

**MEDICAL STAFF
RULES AND REGULATIONS**



**1414 KUHL AVENUE
ORLANDO, FL 32806**

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**RULES AND REGULATIONS
OF THE MEDICAL STAFF OF
ORLANDO HEALTH, INC.**

SECTION I: ADMISSION AND DISCHARGE OF PATIENTS

- A. Physicians, dentists, and podiatrists requesting admission for private patients shall provide the hospital with a provisional diagnosis and shall give such other information as may be required to enable the hospital to take such action as is necessary to protect patients already in the hospital from patients who are or may become a source of danger from any cause whatever.
- B. Emergency patients may be admitted without data required in Section I. A., but the attending physician, dentist, or podiatrist shall be expected to furnish such data within 24 hours after admission of the patient.
- C. All unassigned patients shall be attended by members of the Active Staff, Senior Staff and Active Associate Staff if requested by the department chairman. Unassigned patients shall be assigned to the service concerned in the treatment of the disease which necessitated the admission. No medical staff member shall refuse treatment of a patient because of lack of compensation. Patients with personal physicians, dentists, or podiatrists shall be attended by their personal physicians, dentists, or podiatrists.
- D. For purposes of defining the pediatric age group for assignment of unassigned patients, patients under the age of eighteen (18) years shall be considered pediatric, and patients age eighteen (18) years and older shall be considered adult, with the following exceptions:
 - (1) for purposes of trauma care, in accordance with Florida Trauma Center Standards, pediatric patients shall be those patients with anatomical and physical characteristics of a person 15 years or younger;
 - (2) for purposes of non-trauma orthopedic care and general surgery, patients under the age of sixteen (16) years shall be considered pediatric, and patients age sixteen (16) and above shall be considered adult;
 - (3) further exceptions may be defined by mutual agreement of the applicable adult and pediatric clinical departments on file with the Medical Staff Services and in their respective departmental Rules and Regulations.
- E. Patients shall not be discharged from the hospital until a provisional or final discharge diagnosis has been entered in the medical record by the physician, dentist or podiatrist or taken by the nurse as a verbal order from the physician, dentist, or podiatrist.

- F. Qualified medical personnel to perform medical screening examinations for the purpose of examining and treating emergency medical conditions shall be Emergency Department physicians with the exception of Section I, Part G.
- G. When a woman presents to the obstetrical triage department for evaluation, a qualified triage core nurse who has met criteria established by the Department of Ob/Gyn, may conduct an appropriate medical screening examination and report the results of such examination to the responsible physician who shall determine whether the woman has an emergency medical condition. If the case is beyond the nurse's expertise or training, the responsible physician must conduct further screening as appropriate. If it appears that a non-pregnancy-related emergency medical condition may be present, the patient may be taken to the Emergency Department for further evaluation or an appropriate consultant may be called in to evaluate the patient.

SECTION II: GENERAL STANDARDS OF PATIENT CARE

- A. A hospital formulary shall be prepared and kept up to date by the hospital pharmacist with the approval and under the direction of the Pharmacotherapy Committee of the medical staff. Acceptance of these bylaws, rules and regulations also specifically implies acceptance of this formulary and its use.
- B. Medications and prescriptions brought into the hospital for self-administration by patients must have complete orders by the attending physician, surgeon, dentist, or podiatrist indicating his or her assumption of full responsibility for such medication. Patients without such orders shall not be permitted to use their own medications while a patient in this hospital.
- C. All surgical specimens, other than approved exceptions, shall be sent to the hospital pathologist who shall make such examinations as he or she shall consider necessary to arrive at a pathological diagnosis.
- D. Each patient in the hospital shall be seen within 24 hours after admission and at least once daily thereafter, and within 24 hours prior to discharge by his or her attending physician, dentist, or podiatrist or some other medical staff member designated by the attending physician, dentist, or podiatrist, with the exception of patients admitted for long term care and rehabilitative care, who shall be seen in accordance with applicable standards.
- E. Rounds by Allied Health Personnel and/or residents/fellows without the supervising medical staff member may not be substituted for rounds by a medical staff member.
- F. Each member of the medical staff (other than Active Affiliate, Senior Affiliate, and Honorary members) shall designate a covering medical staff member. In case of failure to name such covering medical staff member, the Chief of Staff (or Vice Chief of Staff in the absence of the Chief of Staff), Chief Executive Officer of the hospital or the Chief

Executive Officer's designee shall have the authority to call any member of the medical staff, should he or she consider it necessary. Each member of the medical staff, except the Honorary Medical Staff, shall keep the Chief Executive Officer of the hospital (or the Chief Executive Officer's designee) informed of his or her correct address and telephone number.

