

**MEDICAL STAFF**  
**RULES AND REGULATIONS**  
**At**  
**MIDLAND MEMORIAL HOSPITAL**  
**Midland, Texas 79701**

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## **MEDICAL STAFF POLICIES, PROCEDURES, RULES AND REGULATIONS**

### **PRINCIPLES OF WORKING TOGETHER**

We, the members of the medical staff, believe in the essential need for an atmosphere of mutual trust and respect if we are to work effectively with each other and with the hospital for the benefit of our patients and the community. To that end, we agree to follow the principles and guidelines listed below, and to promote them with our colleagues and coworkers.

#### 1. Respectful Treatment

All members of the health care provider team and all direct and indirect recipients of health care should be treated in a respectful and dignified manner at all times. Verbal and nonverbal behavior will reflect this respect and dignity of the individual.

#### 2. Language

Language used by all members of the health care team should be professional and respectful at all times. Members should avoid and discourage use of profane, vulgar, sexually suggestive or explicit, intimidating, degrading or racial/ethnic/religious slurring comments in any setting related to the hospital or the care of our patients. References to physicians, hospital staff or the hospital should be appropriate and made in a manner that does not undermine patient confidence or unduly alarm patients or families.

#### 3. Behavior

Behavior toward colleagues, staff, patients, family members and others should be professional and conducive to the harmonious function of the health care team. Medical staff members should avoid behavior or demeanor which could be perceived as threatening, intimidating or harassing, sexually or otherwise.

#### 4. Confidentiality and Privacy

Members of the health care team should maintain complete confidentiality of patient information at all times. Likewise, members should maintain confidentiality of professional issues, including committee business, perceived performance problems and concerns about technique or competence, leaving such matters to be adjudicated in a private, professional setting.

#### 5. Direct Communication and Feedback

Members will communicate directly and constructively when problems or disagreements arise, employing appropriate channels for administrative matters. Discussion of problem behavior should be objective, nonjudgmental, and occur in a confidential, private setting.

### **CLINICAL SECTIONS**

Each Clinical Section may establish its own regulations and procedural rules which do not controvert the Medical Staff Bylaws, Policies, Procedures, Rules & Regulations, and they shall become effective when approved by the Medical Executive Committee.

## **ANESTHESIA SERVICES**

### **Definition of Anesthesia Services**

Anesthesia services involve the administration of general, regional, monitored anesthesia, or deep or moderate sedation.

### **Direction & Responsibility for Anesthesia Services**

All anesthesia services shall be under the direction of the Chair of the Department of Anesthesiology. The Chair must meet the following minimum qualifications:

1. Be a licensed physician (MD or DO) on active staff.
2. Graduation from a medical school accredited by the Liaison Committee on Medical Education (LCME), from an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or from a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates (ECFMG).
3. Completion of an anesthesiology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA.
4. Board certification in specialty recognized by the American Board of Medical Specialties (ABMS) or demonstrates equivalent education, training, and experience.
5. Hold a current ACLS certification.

Responsibility for directing anesthesia services, includes, but is not limited to, the following:

1. Developing policies and procedures governing the provision of all categories of anesthesia services.
2. Specifying the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services that are not subject to the anesthesia administration requirements of 42 CFR 482.52(a).
3. Planning, directing, and supervising all activities of the service;
4. Establishing staffing schedules for the department;
5. Evaluating the quality and appropriateness of the anesthesia patient care;

### **Criteria for Granting Clinical Privileges**

The Chair of the Department of Anesthesia shall have the authority to determine the criteria for granting privileges anesthesia services". MD or DO wishing to administer general, regional, or monitored anesthesia care must meet the following minimum criteria:

1. Graduation for a medical school accredited by the Liaison Committee on Medical Education (LCME), from an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or from a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates (ECFMG).
2. Completion of an anesthesiology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA.
3. Board certified or board eligible in anesthesiology recognized by the American Board of Medical Specialties (ABMS) or demonstrates comparable education, training and experience. *Note: New applicants must adhere to the bylaws 3.2.2(b) board certification.*
4. Hold a current ACLS certification.

MDs or DOs working as Emergency Medicine Physicians who wish to administer moderate and/or deep sedation must meet the following minimum criteria:

1. Graduation from a medical school accredited by the Liaison Committee on Medical Education (LCME), an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates (ECFMG).
2. Completion of an emergency medicine residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA. **OR**
3. Board certified or board eligible in emergency medicine by a board that is recognized by the American Board of Medical Specialties (ABMS). *Note: New applicants must adhere to the bylaws 3.2.2(b) board certification. (This Rule and Regulation excludes all other specialties working in the Emergency Room.) Revised 3/30/11*

MD, DO, Oral Surgeon, Podiatrist or Dentist wishing to administer moderate sedation must meet the following minimum criteria:

1. Completion of a training program in the safe administration of the sedative and analgesic drugs used to establish a level of moderate sedation
2. Training in the recognition of complications associated with sedation/analgesia.
3. Ability to rescue patients who enter a state of deep sedation, including training in basic life support skills (cardiopulmonary resuscitation, establishing an oral airway, bag-valve-mask ventilation, etc.)
4. ACLS Certification
5. PALS Certification (For Pediatric moderate sedation)
6. NRP Certification ( For Neonatal moderate sedation)
7. For initial application: Attestation and documentation of twenty-five (25) cases performed using moderate sedation in the past year. If documentation lacking, taking and successfully passing a test on moderate sedation. (A score of 100% is required to PASS the test).
8. For Reappointment Application: Attestation and documentation of fifty (50) cases performed using moderate sedation in the past two years. If documentation lacking, taking and successfully passing a test on moderate sedation. (A score of 100% is required to PASS the test).
9. Read and understand the *ASA Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists and Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia*.
10. Review of hospital policies.
11. Privilege must be approved by Department Chair and Chief of Anesthesiology

CRNA wishing to administer general, regional, or monitored anesthesia care must meet the following minimum criteria:

1. Licensed as a registered professional nurse by the State in which the nurse practices.
2. Meets any licensure requirements the State imposes with respect to non-physician anesthetists.
3. Graduated from a nurse anesthesia educational program that meets the

- standards of the Council on Accreditation of Nurse Anesthesia Programs.
- 4. Passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists.
- 5. Hold a current ACLS certification.

#### Supervision of a CRNA by the Operating Practitioner Performing the Procedure

If required, supervision – as defined in Anesthesia Department Rules and Regulations – of a CRNA by the MD, DO, Oral Surgeon, Dentist, or Podiatrist performing the procedure is permitted for operative, invasive and other procedures that involved the administration of general, regional, or monitored anesthesia care, or deep sedation

Non-anesthesia Mid-levels wishing to administer moderate sedation must meet the following minimum criteria:

1. Must be under the supervision of a physician who is immediately available and privileged to administer moderate sedation.
2. Completion of a training program, provided through formal education, in the safe administration of the sedative and analgesic drugs used to establish a level of moderate sedation.
3. Training in the recognition of complications associated with sedation/analgesia.
4. Ability to rescue patients who enter a state of deep sedation, including training in basic life support skills (cardiopulmonary resuscitation, establishing an oral airway, bag-valve-mask ventilation, etc.).
5. ACLS Certification.
6. PALS Certification (For Pediatric moderate sedation).
7. For initial application: Attestation and documentation of twenty-five (25) cases performed using moderate sedation in the past year. If documentation lacking, taking and successfully passing a test on moderate sedation. (A score of 100% is required to PASS the test).
8. For Reappointment Application: Attestation and documentation of fifty (50) cases performed using moderate sedation in the past two years. If documentation lacking, taking and successfully passing a test on moderate sedation. (A score of 100% is required to PASS the test).
9. Read and understand the *ASA Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists and Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia*.
10. Review of hospital policies.
11. Privilege must be approved by Department Chair and Chief of Anesthesiology

Approved 8/25/2010

#### **GENERAL CONDUCT OF CARE**

1. All medical staff Policies, Procedures, Rules & Regulations apply to medical staff members and Allied Health Professionals (AHP) providing care at Midland Memorial Hospital (MMH).
2. Medical staff members and AHP shall abide by the terms of the Notice of Privacy Practices prepared and distributed to MMH patients as required by state and federal privacy statutes and regulations, including Health Insurance Portability and Accountability Act (HIPAA).

3. Patients are entitled to participate actively in the decisions about their own care. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.
4. Specific informed consent is needed, with documented patient signature, prior to performance of any invasive procedure. The medical staff member performing or supervising the procedure (if to be performed by an AHP) is responsible for informing the patient of the risks and benefits involved in such procedures, and including alternatives to treatment if appropriate. This responsibility may not be delegated. Nursing staff may assist in assuring the proper consent form is obtained, witnessed and signed, and documented. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.
5. Regardless of the number of consultants called, the attending medical staff member shall maintain primary responsibility for the care of the patient and coordination of the consultants' activities. The admitting medical staff member shall also be the attending medical staff member with the aforementioned responsibilities, unless he/she transfers the patient to another attending medical staff member in accordance with these Rules & Regulations.
6. Each medical staff member must assure timely, adequate professional care for his patients in the hospital by being available at all times, or having available appropriate alternate medical staff members with whom prior arrangements have been made. "Available" is here defined as follows: a) 30 minute response time to answer a page by any of the usual electronic methods in current use; and b) 30 minute response time to physically arrive in the hospital to care for the patient.
7. In the event that an on-call physician or his designated covering physician should not be available, the following should be called in the respective order:
  - A. When the situation is an emergency, any physician in the applicable specialty should first be called.
  - B. Chief of the applicable Section;
  - C. Chairman of the applicable Department;
  - D. Chief of Staff Elect; or
  - E. Chief of Staff.

