



MOUNT CARMEL

MEDICAL STAFF OF MOUNT CARMEL HEALTH

MEDICAL STAFF RULES AND REGULATIONS

2009

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ARTICLE I.

1.1 Admission of All Patients

- (a) Patients shall be scheduled through Central Scheduling. Prior to admission, a provisional diagnosis shall be given to the admitting clerk. Staff physicians shall be responsible for transmitting to the Central Scheduling Office all information concerning a patient to be admitted regarding:
 - i. Pre-admission certification or clearance where required.
 - ii. Any source of communicable or significant infection.
 - iii. Such behavioral characteristics that would disturb or endanger others.
 - iv. Any reasons for protection of the patient from self harm.

Mount Carmel West – No patients admitted under the age of 13 except on obstetrics.
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- (b) Patients with a nervous or mental disease may be admitted to the Psychiatric Unit at Mount Carmel West only by a psychiatrist who retains primary responsibility for the care of the patient.
- (c) Admission of persons with communicable or infectious diseases shall be subject to the approved manuals and policies and procedures of the Infection Control Committee.
- (d) To comply with the Revised Code for Maternity Hospitals, the medical records of gynecologic patients admitted to the postpartum floor shall show the written approval of the Chairman of the Department of OB/GYN or his designee. Approval must be given to or within 24 hours of admission of the patient.
- (e) Dental Patients
 - i. Dental patients admitted as inpatients to the Hospital shall be the dual responsibility of the dentist and a physician and shall be admitted on their combined services. Dental patients admitted for outpatient surgery shall either be the dual responsibility of the dentist and physician or prior examination by a physician member of the Medical Staff shall be obtained.
 - ii. The dental care will be under the control of the dentist.
 - iii. The medical record of a patient admitted for dental care shall include a dental history, a record of the examination of the oral cavity, and preoperative diagnosis recorded and authenticated by the dentist.
 - iv. A physician must be responsible for the medical aspect of the coverage during the entire course of the patient's stay in the hospital, including completion of the medical record.
 - v. A written operative report shall follow the guidelines established for all surgeons.

ARTICLE II.

2.1 ASSIGNMENT OF PATIENTS

- (a) Every admitted or observation patient will be managed by an attending physician who must be a member of the medical staff with approved privileges.
- (b) If the patient has no primary physician, he/she may request a member of the staff or be assigned to a staff member on current assignment in the appropriate department to serve as the attending physician.
- (c) Primary physician responsibility shall belong to the attending physician. In complex care instances there may be more than one physician equally sharing responsibility within agreed upon areas of medical skill or discipline. Nonetheless, the primary responsibility of care shall rest with the attending physician until such time that circumstances change. At such time, by consultation agreement, the attending responsibility may be transferred from one physician to another but only after orders have been entered on the order sheet to transfer the care, stating such transfer and acceptance of responsibility.
- (d) A member of the staff who refers a patient to another member of the staff for primary responsibility shall be recognized on the admission record, notified of such admission and may follow said patient to the extent of medical privileges accorded the referring member of the staff.
- (e) Supervisory physicians on the Clinic teaching services, at the end of their assigned period, shall indicate on the order sheet transference of the patient to the incoming supervisor of the Clinic teaching service, who shall acknowledge the acceptance in writing.
- (f) In the event of an overwhelming volume of patients requiring admission from the Emergency Department (e.g. mass casualty incident, pandemic flu), the President of the Medical Staff (or his/her designee) will identify a process to equitably assign patients to all credentialed members of the medical staff.

ARTICLE III.

3.1 ORDERS

- (a) All orders for treatment, including but not limited to verbal, telephone, restraint, post-operative, admission, or discharge, shall be given, in writing, and signed and dated by a licensed physician, dentist, or podiatrist.
- (b) Verbal or telephone orders accepted by a Registered Nurse, a Licensed Practical Nurse, Case Manager, Radiology Technician, Pharmacist, Dietician, Physical Therapist, Respiratory Therapist, or Occupational Therapist as allowed within their respective legal scope of practice must be signed and dated by a licensed physician, dentist, or podiatrist.
- (c) Use of verbal and telephone orders will be minimized and avoided whenever possible. All verbal and telephone orders should be signed by a practitioner responsible for the care of the patient as soon as possible but within 48 hours while the patient is admitted. Verbal and telephone orders for restraints and code status must be signed by a practitioner responsible for the care of the patient within 24 hours. Verbal and telephone orders given day of discharge should be authenticated by the practitioner no later than 30 days post discharge.
- (d) Restraint orders require daily signature and must be dated and timed.
- (e) House physicians and licensed resident physicians, under the direction of a staff member, may sign any order, verbal or written, without any requirement for countersignature by the attending physician. Signature requirements remain as noted in 3.1.a.-d.
- (f) Post-op orders shall be written upon completion of surgery, before the patient is transferred to the next level of care. In addition, if the surgeon accompanies that patient from the operating room to the next unit or area of care, the operative note or progress note can be written in that unit or area of care.
- (g) Admission orders shall be written by the attending physician or his/her designee.

