LUTHERAN HOSPITAL OF INDIANA
FORT WAYNE, INDIANA

MEDICAL STAFF RULES AND REGULATIONS

ADOPTED BY EXECUTIVE COMMITTEE
JUNE 28, 1993

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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. ADMISSIONS AND CARE OF PATIENTS

2.1 All admissions to the Hospital shall be arranged through the Patient Registration Department with the exception of pediatric patients.

2.2 The type of admission shall be determined by the admitting physician. Patient Registration will be notified of the type, emergency, urgent, or elective.

2.2.A Emergent. The patient must be admitted to receive emergency services...after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a) placing the patient's health in serious jeopardy;
b) serious impairment of bodily functions; or
c) serious dysfunction of any bodily organ or part.

Urgent. The patient must be admitted for a prompt diagnostic workup or treatment of a medical disorder that could become an emergency if not diagnosed or treated in a timely manner; that delay is likely to result in prolonged temporary impairment; and that unwarranted prolongation of treatment increases the risk of treatment by the need for more complex or hazardous treatment or the risk of development of chronic illness or inordinate physical or psychosocial suffering by the patient.

Elective. The health of the patient is not endangered by delayed admission. Such patients are usually scheduled for admission several days to several weeks in advance.

2.3 Anyone with admitting privileges shall provide at the time of admission information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self harm.

2.4 When there is no bed available for admission of a patient to an Intensive Care Unit (ICU), and the attending physicians disagree on which patient will be transferred, the following procedure will be followed:

2.4.A The responsibility for the decision lies with the Chairman of the Critical Care Committee or his designee.

2.4.B If the attending physician disputes the decision of the committee, the matter shall be referred to the President of the Medical Staff or the Chief Medical Officer

2.5 Inpatients shall receive daily physician or Nurse Practitioner/Physician Assistant visits (some exceptions for day of discharge).

2.6 Patients shall be discharged only on written order of a member of the Medical Staff or a Specified Professional Personnel or Nurse Practitioner/Physician Assistant.

2.7 Required Consultation

2.7.A Consultation with two members of the Active Staff shall be required in all therapeutic abortions, with the exception of therapeutic abortion of an anencephalic fetus, which will be permitted when the following conditions have been met:

(1) Twenty-four (24) hours has elapsed from the time of notification of the patient and informed consent is obtained and the elected method is done.

(2) Diagnosis has been made by an ultrasound exam or other radiographic study.

(3) Consultation with other members of the Medical Staff will not be required in this instance, with the exception of a radiologist to confirm the findings of the ultrasound exam or other radiographic study.

(4) The patient has been informed of the risks of the intended method of pregnancy termination such as dilation and curettage or prostaglandin induction of labor.

2.7.B All consultations shall be recorded in the medical record.

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

PART III. DRUGS, ORDERS AND TESTS

3.1 Automatic stop orders are to be applied to the following categories of drugs:

A. Schedule II controlled substance -- 5 days

B. Antineoplastics -- 5 days

C. Anticoagulants -- 5 days (excluding Coumadin)

D. Amphetamines -- 10 days

E. Antibiotics -- 10 days unless otherwise specified by the doctor's written order

The attending physician will reorder the drug, change the order, or cancel the order upon notification of the stoppage of the drug.

3.2 Pharmacy Operating Policies

3.2.A Formulary

(1) A listing of all Drug Formulary items stocked in the Pharmacy will be maintained in binders to be located at each nursing station.

(2) 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 physician specifically writes "Do Not Substitute" on the patient order sheet.

3.2.B Requests for new drugs to be used in the Hospital prior to their need--it is recommended that Staff physicians contact the Director of the Pharmacy, either in person or by using the special request forms which are included in the Pharmacy Catalogue in the nursing stations when a new item is desired.

3.2.C Additions and Deletions to the Hospital Formulary

(1) 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.

(2) Requests for new drugs to be used in the hospital prior to Pharmacy-Therapeutics approval should be made to the director of the Pharmacy, either in person or by using the special request forms which are included in the Hospital's formulary binder located in the nursing stations.

(3) Staff members shall be notified whenever a drug is under consideration for deletion so that they may submit evidence for its retention.

(4) Investigational drugs may be administered following IRB approval and in accordance with IRB guidelines. All investigational drugs are to be dispensed from the Pharmacy Department.

3.2.D Information services--the Pharmacy shall maintain an adequate library and an extensive product information file to make information concerning drugs available to the Staff members.

