

APPLETON  MEDICAL
CENTER

THE DA  CLARK
MEDICAL CENTER

MEDICAL STAFF RULES

&

REGULATIONS

Rev. 10/03; 06/11

Medical Staff Rules and Regulations

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Section I. Admissions

- A. A patient may be admitted to Appleton Medical Center or Theda Clark Medical Center by a physician, podiatrist or dentist appointee of the medical staff, provided that a patient admitted by a dentist or podiatrist appointee shall have a medical history and physical examination by the patient's attending physicians. All practitioners shall be governed by the official admitting policy of the hospital.
- B. Each patient shall be the responsibility of a physician appointee to the medical staff. Such practitioner shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
- C. All persons who present to the Emergency Department for treatment will receive a medical screening examination. Identified individuals who may perform medical screening examinations of persons presenting for treatment to the Emergency Department are:
 - 1) Emergency Department Registered Nurses who have at least one year of Emergency Department service.
 - 2) All physicians who are on the medical staff of the hospital.
- D. All orders for treatment shall be in writing. (For the purposes of all references to "written" documentation requirements in the medical record, handwritten, dictated and typed, or electronically transmitted orders and/or reports are all acceptable methods of documenting in the record.) Orders dictated over the telephone shall be signed, dated and timed by the person to whom dictated with the name of the physician or dentist per his/her own name. Verbal and telephone orders shall be authenticated by the prescribing medical staff members in accordance with record completion policies. Another member of the medical staff involved in that patient's care and treatment may sign the verbal or telephone order; however, it is with the expressed understanding that the physician signing the document shall take full legal and professional responsibility for the treatments and medications prescribed in the orders.
- E. Standing orders shall be formulated by the appropriate clinical department and approved by the medical staff. These orders shall be followed insofar as proper treatment of the patient will allow and when specific orders are not written by the attending physician, dentist, or podiatrist, they shall constitute the orders for treatment.

Section 2. *Records*

- A. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examinations, special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, clinical resume, and autopsy report, when performed.
- B. When the history and physical examination are not recorded before an operation, the procedure shall be canceled, unless the attending practitioner states in writing, that such delay would be detrimental to the patient.
- C. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written daily on all patients.
- D. Operative reports must contain a description of the findings, the technical procedures used, the specimens removed, the estimated blood loss, the preoperative and postoperative diagnosis, and the name of the primary surgeon and any assistants. Also, a brief handwritten notice shall be made in progress notes of the chart immediately post-operatively.
- E. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. Except in emergency, so verified on the record, when operative procedures are involved, the consultation note shall be recorded prior to operation.
- F. The current obstetrical record shall include a complete prenatal record, which may be a copy of the standard form previously adopted by the obstetrical department. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
- G. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.
- H. The final diagnosis shall be determined by the attending physician, dentist, or podiatrist. This will be of equal importance to the actual discharge order. The determination of the final diagnosis and procedures must be completed within 28 days of discharge. A coding summary is required on inpatient records.

The discharge summary concisely summarizes the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the final diagnosis, the condition of the patient on discharge, and any specific instructions given to the patient and or family, as pertinent. Instructions include those relating to physical activity, medication, diet, and follow-up care. A final progress note may serve as the discharge summary in the case of patients with problems of a minor nature that 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 must include the outcome of the hospitalization, the final diagnosis, the case disposition, any instructions given to the patient and/or family, including any provisions for follow up care.

- J. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- K. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the chief operating officer or his/her designee. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be recommended by the executive committee of the medical staff.
- L. The patient's medical record shall be completed as soon as reasonably possibly after discharge. To this end, each physician, dentist, and/or podiatrist involved in the care of the patient shall dictate and sign all necessary information, consultation, notes, discharge summary, etc., as appropriate, no longer than 28 days following the patient's discharge.
- M. The practitioner's 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.
- N. All previous orders are canceled when patients go to surgery.
- O. All drugs and medications administered to the 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. Drugs for bona fide clinical investigations may be exceptions. These 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 Food and Drug Administration.
- P. The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rests with the practitioner responsible for the care of the patient.