ARTICLE IV.

4.1 CONSENTS AND PERMISSION

Consent and permission forms shall be completed pursuant to hospital policy. Physicians are responsible, prior to the procedure, for obtaining the patient's informed consent. If a designee of the physician documents consent on the standard hospital form, the physician's progress note must reflect discussion with the patient and/or decision-maker concerning the risks, benefits, expected outcomes and other alternatives to the procedure under discussion.

ARTICLE V.

5.1 DISCHARGES

- (a) Patients shall be discharged only on the order of the attending physician, or his/her designee.
- (b) Patients who demand discharge against medical advice shall sign a release form properly attested by the patient or his legal representative.
- (c) At the time of discharge, or as soon thereafter as practical, but within 30 days, the attending physician shall complete and sign, date and time the record.
- (d) No discharge will be considered valid without a diagnosis.

ARTICLE VI.

6.1 REQUIRED CONSULTATIONS

- (a) The requirements for consultations with another qualified physician, except in emergencies, shall be accomplished in accordance with Departmental Rules and Regulations.

6.2 RESPONSIBILITY

- (a) The patient's attending physician has the responsibility of requesting consultations.
- (b) The department Chair is empowered to intervene and request that a consultation be sought for appropriate indication.
- (c) Consultation requests will be designated by the attending physician as "urgent" or "routine." The consultant will evaluate patients requiring "urgent" consultation on the same day that the consult request is written. A routine consultation shall be performed within 24 hours of the time that the practitioner is notified of the consultation request.

6.3 RECORDS

- (a) When requesting consultation the attending physician or his designee shall be required to indicate in writing the reason for requesting consultation.
- (b) In all cases, a consultant shall make and sign a record of his/her findings, opinions and recommendations as a part of the hospital record. Entries must be signed, dated and timed.

6.4 CONSULTATIONS BY RESIDENTS

- (a) Consultations that are part of the training program shall be valid when reviewed and approved in writing by a member of the teaching staff in the consulted specialty.
- (b) The medical staff recognizes the supervision requirements of the respective Residency Review Committees on Accreditation Council in Graduate Medical Education, including the concept of "progressive responsibility." Accordingly, the staff delegates the responsibility for development and periodic review of supervision requirements to the specialty Program Directors and the Graduate Medical Education Committee. Said requirements, and required updates, shall be forwarded to the Medical Executive Committee for adoption, and disseminated to the involved Department Chairs for distribution to involved medical staff/faculty.

- (b) Other consultations may be made only under conditions of urgency and shall be reviewed by a member of the medical staff who would otherwise have been called as a consultant for this patient. Also, they may be made preliminarily at the direction of a consultant who will be responsible for any opinion or action growing out of the preliminary consultation and who will review the preliminary consultation and confirm or modify it over his/her signature which must be dated and timed.

ARTICLE VII.

7.1 MEDICAL RECORD CONTENTS AND DOCUMENTATION REQUIREMENTS

- (a) Record Completion
 - i. Each member of the medical staff is expected to maintain an adequate, current medical record for each patient.
 - ii. The attending physician shall be responsible for the preparation of a complete medical record for each patient within 30 days following discharge regardless of patient type.
 - iii. A complete medical record is defined as one that has all entries, dictation and signatures completed.
 - iv. No record is to be placed in permanent file until completed and signed.
 - v. In the event a medical record remains incomplete by reason of death, resignation or inability of a staff member to complete the record, the Health Information Management Department may request the Department Chair to consider the circumstances and approve the record for filing via placement of a signed memorandum in the medical record describing such reasons.

