

**HENDRICKS REGIONAL HEALTH
MEDICAL STAFF RULES AND REGULATIONS**

Article 1 Admission of Patients

1.1 Admission of Patients Responsibilities

- (a) Shall be scheduled by the Registration department.
- (b) Prior to inpatient admission, a provisional diagnosis will be given to the house supervisor.
- (c) Outpatient surgery patients admitted will require an admitting diagnosis and an admitting order.
- (d) Collaborate with care coordination to determine appropriate admission status (inpatient, observation, or outpatient in bed).
- (e) Medical Staff member will be responsible for communicating to the House Supervisor information concerning a patient to be admitted regarding:
 - (i) Preadmission certification or clearance where required (elective admission).
 - (ii) A source of communicable disease or significant infection.
 - (iii) Behavioral characteristics that would disturb or endanger others.
 - (iv) Any reason for protection of the patient from self-harm.

1.2 Admitting Prerogatives

- 1.2-1 Only a member in good standing of the medical staff who has been granted appropriate clinical privileges may admit patients to the hospital.
- 1.2-2 Oral surgeon members of the staff may admit patients to the hospital, and may perform their own history and physical examination on inpatients designated as ASA (American Society of Anesthesiologists) I, II, III. For patients with ASA designations of IV and V, the oral surgeon must request consultation with an appropriate physician.
- 1.2-3 The medical staff member who is responsible for the care of the patient must be identified and verified by Registration.

1.3 Timely Visitations After the Patient is Admitted

The attending practitioner or designee must evaluate all patients admitted to the hospital within a clinically reasonable amount of time, **based on acuity**, not to exceed 24 hours. Likewise, a consulting practitioner must see a patient within a clinically reasonable amount of time, based upon acuity, not to exceed 24 hours.

Article II Assignment and Attendance of Patient

2.1 Assignment to Service

All patients are assigned to the service concerned with the treatment of the problem or disease, which necessitated admission. On-call physicians are required to respond to the hospital to attend the patient in a timely manner and to provide legally defined stabilizing care to presenting patients and those being transferred to a higher level of care under the Emergency Medicine Trauma and Labor Act (EMTALA).

In compliance with EMTALA any on-call physician who refuses or fails to respond in a timely manner necessitating the patient to be transferred for necessary evaluation and care will be listed on the patient's permanent record and may be subject to peer-review. Should the medical staff member of the assigned service disagree with the emergency medicine physician's determination, he/she must work

collaboratively with the emergency physician and an attending from another service to be certain patient disposition is both appropriate and timely.

2.2 Attendance of Patients

Generally, treatment of self, immediate family or others with whom there is a close emotional attachment should be limited to care for illness or conditions in which the diagnostic, therapeutic or procedural approaches are low-risk and brief in nature.

Where a close emotional attachment exists the ethics committee chair and service chair should provide guidance.

In the case of emergency services in which another qualified physician (healthcare provider) is not readily available, it is acceptable to provide any and all necessary stabilizing and/or life-saving care as defined in Section 5.6-1 of the Medical Staff Bylaws.

2.3 Participation on the On-Call Roster

Practitioners granted clinical privileges may be required to provide on call services commensurate with their clinical activity and presence in the community. Physicians that have offices within Hendricks County and that are members of the active medical staff may be expected to provide a disproportionate share of on-call coverage (rather than *pro rata*). However, in situations in which reasonable coverage cannot be obtained utilizing only active staff, affiliate members of staff may be required to provide coverage regardless of primary office location if their clinical activity is such that public perception is their services are routinely available in the community. Call responsibilities for practitioners who rarely provide services in the community or do not routinely admit patients to the hospital will be determined on a case-by-case basis during the initial credentialing process by the Medical Executive Subcommittee on Call Coverage described below. Their clinical activity will be monitored and evaluated no less than every two years at the time of reappointment.

2.3.1 Medical Executive Subcommittee On Call Coverage

The Medical Executive Subcommittee On Call Coverage shall include the chief of the medical staff, appropriate service committee chair, medical director of the Emergency Department, member of the Physician Relations Committee, Chief Medical Officer, and other medical staff members as needed. The Medical Executive Subcommittee on Call Coverage has been delegated authority for evaluating issues related to on call coverage. That responsibility extends to assessment of available specialties and making recommendations for call assignments based on the needs of the Hendricks County community. The subcommittee also evaluates the reasonableness of gaps in the call schedule and monitors growth of specialty groups and clinical activity in the community. During the credentialing process, when call is not initially assigned to newly appointed practitioners, monitoring of clinical activity will be ongoing with re-evaluation of call responsibilities and call assignments made as warranted.

