

RULES AND REGULATIONS OF THE MEDICAL STAFF OF COMMUNITY HOSPITAL OF BREMEN

CONTENTS

- 1-Admission and Discharge of Patients
- 2-Documentation Guidelines
- 3-Use of Medical Records
- 4-Consultations
- 5-Surgery
- 6-Obstetrics
- 7-Emergency Department
- 8-Pharmacy
- 9-Infection Control
- 10-Podiatry
- 11-Miscellaneous

1) ADMISSION AND DISCHARGE OF PATIENTS

- a) The Hospital shall allow admission of patients suffering from all types of diseases, but shall not continue to offer services for patients requiring only prolonged rest or custodial care. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to the staff, or who have been granted temporary privileges. Specific privileges granted shall be based on previous training and experience and reviewed by the Medical Staff Committee of the Medical Staff.
- b) Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.
- c) Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self harm.
- d) All patients presenting to the hospital for care without admitting orders from a member of the Active or Associate Medical Staff shall be evaluated in the Emergency Department by the Emergency Department physician on duty.
- e) Each member of the Medical Staff shall reside within a reasonable proximity of the hospital in order to provide for the needs of admitted patients. When a members is not available due to travel or illness, they shall name a member of the Medical Staff from the local area who may be called to attend his patients. A rotating call schedule can fill this purpose. In an emergency situation, the Administrator of the Hospital working with the appropriate medical staff leadership shall have the authority to call any member of the Medical Staff to provide back-up if necessary.
- f) All patients admitted to the hospital shall be seen in the hospital by their attending physician or designee within 24 hours of admission and daily thereafter for non-swing bed admissions. These guidelines do not apply for patients admitted for IV fluids, transfusion of blood or blood products, the administration of IV medications, or hospice care. Any critically ill patient or patient who becomes critically ill after admission shall be seen as

soon as possible, unless the attending physician has anticipated such and has adequately provided for this in the patient care orders. A critically ill patient is defined as one with unstable or poor vital signs who is suffering from a potentially life threatening condition.

- g) Hospital policies and procedures will be in place governing some activities of the medical staff in lieu of what has historically been called “standing orders”. The use of order sets, protocols like ACLS, ALSO, etc. allow a complex set of activities to be performed without the direct input of the provider in the specifics.
- h) Physicians who are credentialed and have been granted clinical privileges as well as other hospital clinical personnel (e.g. RN’s, Allied Health Professionals, physical therapy, respiratory therapy, social services, dietary, pharmacy, coding professionals (query forms only) physician assistant, and occupational therapy etc) may enter remarks as to the recommendations, progress, etc. of care for the patient. These notations shall be made preferentially into the hospital’s electronic health record or through dictation. Documentation on paper is the least desirable method and should be reserved for emergency situations only or when no appropriate means for electronic documentation is available.
- i) All orders for treatment shall be entered into the electronic health record. Though direct order entry by the provider is preferred, it is not always practical. An order shall be considered acceptable if given verbally to a registered nurse, or registered pharmacist. In emergency situations, written orders are acceptable, but should be later processed into the electronic health record. The Attending Physician must electronically sign all orders before the chart is considered completed after discharge.
- j) The attending physician or his/her designee is required to provide specific documentation regarding the need for ongoing hospitalization for each patient. The documentation must support the diagnosis, have justification and indication for all procedures or special treatments and must describe thoroughly the patient’s progress and response to medication and treatments. When possible a statement about the presumptive timeline of care should be noted.
- k) Patients shall be discharged only by order of the attending physician. The attending physician shall see that the medical record is complete, state his/her final diagnosis and sign the record in a timely manner. Should a patient leave the hospital against medical advice or without proper discharge, a notation of the incident shall be recorded in the patient’s medical record, and, if possible, the proper form signed by the patient (discharge against advice).
- l) In the event of a hospital death, the deceased shall be pronounced dead within a reasonable time and the body shall not be released until this is done. This may be done by an attending physician or his/her designee or this responsibility may be delegated to a Registered Nurse after proper information has been received from the Attending Physician.

2) DOCUMENTATION GUIDELINES

- a) The Medical Staff shall approve all changes in the components of the medical record. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall be complete enough to facilitate the highest quality of patient care and allow any other similarly trained provider to assume care efficiently and safely should the need for a transfer of care happen. This documentation should include identification data; chief complaint; pertinent past medical history; pertinent family and social history; history of the present illness; physical exam; focused system review; special reports such as consultations; clinical laboratory data; x-ray reports, etc;

provisional diagnosis; medical and/or surgical treatment; operative diagnosis; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note.