3.3 An automatic stop order becomes effective for all medications when the patient goes to surgery. Medications are resumed postoperatively upon the written order of the physician. All Emergency Department orders are considered to be one-time orders unless otherwise specified.

3.4 Intravenous therapy may be given by a member of the Intravenous Therapy Team in this Hospital. Intravenous admixtures are to be prepared within the Pharmacy Department under laminar air flow except for emergency situations.

3.5 Verbal orders regarding medications and nursing functions shall be dictated to the following Lutheran Hospital associates: 1) registered nurses; 2) licensed practical nurses; 3) registered pharmacists; 4) credentialed respiratory care practitioners (inhalation medications only); and 5) radiology and nuclear medicine technologists who are administering medications as part of procedural protocol. Verbal and/or telephone orders regarding medications or specific patient care functions may also be taken by a registered nurse or a licensed practical nurse who is providing services as an allied health professional to patients of his/her employer.

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

A. The radiology secretary may take orders for procedures. This is followed by a written order from the physician. Radiographic IV contrast materials and radioisotopes are considered ordered when the specific procedure is ordered.

B. Cardiac Rehab associates may take verbal and/or telephone orders for departmental procedures.

C. 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.

D. A registered dietician may take a verbal and/or telephone order for nutritional aspects of care.

E. Verbal orders to admit a patient as either inpatient or observation status may be taken by the Patient Registrars. Patient Registrars may not take orders for treatment.

F. Case Managers/RN's may take verbal and/or telephone orders for: admitting a patient to either inpatient or observation status; discharge/care related to home health services; discharge/level of care to any extended, long term or continuum of care facility; and need for ambulance/stretcher transport.

G. Case Managers/SW's may take verbal and/or telephone orders for: discharge/services to any extended, long term, or continuum of care facility (rehab, hospice, LTAC); discharge related to home health services; and need for ambulance/stretcher transport.

Verbal and/or telephone orders are discouraged except in emergency situations. 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. The physician who gave the verbal order or another practitioner (who is credentialed and granted privileges to write orders) who is also responsible for the care of the patient shall authenticate and date any order including but not limited to medication orders as soon as possible, and in no case, longer than thirty (30) days from dictating the verbal order. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action. Orders for outpatient tests require documentation of a diagnosis for which the test is necessary.

When there is a need for clarification of the order of an attending physician, 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 physician.

3.6 Daily laboratory tests ordered for an unspecified duration, shall be called to the attention of the attending physician upon the expiration of three (3) days. The attending physician will reorder, change, or cancel the test. The exception to this order would be if the physician specifically specifies an expiration of more than three (3) days.

3.7 Medications brought from home by the patient are to be identified by the Pharmacy Department. The physician'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:

A. The physician writes an order;

B. The patient is competent to administer.

PART IV. MEDICAL RECORDS

4.1 The purposes of the medical record are:

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

B. To furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay, or while being followed in the hospital-administered home care program;

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

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

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

4.2 Attending Physician's Responsibilities

4.2.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; 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.

4.2.B Inpatient medical records shall include at least the following:

(1) Identification data including patient's full name, address, and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.

(2) An admission note should be present on the chart within 24 hours of admission, which validates the reason for admission and outlines the plan of treatment.

(3) History and physical examination - refer to Medical Staff Policy.

(4) Diagnostic and therapeutic orders (verbal, standing, or written) shall be authenticated by the responsible practitioner.

(5) A discharge order given by a Medical Staff member, resident, or Specified Professional Personnel is required to release a patient.

(6) The informed consent is the responsibility of the attending physician to obtain. The medical record shall contain evidence that an informed consent form shall be signed by the patient or legal guardian and by a witness and shall be made a part of the record before any major procedure is performed.

(7) Progress notes shall reflect the condition of the patient and shall be recorded daily on all patients. The progress note shall present a chronological picture and an analysis of the clinical course of the patient. In cases where multiple physicians are involved, a single progress note will meet this requirement.

(8) Consultation reports shall contain the written opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

(9) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature. Staff physicians, residents, qualified oral surgeons, and clinical medical students are the only individuals competent to write or dictate the medical history and physical examination. (Qualified oral surgeons are those individuals who have successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education, and have been granted privileges to record history and physical examination on patients who are Class I anesthesia risks.) In any case in which it is anticipated that controlled hypotension is to be used, a medical consultation is required prior to admission of the patient.

