



Medical Staff Rules & Regulations

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Medical Staff Rules & Regulations
Mary Washington Hospital, MediCorp Health System

SECTION A: ADMISSION AND DISCHARGE OF PATIENTS

A.1 Admitting Responsibilities

A.1. All admissions shall be by an individual privileged to admit based on assigned staff category and privileges consistent with state law and other regulatory requirements as may apply. The admission shall be by an individual whose clinical specialty is appropriate to the patient's medical needs.

A.1.a. The admission order should identify the attending physician. If not otherwise specified, the admitting physician shall be considered the attending physician.

A.1.b. The designated attending, or his coverage, is responsible for: the ongoing medical care and treatment of each patient assigned to his/her service; prompt completion and accuracy of the medical record; providing timely and clear patient care orders; communicating with the patient and family regarding the medical plan of care; transmitting medical records, if appropriate, to referring practitioner or a facility receiving a patient in transfer; and providing appropriate discharge instructions.

A.1.c. Whenever any or all of these responsibilities are transferred to another appointee, a statement recording the transfer of such responsibility shall be entered on the order sheet of the patient's medical record.

A.2 Allied Health Professionals - Allied Health Professionals may, if authorized by the Board and with appropriate support and supervision by the Allied Health Professional's employing/supervising medical staff appointee, initiate the procedure for admitting a patient (for example, a mid-wife). The supervising medical staff appointee or his coverage shall be available, appropriately supervise the Allied Health Professional and retain, at all times, the overall responsibility for the patient's care throughout the hospitalization.

A.3 Admission Diagnosis & Special Precautions

A.3.a. The first progress note, "admission note", shall provide a provisional diagnosis and critical findings from the admission exam sufficient for other practitioners to provide patient care pending availability of the documented history and physical report.

A.3.b. The admitting practitioner shall notify hospital staff of any situation which places the patient, family or persons caring for the patient in danger from any source in order that appropriate safety precautions may be taken.

A.4 Assignment of Patients - Patients who do not have a private physician shall be assigned to an appointee of the Medical Staff on duty in the department to which the illness of the patient indicates assignment. Department Chiefs, Division Chairs, or their designee(s), shall be responsible for providing an on-call schedule for unassigned patients. The Medical Staff Office is available to assist with developing call schedules conditioned upon medical leaders providing clear instructions regarding the rotation method for the call schedule. When questions arise, the Medical Office will confer with the appropriate Department Chief for clarification.

A.5 Continuity of Care and Responsibilities for Hospitalized Patients - Practitioners must provide timely and appropriate professional care for hospitalized patients by being available, or having available through his office, a qualified alternate appointee with whom prior arrangements have been made. Failure of an appointee to meet these requirements may result in correction action.

A.6 Bed Assignment For Admitted Patients - Practitioners must provide sufficient clinical information for hospital staff to make appropriate bed assignments and facilitate triage activities. Bed assignments shall be made in accordance with current patient care needs and hospital capacity.

A.6.a. Pre-operative admissions include patients already scheduled for surgery. If it is not possible to handle all such admissions the Department Chief and OR Director will coordinate a plan of action.

A.7. Transfer Priorities - Except in emergencies, no patients shall be transferred to another unit without prior consultation with and approval of the attending.

A.8 Admission/Transfer from Special Care Units - Admission, transfer to and discharge from Special Care Units shall be conducted in accordance with relevant hospital standards.

A.9 Care of Patients With Psychiatric And Substance Abuse Problems - Psychiatric consultations should be initiated for patients with known or suspected psychiatric and substance abuse problems. The nursing staff shall be completely informed of the need for suicide precautions. A psychiatric consultation shall be requested on any patient known or suspected to be suicidal.

A.10 Documentation for Justifying Continued Hospitalization - The attending and consulting staff shall document care in a manner which clearly delineates the need for admission and continued acute care. This shall include providing documentation in accordance with hospital standards and external agencies, including but not limited to, hospital licensure agency, CMS peer/quality review organization, accrediting bodies and third party payors. Discharge needs shall be anticipated and documented so that there is sufficient time for hospital staff to plan and coordinate arrangements for the appropriate continuum of care and patient or family education.

