

**RULES & REGULATIONS
OF THE
MEDICAL STAFF**

REVISIONS

ST. LUKE'S METHODIST HOSPITAL

CEDAR RAPIDS, IOWA

2011

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PART I: ADMISSION OF PATIENTS

1.1 Types of Patients

The hospital accepts patients for care without regard to race, creed, sex, national origin, or source of payment. Admission of any patient is contingent on the need for hospital care, adequate facilities, and personnel being available to care for the patient.

1.2 Admitting Prerogatives

A patient may be admitted to the hospital only by a member of the medical staff as defined in the current Medical Staff Bylaws.

1.3 Admission Priorities

The medical staff will admit patients on the basis of the following order of priorities:

- a. Emergency admissions. If it is not possible to handle all such admissions, the chairman of the relevant department may decide the priority of any such admission.
- b. Elective preoperative admissions -- this includes all patients already scheduled for surgery
- c. Routine admissions - this will include elective admissions involving all services

1.4 Admission Information

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason has been documented in writing as required by the medical staff bylaws. In the case of an emergency, such diagnosis shall be recorded as soon as possible.

The admitting practitioner is responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patient might be a source of danger to themselves or others.

PART II: ASSIGNMENT & ATTENDANCE OF PATIENTS

2.1 Assignment of Patients

A patient to be treated or admitted on an emergency basis who does not have a private practitioner may request a practitioner from the appropriate department on-call roster. If a patient is unable to select a medical staff member from the appropriate department call roster, then the patient will be temporarily assigned to either a member of the appropriate department on call roster, or to a member of the hospitalist admitting staff. These assignments will be on a rotating basis within the clinical departments. Consistent with available department resources, each clinical department and/or subsection will submit a monthly on call roster to the ED for the purpose of admitting patients who do not currently have a physician who is a member of the medical staff with admitting privileges.

Departments (and subsections) will determine how they provide that coverage according to the following guidelines.

- a. All departments (or subsections) shall establish a formal call schedule among members of the department.
 - 1) The department shall file with the hospital's Emergency Department a monthly list for the call rotation.
 - 2) Members of a department (or subsection) may be excused from the call rotation consistent with these bylaws.
 - 3) Departments will also establish a call schedule for inpatient consultations. This may or may not represent the same Emergency Department call schedule.
- b. Emergency Examination and Transfer Policy – See EMTALA policy.

2.3 Attendance of patients

- a. Members of the medical staff shall attend their patients, admitted or in observation status, at least daily, with progress notes being written or dictated. Some special care units may require more frequent documentation, based on patient needs.

- b. Each practitioner must assure adequate and timely professional care as defined by each department, for his/her patients in the hospital by being available, or having available through his/her office, an eligible alternate practitioner with whom prior arrangements have been made, and who has similar clinical privileges at the hospital.
- c. In certain circumstances, some physicians, departments, or services may have formal working agreements to share care responsibilities with other physicians or groups (example: The orthopedic department may establish an agreement with the hospitalists to provide medical care to their patient.) In other situations, physicians may provide consultative services. The attending physician, who bears the responsibility to supervise and coordinate the care of the patient, will keep staff informed of the responsibilities of each provider. All providers will document their care in the progress notes of the chart.

PART III: CONDUCT OF CARE

3.1 General

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary consultation and for transmitting reports of the patient to the referring practitioner.

3.2 Transfer of Responsibility

When primary responsibilities for a patient's care are transferred to another medical staff member, a written note covering the transfer of responsibilities shall be entered in the medical record.

3.3 Dentists and Podiatrists

3.31 Dentists: A patient admitted for dental care is the dual responsibility of the dentist and a physician member of the medical staff.

a. Dentist's Responsibilities include providing:

- 1) Identification of a physician who will be responsible for the medical care of the patient.
- 2) a detailed dental history justifying hospital admission;
- 3) a detailed description of the examination of the oral cavity and a preoperative diagnosis;
- 4) a complete operative report, describing the findings and techniques, which will be completed immediately following surgery. In cases of extraction of teeth, the dentist shall clearly record in the medical record the number of teeth and fragments removed.
- 5) progress notes which are pertinent to the oral condition; and a
- 6) discharge summary.

b. Physician's Responsibilities include:

- 1) A history and physical examination to determine the patient's condition prior to anesthesia and surgery; and
- 2) supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on written order of the dental member of the medical staff with concurrence of the medical staff physician.

