



BAY REGION

Medical Staff Services

# MEDICAL STAFF RULES

**MCLAREN BAY REGION  
MEDICAL STAFF RULES**

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I. GENERAL RULES

A. Admission of Patients

1. Admitting Privileges: A patient may be admitted to the hospital only by a currently licensed physician, oral surgeon or podiatrist with clinical privileges in the hospital. Only currently licensed physicians, oral surgeons, and podiatrists are directly responsible for medical diagnosis and treatment. Oral and maxillofacial surgeons and podiatrists with clinical privileges may initiate the procedure for admitting and perform the history and physical examination unless concurrent medical problems are noted at which time an appropriate physician member of the Medical Staff must be included as a consultant. This Medical Staff member shall then assume responsibility for the overall medical aspects of the patient's care throughout the hospital stay, including medical history and physical examination.
2. Provisional Diagnosis Required: Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be recorded within twenty-four hours.
3. Critical Patients: Patients admitted to the critical care units will be seen in a timely fashion by the admitting physician or appropriate consultant.
4. Dangerous Patients: Physicians, dentists and podiatrists admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger for any cause whatsoever.
5. Medical Staff Coverage: All acute care patients shall be under the continuing daily care of a physician. If a member of the staff is not available, he must identify another member of the medical staff in advance to attend his patients in his absence and must notify the Medical Staff Office, either in writing or verbally. In case of failure to identify appropriate coverage, the chairman of the appropriate department, the Chief of Staff, chief executive officer, or their designee, shall have authority to call any member of the staff should he consider it necessary. To determine which physician is on call, ancillary departments may: 1) Call the attending physician office/answering service; or, 2) May reference the Physician Vacation/Out of Town list generated by the Medical Staff Office; or 3) May reference the E.D. Specialty On-Call Schedule. Physicians cannot sign out to the Emergency Room.
6. Non-Invasive Diagnostic Coverage: Coverage arrangements for interpretation of all inpatient and outpatient Special Diagnostics studies are as outlined in Article I.A.4 above.
7. Documentation for Admission Following Outpatient Procedure or Ambulatory Surgery: When a patient is admitted to inpatient status following an outpatient procedure, or is admitted after ambulatory surgery, there must be documentation setting forth the reason for such admission.

B. Admission Priority

When a rising hospital census indicates there may be a shortage of facilities, staff will have priority for admissions in the following order:

- (a) Emergency admissions
- (b) Urgent admissions
- (c) Patients already scheduled for surgery
- (d) Elective admissions

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Physicians must declare to the on-duty admitting clerk any emergency or urgent admission and shall be prepared to justify, in accordance with the Utilization Review Plan, that said admission was appropriate. The history and physical and chart documentation must clearly justify the emergency or urgent admission as soon as possible, but within 24 hours after admission.

C. Discharge of Patients

1. The Attending physician is responsible for the discharge of patients. If a physician seeing a patient in consultation wishes to discharge a patient, it must be cleared with the attending physician prior to discharge being completed.
2. If, during the course of treatment, the care has been transferred to another physician, it shall be so documented. Therefore, that physician assuming the care becomes responsible for discharging the patient.

II. PATIENT CONSENTS

Informed Consent: A specific consent form that adequately documents that the patient was informed of the nature of risk, alternatives, and consequences inherent in any condition requiring special treatment or procedure shall be obtained by the physician at the time of the explanation to the patient except in emergency. Other information required includes the identity of the patient, the date, the procedure or treatment to be rendered (in layman's terminology, when possible), the names of the individuals who will perform the procedure or administer the treatment and authorization for any required anesthesia. When consent is not attainable, the reason shall be entered in the record.

Only as a guide, the following elements are suggested to constitute an informed consent:

- A. Nature of his/her condition
- B. Nature of the procedure
- C. Benefits to be reasonably expected from procedure compared with alternative approaches
- D. Possible risks/complications of procedure
- E. Alternative of not performing procedure
- F. Expected outcomes if procedure not performed

III. MEDICAL RECORDS

A. Ownership and Removal of Medical Records

Medical records are the property of the hospital and are maintained for the benefit of the patient, the medical staff, and the hospital. Original medical records may be removed from the hospital jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Copies of portions thereof, may be given out with the written authorization of the patient and in conformance with hospital policies.

B. Completion of a History & Physical Examination

1. All patients who are admitted to the hospital as an inpatient, outpatient for observation, ambulatory surgery, or procedures which require I.V. conscious sedation, shall have a history & physical examination completed by a physician or Allied Health Professional with privileges to perform a history & physical. The history and physical must be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services. The H&P may be handwritten or transcribed, but always

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must be placed within the patient's medical record within 24 hours of admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first.