A.11 Discharge Documentation - Patients shall be discharged on order of an attending, or his designated coverage. Discharge instructions shall be documented in accordance with hospital standards. The attending or discharging physician shall be responsible for preparing discharge instructions in accordance with hospital standard. Should a patient leave the hospital against the advice of the attending, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

A.12 Management of Patient At The Time of Death - The management of the patient at the time of death shall be carried out in accordance with hospital standard. The physician is responsible for completing the required documentation in conformance to the statutes of the Commonwealth of Virginia.

A.13 Autopsies - An autopsy shall be performed only with written consent of a legally authorized individual in accordance with the statutes of the Commonwealth of Virginia or as otherwise required by law. The Medical Staff shall make an attempt to secure autopsies as outlined in the hospital Autopsy Utilization Plan.

SECTION B: CONSULTATIONS

B.1. A consultation shall be obtained when the patient requires care that is outside the attending practitioner's specialty and/or approved scope of privileges.

B.2. Staff are expected to request and provide consultation in a timely manner in accordance with the guidelines set forth in the Medical Staff's Consultation Standard (attached).

SECTION C: GENERAL CONDUCT OF PATIENT CARE

C.1 History & Physical Exams For Inpatients & Surgical Patients - A history and physical (H&P) examination must be performed by an individual privileged/authorized to perform an H&P. All H&Ps must be performed or countersigned by a medical doctor (M.D.), doctor of osteopathy (O.D), oral surgeon, dentist or podiatrist who has been granted such privileges, for all patients admitted to the hospital and patients scheduled for surgery (procedures performed in the main OR and C-Section Suite). The H&P for an admitted patient must be performed no later than 24 hours after admission. If a medical history and physical examination have been performed within 30 days before the admission (calculated from the date the H&P was originally dictated/documentated) the H&P may be used conditioned upon the patient being evaluated by an individual authorized/privileged to perform a H&P and documenting in the medical record no later than 24 hours after admission that the H&P is unchanged or noting updates and/or additions to the H&P. For patients undergoing surgery, the pre-surgery assessment performed and documented by the Anesthesiologist shall serve as the H&P update date. Staff shall comply with a requirements set forth in the Medical Staff H&P Standard.

C.1.a. Medical Assessments For Outpatient Invasive Procedures - A focused medical assessment must be performed or revalidated as current within 30 days prior to an outpatient invasive procedure performed in conjunction with procedural (moderate) sedation. The content of the medical assessment must comply with the guidelines established in the Hospital's Procedural/Moderate Sedation Standard/Policy and must be performed or validated by a practitioner privileged. authorized to perform an H&P.

C.2 Progress Notes - Progress notes shall be recorded daily by the attending practitioner or his coverage/designee at the time of observation sufficient to permit continuity of care and transferability. Progress notes should provide a chronological pertinent report of the patient's course of care. Entries must be legible and authenticated (signed) by the persons responsible for evaluating the patients. Progress notes shall be dated and timed.

C.3 Orders - Patient care orders shall be initiated by an appointee of the medical staff or an authorized allied health professional consistent with his/her approved clinical privileges or authorized scope of practice and in accordance with the practitioner's professional licensure/registration. Orders shall be signed, dated and timed.

C.3.a - Legibility - Orders and progress notes shall be written clearly, legibly and completely. Orders which are illegible or improperly written shall not be carried out until rewritten or understood. A pattern of illegible documentation may result in documentation restrictions imposed by the Medical Executive Committee.

C.3.b - FAX Orders – Signed, dated, and timed facsimile (FAX) orders may be used in accordance with organizational procedure.

C.3.c - Verbal Orders - Verbal orders may be used in accordance with the organization's Verbal Orders (Read Back) Standard. Verbal orders must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. Verbal order must be authenticated (signed) in accordance with Virginia regulations (72 hrs.)

C.3.d - Protocol Orders – Protocol Orders may be used in accordance with the organization's Protocol Implementation Standard.

C.3.e. – Other Medical Record Entries – All medical record entries must be legible, complete, dated, timed and authenticated by the author.

