

# **BEAUMONT**

## **Beaumont Hospital – Wayne**

### **Medical Staff Rules and Regulations**

**Revised: 8/09/17**  
**Approved: 10/26/17**

BEAUMONT HOSPITAL – WAYNE

MEDICAL STAFF RULES/REGULATIONS/POLICIES

**ADMISSIONS/CARE OF THE PATIENT**

“All persons admitted to a hospital shall be under the continuing daily care of an attending physician licensed to practice in the state of Michigan.”

1. licensed physician must see the patient at least once every day while the patient is an inpatient
2. No patient shall be admitted to the hospital until a provisional diagnosis has been stated.
3. Patients shall be discharged from the hospital only on the order of the attending physician.

Approved 1/30/75; Reviewed 2/07/14  
Revised 8/27/14

**IMPLEMENTATION OF NOW AND STAT ORDERS IN THE EMERGENCY ROOM PRIOR TO PATIENT TRANSPORT TO THE NURSING UNITS**

Bridging orders will be given by the ER physicians. Implementation of NOW and STAT orders in the Emergency Room will occur before the patient is taken to the floor. Any orders in addition to these will be retrieved by the floor nurse once the patient is transferred.

Approved 7/14/92, 1/12/99; Reviewed 2/07/14  
Revised 8/27/14

**AUTOPSIES**

Autopsies requested on deceased who are dead on arrival in the Emergency Room and who are released by the county coroner’s office will not be done at Annapolis Hospital. The family will be referred to their funeral director who can obtain a pathologist to perform an autopsy. In this instance, they will be notified of the charges by the outside pathologist. All hospital autopsies must be ordered by the attending physician and a signed consent must be obtained from the nearest of kin to the deceased. The Pathologists will coordinate the process of checking the appropriateness of consent and indication for autopsy. The deceased must have been an in-patient at BEAUMONT HOSPITAL - WAYNE for over 24 hours. The Pathology office and a Pathologist will facilitate the process for inpatient physician ordered autopsies. Arrangements will be made to get the autopsy performed in a timely manner. Family requested autopsies are not considered hospital autopsies, but private autopsies.

Approved 3/90; Reviewed 2/11/13  
Policy reviewed and approved with no changes 9/13/99  
Revised 10/92; 8/27/14

**AUTOPSY CRITERIA**

1. Unanticipated death or unknown complications may have caused death.
2. Intraoperative or intraprocedure death.
3. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
4. All deaths due to accidents in the hospital.
5. All deaths on a psychiatric service.
6. Obstetrical deaths or death incident associated with pregnancy.

7. Neonatal and pediatric deaths, including those with congenital malformations.

Approved 5/12/05; Reviewed 2/11/13; 2/07/14  
Revised 8/27/14

### **MEDICAL EXAMINER AUTOPSY CRITERIA**

1. Death by violence (shooting, stabbing, beating, drowning, poisoning, etc.)
2. Accidental deaths (auto, burns, falls, etc.)
3. Sudden and unexpected deaths of persons in apparent good health.
4. Deaths occurring without medical attendance by a physician within 48 hours unless a reasonable cause of death can be certified.
5. All deaths pronounced in an emergency department should be reported in order to provide an adequate medical examiner record if necessary for certification.
6. Deaths under suspicious, unusual or unexplained circumstance. Included in this category are all individuals who are admitted to a hospital unconscious and remain unconscious until death.
7. Prisoners dying while in custody or dying from injuries sustained while in custody.
8. Deaths as a result of an abortion whether self-inflicted or otherwise.
9. Deaths occurring as a result of medical treatment or during anesthesia.
10. Family will need to complete: a) Medical examiner medical record consent form. b) Medical examiner identification form. These forms are available in the emergency department.

Approved 8/27/14

### **CHAIN OF COMMAND**

In the best interest of quality of care and patient safety, the Chain of Command establishes a clear procedure to be followed to ensure the medical direction of patient care in the event that an attending or consulting physician is unable or unavailable to manage his/her patients, and/or to ensure there is a method to resolve conflicts in patient care management or when other conflicts or unexpected situations arise.

The chain of command for medical direction shall be as follows:

1. Attending physician/covering physician/House Officer
2. The Chief of the Department. If unavailable, Vice Chief of Department or designee.
3. The Chief of Staff. If unavailable, Vice Chief of Staff or designee.

