

MEDICAL STAFF

RULES AND REGULATIONS

Revised September 21, 2015

RULES & REGULATIONS

TABLE OF CONTENTS

I.	General	Page 3
II.	Admission and Discharge	Page 6
III.	Medical Records	Page 7
IV.	Drugs/Medications	Page 10
V.	Surgical Care.....	Page 11

**BLAKE MEDICAL CENTER
MEDICAL STAFF
RULES AND REGULATIONS**

I. GENERAL

- A. Members of the Medical Staff are expected to reside within reasonable distance from the hospital so that they may respond promptly in an emergency situation.
- B. Emergency Department referrals for a patient without a private physician shall be made only to members of the Medical Staff of Blake Medical Center. The referring physician will be required to see the patient within seven (7) days.
- C. Patients admitted through the Emergency Department must be seen by the attending physician within twenty-four (24) hours or sooner if requested by the Emergency Department physician. Patients admitted to ICU/CCU must be seen within twelve (12) hours and those admitted to PCU must be seen within eighteen (18) hours of admission.
- D. Patients who have suffered a cardiopulmonary arrest in the Emergency Department or other areas of the hospital are the responsibility of the primary physician or his designee. The Emergency Department physician or any other physician responding to the code is not responsible for disposition and continued care of that patient.
- E. A physician on call for the Emergency Department who, for any reason, is unable to take his call must be covered by someone in the same specialty. The only exception will be when there is only one physician on staff in a specialty. In that case, the physician must obtain permission from the chief of staff to allow other coverage.
- F. It is expected that all physicians on the Medical Staff will obtain appropriate consultation whenever the medical or surgical condition of the patient warrants such consultation.
- G. Within twenty-four (24) hours of being notified of a consult, the consultant must either see the patient or personally notify the referring physician that they are unable to fulfill the request for consultation.

In those situations where the consulting physician refuses to see the patient, and the situation cannot be resolved within a reasonable amount of time by the attending, nursing staff will contact the department chair who will assign an appropriate consulting physician to cover the consult; assignments to consult will be rotated to avoid undue burden to any one physician. Physicians who refuse to

see a consult will be required to attend the next MEC and/or Board of Trustees meetings.

- H. Psychiatric consultation shall be ordered on all patients who are determined to be at risk for suicide. Patients at risk of suicide, who have attempted suicide, or have overdosed, will receive a psychiatric consultation and treatment; and, the physician of record shall be notified.
- I. Each member of the Medical Staff or any allied health professional maintaining clinical privileges is responsible to provide the Medical Staff Office with copies of their current professional license/certificate, DEA Registration, Certificate of Insurance stating limits of coverage, dates of coverage and retro date (either prior acts or tail coverage) at the time of appointment, reappointment or at the expiration of any of the above, to assure current information in their credential file.
- J. A physician requesting elevation from Courtesy to Active Staff will be sent a new privilege form for his specialty. This will serve as his regular two-year appointment. Such physicians, if not having made use of the hospital facilities in the past, may be asked to document their activities during that time spent on Courtesy Staff and why they wish to retain privileges. A condition of reappointment may be the requirement for a new preceptorship.
- K. There is a Medical Staff policy that addresses the responsibility of the Board, the Medical Staff and the hospital with regard to actions involving the impaired medical staff practitioner. It provides direction for identification; evaluation, action and referral for treatment should a member of the Medical Staff be identified as an impaired practitioner.
- L. Subject to the discretion of the administrator, access to all medical records of all patients shall be given to all staff members in good standing for bona fide study and research, consistent with the ruling if confidentiality of personal information concerning the individual patient.
- M. Former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Studies shall be approved by the Mortality and Morbidity Committee prior to the beginning of the study. Any non-physician requiring access to medical records must receive permission from the administrator or his designee
- N. Physicians are required to notify the Medical Staff Office of their resignation from the Medical Staff should they decide to leave the area. If correspondence is not received, Certified Letters will be sent to the last known residence address and

office address, requesting a letter of physician plans to resign his clinical privileges at the hospital. If no response is received within ten days, the physician will be considered to have resigned his staff privileges.