C.3.f. - The attending and consulting practitioner(s) shall maintain appropriate communication to ensure the appropriateness of medications and other patient care orders specific to the patient's current condition and care setting. Practitioners performing surgical, invasive, or diagnostic procedures are responsible for reviewing current orders for appropriateness. Under no circumstances shall any medication(s) be discontinued without notifying the practitioner, or his coverage, who initiated the order.

C.4 Drugs - All drugs and medications administered to patients shall conform to standards established by the Pharmacy and Pharmacy and Therapeutics Committee. The Committee shall have jurisdiction for policies and procedures concerning automatic stop orders and for control and administration of drugs brought into the hospital by the patient for the patient's use while hospitalized.

C.5 Radiology Service Requests The requesting practitioner is responsible for providing on the request form the reason(s) for the radiological examination. Authenticated reports of radiological examinations shall be placed in the patient's medical records within twenty-four (24) hours except those examinations which may require double readings.

C.6 Pathology Service Requests –Requests for pathological examination of tissue shall contains sufficient reasons(s) for the pathological examination. Authenticated reports of pathological tissue examination shall be placed in the patient's medical record within 24-72 hours, except when special studies or additional consultation is required, or because of intervention of the weekend or holiday. When a report is delayed, a provisional report may be submitted, pending the final report.

C.7. Laboratory Studies shall be performed by the Department of Pathology or by an appropriately licensed and accredited reference laboratory recommended by the Department of Pathology and approved by the Medical Staff

C.8 Removal of Tissue or Foreign Body All specimens removed during a surgical procedure will be referred to the Department of Pathology for examination and documentation unless exempted from referral by the Department of Surgery following consultation with the Pathology. Specimens without pathology will be referred for peer review to the appropriate clinical division.

C.9 Infection Control Surveillance Standards for the surveillance of hospital infections and the control thereof shall be developed and reviewed by the Infection Control Committee.

C.10 Blood Usage Policy - Transfusion and blood usage standards shall be developed by the Blood Bank Director. The Blood Bank Director, or his designee, may intervene if concurrent utilization monitors raise question with regards to clinical justification for blood If patterns of questionable utilization are identified, they shall be brought to the attention of the appropriate medical services.

C.11 Disaster Plan In the event of major disaster, external or internal, the disaster plan developed by the Hospital shall be in effect. Once initiated, Department Chiefs shall be available to assist management implement the plan and will determine most appropriate utilization of medical resources, including medical volunteers. Appointees of the Medical Staff shall cooperate in any change in direction of professional care of their patients as may be deemed necessary. In the event routine Communication methods are disrupted during a major disaster, medical staff should report to the Medical Staff Office/Lounge and await assignment.

C.12 Institutional Review Board – Drugs and medical devices for clinical investigation shall be approved and utilized consistent with standards established by the Institutional Review Board.

SECTION D: SURGICAL PROCEDURES

D.1 Authorization and Informed Consent Authorization from the patient or the appropriate individual acting on the patients behalf shall be obtained prior to operative or significant invasive procedures consistent with the hospital's standard on consent.

D.2 Anesthesia Records – Anesthesia assessments prior to surgery, during surgery and post-surgery will be performed in accordance with guidelines established by the Division of Anesthesia.

D.3 Operative Report Requirements – A detailed operative report, dictated or written, shall be performed by the practitioner performing the surgery. The report shall be completed as soon as possible after surgery, filed in the medical record and authenticated. The official operative report must identify the surgeon and surgical assistants; contain a description of surgical findings; operative technique used; any unusual surgical events or complications and actions taken in response; blood loss including transfusion and adverse transfusion reactions, if any; specimens removed; post-operative diagnosis; and any other relevant information necessary.

D.3.a A post-operative note shall be documented following surgery by the surgeon. The note shall indicate who performed the procedure; the general nature of the procedure performed; how the patient tolerated the procedure; significant findings, including excessive blood loss; and any unusual operative or immediate post-operative events and actions taken.

D.3.b. Vasectomies, salpingectomies and abortions performed in Mary Washington Hospital shall conform with the statutes of the Commonwealth of Virginia.

D.4 Policy Development The Department of Surgery, in cooperation with the Operating Room Committee, shall maintain surveillance of and develop standards/policies for the surgical suite. All practitioners shall practice in accordance with the established standards. Noncompliance may be the basis for corrective action.