Unless specifically exempted by the Medical Executive Committee through the process outlined in the Bylaws, Section 3.3 B, an appointee of the medical staff exercising any privileges agrees that, when he/she is the designated practitioner on call, he/she will accept responsibility during the time specified by the published schedule for providing care or counsel to any patient referred to the service for which he/she is providing on call coverage. For medical or surgical practices that establish their own on-call schedule, the practitioners are required to provide the hospital operator with the name of the actual practitioner responsible for on-call coverage at Hendricks Regional Health at least seven (7) days in advance of the rotation. All physicians are expected to furnish the operator with up-to-date contact information. If a given specialty fails to submit a call schedule for a given month or if the schedule submitted leaves gaps that are historically different from what is reasonable and customary for that service, then the CMO, in consultation with the Chief of Staff and the appropriate Service Chief, will develop and distribute the specialty call schedule for that given month. Each group is then responsible for supplying the individual physician's name that will cover each period delineated on the call schedule.

The major medical and surgical services are generally expected to provide continuous on-call coverage for the emergency department and hospital-owned immediate care centers. When conditions develop that may result in gaps in the on-call schedule, the involved practitioner(s) is required to notify the chief of staff in advance. If there is a conflict with the published schedule that results in a gap in coverage, it is the staff member's responsibility to notify the applicable service chairperson and the emergency room director at least forty-eight (48) hours prior to the scheduled rotation. The Medical Executive Subcommittee On Call Coverage will evaluate the reasonableness of the gap and a report will be presented for review and approval at the next Medical Executive Committee meeting.

The call schedule may not refer to a physician group, but must instead delineate a specific physician who is responsible to fulfill the call requirement. If an answering service is utilized as a step in contacting the physician, it is still necessary to define the physician.

Physicians are permitted to provide simultaneous call coverage at more than one institution when on-call for Hendricks Regional Health. Elective procedures and surgeries may be scheduled when on-call; however, the physician is expected to respond to the ED in the appropriate time frame, unless he/she is actively involved in a case at the time of contact.

In the event that the on-call physician is unavailable (due to events beyond his/her control or is performing a surgery or procedure), the emergency physicians will contact other appropriate physicians to provide stabilizing care until the on-call physician becomes available. In the event that another member of the specific specialty is not available, the physician with the competencies that most closely reflect the patient's needs would be contacted for aid.

2.4 Unassigned Patients

An unassigned patient:

- a). reports no ongoing relationship with a physician on the medical staff with admitting privileges, and
- b) makes no request for a specific doctor.

The following special situations also exist:

- A patient may also be considered unassigned if he/she has a relationship only with a medical or surgical specialist whose area of specialization is not germane to the present indication for admission or observation.
- If a patient's usual physician has a formal or *ad hoc* arrangement with another physician(s) to admit on his/her behalf, then the patient is not unassigned.
- Patients a) who are residents of extended care facilities without any ongoing relationship with an admitting physician and/or b) whose only contact with a member of the medical staff was during a prior admission, are considered unassigned if greater than 12 months have elapsed since the last admission.
- A patient may be considered unassigned if his/her relationship with a member of the medical staff has been permanently severed regardless of the amount of time that has elapsed since the prior contact. This situation can exist regardless of whether it was the patient or the practitioner who ended the prior association.

The policy delineated above is to be followed by Emergency Department and Immediate Care center practitioners when determining whom to contact regarding admission or observation patients. Should an exception become necessary, the E.D. or Immediate Care practitioners will notify the admitting physician.

If the admitting physician notices an error, he/she may transfer the patient to the more appropriate practitioner before assessing the patient provided that:

- a) there is adequate time allowed for the new attending to assess the patient before a violation of the Medical Staff Rules and Regulations would occur, and
- b) the patient does not require urgent or emergent attendance by the attending of record. Furthermore, such a transfer of responsibility must occur after direct communication and *agreement* between the practitioners.

Article III **General Responsibility for and Conduct of Care**

3.1 Generally

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of those portions of the medical record for which he/she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to coordinate treatment with other practitioners involved in the patient's care. Such coordination includes communications with the patient or relatives of the patient as maybe appropriate. Members must return emergency/stat pages as soon as possible, urgent pages within 15 minutes and routine pages within 30 minutes. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is effected pursuant to Section 3.2.

3.2 Transfer of Responsibility

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another service, a note covering the transfer of responsibility and acceptance of the same must be entered on the physician's order sheet. This transfer of responsibility can occur only after direct contact between the admitting or current attending practitioner and explicit acceptance by the other service.

A transfer of responsibility must occur when a practitioner will not be physically able to present to the patient's bedside in a timely manner. Specifically, the primary service may NOT utilize tele-medicine in lieu of finding appropriate coverage during her/his absence or inability to respond to the hospital in a timely fashion.

3.3 Alternate Coverage

Each practitioner must assure timely, adequate, professional care for his patients in the hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. In the absence of such designation, the chief executive officer, the chief medical officer, the chief of the medical staff or the applicable service chairman has the authority to call any member of the staff with the requisite clinical privileges to care for the patient.

3.4 Dentists, Podiatrists, and Allied Health Professionals

Dentists, podiatrists, and independent allied health professionals may treat patients under the conditions provided in Sections 5.3 and 5.4 of the Medical Staff Bylaws and in Section 1.2-2 of these Rules and Regulations.