G. DESIGNATION AND RESPONSIBILITIES OF MANAGING PHYSICIAN:

- (1) The attending physician shall be considered the managing physician unless otherwise specified under physician orders. (An attending physician refers to an admitting physician.)
- (2) There shall be a managing physician for every patient admitted to OH.
 - a. The name of the managing physician shall be clearly specified on the front of the chart or in the electronic medical record at all times.
 - b. Any change in the managing physician during the stay of the patient requires a physician order.
- (3) Responsibilities of the managing physician:
 - a. The managing physician shall be responsible for coordination of the patient's care.
 - b. The managing physician shall be available for communication with the patient's family on a routine basis.
 - c. Should there be a conflict in patient care, the managing physician shall be responsible for resolving the conflict.
- (4) Patients with a primary surgical problem shall be admitted to a surgeon.
 - a. Patients with a primary surgical problem within thirty (30) days of surgery shall be admitted to their surgeon of record.
 - b. Patients admitted for a non-surgical problem within thirty (30) days of surgery shall have their surgeon of record notified of their admission. The attending physician shall notify the surgeon of record.
- (5) Physicians providing coverage for the managing physician shall assume all responsibilities of the managing physician.

H. CONSULTATIONS

- (1) The managing/attending physician is the only physician who should request consultations, except in emergency situations. A consultant must be well qualified to give an opinion in the field in which his or her opinion is sought. He or she shall be a member of the OH medical staff with clinical privileges.
- (2) For the process to obtain physician consults and the responsibilities of consultants, refer to hospital policy and procedures.

I. AUTOPSIES

- (1) Every member of the medical staff shall be actively interested in securing autopsies whenever a death occurs that meets the following criteria. All autopsies shall be performed by a hospital pathologist or by a physician to whom the hospital pathologist may delegate the duty.
- (2) Indications for Performing Autopsies:
 - a. Deaths in which an autopsy may help explain unknown and unanticipated medical complications to the attending physician.
 - b. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
 - c. Cases in which autopsy may help allay concerns of, and provide reassurance to, the family and/or the public regarding the death.
 - d. Unexpected or unexplained deaths during the following: any dental, medical or surgical procedure and/or therapies.
 - e. Deaths of patients who have participated in clinical trials approved by the Institutional Review Board.
 - f. Unexpected or unexplained deaths that are apparently natural and not subject to forensic jurisdiction.
 - g. Natural deaths that are subject to, but waived by a forensic medical jurisdiction, such as persons dead on arrival at hospital; deaths occurring in hospitals within 24 hours of admissions; and deaths in which the patient sustained an injury while hospitalized.
 - h. Deaths resulting from high-risk infections and contagious diseases.
 - i. All obstetric deaths.
 - j. All perinatal and pediatric deaths.

- k. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have bearing on survivors or recipients of transplant organs.
- l. Deaths known or suspected to have resulted from environmental or occupational hazards.

J. AUTOPSY REPORTS

When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within two (2) working days, and the complete protocol should be made part of the record within forty-two (42) days with rare exceptions for complex cases.

SECTION III. MEDICAL RECORDS

A. PROCEDURES/MEDICAL RECORDS

- (1) Each medical staff member shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current and contain sufficient information to identify the patient, to support the diagnosis and the treatment, and to document the results accurately.
- (2) All clinical entries in the patient's medical record shall be accurate, legible, dated, and timed, contain no prohibited or unapproved abbreviations, and be signed by the medical staff member initiating the order or report. A physician group can permit their partners to sign for each other. Authorization is granted by having a signed affidavit on file in the HIM Department. All errors noted in the written medical record shall be single-lined out, noted as error, and legibly dated, timed and initialed. In the electronic medical record follow the specific system's process for correction of errors.
- (3) A medical record shall be considered complete when the required contents are assembled and signed following discharge of the patient. Failure of the medical staff member to complete medical records within thirty (30) days of discharge and after written warning of such delinquency shall be grounds for automatically relinquishing a staff member's elective admitting and surgical privileges.
- (4) Notwithstanding the above, if a medical staff member's documentation in a medical record necessitates the initiation of a coding query through the Physician Coding Query process, the medical record will be considered incomplete until such time as the medical staff member has responded to the query and the query has been resolved.

