgery Center*
- (c) *Endoscopy Unit*
- (d) *Bronchoscopy Procedure Room*
- (e) *Special Studies Unit (Cath Lab)*
- (f) *Radiology Department*
- (g) *Emergency Department*

- (h) *Special Care Units (CICU, Pre/Post Cath Unit)*

7.2-3 Credentialing Responsibility

- (a) *Department of Anesthesiology.*
The Department of Anesthesiology is responsible for privileging of all licensed Practitioners whose primary clinical activity is the provision of anesthesia services, i.e., Members of the Department of Anesthesiology.
- (b) *Other Professional Staff Departments.*
Respective departments of the Professional Staff are responsible for delineating Privileges for Level II anesthesia as it incidentally applies to the scope of clinical practice within the department. Such delineation at a minimum shall be medication-specific and in accordance with the Formulary.

7.2-4 Medico-Administrative Responsibilities

The Chairman of the Department of Anesthesiology, or his designee, shall participate with other Departments/services in the development of mechanisms and material that help to provide uniform quality of anesthesia services throughout the Hospital. These include, but are not limited to, the following:

- (a) Mechanisms to assure anesthesia services are consistent with patient needs and with current knowledge concerning anesthesia practice.
- (b) Type and amount of physical resources required.
- (c) Mechanisms to effectively monitor and evaluate the quality of anesthesia services throughout the Hospital including:
 - (i) Anesthesia safety guidelines.
 - (ii) Policies relating to operational and interdisciplinary clinical practice as well as the program for cardiopulmonary resuscitation.
 - (iii) Continuing medical education as appropriate.

7.2-5 Administration

It shall be the responsibility of the Chairmen of the Department of Anesthesiology and each Department to assure compliance with this policy.

7.3 USE OF ANESTHESIA OUTSIDE THE SCOPE OF LEVELS I AND II

7.3-1 Credentialing Responsibility

Privileges for use of anesthesia medications, which do not fall within the definition of Level I and/or Level II, shall be requested and considered by the Department of Anesthesiology.

7.3-2 Other Considerations

Requests for use of anesthesia medications not currently included on the Hospital's Formulary will be forwarded to the Chairman of the Department of Anesthesiology for categorical evaluation prior to consideration of the request.

ARTICLE VIII. PROFESSIONAL STAFF MEETINGS

8.1 ANNUAL MEETING

The annual meeting of the Professional Staff shall take place in October. Notice of date, time, and place shall be sent to all Members at least fourteen (14) business days in advance.

8.2 REGULAR PROFESSIONAL STAFF MEETINGS

8.2-1 Regular business meetings shall be held in the months of January, April, and July. Notice of date, time, and place shall be sent to all Members at least fourteen (14) business days in advance.

8.2-2 Organized Departments must meet at least quarterly to present educational programs and conduct clinical review of practice within the department.

ARTICLE IX. DEPARTMENT/SECTION RULES

9.1 DEPARTMENT/SECTION RULES

Each Professional Staff Department, and Section if applicable, shall establish, through the Department Chairman, written rules for the operation of that Department/Section. Such rules are subject to approval by the PSEC and the Board.

ARTICLE X. ADOPTION AND AMENDMENT

10.1 PROFESSIONAL STAFF RESPONSIBILITY AND BOARD INITIATION

The principles stated in the Bylaws of the Professional Staff and the Hospital regarding Professional Staff responsibility and authority to formulate, adopt, and recommend General Rules affecting the Professional Staff, and amendments thereto, and the circumstances under which the Board may resort to its own initiative in accomplishing those functions shall apply as well to the formulation, adoption, and amendment of the General Rules.

10.2 AMENDMENT

The General Rules may be amended or repealed, in whole or in part, by the PSEC of the Professional Staff, acting on its own initiative or following consultation with the Professional Staff as a whole, subject to the approval of the Board.

Bylaws Committee Approved 12/05/05
Joint Conference Approved 12/12/2005
PSEC Approved 1/23/2006
Quarterly Professional Staff Approved 1/24/2006
Board of Trustees Approved 2/21/2006

Print Date: 2/19/2007

10.3 ADOPTION

10.3-1 Professional Staff

The foregoing General Rules were adopted and recommended to the Board of Trustees by the PSEC in accordance with and subject to the Bylaws of the Professional Staff.

ADOPTED AND APPROVED ON:

January 24, 2006
DATE

CO-CHIEF OF THE PROFESSIONAL STAFF

CO-CHIEF OF THE PROFESSIONAL STAFF

SECRETARY OF THE PROFESSIONAL STAFF

13.3-2 Board of Trustees

The foregoing General Rules were adopted and approved by resolution of the Board of Trustees after considering the PSEC's recommendation and in accordance with and subject to the Ingham Regional Medical Center's Corporate Bylaws.

ADOPTED AND APPROVED ON:

February 21, 2006
DATE

CHAIRMAN OF THE BOARD

SECRETARY OF THE BOARD