

**Rehabilitation Hospital Rules and Regulations**

REHABILITATION HOSPITAL OF FORT WAYNE

MEDICAL STAFF RULES AND REGULATIONS

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REHABILITATION HOSPITAL OF FORT WAYNE

## MEDICAL STAFF RULES AND REGULATIONS

### A. ADMISSION AND DISCHARGE OF PATIENTS

1) The Hospital shall accept patients for care and treatment who will benefit from the services afforded. The patient's condition must require the treatment and nursing care by an interdisciplinary rehabilitation team and the 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, social services, psychological services or prosthetic-orthotic services.

2) A patient may be admitted to the Hospital by a member of the Medical Staff, only. All practitioners shall be governed by the official admitting policy of the Hospital.

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 staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

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

5) Practitioners admitting patients on an emergency basis shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart within twenty-four (24) hours of admission.

6) Each member of the staff who does not reside in the immediate vicinity of the Hospital shall name a member of the medical staff who is resident in the area who may be called to attend his

patients in an emergency, or until he arrives. In case of failure to name such associate, the Chief Executive Officer or Medical Director shall have authority to call any member of the active staff in such an event.

7) The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

8) For the protection of patients, the medical and nursing staffs and the Hospital, precautions to be taken in the care of the potentially suicidal patient include:

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

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

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

9) The attending practitioner is required to document the need for continued hospitalization after specific period of stay as identified by the Utilization Review policy of this Hospital. This documentation must contain:

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

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. These conferences must be held at least biweekly.

c. Plans for post-hospital care.

10) Patients shall be discharged only on a written order of the attending practitioner. 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.

11) In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local and state law.

12) Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written witnessed telephonic or telegraphic consent of proper legal relative or legally authorized agent. All autopsies shall be performed by a contractual service of the Hospital or a physician delegated the duty. See Section E for criteria.

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

## B. MEDICAL RECORDS

1) The attending practitioner shall be responsible for the preparation of a completed and legible medical record for inpatient care. The medical record shall contain sufficient information or identify the patient clearly, to justify diagnosis and treatment, and to document the results accurately. This record shall include the patient's name, address, date of birth, and next of kin;

the medical history of the patient, including the following information: details of the present illness, including, when appropriate assessment of the patient's emotional, behavioral, and social status needs appropriate to the age of the patient; an inventory by body systems; a statement of the conclusions or impressions drawn from the admission history and physical and physical examination; a statement of the course of action planned for the patient while in the hospital; the goals of treatment and the treatment plan; diagnostic and therapeutic orders; consultation reports; nursing notes and entries by non-physicians that contain pertinent, meaningful observations and information; reports of procedures, tests, and their result; conclusions at termination of hospitalization; and autopsy report when performed.

2) A complete admission history and physical examination shall be recorded 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. Outpatients shall not require an admission history and physical.

3) Pertinent progress notes shall be recorded at the time of observation and shall suffice to assure continuity of care and transferability. They should provide a chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment. The patient's clinical problems/treatment goals should be clearly identified and correlated with specific orders as well as test, procedure and treatment results. Progress notes shall be written at least daily on critically ill patients, on patients with difficulty in diagnosis/management, and on patients as required by third-party payers or regulatory agencies. Progress notes will be written no less frequently than three times a week by the physician involved in the care of a patient. Progress notes should be integrated for continuity of care.

4) 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 record.

5) All clinical entries in the patient's medical record shall be accurately dated and authenticated. The medical record must be clear, concise, complete and current.

6) Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Records Department.

7) Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order. All infections treated shall be included in the final diagnosis.

8) A discharge summary (clinical resume) shall be written or dictated on all medical records within fifteen (15) days of discharge of patients hospitalized. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

9) 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.

10) 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. In case of readmission of the patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be 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 determined by the Executive Committee of the Medical Staff.