Approved 5/17/06; Reviewed 4/8/13

### **COMMUNICATION**

Paging Priority Medical Staff members will be contacted in accordance with their calling preferences utilizing the following priority system:

Stat = 0-15 minutes  
Now = 0-30 minutes  
Routine = 0-120 minutes

The physician should respond within the time noted. Physicians are to update their calling preferences (posted on the Physician Directory on Oaknet) annually. Hospital employees are to be reminded annually use the physician's calling preferences.

Approved 12/12/89; Reviewed 4/8/13; 2/07/14  
Revised 8/27/14

## **CONSULTATION**

### 1. Priority System for Consultation Response and How the Consultant Will be Notified

Emergency Consults - Patient must be seen within three (3) hours. The referring physician is responsible for contacting the consultant with background information and to verify the consultant is available to see the patient within the required timeframe.

Urgent Consults - Patient must be seen within 12-14 hours.

Routine Consults - Patient must be seen within 24 hours.

Approved 3/10/92

Due to illegibility, all consults must be dictated.

Approved 8/1/02

## **CONTINUING MEDICAL EDUCATION MISSION STATEMENT**

The Continuing Medical Education Program at Annapolis Hospital is sponsored by the medical staff as a service to the physicians at Annapolis Hospital and the surrounding Western Wayne County.

The Continuing Medical Education Program at Annapolis Hospital strives to maintain, or increase the knowledge, skills and professional performance and relationships that physicians use to provide services for patients, the public or the profession.

Approved 3/12/91

Approved 8/12/97

## **CRITICAL CARE UNIT ADMISSION/DISCHARGE POLICY**

### Philosophy and Purpose:

The Critical Care Units (ICU, CCU, IMC) have been established to give patients with serious, acute, life-threatening but reversible conditions, who are admitted to Annapolis Hospital, an accessible designated area of the hospital providing concentrated, competent and specially trained nursing and supportive personnel, together with diagnostic, monitoring and special therapy equipment, designed to reduce morbidity and mortality.

### Policy:

The Critical Care Unit provides services that include both intensive monitoring and intensive treatment. During times of high utilization and scarce beds, patients requiring intensive treatment (Priority 1) have priority over monitoring (Priority 2) and terminally or critically ill patients with a poor diagnosis for recovery (Priority 3). Eligibility for admission and discharge is also based upon reversibility of the clinical problem as well as the likely benefits for Critical Care Unit treatment and expectation of recovery.

### Categorization Criteria:

1. Critically ill, unstable patients in need of intensive treatment such as ventilator support, continuous vasoactive drug infusion, etc. Examples of such patients may include, but are not limited to, patients in septic shock, acute MI patients status post thrombolytic therapy, or carotid endarterectomy patients receiving vasoactive drugs. Priority 1 patients have no limits placed on therapy.

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2. Patients who, at the time of admission, are not critically ill but whose condition requires the technologic monitoring services of the Critical Care Unit. These patients would benefit from intensive monitoring (i.e., peripheral or pulmonary arterial lines) and are at risk for needing immediate intensive treatment. Examples of such admissions may include, but are not limited to, patients with underlying heart, lung, or renal disease who have a severe medical illness or have undergone major surgery. Priority 2 patients have no limits placed on therapy.

3. Critically ill, unstable patients whose previous state of health, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from Critical Care Unit treatment. Examples of such admissions may include, but are not limited to, patients with metastatic malignancy complicated by infection, pericardial tamponade, or airway obstruction, or patients with end-stage heart or lung disease complicated by a severe acute illness. Priority 3 patients receive intensive therapy to relieve acute complications, but therapeutic efforts might stop short of other measures such as intubation or cardiopulmonary resuscitation. Hospice patients are included in the Priority 3 category.

Approved 7/14/92  
Revised 6/8/93

### **DEATH CERTIFICATES**

The attending physician is responsible for completion of the Death Certificate except in cases referred to the Medical Examiner.

Reviewed 4/8/13

### **DISASTER PLAN PARTICIPATION**

Medical staff members are available for assignment by the Chief of Staff to insure all victim care areas have medical staff coverage.

The Emergency Department physician may request hospital staff physicians to assist in the treatment of patients.

Approved 8/80; Reviewed 4/8/13  
Revised 10/89

### **DUES AND ASSESSMENT**

Members of the medical staff shall pay dues as are determined by the action of the Medical Staff Executive Committee. Funds accumulated from dues will be used as determined by the Medical Staff Executive Committee, unless > \$10,000, in which case, approval by the Medical Staff may be sought.