### **ADMISSION OF PATIENTS**

1. A patient may be admitted to the hospital only to the service of a member of the medical staff. All medical staff members shall be governed by the official admitting policy of the hospital.
2. Existence of any advanced medical directives shall be determined at the time of admission, and likewise any existing Medical Power of Attorney.
3. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
4. If any question as to the validity of admission to or discharge from the Critical Care Unit should arise, the question shall be resolved through consultation with the Chairman of the Medical Staff Quality Council. Criteria for admission to Critical Care Units--including Intensive Care, Cardiac Care, and Telemetry--will be established in writing by the Medical Staff Quality Council and recommended to the MEC for approval. Criteria for admission to Pediatric Intensive Care will be developed by the Pediatric Section and approved by MEC.

5. In-patient admissions are prioritized as follows: a) Emergency; b) Urgent--within 24 hours; c) Regular--Scheduled, Routine and Elective.
6. Out-patient admissions are prioritized as follows: a) Same Day Surgery; b) Ambulatory Care; c) Testing & Diagnostic.
7. A patient to be admitted to an intensive level of care will be seen by an appropriate physician, which may include the Emergency Room physician, within two hours of notification of patient arrival. If the admitting physician delegates the patient to another physician, the admitting physician must personally discuss the delegation with the accepting physician and obtain consent to delegate the responsibility.
8. Special Care Patients: a) Suicidal patients--known or suspected--will be medically and surgically stabilized as necessary. Once stabilized they will be transferred to an appropriate facility with psychiatric services; b) Agitated/belligerent/incarcerated patients--will be controlled with the assistance of Hospital Security/local police or other appropriate County/State/Federal security forces, while appropriate medical care is provided.
9. Diversion Protocol: MMH is not able to provide all types of medical care at all times to all patients. MMH and its medical staff will establish and follow diversion protocols, approved by the Medical Executive Committee (MEC) and Board of Trustees (BOT), to handle situations when certain medical specialty areas cannot be covered by the medical staff, when certain services are not within the resource capabilities of MMH, and when certain patients have limited care eligibility. These protocols will be in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA) and other appropriate state and federal statutes and regulations.

## **CARE OF PATIENTS**

### **Orders**

1. Orders entered in the patient Medical Record are accepted from medical staff members and approved AHP only.
2. All orders for treatment shall be in writing and dated. Orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
3. A verbal order may be substituted for a written order only if dictated by the responsible medical staff member or AHP to an authorized employee. All medical staff members and AHP must identify themselves and their credentials when talking over the telephone to MMH employees. Employees authorized to take verbal orders are specifically the following: a registered nurse, licensed vocational nurse, registered dietitian, occupational therapist, physical therapist, speech therapist, radiology technician, registered respiratory therapist, certified respiratory technician, pharmacist, clinical laboratory technician or clinical laboratory scientist for services related to their particular field. Such verbal orders must be transcribed and signed by the authorized person receiving the order from the attending medical staff member or AHP. A verbal order must be authenticated by the medical staff member, or by a practitioner responsible for the care of the patient, within 48 hours before the record is filed permanently.
3. All previous orders are canceled when a patient is transferred to a surgery or other specialty service different from the service in which the patient is currently located. This rule does not apply to brief invasive procedures--performed in endoscopy, radiology, surgery and elsewhere, for placement of lines, devices and airways, and short, limited biopsy procedures--from which the patient immediately returns to the same service occupied pre-procedure.



4. All forms to be utilized by the medical staff, that are part of the permanent medical record, shall first be approved by the Medical Staff Quality Council prior to their implementation. All pre-printed orders shall be signed by the medical staff member with each use.
5. Orders may be written, printed, or photocopied, and sent in with a patient, provided such orders have been signed by the medical staff member only on MMH-approved forms.

### **Medications**

1. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations.
2. No investigational drugs, devices or other agents may be used for patient care in MMH without prior approval by the IRB. Drugs for bona fide clinical investigations shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.
3. All drug orders for analgesics (Schedule 2, 3, 4 and 5) that are administered orally or parenterally shall be automatically discontinued after 7 days, unless reordered.

*Revised 1/31/07*

4. Other open-ended orders shall be automatically discontinued in the following manner, subject to the previous paragraph's conditions:

antibiotics	7 days
sedatives-hypnotics	7 days
anticoagulants	7 days
barbiturates	7 days*
Ketorolac IM (Toradol)	3 days

\* If a barbiturate is intended for anticonvulsant use, and is so stated to be in the written order, then the medication would have a 30-day automatic stop order. (See 6 below.)

5. All other drug orders shall be discontinued after 30 days.
6. Discontinuation of antibiotics, anticonvulsants, or anticoagulants shall not occur until the ordering physician, or in his absence the responsible covering medical staff member or Section Chief, is notified.
7. As far as possible, the use of proprietary remedies shall be avoided. When such are ordered for private patients by the attending practitioner, they will be secured and a special charge made to the patient. Medications brought to MMH by patients, or others accompanying them, will be given to the patient's MMH nurse and identified by the medical staff Member or MMH pharmacist. Identified medications will be administered from the MMH pharmacy on the order of the medical staff member as to dosage, method and frequency of administration. Unidentified, foreign or unapproved medications will not be administered. Medicines received by inpatients shall be ordered from the hospital Pharmacy.