- O. Physicians shall abide by the hospital policy for Deep/Moderate Sedation/Analgesia.
- P. In order to comply with the provisions of federal and state law in respect to EMTALA and State Emergency Access to Care, the hospital and the Medical Staff deem qualified the Emergency physician and ARNP and PA contracted by Emergency Physician Group to provide appropriate medical screening; necessary stabilization treatment for emergency medical conditions; and provide for the appropriate transfer of the patient when the hospital does not have the capability or the capacity to provide the treatment necessary to stabilize the medical condition.
- Q. If a Physician has agreed to undertake to provide on-call services for the hospital, it is the responsibility of that on-call Physician to respond within a reasonable period of time.
- R. By its adoption of this rule and for the purpose of implementing the Medical Staff Bylaws, the Medical Executive Committee affirms that no provision of Medical Staff Bylaws nor these Rules and Regulation shall require, nor shall be deemed to require, any member of the Medical Staff to provide on-call coverage at the hospital unless such Physician has voluntarily agreed to do so, either with or without compensation from the hospital; provided, however, that notwithstanding the foregoing, in the event of a documented need, the Medical Executive Committee shall have the power to require any specialty or subspecialty to establish a mandatory call schedule with compensation at fair market value provided by the Hospital lasting for no more than a maximum of one hundred eighty (180) days, as long as such call obligations are assigned equally within the specialty or subspecialty and no member of the Medical Staff shall be required to take call more than a reasonable number of days during such period after giving due consideration to the physician's specialty or subspecialty.
- S. Physicians shall abide by the Policies and Procedures of the Medical Staff, which are available upon request to the Medical Staff Coordinator.
- T. Pre-printed orders shall be formulated by conference between the Medical Staff member and the administrator. They can be changed only by mutual consent of the Medical Staff member and the administrator, and the latter shall notify all personnel concerned. The attending physician shall sign the orders. Pre-printed orders shall be reviewed on an annual basis.

- U. The ER Physician must notify the Attending/Covering Physician of an admission of a patient to their service. Emergency physicians do not provide continuing inpatient care. The admission orders that they write are a courtesy to the Medical Staff. The responsibility for the patient is handed over to the attending/admitting physician at the time of admission to the hospital.
- V. A physician, when requiring someone to cover for him, shall be covered by a physician in the same specialty. The only exception will be when there is only one physician on staff in a specialty.
- W. Pediatric patients are those patients under the age of 18 years. However, trauma patients 16 years of age or older may be admitted under trauma services and burn patients 6 years of age and older and weight greater than 30 kilograms may be admitted to the burn service.

Pediatric patients presenting as “trauma alerts” may be admitted for observational purposes after initial stabilization and resuscitation. As necessary, transfer arrangements will be made to a State approved trauma facility.

Pediatric care may include the following scenarios:

- 1) Evaluated, treated and discharged as appropriate
- 2) Evaluated, treated with life-saving measures, stabilized, and transferred to a higher level of pediatric care (i.e. State approved pediatric trauma/burn facility)
- 3) Pediatric trauma patients may be admitted for continued observation after initial treatment and stabilization. Should the need arise, they will subsequently be transferred to a higher level of pediatric trauma care
- 4) Pediatric burn patients may be admitted for continued care and treatment after initial stabilization. Should the need arise, they will subsequently be transferred to a higher level of pediatric burn care
- 5) Pediatric patients under the care of the burn clinic may also receive follow-up care under the direction of the burn clinic.

II. ADMISSION AND DISCHARGE

- A. Patients may be admitted to, and/or treated at Blake Medical Center only by a member of the Medical Staff, in accordance with hospital admitting policies and the Medical Staff Bylaws. Every patient admitted to Blake Medical Center shall be admitted by, and remain under the care of, a staff physician.
- B. Except in emergencies, no patient shall be admitted to the hospital until 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 a patient shall be held responsible for getting such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection from self-harm.
- D. Patients shall be discharged only on order of the attending physician involved in the patient's care.

III. MEDICAL RECORDS

- A. All entries in the medical record, including orders and progress notes, are dated and timed.
- B. A History and Physical Examination (H&P) must be completed within twenty-four (24) hours of admission for both Inpatients and Medical Observation patients. The attending (admitting physician, surgeon, interventionalist) physician is responsible for performing the H&P. If the H&P was performed within thirty (30) days prior to the admission or readmission by the physician, a copy of this examination may be used in the medical record, provided an update on the patient's medical condition is recorded in the medical record within twenty-four (24) hours after inpatient admission, or prior to surgery. All H&P Examinations will include the date of the exam, including H&Ps received from physician's office. Unless otherwise noted, the date of dictation will be recognized as date of exam.

The following procedures are excluded from History and Physical requirement: Thoracentesis, Paracentesis, Percutaneous Breast Biopsy, Nephrostomy & Biliary Tube changes, AV Fistulagrams, Lumbar punctures, Myelograms, Venograms, PICC Lines and Manometry.

