REHABILITATION HOSPITAL OF FORT WAYNE

FORT WAYNE, INDIANA

MEDICAL STAFF

RULES AND REGULATIONS

ADOPTED BY MEDICAL STAFF
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REHABILITATION HOSPITAL OF FORT WAYNE
MEDICAL STAFF RULES AND REGULATIONS

PART I. GENERAL CONSIDERATIONS

1.1 All members of the Medical Staff and all those granted privileges by the Board of Trustees shall abide by these Rules and Regulations and all other policies and manuals applicable to Medical Staff members.

1.2 For the purpose of these Rules and Regulations, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

PART II. ADMISSION AND DISCHARGE OF PATIENTS

2.1 The Hospital shall admit patients for care and treatment through the Admissions Office. The patient's condition must require the treatment and nursing care of an interdisciplinary rehabilitation team including 24-hour availability of a physician with special training or experience in the field of rehabilitation. The patient must require a relatively intense level of physical therapy or occupational therapy and, if needed, speech therapy, respiratory therapy, psychological services or prosthetic-orthotic services.

2.2 A patient may be admitted to the Hospital, based on the Utilization Management Program, by a Medical Staff member with admitting privileges.

2.3 A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion 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 Medical Staff member, an order covering the transfer of responsibility shall be entered on the physician order sheet of the medical record.

2.4 Medical Staff members are discouraged from providing care to their own family members.

2.5 Each Medical Staff member who does not reside in the immediate vicinity of the Hospital shall name a Medical Staff member who resides in the area and who may be called to attend his patients in an emergency. In case of failure to name such associate, the Chief Executive Officer, or his designee or Medical Director(s) shall have authority to call any member of the medical staff in such an event.

2.6 No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

2.7 The admitting practitioner shall provide at the time of admission information necessary to assure the protection of the patient from self harm and protection of others when his patient might be a source of danger.

2.8 Patients rights shall be adhered to by all practitioners.

2.9 In the care of the potentially suicidal patient, precautions to be taken for the protection of patients, medical staff and hospital staff include:

2.9.a Any patient known to be suicidal in intent shall not be admitted.

2.9.b Any patient suspected to be suicidal subsequent to admission must have consultation by a member of the psychiatric/psychological staff.

2.9.c Any patient who becomes known or highly suspect of being suicidal may be transferred to a psychiatric unit in another hospital in accordance with hospital policy.

2.10 The attending practitioner is required to document the need for continued and/or extended hospitalization as identified by the Utilization Management Program of this Hospital. This documentation must contain:

2.10.a An adequate written record of the reason for continued and/or extended hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

2.10.b The patient's records must reflect evidence of a coordinated program, including documentation that rehabilitation team conferences were held with regularity to:

(1) Assess the patient's progress or the problems impeding progress;

(2) Consider possible resolutions to such problems; and

(3) Reassess the validity of the rehabilitation goals initially established.

2.10.c Plans for post-hospital care.

2.11 Patients shall be discharged only on written order of the attending practitioner. Consulting practitioners may write orders for transfer of the patient to a tertiary care facility, if in concordance with the attending practitioner, and if the medical needs cannot be met at this facility.

Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and a "Discharge Against Medical Advice" form will be signed by the patient or family member.

2.12 In the event of a Hospital death, the deceased shall be pronounced by the attending practitioner or designee(s). Policies with respect to release of the deceased shall conform to local and state law.

2.13 Every member of the Medical Staff is expected to secure autopsies, as appropriate. No autopsy shall be performed without written consent of proper legal relative or legally authorized agent. All autopsies shall be performed by a contractual service of the Hospital.

The original autopsy report shall be made a part of the patient’s record. The provisional anatomic diagnosis should be recorded in the medical record within three days, and the complete protocol should be made part of the record within 60 days. (See Part VII)

PART III. MEDICAL RECORDS

3.1 The purposes of the medical record are:

3.1.a To serve as a basis for planning patient care and for continuity in the evaluation of the patient's condition and treatment;

3.1.b To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay;

3.1.c To document communication between the responsible practitioner and any other health professional who contributes to the patient's care;

3.1.d To assist in protecting the legal interests of the patient, the Hospital, and the responsible practitioners; and

3.1.e To provide data for use in billing, continuing education, and in research.