- b) For all patients admitted for a surgical procedure of any type, a complete history and physical examination (H&P) shall in all cases be recorded within seven (7) days prior to admission (or at the time of admission but prior to the actual surgical procedure). A complete pre-operative history and physical examination performed less than 30 days prior to admission will be acceptable if included in the hospital record, provided there is documentation that a bedside evaluation has been completed prior to surgery and that no changes in the patient's condition or examination are noted. If there have been changes in the patient's history or exam, these changes must be recorded in the clinical record.
- c) For all patients admitted for non-surgical care, an H&P shall be properly documented within 24 hours after admission. The H&P shall be dictated with an appropriate chart notation including basic information about the care of the patient if it is anticipated that other providers will need this information prior to availability of the dictation.
- d) Patients seen in the Emergency Department will have proper documentation of their visit dictated by the ER physician. If it is anticipated that the patient's Attending Physician will require information about the patient's ER visit prior to availability of the dictation, then a brief written note may be prepared and delivered to the Attending Physician or a phone conversation of similar information made.
- e) Pertinent progress notes shall be recorded sufficient to permit continuity of care and transferability. Progress notes should be entered directly into the electronic health record or dictated with only enough written information to facilitate ongoing care in situations where this information needs to be available prior to availability of the dictation. Progress notes should be completed at least daily on all patients except those in swing bed. Progress notes give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment. A discharge summary shall be dictated on all medical records of patients hospitalized. If the discharge summary is dictated on the same day of discharge, no discharge progress note is required. If a discharge summary is not dictated on the day of discharge, progress note must be dictated with the anticipation that a full discharge summary will be forthcoming at a later date. A final progress note summary may be substituted for a discharge summary of normal newborn infants and uncomplicated obstetric deliveries. The progress note summary must contain outcome of hospitalization, the case disposition, and any provisions for follow-up care. Patients admitted and discharged on the same day and seen only once by the attending physician may have a single dictation encompassing all elements of an H&P, progress note, and discharge summary. At the time of transition between hospital level of care to swing bed an appropriate discharge summary and new admission note will be needed. At the time of transition between levels of hospital care (observation and acute inpatient for example) no such formal notation is needed as long as proper documentation is available to explain the transition. A patient in swing bed who transitions to a surgical procedure must be discharged and (if returning to the medical floor) re-admitted with brief, but appropriate, documentation of the need for this transition which may reference other documents such as a recent previous H&P.
- f) It is anticipated that the hospital will evolve toward more robust forms of electronic documentation. The language in this section reflects current technology, but the principles here should be considered generally applicable to future technology.
- g) All clinical entries in the record shall be accurately dated, timed, and signed

- h) Symbols and abbreviations may be used only when approved by the Medical Staff. This list shall be available at nursing stations and in the Medical Records Department.
- i) Authentic signature/initials are required on all patient records where an e-signature is not available or feasible. Use of rubber stamps will not be permissible. A log of physician signatures/initials is kept in the Medical Records Department and is available upon request.
- j) If the medical record is not complete at the time of discharge, the following action will be taken by the Hospital:
 - i) If the record is not complete 23 days after patient discharge, the attending physician will be notified that he/she will be suspended from the Medical Staff on the 30th day unless the documentation is completed.
 - ii) When suspended from the Medical Staff, a physician may not see patients, including those previously scheduled for surgery, and may not attend patients in active labor. In unusual circumstances, patients may be admitted after consultation with and approval by the Chair of the Clinical Department concerned, or the Medical Staff President, who will then notify the Hospital CEO or his/her designee.
 - iii) The physician may regain membership on the staff only by completing all of his/her incomplete records.
 - iv) If a member of the staff has been unable to take care of his/her charts because of illness or absence from the community, the CEO shall, when notified, delay the application of this regulation for a reasonable period of time.
 - v) The medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff President.

3) USE OF MEDICAL RECORDS

- a) All medical records are the property of the Hospital and may be removed only by a Court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient be service or pay, and whether he/she be attended by the same physician or by another.
- b) Free access to all medical records of all patients shall be afforded to staff physicians in good standing for bonafide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
- c) Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. No attorney or insurance representative may have access to the patient's chart while the patient is still confined to the hospital without expressed written permission of the patient.
- d) With the availability of patient records electronically comes the responsibility of the proper use of that data when accessed remotely. Federal statute guides the use of patient-identified health information and the hospital will hold anyone remotely accessing patient data to these standards.