### **Clinical Responsibilities**

1. Patients receiving ordered medical services will have documentation of their medical conditions appropriate to the level of service contemplated, in accordance with the relevant Medical Staff policy entitled: History and Physical Examinations for Patients Receiving Medical Services at Midland Memorial Hospital". *Revised 5/31/08*

2. If an Independent Allied Health Professional (AHP) (e.g. physician assistant, nurse practitioner, etc) is granted privileges to perform part or all of the H & P, the findings and conclusions are countersigned within 24 hours by a qualified physician. *Revised 12/17/08*
3. When a patient is readmitted within 30 days for the same or a related problem, the earlier H&P may be used, provided the original information is readily available, via the medical record of that earlier admission. An interval history and physical examination reflecting any subsequent changes then may be used in the medical record of the current admission.
4. The medical record shall document a current, thorough physical examination prior to the performance of surgery or other invasive procedure.
  - a) When the H&P are not recorded before a surgical or other invasive or potentially hazardous procedure, the patient shall remain at his/her present location and the procedure shall be postponed until such time as the H&P is documented in the medical record. *Revised 1/31/07*
  - b) When the medical staff member states that the procedure is such an emergency that there is no time to record the required information, the procedure may continue. In such instances, the member must dictate full H&P and operative reports, with documentation of the emergent nature of the case, immediately post procedure. The immediate post-operative note should include, in writing, relevant information substantiating the preoperative diagnosis and the patient's ability to undergo the procedure.

#### **Clinical Responsibilities** (continued)

5. A medical staff member's note will suffice for an admitting history and physical, provided it contains all the components of a complete H&P. All invasive procedures require a pre-operative history and physical except as specifically authorized by the MEC. The medical staff member scheduled to perform an invasive procedure must document relevant information about the planned procedure.
6. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending medical staff member's office record. An interval admission note must be written to document either 1) that there has been no subsequent change or 2) such changes as have occurred since the office H&P until the time of admission.
7. All clinical entries in the patient's medical record, including dictation and transcription, shall be accurately dated and signed.
8. In all operative and invasive procedure cases, prior to the start of the procedure, a time-out will be called. At that time the surgeon or other medical staff member or AHP procedure list, if involved, and assistant will verbally confirm and document in writing in the patient's medical record the surgical site marking by surgeon or patient.
  - a) Correct patient;
  - b) Correct procedure;
  - c) Correct side/site/approach, as applicable
9. All invasive procedures involving laterality, except in emergencies, require confirmation of the correct site prior to transporting the patient into the Operating Room (OR) or other procedure room and prior to site draping. The surgeon or other medical staff member or AHP procedural list will confirm the correct site according to MMH protocol. Whenever possible, protocol will also involve the patient in this site confirmation process.
10. For cases involving identification of levels/sides of the spine, an instrument will be placed at the proposed surgical site, and an X-ray taken. The X-ray will be read perioperatively by the medical staff surgeon involved.

11. Dictations required for operative and other invasive procedures should be accomplished immediately following the procedure. All invasive procedures require immediate written documentation to include the following:

- a) Date and time of procedure
- b) Pre- and Post-procedure diagnoses;
- c) Name and type of procedure;
- d) Names of those involved, including surgeon or other medical staff member or AHP procedural list, assistant(s), and anesthesia provider (if involved);

A description of the significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedure include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues)

- e) Type of anesthesia;
- f) Anesthesia administered by;
- g) Estimated blood loss;
- h) A description of techniques, findings, and tissues (specimens) removed or altered
- ï) Prosthetic devices, tissues, transplants or devices implanted (including blood components transfused)
- j) Patient conditions and complications, if any.

12. All specimens removed during operative and other invasive procedures will be sent to pathology for examination, with exceptions to this formulated in a list agreed upon by involved Sections and approved by MEC.

13. At the time services are rendered, progress notes shall be legibly recorded with date, time, discipline and signatures in a manner that gives a chronological report of the patient's condition in the hospital, a reflection of any change in the patient's condition and results of tests and treatment, and a continuous update and modification of the treatment plan stating the reasons for continuous hospitalizations.

Revised

1/24/2010

Daily visitations by physicians and/or Advance Practice Nurse (APN) or Physician Assistant (PA) will be documented in progress notes. A progress note shall be written each time the treating physician or licensed independent practitioner visits the patient.

The attending physician is required to see all inpatients within the first 24 hours of admission and as necessary throughout the remainder of the hospital stay. The visit(s) will be documented in a progress note.

Any patient in critical care must have a daily physician visit and this will be documented in a progress note.

Physicians who admit patients for uncomplicated obstetrical management by a Certified Nurse Midwife (CNM) pursuant to a physician-driven protocol shall not be required to visit these patients unless so requested by the CNM.