- (5) A medical staff member who is ill or on vacation or leave of absence shall not be penalized for having incomplete medical records, providing he or she notifies the Corporate Director of the Health Information Management Department. The medical staff member shall be given three (3) days from the time he or she again becomes available to satisfy the 30-day requirement. Extension shall not apply to absences of less than three (3) days, or in instances where records are delinquent prior to departure.
- (6) Medical records shall not be filed until complete, except on order of the Medical Record Committee.
- (7) Chronic failure of a medical staff member to maintain complete, accurate, and timely records of his or her patients shall be reported to the respective department chairman. Automatic resignation of all hospital privileges shall result for any staff member whose suspension continues in effect in excess of fourteen (14) days following the onset of suspension of admitting and surgery privileges for failure to complete medical records. Only upon completion of all medical records and payment of the application fee together with a \$500 fine may the individual then reapply through the Credentials Committee as a new applicant for medical staff privileges.
- (8) Eight suspensions within a two-year reappointment period for failure to complete medical records shall result in a fine of \$1000 or a requirement of three (3) hours of approved Continuing Medical Education on medical records management. Thereafter, every third suspension within the same two-year reappointment period shall result in an additional fine of \$1000 with no option for substitution of Continuing Medical Education in lieu of the fine. The failure to pay any fine when due (or to attend continuing medical education, if applicable) shall be considered a voluntary resignation from the medical staff and the individual may reapply as a new applicant only upon completion of all medical records and payment of all applicable fines and fees.
- (9) Any chart that does not have the physician's dictation number on all written orders is considered incomplete. Failure to use the assigned four-digit dictation number on a written order shall result in the following action:
 - First incident: the medical staff member shall receive a call from the department chair or designee.
 - Second incident: the member shall receive call from the Leadership Chair and/or Chief of Staff.

- Third incident: the member shall be required to appear before the Medical Staff officers.
- Fourth incident: the member shall be required to appear before the respective Leadership Committee and/or MEC.
- Fifth incident: the member shall be required to attend an approved three hour CME course or pay a fine of \$500. Failure to attend approved CME course or pay fine when due shall be considered a voluntary resignation from the medical staff and the individual may reapply as a new applicant only upon completion of all medical records and payment of all applicable fines and fees.

B. HISTORY AND PHYSICAL EXAMINATION FOR HOSPITAL CARE

- (1) Medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration for each patient, described in the table below, by a physician or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. The medical history and physical examination must be available in the patient's medical record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services.
- (2) When the medical history and physical examination are completed within 30 days before admission or registration, there must be an updated medical record entry documenting an examination for any changes in the patient's condition (e.g., "History and Physical reviewed, patient examined, no changes"). This updated examination must be completed and documented in the patient's medical record within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services.
- (3) An H&P performed more than 30 days prior to admission or registration does not comply with the CMS currency requirements and a new H&P must be performed.
- (4) The history and physical examination, the update (if required), the results of any indicated diagnostic tests, as well as a provisional diagnosis are recorded before the operative or other procedures, with the exception of emergencies, by the physician responsible for the patient (prior to surgery or any potentially hazardous diagnostic procedure). Emergent cases do not require a history and physical examination to be available in the chart prior to the start of the case; however, they must be completed as soon as possible after the surgery or other procedure has ended.

- (5) The medical history should include the chief complaint, details of the present illness (including, when appropriate, assessment of the patient's emotional, behavioral and social status), relevant past, social and family histories, and an inventory of pertinent body systems. The physical examination shall reflect a current physical assessment of pertinent body systems. The history and physical must also include a statement of the conclusions or impressions drawn from the history and physical, and a statement of the course of action planned for the patient while in the hospital. The medical history and physical examination, and any update must be signed, dated and timed.
- (6) Newborn records must document a complete physical examination on birth and again prior to discharge; provided that, if the infant is discharged within 36 hours of birth, with the diagnosis of "Term Male (Female) Delivery" (ICDV30-39) and with no other diagnosis than newborn physiologic jaundice (ICD 774.6), the birth and discharge examinations may be one and the same.
- (7) Patients admitted for dental care must have a history and physical and evaluation of overall medical risk by a physician member of the medical staff. The dentist is responsible for that part of the history and physical related to dentistry. Qualified oral-maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examinations on those patients if they have such privileges.
- (8) Patients admitted for podiatric care must have a history and physical and evaluation of overall medical risk by a physician member of the medical staff. The podiatrist is responsible for that part of the history and physical related to podiatry.
- (9) If a supervising physician has delegated the responsibility of completing or updating an H&P to another qualified Allied Health Personnel who has been granted these privileges, the H&P or update shall be countersigned by the supervising physician within 24 hours.

Type of admission	Admission classification	H&P requirement
<p>Medical admission – (non-surgical/procedural) admission – examples include treatment of pneumonia, heart failure, etc.</p>	<p>May be inpatient or observation</p>	<ul style="list-style-type: none"> • Requires a complete H&P to be written, dictated or entered into Sunrise within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. Must be signed, dated and timed. • This may be an H&P completed in the physician's office within 30 days prior to admission or registration. However, the H&P must be updated within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. The update must include H&P reviewed, patient examined, details of any changes (or a statement that there are no changes), a signature, date and time. If there are no changes, the update may be in the form of a stamp that states: "History and physical reviewed; patient examined; No changes." This must be signed, dated and timed. This update may also be described in a progress note that is signed, dated and timed.
<p>Surgical admission – includes admission for surgical treatment of a disease or injury</p>	<p>May be inpatient, observation, short stay or outpatient</p>	<ul style="list-style-type: none"> • Requires a complete H&P to be written, dictated or entered into Sunrise within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. Must be signed, dated and timed. • This may be an H&P completed in the physician's office within 30 days prior to admission or registration. However, the H&P must be updated within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. The update must include H&P reviewed, patient examined,