4) CONSULTATIONS

- a. The attending physician is responsible for ordering consultations. Consultation requests not made directly from physician to physician must include adequate information transfer in order

to express to the consultant the nature and urgency of the request. Appropriate reasons for consultation include, but are not limited to:

- i) Cases in which an infant or child is felt to be seriously ill, but not yet in need of transport to another facility
 - ii) Cases in which a surgery or procedure outside of the scope of practice of the attending physician may be required to improve the health of the patient.
 - iii) Cases in which a diagnosis is discovered outside of the scope of practice of the attending physician which requires the knowledge of a physician in another field to improve the health of the patient.
 - iv) Cases in which a patient requests a test, medication, or procedure which is either not indicated or for which the patient is at high risk of complications from proceeding.
 - v) Cases in which a patient is failing to improve or is worsening and the cause of this is unknown to the attending physician despite appropriate investigation.
 - vi) Cases in which there is doubt as to the best therapeutic measure to be used.
 - vii) Cases in which mental health issues do not allow reliable assessment of the patient or in which there is an emergent risk of suicide.
- b) Consultants
- i) A consultant must have full privileges in the specialty field in which his/her opinion is sought.
- c) Consultation Etiquette
- i) The attending physician is responsible for personally requesting consultations. A written order for consultation or a verbal order for nursing staff to call a consultant is not acceptable, though they may help facilitate the consultation by contacting the physician or office and directing them in how best to have the consultant reach the attending physician.
 - ii) A satisfactory consultation includes examination of the patient and the medical record within a timely manner. An opinion by the consultant must be included in the medical record which should indicate whether the consultant will continue to follow the patient daily or whether the consultation is considered complete. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation. As is requested of the physician ordering the consultation, the consultant physician is asked to provide robust feedback to the ordering physician so as to share information in ways that are best able support the care of the patient.
- d) Consultation and Transfer to outside entities
- i) Any transfer of a patient to another facility is governed by federal law. This transfer consultation is required to be a verbal consultation between the transferring and receiving physician. Proper paperwork will be required and can be completed initially by our hospital staff.
 - ii) In most cases where transfer to another facility is needed, the attending physician should be physically present during the consultation and transfer decision-making process in order to communicate the most recent and highest quality information to the receiving physician.

5) SURGERY

- a) Except in cases of emergency, patients scheduled for operation shall be admitted a minimum of 1-2 hours prior to the scheduled operation.
- b) The surgeon shall be responsible for completion of the surgery consent form. This responsibility may be delegated to hospital personnel, but it should be obtained sufficiently

early to ensure that the patient is normally alert. In any event, it must be completed before the patient is taken to the Operating Suite.

- c) History and Physical examinations are to be completed as noted in the section on Admission and Discharge documentation above. If a history and physical examination is not recorded on the chart before the time stated for operation, the operation shall be cancelled, unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.
- d) Guidelines of required tests, to be done before surgery, will be posted in surgery.
- e) Operative reports shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written (or dictated) within 24 hours following surgery for outpatients as well as inpatients, and the report promptly signed by the surgeon, and made a part of the patient's current medical record.
- f) All specimens removed during surgery shall be submitted to the Hospital Pathologist who shall make and submit a signed report of such examination(s) as may be necessary to arrive at a pathologic diagnosis. This shall be a part of the patient's record. Exceptions are as follows: Specimens that do not permit fruitful examination or that rarely show pathological change such as cataracts, orthopedic appliances, foreign bodies, traumatically amputated members, foreskin, grossly normal placentas, teeth (number and fragments to be recorded in the medical record), hernia sack contents, scar tissue, toenails and fingernails, and the like. They shall be disposed of in accordance with hospital policy.
- g) The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow up of the patient's condition and anesthesia equipment check
- h) If the attending physician is not assisting in the surgery, then the history and physical should be done by the surgeon. For podiatry cases, and H&P clearing the patient for surgery must be filed by a member of the Active Medical Staff within the 7 days prior to surgery.
- i) Except in cases of emergency, patients admitted for surgery shall be scheduled for admission by the surgical scheduler.
- j) All required lab work shall have been done before admission and reports available at the time of surgery. If the surgeon is unreasonably late (30 minutes) or delayed in reaching the operative suite at the hour a given procedure is scheduled, it shall be the prerogative of the supervisor of surgery to proceed with the next scheduled case.
- k) The operating surgeon shall be responsible for the selection and use of a qualified medical assistant during any surgical procedure considered hazardous to the patient.
- l) All previous orders are cancelled when patients go to surgery. Medication Reconciliation and pre-op order reconciliation may facilitate the return of the patient to the Medial Unit.
- m) All dental patients shall be admitted under the names of both a physician and a dentist. The physician shall be responsible for the history and physical examination and the overall medical care of the patient, including surveillance of orders written by the dentists. The dentist shall be responsible for the dental surgery and the pre and post operative orders pertaining to the dental procedure.