11) Free access to all medical records of all patients shall be afforded to all members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be obtained and studied. Subject to the discretion of the Chief Executive Officer, 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.

12) 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.

13) 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 signed by the practitioner.

14) The patient's medical record shall be complete at the time of discharge, including progress notes, final diagnosis and (dictated) clinical resume. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the medical record department for fifteen (15) days after discharge. The medical record is to be completed by the physician within fifteen (15) days from the date of discharge. If a record remains incomplete at fifteen (15) days post discharge, the Medical Record Coordinator shall notify the practitioner of the deficiency. If the practitioner fails to complete deficient charts within 15 days of notification, he/she may be suspended. (See Bylaws Section 7.7.8) All medical records not completed

within 30 days shall be reported at the next regular meeting of the Medical Executive Committee for determination of further action.

### C. GENERAL CONDUCT OF CARE

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 Admitting Office should notify the attending practitioner whenever such consent has not been obtained. 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. Furthermore, the "Patient's Rights Policy", appended hereto, are to be adhered to by all practitioners. 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 or surgical procedure should be obtained. Appropriate forms for such consents should be adopted with the advice of legal counsel.

Patients admitted to the Hospital shall have diagnostic procedures as identified by the physician with the written reason as to why they are ordered.

2) All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his sphere of competence and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated with the name of the practitioner per his or her own name.

The responsible practitioner shall authenticate such orders within twenty-four (24) hours, and failure to do so shall be brought to the attention of the Executive Committee for appropriate action.

Duly authorized persons shall be licensed registered nurses, the pharmacist, registered physical therapists for physical therapy orders; registered respiratory therapists for respiratory therapy; registered occupational therapists for occupational therapy ; and certified speech/language pathologists for speech therapy orders.

Automatic Stop Orders: All drug orders for Schedule II substances, anticoagulants, and antibiotics shall be automatically discontinued after the approved number of days as follows:

Schedule II Substances - seventy-two (72) hours; anticoagulants - seven (7) days; and antibiotics - ten (10) days, unless the order indicates an exact number of doses to be administered, an exact period of time for the medication to be administered, or the attending physician reorders the medication. Physicians will be notified of discontinued drugs.

3) 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) All drugs and medications administered to the patient shall be in accordance with the Hospital formulary system. When so ordered by the physician, the only medications that are allowed to be kept at the bedside are antacids, nitroglycerin, throat lozenges and sprays, topical ointments and birth control pills.

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

6) Except in an emergency, consultation is required in the following situations:

- a. When the patient is not a good risk for treatment
  
- b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed
  
- c. Where there is doubt as to the choice of therapeutic measures to be utilized
  
- d. In unusually complicated situations where specific skills of other practitioners may be needed
  
- e. In instances in which the patient exhibits severe psychiatric symptoms
  
- f. When requested by the patient or his family
  
- g. In instances when a patient has failed to respond to treatment

7) The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization, except in an emergency, to permit another attending practitioner to attend or examine his patient. The consultant is expected to respond within 24 hours for urgent care or 72 hours for non-urgent care, i.e. podiatry, dermatology care.

8) Routine blood pressure readings shall be done at a minimum of once a day on patients with admission history or diagnosis of hypertension.

9) Outpatient treatment orders shall include a time or treatment limitation order or must be renewed every thirty (30) days.

10) Physician visitation requirements should meet Joint Commission on Accreditation of Hospitals and the Commission for Accreditation of Rehabilitation Facilities requirements whereby: "There should be direct contact by a physician on any day in which there is an active interdisciplinary treatment program. The nature of each person's needs may dictate greater contact, but in no event should physician contact be less than three (3) times per week." Additionally, the attending physician or designee must be available on a twenty-four (24) hour basis.

#### D. EMERGENCY SERVICES

The Emergency Service of the Hospital shall be under the direction of the Chairman of the Medical Executive Committee. A list of on-call physicians shall be posted at the Nursing stations.