Assessments in addition to the regular dues may be levied on all members of the medical staff by action of the majority of the medical staff.

Members, whose dues or assessments have not been paid after two written notifications, shall be recommended for suspension to the Medical Executive Committee by the Secretary/Treasurer.

Approved 1/30/75; Reviewed 2/07/14  
Revised 8/27/14

### **EMERGENCY MEDICAL SCREENING EXAMINATION – QUALIFIED MEDICAL PERSONNEL**

A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act (“EMTALA”) and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under the delegation and supervision of a physician member of the Hospital’s medical staff: Licensed specialty certified nurse practitioners; License specialty certified nurse midwives (obstetrics only); and, Physician Assistants.

For nonresident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes required in the Medical Staff Bylaws specifically to include the appropriate Medical Executive Committee (“MEC”) and Board approved clinical delineation of privileges form. Actions on membership and privileges shall be subject to MEC and Board approval. Resident physicians may perform the medical screening examination under the supervision of the Emergency Department physician or pursuant to authority granted by the graduate medical education program as evidenced by the resident’s progressive responsibility as provided in the residency program’s policies and resident documentation.

Approved 10/2015

### **EMERGENCY ROOM CALL RESPONSIBILITY**

Based on the legal requirements established by the COBRA legislation, it is necessary that the individual accepting Emergency Room on-call responsibility for his/her specialty, must make themselves available to referring physicians or requests from the Emergency Room physicians for all patients requiring treatment at Annapolis.

The on-call physician agrees to provide treatment to all patients who present themselves to the Hospital’s Emergency Department. The on-call physician shall not refuse to treat or discriminate in rendering treatment on any basis which violates any federal, state or local law in regulation, including but not limited to anti-discrimination laws.

If a physician routinely trades call, is a high utilizer, or does not respond to call they should be removed from the call schedule.

Approved 4/14/98

### **HOUSE PHYSICIAN RESPONSIBILITIES**

1. Responsible for evaluation and treatment of patients for various complaints and emergent issues on the medical and surgical units when private attending physician is not available. Evaluation and treatment of patients in the Intensive Care Unit for urgent and non-urgent problems.
2. Evaluation of patients who are injured in the course of their hospital stay on the floors, such as the patient who falls out of bed.
3. The performance of such procedures as the starting of intravenous lines and the passage of nasogastric tubes in those instances when the nursing staff is unable.
4. Respond to all codes and rapid responses called during their shift; perform such emergency procedures as CPR, endotracheal intubation, central venous line placement.
5. All house physicians at Beaumont Hospital – Wayne are to hold current certification in advanced cardiac life support.

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6. Demonstrate current clinical competency in required procedures such as central venous catheter placement, intubation, and line placement.
7. Be appropriately credentialed by the appropriate Department.

Approved 8/16/88; Reviewed 2/07/14  
Revised 8/27/14

### **INTENSIVE CARE**

#### **Preamble:**

By clarifying the expectations of physician leadership, this rule seeks to improve patient safety and clinical outcomes, increase the efficiency of service, and enhance the quality of care environment for patients and all healthcare professionals. It concurrently seeks to foster a collegial atmosphere with administration to achieve these goals.

#### **Intensivist Co-management:**

All ICU patients shall be at least co-managed by the attending physician and an Intensivist trained in Critical Care Medicine (Board certified/eligible).

#### **Intensivist Availability:**

The Intensivist shall be present in critical care units a minimum of eight (8) hours per day, seven (7) days per week.

For hours when an Intensivist is not on site, a physician or nurse trained in FCCS (Fundamentals of Critical Care Support)/ACLS (Advanced Cardiac Life Support) will be available on site, to render care immediately to patients in the ICU.

The Intensivist on call shall be expected to call back to the ICU on STAT pages within five (5) minutes.

The Intensivist on call shall abide by the Medical Staff Rules and Regulations on STAT consultation response, and shall be expected to return to the ICU for STAT consults within one (1) hour of notification, when clinically indicated.

#### **Chain of Command:**

A clear chain of command is established for the ICU to ensure there is no lapse in medical direction of ICU patients in the event that an attending physician is unable or unavailable to adequately manage his/her patients, and or/to ensure there is a method to resolve conflicts in patient care management.

In the event of a medical emergency, the House Physician, ER Physician, or Anesthesiologist in house shall be contacted to provide bedside medical direction until the attending or Intensivist can be contacted.