3.2 Admitting/Attending Physician's Responsibilities

3.2.a The attending physician shall be held responsible for the preparation of a complete medical record for each of his patients. A complete medical record shall contain the following:

(1) Identification data; when not obtainable, the reason shall be entered in the record;

(2) The medical history of the patient;

(3) The report of a relevant physical examination;

(4) Diagnostic and therapeutic orders;

(5) Evidence of appropriate informed consent (for invasive procedures), when applicable; when consent is not obtainable, the reason shall be entered in the record;

(6) Clinical observations, including results of therapy;

(7) Results and/or reports of procedures and tests; and

(8) Summary of treatment with final diagnoses and disposition.

3.3 Inpatient medical records shall include at least the following:

3.3.a Identification data including patient's full name, address, date of birth, and next of kin. A permanent identification number shall be assigned which identifies the patient and all medical records;

3.3.b An admission note shall be present on the chart within twenty-four (24) hours of admission, which validates the reason for admission and outlines the plan of treatment;

3.3.c A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, and be dated and timed and signed by the practitioner.

3.3.d The admission medical history of the patient shall include:

(1) Chief complaint;

(2) Details of present illness including, when appropriate, assessment of the patient's emotional, behavioral, and social status; and

(3) Relevant past, social, and family histories

(4) Inventory of body systems.

For adolescents, an evaluation of developmental age factor, immunization status, educational needs, and the family's expectations and involvement should be included, as appropriate.

A medical history and physical examination (H&P) must be completed and documented within seven (7) days prior to admission or within 24 hours following admission, whichever comes first. The H&P must be performed and authenticated by a practitioner who is authorized to do so by the Medical Staff. An H&P performed seven (7) days prior to admission may be accepted, but must be accompanied by durable, legible practitioner documentation indicating the H&P was reviewed, and noting changes, if any, in the patient's condition. An updated examination must be completed and documented within 24 hours after admission when utilizing such H&P. The H&P shall include a statement of conclusions, impressions, and course of action plan which includes goals of treatment and treatment plan. The history and physical and any updates is the responsibility of the admitting practitioner but may be done by other practitioners within that same practice group; or by other practitioners that have privileges at the hospital but are not in that practice group. History and physicals may be done by nurse practitioners or physician assistants who have been granted appropriate privileges.

3.3.e A comprehensive physical examination shall be completed and on the chart within twenty-four (24) hours of admission to the Hospital. This report should include all pertinent findings resulting from an assessment of all systems of the body. History and physicals are required on observation patients and Baclofen Trial patients. If H&P is dictated, four hours should be allowed for transcription.

3.3.f When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.

3.3.g Diagnostic and therapeutic orders (verbal, standing or written) shall be written on the order sheet and must be authenticated by the responsible practitioner.

(1) All diagnostic procedures shall have a written reason as to why they are ordered.

(2) Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatments and any other diagnostic or therapeutic procedures shall be completed promptly and filed in the patient's medical record.

3.3.h Progress notes shall be recorded at the time of observation to assure continuity of care and transferability. They shall provide a chronological report of the patient's clinical course in the hospital, reflecting any change in condition and/or results of treatment. The patient's treatment goals shall be clearly identified and correlated with specific orders, tests, procedures and treatment results. Progress notes will be written no less frequently than three (3) times a week by the physician involved in the care of the patient. Progress notes shall be integrated for continuity of care.

3.3.i Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record.

3.3.j All treatments, examinations and procedures shall be documented in the medical record within 24 hours of completion

3.3.k All clinical entries in the patient's medical record shall be accurately dated and timed and authenticated by the person (identified by name and title) who is responsible for ordering, providing, or evaluating the service furnished. The medical record must be legible, concise, complete and current.

3.3.l Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved and prohibited abbreviations shall be kept on file in the Medical Records Department.

3.3.m A discharge order given by a Medical Staff member is required to release a patient. A discharge summary (clinical resume) shall be completed on all medical records within thirty (30) days of patient's discharge.