Each dentist, podiatrist, and allied health professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he provides to the patient. More specifically, dentist and podiatrist members of the staff are responsible for the following:

- (a) A detailed dental/podiatric history and description of the dental/podiatric problem documenting the need for hospitalization and any surgery;
- (b) A detailed description of the examination of the oral cavity/foot and a preoperative diagnosis;
- (c) A complete operative report, describing the findings, technique, specimens removed, and postoperative diagnosis;

- (d) Progress notes as are pertinent to the dental/podiatric condition;
- (e) Pertinent instructions relative to the dental/podiatric condition for the patient and/or significant other at the time of discharge;
- (f) Final discharge summary note.

3.5 Policy Concerning Immediate Questions of Care

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or questions the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the attending physician. If the matter is not resolved between the nurse or other health care provider and the physician the matter may be referred to the individual's supervisor who may in turn refer the matter to the chief of service and/or hospital administrative staff.

3.6 Consultations

3.6-1 Responsibility

The attending practitioner is personally responsible for obtaining an urgent or after hours consultation from a qualified practitioner, as indicated or when required pursuant to the guidelines in section 3.6-2 below. The attending will personally contact the consultant to communicate pertinent patient information necessary for the consultation. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

3.6-2 Guidelines for Obtaining Consultations

Unless the attending practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician or his associates within 24 hours is required in the following cases:

- (a) Any patient known or suspected to be suicidal.
- (b) Consultations are also required as established in the Rules and Regulations of the specific service, and where requested by the patient or legally responsible member of the patient's family.
- (c) Where diagnosis is obscure, or where doubt exists as to the best therapeutic measures to be taken, including cases where the disorder or complications are not in the field of the attending physician's practice.
- (d) A consultation may be required for patients who are not good surgical or anesthetic risks.

For urgent cases physician-to-physician request for consultation is required. The attending physician will contact the consultant to provide appropriate information to aid in the evaluation of the patient.

3.6-3 Qualifications of Consultant

Any qualified practitioner may be consulted for opinion regardless of his staff category assignment.

A consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges to manage hospitalized patients.

3.6-4 Documentation

- (a) Consultation Request: When requesting consultation, the attending practitioner must indicate in the medical record the medical necessity and/or reason for the request and the extent and involvement in the care of the patient expected from the consultant, e.g., "for consultation and opinion only," "for consultation, orders, and follow-up regarding a particular problem."
- (b) Consultant's Report: The consultant must make and sign a report of his findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become a part of the patient's medical record.
- (c) Attending Practitioner's Response to Consultant's Opinion: In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, he shall either seek the opinion of a second consultant or record in the progress notes his reasons for electing not to follow the consultant's advice.

In cases of required consultation when the attending practitioner does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the applicable service chairman for final advice. If the attending practitioner obtains the opinion of a second consultant and does not agree with it either, he shall again refer the matter to the applicable service chairman.

3.7 RADIOLOGIC INTERPRETATION

A board certified or board eligible radiologist member of the medical staff shall perform or otherwise supervise the performing of and render interpretations of all radiologic examinations and other procedures resulting in a permanently diagnostic recorded image at Hendricks Regional Health, except echocardiography, diagnostic and interventional cardiac procedures, dental radiography, peripheral vascular angiography and interventional procedures, which may also be performed and interpreted by appropriately trained members of the Medical Staff who have requested and been granted such privileges.

The use of ultrasound for bedside procedures in the ER, ICU or OB will guiding procedures (e.g., central line placement, regional blocks, etc.) for screening evaluation in the emergency department and/or obstetrics department will not be a diagnostic read.

3.8 MEDICAL RESIDENTS

Any physician granted temporary medical resident privileges will be required to be supervised by a board certified or board eligible member of the medical staff in their specialty. Medical residents may not supervise the performance of any dependent allied health personnel, i.e., CRNA's.

ARTICLE IV **TRANSFER OF PATIENTS**

4.1 TRANSFER OF RESPONSIBILITY

4.1.1 GENERAL REQUIREMENTS

A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including consent to receive the patient and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

4.1.2 Demanded by Emergency or Critically Ill Patient

A transfer demanded by an emergency or critically ill patient or his family or significant other

(SO) is not permitted until a physician has explained to the patient or his family or SO the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

ARTICLE V **DISCHARGE OF PATIENTS**

5.1 REQUIRED ORDER

A patient may be discharged only on the order of the attending practitioner or physician designee. In the event of a disaster when the attending physician or designee may not be accessible or is no longer able to provide discharge information, the chief of service / designee will assume responsibility for assessing patients for discharge and providing discharge orders and documentation. In order to facilitate the transition of care between providers, it is essential that the discharge summary document is available to the next provider, at a minimum, by the time of the patient's next appointment. Thus, a concise discharge summary, from the attending practitioner or physician designee, must be dictated on each patient within 48 hours of patient discharge. This document should include, at minimum, the principal diagnosis, secondary diagnoses, co-morbidities, complications, procedures, and pending tests/diagnostics.

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, and the patient will be requested to sign the appropriate release form, attested by the patient or his 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, a notation of the incident must be made in the patient's medical record. A patient leaving against medical advice must be advised of all material risks of his/her action but should not be threatened that leaving will result in the denial of future health care.