The chain of command for medical direction of ICU patients shall otherwise be as follows:

1. Attending physician or covering physician
2. The ICU Medical Director or designee
3. The Chief of Medicine
4. The Chief of Staff

#### **Medical Leadership in ICU:**

The ICU Medical Director (or designee) shall provide direction for day-to-day operations, establish and enforce Admitting and Discharge criteria (as endorsed by the Medical Executive Committee), act as the gatekeeper for those functions, and provide triage direction for monitored bed utilization.

The ICU Medical Director (or designee) shall assume at least co-supervisory responsibility and authority for any residents and/or physician extenders rotating through the ICU.

Approved 12/9/03

## **MEDICATION PRESCRIBING GUIDELINES**

### **The following policies and procedures apply to the prescribing of medications**

**Patient's Own Medication:** Patients may not take any medications (OTC or legend) except on the direct order of the attending physician. Patient will be advised not to use their medications from home. If the patient insists, they will be advised that their actions of non-compliance jeopardize their healthcare and deviate from the standard of care. They may wish to seek care elsewhere. The utilization of a patient's own medication is discouraged. A patient may be administered his/her own medication on the written order of their physician if the medication is not stocked by the hospital pharmacy or if the use of the patient's medication is required by regulation. Medication brought in by the patient to be used during their stay must meet the following conditions:

1. The medication container is clearly and properly labeled.
2. The contents of the containers have been examined, and positively identified by a hospital pharmacist.

### **Elements of a Complete Drug Order:**

All drug orders must be complete and include the following information:

1. Patient Name
2. Date and time of order
3. Name of drug (preferably generic name)
4. Dosage strength or concentration
5. Dosage form (i.e. tablets, capsules, inhalants, etc.)
6. Route of Administration
7. Frequency of Administration (number of doses) if applicable
8. Quantity and/or duration, if applicable
9. Dilution, rate, and time of administration if applicable
10. Signature and date.

### **Drug Monitoring and Automatic Drug Substitution**

1. In certain situations, the pharmacist may automatically intervene to assist prescribers in dosing and monitoring specific drugs/drug classes (e.g., antimicrobial drug therapy). This will only occur for those drugs/drug classes approved by the Pharmacy and Therapeutics Committee and subsequently approved by the Quality Council and Medical Executive Committee. The prescriber will always retain the ability to bypass any intervention.

### **The following policies govern the duration of an effective order.**

#### **1. Automatic Expiration of Drug Orders**

All medications prescribed without duration of therapy specified will be subject to the specific stop order policy.

#### **2. Medication Renewals**

- Verbal orders are discouraged.
- Verbal orders are not acceptable except from a physician or authorized prescriber.
- Medication reconciliation will be performed at each change in level of care.

#### **3. Time Limitations**

If there are time limitations affecting the validity of an order, they are to be included in the order.

### **Policies Affecting Validity of Orders**

Refer to OHS Corporate Clinical Policy & Procedure Manual Medication Management Section: Policy Title "Medication Prescribing Guideline."

### **The Formulary Drug System**

1. The formulary system is to promote the rational, safe and cost effective medication therapy for patients.
2. The Pharmacy and Therapeutics Committee (P&T) will produce a list of medications available for use at the hospital. This list, known as the formulary, will be reviewed routinely for appropriateness and items will be deleted or added based on the medication needs of our patients and the latest evidence



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based medication studies. Once a medication is approved for formulary, it is available for all FDA indications and for all age groups specified.

3. The Pharmacy and Therapeutics Committee can approve additional indications or restrictions not addressed by the FDA when the action is supported by appropriated evidence based medical data.
4. Members of the medical staff, licensed independent practitioners and health care staff involved in ordering, dispensing, administering and/or monitoring effects of medication may petition the committee in writing to review a medication, an indication or a restriction for inclusion or deletion from the formulary. The Pharmacy Department in collaboration with the requestor, will prepare a review of the available data. The requestor will be encouraged to present the petition to the P&T Committee.
5. When a medication becomes available as a generic drug, the Pharmacy will select the source of the medication based on FDA generic equivalence status, the cost of the medication and the availability of the medication.
6. Because the hospital formulary contains a select list of drugs, the pharmacist, upon receipt of a non-formulary medication order, may automatically substitute a therapeutically equivalent alternative as approved by the Pharmacy and Therapeutics Committee intended to provide the same medicinal results.

### **Investigational Drugs**

Investigational drugs may be used in accordance with hospital policy.

### **Look –Alike and /or Sound –Alike Drug Names**

The list of look-alike, sound-alike medications will be reviewed on an on-going basis for addition or deletion to formulary based on the Institute for Safe Medication Practices (ISMP) or regulatory recommendations.