2. The history and physical examination shall include, but not by way of limitation, a description of the chief complaint, details of the present illness, relevant past social and family history and a physical exam and review of systems of a patient.
3. Patients admitted for treatment of substance abuse shall also have the results of a mental status examination included in their H&P report.
4. If a complete H&P and a mental status examination, if necessary, has been performed within 30 days prior to a patient's admission, such as in the office of a physician staff member, or when appropriate, in the office of a qualified oral/maxillofacial surgeon or podiatry staff member, then in such event a durable, legible copy of the H&P may be used in the patient's hospital medical record; provided, (1) there is a supplemental document attached updating the original H&P and, (2) the H&P contains all of the elements essential to a history and physical examination as provided in Section III, B, 3, above. If the consultation note contains all of the elements necessary in an H&P, the consultation note may take the place of the H&P if the attending physician reviews it, documents concurrence, and signs it.
5. When a medical history and physical examination has been completed within 30 days before admission or registration, an updated medical record entry must be completed and documented in the patient's medical record within 24 hours after admission or registration. The examination must be conducted by a licensed practitioner who is credentialed and privileged to perform an H&P. In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services. The update note must document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment. The physician or qualified licensed individual uses his/her clinical judgment based upon his/her assessment of the patient's condition and co-morbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record.

If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed (71 FR 68676). Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services. Additionally, if the practitioner finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document in the medical record a new H&P within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

**C. Interval History and Physical**

When a patient is readmitted within 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, provided the original information is readily available.

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D. Short Stay History and Physical Form

A Short Stay history and physical form may be used for all patients admitted to the hospital as an outpatient for observation, ambulatory surgery and all minor surgical procedures. Any conversion from outpatient, observation or ambulatory surgery to inpatient requires a full history & physical.

E. Preoperative Requirements

1. Elective Surgical Procedures: When a patient goes to the Operating Suite for elective surgical procedures, he/she shall be accompanied by an informed consent, a recorded history and physical exam, and all other available information pertinent to the care of the patient, such as consultation, pre-anesthetic evaluation, prior records, appropriate x-rays and reports of inpatient and outpatient diagnostic studies and therapy. For patients going to surgery not requiring services of an anesthesiologist, the laboratory studies are at the discretion of the surgeon, e.g., cases to be done under local anesthesia.

With all of the ordered laboratory studies drawn and reported, EKG recorded with reading, x-ray reports, consult dictated, along with history and physical on the chart, the ordered preoperative medications may be given.

The Circulating R.N. notifies the surgeon and anesthesiologist when an H&P is missing and anesthesia is not started until the surgeon produces an H&P for the chart.

2. Emergency Surgical Procedures: In the event of a surgical emergency, as much information as possible should be documented. It must include the reason the history and physical and informed consent were unobtainable.

F. Medical Records, Notes and Summaries:

1. Contents of a Complete Medical Record: The medical record of a patient shall contain sufficient information to identify the patient, as defined in III.B.1, support the diagnosis, justify the treatment, document the course and results accurately, and facilitate continuity of care among health care providers. Each medical record must contain at least the following:

- (a) The patient's name, address, date of birth, and the name of any legally authorized representative;
- (b) The patient's legal status, for patients receiving mental health services;
- (c) Emergency care provided to the patient prior to arrival, if any;
- (d) The record and findings of the patient's assessment;
- (e) A statement of the conclusions or impressions drawn from the medical history and physical examination;
- (f) The diagnosis or diagnostic impression;
- (g) The reason(s) for admission or treatment;
- (h) The goals of treatment and the treatment plan;
- (i) Evidence of known advance directives;
- (j) Evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy;
- (k) Diagnostic and therapeutic orders, if any;
- (l) All diagnostic and therapeutic procedures and tests performed and the results;

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- (m) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- (n) Progress notes made by the medical staff and other authorized individuals.
- (o) All reassessments, when necessary;
- (p) Clinical observations;
- (q) The response to the care provided;
- (r) Consultation reports;
- (s) documentation by the managing physician of clinical stage of cancer in one or more of the following medical record locations:

1. Hospital Medical Record

- a. History and Physical
- b. Operative Report – Indications for Surgery
- c. Surgery Consult
- d. Radiation Oncology Consult
- e. Oncology Consult
- f. Oncology Infusion Clinic Orders
- g. Written Progress Note
- h. AJCC Staging Form

2. Physician Office Record\*

\*It is desirable that a copy of the physician office record with clinical staging be available in the hospital medical record prior to treatment.

- (t) Every medication ordered or prescribed for an inpatient;
- (u) Every dose of medication administered and any adverse drug reaction;
- (v) Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
- (w) All relevant diagnoses established during the course of care; and
- (x) Any referrals/communications made to external or internal care providers and to community agencies.

2. Contents of other Outpatient Service Record:

- (a) The patient's name, address, date of birth, and the name of any legally authorized representative;
- (b) The patient's legal status, for patients receiving mental health services;
- (c) The reason(s) for the diagnostic test
- (d) Evidence of informed consent for procedures and treatments for;
- (e) Diagnostic and Therapeutic orders, if any;
- (f) All diagnostic and therapeutic procedures and tests performed and the results;
- (g) Every medication ordered or prescribed;
- (h) Every dose of medication administered and any adverse drug reactions;
- (i) All relevant diagnoses established during the course of care.