Nursing Service shall be responsible for notifying the appropriate physician, giving emergency care and referring the patient to the nearest facility capable of providing the care needed. Before transferring a patient to an acute care hospital, basic life support and/or first aid measures needed to minimize any deterioration of the patient's condition will be provided.

1) 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 shall be developed by a committee which includes at least two members of the Medical Staff, the director of nursing services or her designee, and a representative from Hospital Administration. It shall be reviewed and approved annually by the medical staff and Governing Board.

2) The disaster plan should make provision with the Hospital for:

a. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials

- b. An efficient system of notifying and assigning personnel
  
  - c. Unified medical command under the direction of a designated physician (the chairman of the committee or designated substitute)
  
  - d. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care
  
  - e. Prompt transfer, when necessary, and after preliminary medical services have been rendered, to the facility most appropriate for administering definitive care
  
  - f. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved
  
  - g. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy
  
  - h. Security measures in order to keep relatives and curious persons out of the triage area
  
  - i. Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual and advance arrangements with communications media to help provide organized dissemination of information
- 3) All physicians shall be assigned to posts, and it is their responsibility to report to their assigned stations.

The services will work as a team to coordinate activities and directions. In case of evacuation of patients from the Hospital to another, or evacuation from Hospital premises, the Chief Executive Officer will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Executive Committee and the Chief Executive Officer

of the Hospital. In their absence, alternates in Administration are next in line of authority.

4) 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 Administration, Nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

#### E. AUTOPSY CRITERIA

Based on the following criteria, autopsies should 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

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, (Appendix A) this must be documented in the Physician's Progress Notes.

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 attending physician shall select a pathologist to perform the autopsy. Provisional anatomic diagnosis shall be recorded in the medical record within 72 hours and the completed autopsy findings should be a part of the medical record within three (3) months.

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

## F. USE OF RESTRAINTS

1. Use of safety devices, restraints and seclusion will follow the policy, procedure and protocols approved by the medical staff. Any practitioner may immediately order such items as specified in the approved safety protocols to protect against immediate harm to or by a patient, providing that such order is reviewed as soon as possible. The use of certain devices that may present potential for patient injury is restricted. Use of the safety protocols will be evaluated during team conferences.

2. If it is determined that the use of restraints or seclusion is necessary for the protection of the patient or the protection of others, the attending physician is responsible for providing a written or verbal time limited order for the restraint or seclusion. Verbal orders must be reduced to writing immediately, and countersigned by a practitioner within 24 hours.

## APPENDIX A

### GUIDELINES FOR DEATHS REPORTABLE

### TO THE ALLEN COUNTY CORONER

The Coroner is responsible for establishment of the facts in order to determine the cause and manner of death.

In general, any person who dies by violence or accident, or dies when in apparent good health, or is found dead in any suspicious, unusual or unnatural manner, becomes a Coroner's Case. However, good judgment and a knowledge of the circumstances by persons involved, such as nurses, ambulance personnel, etc., is essential in determining whether the Coroner should be notified. Some cases will very clearly require the Coroner, e.g., gunshot wounds or automobile accidents. There will be times, however, when factors such as age and scene of occurrence will influence the decision to notify the Coroner.

The following list describes cases that should be investigated:

1. Homicide
2. Suicide
3. Accident
4. Illegal abortion
5. Death under suspicious, unusual, or unnatural circumstances.
6. Death related to disease that might constitute a threat to public health (overlaps duties of county health officer).
7. Death related to disease resulting from employment or to an accident while employed.
8. Death occurring in the course of a therapeutic or diagnostic procedure. This is a sensitive

area and these cases are difficult, at best. However, the Coroner's Office should act as an independent, fact-finding agency in the investigation of any unexplained death in a hospital.

9. Death of inmates occurring in any place of penal incarceration. There is no requirement for the Coroner to investigate nursing home deaths unless notified of suspicious or negligent activity, or unless a death is thought to be due to an accident.