- C. History and Physical Minimal Content

The History and Physical must include the following:

- Chief complaint
- History of present illness
- Allergies and know reactions
- Past medical history
- Relevant family and social history
- Physical examination
- Pertinent findings resulting from a review of systems
- Conclusion or impression
- Treatment plan/course of action

- D. Definition of Invasive Procedures: "Invasive procedure" is defined as the surgical entry into tissues, cavities, or organs and, in addition, will include, but may not be limited to the following:
- Endoscopy
 - Transesophageal Echocardiogram (TEE)
 - Central Line Insertions (involving primary entry into a major vessel)
 - Cardioversion
 - Cardiac Ablations
 - Pacemakers
 - Internal Defibrillator check (ACID)
 - Interventional Radiology Procedures
 - Insertion of Chest Tube
- E. The medical record contains a concise discharge summary that includes the following:
- Reason for hospitalization
 - Procedures performed
 - Care, treatment, and services provided
 - Patient's condition and disposition at discharge
 - Information provided to the patient, family, or other caregiver
 - Provision(s) for follow-up care
- F. All patient medical records must be completed within thirty (30) days of discharge. A complete medical record is one that has all dictation and signatures completed by all physicians on the chart. Delinquency in completing charts will lead to loss of privileges.

The notification cycle for delinquent records and suspension of admitting privileges will consist of three (3) written notifications:

1. The first notification, which will list all incomplete records, their age, and the due date for completion, will be sent 15 days post-discharge. This notification will be faxed or emailed to the physician's office.
2. A second notice (warning) will be sent 1 week after the first to physicians who still have the same outstanding incomplete records. The notice will include a list of the charts that are going to be delinquent if not completed within the stated timeframe. This notification will be faxed or emailed to the physician's office.
3. The third letter (suspension of privileges) will be sent the following week if the chart(s) have reached 30 days post-discharge. Suspension will include elective admitting privileges and scheduling of elective procedures. Any and all call obligations shall be honored. This suspension of privileges letter will be faxed and mailed via certified US mail to the physician's office.
4. Physicians failing to complete delinquent records within 30 days after suspension of privileges will be notified by certified mail to appear before

the Medical Executive Committee (MEC). If the physician fails to attend the Medical Executive Committee, it shall be deemed as an automatic suspension of all clinical privileges. Appearance at MEC will result in an imposition of a \$100 fine payable to the Blake Medical Center Medical Staff.

- G. The physician shall be responsible for preparation of a complete medical record of each patient. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports (consultants, clinical laboratories, x-ray and others), provisional diagnosis, medical and surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge summary and/or final progress note (which includes condition at discharge, discharge instructions and follow up care required) for uncomplicated stays (less than 48 hours), or autopsy when available. No medical record shall be filed until it is complete except on order from the Medical Records Committee.
- H. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute for the purpose of appearance in court, or for the transport to the HIM Shared Service Center or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing.
- I. Documentation of abbreviations and symbols will follow hospital guidelines.
- J. Orders for treatment must be in writing. An order shall be considered to be in writing if dictated by a physician to authorized persons* and subsequently signed by the prescribing physician. Dictated orders shall also be by the person to who dictated with a notation of physicians' name.
- K. All diagnostic and therapeutic verbal orders associated with any potential hazard to the patient as determined by the Medical Staff, must be authenticated by the responsible physician within 24 hours. The following orders determined by the Medical Staff constitute a potential hazard:
 - 1. No Code - Do Not Resuscitate Order (DNR)
 - 2. Chemotherapy Drugs
 - 3. Investigational Drugs
 - 4. Restraint Orders
- L. In addition to Registered Nurses and Licensed Practical Nurses, persons authorized by the hospital to receive verbal orders in their field of expertise: Respiratory Therapists; x-ray Technologists; Nuclear Medicine Technologists; Dieticians; Occupational Therapists; Physical Therapists; Pharmacists; Speech Therapists; Social Workers; Recreational Therapists and Medical Technologists.

- M. There must be a pre-anesthesia note written by the anesthesiologist in the medical record of all patients that specifically includes information relative to the choice of anesthesia for the procedure anticipated. The medical record shall also reflect a post-anesthesia visit.
- N. Daily progress notes must be written by the physician of record. While recommended, a progress note is not required on the day of discharge. The physician of record shall denote the attending physician or his covering physician on the case that sees the patient during a twenty-four (24) hour period.
1. Progress notes shall reflect the author's daily assessment and plan for the patient and support the patient's progression from admission through discharge. The inclusion of pasted excerpts from progress notes other than those written by the author, shall be attributed to the originating physician.
 2. Physicians caring for subacute or Hospice patients shall visit those patients when medically necessary or, at a minimum, monthly.
 - a. Progress note must be written every time the physician visits the patient.
- O. Physician verbal orders, including phone orders, must be authenticated by the prescribing/ordering physician within forty-eight (48) hours.
- P. Full operative reports are dictated or documented in the medical record immediately after surgery and/or invasive procedure but no later than 48 hours. Operative reports shall include the name of the primary surgeon and assistants, findings, a detailed account of the technical procedures, tissues removed or altered, and pre and postoperative diagnosis.