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3. Filing Incomplete Records:  
No medical record shall be filed until it is complete except on order of the Utilization & Record Management Committee.
4. Final Progress Notes:  
A case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress notes or discharge summary shall include any instructions given to the patient or family.
5. Transfer Summary:  
A transfer summary is required for all patients who are transferred to a long-term care facility (LTCF), or a Rehabilitation Unit, outside of McLaren Bay Region. The physician attending the patient to be transferred shall cause the transfer summary to be prepared in accordance with his or her instructions, which can be transmitted orally to the floor nurse to expedite the preparation of the transfer summary. The transfer summary shall be addressed to the Medical Director of the LTCF or the particular Rehabilitation Unit. An appropriate form for the transfer summary, including a pending discharge summary, may be utilized by the attending physician. The transfer summary shall include, but not by way of limitation, a final diagnosis resulting from the attending physician's prognosis, comments, and any information necessary to assign the patient a Diagnostic Related Group (DRG). In most cases, a transfer summary must accompany the patient being transferred so that the transferred patient can be properly admitted to the transferee facility. In some cases, if circumstances prevent the transfer summary from accompanying the transferred patient, the transfer summary shall, in any event, be delivered to the director of the transferee facility no later than 24 hours from the date of the order of transfer.
6. Medical Records Guidelines:  
Any guidelines regarding the completion, signing and filing of medical documents approved by the Medical Executive Committee shall be incorporated by reference in this subparagraph of the Medical Staff Rules.
- G. Dating and Authentication:  
Dating and authentication of clinical entries in the patient's medical record shall, at a minimum, include: Discharge Summaries, or Discharge Notes, H&Ps, Operative Reports, and Consultations. Authentication means to establish authorship by written signature, identifiable initials, computer key or electronic signature. The use of rubber stamp signatures is acceptable under the following strict conditions:
  1. The practitioner whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it.
  2. The practitioner places in the administrative offices of the hospital, a signed statement to the effect that he is the only one who has the stamp and is the only one who will use it.
- H. Abbreviations and Symbols:  
Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations shall be kept on file in the medical record department and in all patient care areas.

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I. Progress Notes:

1. General: Pertinent progress notes shall be recorded at the time of observation and sufficient to permit continuity of care and transferability. The interval shall not exceed 24 hours. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.
2. Critical Patients: Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

J. Operative Reports:

Operative reports shall include the provisional diagnosis, the procedure(s) performed and description of each procedure, a description of the findings, the specimens removed, the disposition of each specimen, the post-operative diagnosis, the name of the primary surgeon and any assistants; and, estimated blood loss, if applicable. Operative reports should be written or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.

K. Discharge Summary:

The discharge summary should concisely recapitulate the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, as pertinent. The condition on discharge should be stated in terms that permit measurable comparison with the condition on admission avoiding the use of vague terminology, such as "improved." Consideration should be given to instructions relating to physical activities, medication, diet, and follow-up care. A discharge summary (clinical resume') shall be written or dictated on all medical records. 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 written or dictated within 7 days of discharge and authenticated by the responsible practitioner.

If a patient remains in the hospital over 24 hours after the discharge summary was dictated, an addendum indicating why the patient remained in the hospital is required.

L. Diagnosis:

Final diagnoses should be recorded. All diagnoses confirmed should be recorded throughout the patient's stay as part of the progress notes and included in the discharge summary.

As an alternative, confirmed diagnoses may be handwritten on the Discharge Diagnoses and Procedures form.

M. Medical Records--Completion:

All patient's medical records shall be completed no later than 30 days after discharge. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, a pending diagnosis shall be stated, and the patient's record will be available for revision to a definitive diagnosis at a later date.

Incomplete medical records will be completed in the HIS medical record incomplete area. The medical records shall not be taken out of the HIS medical record incomplete area for physician to complete in other areas of the hospital. This does not affect the policy of taking medical records to the appropriate units when patients are admitted.

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N. Incomplete Records

The delinquent medical record list is published on the 1<sup>st</sup> and 15<sup>th</sup> of every month, at which time those individuals with delinquent charts over 30 days from the date of discharge shall be suspended until such time as those delinquent charts are completed. Physicians suspended for delinquent charts shall lose all admitting privileges; and, the ability to schedule or perform surgery, perform consultations, or to accept referrals. The physician may continue to render care to his/her patients in the hospital. This action does not trigger a fair hearing and is not reportable.

Individuals will get a one-time 7-day grace period annually to complete their delinquent records. If their records are not completed after that 7-day grace period, their privileges will then be suspended. The next time they have charts over 30 days, their privileges will be immediately suspended without any grace period until such time as those delinquent records are completed. This action does not trigger a fair hearing and is not reportable.