SECTION E: EMERGENCY SERVICES (ED) AND UNASSIGNED ON-CALL REQUIREMENTS

E.1 Evaluation by Emergency Department Physicians

E.1.a An Emergency Department physician or their physician's assistant shall give initial emergency treatment to all patients who present to the Emergency Department unless the patient requests their physician or has made arrangements to meet a physician in the department. The Emergency Department physician, however, shall retain the obligation to evaluate and begin treatment prior to the arrival of the patient's physician if life-threatening or health-threatening situations appear present where a lapse in time could produce greater incapacity or protracted

convalescence unless immediate attention and care is given by the Emergency Department physician or his emergency consultant.

E.2 Patient Requesting Primary Physician

E.2.a. If the patient requests his primary or other specific physician, immediate contact with that doctor, or his covering, will be made, who may either elect to see the patient or refer the patient back to the E.D. physician for evaluation. If the Emergency Department is unable to establish contact with the patient's requested physician or his coverage after twenty (20) minutes of appropriate attempts, the patient will be asked if he wants to be seen by the emergency physician.

E.2.b. If there will be a delay before the patient's requested physician can come to the E.D., the patient shall be informed and given the alternative of being seen by the E.D. physician. If at any time the patient becomes unstable, the E.D. doctor will initiate care.

E.3 EMTALA Compliance

Notwithstanding any provision of these bylaws or rules & regulations, the Emergency Department shall at all times comply with applicable rules and regulations, both state and federal, including, but not limited to, EMTALA.. A medical screening examination will be performed to determine if an emergency medical condition exists by an Emergency Department physician, staff physician, or non-physician practitioner authorized to conduct a medical screening exam ("qualified medical personnel"). Non-physician categories approved to perform medical screening exams include: Emergency Department Physician Assistant (PA) working under the supervision of an ED physician or, for Obstetrical patients, specifically designated L&D RNs performing a screening exam in accordance with criteria approved by the OB Department with telephone contact with staff Obstetrician.

E.4. Guidelines for Specialty Referral

E.4. a The Medical Staff shall provide a major and specialty call roster and related guidelines in order to promote timely, orderly, and appropriate emergency medical care. The Medical Staff recognizes that once a patient has been evaluated by an emergency department physician that a patient/physician relationship has been established. The Emergency Department physician may vary from these guidelines utilizing his/her professional judgment and knowledge regarding the patient's immediate medical needs. Guidelines for follow-up referrals will be found in Section E.9.

E.4.b If medical consultation, specialized treatment, or hospital admission is warranted by the patient's condition, the Emergency Department physician shall contact the patient's physician or his coverage. If the patient does not have an established physician appropriate for the patient's current medical needs, the physician on ED call will be contacted unless the patient requests a specific physician who is willing to accept the patient and able to respond in a timely manner.

E.4.c The Emergency Department physician will make a good faith effort to make referrals consistent with the patient's insurance requirements, if known.

E.5 Emergency Department Call Assignments/Responsibilities

E.5.a The Medical Staff major and specialty call roster is provided by the Medical Staff for cases requiring consultation, specialized care or admission, and is the only call roster subject to the assignment/responsibilities set forth in Section E.4. Responsibilities of call for Emergency Department follow up patients are covered in Section E.8.

E.5.b Medical Staff appointees, except those specifically excluded by their department, shall be required to take their proportionate share of Emergency Department call consistent with the provisions of their assigned staff category.

E.5.c The designation of Medical Staff to major and/or specialty Emergency Department call shall be made by each clinical specialty. Family Practice appointees will be assigned to the Medical Emergency Department call.

E.5.d Scheduling of major and specialty Emergency Department calls shall be the responsibility of each division chair. Original schedules and on-call changes shall be provided/communicated to the Hospital in a timely manner.

E.5.e. The staff physicians on E.D. call must be available, by telephone or in person. If after twenty (20) minutes of appropriate attempts, the E.D. has failed to reach the physician designated as the physician on call for the Emergency Department, the E.D. physician may contact the department chairman or the President of the Medical Staff, who will arrange for care of the patient.