3.32 Podiatrists: A patient admitted for podiatry care is the dual responsibility of the podiatrist and a physician member of the medical staff.

a. Podiatrist's Responsibilities

- 1) Identification of a physician who will be responsible for the medical care of the patient;
- 2) a detailed podiatry history and physical justifying hospital admission or surgery;
- 3) a detailed description of the examination of the foot and a preoperative diagnosis;
- 4) a complete operative report describing the findings and techniques will be completed immediately following surgery. All tissues removed shall be sent to the hospital pathologist for examination except those specifically excluded by hospital policy;
- 5) progress notes as are pertinent to the foot condition;
- 6) perform only those procedures for which he/she is specifically privileged;
- 7) complete the medical record as required by the bylaws

- b. Physician's responsibilities include:
 - 1) A history and physical examination to determine the patient's condition prior to anesthesia and surgery; and
 - 2) supervision of the patient's general health status while hospitalized.
- c. The discharge of the patient shall be on written order of the podiatrist member of the medical staff with concurrence of the medical staff physician.

3.4 Special Conditions for Residents or Fellows in Training:

Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Medical Education Committee or medical director in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows, including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care. The postgraduate education program director or committee must communicate periodically with the medical executive committee (MEC) and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to ensure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

3.5 Policy Concerning Immediate Questions of Care

If a nurse or any other health professional has questions regarding the care or orders provided to any patient he/she shall call this matter to the attention of the attending physician. If the questions are not answered to their satisfaction, the nurse or other professional shall direct their concern to their supervisor according to the Hospital's Chain of Command Policy

3.6 Consultations

A request for consultation to a physician of a different specialty, or within the same specialty, is performed to enhance the care of the patient in circumstances in which specialized knowledge, skills, or abilities can be offered to the patient. To meet these needs, consultation is primarily the attending physician's prerogative. Consultations may be obtained from any qualified medical staff member with clinical privileges. The attending physician will decide from among those readily available qualified consultants. However, each department will establish a consultation schedule to ensure that a member of their department is available for inpatient consultations. (This schedule may also represent the department call schedule for emergency care.) Consultations should be performed in a timely fashion, with the written consultation report entered into the patient medical record within 24 hours after the request for consultation is received. If the consulting physician is unable to accomplish the consultation within 24 hours, the consulting physician will directly notify the attending physician. Direct physician to physician communication is also highly recommended. Consultation may result in shared responsibility for the patient or a transfer of primary responsibility of the patient's care.

In certain circumstances, patients and family may request consultations. Other care providers or hospital administrators may suggest consultation. The attending practitioner will determine the appropriateness of these requests. However, for quality of care concerns, the CEO or his designee, the Administrative Medical Director, or the President of the Medical Staff may require consultation or transfer of care as outlined in the Medical Staff Bylaws.

Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff. The suicidal patient shall be admitted to the appropriate care unit and given proper care to avoid future suicidal attempts.

3.6-1 Consultant Documentation

- a. Consultant's Written Report: Consultations shall show evidence of:
 - 1) A review of the patient's record by the consultant,
 - 2) pertinent findings on examination of the patient, and
 - 3) the consultant's opinion and recommendations; this report shall be made a part of the patient's record.
 - 4) operative procedures are involved, when included
- b. If there is a disagreement between the attending physician and the consultant regarding the course of

care, the disagreement may be resolved by seeking additional input from the relevant department chair.

3.7 Consultation in Specialized Care Units

Special consultation requirements may be established by departments for specialized care units. Consultation or co-management is required by physicians with intensive care credentials in the following units:

- a. Pediatric Intensive Care Unit
 - 1) All patients requiring ventilatory support;
 - 2) Any patients receiving continuous infusion of IV insulin for diabetic ketoacidosis or IV vasopressor agents;
 - 3) Any patient with a central nervous system infection;
 - 4) Any patient with severe dehydration including children with sodium's of greater than or equal to 150 or less than or equal to 125;
- b. Neonate Intensive Care Unit:
 - 1) All patients requiring ventilatory support. Post-operative patients requiring ventilatory support for less than two hours are excepted.
 - 2) Any patient receiving continuous infusion of IV insulin or IV vasopressors.
 - 3) Any patient with a central nervous system infection.
 - 4) All patients admitted to the NICU who require oxygen for greater than two hours.
 - 5) Pre-mature infant care under 1800 grams or less regardless of gestational age, complicated.
 - 6) Medical treatment of infants over 24 hours.
- c. ICU/CCU Admission:
 - 1) Hemodynamically unstable multiple trauma
 - 2) CAB returning from the operating room (ICU only)
 - 3) Invasive intracranial pressure monitoring (ICU only)
 - 4) Mechanical ventilation(~~invasive and noninvasive-BiPaP~~)
 - 5) Intra-arterial thrombolytic administration (acute MI/PE)
 - 6) Hemodynamic monitoring
 - 7) Other patients in the unit will be evaluated for transfer out of the ICU/CCU to accommodate these patients according to the chart and proper placement. Recovery room can remain open for surgical patients.
- d. Criteria for Consultation in ICU/CCU.

A qualified consult is required within one hour for the following:

 - 1) Surgeon for multiple trauma associated with chest and/or abdominal injuries;
 - 2) neurosurgeon for injuries associated with major intracranial trauma or patients requiring intracranial pressure monitoring;
 - 3) cardiologist consult for patients with potential life-threatening arrhythmias;
 - 4) IABP therapy requires consult from cardiovascular surgeon or cardiologist;
 - 5) intravenous cardiac thrombolytic therapy requires consultation from cardiologist;
 - 6) mechanical ventilatory management requires consultation from ~~anesthesiologist, pulmonologist, or internal medicine or cardiologist. The consultation must have ventilator privileges;~~
 - 7) transvenous pacemaker requires cardiologist consultation. Cardiologist must have pacemaker privileges.
 - 8) Hemodialysis or peritoneal dialysis requires consultation from nephrologist.
 - 9) Thrombolytic therapy for CVA requires a neurologist consult.
 - 10) Any patient requiring extended critical care services for more than 24 hours requires a Critical Care Specialist Consultation. Patients admitted to Critical Care units during the late evening or night and remaining in the Critical Care units for more than 24 hours will be considered for a Critical Care Specialist Consultation the following morning. Consideration will also occur during normal routine morning rounds when the length of stay is greater than 24 hours. The attending physician may select the consultant, or the Critical Care units will have available a list of the Critical Care Specialist on-call.

3.8 Supervision of allied health professionals

Physicians who are supervisors for allied health professionals are responsible for the coordination of the care provided. Policies regarding co-authentication of notes and orders are established by the clinical department or service the provider works in and approved by the Allied Health Professionals Committee. Only in emergency situations, will non-supervising members of the medical staff be expected to assist or provide consultative guidance to allied health professionals.

PART IV: TRANSFER OF PATIENTS

4.1 Transfer to Another Facility

4.1-1 General Requirements for transfer requires:

A patient shall be transferred to another medical care facility only upon:

- a. the written order of the attending practitioner, only after arrangements have been made for admission and
- b. formal acceptance by a physician with the other facility and the facility must accept too, including its consent to receiving the patient, and only after
- c. the patient is suitable for transport.
- d. Pertinent medical information must accompany the patient.

4.1-2 Emergency Requirements

- a. Patients transferred from the Emergency Department or Obstetrics Department may only be transferred based on specific policy as outlined in the EMTALA policy.
- b. Transfer of patients in observation status, whose clinical care has not been entirely stabilized, must also follow the EMTALA policy.
- c. If the transfer is demanded by an inpatient (or person with Power of Attorney), the transfer may only occur if a physician has explained to the patient or his/her designee, the seriousness of their condition and has evaluated whether the patient is sufficiently stabilized for safe transport. Release forms should be signed and included in the patient's medical record.

PART V: DISCHARGE OF PATIENTS

5.1 Required Order

The patient shall be discharged only on a written order from the attending practitioner or designee. The attending practitioner is responsible for documenting the principal diagnosis, secondary diagnoses, comorbidities, complications, principal procedures, and additional procedures.