## **CONSULTATION SERVICES**

1. A consultation will show evidence of a review of the patient's medical record by the consultant medical staff member, pertinent findings on examination of the patient by the consultant, the consultant's diagnostic opinions

and recommendations. A written and/or dictated report will be provided at the time of consultation, documenting these findings, and will be incorporated into the patient's medical record.

2. The patient's attending medical staff member is responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another medical staff member to attend or examine his patient, except in an emergency. The attending medical staff member shall personally call the consultant and discuss the case with him.
3. A consultation requested by a medical staff member or attending physician must be done personally by a medical staff member. AHPs may participate in the care of the patient, but the patient must be seen by the AHP's sponsoring physician.

*Revised 6/27/07*

4. If the attending practitioner is unable to obtain an appropriate consultation, the medical staff member on call for the Emergency Room who is able to provide that consultation shall be obligated to do so if the attending practitioner:
  - a) has assessed the patient first and determined the need for the consult personally;
  - b) has declared the need for the consult to be an emergency; and
  - c) has contacted the consultant personally.
5. In circumstances of grave urgency, or where consultation is required by the rules of the hospital, the Administrator of the hospital shall at all times have the right to call in a consultant or consultants, after obtaining approval from the Chief of Staff or, in his absence, the Chief-elect of the medical staff.
6. The medical staff has a duty through its Department Chairmen and Section Chiefs, appropriate committee chairmen, and the Medical Executive Committee to make certain that members of the medical staff do not fail in the matter of calling and responding to consultations as needed.

1. **TRANSFERRING PATIENT CARE RESPONSIBILITIES** Revised 5/28/14A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital. Whenever these responsibilities are transferred to another staff member, an order covering the transfer of responsibility shall be entered in the medical record, as well as a medical staff to medical staff member personal contact made first.
2. In-house patient transfers will be prioritized by current administrative guidelines.

### **DISCHARGE OF PATIENTS**

1. The attending medical staff member shall participate in discharge planning for his patient.
2. Patients shall be discharged only on a written order by the attending medical staff member, or his/her designee.  
Revised 5/28/14
3. Should a patient leave the hospital against the medical advice of the attending medical staff member, or without proper discharge, a notation of the incident shall be made in the patient's medical record on the form entitled "Release of Responsibility for Leaving Against Medical Advice".
4. A medical staff member may not, unless a patient signs a Release of Responsibility, release the patient from the hospital for the purpose of receiving professional care, consultation, or treatment in a practitioner's office or another health care facility, or for a leave of absence for any reason.
5. The attending medical staff member or his designee shall write or dictate a complete clinical discharge summary.

6. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants, and patients cared for using the short medical record form. For these exceptions, a final summation progress note shall be sufficient.
7. A discharge summary shall include: a) final diagnosis; b) additional diagnoses; c) summary of hospital course; d) list of all invasive procedures and major diagnostic studies; e) summary of transfusions and/or tissue transplants; f) condition at discharge; g) discharge instructions--to include list of all medications, nutritional status, home care, if needed, and follow up appointments.
8. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.
9. In the event of a patient death, the attending medical staff member or his designee shall pronounce the deceased within a reasonable time. The body may not be released from the unit until an entry has been made and signed in the patient's medical record by the attending medical staff member or his designee.
10. The attending medical staff member or his designee also shall dictate a death summary which includes at least the clinical course and pertinent laboratory and radiologic findings. A sufficiently comprehensive death summary may substitute for a discharge summary.
11. Policies shall conform to local law with respect to release of the dead.
12. All medical staff members should attempt to secure autopsies when appropriate. Physicians, when considering autopsy, should document the discussion with the family and the outcome in the Progress Notes. **See Midland Memorial Hospital Autopsy Criteria Policy.**

(Revised 10/26/2011)

### **EMERGENCY CARE SERVICES**

1. Medical staff members admitting emergency cases shall be prepared to justify to the Utilization Management Committee of the medical staff and Administration of the hospital that the said emergency admission was a bona fide emergency. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.
  1. The emergency physicians of the Emergency Department shall be only those practitioners who possess specific clinical privileges for emergency medicine.
  2. The Medical Director of the Emergency Department shall have the responsibility of providing 24-hour immediate physician coverage of the Emergency Department and of assuring that the physician on duty is in the hospital building at all times.
  3. When the patient arrives in the Emergency Department, the patient will receive treatment from the ER physician or their private physician. If the patient requires clinical skills or privileges beyond those of the emergency physician, the patient's private physician or the "on-call" physician for the appropriate specialty shall be called.
  4. There may be times when no listed or unlisted consultant is available for coverage. In those instances, the Emergency Department will arrange for transfer of those patients needing such services to a facility where the services are available, in accordance with EMTALA regulations, and established diversion protocols.5. In the event that an on-call physician should not be available, the following should be called in the respective order:
    - a) Any physician in the applicable specialty if an emergent situation so requires;
    - b) Medical Director of the Emergency Department;
    - c) Chief of the applicable Section;

- d) Chief-elect of the Medical Staff; or
- e) Chief of the Medical Staff.