E.5.f Once consulted, the staff physician on call must respond in person to the Emergency Department within thirty (30) minutes if the E.D. physician feels the patient requires urgent care. If the patient is stable, that staff physician may request the patient be held in the E.D. until appropriate studies are obtained with permission of the E.D. physician. If the patient requires admission, that physician may direct that the patient be admitted to the hospital and provide verbal orders until his arrival, or request that the patient be evaluated and admission orders written by the House Physician. If the patient does not require admission, that physician may direct the E.D. physician to give definitive treatment.

E.5.g If there is disagreement between the Emergency Department physician and the staff physician on call regarding disposition of an Emergency Department patient, the staff physician must come to the Emergency Department, examine the patient and make disposition.

E.5.h If a physician on E.D. call is consulted about a patient with whom there is pending litigation or threats of pending litigation, or with whom he has formally severed the doctor/patient relationship with proper documentation, that physician is responsible for seeing the patient unless he/she personally arranges for alternative care.

E.6 Referral of Patient to Attending Staff

E.6.a. Upon admission, the admitting physician will assume complete overall control of the patient and is responsible for calling any additional consultants as needed if they have not already become involved in the care of the patient.

E.6.b. Consulting and/or admitting physicians who see a patient in the Emergency Department must document on the Emergency Department record their examination and recommendations or if such is dictated, a notation of "H&P dictated" must be made on the chart. Any physician who renders treatment or performs any procedure on a patient must personally document such on the E.D. record.

E.7 Admission Orders

E.7.a. Physician orders must be given (verbal or written) prior to admitting Emergency Department patients to the Hospital. STAT orders on admitted patients should be carried out on the ward unless there is excessive delay transferring the patient to the ward. STAT orders to be carried out in the Emergency Department must be written on the Emergency Department sheet. STAT

orders on patients going directly to O.R. will be carried out in the Emergency Department unless otherwise directed by the attending physician.

E.8 Transfer to Other Facilities

E.8.a When an E.D. physician sees a patient he believes should be transferred, and if there is no expression of preference for a private physician by the patient or the family, the Emergency Department physician may proceed directly with the transfer.

E.8.b Transfer of all patients from the Emergency Department will be directed by specific care needs and no patient will be arbitrarily transferred without clinical care justification.

E.8.c Injuries and conditions generally transferred after emergency treatment are severely burned patients, certain neurosurgical conditions, certain mental disorders, multiple trauma, and certain pediatric cases per departmental protocol.

E.8.d The Emergency Department is to be used for initial evaluation, treatment, and stabilization of critically ill patients and not for prolonged management of patients best care for in specialized units.

E.9 Follow Up of Emergency Department Patients

E.9.a Each patient discharged from the Emergency Department will be provided with the name of an appropriate specific private follow-up physician and/or related health/mental agency. The name of the follow-up physician will be derived from the specific on-call schedule on the day the patient comes to the Emergency Department. The patient will be instructed to contact that physician or agency for an appointment if follow-up care is required or if further problems related to the initial complaint develop. It will be the patient's responsibility to contact that physician if further care is needed or desired. Patients who have an established private physician will be referred to that physician for follow-up care, unless another sub-specialty treatment is required, in which case the patient will be referred to the subspecialty physician on call, or previously seen. If urgent and specific follow-up care is required, the E.D. physician or staff will communicate directly with that physician or his office.

E.9.b Copies of the Emergency Department record will be sent to the private physician on their patients seen in the E.D. and/or to the physician that the patient was referred to for follow-up care.

E.9.c The physician to whom a patient is referred for follow-up care will assume responsibility and be available for the patient's follow-up care for the specific incident that occasioned the Emergency Department visit. If he is not available during any of that time, the physician covering for him will be responsible. This will not imply that the physician is then to be considered as the patient's personal physician.

E.9.d If the patient subsequently contacts the follow-up physician, the physician will be responsible for at least a single, timely follow-up visit. Further on-going care will be according to the dictates of the personal patient-doctor relationship so established.

E.9.e If problems occur and the patient returns to the E.D. prior to making any contact with the on-call physician assigned to his follow-up to the E.D., the patient becomes the responsibility of the on-call physician on the day the patient returns to the E.D. if consultative treatment, admission, or referral is needed.