On the 1<sup>st</sup> and 15<sup>th</sup> of every month those individuals that will have delinquent charts at the time of the next list will receive a written notification and a phone call of impending suspension notifying them that unless they do their records, they will be on the delinquent list the next time it is published.

1. EXCEPTIONS TO RULES AS SET FORTH IN N:

A. In the case of vacations, the following procedures shall apply:

1. The physician shall give the Medical Staff Office a notice, either in writing or verbally, indicating the beginning and ending date of a vacation.
2. The Medical Staff Office, upon receipt of such notice of a vacation, shall notify the Health Information Services Department of the vacation period of the physician.
3. After the date of such notice to the Medical Staff Office, no medical records, including medical histories and physical examinations, shall be deemed delinquent during a period 48 hours prior to the commencement of the vacation and 48 hours after the ending date of the vacation.

B. In the case of illness, the following procedures shall apply:

1. The physician shall attempt to give notice of the commencement of an illness to the Medical Staff Office. If, however, the physician is unable to give such notice because of such illness, then the actual beginning and ending dates of such illness shall control.
2. The Medical Staff Office shall notify the Health Information Services Department of the beginning and ending dates of the physician's period of illness.
3. After the date of such notice to the Medical Staff Office, or if no notice is given because of the illness of the physician, then after the date of commencement of the illness, no medical records, including medical histories and physical examinations shall be deemed delinquent during a 48 hour period prior to the date of notice of the beginning of such illness or if no notice, then 48 hours prior to the actual beginning date of such illness and 48 hours after the ending date of such illness.

C. The intent of this exception is to give relief to the physician from a change of status by reason of any delinquency occurring during a period of 48 hours prior to the date of notice of commencement of a vacation or illness of 48 hours prior to the actual date of said illness and 48 hours after the ending of such vacation or illness.

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- D. If any change of status of a physician is made by a decision of the Health Information Services Department under N, then the physician may appeal such decision to the Chief of Staff who may confirm, modify or overrule such decision.

The procedures under N shall continue until such time as the Chief of Staff, on appeal of the physician, should modify or overrule the decision of the Health Information Services Department.

IV. DEATHS

In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his physician designee within a reasonable time. Policies with respect to release of dead bodies shall conform to local law.

V. AUTOPSIES

It shall be the duty of all staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent signed in accordance with state law. All autopsies shall be performed by the hospital pathologist or by a physician delegated this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within 72 hours and the complete protocol for uncomplicated cases shall be completed within 30 days.

- A. The Medical Staff is responsible for developing criteria for physicians to follow when considering which patients should have autopsies. The criteria are not intended to limit the solicitation of an autopsy in any particular case. They should be used to underscore those situations in which an autopsy is most desirable.

The following criteria from the College of American Pathologists will be used in determining when a request for autopsy is appropriate:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;
2. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds;
3. Cases in which autopsy may help to allay concerns of, and provide reassurance to, the family and/or the public regarding the death;
4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies;
5. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards;
6. Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction;
7. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction such as persons dead on arrival at hospitals; deaths occurring in hospitals within 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized;

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8. Deaths resulting from high-risk infections and contagious diseases;
  9. All obstetric deaths;
  10. All perinatal and pediatric deaths;
  11. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs; and
  12. Deaths known or suspected to have resulted from environmental or occupational hazards.
- B. Documentation of refusal of autopsy, by family, is noted on the patient's record by the nurse and/or physician.
- C. Time frames for completion of autopsies are monitored.
- D. Autopsy reports are distributed to physicians involved with the patient's care by the Health Information Services Department. Medical Examiner cases should be distributed as per administrative policy.
- E. Autopsy findings will be incorporated into the organization-wide performance improvement program as follows:
1. Findings of the review will be used primarily to generate educational presentations for the Medical Staff.
  2. Peer review concerns will be referred to the appropriate Medical Staff Department for consideration and/or action.
  3. A posted notice will be made to inform Medical Staff members when an autopsy is to be performed, and the attending physician will be notified in advance by the Pathologist.

VI. RESEARCH

All staff physicians shall have ready access to all appropriate medical records for the purpose of continuing research in patterns of care as well as outcome. However, such access shall be granted only after the physician has made a written request to the executive committee which includes a statement of the purpose of his research. This restriction shall not, however, restrict any physician from doing studies regarding patients wherein he is an attending, consulting, and/or admitting physician.

HUMAN SUBJECT RESEARCH STUDIES

Any member of the Medical Staff who wishes to conduct research involving human subjects at Hospital facilities, whether or not for publication purposes, shall first submit the study to the McLaren Health Care Corporation Institutional Review Board (the "Corporate IRB"). Any such member of the Medical Staff (an "Investigator") shall enroll patients and shall conduct the study in accordance with the protocol approved by the Corporate IRB and with any requirements of the Board, including without limitation, requirements for maintaining records of informed consent for each such subject and for continuous reporting of study progress and events. The Investigator acknowledges that he/she is responsible for safeguarding the rights and welfare of each research subject, and that the subject's rights and welfare take precedence over the goals and requirements of the research.