Approved 1/75; Reviewed 2/07/14  
Revised 11/92; 9/96; 4/13; 8/27/14

## **MEDICAL RECORDS**

### **Introduction**

A medical record shall be maintained on every patient admitted to care in the hospital. It shall contain sufficient information to justify the diagnosis, to warrant treatment and explain the end results.

Every patient shall have an attending physician who shall be held responsible for the preparation of a medical record and a complete dental record when applicable, for each patient. All medical records shall contain the following:

1. Identification data
2. Chief Complaint
3. Preliminary note
4. The medical history of the patient
5. The report of a relevant physical examination
6. Provisional diagnosis
7. Diagnostic and therapeutic orders
8. Evidence of appropriate informed consent
9. Clinical observations, including results of therapy
10. Reports of procedures, tests, and the results
11. Principle diagnosis
12. All secondary diagnoses
13. Principle procedures and secondary procedures
14. Discharge summary
15. Necropsy report

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Dental patient records must include a dental diagnosis written by the dentist and an operative report dictated and signed by the dentist.

Entries in the medical record may only be made by persons given this right by approval of the Health Information Management Committee. Each entry of a clinical event must be dated and authenticated.

### Accessibility and Confidentiality

The original medical record is the property of the hospital, and shall not be removed from the premises without a court order, subpoena or statute. Unauthorized removal of the records from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee.

Release of information from a medical record shall be made to the patient or to authorized third parties only in accordance with the provisions of applicable State and Federal law and hospital Medical Record policies.

Other than the attending physician, surgeon and consultant or appropriate medical staff committees established by the medical staff bylaws, no member of the medical staff, other than the chief of Staff, and the chiefs of Departments, or persons delegated by them shall have the authority to review a patient's medical record. Hospital records, however, may be used for scientific, educational and statistical purposes, and in publications, provided the confidentiality of the patient is maintained. The use of the medical records for these purposes must have the prior approval of the Administrator or Executive Committee of the Medical Staff.

### Consent

Evidence of appropriate informed consent. The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate, including emergency treatment and outpatient procedures. This information should include the identity of the patient, the date, the procedure or treatment to be rendered (in layman terminology when possible), the name(s) of the individual(s) who will perform the procedure or administer the treatment, authorization for any required anesthesia, and indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient, and authorization for disposition of any tissue or body parts as indicated. The signature of the patient or other individual empowered to give consent should be witnessed. The practitioner with clinical privileges who informs the patient and obtains the consent should be identified in the medical record.

### Content of the Record

All medical record and dental records must be completed as follows:

1. History and Physical Examination: The history and physical shall be completed within the first 24 hours of admission to inpatient services. The inpatient H&P may be done within and no more than 30 days prior to admission and must be updated at the time of admission. Such history and physical examination must be recorded before any surgical operation is undertaken unless the physician certifies that any delay incurred for this purpose would constitute a hazard to the patient's life. If a history and physical is not dictated within 48 hours of admission, the attending physician will receive notice of suspension of elective admissions and surgical privileges by the Medical Records Department. The H&P, including short stay admissions, must be completed electronically.
2. Obstetrical records should include all prenatal information. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable. Forms as approved by the Medical Record Committee may be used for obstetrical, gynecological and newborn patients. All Labor & Delivery notes must be dictated within 24 hours of the procedure.
3. Use of Short Form (48 hour). The use of the 48 hour form medical record shall be used in the following cases:

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On those patients who stay 48 hours or less, the attending physician may elect to utilize the abbreviated form approved by the Medical Record Committee.

4. Readmission. Upon readmission a complete History and Physical examination as detailed below shall be performed except as detailed below shall be performed except when the patient is readmitted within 30 days of the previous discharge. In this case an interval note which states the reason for readmission and an abbreviated physical examination demonstrating the changes since the last admission is sufficient.

5. The medical history of the patient. This should include the chief complaint, details of the present illness, including when appropriate, assessment of the patient's emotional, behavioral and social status, and family histories, inventory by body systems, and allergies.

6. The report of the physical examination. The report should reflect a comprehensive current physical assessment and a statement of the conclusions or impressions drawn from the admission history and physical examination, and a statement of the course of action planned for the patient while in the hospital.