E.9.f Returned lab/cultures/x-rays ordered by Emergency Department physicians on patients previously seen in the Emergency Department that require any follow-up, will be the responsibility of the Emergency Department to handle and contact the patient and/or follow-up physician, if necessary. Private physician - or consulted physicians - will be responsible for any follow-up required on ancillary services that they initiated for their patients. The Emergency Department will notify private physicians as appropriate of follow-up x-rays that are returned to the E.D.

E.10 Outlying Service Area Physician Responsibilities

E.10.a Medical Staff whose primary service areas are in Ladysmith, Dahlgren, Bowling Green, and other areas specifically designated by the Medical Staff, shall be obligated to all sections of Emergency Department Rules and Regulations except as modified herein.

E.10.b Outlying service area physicians will participate in equal rotation in general Emergency Department call according to their department schedules, and will accept consults and admissions from the Emergency Department. However, if patient desires, they will personally arrange specific alternative on-going out-patient follow-up and management after hospital discharge with a physician closer to the patient's own residence.

E.10.c Unassigned patients seen in the Emergency Department and subsequently discharged on the day an outlying service area physician is on general Emergency Department call, shall be referred to the physician on an alternative Emergency Department call for follow-up care. This alternate schedule shall be prepared by the Departments of Medicine and Family Practice from volunteer participating physicians.

E.10.d Unassigned patients from outlying geographic areas seen in the Emergency Department and subsequently discharged shall be given the option of follow-up with the on-call physician or with a local physician in their specific outlying geographic area.

E.11 Alternate Plan for Emergency Department Coverage

E.11.a In the event that the present full time coverage of the Emergency Department is discontinued in part or whole, an alternate plan will be instituted immediately by the Medical Staff Executive Committee, the President of the Hospital, and the Emergency Department Director, if available.

E.11.b In concert with any remaining Emergency Department physicians, the Medical Staff shall be responsible for full 24-hour coverage in the Emergency Department.

E.11.c Activation of an alternate Emergency Department coverage plan shall be made under the following conditions:

E.11.c.1. Discontinuation of the present full-time coverage in the Emergency Department.

E.11.c.2. Due to unforeseen, sudden conditions, including but not limited to death, accident, illness, the present full-time coverage by Emergency physician staff falls below four (4). In this case, temporary activation of a partial alternative coverage plan will be instituted.

E.11.d The Hospital Administration and Director of Emergency Department will assure that immediate steps shall be taken to provide Emergency Department coverage so that this alternate coverage plan by the Medical Staff shall be of the shortest duration possible.

E.11.e In the event that lapse in Emergency Department physician coverage is due to failure of contract negotiations between Administration and Emergency Department physicians, the Medical Staff may refuse to activate the alternate plan for Emergency Department coverage.

E.12 Criteria For Retirement or Removal From Unassigned ED Call

E. 12.a - A practitioner shall be eligible to request retirement from Emergency Department unassigned call responsibility if s/he has reached a specified age or number of years of unassigned emergency on-call service. Unless otherwise stipulated in a department or division's rules and regulations, the criteria for retirement shall be 60 years of age or 25 years of unassigned emergency department call for Mary Washington Hospital (whichever occurs first).

E.12.b - An appointee of the staff may be excused from Emergency Department call by virtue of disability. Requests for removal for disability are subject to review and approval of the appropriate Department Chief, Division Chair and Executive Committee

E. 12.c. - A practitioner shall not automatically be removed from Emergency Department unassigned call without prior consultation by the individual responsible for developing the call schedule. This provision is intended to address only unassigned Emergency Department call. These criteria shall take precedence over any rule or customary practice established by a department, division, or specific specialty.

SECTION F: MEDICAL RECORD MANAGEMENT

F. 1 Purpose of the Medical Record – A medical record must be maintained for every persons evaluated or treated as an inpatient, outpatient, or emergency patient. The purpose of a thorough and timely medical records contributes to quality patient care by access to important clinical information necessary to plan the patient's care plan and promote continuity of care.

F.2. Medical Record Content – The medical record must be sufficiently detailed to enable the practitioners responsible for the patient to provide continuing care of the patient to determine later what the patient's condition was at a specific time; to understand the diagnostic and therapeutic procedures performed, determine the patient's response to treatment; provide necessary background for a consultant; for another practitioner to assume the care of the patient at any time; and allow for the retrieval of information required for medical record coding and various clinical review/audit functions such as utilization, quality review and peer review.