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**VII. EMERGENCY MEDICAL SCREENING, EMERGENCY ADMISSIONS AND ON CALL RESPONSIBILITY**

**A. Emergency Medical Screening Obligation Generally**

1. The Hospital is obligated and shall provide, upon request and within its capabilities, appropriate medical screening examination, stabilizing treatment and/or an appropriate transfer to another medical facility to any individual with an emergency medical condition, regardless of the individual's eligibility for Medicare, in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended.
2. The medical screening examination, in accordance with current Hospital policy, may be performed by a physician and/or by such other qualified medical personnel as are delegated by the supervising physician and deemed qualified to determine the presence or absence of an emergency medical condition.
3. Any Physician with on call responsibilities requested to provide emergency medical treatment must respond in a timely manner, or personally arrange for an appropriate alternative Physician to timely provide emergency treatment for patients in the Emergency Department, inpatients requiring emergency specialty consultation or patients in labor. Failure to meet this obligation may result in Emergency Medical Treatment and Active Labor Act (EMTALA) consequences for the Hospital and the offending Physician.

**B. On Call Procedures and Responsibilities for Members**

1. Consistent with Bylaws Section 15.7, the responsibility for the city call service shall be shared equally among members of the Active, Provisional and Consulting Medical Staff within their respective departments, unless a different arrangement is agreed upon. Each Active and Provisional Medical Staff Member is responsible for on call service as assigned by his/her Department Chairperson.
2. When an appropriate on call Physician is contacted by an attending Department Physician and is unable to provide care, it is the on call Physician's responsibility to contact another appropriate Physician to assume the care, and to inform the Emergency Department Physician or inpatient attending of the arrangement.
3. The on call Physician is expected to respond within thirty (30) minutes driving time under normal conditions when requested to appear personally.
4. If the on call Physician and the Emergency Department attending physician or inpatient attending disagree as to the disposition or plan of care of the patient, the on call Physician will appear within thirty (30) minutes driving time under normal conditions to personally evaluate the patient.
5. If the on call Physician cannot fulfill his/her call responsibilities for any reason, it is his/her responsibility to find an appropriate alternate and to notify the Emergency Department attending physician or inpatient attending of the alternate(s), coverage dates and times.
6. If a Physician fails to respond to an on call service request in a timely manner, the behavior will be reported to the Department Chairperson of the Member. The Physician will be available within two (2) business days of a request to meet with the Chief of Staff, or designee, when the responsibilities outlined in this protocol are under investigation. If successive infractions of on call coverage occur, the Member may be:

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- (a) referred to his/her Department
- (b) referred to the Medical Executive Committee
- (c) made subject to other disposition according to the Disruptive Physician policy

7. In the event the on call Physician disagrees with the conclusion of the Emergency Department attending physician or inpatient attending physician that his/her presence is immediately required, he/she shall nevertheless come to the Hospital in accordance with the timeframes outlined in this protocol. He/she may, however, request Administration to review the case.

C. Responsibilities of Departments

1. Each Department Chairperson is responsible for assignment of on call duties. He/she must ensure that all specialties and subspecialties in his/her Department are covered by an on call Physician on a 24/7 basis and his/her Department's members fulfill their obligations. Special consideration can be given for specialties and subspecialties with less than three (3) physicians; in which case, a minimum of 10 days per month including at least one weekend is required for coverage of unassigned ED patients.
2. The on call schedule will be provided to the Emergency Department and the Medical Staff Office in no less than one-month increments.

D. Responsibilities of the Emergency Department

All pertinent information pertaining to the patient must be available to the on call Physician for evaluation. The information shall be faxed to the office of the on call Physician for appropriate outpatient follow-up when indicated.

E. Process for Reporting And Investigation of On Call Protocol Violations

1. If a Medical Staff member fails to respond to an on call service request in a timely manner, this will be reported immediately to his/her Department Chairperson or, if he/she is not available, Administration will arrange for evaluation and/or care of the patient.
2. The Emergency Department attending physician or inpatient attending physician will immediately notify the on call administrator if:
  - (a) An on call Physician refuses to timely come in; and,
  - (b) A substitute Physician cannot be found; and,
  - (c) The patient is or may be transferred to another facility as a result of this.
3. If patient care was provided by another Physician because the on call Physician failed to respond, the Emergency Department attending physician or inpatient attending physician will notify Risk Management the next business day.
4. Risk Management and Compliance, in conjunction with Administration, will investigate any occurrence related to a potential or actual violation of the on call protocol in a timely manner when EMTALA rules appear to be infringed.