**CALL RESPONSIBILITIES** Revised 8/29/2015

**1. EMERGENCY DEPARTMENT AND SERVICE CASES**

a. **PARTICIPATION:** All members of the Medical Staff, except those excused by their staff category as defined in the Medical Staff Bylaws or excused by the Medical Executive Committee shall be required to participate in the Emergency Department On Call Coverage Schedule. Revised 8/29/2015

b. **CALL COVERAGE:** Each service taking call shall make every effort to provide coverage twenty-four (24) hours a day throughout the year. For each specialty, each individual taking call will be expected to share call equally. Revised 8/29/ Emergency call will take place 24 hours a day, seven days a week.

c. **ON CALL SCHEDULE OF COVERAGE:** Each on-call service will create and provide to the Medical Staff Office (MSO) a call coverage schedule during the last week of the month preceding the scheduled month; the Medical Staff Office (MSO) will formulate and provide at monthly intervals the Emergency Department On Call Schedule of Coverage. Revised 8/29/2015 “On-call” coverage shall be provided to the Emergency Department from the Active, Consulting and Provisional staffs in the following specialties and subspecialties:

Anesthesiology	Nephrology	Pathology
Cardiology	Neurology	Pediatrics
Cardiovascular Surgery	Neurosurgery	Pulmonology
Gastroenterology	Obstetrics	Radiology
General Surgery	Ophthalmology	Urology
Gynecology	Orthopedics	
Internal Medicine	Otolaryngology, Head and Neck	

Each Clinical Section shall be responsible for providing to the Medical Staff Office an accurate and current list of the on-call coverage. Medical staff members requesting modification for the on-call schedule for personal reasons must notify the Medical Staff Office (MSO) in advance of the change and provide the alternative coverage for their assignment. Revised 8/29/2015 Medical staff members are responsible for fulfilling their Emergency Department on-call responsibilities unless such notification has occurred, and they have been excused in advance. Changes to the call schedule are to be made through the Medical Staff Office. Both medical staff members involved in any changes must provide written documentation of the change to the MSO or designee. Revised 8/29/2015

The current and updated listing of coverage for the ED is available on the hospital web link. Revised 5/28/14; 8/29/15

d. **DURATION OF ON CALL COVERAGE SCHEDULE:** When a medical staff member is scheduled for a particular day/date for the Emergency Department On Call Coverage Schedule, he is on call from 7:00 a.m. the day of call until 7:00 a.m. the following morning. Revised 8/29/2015

## **2. EMERGENCY DEPARTMENT ON CALL COVERAGE RESPONSIBILITIES**

a. **PRIVATE PATIENTS:** Medical staff members shall not refer their private patients to the Emergency Department for coverage by the assigned member when they are not available for practice, unless it is for referral or consultation to a member at such member's request. Revised 8/29/2015

b. **AVAILABILITY:** A medical staff member on Emergency Department call should be readily available via telephone or in person. Response time for the on call member is thirty (30) minutes from initial contact. If, in the opinion of the Emergency Department physician, immediate direct patient consult is needed, the consulting physician will provided said consult within thirty (30) minutes after contact. Revised 8/29/2015 Failure of the "on call" physician to respond as requested may subject the physician to disciplinary action. Revised 8/29/2015

### **c. SUBSTITUTIONS FOR E.R. COVERAGE:**

1. The member assigned to provide the call-coverage is responsible for responding to all calls. If unavailable due to involvement with a case requiring immediate attention, the medical staff member will communicate to the requesting provider a best estimate of the response time. The decision then can be to await the on-call provider or to find alternative consultation depending upon the immediacy of the need. If elective surgeries or other professional obligation may be expected to interfere with con-call response time, every effort will be made to arrange alternative back-up coverage. Revised 8/29/2015

2. Any Medical staff member covering for another medical staff member is required to provide the care and medical record documentation appropriate to that provided by the absent medical staff member, including H&P, consultation, orders, progress notes, and discharge or death note. If the covering medical staff member has provided the bulk of the care rendered to the patient while covering for an attending medical staff member, the covering medical staff member shall be responsible for the complete discharge summary.

d. **CURRENT CONTACT INFORMATION:** Revised 8/29/2015 Medical staff members must keep the medical staff office apprised of current contact information, including at a minimum correct office and home telephone numbers, and pager or cell phone number(s). Unless a medical staff member has checked out to a covering medical staff member, the medical staff member must be available at all times as defined in General Conduct of Care. Medical staff members must--except as indicated in 1b should be available to MMH outside of office hours. The medical staff office will disseminate medical staff contact information to appropriate MMH personnel.