(1) The discharge summary shall concisely document the reasons for admission, the principal and additional or associated diagnoses, the procedures performed, the treatment rendered, the condition of the patient at discharge, and any specific instructions given to the patient and/or family.

(2) In all instances, the content of the medical record shall be sufficient to justify the diagnosis, warrant the treatment provided and summarize clinical progress and/or outcomes.

(3) All summaries shall be authenticated by the responsible practitioner.

3.3.n In the event of death, a final progress note or summary is required which shall indicate the reason for admission, the findings, the course in the Hospital, and events leading to death.

3.3.o Medical Staff shall ensure, in collaboration with Indiana Organ Procurement Organization and consistent with federal and state laws and rules and regulations, that the family of each potential donor, or person legally responsible for a potential donor, is informed of the option to donate organs, tissues and eyes, or to decline to donate.

Reference to pertinent Indiana anatomical gift legislation shall appear on the appropriate forms used for organ donor transplantations and shall be reviewed annually or as required by law or applicable regulation.

3.3.p Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. Appropriate safe guards shall be applied to protect confidential records and to minimize the possibility of loss and/or destruction of the records.

3.3.q 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 Executive Officer, or his designee. In case of readmission of the patient, all previous records shall be available for the use of the

attending practitioner. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

3.3.r Free access to all medical records of all patients, consistent with preserving the confidentiality of information of the individual patients, shall be afforded to members of the Medical Staff for bona fide study and research. All such projects shall be approved by the Medical Executive Committee. Subject to the discretion of the Chief Executive Officer or his designee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.3.s The parts of the medical record that are the responsibility of the attending practitioner shall be authenticated by his signature. The attending practitioner shall countersign any documentation completed by, and all entries made by other health professionals acting on his behalf. All entries made by properly credentialed Allied Health Professionals do not require a signature as long as they are acting within their approved scope of practice. All Allied Health Professionals progress notes, history/physical examinations, discharge summaries and consultations must indicate the name of the collaborating practitioner.

The use of a rubber signature stamp is prohibited except for clarification of a practitioner's handwritten signature. Electronic signatures may be used only by the individual to whom the electronic code has been uniquely assigned.

3.3.t A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

3.3.u The patient's medical record shall be completed by the practitioner at the time of discharge and/or within thirty (30) days of patient discharge. The medical record is available through the portal or in the Medical Record Department for completion. A medical record shall be considered complete when required reports have been dictated and/or written and signed and all progress notes and doctors' orders have been signed. If a record remains incomplete at fifteen (15) days post discharge, the Director of Quality shall notify the practitioner of the deficiency. If the practitioner fails to complete the deficient chart within fifteen (15) days of notification, he may be requested to go before the Medical Executive Committee for disciplinary action. All medical records not completed within thirty (30) days shall be reported at the next regular meeting of the Medical Executive Committee. Delinquencies that are identified per practitioner that are unresolved or indicate a pattern will be brought forward by the Director of Quality and the Chief Executive Officer/designee to Medical Executive Committee.

One week prior to the next Medical Executive Committee meeting, the delinquent practitioner will receive a certified letter notifying him that his admitting privileges will be discussed for determination of further action by the MEC and Board of Trustees up to and including suspension.. After the Board of Trustees meeting, one additional letter will be mailed to the delinquent practitioner notifying him of the outcome. Practitioners under suspension will be expected to continue care for hospitalized patients. Such practitioners shall remain suspended until the delinquent records have been completed.

Three (3) such suspensions of admitting privileges within any 12 month period shall be sufficient cause for termination of the practitioner's privileges.

The practitioner will not be responsible for:

(1) Charts not available on portal or in the Medical Records Department;

(2) Completing charts prior to the next completion period if on vacation or ill for seven working days within his completion period, and this was reported to the Medical Records Department prior to the end of his completion period.

The practitioner will be responsible for:

(1) Requesting assistance from Medical Records Department if unable to locate chart on portal or if practitioner needs access to paper chart;

(2) Completion of all charts available;

(3) Any dictation missed on charts provided;

(4) Notifying the Medical Records Department of vacations or illnesses.