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5. Violations of the on call protocol will be referred to the physician's Department. The Department's disposition of the issue will be done in accordance with the provisions of the Medical Staff Bylaws, Appendices, Rules and Policies.
- F. Patients who are admitted on an emergency basis and do not have an established relationship with a Physician will be assigned to the care of a Member on call. The Chairperson of each Department shall provide a schedule for such assignments to the Department of Emergency Services and to the Medical Staff Office.

**VIII. CONSULTATION**

**A. Requirements:**

In all cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is a doubt as to the best therapeutic measures to be utilized, consultation is recommended and is appropriate. Obviously, judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital through its department chairmen and Chief of Staff to see that members of the staff do not fail in the matter of calling consultants as needed. A consultant must be qualified to give an opinion in the field in which his opinion is sought. All request for consultations shall include, but not by way of limitation, the urgency and the inclusiveness of the consultation. Such requests shall become a part of the consultation report.

**B. Qualified Consultants:**

Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise and the consultation must be performed by the end of the next day of initial notification of the request, unless otherwise specified by the ordering physician.

**C. Responsibility to Request Consultation:**

The attending practitioner is primarily responsible for requesting consultation when indicated and to personally make arrangement to call in a qualified consultant by providing written authorization except in an emergency.

1. A consultation has to be made to a specific physician not to a medical service; e.g. Neurology
2. If a consultation is requested on a hospitalized patient and the consultant is
  - not available, or
  - refuses the consultation, the following action will take place:
    - the attending physician will be notified and can then
    - name another consultant, or
    - use the Emergency Department call schedule to select another consultant. If the Emergency Department call schedule is used, the consultant cannot refuse the consultation



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D. Content of Consultation Report:

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

E. Requests for Consultation by Nursing:

If a nurse has any reason to doubt or question the care provided to any patient, she/he will follow the Chain of Command Policy.

IX. ORDERS

A. General

1. Legibility and Terminology: The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until clarified either verbally or in writing.
2. The physician or his answering service will be called by nursing personnel as soon as possible after a patient's admission for the purpose of notification of the patient's arrival and/or securing orders.
3. The physician shall provide orders prior to or at time of admission.

B. Standing Orders

Standing orders, for the physicians who have them, will be available at the appropriate nursing station. These "standing orders" will be reviewed or revised by the physician involved every three (3) years, and may be changed only by signature of the physician. Written orders accompanying a patient supersede all standing orders.

C. Stop Orders

"Stop order" policies for medications, physical and inhalation therapy and other orders and procedures will be developed where appropriate, by departments and/or committees and shall require approval by the medical staff. They shall be subject to periodic review and updating.

D. Blanket Orders

Blanket orders are unacceptable, such as "resume home meds" and "resume meds as at home."

X. SURGICAL CARE

A. Assistants at Surgery:

In any procedure with unusual hazard to life, there must be a qualified physician present and scrubbed as first assistant.

B. Previous Orders:

All previous orders are to be canceled when patients go to surgery.

C. Item Count:

Refer to O.R. policy.

XI. SPECIMENS (including Tissues)

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A. General Rule:

Specimens (including tissues) removed during a surgical procedure must be forwarded to the pathologist for evaluation, unless an exception is applicable.

1. At the time of removal, such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and source in the operating room.
2. Each surgically removed specimen shall be accompanied by pertinent clinical information, and to the degree known, the preoperative and postoperative diagnosis.
3. Receipt by the laboratory of all surgically removed specimens for examination shall be documented.
4. Every gross specimen sent to the laboratory shall be examined by a pathologist.
5. The determination of which categories of specimens requiring only a gross description and diagnosis shall be made jointly by the pathologist on duty and the Medical Staff by proper vote at a Quarterly Medical Staff meeting.
6. Any decision to rely only on gross diagnosis requires considerable judgment and, therefore, such judgment shall be made sparingly.

B. Exceptions to General Rules:

The Medical Staff, in consultation with the pathologist, shall decide whether a specimen removed during a surgical procedure should be exempted from the general rule.

1. Exceptions to the general rule are made only when the quality of care will not be compromised by the exception, and provided even in the case of the exception, that another suitable means of verification of the removal has been used, and when there is an authenticated operative or other official report that documents the removal of such specimen.
2. The limited categories of specimens that may be exempted from the requirements that such specimens be examined by a pathologist include, by way of example only, but not by way of limitation, specimens that by their nature or condition do not permit productive examination, such as:
  - (a) Cataracts
  - (b) Skin scars
  - (c) Orthopedic Appliances (screws, pins, plates)
  - (d) Teeth or fragments, provided the number of teeth removed is recorded on the operative record
  - (e) Placentas
  - (f) Foreskin
  - (g) Foreign bodies
  - (h) Portion of rib removed to enhance operative exposure
  - (i) Bullets (Will be given directly to Law Enforcement Representative according to policy)
  - (j) Therapeutic radioactive sources removed (Will be returned to Radiology)
  - (k) Pacemaker generators
  - (l) Debridement specimens
  - (m) Blepharoplast specimens

XII. ANESTHESIA

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A. Scheduling Procedures:

All procedures that require a general anesthetic will be scheduled in the surgical or obstetrical suite.