5.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his 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 shall so state in writing and the statement must be made a part of the patient's medical record.

ARTICLE VI **ORDERS**

6.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be written clearly, legibly, and completely and signed, dated, and timed by the practitioner or assigned credentialed provider responsible for them.

Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse or other clinical staff.

Orders for diagnostic tests, which necessitate the administration of test substances or medications will be considered to include the order for this administration. All orders shall include the date, time, and signature of the prescribing practitioner. Outpatient tests ordered will require a diagnosis of medical necessity for each test. Screening examinations must be designated as such on the order. Outpatient test results shall be reviewed by the ordering provider (or his/her designee) within a reasonable amount of time, with appropriate follow-up action noted in the outpatient record.

6.1-1 INFUSION CENTER ORDERS

Orders for medication administration and blood/blood products may be faxed or escribed to the department or sent in with the patient. The orders shall include the date, time, and signature of the prescribing practitioner and the patient's name and diagnosis on the order.

Orders will be accepted from credentialed licensed independent practitioners who are formally affiliated with the Hendricks Regional Health Medical/Independent Allied Health Staff. Orders from practitioners who are not affiliated will be accepted only if a credentialed member of the medical staff countersigns the orders. Should the affiliated patient require additional orders, the HRH practitioner would be responsible for care.

6.1-2: Orders for Intervention by Non-credentialed, Licensed Health Professionals

When ordering patient care that is to be performed by non-credentialed, licensed health professionals (e.g., physical, occupational or speech therapy), the LIP (licensed Independent practitioner) must indicate:

- (a) if a specific protocol is to be utilized in the care of a particular patient, or
- (b) if the LIP delegates the evaluation, development and implementation of the treatment plan to the appropriately trained and licensed professional for the LIP's review and approval. The orders must be within the scope of licensure, training, and position description of the non-credentialed health professional. If the order does not pertain to an approved protocol, then the treatment plan must individualized and must include a) goals that are reflective of patient and family input (if appropriate) and, b) type amount, frequency and likely duration of services by the non-credentialed, licensed health professional. Regardless of whether the order is for a specific protocol or for delegation of the evaluation and treatment planning to occur, the LIP retains responsibility for the conduct of care provided to the patient and can continue/discontinue such interventions at any time.

6.2 PRE-PRINTED AND STANDING ORDERS

All standing orders shall be entered into the "Physician Orders" sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. Pre-printed orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. All pre-printed and standing orders must be reviewed at least annually and revised as necessary. Pre-printed and standing orders must be reviewed for each individual patient such that all orders are considered medically necessary for that patient.

6.3 VERBAL ORDERS

6.3.1 BY WHOM AND CIRCUMSTANCES

Telephone or other verbal orders may be taken only by a practitioner, a registered nurse and a licensed practical nurse, except that the following personnel may take verbal orders for medication, treatment, and/or procedures within their respective areas of practice and which they will prepare, deliver, or perform: Registered pharmacist, certified respiratory therapist, radiology technician, certified registered nurse anesthetist, occupational therapist, speech pathologist, physical therapist, registered dietitian, registered nurse, licensed practical nurse, certified physician assistant, paramedic, social worker, advanced practice registered nurse, cardiovascular technologist, exercise physiologist, radiologic technologist, registered polysomnographic technologist, medical assistant in ambulatory

practice , certified medical assistant in ambulatory practice, medical students, CRNA students, and scribes.

Telephone orders will be accepted only from the responsible practitioner or his designee provided the designee is a member of the medical staff with equivalent privileges. In general, verbal and telephone orders are to be avoided except when no other practical method exists to provide the order. Under no circumstances are verbal or telephone orders to be used to circumvent the use of computerized practitioner order entry (CPOE).

6.3.2 DOCUMENTATION

All verbal orders shall be transcribed in the proper place in the medical record, shall include the date, time, name, and signature of the person transcribing the order and the name of the practitioner, and shall be countersigned by the prescribing practitioner or his associate promptly (generally within 24 hours). Telephone orders that are received and read back will be authenticated as outlined in the **Administrative Verification of Verbal /Telephone Orders and Critical Values Policy**.

6.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

Advanced Practice Providers may write orders only to the extent, if any, specified in the position description and consistent with the scope of services individually defined for him.

6.5 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued, unless a specific order is written otherwise, when the patient goes to surgery or is transferred from ICU and Progressive Care Unit.

6.6 STOP ORDERS

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified. All orders for DEA class II medications, sedative, anticoagulants, and antibiotics, shall be reviewed by a pharmacist on a daily basis. It is generally recommended that they be discontinued after 7 days, unless originally ordered for a specific number of doses or for a specific period of time or for specific indications that require longer periods of administration.

6.6.2 NOTIFICATION OF STOP

The applicable unit (nursing/pharmacy/respiratory therapy) notifies the prescribing practitioner by verbal or written communication before an order is automatically stopped.