## **3. COVERAGE CHANGES**

a. **CHANGE NOTIFICATION:** Notification of change must be made in writing or in an email to the Medical Staff Office of the Hospital; the MSO will in turn notify all other services including but not limited to the Emergency Department and the Hospital Communication Service. Revised 8/29/2015

b. **WRITTEN NOTIFICATION:** Such written notification must be received by the MSO at least twenty-four (24) hours prior to the effective date of call-coverage change with the exception of emergency circumstances. In emergency cases, notification will be made as soon as reasonably possible. Revised 8/29/2015

c. **MAINTAIN RESPONSIBILITY:** As stated in the Medical Staff Bylaws, the member shall maintain responsibility for Emergency Department Call as assigned and may not request Call to be covered by a physician on suspension. Revised 8/29/2015

d. **MEDICAL RECORD DELIQUENCY:** If a physician suspended for medical records delinquency is on E.R. Call, emergency admissions through the Emergency Department shall be permitted ~~but~~ and shall be subsequently reviewed. Revised 8/29/2015

#### **4. EMERGENCY DEPARTMENT ADMISSIONS AND CONSULTATIONS**

a. **EMERGENCY DEPARTMENT ADMISSIONS:** The Emergency Department patient who, in the opinion of the Emergency Department physician, needs to be admitted will be assigned to the On Call Medical Staff member who is covering that area of service that day. If the On Call Medical Staff Member questions the necessity for the patient's admission, the member is required to personally evaluate and examine that patient within the parameters of the established appropriate response time. The on-call medical staff member will assist in managing the conditions within his or her area of specialty including as required admission, transfer or discharge with appropriate plan of care. Revised 8/29/2015

b. **ASSIST WITH TRANSFER OF PATIENT:** In circumstance where transfer is recommended the on-call physician recommending transfer will assist in arranging transfer, including the EMTLA mandated physician to physician communication with the accepting physician. Revised 8/29/2015

#### **5. CONSULTATIONS**

a. **REQUEST OF CONSULT:** The on-call medical staff member at the time a consult is requested or the order is placed shall be obligated to accept emergency and non-emergency consultations including those requested for inpatients. Emergency consultations will be communicated telephonically or in person from the requesting physician to the on-call medical staff member. Revised 8/29/2015

b. **TIMING OF CONSULTS:** Emergent consults will take place within thirty (30) minutes unless agreed otherwise between the requesting physician and the on-call medical staff member. In any case of disagreement on the timing of the consultation the decision will be the physician requesting the consult unless the on-call medical staff sees the patient as emergent consult and decides on appropriate follow up. Revised 8/29/2015

c. **CONSULTANT NOT ON-CALL:** A medical staff member who is not "on call" as a consultant but is notified of the presence of one of his/her patients in the Emergency Department must either:

- a) provide initial evaluation of the patient within a reasonable length of time and arrange for any necessary consultation; or
- b) relinquish evaluation and management of the patient to the care of the emergency physician.

#### **6. COMMUNITY PRACTICE**

Medical Staff with community practice will be responsible for their own patients or responsible for ~~assuring~~ arranging on-call coverage for their patients. When a prior written agreement between the Hospitalist Service or Pediatric Hospitalist Service has been established, Medical Staff may transfer On-Call responsibility for their patient's to the appropriate Hospitalist Service. Revised 8/29/2015

7. **ALLIED HEALTH PROFESSIONALS (AHP)** working with On-Call Medical Staff Members: appropriately credentialed and privileged Physician Assistants or Nurse Practitioners, sponsored by an on-call medical staff member may serve as first call for the on-call medical staff member.

a. **FIRST CALL:** The physician requesting the consult must agree to the AHP taking first call. Otherwise the on-call medical staff member remains obligated for first call. Revised 8/29/2015

b. **EMERGENT CONSULTS:** The on-call medical staff member will see all emergent consults as early as possible but within ~~six~~ twenty-four (24) hours. Revised 8/29/2015

8. **EXEMPTION FROM CALL:** When an Active staff member has reached the age of 60 years, and has participated in five (5) consecutive years of ED on-call coverage immediately prior to reaching the age of 60 years, he/she may opt to be removed from emergency on-call coverage.

Revised 5/28/14



## **MEDICAL RECORDS**

1. A medical record will be initiated and maintained for every individual assessed or treated at MMH. A medical record will incorporate information from each and every episode of care contact between MMH and the patient.
2. The attending medical staff member shall be responsible for the preparation of a complete and legible medical record for each patient documenting an episode of provision of care. Its content shall be pertinent and current. This record shall include identification data; medical and physical examination appropriate for the medical services provided as outlined in the policy titled History and Physical Examination for Patients Receiving Medical Services at Midland Memorial Hospital special reports such as consultations, clinical laboratory and radiology services and others; provisional diagnoses; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnoses; condition at discharge; discharge summary; and autopsy report when performed.  
*Revised 5/31/08*
3. All clinical entries in the patient's medical record, including dictation and transcription, shall be accurately dated and signed. Electronic initial/signature methods may substitute for written methods where approved by the MEC. Written entries must be made in ink. The use of rubber stamp signatures will always remain consistent with CMS regulations. *Revised 5/28/14*
3. Dictations required for operative and other invasive procedures should be accomplished immediately following the procedure. All invasive procedures require immediate written documentation, as described in Clinical Responsibilities
4. Progress Notes will be written daily on all patients. Progress notes in the Rehab Unit will be timed in accordance with pertinent state and federal statutes and clinical need.
5. Symbols and abbreviations may be used only when they have been approved by the medical staff.
6. Cancer staging forms are required to be completed according to procedures adopted by the Cancer Committee.
7. A discharge clinical summary shall be recorded as outlined in Discharge of Patients and On Call Coverage.
8. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
9. Medical records may be removed from the hospital's jurisdiction and safe-keeping only in accordance with a court order, subpoena or statute.
10. In case of readmission of a patient, previous records shall be available for the use of the attending medical staff member. This shall apply whether the patient is attended by the same medical staff member or by another.
11. IRB approval is required for, and prior to, any study and research project.
12. Medical staff members shall respect HIPAA regulations regarding privileged patient information, and shall not access patient records without clear need for providing care to that patient, or for approved quality improvement purposes.
13. A medical record shall not be filed permanently until it is completed by the responsible member(s) or is ordered filed by the Chairman of the Medical Staff Quality Council.
14. The patient's medical record shall be completed at the time of discharge, including progress notes, dictated operative report, final diagnoses, handwritten or dictated clinical summary, and signatures where appropriate. The attending medical staff member shall be responsible for this discharge clinical summary with the exceptions noted above.