B. Post Anesthesia Recovery Procedure:

1. A five-component scoring system shall be utilized to assess a patient's postoperative status by the recovery room nurse.
2. The "discharge criteria" form shall incorporate the five-component scoring assessment and the Anesthesiologist authorizes release of patients from the Recovery Room based on this criteria using the Aldreti Scale.
3. A rating of 0, 1, or 2 shall be given to each sign, depending on its absence or presence. The ratings given to each sign shall be added and shall become the discharge score.
4. Acceptable discharge scores for specific types of anesthesia are:
  - a.) Regional = 8
  - b.) General = 8
  - c.) Local = 9-10
  - d.) Conscious Sedation = 8-9
5. The acceptable discharge scores set forth in 4 above shall apply unless any one or more of the following exceptions are present.
  - a.) Altered state of consciousness secondary to head injury or other cause.
  - b.) Inability to move extremities due to CVA, neurologic injury or absence of extremity.
  - c.) Patient on mechanical ventilation.
6. When one or more of the exceptions set forth in 5 above are present, one rating point shall be deducted from the acceptable discharge score for each of the exceptions found to be present.
7. The patient's stay shall be extended until acceptable discharge scores as set forth here is attained.

XIII. DISASTER CALL

All staff members will be subject to service under call of the chief executive officer or his designee in case of common disaster.

XIV. SUICIDAL PATIENTS

For the protection of patients, the medical and nursing staffs, and the hospital, any patient admitted to the hospital with documented suicidal tendencies shall have a psychiatric consultation ordered, within 24 hours following admission, or when that information becomes known, regardless of whether the patient agrees or not. If the patient refuses at the time of the actual consultation, it should be clearly documented, listing the reason for the refusal in the medical record. For patients who have documented suicidal tendencies, it is recommended that there be a person in attendance at all times until he has a psychiatric consultation.

XV. CPR TRAINING

Staff members are encouraged to participate in basic cardiopulmonary resuscitation training.

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XVI. DRUGS

- A. Stocked and Investigational: All drugs and medications administered patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations or FDA approved and authorized by the Pharmacy and Therapeutics Committee as outlined in the hospital formulary policy. Drugs for bonafide clinical investigations may be exceptions. These shall be used in full accordance with hospital policy and the Statement of Principles Involved in the Use of Investigational Drugs in Hospital, 1957, American Hospital Association, the American Society of Hospital Pharmacists and all regulations of the Federal Drug Administration.
- B. Drugs: A method to control the utilization of drugs shall be developed by the medical staff through its pharmacy and therapeutic committee.
- C. Drugs Brought in by Patients: A method for control of drugs brought into the hospital by patients shall be established through the pharmacy and therapeutic committee.

XVII. CLINICAL DEPARTMENTS

- A. All clinical departments which may be organized per the medical staff bylaws ARTICLE VIII shall be subject to approval by the medical staff and the board of directors. Each department or service shall develop its own rules and regulations and standards for the qualifications of the staff for membership in the service.
- B. Each department shall develop policies and procedures for discharging department responsibilities on a 24-hour basis to the hospital and the community for appropriate care of emergencies and referrals. Each member shall be required to have adequate coverage when not available and not be allowed to sign out to the Emergency Department.
- C. Departmental rules, regulations, policies and procedures shall be reviewed every two years.

XVIII. HOUSE STAFF

The Family Medicine Residency and Internship programs and any other residency programs of McLaren Bay Region Mandate the following requirements:

A. APPROVAL OF CANDIDATES

The Director of Medical Education will recommend appointment and reappointment of candidates for the Graduate Medical Education Program after evaluation, consideration, and approval by the Medical Education & Training Committee. These candidates must then be recommended for approval by the Medical Executive Committee for action by the Board of Directors on an annual basis.

B. SUPERVISION

1. That any trainee's participation in patient care is under the direct supervision of an attending staff member of McLaren Bay Region and with knowledge of the Office of Medical Education & Training and the Director of Medical Education per GME policy.
2. That the trainee's participation in procedures is under the direct supervision of the attending physician and that attending physician must be present during the performance of procedures on patients assigned to that trainee per GME policy.
3. A job description will be kept on file in the Medical Staff Office.

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4. Resident Physicians' orders can be acted on at any time by nursing personnel.
5. Resident Physicians' and Interns' orders do not require countersignature according to the guidelines of the American Osteopathic Association. Medical Students' orders require countersignature.
6. Countersignatures by the attending physician are required on Discharge Summaries, History and Physicals, Consultations, and Procedure Notes. The Procedure Notes include: Operative Summaries, Procedural Summaries, and Delivery Notes.
7. Resident Physicians' and Interns' Daily Progress Notes do not need to be countersigned by the attending. The attending must write their own daily progress notes reflecting the level of involvement according to the HFCVA Guidelines put forth July 1, 1996. Countersignature is required for Medical Students' Daily Progress Notes.
8. Countersignatures will comply with any and all regulatory body requirements.