6.7 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS

Blood transfusions and intravenous infusions must be started by a physician responsible for the patient's care or by a registered nurse. The order must specifically state the rate of infusion.

6.8 SPECIAL ORDERS

6.8.1 PATIENT'S OWN MEDICATIONS AND SELF-ADMINISTRATION

Medications brought into the hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the attending practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner.

6.8.2 Code Classification Orders

Critically ill patients will be classified according to the following system. All patients are considered All Resuscitative Efforts, unless so stipulated by the physician order. This classification system will be used at the physician's discretion. If the physician does not indicate classification, the patient is automatically classified All Resuscitative Efforts.

- All Resuscitative Efforts
- DNR
- DNR with exceptions

All Code Classifications other than All Resuscitative Efforts must be written as a physician's order. If given verbally to a nurse, the order must be witnessed by two nurses at the time it is given and should be carefully documented and signed within twenty-four (24) hours by the attending physician.

6.8.3 RESTRAINT ORDERS

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. A restraint can be a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient condition. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, staff member or others and must be discontinued at the earliest possible time. A thorough comprehensive RN assessment of the patient will be completed to include a determination of nonviolent/non self-destructive behavior or violent/self-destructive behavior. Violent or self-destructive behavior is identified as behavior that jeopardizes the immediate safety of the patient, staff, or others.

- A. Orders: The use of each restraint or seclusion episode must be in accordance with the order of a physician who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with Indiana Law. Order for restraint or seclusion must never be written as a standing order or on an as-needed basis (PRN). The order must include:
1. Date and time of order
 2. Justification/rationale for use
 3. Type of restraint

The order must be obtained either during the emergency application of the restraint or immediately after the restraint has been applied. If the attending physician does not order the restraint or seclusion, the attending physician must also be consulted as soon as possible; this can be achieved via a telephone call.

- B. Non-violent initial order and renewal:
1. Ordering provider does not need to be physically present to re-evaluate the need for continuing the restraint or seclusion
 2. Order is required to be reviewed every twenty four (24) hours
- C. Violent/self-destructive behavior initial order and renewal:
1. When restraint or seclusion is used for behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, a physician or registered nurse who has been trained in accordance with the hospital policy must see the patient face-to-face within one hour after the initiation of the intervention. If a trained RN performs the face-to-face evaluation, the attending physician responsible for the care of the patient must be consulted as soon as possible after completion of the evaluation. The practitioner must evaluate and document the following:
 - a. Patient's immediate situation
 - b. Patient's reaction to the intervention
 - c. Patient's medical and behavioral condition
 - d. Need to continue or terminate the restraint or seclusion
 2. Each order used for this type of behavior may be renewed with the following limits for up to a total of 24 hours:
 - a. 4 hours for adults 18 years or older
 - b. 2 hours for children and adolescents 9 – 17 years of age
 - c. 1 hour for children under 9 years of age.
 3. After 24 hours before writing a new order for the use of restraint or seclusion for this type of behavior, a physician who is responsible for the care of the patient must see and assess the patient.

- D. Hospitals must report to CMS each death associated with the use of seclusion or restraint. The hospital must report the following:
1. Each death that occurs while a patient is in restraint or seclusion at the hospital
 2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 3. Each death known to the hospital that occurs within one week after restraints or seclusion where it is reasonable to assume that restraints or placement in seclusion contributed directly or indirectly to a patient's death.

6.9 **Formulary and Investigational Drugs**

6.9.1 Formulary

The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary. All drugs and medications administered to patients with the exception of drugs for bona fide clinical investigations shall be those listed in the latest edition of: United States Pharmacopoeia; National Formulary; New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

A formulary is a compilation of pharmaceuticals, which are approved by the medical staff. These drugs satisfy the hospital's therapeutic requirements and are cost effective.

The drugs in the formulary have been approved by the Pharmacy and Therapeutics Committee and allow the substitution of generic and therapeutic equivalent products within the committee guidelines which are approved by the Medical Staff.

6.9.2 Investigational Drugs

All clinical research and use of investigational drugs will be in accordance with the Hendricks Regional Health Research and Institutional Review Board Policy and Procedure (See administrative Policies).

ARTICLE VII. **INPATIENT MEDICAL RECORDS**

7.1 Required Content

The attending practitioner, other medical members as applicable, and residents involved in the care of the patient shall be responsible for the preparation of and legible content of the record for each patient. The record's content shall be pertinent, accurate, legible, timely, and current. The record shall include:

- (a) Identification Data
- (b) Personal and family medical histories
- (c) Description and history of present complaint and/or illness
- (d) Physical examination report
- (e) Diagnostic and therapeutic orders
- (f) Evidence of appropriate informed consent, as needed
- (g) Treatment provided
- (h) Progress notes and other clinical observations, including results of therapy
- (i) Special reports, when applicable (such as, clinical laboratory, radiology, radiotherapy, EEG, EKG, pre- and post-anesthesia, operative, and other diagnostic and therapeutic procedures, etc.)