5.2 Leaving Against Medical Advice

If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified of the patient request. The patient shall be requested to sign the appropriate release form, attested by the patient or his/her legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending practitioner or without proper discharge after being informed of the risks and benefits of further care, a notation of the incident must be made in the patient's medical record.

5.21 Leaving Against Medical Advice- Special Considerations

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he/she shall so state in writing and the statement must be made a part of the patient's medical record.

If an inpatient, who is requesting discharge, is determined to be at risk to harm himself or others, a 24 hour hold order will be initiated by the physician to evaluate whether committal procedures should be initiated.

5.3 Termination of the Physician-Patient Relationship

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, or responsible party sufficiently in advance of withdrawal to permit another medical attendant to be secured.

5.4 Patient Request to Terminate Physician-Patient Relationship

Patients may request a transfer of their care to another practitioner:

- a. If the patient has identified another practitioner, the practitioner must be a member of the medical staff and have clinical privileges that allow for care for the patient's medical condition. The physician must be willing to accept the transfer of the patient.
- b. If the patient has not identified another practitioner, hospital or members of the medical staff should communicate such requests to the attending physician. The attending physician may seek another member of the medical staff with the same clinical privileges to accept the patient in transfer.
- c. If the request cannot be accommodated, transfer to another facility may be considered, but only if the patient is medically stable. The policy on transfer to another facility must be followed.

PART VI: ORDERS

6.1 General Requirements

All orders for treatment shall be documented and authenticated by the responsible practitioner and become a part of the patient's permanent record. The practitioner's orders must be clear, legible, complete and free of unapproved abbreviations. Orders which are illegible or unclear shall not be carried out until clarified. Members of the medical staff are responsible for co-signing the orders of students under their supervision. A policy regarding basic requirements for co-authentication of the orders of allied health professionals has been established by the Allied Health Professionals Committee. Each department will establish relevant standards in compliance with this policy.

6.2 Pre-printed Orders

A practitioner's pre-printed medical orders are those order sets that have been developed and placed on a computerized A-1 order form. All orders for medications shall include the following:

- a. Only approved formulary medications may be included on pre-printed order sets.
- b. Specify the circumstances under which the medication is to be administered.
- c. Specify the types of medical conditions of the patients for whom the orders are intended.
- d. Be reviewed and revised by the prescribing practitioner on a regular basis as specified by hospital policies and procedures.
- e. Be specific for accuracy in medication prescribing, including name of medication, dosage, route and frequency of administration (qualification is to be included for PRN medications); free of unapproved abbreviations and
- f. Be timed, dated, signed by the prescribing practitioner not to exceed thirty (30) days following a patient's discharge, and included in the patient's medical record.

6.3 Verbal Orders

6.3-1 By Whom and Circumstance

A verbal order shall be considered to be valid if dictated to a registered nurse, a licensed practical nurse, or a paramedic specialist and subsequently documented in the patient's chart. If the order is taken by the licensed practical nurse or a paramedic specialist, it will not be acted upon until it has been verified by a registered nurse. Verbal orders (including medications, diagnostic or therapeutic) issued to ancillary services (i.e. physicians' assistants, physical and occupational therapy, recreation therapy, registered pharmacist, respiratory therapist/technician, laboratory technician, radiology technician, speech pathologist, audiologist, dietitian, social worker) shall be considered to be valid if dictated to any authorized personnel functioning within his/her competence and authorized responsibility and signed by the responsible practitioner. For verbal or telephone orders or for telephonic reporting of critical test results, the ordering physician must verify the complete order or test result by having the person receiving the order or test result, "read-back" the complete order or test results. If a registered nurse or ancillary services discipline has a reason to question the order or test result, the clarity in the care/treatment of the patient, the physician providing the verbal order will be called for further clarification. No telephone orders or verbal orders will be accepted for chemotherapeutic medications.g

All physician orders for chemotherapeutic medications are to be written by the ordering physician or the physician's designee.

6.3-2 Documentation

All orders dictated over the telephone should include the following:

- a. Only approved formulary medications may be included on verbal orders.
- b. Specify the circumstances under which the medication is to be administered.
- c. Be specific for accuracy in medication prescribing, including name of medication, dosage, time period, route and frequency of administration (qualification is to be included for PRN medications).
- d. Be free of unapproved abbreviations.
- e. Be timed, dated, signed by the prescribing practitioner not to exceed thirty (30) days following a patient's discharge, and included in the patient's medical record.