XIX. REGULATORY AGENCIES

The members of the medical staff agree to abide by the rules and regulations required by all legal and regulatory agencies with which the hospital is either required by law or by voluntary agreement to meet.

XX. PHYSICIAN'S VERBAL AND TELEPHONE ORDERS

All physician orders shall be in writing. An order shall be considered to be in writing if given (directed) to the following personnel:

- Registered or Graduate Nurse (RN or GN)
- Registered Pharmacist (RPh)
- Licensed Physical Therapist/Physical Therapy Assistant (LPT or PTA)
- Registered or Registry Eligible Respiratory Therapist (RRT)
- Certified Respiratory Therapy Technician (CRTT)
- Clinical Psychologist (CPsy)
- Occupational Therapist (OT)
- Speech Pathologist (SP)/Audiologists (Aud.)
- Clinical Specialist (CS)
- Registered Dietitian (RD)
- Advanced Emergency Medical Technician (AEMT)
- Registered Radiological Technologists (RRT)
- Exercise Physiologist
- Registered Cardiovascular Technologist (RCVT)
- Registered Cardiovascular Invasive Specialist (RCIS)
- Medical Assistant (Medical Clinics)
- Registered Cardiac Sonographer

The foregoing individuals may accept only those orders that pertain to their departments, also inpatient laboratory studies and non-invasive diagnostic procedures except RNs or GNs who may accept all physician verbal orders.

Telephone orders for outpatient radiographic and laboratory procedures, while scheduled through clerical personnel, will be performed only after receipt of the requesting physician's order or by direct communication with a physician in the department.

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Orders of non-staff physicians (MD, DO, DDS, or DPM) for ancillary diagnostic tests and studies will be recognized by hospital and medical staff. Each ancillary department shall determine which diagnostic tests and studies will be allowed by non-staff physicians.

Non-Staff physician standing orders shall be in writing on the physician's prescription form, signed and dated by the physician, and shall be valid for not longer than 90 days, and must be renewed in writing. Original diagnostic and therapeutic reports will be forwarded to the prescribing physician to inform the patient and to interpret the results of tests or studies. Non-Staff physician orders to be done "on demand" by the patient are not acceptable.

It shall be the responsibility of the ancillary department to obtain appropriate authentication of all such orders before carrying them out. Policies and procedures for obtaining such authentication with the appropriate assistance of the medical staff shall be developed and maintained in the hospital manuals and shall be approved by the appropriate medical staff departments, committees, and the executive committee of the medical staff. A current listing of physicians shall be maintained in the health information services department. Verbal or telephone orders are to be used sparingly and shall be recorded on the physician's order sheet only by one of the above-authorized individuals receiving the order and authenticated as soon as possible. Verbal orders for DNR, restraints, and experimental drugs must be authenticated within 24 hours. Verbal orders for chemotherapy drugs will not be accepted. All other verbal or telephone orders are to be signed, dated and timed as soon as reasonably possible, not to exceed 30 days; or, in accordance with CMS and/or Joint Commission requirements. In order for the chart to be considered complete, the physician, either ordering or authenticating, must sign, date and time the verbal or telephone order.

XXI. PARLIAMENTARY PROCEDURE

Robert's Rules of Order shall apply to any question of parliamentary procedure not covered by these bylaws or rules.

XXII. ADOPTION AND AMENDMENT

Subject to approval by the board, the medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general privileges found in the Bylaws. The procedures outlined in Article Fifteen and Sixteen of the Bylaws shall be followed in the adoption and amendment of the rules and regulations, except that staff action shall occur at any properly called meeting, regular or special, when a quorum is present, and a resolution or motion is passed by a 'majority vote' as defined in DEFINITIONS.

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**ADOPTION AND AMENDMENT**

These Rules and Regulations were adopted and recommended to the Professional Affairs Committee of the Board by the Medical Executive Committee in accordance with, and subject to, the Medical Staff Bylaws.

ADOPTED by the MEDICAL STAFF on: December 13, 1995  
Date

**BOARD**

These Rules & Regulations were approved and adopted by resolution of the Professional Affairs Committee after considering the Medical Executive Committee's recommendations and in accordance with and subject to the hospital corporate bylaws.

ADOPTED by the PROFESSIONAL AFFAIRS COMMITTEE on  
February 5, 1996  
Date

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Revisions: 10/07/96 10/22/07  
04/07/97 04/28/08  
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S. M. Vandenbelt, M.D.  
Chief of Staff

G. Bosco, Chairman  
Professional Affairs Committee