Type of admission	Admission classification	H&P requirement
		<p>details of any changes (or a statement that there are no changes), a signature, date and time. If there are no changes, the update may be in the form of a stamp that states: "History and physical reviewed; patient examined; No changes." This must be signed, dated and timed. This update may also be described in a progress note that is signed, dated and timed.</p> <ul style="list-style-type: none"> • Emergent cases do not require an H&P to be available in the chart prior to the start of the surgery or procedure. It must, however, be completed as soon as possible after the surgery or procedure has ended.
OB delivery	Inpatient	<ul style="list-style-type: none"> • If prenatal records are not available, an H&P must be completed, signed, dated and timed within 24 hours after admission or registration but before delivery, surgery or procedure requiring anesthesia services. • Prenatal records completed in the physician's office within 30 days prior to admission or registration may be used as an H&P for these patients. However, this must be updated within 24 hours after admission or registration but before delivery, surgery or procedure requiring anesthesia services. • The update must include H&P reviewed, patient examined, details of any changes (or a statement that there are no changes), a signature, date and time. If there are no changes, the update may be in the form of a stamp that states: "Prenatal records

Type of admission	Admission classification	H&P requirement
		<p>reviewed; patient examined; No changes.” This must be signed, dated and timed. This update may also be described in a progress note that is signed, dated and timed.</p> <ul style="list-style-type: none"> • Emergent cases do not require an H&P to be available in the chart prior to delivery or the start of the surgery or procedure. It must, however, be completed as soon as possible after the delivery, surgery or procedure has ended.
<p>Invasive procedure admissions with procedural sedation: examples included angio, port placement, cardiac cath, endoscopy, cardioversion, TEE, etc.</p>	<p>May be inpatient, observation, short stay or outpatient</p>	<ul style="list-style-type: none"> • Requires a complete H&P to be written, dictated or entered into Sunrise within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. Must be signed, dated and timed. • This may be an H&P completed in the physician’s office within 30 days prior to admission or registration. However, the H&P must be updated within 24 hours after admission or registration but before a surgery or procedure requiring anesthesia services. The update must include H&P reviewed, patient examined, details of any changes (or a statement that there are no changes), a signature, date and time. If there are no changes, the update may be in the form of a stamp that states: “History and physical reviewed; patient examined; No changes.” This must be signed, dated and timed. This update may also be described in a progress note that is signed, dated and timed. • Emergent cases do not require an H&P to be

Type of admission	Admission classification	H&P requirement
		<p>available in the chart prior to the start of the surgery or procedure. It must, however, be completed as soon as possible after the surgery or procedure has ended.</p>
<p>Invasive Radiologic Procedures that do not require moderate/procedural sedation- Examples include, but are not limited to: Nephrostomy tube exchange; Feeding tube exchange/removal; Abscess Drain/ drainage/ fluid collections- superficial; Breast Biopsy; Thyroid/Neck biopsy; Lymph Biopsy; Inguinal Biopsy; Mammography- Core biopsy; Mammography- needle locs; Ductogram; Other Biopsy (ex: rib, leg)- superficial; Hip Injections; Cholangiogram- injection of an existing catheter; Paracentesis; Thoracentesis; Amniocentesis; Chorionic Villous Sampling(CVS); Myelograms; Lumbar Punctures; Arthrograms; Hip Aspirations; Cyst Aspirations</p>	<p>May be inpatient, observation, short stay or outpatient</p>	<ul style="list-style-type: none"> • No H&P Required
<p>Non-invasive procedures with moderate/procedural sedation – examples include ECHO, MRI/CT, etc.</p>	<p>May be observation, short stay, or outpatient</p>	<ul style="list-style-type: none"> • No H&P required • ASA and airway assessment must be documented by physician • For pediatric population, complete preanesthesia assessment required
<p>Non-invasive procedures without sedation</p>	<p>Outpatient</p>	<ul style="list-style-type: none"> • No H&P required • Only requirement is a valid order.
<p>Other outpatient therapies - examples include blood transfusion, chemotherapy, and other infusions</p>	<p>Outpatient</p>	<ul style="list-style-type: none"> • No H&P required • Only requirement is a valid order.

C. DIAGNOSTIC AND THERAPEUTIC ORDERS

On the rare occasions when orders are not electronic, orders must be written clearly, legibly, and completely, and signed with dictation number, date and time.