- (b) General Contents: All entries must be legible, timed, dated and authenticated. Each patient record shall include, if applicable:
 - i. Identification data
 - ii. Complaint/symptoms
 - iii. Personal history
 - iv. Family history
 - v. History of present illness, including care provided prior to arrival, if any
 - vi. Physical examination
 - vii. Conclusions or impressions drawn from the medical history and physical exam including admitting diagnosis.
 - viii. Reasons for admission or treatment
 - ix. Goals of treatment and treatment plans, including evidence of Advance Directive
 - x. Progress notes stating medical or surgical treatment and patient's response to care
 - xi. Informed consent
 - xii. Pre- and post-anesthesia notes, including pre-induction assessment, pre- and post-sedation notes
 - xiii. Operative/invasive procedure report handwritten immediately post-op
 - xiv. Operative/invasive procedure report – dictated
 - xv. Physician's diagnostic and therapeutic orders
 - xvi. Physician's orders for discharge from post anesthesia care unless discharge is according to criteria approved by the medical staff
 - xvii. Special reports
 - Consultations
 - Clinical laboratory results
 - X-ray reports
 - Anesthesia reports

- Pathologic report
 - Other test results
 - Autopsy report – dictated
- xviii. All relevant final principal and secondary diagnoses, complications and procedures performed which are written without use of symbols and abbreviations
- xix. Conclusions at termination of hospitalization
- xx. Discharge instructions to the patient and family
- xxi. Medications ordered and administered
- xxii. Discharge summaries, final note or transfer summary; including reason for hospital admission, significant findings, procedures performed and treatment rendered, the patient's condition at discharge and patient discharge disposition
- xxiii. For the purpose of chart completion, a practitioner's signature shall either be hand written or electronic

(c) History and Physical

- i. The history and physical examination shall be completed and presented on the medical record within 24 hours after admission.
- ii. The history and physical shall be completed and present on the medical record prior to any surgical or invasive procedures unless the operating surgeon or procedural physician states, in writing, that delay would constitute a hazard to the patient. If delayed, then the history and physical must be present in the medical record within 24 hours.
- iii. If the history and physical is less than 30 days old, an H&P update note is required describing any change in status, new diagnosis, new medications, allergies etc., or a statement indicating no changes exist since prior evaluation. The H&P update note must be signed, dated and timed and present in the medical record as required above.
- iv. A history and physical greater than 30 days old may not be used in the medical record. A newly completed, signed, dated and timed history and physical is required. An H&P done by an outside physician is acceptable provided the admitting physician reviews the content, and documents any changes. This entry must be dated, timed and authenticated.
- v. The long form or dictated history and physical shall contain:
- Chief complaint
 - Details of present illness or condition including, when appropriate, assessment of patient's emotional and behavioral status
 - Past medical or surgical history
 - Medications and allergies
 - Relevant social history appropriate to patient's age
 - Clinically relevant family history
 - Inventory of body systems
 - Physical examination
 - Diagnostic results, if available
 - Diagnosis/problem list with initial plan of care

- If the history and physical exam is completed by a designee of the admitting physician, the admitting physician must validate the content with a signature which is dated and timed.
 - vi. A short version H&P is required on all outpatient and ambulatory patients. Entries must be signed, dated and timed. The short version H&P shall contain:
 - Chief complaint
 - Details of present illness or condition including, when appropriate, assessment of patient's emotional and behavioral status
 - Past medical or surgical history
 - Medications and allergies
 - Relevant family and social history appropriate to the patient's age
 - Physical examination
 - Diagnostic results, if available
 - Diagnosis/problem list with initial plan of care
 - vii. If the history and physical exam is completed by a designee of the admitting physician, the admitting physician must validate and review the content with a signature. Entries must be signed, dated and timed. Practitioners authorized by the organization as designees include, but are not limited to:
 - Licensed Independent Practitioners
 - Residents
 - Advanced Practice Nurses
 - H&P Assessment Competent Registered Nurse
 - Physician's Assistant
- (d) Summary List
- i. Ambulatory care records maintained in hospital affiliated clinical settings must have a summary list created for patients having three (3) or more visits. The summary list shall include:
 - Known significant medical diagnoses and conditions
 - Known significant operative and invasive procedures
 - Known adverse and allergic drug reactions, and
 - Known medications prescribed for or used by patient
 - Entries must be signed, dated and timed
- (e) Informed Consent
- i. Documentation of informed consent will be placed in the medical record prior to the procedure or treatment.
 - ii. Informed consent consists of:
 - The nature and purpose of the procedure
 - What the procedure is expected to accomplish
 - Reasonably known risks, benefits and alternatives
 - Likelihood of success

- Who will perform the procedure and
 - Discussion regarding patient questions.
 - Entries must be signed, dated and timed.
- iii. Informed consent is required for all procedures as listed in the hospital administrative policy.