PART IV. DRUGS, ORDERS AND TESTS

4.1 A general consent form, signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission. The Admissions Office shall notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

4.2 In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment shall be obtained. The informed consent is the responsibility of the attending physician to obtain. Appropriate forms for such consents shall be adopted with the advice of legal counsel.

4.3 All orders for treatment shall be in writing, dated, timed and authenticated. A verbal/telephone order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of competence and dated and authenticated by the responsible practitioner.

4.3.a Verbal orders regarding medications and nursing functions shall be dictated to the following duly authorized persons:

(1) Registered nurses;

(2) Licensed practical nurse;

(3) Registered pharmacists;

(4) Respiratory care therapists (inhalation medications only); and

(5) Registered nurses or licensed practical nurses that are providing services as an allied health professional to patients of their employer.

Verbal and/or telephone orders may be taken by other Rehabilitation Hospital associates that relate directly to the care and procedures they provide.

(1) Verbal and/or telephone orders may be taken by a licensed/registered occupational therapist, physical therapist or speech pathologist that relates to these therapies only;

(2) A registered dietitian may take a verbal and/or telephone order for nutritional aspects of care;

(3) Case Managers may take verbal and/or telephone orders for discharge/care related to home health services, discharge/level of care to any extended, long term or continuum of care facility and the need for ambulance/stretcher transport.

Verbal and/or telephone orders are discouraged except in emergency situations. All verbal/telephone orders shall be written down, then read back and verified with the ordering practitioner. All verbal and telephone orders shall be signed by the qualified person to whom the order is dictated. The recipient’s name, the name of the practitioner, and the date and time of the order shall be noted. The recipient shall indicate that he/she has written or otherwise recorded the order, and shall read the verbal order back to the practitioner and indicate that the individual has confirmed the order. All verbal orders in the medical record shall be given by practitioners directly involved and appropriately credentialed in patient care. All verbal orders shall be authenticated by the prescribing practitioner, or any practitioner who is responsible for the care of the patient and has been granted privileges to write orders in the hospital may authenticate a verbal order

made by another practitioner. The practitioner shall authenticate read-back and verified orders no later than 30 days after the patient's discharge. Failure to do so could be brought to the attention of the Medical Executive Committee for appropriate action.

When there is a need for clarification of the order of an attending practitioner, the pharmacist receiving the order shall contact the attending practitioner. When the order is clarified, it may be conveyed directly to the nurse by the attending physician or by the pharmacist at the discretion of the attending practitioner.

Verbal/telephone orders shall be tagged by Nursing personnel to alert the practitioner that he has orders to sign.

4.4 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. The use of "renew", "repeat", and "continued" orders are not acceptable.

4.5 Drugs shall be U.S. Pharmacopoeia, National Formulary, and Food and Drug Administration approved with the exception of drugs for bona fide clinical investigations, which shall be approved for use by the Medical Executive Committee and/or duly appointed subcommittee.

4.5.a Investigational drugs may be administered following Lutheran Health Networks Internal Review Board approval and in accordance with IRB guidelines. All investigational drugs are to be dispensed from the Pharmacy Department.

4.6 All drugs and medications administered to the patient shall be in accordance with the Hospital formulary system.

4.6.a Medication orders written for trade-name drugs will be filled with the formulary drug, but not necessarily with the brand name called for under the registered trade name unless the practitioner specifically writes "Do Not Substitute" on the patient order sheet.

4.6.b The decision to add or delete a drug from the Hospital Formulary is the responsibility of the Pharmacy-Therapeutics Committee and shall be based on criteria consistent with scientific information that support basic objectives of the Committee.

4.6.c Requests for new drugs to be used in the hospital prior to Pharmacy Therapeutics Committee approval should be made to the Pharmacy Director.

4.6.d Medical Staff members shall be notified whenever a drug is under consideration for deletion so that they may submit evidence for its retention.

4.7 The Pharmacy shall maintain an adequate library and an extensive product information file to make information concerning drugs available to the Medical Staff members.

4.8 Medications brought from home by the patient are to be identified by the Pharmacy Department. The practitioner's order to continue medications from home shall list the specific medication, dosage, and instructions. Medications brought from home may be self-administered by the patient if the following criteria are met:

4.8.a The practitioner writes an order; and

4.8.b The patient is competent to administer.