F.3. Diagnostic and Therapeutic Reports – The medical record must contain reports pertinent to care of the patient including: pathology and clinical laboratory reports; imaging studies; other diagnostic results; surgery/invasive procedures; and results of medical assessments and treatments. Diagnostic, surgical and other therapeutic procedures must recorded and authenticated (signed). Reports of care from other facilities may be entered into the record for informational purposes.

F.4. Discharge Diagnoses & Procedures - A complete listing of diagnoses and procedures must be completed and signed by the attending physician or his coverage at the time of discharge or as soon as possible thereafter. The principal (primary) diagnosis shall be the condition, established after study, to be chiefly responsible for occasioning the admission of the patient to the hospital. Secondary diagnoses will be all conditions that exist at the time of the admission or that develop subsequently and affect the treatment and/or length of stay. The attending/discharging practitioner is responsible for the accuracy of the text description of the diagnoses and procedures. Medical records coding staff are responsible for accurate assignment of diagnosis and procedure codes.

F.5 Discharge Summary – A inpatient discharge summary should concisely summarize the reason for hospitalization; significant findings; surgical and other significant invasive procedures performed; general description of the course of inpatient care; condition on discharge; and planned follow-up. In lieu of a dictated discharge summary, a final progress note may be entered into the record for patients who required less than a forty-eight (48) hours/ two (2) days length of stay, to include (including uncomplicated obstetrical deliveries and normal newborns.)

F. 6. Use of Signature Stamps – A signature stamp is defined as a stamp facsimile of the practitioner's signature. A practitioner who plans to use a signature stamp, must provide the medical records department with his/ her signed statement that she/he will be the only person who will utilize the stamp.

F.6.a. A typed name stamp used in conjunction with the practitioner's signature for the purpose of helping staff identify the signature is does not require a signed statement. A name stamp may not be used in lieu of a signature.

F.7. Medical Abbreviations – Practitioners shall comply with the hospital's standard on Abbreviations & Dose Expressions.



F.8. Medical Record Completion and Delinquency - Medical records without required reports and authentication shall be classified as “incomplete” by the Medical Records Department. If the record remains incomplete thirty (30) days following the patient's discharge/treatment, the record will be categorized as “delinquent”.

F.8.1. –The Medical Staff recognizes the importance of the medical record as an integral element of quality patient care and as it impacts regulatory compliance and hospital finances. The Chiefs of Service are delegated responsibility for promoting compliance with medical record completion requirements.

F.8.2. - The Medical Records Department is responsible for developing and implementing a process for notifying practitioners of the status of their medical records completion. Medical Records is responsible for informing the Chiefs of Services if practitioners fail to respond to requests to complete medical records.

F.8.3. – The Medical Executive Committee has ultimate medical authority for developing procedures to promote timely medical record completion.

F.8.4 - The Department Chief is responsible for taking actions necessary to ensure practitioners assigned to the department are making appropriate efforts to complete medical records consistent with the requirements set forth herein. Any practitioner with incomplete records is subject to automatic relinquishment of clinical privileges as outlined in the Medical Staff Credentialing Policy Article III, Part E, Section 1 (“Failure to Complete Medical Records). However, the Chief may waive imposition of relinquishment of clinical privileges if s/he believes relinquishment will adversely impact patient care and/or the orderly operation of the hospital. If suspension is to be instituted, the Chief shall provide the affected practitioner with a written notice of the suspension. Such notice shall also be provided to the admissions staff and, if applicable, other patient care areas. When notified of suspension, the involved practitioner shall be responsible for making arrangements for medical coverage of his patients and notifying the patient and family of such transfer. Unless otherwise stipulated by the Chief, reinstatement of clinical privileges may be instituted when the medical records have been verified as complete which includes required authentication (signature). Notice of reinstatement shall be provided to the admissions staff and patient care areas.

<p>Readopted: April 1998</p> <p>Revised: April 1999 September 2002 September 2003 January 2004 April 2004 April 25, 2007</p>	 <p>Daniel Hoffman, M.D. Medical Staff President</p>	 <p>Fred M. Rankin III President & CEO</p>
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