6) OBSTETRICS

- a) Consultation is encouraged with another Obstetrics provider for the following:
 - i) toxemia of pregnancy
 - ii) preterm labor with possibility of preterm delivery

- iii) hemorrhage (antepartum or post-partum) with vital sign abnormalities suggesting significant volume loss.
- iv) fetal malposition
- v) prolonged labor or complications of labor
- vi) a woman presenting in labor with a history of previous c-section
- vii) any operative procedure other than vacuum assisted delivery, episiotomy, fetal scalp electrode placement, or intrauterine pressure catheter placement.
- viii) all cases of maternal sepsis, either puerperal or abortal
- b) The use of oxytocic drugs in the undelivered patient is a potentially hazardous procedure for mother and infant. Therefore, the following procedures should be followed:
 - i) Oxytocic drugs should be administered only on the order of the attending physician and with proper informed consent by the patient.
 - ii) Oxytocic drugs should be administered in accordance with the established policy for their safe use as found on the OB unit. The attending physician or his/her designee should be readily available while the Oxytocic is being administered.
- c) Under no circumstances is the termination of a normal pregnancy permissible in this hospital. Any circumstance in which interruption of an abnormal pregnancy is considered requires consult with colleagues prior to proceeding.
- d) A D&C for incomplete abortion is permitted when in the attending physician's judgment the procedure is warranted. He/she may be aided by a negative pregnancy test, passage of tissue, or severe hemorrhage threatening the mother's life. All clinical impressions must be documented on the chart prior to surgery. If any uncertainty exists in regards to the status of the pregnancy, a consultation is required.
- e) Prenatal laboratory work is to be consistent with guidelines set forth by the AAFP and/or the ACOG and should be available on the OB unit between the 36th and 38th week gestation. The hospital reserves the right to collect any specimens required to meet this requirement if a woman presents in labor and for whom these results are unavailable.

7) EMERGENCY DEPARTMENT

- a) The basic operation of the Emergency Department as well as performance of each member in the department will be monitored. The Emergency Department shall review and evaluate on a regular basis the quality of medical care given in the department.
- b) An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:
 - i) adequate patient identifying information
 - ii) information concerning the time of the patient's arrival, means of arrival, and by whom transported pertinent history of the injury or illness including details
 - iii) relative to first aid or emergency care given the patient prior to his/her arrival at the hospital, allergic condition and tetanus status when indicated
 - iv) description of significant clinical and laboratory findings
 - v) diagnosis
 - vi) treatments rendered
 - vii) condition of patient on discharge or transfer
 - viii) instruction to patient/family
- c) Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy

- d) There shall be an ER committee of the medical staff that meets regularly and includes attending physicians who are not working in the emergency department.

8) PHARMACY

- a) All drugs and medications administered to patients shall be those listed in the latest edition of the U.S. Pharmacopia, National Formulary, American Hospital Formulary Service, AMA Drug Evaluations. Experimental drugs shall be used in full accordance with “statement of principles involved in the use of investigational drugs in hospitals” AMA publications and all regulations.
- b) Orders for narcotics Class II shall automatically expire after 72 hours. Orders for IV antibiotics shall automatically expire after 72 hours. Orders for antibiotics shall automatically expire after seven (7) days, and IV anticoagulants after 24 hours unless otherwise specified and in the original order. These stop orders shall be automatically extended, until the following day when the attending physician has had an opportunity to see the patient.

9) INFECTION CONTROL

- a) There is to be an effective infection control program within the Hospital. The program shall include an Infection Control Nurse, an Infection Control Committee, and guidelines provided by the U.S. Department of Health and Human Services and the Indiana State Department of Health.
- b) Patients shall be placed in appropriate isolation for the effective management of various infectious diseases. This may be done initially without a physician order to facilitate its timely application to support public health with proper follow-up communication with the attending physician.

10) PODIATRY

- a) All podiatric surgery patients are to have their H&P performed by a primary care physician in a timeframe that allows for adequate assessment of operative risk.
- c) At the time that a patient is scheduled for podiatric surgery, his/her primary care physician will be notified by the Surgery Department. If necessary, a request for an H&P can be made and the proper timing for said evaluation can be relayed to the physician.

11) MISCELLANEOUS

- c) As per the hospital disaster plan, available physicians shall be assigned disaster duties in the hospital, and it is their responsibility to report to their assigned stations. In cases of disaster, all physicians on the Medical Staff agree to relinquish direction of the professional care of their patients to the physicians available at the hospital during the disaster.
- d) If a nurse has reason to question the care of a patient, he/she shall bring this to the attention of the attending physician as well as the nursing supervisor. If the question is unresolved, he/she can discuss it with the Director or VP of Nursing services, who can bring it to the attention of the Medical Staff President if warranted.

Signed and approved:

Lindy Sergeant, M.D.
Medical Staff President

06/09/2017
Date

Carol Hochstetler
President, Board of Directors

08/24/2017
Date

David Bailey
President/CEO

08/24/2017
Date