- (j) Pathological findings
- (k) Final diagnosis without the use of symbols or abbreviations
- (l) Condition on discharge, including instructions, if any, to the patient or significant other on post-hospital care
- (m) Autopsy report, when available

7.1-1 SIGNATURES

A complete written or electronic signature shall consist of a minimum of the first initial of the first name, the full last name, and earned degree or license. The written signature shall be the same as his/her signed name on the signature card obtained by the Medical Staff Office at the time of initial credentialing. A complete signature is required for the following documents:

- (a) Final Diagnoses on Summary Sheet or Attestation Form
- (b) Operative Dictations
- (c) Discharge Summaries

Within electronic documentation and CPOE, the signature shall be affixed by the use of a private password that complies with all regulatory requirements. This password shall be kept confidential by the practitioner and will not be shared for any reason.

7.2 HISTORY AND PHYSICAL EXAMINATION

7.2-1 Generally

A complete history and physical examination must be recorded in the chart within 24 hours after admission of the patient. The H & P must indicate the reason for hospitalization and the diagnostic/therapeutic plan. The history and physical examination report must include the chief complaint, details of the present illness, all relevant current and past medical, social, and family histories, the patient's emotional, behavioral, and social status when appropriate, and all pertinent findings resulting from a comprehensive, current assessment of all body systems.

Osteopathic physicians will complete and document an osteopathic musculoskeletal examination on their admitted patients unless the examination is contraindicated. Contraindications must be documented in the medical record.

7.2.2 USE OF REPORTS PREPARED PRIOR TO CURRENT ADMISSION

- (a) External to Hospital: If a qualified member of the medical staff of the hospital has obtained a complete history or has performed a complete physical examination within seven (7) days prior to the patient's admission to the hospital, a durable, legible copy of the report may be used in the patient's hospital medical record, provided that an interval admission note is recorded that includes all additions to the history and any changes in the physical findings subsequent to the original report.
- (b) On Prior Admission: When a patient is readmitted to this hospital within thirty (30) days, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.
- (c) Following completion of history and physical if no changes, physicians may document "No change in the History and Physical" followed by signature, date, and time.

7.3 **PREOPERATIVE DOCUMENTATION**

7.3-1 HISTORY AND PHYSICAL EXAMINATION

A relevant history and physical examination is required on each patient having surgery. Except in an emergency so certified in writing by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until after the preoperative diagnosis, history, physical examination, and appropriate studies and test results have been recorded in the chart. If the history and physical examination have been dictated but are not in the chart at the time of surgery, a written note must be entered before surgery stating the basic nature of the proposed surgery/procedure and the condition of the heart and lungs, allergies known to be present, other pertinent pathology and information relating to the patient, and that the history and physical have been dictated. **If not recorded, the anesthesiologist responsible for the patient's anesthesia care shall not allow the surgery to proceed.** In case of emergency, the responsible practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of the procedure, and the history and physical examination shall be recorded immediately after the emergency procedure has been completed.

7.3-2 **PREOPERATIVE ANESTHESIA EVALUATION**

The anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) must conduct and document in the record a preanesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op 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.

The anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) must conduct and document in the record a post-operative status of the patient as evaluated on admission to and discharge from the postanesthesia recovery area. The documentation includes a record of vital signs and level of consciousness; intravenous fluids administered, including blood and blood products; all drugs administered; postanesthesia visits; and any unusual events or postoperative complications and the management of those events.

7.4 **PROGRESS NOTES**

7.4-1 Generally

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the provider.

Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes must be written by the attending service every twenty four hours daily.

7.5 **OPERATIVE, SPECIAL PROCEDURE, AND TISSUE REPORTS**

7.5-1 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. The practitioner must enter an operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend to the patient. The complete report must be documented within twenty-four (24) hours following the procedure.

7.5-2 TISSUE AND EXAMINATION REPORTS

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses.

An authenticated report of the pathologist's examination shall be a part of the medical record.

7.5-3 PRE-PROCEDURE REVIEW OF EXTERNAL HISTO-PATHOLOGIC DIAGNOSIS

When a patient enters this hospital to undergo a definitive therapeutic procedure based on histo-pathologic diagnosis made elsewhere, the attending practitioner must provide a report which substantiates the indications for surgery. This report will become a part of the medical record.

7.6 OBSTETRICAL RECORD

The current obstetrical record must include a complete prenatal record. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

7.7 ENTRIES AT CONCLUSION OF HOSPITALIZATION

7.7-1 DISCHARGE SUMMARY

In General: A discharge summary must be recorded for all patients within 48 hours of patient discharge. The principal diagnosis, any secondary diagnoses, comorbidities, complications, principal procedure, and any additional procedures must be recorded in full, and must be dated and signed by the attending provider. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, and treatment rendered and the condition of the patient on discharge stated in a manner allowing specific comparison with the condition on admission. The following definitions are applicable to the terms therein:

- (a) Principal Diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- (b) Secondary Diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
- (c) Comorbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis and is thought to increase the length of stay by at least one day (for about 75% of the patients.)
- (d) Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of the hospital observation and treatment and modifying the course of the patient's illness or the medical care required and is thought to increase the length of stay by at least one day.
- (e) Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
- (f) Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.
- (g) Pending tests/diagnostics (if applicable): Any pending test or diagnostic pending at the time of the discharge pertinent to the individual stay.