(10) All treatments, examinations, and procedures should be documented in the medical record within 24 hours of completion.

(11) Clinical laboratory, radiology, and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion.

(12) All surgical specimens removed shall be sent to the laboratory, and an acknowledgement that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted.

(13) A postoperative handwritten note for the chart shall be completed immediately after any surgical/invasive procedure. A full operative note shall be dictated within 24 hours when conscious sedation, general anesthesia, regional anesthesia including blocks, MAC, and local anesthesia is administered. A postoperative handwritten note and a full dictated report are also required for any case done in the operative suites. The operative reports shall include: date of surgery, pre- and postoperative diagnosis, procedure performed, surgeon, specimen removed, findings, type of anesthesia, estimated blood loss, drains and complications if any, and narrative description of the procedure.

(14) A preanesthesia evaluation shall be completed within 48 hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intraoperative anesthesia record during the procedure. The physician administering the anesthesia shall be responsible for the completion of a postanesthesia report within 48 hours.

(15) When an organ is obtained for transplantation from a live donor, the medical record shall meet the same requirements as any surgical inpatient medical record. When the donor organ is obtained from a brain-dead patient, the medical record of the donor shall include the date and time of brain death, documented by and identification of the physician who determined the death, the method of transfer and machine maintenance of the patient for organ donation, as well as an operative report. 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.

(16) A discharge summary written or dictated at the time of discharge should 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. For hospitalizations under 48 hours, the final progress note may serve as a discharge summary. However, it must contain: (1) the outcome of the hospitalization; (2) disposition of the case; (3) instructions given and provisions made for follow-up care, and; (4) must include the discharge diagnosis.

(17) 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.

(18) Final diagnoses, operations, and procedures shall be coded in ICD-9-CM codes. No abbreviations are acceptable in final diagnoses, operations, and procedures.

(19) The attending Medical Staff member, Specified Professional and properly credentialed allied health professional shall sign all entries he/she makes in the medical record. The Medical Staff member shall cosign entries made by residents and medical students under his supervision. Orders entered by properly credentialed allied health professionals do not require a cosignature as long as they are acting within their approved scope of practice. All Allied Health Professional progress notes, history/physical examinations, discharge summaries and consultations must indicate the name of the collaborating physician. Use of rubber signature stamp is prohibited. Electronic signatures may only be used by the individual to whom the electronic code has been uniquely assigned.

4.2.C Outpatient medical records shall include the following:

(1) Identification data including patient's full name, address, and date of birth. A permanent identification number shall be assigned which identifies the patient and all medical records.

(2) History and physical examination - refer to Medical Staff Policy.

(3) Diagnostic and therapeutic orders (verbal, standing, or written) shall be authenticated by the responsible practitioner. A discharge order given by a Medical Staff member, resident, or Specified Professional Personnel is required to release a surgical patient.

(4) The informed consent is the responsibility of the attending physician to obtain. The medical record shall contain evidence that an informed consent has been obtained by the attending physician or other treating physician before any major procedure. The informed consent form shall be signed by the patient or legal guardian and by a witness and shall be made part of the record before any major procedure is performed.

(5) Opinions requiring medical judgment are to be written or authenticated by Medical Staff members, residents, and other practitioners who have been granted clinical privileges. This includes, but is not limited to, the medical history and physical examination. The parts of the medical record that are the responsibility of the physician or dentist in charge of the patient shall be authenticated by his signature. Staff physicians, residents, medical students, qualified oral surgeons, and clinical medical students are the only individuals competent to write or dictate the medical history and physical examination.

(6) All treatments, tests, examinations, and procedures should be documented in the medical record within 24 hours of their completion.

(7) Clinical laboratory, radiology, and nuclear medicine examinations shall be entered in the patient's record within 24 hours of completion if possible. reports from approved laboratories outside the Hospital are acceptable in lieu of tests performed inside the Hospital. Laboratory procedures must be done within five days prior to treatment.

(8) All surgical specimens removed shall be sent to the Laboratory, and an acknowledgement that the tissue has been received and a gross description of the findings shall also be made a part of the patient's record. The microscopic examination is to be carried out by the pathologist when in his opinion such examination is necessary for the proper diagnosis of a disease state in the tissue submitted.