(f) Orders

- i. All orders for treatment shall be signed, dated and timed.
- ii. House officers under the direction of a staff member, may write and sign orders.
- iii. Orders for resuscitation must be signed within 24 hours.
- iv. Restraint orders require daily signature.
- v. Current members of the medical staff may sign records for a covering physician or designated staff alternate for record completion at the discretion of the responsible practitioner.

(g) Operative Note and Report

- i. All operations/procedures performed shall be fully described in the medical record by the attending physician.
- ii. A pre-operative diagnosis is recorded before surgery by the licensed independent practitioner responsible for the patient.
- iii. Immediately post-op, an operative progress note is entered in the medical record and shall include, at minimum:
 - name of the primary surgeon(s) and assistant(s)
 - estimated blood loss (Note: In procedures where blood loss is not expected to occur, such as, but not limited to, cardiac catheterizations, endoscopy, or minor bedside procedures, documentation of blood loss is required only when blood loss actually occurs.)
 - findings
 - technical procedure used
 - specimens removed
 - Pre- and post-op diagnosis
 - Entries must be signed, dated and timed
- iv. Additional post-operative documentation includes the patient's vital signs and level of consciousness, medications (including intravenous fluids), blood and blood components, any unusual events or postoperative complications, and management.
- v. A dictated procedure note is also required.

(h) Anesthesia Assessment and Administration Documentation

- i. The medical record of any outpatient/same-day surgery patient having moderate or deep sedation will contain:

- A history and physical examination, diagnostic test results, anesthesia, drug and allergy information and preoperative diagnosis.
- A pre-sedation or pre-anesthesia assessment, including anesthesia risk.
- Documentation of patient's candidacy for the planned anesthesia.
- Re-evaluation of patient status documented immediately before moderate or deep sedation use and before anesthesia induction.
- Peri-operative documentation including unusual events, physiologic readings, treatments and responses to treatments.
- Documented assessment of post-operative status on admission to and discharge from post-anesthesia recovery area.
- Entries must be signed, dated and timed

(i) Progress Notes

- i. Pertinent progress notes shall be recorded at the time of each patient observation.
- ii. Progress notes shall be written daily by the attending physician or physician designee on all patients.
- iii. Progress notes must be legible, signed, dated and timed by the author.

(j) Discharge Summary/Final Note

- i. The dictated discharge summary, final handwritten progress note or completed discharge summary form for patients hospitalized greater than 48 hours contains:
 - The reason for hospitalization
 - Significant findings
 - Procedures performed and treatment rendered
 - The patient's condition at discharge, and
 - Instructions to the patient and/or family and discharge disposition
- ii. When preprinted discharge instructions are given to the patient and/or family, the record should so indicate.
- iii. Physicians caring for observation patients may also choose to dictate an Observation H&P/Summary Note, which includes the H&P evaluation information and the required elements of a discharge summary noted above. This would eliminate the need to handwrite a separate final progress note, complete a handwritten discharge summary or a handwritten Observation summary note.
- iv. A final, handwritten progress note or completed handwritten discharge summary or handwritten Observation Summary Note form, may be substituted in lieu of dictation in the following circumstances:
 - Patients with problems of a minor nature who require less than a 48 hour period of hospitalization. This includes Inpatients and Observation patients, but excludes Outpatient in a Bed patient types.

- The case of normal newborn infants and uncomplicated obstetrical deliveries.
 - Content of these substitutions shall contain the same elements stated in Section 7.1(a-e) above, and shall be legibly written.
- Entries must be signed, dated and timed

(k) Transfer Summary

- i. When a patient is transferred within the same organization from one level of care to another or the caregivers change, a transfer summary may be substituted for the discharge summary. A transfer summary briefly describes the patient's condition at time of transfer and the reason for transfer. When caregivers remain the same, a progress note may suffice.

(l) Death Summary

- i. In the event of death, a dictated death summary is required. This summation should include:
 - Reason for admission
 - Findings and course in the hospital
 - Event leading to death
 - Time and date of death

(m) Birth Certificates

- i. Completed birth certificates are to be signed at the time of birth or within 72 hours.

(n) Authentication

- i. All entries in the medical record must be signed by the person making the entry with an authorized signature facsimile (written signature, computer entry, signature stamp). Authentication includes date and time of signature.
- ii. Only the practitioner must personally use the signature stamp and he/she cannot delegate another individual to use his/her stamp.
- iii. Computer signature must be used with personal signature password protection.
- iv. Current members of the medical staff may sign records for a covering physician or be designated a staff alternate for record completion at the discretion of the responsible practitioner.
- v. Inappropriate use of passwords or signature stamps violates the Policies and Procedures of the Medical Staff and staff members may be subject to sanctions by the Medical Executive Committee.