7. A brief history and physical is required for outpatients undergoing surgeries/procedures done in the operating room or outside of the operating room, who are undergoing invasive procedures which place them at significant risk and/or who will be receiving moderate sedation. The H&P must be completed and on the record prior to the procedure. The history and physical must contain at a minimum, the reason for the procedure, significant medical problems, medications, allergies, vital signs, and examination of the heart, lungs and body system or part where the procedure will be performed. Such history and physical may be dictated up to and no more than 30 days prior to date of procedure provided it is updated to reflect the patient's current status at the time of the procedure.

Approved 10/9/02

Approved 1/14/04

Approved 8/10/04

Approved 9/13/05

8. Progress Notes: Progress notes made by the medical staff should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

9. Diagnostic and Therapeutic Orders: All orders for treatment shall be in writing and dated and signed by the attending physician. Verbal orders may be accepted and transcribed by the authorized personnel and shall be dated and signed by the person to whom dictated along with the name of the dictating physician. Personnel authorized to accept appropriate verbal or phone orders shall be: dietitians, pharmacists and registered nurses, physical therapists, occupational therapists, speech/language pathologists, audiologists, exercise physiologists, laboratory personnel and respiratory therapists for orders specific to the treatments provided by the discipline. At this next visit the attending physician shall sign such order. In the case of phone orders taken by laboratory personnel, a written order shall be faxed by the physician within 24 hours.

Physician Extenders: Physician Assistants (PA); Certified Registered Nurse Anesthetists (CRNA); Certified Nurse Midwives (CNM), and Nurse Practitioners (NP) may also give verbal orders/telephone orders, according to formulary and their privileges as recommended by MEC and granted by the Board of Trustees. The order shall be reviewed and electronically signed (as per HIM Policy) by the responsible physician extender or the covering physician within twenty-four (24) hours.

10. Consultation: Except in an emergency, consultations with another qualified physician should be considered by all members of the medical staff whenever serious complications arise, where the diagnosis is obscure, or where there is doubt as to the best therapeutic measures to be utilized. The consultation report shall contain a dictated opinion by the consultant that reflects an actual examination of the patient and the patient medical record. Consultations may be used as the admitting H&P provided they contain the elements of a complete history and physical as defined by the Rules and Regulations of the medical staff.

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Referrals and transfers: If the consultant is to assume the entire management and responsibility of the patient following consultation, the patient shall be transferred to him by the attending physician who will write an order on the medical record for such transfer.

11. Surgical records (operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia) shall contain:

- a) Preoperative diagnosis to surgery.
- b) Preanesthesia evaluation.
- c) Current thorough physical examination prior to surgery.
- d) The operative report shall be completed according to the Medical Record Completion criteria and include:
  - i) The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
  - ii) preoperative diagnosis
  - iii) postoperative diagnosis
  - iv) description of operative procedure
  - v) detailed description of findings and specimens removed including any complication, unusual event such as shock or hemorrhage and estimate of blood loss
  - vi) condition of patient upon completion of procedure/surgery

### Brief Op Note

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the names(s) of the primary surgeon(s) and his or her assistants, procedure performed and a description of each procedure finding, estimated blood loss, specimens removed and postoperative diagnosis.

Reviewed 2/7/2014

Revised 8/27/14

12. Clinical Resume: A resume of the patient's clinical course is required of all charts except 48-hour stays, normal newborns and outpatient surgery. A final summation-type progress note shall be sufficient for these cases. The clinical resume shall contain:

- a) Reason for hospitalization
- b) Significant findings
- c) Procedures performed and treatment rendered
- d) Condition of the patient on discharge
- e) Any specific instructions relating to physical activity, medications, diet and follow-up care given to the patient

The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology. When reprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet should be filed on the medical record.

In the event of death, a summation statement should be added to the record either as a final progress note or as a clinical resume. This final note should indicate the reason for admission, the findings and course in the hospital and the events leading to death.

When a necropsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three days, and the complete protocol should be made part of the record within ninety days.

13. Final Diagnosis: The principle diagnosis and all relevant secondary diagnoses established at the time of discharge, as well as the principle and all secondary operative procedures performed should be recorded using acceptable disease and operative terminology. These must be recorded using acceptable

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disease and operative terminology. These must be recorded within 25 days of discharge. If not documented within 25 days, suspension of privileges will occur.

Approved 11/14/07  
Revised 5/10/07  
Revised 9/13/07  
Revised 10/8/09

### Emergency Room Records

A medical record shall be maintained on every patient treated in the Emergency Room. It shall contain:.