6.4 Automatic Cancellation of Orders

All previous orders are automatically discontinued when a patient undergoes general anesthesia with surgery or transfers to another level of service. There shall be a written order following general anesthetic with surgery to renew proper medications. Medications will not be issued unless such an order exists and that the order specifies the names of the medications to be reinitiated. The medical record shall be flagged to indicate this has occurred and a listing of the discontinued orders shall be attached thereto.

6.5 Special Orders

6.5-1 Patient's Own Medications & Self Administration

1. Self Administered Medications:

A physician order is required for the patient to participate in the Self Administered Medication program. The Medication Administration Guide will reflect that the medication is "at bedside," if so ordered per physician and patient meets criteria of program as outlined below.

Conditions that may exclude the patient from participation in this program are:

- Physical condition (patient is too ill).
- Language barrier.
- Inability to comprehend instructions (either due to mental inability, fatigue or literacy concerns).
- History of noncompliance with other regimens.
- Controlled substances are excluded from the program.

2. Patients' Own Medications:

To assure proper administration of patient medications and to minimize self administration per hospital policy and procedures: Patients are permitted medication self administration in accordance with the following requirements:

- a. The medication must be in the original prescription/manufacturer container and positively identified by the physician or by the hospital pharmacy prior to administration.
- b. The practitioner must state on the order sheet that the patient's own medication may be used. The registered nurse will contact the physician for clarification of orders if required.
- c. Self administered patient medications must be listed on the order sheet. The practitioner or hospital pharmacist is responsible for identification and proper labeling. Unless otherwise permitted all medications will be administered by a nurse.

6.5-2 ~~Do Not Resuscitate~~

Refer to the hospital's Standard Operating Procedure: "Do Not Resuscitate"

6.6 Formulary & Investigational Drugs

6.61 Formulary Drugs: The pharmacy is authorized to stock and dispense a single acceptable item for each medication with a definite United States Pharmacopeia or National Formulary designation even when the brand is requested by different brand names. The pharmacy is also approved to dispense therapeutic interchange drugs approved by the Medical Executive Committee. The Joint Pharmacy & Therapeutics,

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Committee is charged with the responsibility for reviewing the brands available for each therapeutic agent, and shall select the brand to be stocked and dispensed on the basis of price, quality, and efficacy. Recommendations of the Joint Pharmacy & Therapeutics Committee are referred to the Medical Executive Committee for final approval. If the practitioner wishes the specific brand for which he/she writes the order, he/she shall write "Dispense as written".

All medications administered to patients shall be those approved by the FDA. Medications 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 medications in hospitals and all regulations of the Food and Drug Administration.

6.62 Investigational Medications A practitioner wishing to administer, or have administered, an investigational medication must follow policy and procedures in accordance with Hospital policy on Investigational Medications. Investigational medications shall refer to those medications which have not been approved by the Federal Food and Drug Administration.

- a. Principal investigator refers to the physician signing the FDA release for obtaining new medications.
- b. The principal investigator must obtain approval from the Joint Institutional Review Committee for use of the investigational medication and devices in the hospital.
- c. Investigational medications and devices must be ordered and used only under the direct supervision of the principal physician-investigator or registered physician co-investigators.
- d. The principal investigator assumes the responsibility for:
 - 1) Obtaining the medication and/or device from the sponsor
 - 2) Obtaining the necessary written patient consent
 - 3) Maintaining records of disposition and receipt of each drug or device
 - 4) Maintaining proper records of case histories and results
 - 5) Reporting adverse events and side effects
 - 6) Filing the appropriate reports with the sponsor, manufacturer and/or relevant federal government agencies
 - 7) Returning all materials to the sponsor upon completion of the use of the medication or device
- e. In the event of an emergency situation, arrangements shall be made for the principal investigator or hospital administrative personnel to have access to any study codes.
- f. Members of nursing and house staff shall not administer investigational medications until adequate information concerning the safety and efficacy of the medication is made available, including information regarding pharmacology, toxicology, and treatment of adverse events.
- g. Outpatients or discharged inpatients shall receive investigational medications from the physician's office and not from the hospital, unless otherwise specifically approved by the medical executive committee

h. Patients admitted to the hospital continuing on an external protocol with investigational medications will be permitted to receive their investigational medications only after adequate information concerning the medication, including information regarding pharmacology, toxicology, and treatment of adverse events, is made available. Additionally, a copy of the patient's signed consent form is to be obtained from the principal investigator or the patient.