(1) VERBAL/TELEPHONE ORDERS

- a. The use of verbal/telephone orders is discouraged. If verbal/telephone orders are used, they should be used only infrequently and should be limited to those situations in which it is impossible or impractical for the ordering practitioner to write the order either manually or electronically. Verbal/telephone orders are not to be used solely for the convenience of the ordering practitioner.
- b. All verbal orders shall be read back to the person dictating the order to verify accuracy.
- c. All verbal/telephone orders shall be signed by the registered nurse or other authorized personnel to whom dictated with the name of the physician by his or her name. Categories of persons authorized to accept verbal/telephone orders and write or electronically generate those orders through OH's automated order entry system are:
 - i. Registered nurses, advanced registered nurse practitioners, certified registered nurse anesthetists and graduate nurses
 - ii. Physician assistants
 - iii. Respiratory therapists
 - iv. Radiology/Nuclear Medicine technologists
 - v. Cardiovascular technologists
 - vi. Cardiovascular sonographers
 - vii. Laboratory technologists
 - viii. Licensed practical nurses
 - ix. Registered rehabilitation therapists, e.g. physiotherapists, speech therapists and occupational health therapists and audiologists
 - x. Orthopedic technicians
 - xi. Registered pharmacists and registered pharmacy interns

- xii. Registered dieticians
 - xiii. Social work discharge planners
 - xiv. Licensed clinical social workers, licensed mental health counselors and licensed marriage/family therapists
- d. All verbal/telephone orders must be authenticated by the physician, dentist, or podiatrist initiating the order (or by a group member who is authorized to sign for that individual under Section III.C (1) c. above). Verbal/telephone orders should be authenticated at the next opportunity (i.e., the next time the patient is assessed and/or information is documented in the medical record) and must be authenticated within 24 hours when such orders prescribe controlled drugs, Do Not Resuscitate and Restraint and within 48 hours for all other orders.

(2) STANDING ORDERS/ORDER SETS

Standing orders/order sets may be used by individual physicians, dentists, or podiatrists. These orders shall be followed insofar as proper treatment of the patient shall allow, and when specific orders are not written by the attending physician, dentist, or podiatrist they shall constitute the orders for treatment. Standing orders/order sets shall not, however, replace or cancel those written for the specific patient.

(3) RESTRAINT ORDERS

A physician's order is required for non-violent and violent restraint use. Written or verbal orders for initial or continued restraint use are time limited.

(4) WRITTEN/ELECTRONIC ORDERS

It is the expectation that all orders are entered electronically (a, b, d, g, j and k only apply to written orders).

- a. Written orders must be legible.
- b. Print must be large enough to reproduce easily by fax or copy.
- c. Prohibited or unapproved abbreviations may not be used. All other abbreviations must conform to the approved abbreviation list.
- d. Orders must be written with pens/devices capable of transferring legibly through multiple copies. Felt tip pens may not be used.

- e. Changes to existing orders must be made by way of new orders. Existing orders may not be corrected/scratched over.
- f. All admitting orders must include patient allergies.
- g. All physician orders must be accompanied by a legible identifier consisting of the physician's assigned four-digit dictation number, in addition to the prescriber's signature, date and time.
- h. Direct admissions must be accompanied by physician orders.
- i. Patients undergoing a change in level of care must have current orders reviewed and signed.
- j. The patient's full name must be documented on the order sheet prior to order being written.
- k. Physician must use OH's order sheets or office letterhead for direct admissions.
- l. Medication Orders
 - i. All medication orders, to be complete, must contain date and time, medication name, dose/strength, quantity or duration (as appropriate), route and frequency, Note: Required elements of medication order may not appear in the Message or Instruction Field with Computerized Physician/Provider Order Entry (CPOE). Medication orders cannot be generated by way of a communication order to the nurse or other healthcare professional.
 - ii. Abbreviations may not be used for medication names (Exception: Selected electrolytes and vaccines). All other abbreviations must conform to the approved abbreviation list.
 - iii. Orders should include height/weight/allergy/creatinine where applicable.
 - a) Chemotherapy orders should include patient height, current weight, and body surface area, where applicable.
 - b) Pediatric orders should include patient weight, and mg per kg/dose.
 - iv. All PRN orders must include indication and frequency.

- v. Medication orders should not contain trailing zeros (i.e. 5 mg vs. 5.0 mg), should include a pre-decimal zero where applicable (i.e. 0.5 mg vs .5 mg), and units should be spelled out (i.e. Units vs. U.).
- m. There shall be no blanket orders statements (e.g., “Resume pre-op orders,” “continue home meds,” “restart previous meds”).