1. Patient identification
2. Time and means of arrival
3. Pertinent history of illness or injury and physical findings including vital signs
4. Emergency care given to the patient prior to arrival
5. Diagnostic and therapeutic orders
6. Clinical observations including results of treatment
7. Report of procedures and test results
8. Diagnostic impression
9. Conclusion at the termination of evaluation/treatment, including final disposition. The patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care
10. A patient's leaving against medical advice

### Signatures

All entries in the medical record must be dated and authenticated. Such identification may include written signatures or initials. When rubber stamp signatures are authorized, the individual whose signature the stamp represents shall place in the administrative offices of the hospital a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it. There shall be no delegation of the use of such stamp to another individual. The parts of the medical record that are the responsibility of the medical practitioner shall be authenticated by him.

### Abbreviations

The use of abbreviations shall be consistent with the hospital's policy on "Use of Abbreviations, Acronyms and Symbols in Clinical Documentation." Abbreviations identified as unacceptable will not be used.

A copy of this policy is available on OakNet.

Approve 10/10/92  
Approved 9/13/05

### Medical Record Completion System

The patient's record must be completed within 30 days after discharge.

1. All clinical privileges will be suspended for any physician placed on suspension for incomplete records.

Approved 2/13/96

### Inpatient/POS/Observation Cases/ED Records

Physicians receive notification of all incomplete records available for completion on a weekly basis.

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Physician can access the document imaging system to view incomplete records. Physicians will also receive notification via text page or by fax.

1. 14 days from discharge – text page to physician and/or fax to office, Streamline Inbox notification
2. 21 days from discharge – text page to physician and/or fax to office, Streamline Inbox notification
3. 26 days after discharge – Liaison contacts physicians and letter from Chief of Staff is faxed to office
4. 28 days from discharge – Physician admitting and consultation privileges are suspended. Surgeons will be prohibited from boarding new cases. Exceptions to suspension, necessary for patient safety, will be referred to the Chief of the Department and/or Administration for consideration
5. If physician reports an absence from practice of more than five days, he will receive a five day exemption from suspension due to delinquent medical records.

### History & Physicals/Operative Reports

When an H&P/OR has not been completed within 24 hours, the physician will receive notification. If the H&P/OR is not provided within 24 hours after notification, he/she will receive a phone call or facsimile that an H&P is required.

### Vacation Policy

Vacations are defined as a physician who will be away five or more consecutive days. It is the responsibility of the physician to notify the Medical Staff office, verbally or in writing, of vacation schedules. Physicians on vacation will be allotted one-week post vacation to complete medical records.

Any physician on the incomplete list prior to vacation will remain on the list throughout vacation. Failure to notify the Medical Staff office of vacation invalidates the one-week grace period.

Approved 02/15/11

## **NO FURTHER LIFE PROLONGING MEASURES**

The Board of Trustees and the Medical Staff of Annapolis Hospital (“the Hospital) are dedicated to providing treatment in accordance with the standard of care and principles of medical ethics.

The Hospital respects the legal and moral prerogatives of patients to make their own decisions about the medical care and treatment recommended by their physician and the rights of individual physicians to practice their profession in a manner consistent with their personal, religious, ethical and moral beliefs and professional standards.

The purpose of this policy is to state the policy of the Hospital with regard to obtaining informed consent to the Refusal and Withdrawal of Medical Treatment, including the entry of orders not to perform full cardiopulmonary resuscitation (“DO Not Resuscitate” or “DNR” Orders), and to provide the Medical Staff with guidelines to follow when making a medical judgment concerning the appropriateness of a DNR Order for any individual patient. This policy applies only to obtaining consent to the Refusal or Withdrawal of Medical Treatment for patients who have a terminal illness or who are in an irreversible coma.

Approved 6/12/90

## **REPORTING OF SUBSECTION**

That the subsection of departments reports any recommendations to the whole department, and if the recommendations of the subsection is not accepted by the department, then the Executive committee will make the final decision as to the policy. The subsection has the right to petition the Executive Committee regarding this recommendation even if they are not accepted by the whole department.

Approved 6/12/90

### **PHYSICIAN AVAILABILITY**

When a member of the medical staff is unavailable, he shall designate a member of the medical staff to attend his patients and shall notify the administrator's office in writing, to this effect. In case of failure to name such an associate, the Chief of Staff of the hospital shall, if necessary, have the authority to call on any member of the staff, who in his judgment will adequately provide care for the physician's patients.