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6.7 Do Not Resuscitate

Refer to the hospital's Standard Operating Procedure: "Do Not Resuscitate"

PART VII: MEDICAL RECORDS

7.1 Required Content

The attending practitioner, other medical staff members, as applicable, and house staff and other authorized hospital personnel involved in patient care are responsible for the preparation of a complete and legible medical

record for each patient. The record's content shall be pertinent, accurate, durable, timely, authenticated, and current. The record shall include:

- a. Patient Identification data; (including the name and address of the personal representative, conservator, guardian, or durable power of attorney, if one has been appointed, for the patient.
- b. Chief complaint, current and past medical history, review of body systems, review of social and family histories;
- c. A summary of the patient's and patient's family psychosocial needs, as appropriate, to the patient's age;
- d. A statement on the conclusions or impressions drawn from the admission history and physical examination;
- e. A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate;
- f. Diagnostic and therapeutic orders;
- g. The dose, strength, rate and route of administration will be specified for all medications ordered or prescribed for every inpatient or outpatient,
- h. Evidence of appropriate informed consent as required by hospital policy and state law;
- i. Clinical observations and patient's response to care and services provided;
- j. Progress notes made by the medical staff and other authorized staff;
- k. Consultation reports;
- l. General Allergies including medication allergies, food allergies, and adverse reactions;
- m. Test results including operative reports and other invasive tests or procedures;
- n. Reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and medical imaging examinations or treatments;
- o. Identification of audiovisual records and the location of those records, if applicable;
- p. Records of donation and receipt of transplants and/or implants;
- q. Final diagnosis(es);
- r. Clinical resumes and discharge summaries;
- s. Release forms, if applicable;
- t. Discharge instructions to patient/family;
- u. Results of autopsy, when performed;
- v. Evidence of known advanced directives and DNR status

7.2 History and Physical Examination

7.2-1 General Principles

A complete history and physical examination must be recorded in the chart or dictated within 24 hours after admission of the patient. If not dictated, the chart must contain an admission note within 24 hours that provides pertinent findings from the history and physical examination. If the history and physical is not completed within 24 hours, the affected practitioner may be subject to disciplinary proceedings including but not limited to suspension of admitting privileges, consistent with the medical staff bylaws.

7.2-2 Use of Reports Prepared Prior to Current Admission

- a. New Admissions- it is the obligation of the admitting physician to either perform a current history and physical examination, and document findings, or to obtain a written copy of a history and physical examination for inclusion in the medical record, performed within the last 30 calendar days by any of the following categories of providers:
 - 1) Another member of the medical staff with history and physical privileges, and admitting privileges.
 - 2) A member of the medical staff with history and physical privileges, but without admitting privileges.
 - 3) Nonmembers of the medical staff who are licensed to practice medicine in the state of Iowa.
 - 4) Allied health professionals licensed to practice independently in Iowa.
- b. Prior Admission within the last 30 days:
 - 1) Same or similar medical condition- the most recent history and physical examination must be available, and will be updated to reflect any interval changes in the patient's clinical condition.
 - 2) Where there is a significant change in the patient's condition occurring within 30 days prior to the planned hospital admission- a complete history and physical examination must be performed and documented in the medical record.
- c. Authentication of prior or outside medical records and reports- all prior or outside history and physical examinations must be co-signed by the admitting physician at the time of admission.

7.2.-3 Short Form (Refer to policy on History & Physical – Ambulatory Procedures)

A short history and physical examination form may be used for patients admitted for minor surgical procedures and for patients whose hospital stay is not expected to exceed 24 hours.