- Q. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.
- R. Every attending physician, dentist, and/or podiatrist shall attempt to secure an autopsy in all cases of unusual death, medico-legal concern, or of special educational interest.
- S. Except in emergency, the attending physician, dentist, and/or podiatrist shall obtain consultation of a second physician in cases in which criminal activity is suspected.
- T. When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record, as well as, the complete protocol.
- U. Documentation in the medical record shall be done on a timely basis. Dictation of a history and physical examination report (H&P) shall be done within 24 hours after admission. H&Ps may be completed within 30 days, prior to admission; however an updated examination of the patient, including any changes in the patient's condition must be completed and documented in the medical record within 24 hours after registration, but prior to surgery or procedure (Policy 561). Consultations shall be dictated within 24 hours of the consult. Emergency reports shall be dictated within 24 hours of the visit. Operative reports and reports of other invasive procedures (i.e., cardiac catheterization, endoscopy, angiography, etc.) shall be dictated immediately after the procedure, but no later than 24 hours following the procedure. Pathology reports shall be dictated within 48 hours of completion of the procedure. Radiology reports (diagnostic, nuclear medicine, ultrasound, CT, MRI, etc.) and reports of other noninvasive diagnostic services (EEG, EMG, pulmonary function, echocardiograms, etc.) shall be dictated within 24 hours of completion of the procedure. Progress notes are to be written at the time of the observation and at least daily. When an autopsy has been performed, the provisional anatomic diagnosis shall be dictated within three days, and the complete protocol within 45 days of death. The entire medical record is to be completed within 28 days of discharge.
- V. Paper Medical Records shall be kept on-site in their entirety for a minimum of two years.
- After two years records may be thinned and sent to off-site storage.
- Records in long-term storage shall be made available upon request. Records will be retained per ThedaCare Policy 537-Retention and Preservation of Patient Care Records.
- W. Radiology and all other imaging films shall be retained for seven years since the most recent film with the exception of mammograms which will be kept permanently and films on minors which will be kept until patient reaches age 18 plus three years. Films of patients who have expired will be kept for five years past death. At the end of the retention period, films will be recycled for silver through a company selected by the Department of Radiology.

Section 3. Disaster Planning

- A. There shall be a plan for the care of mass casualties at the time of any major disaster based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It will be developed by appropriate departments and committees of the medical staff. The resultant plan shall be approved by the medical staff and governing body.
- B. The disaster plan should make provision within the hospital for:
- (1) Availability of adequate basic utilities and supplies, including gas, water, food, and essential medical and supportive materials.
 - (2) An efficient system of notifying and assigning personnel.
 - (3) Unified medical command under the direction of a designated physician.
 - (4) Conversion of all useable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
 - (5) Prompt transfer, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.
 - (6) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he/she is moved.
 - (7) Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy.
 - (8) Maintaining security in order to keep relatives and curious persons out of the triage area.
 - (9) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.
- C. All medical staff appointees shall be assigned to posts, (either in the hospital or in the auxiliary hospital, or in mobile casualty stations) and it is their responsibility to report to their assigned stations. The chief of the clinical services in the hospital and the chief operating officer of the hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another, or evacuation from hospital premises, the chief of the clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the departmental chair and the chief operating officer of the hospital and in their absence, the vice chair and alternate in administration are

next in line of authority respectively.

- D. The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing, and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a written report and evaluation of all drills.

Section 4. Departments

- A. Since the hospital is organized as a departmentalized hospital, each department may have its own rules and regulations. When rules and regulations have been adopted by a department, they shall be considered a part of this document and incorporated into it when approved by the executive committee of the medical staff.
- B. No regulations, rules or orders, which in any way limit or conflict with anything in the hospital or medical staff bylaws, or which are in conflict with any known law or regulations may be approved.
- C. Each department shall keep a written record of its rules and regulations. These rules and regulations shall be reviewed yearly by the department.
- D. General practitioners and family practitioners shall be assigned to the Department of Family Practice.