(5) **CONDITIONAL ORDERS**

- a. Conditional orders **are** permitted when:
 - i. Clear triggers are indicated (e.g. “if BP less than 90 systolic, hold lisinopril today” or “if INR greater than 4 hold Coumadin today”). Ambiguous triggers which require interpretation (examples: “if normal,” “if low,” “if high,” or “out of range”) are not allowed.
- b. Conditional orders **are not** permitted when:
 - i. Orders for discharge are based on clearance from consulting physicians or pending test results (examples of prohibited orders: “Ok to discharge if ok with cardiology” or “Discharge home if stress test normal”).
 - ii. Orders for procedures are based on clearance from consulting physicians (example of prohibited orders: “Ok to go to MRI if Ok with Obstetrician”).
 - iii. Orders for medication are conditional upon another prescriber’s approval.

(6) **COMMUNICATION/INFORMATION ORDERS**

- a. Communication orders cannot be used for medication orders.
- b. Suspending and unsuspending orders must be carried out by using the electronic medical record’s “Suspend” and “Unsuspend” functions and not by writing a communication/information order.

D. CLINICAL OBSERVATIONS

(1) CONSULTATIONS

- a. The consultation request shall include the reason as stated by the attending physician, dentist, or podiatrist.
- b. The consultation report shall reflect evidence of a review of the medical record, actual examination of the patient, pertinent findings, opinions, and recommendations.

(2) PROGRESS NOTES

- a. All medical staff progress notes shall be dated, timed and signed by the medical staff member who recorded them and shall give a pertinent chronological order of the patient's course in the hospital.
- b. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes as well as results of tests and treatment. They shall be recorded at the time of observation and written to permit continuity of care and transferability of the patient. Progress notes shall be written at least daily, except in Rehabilitation Units where inpatients shall be seen and progress notes recorded at least three times per week. For stays of less than 48 hours, a final progress note shall be made upon discharge.
- c. There must be evidence on the progress notes of the medical record that includes justification for the use of special procedures. Special procedures that require special justification include the following:
 - i. Restraint or seclusion;
 - ii. Electroconvulsive and other forms of convulsive therapy;
 - iii. Psychosurgery or other surgical procedures that alter or intervene in an emotional, mental, or behavioral disorder;
 - iv. Other special treatment procedures for children and adolescents.
- d. Indications for use of blood products must be documented in the medical record.

E. REPORTS OF PROCEDURES, TESTS AND THE RESULTS

(1) OPERATIVE/INVASIVE REPORTS

- a. A brief operative/invasive progress note must be handwritten or electronically entered in the medical record immediately after an operative/invasive procedure and must be available for viewing prior to transfer to the next level of care. The brief operative/invasive progress note must include 1) name(s) of the primary practitioner(s) and his or her assistant(s), 2) procedure performed and a description of each procedure finding, 3) estimated blood loss, 4) specimens removed, and 5) postoperative diagnosis.
- b. In addition, a comprehensive operative/invasive procedure report must be dictated, written or entered electronically into the medical record within twenty-four (24) hours following the procedure to include 1) the name(s) of the primary practitioner(s) and any assistant(s), 2) the name of the procedure performed, 3) a description of the procedure, 4) findings of the procedure, 5) any estimated blood loss, 6) any specimen(s) removed and 7) postoperative diagnoses.
- c. If the comprehensive operative/invasive procedure report is handwritten or entered electronically into the medical record immediately after an operative/invasive procedure and available for viewing prior to transfer to the next level of care, then a brief operative/invasive progress note is not required.

(2) PATHOLOGY REPORTS

The pathologist is responsible for the preparation of a descriptive diagnostic report of gross specimens received from surgical procedures and of autopsies performed. These reports shall be signed by the pathologist and made part of the medical record.

(3) RADIOLOGY REPORTS

The radiologist is responsible for the preparation of all radiology reports of examinations performed. These reports shall be signed by the radiologist and made a part of the medical record.

F. CONCLUSIONS

(1) DIAGNOSES

- a. No abbreviations or symbols may be used in recording diagnoses and operative/invasive procedures performed.
- b. All diagnoses and operations should be recorded using acceptable disease and operation terminology.

(2) FINAL DIAGNOSES

The patient may not be discharged until the principal and additional or associated diagnoses, established by the time of discharge as much as possible, have been recorded. In the sequence of final diagnoses, the first should explain the reason for the patient's admission to the hospital. The final diagnosis should also include any complications occurring during hospitalization. These, as well as all operative procedures performed, should be recorded on the cover sheet of the medical record and/or in the Clinical Resume and signed by the physician, dentist, or podiatrist.