7.3 Preoperative Documentation

7.3-1 History and Physical Examination

Except in an emergency, no patient may undergo a surgery or any other potentially hazardous procedure without having a relevant written H&P in the patient's record which includes the pre-operative diagnosis, relevant medical history, physical examination, and required diagnostic testing including appropriate laboratory and imaging tests results. If the H&P is dictated, but not in the patient chart, a written note must be entered into the patient's medical record which documents the indication for surgery, and appropriate physical examination including cardiopulmonary examination, known allergies, and other pertinent information, including the statement that a complete H&P has been performed and dictated.

In an emergency, the physician performing the surgery/procedure must enter a written note declaring that a medical emergency exists which precludes complying with the above procedure.

7.3-2 Preoperative Anesthesia Evaluation

The anesthesiologist must perform and document in the record a pre-anesthesia evaluation of the patient's condition including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic history, any potential anesthetic problems, ASA (American Society of Anesthesiologists) patient status classification, diagnostic test results and orders for pre-operative medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered.

7.4 Progress Notes

7.4-1 General Principles

The attending practitioner is required to document the need for admission and continued hospitalization. Progress notes are written or dictated contemporaneous with the actual time a patient is visited. Daily progress notes are written or dictated by the attending physician or a properly designated allied health professional with appropriate delegated activities permitting this activity. Progress notes are sufficiently detailed to describe the condition of the patient, treatment plans, and permit continuity of care or transfer ability to another service, if warranted.

Each progress note must be:

- a. Dated, timed, and authenticated by the author of the document.
- b. Identify and respond to clinical issues raised by other consultants or practitioners; 12

- c. Legible;
- d. Reflective of the patient's clinical examination on that particular day

Progress notes shall be written at sufficiently frequent intervals, at least daily, more often on critically ill patient if needed, and those where there is difficulty in diagnosis or management of the clinical problem.

7.5 Operative & Special Procedures and Tissue Reports

7.5-1 Operative reports will list assistants in surgery, a pre-operative diagnosis, describe the findings observed at surgery, and will provide a detailed description of the surgical technique, list any tissue removed at surgery, and provide a post operative diagnosis. A written operative report should be dictated or written immediately following surgery for all surgical patients and entered into the patient chart. If a written operative report is not immediately available in the patient chart after surgery, the surgeon will enter a written operative progress note in the patient's chart providing a description of the surgery and relevant information for those physicians participating in the post operative care of the patient.

7.5-2 Tissue Examination and Reports

All specimens removed at the time of surgery or procedure shall be sent to Pathology in accordance with the St. Luke's Hospital policy.

7.6 Obstetrical Record

The current obstetrical record shall include a complete prenatal record. The prenatal record shall be written on the standard maternity history form transferred to the hospital before admission from the attending practitioner's office, and an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in physical findings.

7.7 Discharge Documentation

7.71 Discharge Summary

- a. A discharge summary will be written or dictated on all medical records of patients hospitalized over 48 hours.
- b. The final diagnosis entered on the Face Sheet by the attending practitioner in addition to a final progress note may be substituted for the discharge summary on the following types of patients:
 - 1) Those with problems of a minor nature who require less than 48 hours of hospitalization;
 - 2) normal newborn infants;
 - 3) patients having uncomplicated deliveries;

7.72 Patient Instructions

The clinical summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care. If no instructions were required, a record entry must be made to that effect.

7.8 Authentication

Authentication means to establish authorship by written signature, identifiable initials or electronic signature. The use of rubber stamp signatures is not acceptable. All patient medical record entries must be legible, complete, dated, timed, and authenticated in writing or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

- a. For authentication, in written or electronic form, a method must be established to identify the author.
- b. **When state law and/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules and regulation must address counter-signature requirements and processes.
- c. The practitioner must separately date and time his/her signature authenticating an entry, even though there may already be a date and time on the document, since the latter may not reflect when the entry was authenticated.

The following areas of the medical record require the responsible practitioner's signature or countersignature by attending physician of student or residents.

- a. Face sheet
- b. Admission progress notes and orders
- c. History and physical examination
- d. Consultation reports
- e. Progress Notes
- f. Immediate pre-operative and post-operative progress notes
- g. Anesthesia notes
- h. All operative or special procedure reports
- i. Discharge summary/clinical resume
- j. Narcotic orders and all other clinical entries, diagnoses, orders, reports and progress notes personally given or written by him/her.