7.7.2 INSTRUCTIONS TO PATIENT

The discharge process is intended to provide patients with adequate information and necessary resources to improve or maintain their health during the post-hospital period and to prevent adverse events and unnecessary re-hospitalization. Thus, the attending physician and any/all consultants will work collaboratively with hospital staff to assure that patients receive all the information required on the discharge instructions sheet(s) and checklist, as detailed in HFAP Accreditation Requirements (Standard 14.06.17 or similar). All information provided to the patient must be legible and free from medical or other abbreviations.

7.8 AUTHENTICATION

All clinical entries in the patient's medical record must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, electronic signature (stamped signatures are not acceptable on any medical record). Facsimile of original written or electronic signatures are acceptable.

7.9 USE OF SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved symbols and abbreviations is available at each nursing station and in the Health Information Management Department.

7.10 FILING

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of death, resignation, or other unavailability of the responsible practitioner to complete the record, the Medical Executive Committee shall consider the circumstances and may enter such reasons in the record and order it filed. Refusal of a practitioner to complete a medical record may be grounds for peer review action under section II A of the Peer Review Policy.

7.11 OWNERSHIP AND REMOVAL OF RECORDS

All patient medical records, including, but not limited to, X-ray films, pathological specimens and slides are the property of the hospital only as prescribed by law. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof from the hospital are grounds for disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by appropriate authorities of the medical staff and Board of Trustees.

7.12 ACCESS TO RECORDS

7.12-1 BY PATIENT

A patient, may, upon written request have access to all information contained in his medical record, unless access is specifically restricted by the attending practitioner for medical reasons or is prohibited by law.

7.12-2 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall also be made available to authorized hospital personnel, medical staff members or others with an official, hospital approved interest for the following purposes:

- (a) Automated data processing of designated information
- (b) Activities concerned with assessing the quality, appropriateness, and efficiency of patient care
- (c) Clinical unit/support service review of work performance

- (d) Official surveys for hospital compliance with accreditation, regulatory, and licensing standards
- (e) Approved educational programs and research studies

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.12.3 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES

Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or by law to receive this information.

7.13 INCOMPLETE CHARTS

All members of the medical staff of Hendricks Regional Health are required to complete their medical records within the time frame stipulated in the Medical Staff Rules and Regulations, to support a medicolegal sound medical record and to assist in meeting completion requirements of the various regulatory agencies of which HRH is accredited.

7.13-1 Chart Completion Requirements

Chart completion requirements are as follows:

- A. History and physical exam completed within 24 hours of admission. History and physical exam is required to be on the chart prior to surgery.
- B. Operative note/delivery summary completed within 24 hours of surgery/delivery.
- C. All Queries responded to within 7 days.
- D. Discharge summary must be completed within 48 hours of discharge.

7.13-2 Inpatient, Same Day Care, and Observation Patient:

- A. Health Information Management will analyze and enter charts incomplete within two to four working days after discharge. Incomplete discharge summaries will be entered the first (1st) working day following discharge. The date available to the physician will be the date entered incomplete—not the patient's discharge date.
- B. Physicians will be responsible for adhering the requirements set forth above for completion of all medical records.
 - 1. If all records are not completed at 30 days, a Certified letter from the Chief Medical Officer will be sent noting privileges are suspended until all Medical Records are completed.

7.13-3 Variation From Acceptable Practice Patterns

- A. Delinquent Record criteria:
 - 1. H&P—delinquent 24 hours after admission. Note: H&P is required prior to surgery.
 - 2. Operative note delinquent 24 hours following the surgery.
 - 3. Delivery summary delinquent 24 hours after delivery.

4. All queries delinquent at 8 days.
5. Discharge summary is considered delinquent at 48 hours. Chart completion is considered delinquent after day 30.
6. Signatures not completed within 30 days.

B. Monitoring Body

The Medical Executive Committee shall monitor completion of medical records and implement any corrective action deemed necessary. The director of Health Information Management will submit monthly reports to The Medical Executive Committee (MEC) indicating completion percentage and physicians who have been subject to the repercussions as listed below. The report will also indicate special circumstances (i.e. prolonged vacation, illness, chart not available etc,) that may be responsible for certain delinquencies that resulted in time-limited extensions for completion. Quarterly QI reports will be sent to Quality Steering Committee with the regular Medical Record Reporting data.

7.13.4 Repercussions for Delinquent Inpatient Medical Records:

A. Administrative Suspension

1. A letter from Health Information Management will notify medical staff members of any outstanding medical records greater than or equal to 15 days.
2. At 30 days, a certified letter will be sent from the Chief Medical Officer to the physician noting the physician delineated clinical privileges are suspended until all Medical Records are completed.

B. Failure to write or dictate reports that have a 24-hour deadline for completion will be reported monthly to the Medical Executive Committee. Recurring non-compliance will be addressed under the Peer Review Policy.