G. CLINICAL RESUME

- (1) Clinical Resume or Discharge Summary shall be recorded for all medical records of patients at the termination of their hospitalization (see exceptions below) and signed by the responsible physician, dentist, or podiatrist.
- (2) The Clinical Resume should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, final diagnoses, the condition of the patient on discharge (stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved"), and any specific instructions given to the patient and/or family, as pertinent, including instructions relating to physical activity, medication, diet and follow-up care (when preprinted instructions are given to the patient, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the Health Information Management Department).
- (3) A Clinical Resume is required on all patients who expire and should indicate the events leading to death.
- (4) A final progress note may be substituted for the Clinical Resume on medical records of patients with problems of a minor nature who require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or family.

H. ANESTHESIA DOCUMENTATION

(1) PRE-ANESTHESIA EVALUATION

- a. Records of patients scheduled to undergo general anesthesia must show evidence of pre-anesthesia evaluation recorded by a physician with such privileges prior to preoperative medication and surgery.

- b. This evaluation should include the date and time of the visit, information relative to the choice of anesthesia (must at least refer to the use of general, spinal, or other regional anesthesia), information relative to the surgical or obstetrical procedure anticipated, the patient's prior drug history, the patient's other anesthetic experiences, and any potential anesthetic problems.

(2) ANESTHESIA ADMINISTRATION

The anesthetist is responsible for documenting all pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood components. These shall be documented and signed by the anesthetist on the Anesthesia Record.

(3) POST-ANESTHESIA EVALUATION

- a. Post anesthesia documentation (inpatient within 48 hours; outpatient prior to discharge) must address: Temperature, Pulse, Respirations, B/P, O2 sat, airway patency, mental status, pain, presence of nausea or vomiting, and post-op hydration.
- b. Documentation of the visit and findings shall be recorded in the appropriate section to include physician's and/or CRNA's name, date and time of visit, description of the presence or absence of post-anesthesia complications, actions taken, if any, and explanations conveyed to the patient.

I. RESIDENTS COUNTERSIGNATURES

- (1) The following entries in the medical record by residents require countersigning by the supervisory or attending medical staff within 24 hours:
 - a. History and Physical Examinations;
 - b. Consultation;
 - c. Operative Report;
 - d. Labor and Delivery Record;
 - e. Clinical Resume or Final Progress Note;
 - f. Final Diagnosis on Face Sheet;
 - g. Do Not Resuscitate (DNR) Order

J. CONSENTS

- (1) The medical record shall contain evidence of the informed consent of the patient or legal representative for any procedure or treatment for which it is appropriate, including use of blood products. For procedures and treatments requiring informed consent, refer to hospital policy and procedures. The practitioner who informs the patient or legal representative and obtains the consent should be identified in the medical record.
- (2) The informed consent documentation includes:
 - a. Identity of the patient;
 - b. The procedure or treatment to be rendered (layman terminology when possible);
 - c. The name(s) of the individual(s) who will perform the procedure or administer the treatment;
 - d. The authorization for any required anesthesia, if applicable;
 - e. An indication that the risks, benefits and alternatives have been explained to the patient or legal representative by the practitioner;
 - f. The authorization for disposition of any tissue or body parts as indicated;
 - g. The signature of the patient or other individual empowered to give consent (should be witnessed);
 - h. The date and time of the consent.
- (3) Informed consent must be documented prior to the procedure or treatment and before the patient goes under the influence of preparatory narcotics, hypnotic, analgesic or sedative medication.
- (4) Refer to hospital policy and procedures for specific forms of documentation of informed consent for various procedures and treatment.
- (5) EXCEPTIONS TO OBTAINING INFORMED CONSENT
 - a. Emergency and/or Life Threatening situations. When, in the opinion of the physician performing the procedure, an emergency and/or life threatening situation arises and the patient/legal representative is either unable to provide an informed consent or there is insufficient time to obtain an informed consent from the patient/legal representative, the physician performing the procedure documents in the Progress Notes:

- i. Why the emergency procedure, treatment, or test needs to be performed; and
 - ii. The patient/legal representative is unable or unavailable to provide informed consent; and
 - iii. Delay in treatment or testing could be detrimental to the patient, and the reason there is insufficient time to obtain the consent of the patient/legal representative (e.g. this may include instances involving the emergent alteration of in-progress surgery or procedure); and
 - iv. If the situation permits, any consults that concur with the emergent need for the procedure; and
 - v. The physician performing the procedure notifies the patient/legal representative concerning the procedure, treatment, or test as soon as possible; and
 - vi. Attempts to contact authorized persons are documented in the patient's medical record.
- b. Court Orders for procedures require no additional consent. Court orders must be placed in the medical record.

K. RELEASE OF RECORDS/PROTECTED HEALTH INFORMATION (PHI)

- (1) Medical records are confidential PHI. Disclosure of confidential patient information, whether in written, electronic or oral form, even inadvertently, may be a violation of state or Federal law (HIPAA) and may subject you and OH to fines and other penalties.
- (2) Medical records are the property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute.
- (3) Unauthorized removal of medical records from the hospital is grounds for suspension of the medical staff member or such other corrective or disciplinary action which may be taken in accordance with medical staff bylaws.
- (4) In case of readmission of a patient, all previous records shall be available for use by medical staff members as requested.