Co-authentication of elements of the patient's medical record created by allied health professionals is determined by departments according to policy guidelines established by the Allied Health Professionals Committee.

7.9 Use of Symbols & Abbreviations

A listing of unapproved abbreviations is available at each nursing station. Documentation containing unapproved abbreviations will not be recognized.

7.10 Completion of Medical Records

- a. Notification- Members of the medical staff will be notified weekly of the incomplete medical records of their patients available for their completion. Repeated or prolonged delinquencies may subject the member of the medical staff to corrective action according to the medical staff bylaws.
- b. Completion requirements accepted by the medical staff:
 1. A history and physical examination note must be available within 24 hours of admission
 2. Daily progress notes every 24 hours.
 3. Completion of a discharge summary and other documents within 30 days after discharge
- c. Practitioner Relocation or Inability to complete record:
 1. When a practitioner has relocated, the Medical Records department will attempt to have him/her complete the record via secure electronic means.
 2. When practitioner is unable to complete the record due to some circumstance, the department chair will be contacted to assist in the completion of the record.

7.11 Ownership and Removal of Medical Records

All medical records (paper or electronic) are the property of the hospital. Unauthorized removal or distribution of any part of the medical record by a member of the medical staff will be cause for corrective action under the medical staff bylaws, and may include immediate suspension of clinical privileges. Unauthorized removal of medical records by hospital personnel should be reported to the hospital HR department and/or the privacy officer.

7.12 Protection of Medical Records

Control and safekeeping of the record is protected by a written user agreement with all members of the medical staff and hospital employees. To maintain confidentiality, all members of the medical staff and appropriate hospital staff are assigned user IDs and passwords in accordance with hospital policy. The unauthorized use of ID or password information is a breach of medical staff and hospital policy and is subject to corrective action under the medical staff bylaws or hospital policy.

7.13 Access to Medical Records

Unless prohibited by State or Federal law, a patient's representative or legal guardian is entitled to access to any parts of the patient's medical record. All other persons not providing patient treatment, payment, or hospital operations must present a written patient authorization for access to any part of the medical record.

7.14 Correction, Modification, or Amendment of Medical Records

All changes in the medical record need to be authenticated with signature, date and time by the person making the change.

PART VIII: INFORMED CONSENT

All patients have a right to be informed of their health status. Each patient has a right to make informed decisions regarding their care, including the right to accept or refuse treatment. The following principles apply:

- a. Routine medical care is provided to patients with the general informed consent that is required at the time of admission to the hospital.
- b. The patient or their representative is given sufficient information needed to make informed decisions regarding his/her care.
- c. Information is presented in a manner that the patient or their representative can understand.
- d. The practitioner performing the procedure is responsible for assuring informed consent is performed.
- e. The hospital provides written consent forms which should be used to document patients' acknowledgement of receipt of the information and acceptance of the procedure.
- f. In the case of minors, or if injuries or altered mental status are apparent that might preclude a clear comprehension, consent shall be obtained from a parent, legal guardian, person holding power of attorney, or other responsible party.
- g. Emergencies may preclude a thorough informed consent discussion.

PART IX: AUTOPSIES

It is the responsibility of every member of the medical staff to secure autopsies when required by law. Proper consent for an autopsy shall be in accordance with state law. All autopsies shall be performed by a hospital pathologist. The medical staff, specifically the attending practitioner, is notified when an autopsy is being performed. The provisional anatomic diagnoses must be recorded on the medical record within 72 hours; and the complete protocol shall be made a part of the medical record within 60 days. These rules do not apply to cases which, according to law must be referred to the Medical Examiner's Office.

The criteria for determining which deaths an autopsy should be requested are: (St. Luke's SOP #6000-06)

- a. Deaths in which the County Medical Examiner has jurisdiction and are indicated according to Iowa law (Code of Iowa 331.802)
- b. Deaths which are unanticipated and/or unexplained following clinical evaluation, and/or following dental, medical, or surgical diagnostic procedures and/or therapies.

**ADOPTED BY ST. LUKE'S ACTIVE MEDICAL STAFF ON
November 1, 2009**

President of the Medical Staff

Secretary of the Medical Staff

**APPROVED BY ST. LUKE'S BOARD OF DIRECTORS ON
December 1, 2009**

Secretary of the Board of Directors