C. Failure to write or dictate reports that have a 24-hour deadline for completion will be reported monthly to the Medical Executive Committee.

7.13.5 Repercussions for Delinquent Outpatient Medical Records (Employed Providers Only):

A. Definition:

1. An incomplete medical record includes either of the following which are 7 or more days old (i) incomplete notes, (ii) unsigned notes or (iii) unresolved items remaining in a provider EPIC inbasket. A provider's notes are not complete unless the documentation supports the level of billing. Provider records submitted which are not substantially complete, as determined by the CMO/VPMA (or his/her designee) shall be deemed incomplete and subject to repercussions for delinquent medical records.

B. Audits:

1. Audits will be performed every other Friday, commencing on the first Friday of each month. Records which are incomplete (as defined above) as of noon (12:00pm) on those dates shall be deemed incomplete records. The subject provider shall be automatically suspended. The suspension shall include employment and Medical Staff membership and delineated clinical privileges. It shall not constitute adverse action nor trigger rights under the Medical Staff Fair Hearing Plan except as otherwise stated herein.

2. While suspended for non-compliance, a provider cannot care for patients in the inpatient or outpatient setting. During this suspension period, the provider cannot take call. Call coverage must be arranged by the suspended provider with his/her call partners. Providers will be required to use 1 (8 hours) PTO day for each day of the suspension which shall continue until all incomplete records are satisfactorily resolved.

C. Process for Delinquent Medical Records:

1. Delinquent medical records are a breach of a provider's employment agreement to provide specific, accurate, and timely medical records. This also constitutes a failure to comply with Hospital and Medical Staff policies and procedures. Failure to meet such obligations may, in the discretion of the Hospital, be grounds for termination of the employment agreement.

D. Repeated Delinquencies:

1. First instance: Suspension from medical staff and clinical duties including inpatient, outpatient, and call responsibilities. Providers will be required to use 1 (8 hours) PTO day for each day of medical staff suspension.
2. Second instance: A written plan of correction ("POC") which includes process for random chart audits for a minimum of 6 (six) weeks, a notice of breach of contract and opportunity to cure, and non-compliance with Medical Staff Rules and Regulations.
3. Third instance. Grounds for termination for cause and automatic termination of delineated clinical privileges and/or grounds for corrective action under Medical Staff Fair Hearing Process with report to National Practitioner Data Bank, if indicated.

ARTICLE VIII **CONSENTS**

8.1 GENERAL

Each patient's medical record must contain evidence of the patient's or his legal representative's general consent for treatment during hospitalization.

8.2 INFORMED CONSENT

8.2.1 WHEN REQUIRED

The performing practitioner is responsible for obtaining the patient's or his legal representative's informed consent for the procedures and treatments listed below:

- (a) Anesthesia;
- (b) Surgical and other invasive and special procedures;
- (c) Use of experimental drugs;
- (d) Organ donation;
- (e) Radiation and chemotherapy;
- (f) Autopsy;
- (g) Photography, and;
- (h) Observing of a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form;

- (i) HIV testing.
- (j) Blood transfusion
- (k) transfer to another facility

8.2.2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

- (a) Patient identity
- (b) Date when the patient informed and date when patient signed the form, if different
- (c) Nature of the procedure or treatment proposed to be rendered
- (d) Name(s) of the individual(s) who will perform the procedure or administer the treatment
- (e) Authorization for any required anesthesia
- (f) Indication that the risks and complications of the procedure or treatment and of the alternative available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment.
- (g) Authorization for disposition of any tissue or body parts as indicated
- (h) Name of the practitioner who informs the patient and obtains the consent.

8.2.3 SIGNATURES

An informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative) and witnessed by a legally competent third party.

8.2.4 EMERGENCIES

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 8.2.1 without first obtaining informed consent as required therein, such circumstances must be explained in the patient's medical record:

- (a) Emergency/Life Threatening - In an emergency, involving threat to life, a physician needs no consent to perform any treatment necessary which he/she is qualified to perform.
- (b) Urgent/Not Life Threatening - If the physician feels that failure to treat may have adverse consequences, he/she may proceed without a legally executed consent, provided an effort has been made to notify the responsible person to arrange consent.

8.2.5 VERBAL AND TELEPHONE CONSENT

Verbal and/or telephone consent obtained by the physician is valid upon informing the patient or the patient's legal representative of the plan of treatment.

(a) Verbal Consent

Verbal consent may be accepted in cases when the patient, or legal representative, cannot sign due to a physical or literacy incapacity, provided the reason for verbal consent and the witness's name is documented.

(b) Telephone Consent

Telephone consent may be accepted when distance, timing, or lack of availability of legal representative is a bona fide problem and the physician deems the necessity of treatment is such that significant delay could cause harm. Telephone consent must be witnessed and documented, as such.

(c) Witnesses

Witnesses to verbal or telephone consents shall be professional nursing personnel, supervising management personnel and/or administrative position personnel who are knowledgeable about the legal requirements covering informed consent.

Approved by MEC: 09/12/2022