L. ABBREVIATIONS

To avoid misinterpretation, only those symbols and abbreviations on the approved Abbreviation List may be used in the medical record. They may not be used in recording the final diagnosis and consents.

M. RESEARCH

Access to medical records shall be afforded to medical staff members in good standing for bona-fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients and subject to approval by the Medical Record Committee.

N. MEDICAL RECORD REQUIREMENTS FOR ORGAN DONATION

- (1) When the donor organ is obtained from a brain death patient, the medical record of the donor includes the date and time of brain death, documentation by and identification of the physician who determined the death, the method of transfer of the organ and the method of machine maintenance of the patient for organ donation, as well as an operative report.
- (2) When a cadaver organ is removed for purposes of donation, there is an autopsy or operative report that includes a description of the technique used to remove and prepare or preserve the donated organ.

O. AMBULATORY CARE (NON-INPATIENT)

- (1) A medical record shall be maintained for every patient who receives ambulatory care services. This record shall be made a part of the hospital's unit record system, by means of Community Master Patient Index (CMPI).
- (2) Pertinent information shall be recorded and/or updated for each ambulatory care visit. For patients receiving continuing ambulatory care services, the medical record shall contain a summary list of known significant medical diagnoses and conditions, significant operative/invasive procedures, adverse or allergic drug reactions, current medications, over the counter medications and herbal preparations. The list shall be initiated by the third visit.
- (3) Ambulatory surgery is performed only after an appropriate history, physical examination and any required laboratory and x-ray examinations have been completed, and the preoperative diagnosis has been recorded.
- (4) A comprehensive report of every operative/invasive procedure performed is dictated, written or entered electronically into the medical record immediately following surgery, and is authenticated by the individual who performed the procedure.

- (5) The medical record of an ambulatory care patient who has received other than local anesthesia contains documentation that the patient meets established discharge criteria or an examination prior to discharge performed by a physician or, when appropriate, a qualified oral-maxillofacial surgeon. The record also indicates that the patient is accompanied home by a designated person.

P. **USER ACCESS CODE**

Each medical staff member who is granted a User Access Code (UAC) shall be subject to hospital policies and procedures regarding the use of such UAC and shall be required to sign and comply with such user responsibility statements and user confidentiality statements as required by the hospital. Each medical staff member is responsible for all entries made using that member's UAC.

SECTION IV. CLINICAL DEPARTMENTS

Each clinical department shall enact departmental rules, regulations and policies subject to the approval of the Executive Committee. Such rules, regulations and policies shall not in any way conflict with the medical staff bylaws, rules and regulations, or the hospital bylaws, policies, and procedures. Copies of such departmental rules, regulations and policies shall be provided to each member of the department and to applicants seeking membership in the department. Departmental rules, regulations and policies shall be reviewed by the department at least every two (2) years.

SECTION V: ALLIED HEALTH PERSONNEL

- A. Each medical staff member supervising an Allied Health Personnel (AHP) at OH, which AHP is not employed by OH, assumes responsibility and legal liability for the performance and the acts and omissions of such AHP.
- B. Unless otherwise specified in the requirements for a specific category (or categories) of AHP, such medical staff member shall indemnify OH and hold OH harmless from any liability arising from the acts or omissions of the AHP and shall execute an indemnification agreement in a form satisfactory to OH as a condition of the AHP being permitted to render services at OH.
- C. A medical staff member who supervises an AHP at OH shall participate in the evaluation of the AHP in accordance with the policies and procedures of OH.

SECTION VI: SUPERVISION OF RESIDENTS

Supervision by medical staff members of participants in graduate medical education programs in carrying out the participants' patient care responsibilities in accordance with the requirements of

the Accreditation Council for Graduate Medical Education shall be as specified in the policies and procedures within the Division of Graduate Medical Education.

SECTION VII. TRAUMA SERVICES

- A. The Medical Trauma Director is responsible and accountable for administering all aspects of trauma care.
- B. Issues related to trauma that are not able to be resolved by the Medical Trauma Director through the normal hospital organizational structure shall be referred to the Chief of Staff for recommendation and resolution using the powers delegated to the Chief and/or those vested in the respective hospitals and/or departments.
- C. Any physician whose credentials or care is considered below standard by the Medical Trauma Director shall be dealt with through the appropriate contractual stipulation in the case of the contracted physicians or when a member of the medical staff at large, referred to the Chief of Staff or Medical Executive Committee with recommendations. The Chief of Staff and Medical Executive Committee shall address the issue in accordance with hospital bylaws.