(9) A postoperative handwritten note for the chart shall be completed immediately after any surgical/invasive procedure. A full operative note shall be dictated within 24 hours when conscious sedation, general anesthesia, regional anesthesia including blocks, MAC, and local anesthesia is administered. A postoperative handwritten note and a full dictated report are also required for any case done in the operative suites. The operative reports shall include: date of surgery, pre- and postoperative diagnosis, procedure performed, surgeon, specimen removed, findings, type of anesthesia, estimated blood loss, drains and complications if any, and narrative description of the procedure.

(10) A preanesthesia evaluation shall be completed within 48 hours prior to surgery by a physician credentialed to administer anesthesia. The physician administering the anesthesia shall be responsible for completing the intraoperative anesthesia record during the procedure. The physician administering the anesthesia shall be responsible for the patient meeting established postoperative criteria for discharge.

(11) Discharge instructions shall be given to the patient and/or family as necessary, especially for emergency and surgical patients.

(12) 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.

(13) Final diagnoses, operations, and procedures shall be coded in ICD-9-CM codes. No abbreviations are acceptable in final diagnoses, operations, or procedures.

(14) The attending Medical Staff member, Specified Professional and properly credentialed allied health professional shall sign all entries he/she makes in the medical record. The Medical Staff member shall cosign entries made by residents and medical students under his/her supervision. Orders entered by properly credentialed allied health professionals do not require a cosignature as long as they are acting within their scope of practice. All Allied Health Professional progress notes, history/physical examinations, discharge summaries and

consultations must indicate the name of the collaborating physician. Use of rubber signature stamp is prohibited. Electronic signatures may only be used by the individual to whom the electronic code has been uniquely assigned.

4.3 Completion of Inpatient Medical Records

All medical records shall be completed within 30 days of discharge. The Medical Staff Policy titled "Medical Record Delinquency" defines and outlines the corrective action process for physicians with delinquent medical records up to and including potential suspension and denial of reappointment to the Medical Staff.

4.3.A A medical record shall be considered complete when required reports have been dictated and/or written and signed, all progress notes and doctors' orders have been signed, and the face sheet has been completed and signed.

4.3.B Legal Status of the Medical Record

The medical record is the property of the Hospital and shall not be removed except by enforceable subpoena duces tecum, court order, or statute.

4.3.C Accessibility of the Medical Record

(1) Free access to the medical records of all patients shall be afforded to Staff Members and Specified Professional Personnel for bonafide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

(2) Subject to the discretion of the Chief Executive Officer of the Hospital and as permitted by applicable federal and state laws, rules and regulations, 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 were attending such patients in the Hospital.

(3) On readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is to be attended by the same physician or another.

PART V. RULES AND REGULATIONS FOR MEDICAL RESIDENTS AND MEDICAL STUDENTS

5.1 Residents shall be subject to the applicable policies, Rules and Regulations of the Fort Wayne Medical Education Program.

5.2 Medical students shall be subject to the following rules:

A. Medical students shall provide services under the direct supervision of their medical education directors and/or the Medical Staff members to whom they are assigned.

B. First and second-year medical students' activities shall be limited to the observation of patients and training in the taking of patient histories and the performance of physical examinations.

C. Third and fourth-year medical students may take histories and perform physicals, provided that records of such activities are countersigned by an attending member of the Medical Staff. Such students may also assist in surgical, obstetrical, and other invasive procedures, provided that such assistance occurs under the direct and continuing supervision of an appropriately-credentialed Staff member.

PART VI. DISTRIBUTION

6.1 A copy of these Rules and Regulations shall be provided to each Staff member, practitioner, and person granted privileges in any manner or form by the Medical Staff.

PART VII. DISASTER PLAN

7.1 All physicians on the Medical Staff accept the duties and responsibilities as outlined in the Hospital's master disaster plan.

PART VIII. AUTOPSIES

8.1 Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without written consent of a relative or legally authorized agent. All Hospital autopsies shall be performed or supervised by the Hospital pathologists or by a physician delegated this responsibility.

PART IX. AMENDMENT

9.1 Amendment

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

10.1.A A resolution of the Medical Executive Committee recommended to and adopted by the Board; or,

10.1.B A resolution of the Medical Staff and confirmed by the Executive Committee, and approved by the Board.

9.2 Responsibilities and Authority

The procedures outlined in the Bylaws and Hospital Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt, and recommend the Bylaws and amendments thereto, and the circumstances under which the Board 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.

PART X. APPROVAL

Approved by Executive Committee: June 3, 2013

Approved by Board of trustees: June 11, 2013