Section 5. Independent Health Affiliates

Independent health affiliates shall be under the continual surveillance and supervision of the medical staff. Rules and regulations shall be adopted as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws. They shall be developed by the executive committee subject to two-thirds vote of all physicians appointed to the active medical staff. These rules and regulations may be amended at any regular medical staff meeting subject to approval by a two-thirds vote of the active physician appointees present, providing that there is a quorum of physician appointees of the active medical staff.

- (1) Patients admitted for services to be performed by an independent health affiliate shall be admitted by an associate or active physician appointee to the medical staff according to the rules promoted in these bylaws. Services by an independent health affiliate shall be performed contingent upon the approval and under the supervision of the admitting or attending physician. The admitting or attending physician shall at all time bear responsibility for the patient as dictated in these bylaws.
- (2) The attending independent health affiliate shall be responsible for a complete

and appropriate examination and record of each patient, including such information as would be necessary to assure the protection of other patients from any danger from any cause. Records shall be made as to the health affiliate's specific diagnosis, treatment performed, final diagnosis, and condition on discharge. The independent health affiliate shall always be functioning as a consultant to the attending physician and his/her initial entry of paramedical information to the records shall be in the form of an identifiable consultation which shall be available promptly for placement on the medical chart with a copy available to the attending physician.

- (3) The patient's attending physician shall be advised promptly upon the completion of independent health affiliate care provided in the hospital. Patients undergoing such care shall be discharged only on the written order of the attending physician. Independent health affiliates shall not independently admit or discharge patients.

Section 6. Dependent Health Affiliates

- A. The term Dependent Health Affiliate ("DHA") shall include certified physicians' and dentists' assistants, nurse midwives, individuals who have graduated from an approved nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Education Program/Schools or its predecessor, social workers who have satisfied the credentialing requirements for licensure by the employer insurance company, payor source or community agency, or who meet Medicaid credentialing criteria if the employer is an individual physician, psychologists with less than a Ph.D. degree and/or without a clinical psychologist's license from the Wisconsin Department of Licensing and Regulations, operating room technicians (dental and surgical), and other qualified personnel who are direct employees of an appointee or appointees of the medical staff, or who are employees of the hospital.
- B. The duties of a DHA shall not exceed the DHA's training and experience, the limits imposed by any applicable statutes and federal, state, local, hospital, medical staff and departmental rules and regulations, nor the scope of practice of the supervising physician or dentist.
- C. The DHA is not an appointee to the medical staff. The DHA shall be an employee of the sponsoring or supervising physician or dentist or the hospital.
- D. The DHA shall provide permitted patient services only within the limits imposed by the medical staff, departmental and hospital rules and only under the supervision of the sponsor. The level of supervision for each category of DHA shall be defined in the appropriate departmental rules and regulations. No DHA shall redelegate a task assigned to him by the sponsor. All DHAs are to abide by all hospital, medical staff and departmental policies, rules and regulations.
- E. DHAs functioning as surgical assistants may engage in the routine aspects of

assisting in any situations which do not involve unusual hazard to life. Appropriately trained surgical assistants may be given permission to inject local anesthetics (subcutaneously or into joint spaces); close wounds (other than the peritoneum) and remove chest tubes. Any request for the use of a DHA to perform non-routine surgical assistant functions must be specifically identified on the form submitted to the executive committee. Such requests shall be considered by the executive committee on a case by case basis.

- F. An appointee of the medical staff wishing to use a DHA for any purpose in the hospital shall apply on a form and in a manner prescribed by the chief operating officer, listing specifically each activity he/she wishes the DHA to be permitted to engage in. The sponsoring physician or dentist shall biennially submit to the chief operating officer a written evaluation of the clinical performance of any DHA(S) working under him and a request for renewal of permission to use the DHA at the hospital's facilities. The evaluation and request for renewal will be reviewed by the credentials committee. After review, the credentials committee shall make its recommendations to the executive committee. The executive committee's decision shall be communicated to the requesting sponsor in writing. The executive committee's decisions shall be final, unless the executive committee itself chooses to reconsider.