If a report is not dictated or documented within 48 hours of the procedure, it is considered delinquent and the physician may be suspended for delinquent records.

An operative progress note needs to be documented immediately following the procedure (before the patient goes to the next level of care) and should contain pertinent information needed for continuity of care, to include the name of the primary surgeon and assistants, findings, technical procedures used, tissues removed or altered, and postoperative diagnosis and signed by the surgeon.

- Q. Healthcare Insurance Portability and Accountability Act (HIPAA)

Each member of the Medical Staff will be part of the Organized Health Care Arrangement (OHCA) with the Hospital. This is defined in the HIPAA, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts §164.501, as a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. This

arrangement allows for the sharing of protected healthcare information (PHI) for treatment, payment and health care operations as well as any medical staff or hospital committees where this information would be shared. The hospital's Notice of Privacy Practices will explain the OHCA to patients with regard to the sharing of their PHI as a hospital patient. The OHCA will not apply to physicians' private office practices.

IV. DRUGS/MEDICATIONS

- A. The Pharmacy & Therapeutics Committee is responsible for preventing, monitoring and reporting medical errors. The Medical Staff, through its Pharmacy and Therapeutics Committee, will ensure that medications deemed to be toxic or dangerous will have a reasonable time limit and/or stop order for each such medication.
- B. Use of antibiotics should be based on cultures and sensitivity tests except that prophylactic utilization of antibiotics may be made in those specific medical and surgical cases when it has been medically determined that such action is an accepted and appropriate medical practice.
- C. Physicians, dentists, podiatrists, osteopaths and allied health professionals who practice independently by law, such as psychologists, may prescribe drugs within the course of practitioner's professional practice and in accordance with the Bylaws and Rules and Regulations of the Medical Staff. Allied health professionals who work under the supervision of a member of the medical staff, such as CRNA's and P.A.'s are required to adhere to the statutory requirements of their professional practice and established protocols approved by the medical staff.

V. SURGICAL CARE

- A. The surgeon must be in the operating room and ready to commence operation at the time scheduled. In no case will the operating room be held for longer than fifteen (15) minutes past the time scheduled.
- B. The operating surgeon shall have responsibility for having such qualified assistants as required for the operative procedure that is planned.
- C. Preadmission laboratory tests must be performed up to seven (7) days before hospital admission and must be documented in the patient's medical record (time frame defined by current laboratory legislation and AHCA Rules). Any requested lab study must be performed by a licensed laboratory.
- D. Preadmission testing (Lab, ECG or chest film) may be ordered by the surgeon or

the anesthesiologist.

- E. Any testing (Lab, ECG or chest film) required prior to any invasive non-surgical procedure will be determined by the physician.
- F. A surgical operation shall be performed only on written consent of the patient or his legal representative except in emergencies.
- G. When history and physical are not recorded before the time stated for operations, the operations may be canceled unless the attending physician states in writing that such delay would constitute a hazard to the patient.
- H. All operations and invasive procedures require an immediate post-operative note by the operating surgeon either by dictation or in writing. The report should contain the following information:
 - Procedure(s) performed
 - Names of licensed independent practitioner(s) and assistant(s) who performed the procedure(s)
 - Description of the procedure(s)
 - Findings of the procedure(s)
 - Estimated blood loss
 - Specimen(s) removed
 - Post-operative diagnosis
- I. Nurse Anesthetists may be employed by and under the supervision of an anesthesiologist on the Active Staff of Blake Medical Center and be certified by the American Association of Nurse Anesthetists.
- J. Most tissues removed at the time of the surgery should be sent to the pathologist. Examples of items, which may be exempted, are:
 - 1. Specimens that by their nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance an operative exposure;
 - 2. Therapeutic radioactive sources;
 - 3. Traumatically injured members that have been amputated;
 - 4. Foreign bodies (for example, bullets) that for legal reasons are given directly to law enforcement representatives;
 - 5. Foreign bodies shall be retained from a clinical risk management perspective and could be sent to pathology for evaluation and retention based on the surgeon/invasive physician's decision. The surgeon/physician performing the surgery or invasive procedure is responsible for the decision and advisement of the surgery team to retain the specimen and whether to send to pathology for analysis. It is recommended that if the physician informs the staff to discard the foreign

body, that documentation in the medical record reflects the rationale for that decision.

6. Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant;
 7. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics; and
 8. Teeth; provided the number including the fragments, is recorded in the medical record.
- K. Non M.D. / D.O. practitioners with surgical privileges in the operating room shall not be permitted to administer anesthetic agents including local site infiltration without having an M.D. / D.O. physician (Anesthesiologist or Physician with similar surgical privileges) in attendance.