1. Board certified physician in primary care field, or
2. Board qualified physician in primary care field, or
3. Completion of at least two years of family practice or emergency medicine post-graduate training, or
4. Completion of at least two years of post-graduate training in internal medicine or pediatrics with urgent care experience
5. Certified physician assistant with primary care experience, or
6. Certified nurse practitioner with primary care experience.
- 7.

Approved 1/13/98

### **RESPONSIVENESS TO COMMITTEES**

All medical staff members shall comply with all requests for information from any committee assigned a professional practice review function in order to provide for effective professional practice review activities.

1. In initial request for information shall be sent to the medical staff member and he shall be given fifteen days in which to respond in writing to the committee requesting the information.
2. Should the medical staff member fail to respond in writing within fifteen (15) days, he will be sent a second, certified letter, return receipt requested or by had delivery, informing him that he must respond to the committee by a certain date, as determined by the requesting committee or appear before the Medical Executive Committee at its next meeting.
3. If the medical staff member fails to respond to the second request for the information and does not appear before the Medical Executive Committee as scheduled, his admitting privileges including the ability to perform consultations, surgery and obstetrical procedures shall automatically be suspended. Such suspension shall remain in effect until a sufficient response is provided by the medical staff member.

Approved 3/11/03

### **ADDENDUM I**

#### **1. Annual Dues**

Final notice for payment of dues will be sent certified mail and if not paid within 90 days will be considered a voluntary resignation.

Approved 3/24/99

Revised 05/14/15

#### **2. Ballots**

Telephone ballots are not accepted for any election.

### **APPENDIX I**

Policies/Procedures developed by the medical staff committees and approved by the Medical Staff Executive Committee are available per your request through the Medical Staff Office.

## Medical Staff Rules and Regulations

### **1. Artificial Airway Evaluation Policy**

All patients intubated for seven (7) days will be reviewed for possible tracheostomy or change of endotube.

Approved 10/8/91

### **2. Patient Transfer Policy**

The purpose of the policy is to maintain a consistent level of care during transport from one area of the hospital to another.

Approved 1/15/92

### **3. Pressure Ulcer Protocol**

Provides protocol for pressure sore prevention and suggested treatment.

Approved 3/10/92

### **4. Search Committee - Physician Recruitment Procedure**

Provides that the Chief of Staff appoint an Ad Hoc Committee to act in an advisory capacity for input into the development of contract physicians at the hospital and to aid in recruitment for new physicians.

Approved 11/13/90

Revised 3/12/91

### **Stroke Rehabilitation Policy and Procedure**

Provides for the ordering of stroke rehabilitation to include occupational therapy, physical therapy, speech therapy and social services.

Approved 3/10/92

## **APPENDIX II**

### **1. Acute Myocardial Infarction**

Checklist that monitors the clinical processes of patients with a primary diagnosis of acute myocardial infarction.

Approved 5/9/95

### **2. Emergency Medicine Policy**

On-call Medicine/Family Practice physicians will be limited to accepting a total of six patients during one shift. When this limit is reached, a previously identified second on-call physician will be notified and responsible for the balance of new admissions during the shift. This cycle will be repeated as per Policy regarding IM/FM on-call Participation.

Approved 2/22/94; Reviewed 2/07/14

### **3. Ethical Decision Making**

Outlines the definition, organization, membership and role of the Ethics Committee.

Approved 5/9/95

### **4. Informed Consent Policy**

Provides the patient a written order of the procedure that is to be executed.

Approved 7/13/93

Approved 8/14/02



**5. Internal Intensified Review Policy**

Evaluates and addresses quality issues identified by the MPRO.

Approved 7/13/93

**6. Resuscitation Policy**

Nursing personnel may accept a telephone order from the attending physician not to resuscitate a patient providing documentation exists in the medical record demonstrating that the physician has previously discussed this with the family.

Approved 8/10/93

**7. Risk Management**

The Risk Manager and Oakwood Healthcare System Risk Management Department will be assigned a peer review function, to collect any and all information, data and knowledge pertaining to the professional practices within the hospital which the Risk Manager or Risk Management Department becomes aware of during the course of conducting business and such information, data, and knowledge be collected, analyzed, and present to the Quality Assessment Committee on a regular basis and to Administration and the Medical Staff Leadership for the purpose of reducing morbidity and mortality and improving the care provided to the patients in the hospital.

Approved 7/10/95

**BEAUMONT HOSPITAL - WAYNE  
GENERAL MEDICAL STAFF RULES/REGULATIONS/POLICIES**

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