15. When lack of final laboratory or other essential reports at the time of discharge makes completion of the clinical discharge summary impossible, the medical record will be available in the Medical Records Department.

### **DELINQUENT MEDICAL RECORDS**

\*Also refer to the policy: Suspension of Admitting and Clinical Privileges

1. Any medical record lacking an admitting History and Physical within 24 hours of admission and/or a dictated Operative Report, within 24 hours of a procedure will be noted as delinquent. Also any medical record lacking an immediate post-operative note, prior to a patient being moved from the recovery room to another part of the hospital after a procedure will be noted as delinquent. No grace days will apply for these delinquencies. If the record remains incomplete on the tenth (10) day post discharge the practitioner will be sent a suspension notification from Chief of Staff (COS) and/or Medical Staff Quality Council (MSQC) chair.

Revised 5/28/14

2. Physicians will be notified of incomplete records starting at five (5) days post discharge. If the record remains incomplete on the tenth (10) day post discharge the practitioner will be sent a suspension notification from COS/MSQC chair. A copy of the letter will be maintained in the medical records for the practitioner's current appointment cycle.

Revised 5/28/14

3. If records remain incomplete at twenty (20) days, the practitioner will be requested to appear before peers at the Medical Staff Quality Council (MSQC) meeting. The practitioner will be provided an opportunity to show good cause for the failure to complete the records and may be provided a period not to exceed 7 days to complete the records. If records remain incomplete at this point, MSQC may make further recommendations to the Medical Executive Committee. *Revised 7/29/09*
4. If three requests to appear before the MSQC are received within a rolling twelve month period, there will be an automatic one week suspension of clinical privileges.
5. When a practitioner has their clinical privileges suspended, the following applies:
  - a. Practitioner will not be allowed to admit patients to the Main Campus, they may not schedule any procedures (block time will be forfeited during suspension).
  - b. Practitioners may proceed with any prior scheduled procedures. (5A of policy)
  - c. Practitioners may continue to care for patients currently hospitalized.
  - d. Permission must be obtained from the Chief of Staff or Chief of Staff-elect for any emergency admission or procedure.

6. Delinquent or deficient medical records may be waived for absences from the community or sickness provided a request for waiver is made prior to or during the absence and the practitioner was not suspended for record deficiency at the time the waiver was requested. Practitioner must notify Medical Staff Services and/or Medical records of absences from deferment of records. *Revised 5/28/14 Revised 7/29/09*

### **CONFIDENTIALITY OF CREDENTIALS AND PEER REVIEW**

#### 1. Credentials Files

- a. Credentials files are maintained for all medical staff members and AHP on staff, and include the following:
  - original membership application
  - reappointment applications
  - original source verifications
  - letters of reference
  - secondary verifications
  - documentation of liability insurance and claims history
  - correspondence

- National Practitioner Data Bank reports
- b. Files are maintained by the Medical Staff Services Office, and locked when not in use.
  - c. Access is granted to a Medical Staff member to his/her own file during regular business hours, in the presence of an assigned Medical Staff Office employee.
  - d. Access is granted to the Chief Executive Officer, Chief of Staff, Department/Section Chair, Credentials Committee members, MEC, and agents of the BOT, on an as needed basis, and to others as required by law or government regulation.
2. Peer Review Files
- a. Peer review files are maintained on all medical staff members and AHP on staff and include the following:
    - Reappointment profiles, including practitioner specific activity information.
    - Case review reports
    - Incident reports
    - Special or intensified review reports
    - Reports of external peer review
    - Peer review related correspondence
    - Memoranda of informal counseling
  - b. Access is in accordance with Credentials File access (1.c and 1.d).
  - c. Information reporting
    - Any person may provide information to the Medical Staff Office.

### **RESIDENTS AND OTHERS IN TRAINING**

1. If a resident or fellow admits a patient to an intensive level of care, the attending physician must see the patient within two hours.

*Approved 10/04*