4.9 Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within the area of his expertise.

4.9.a A consultation is required in the following situations:

(1) In instances when a patient has failed to respond to treatment;

(2) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(3) Where there is doubt as to the choice of therapeutic measures to be utilized;

(4) In unusually complicated situations where specific skills of other practitioners may be needed;

(5) In instances in which the patient exhibits severe psychiatric symptoms; and

(6) When requested by the patient or his family.

4.10 The attending practitioner is responsible for requesting consultation when indicated. The attending practitioner will provide written authorization to permit another practitioner to examine his patient. The practitioner being consulted (consultant) is expected to respond within twenty-four (24) hours for urgent care or seventy-two (72) hours for non-urgent care, i.e. podiatry, dermatology care.

PART V. EMERGENCY SERVICES

5.1 For the purpose of these Rules and Regulations, an emergency is defined as a condition in which the life of the patient is in immediate danger and in which any delay in administering treatment would increase the danger.

5.2 In an emergency, any Medical Staff member who has clinical privileges is permitted to provide any type of patient care necessary as a life saving measure or to prevent serious harm, regardless of his Medical Staff status or clinical privileges, provided that the care provided is within the scope of the individual's license.

5.3 When giving emergency care which may include basic life support and/or first aid measures needed to minimize any deterioration of the patient's condition prior to transferring the patient to the nearest facility capable of providing the care needed has been initiated, Nursing Service shall be responsible for notifying the appropriate practitioner.

PART VI. DISASTER PLAN

6.1 All practitioners on the Medical Staff accept the duties and responsibilities outlined in the Hospital's master Disaster Plan.

PART VII. AUTOPSY

7.1 In the event of a Hospital death, the deceased shall be pronounced by the attending practitioner or designee(s). Policies with respect to release of the deceased shall conform to local and state law.

7.2 Every member of the Medical Staff is expected to secure autopsies, as appropriate. No autopsy shall be performed without written consent of proper legal relative or legally authorized agent. All autopsies shall be performed by a contractual service of the Hospital.

7.3 Based on the following criteria, autopsies shall be secured by the attending and/or pronouncing physician:

(1) Homicide or suicide

(2) Accident

(3) Illegal abortion

(4) Death under suspicion, unusual or unnatural circumstances

(5) Unexpected or unknown etiology of death

(6) Death related to disease that might constitute a threat to public health

(7) Death related to a disease resulting from employment

(8) Death occurring during a therapeutic or diagnostic procedure

(9) At the request of the immediate family

7.4 The practitioner shall discuss with the family the proposed or required autopsy. If the family declines and the case does not meet the guidelines for reporting cases to the coroner, this must be documented in the Physician's Progress Notes.

If the practitioner securing consent for the autopsy is not the attending practitioner, the practitioner shall notify the attending.

A written consent must be obtained in accordance with state law on the "Authorization for Post Mortem Examination" form. When the consent has been obtained, the contractual service of the Hospital shall be contacted to perform the autopsy. Provisional anatomic diagnosis shall be recorded in the medical record within seventy-two (72) hours and the completed autopsy findings should be a part of the medical record within sixty (60) days.

7.5 It is the responsibility of the pathologist to notify the family of the diagnosis.

VIII. DISTRIBUTION

8.1 A copy of these Rules and Regulations shall be made available to each Medical Staff member, practitioner, and person granted privileges/services in any manner or form by the Board of Trustees.

IX. AMENDMENT

9.1 This Rules and Regulations Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

9.1.a A resolution of the Medical Executive Committee recommended to and adopted by the Board of Trustees; or

9.1.b A resolution of the Medical Staff and confirmed by the Medical Executive Committee, and approved by the Board of Trustees.

9.2 The procedures outlined in the Medical Staff Bylaws and Medical Staff Policies and Procedures regarding Medical Staff responsibility and authority to formulate, adopt, and recommend the Bylaws and amendments thereto, and the circumstances under which the Board of Trustees may resort to its own initiative in accomplishing those functions apply as well to the formulation, adoption, and amendment to this Rules and Regulations Manual.