(o) Confidentiality

- i. A practitioner's access to patient information is limited to necessary use in the treatment of patients, scientific study, or peer review activities.
 - ii. All practitioners are required to maintain the confidentiality of patient information and abide by all relevant local, state and federal laws related to confidentiality and security of patient information.
 - iii. Improper use or disclosure of patient information may be grounds for sanction by the Medical Executive Committee.

- (p) Failure to Complete Medical Records
 - i. Records must be completed according to medical staff policies, hospital policies and regulatory requirements.

ARTICLE VIII.

8.1 UTILIZATION

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

- (a) **Designation of Patient Type:**
A physician shall determine the patient type for all hospitalized patients by written order at the time of admission. If it is determined that the outpatient or observation patient requires an inpatient admission, the patient status shall be changed by physician order documented in the medical record.
- (b) **Admission Note:**
Requirements for an admission note are as specified in Section 7.1.(c).
- (c) **Progress Notes:**
Requirements for progress notes are as specified in Section 7.1.(i).
- (d) **Failure to Comply:**
Pursuant to Medical Staff Bylaws, failure to comply with required documentation frequency may result in corrective action.
- (e) **Extended Duration Evaluation:**
 - The physician advisor or other physician as delegated by the Medical Staff Quality and Peer Review Committee shall evaluate the medical necessity for continued hospital services for patients identified by Case Management/Social Work Services.
 - No physician shall have review responsibility for any extended stay cases in which he/she was professionally involved.
 - All decisions that further inpatient stay is not medically necessary shall be made by the physician advisor or physician members(s) of the Medical Quality and Peer Review Committee and only after the opportunity for consultation with the attending physician.
 - Where there is significant divergence of opinion following such consultation regarding the medical necessity of continued in-hospital services for the patient, the judgement of the attending physician shall prevail.
 - In the event of an adverse determination by the initial physician reviewer, the attending physician may request that a second reviewer, appropriately qualified, review the case. The second reviewer must be mutually agreeable to all persons involved. Adverse determinations by the first and second reviewer may be appealed to the Medical Staff Quality and Peer Review Committee. If judgement is a ruling of overstay, the attending physician shall be in violation of the rule and shall be subject to sanction.
 - When a practitioner is excluded from eligibility for participation in Medicare or Medicaid or similar federally or state funded medical reimbursement programs, his/her medical staff membership is deemed to be voluntarily relinquished until participation has been fully and unconditionally restored.

ARTICLE IX.

9.1 ABORTIONS AND STERILIZATION

The Medical Staff of Mount Carmel must abide by *The Ethical and Religious Directives for Catholic Health Care Services*. Any questions may be addressed by the System Mission Departments. The System Mission Department to provide a procedure for consideration of sterilization based on medical indication on a case by case evaluation.

ARTICLE X.

10.1 ALTERNATES

Each member of the medical staff shall submit to the Medical Staff Office the name of another member of the medical staff who may be called to attend his/her patients when he/she is not available. Until the alternate is named and available, the appropriate department chair shall have the authority to name an alternate from the department.

ARTICLE XI.

11.1 AUTOPSIES

- (a) Autopsies should be considered at least in the following circumstances:
 - Death under age 50
 - Death within 48 hours of a surgical or invasive procedure
 - Death associated with drug reaction
 - Death associated with an unexpected outcome
 - Death within 48 hours of admission
 - All deaths in the Emergency Department
 - Death in an outpatient setting when the known diagnosis would not be expected to result in death

- (a) If an autopsy is considered, documentation must be provided concerning:
 - Attempts to secure permission
 - Mechanism for securing permission
 - System for notifying the physician when performed

ARTICLE XII.

12.1 CERTIFICATES

- (a) Death Certificates shall be signed by the attending physician within 48 hours or by the coroner, if applicable. (Ohio Revised Code 3705.16)
- (b) Birth Certificates shall be signed by the physician/midwife in attendance at the time of the birth or within 72 hours. (Ohio Revised Code 3705.09)

ARTICLE XIII.

13.1 MEETINGS

Robert's Rules of Order shall govern the proceedings of meetings of the medical staff and of its departments and committees. The attendance requirements at these meetings are defined by the Bylaws of the Medical Staff.

Revisions: Discharge Summary/Final Notes
BOT 6/21/04