

# ANGEL MEDICAL CENTER

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## **I. ADMISSION AND DISCHARGE OF PATIENTS**

### **A. Admitting/Attending Physician:**

Only physicians granted medical staff membership and admitting privileges may admit patients to this Hospital. A physician member of the medical staff shall be responsible for the inpatient care and discharge of each patient in the Hospital.

### **B. Responsibility for Patient Protection:**

The Hospital shall accept patients for care and treatment only within the scope of available personnel, adequate facilities and equipment. Patients who are known to be suffering from drug abuse, alcoholism and mental illness shall not be admitted unless proper safety precautions can be taken to safeguard the patient, other patients and employees including a necessary attendant to remain in the room with the patient at all times.

### **C. Transfer of Medical Care:**

Whenever medical care is transferred to another practitioner, the practitioner transferring his responsibility shall personally notify the other practitioner to ensure that the acceptance of that responsibility is clearly understood and then enter an order to transfer in the medical record. Each active medical staff member shall name another member of the Staff as an alternate to assume care of his patients during his absence or make arrangements for suitable locum tenens coverage. In the case of a medical emergency, the designated physician shall be called. In the case the on-call is not available, the CEO or the Chief of Staff shall have the authority to call any other appointee of the Staff to attend to the patient. Failure of an appointee of the Medical Staff to meet these requirements will result in disciplinary action.

### **D. Provisional Diagnosis:**

Except in the case of emergency admissions, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been documented. In the case of an emergency, such statement shall be recorded as soon as possible, but no later than eight hours.

### **E. Unassigned Patients:**

In the case of a patient requiring admission who has no practitioner, the patient shall be assigned to the physician on-call for the specialty to which the illness of the patient indicates.

**F. Discharge of Patients:**

Patients shall be discharged from the Hospital only on the written order of the patient's attending physician or his alternate. If a patient leaves the Hospital against the advice of his attending physician, or without proper discharge orders, every attempt will be made to obtain a signed "Leaving Against Medical Advice" form.

**G. Transfer of Patients within the Hospital:**

Patients shall not be transferred within the Hospital without the approval of attending physician or on-call physician or chairman of the appropriate department.

The order of priority for in-house patient transfers shall be as follows:

1. Emergency service to appropriate nursing unit.
2. From Med/Surg/WHCU to ICU,
3. From ICU to Med/Surg/WHCU,
4. From temporary placement in an inappropriate nursing unit or clinical service to the appropriate service or nursing unit, and
5. From WHCU to Med/Surg.

Admissions to and from special care units shall be in accordance with established criteria. Exceptions shall be approved by the chairman of the appropriate department.

**H. Patient Hospital Utilization:**

Practitioners shall abide by the Hospital's utilization review plan to include the following:

1. The appropriateness and medical necessity of admissions,
2. Continued stay,
3. Supportive services, and
4. Discharge planning.

**I. Patient Death:**

In the event of a Hospital patient death, the deceased shall be pronounced dead and the body shall not be released until every reasonable attempt is exhausted to obtain permission from next of kin or guardian and an order has been received by the physician.

**II. EMERGENCY SERVICES**

**A. Medical Director of Emergency Services:**

The Director of Emergency Services shall have the overall responsibility for directing emergency services.

**B. Emergency Services Policies and Procedures:**

Emergency service policies and procedures shall be approved by the Director of Emergency Services and the Department of Medicine. The Emergency Physician Director shall be responsible for developing and implementing appropriate performance improvement policies and procedures. This shall be in cooperation with other disciplines / services where appropriate.

**C. Medical Staff Coverage:**

Members of the Active Medical Staff, where appropriate, shall accept responsibility for assignment to the list of on-call physicians for their specialties to provide treatment necessary to stabilize an individual with an emergency medical condition including admitting the patient to the inpatient unit. The on-call physician will be available to the Emergency Department for emergency consultations on their patients or unassigned patients with problems in their specialty when needed by the Emergency Department physician. The on-call physician shall respond within 30 minutes of being notified and if the situation warrants, be present in the ER within an additional 30 minutes.

All physicians rendering primary emergency care in the Emergency Department shall have clinical privileges for such care delineated in accordance with Staff and Hospital procedure. The emergency physician is responsible for determining as quickly as possible, what assessments are required to care for the patient's needs.

**D. On-Call Roster:**

An emergency physician duty roster shall be maintained and the designated physician(s) shall be available for rendering emergency patient care twenty-four (24) hours per day, seven (7) days per week or as recommended by the Medical Executive Committee and approved by the Board of Trustees.

**E. Failure to Assume On-Call Responsibilities:**

If a physician assigned to emergency call fails to respond to a request by the Emergency Physician to assume care for an unassigned patient, or

renders himself/herself unavailable, such physician shall be dealt with as follows:

- First Offense: Written warning from the Medical Executive Committee
- Second Offense: If second offense occurs within 24 months of the first offense, physician will be asked to come before the Medical Executive Committee about the matter.
- Third Offense: If third offense occurs within 24 months of the first offense, physician will be suspended for a two week period.
- Subsequent Offenses: If subsequent offenses occur within 24 months of the first offense, the medical staff member may be terminated.

**F. Medical Screenings:**

Medical screenings shall be provided to every individual who presents at the Emergency Department. Medical screenings shall be completed by a physician member of the medical staff per policy.

**G. Care of Patient:**

To clearly establish and transfer responsibility of care, for patients being admitted through the Emergency Department, Emergency physicians should discuss the case of any patient requiring hospital admission with the attending. Only brief orders necessary to treat the patient's acute condition should be written. If a patient requires inpatient admission or observation, in the judgment of the emergency physician and the attending or on-call physician, the patient shall be admitted in the name of the patient's physician or the physician on-call. If in the judgment of the emergency physician, the patient's condition requires continuing practitioner attendance, the emergency physician shall continue to accept responsibility for the patient until the assigned physician comes to the Emergency Department and assumes responsibility for the patient or until the patient arrives, without incident, to his assigned room.

**H. X-Ray Reports:**

In cases where x-ray interpretation of the radiologist differs from that initially made by the emergency physician, enough to require a change in treatment or follow-up, copies of the radiologist's report shall be made available and brought to the attention of the emergency physician, the patient's private physician and the patient.

**I. Emergency Service Medical Record:**

An appropriate emergency service medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's inpatient medical record, current or previous, if such exists. The emergency service medical record shall include appropriate demographic and clinical information including means of arrival conclusions with disposition, condition on discharge, leaving AMA, and discharge instructions and shall be signed by the emergency department physician who is responsible for its clinical accuracy.

**J. Transfers:**

EMTALA Law and the Hospital's policies and procedures for patient transfers to other facilities shall be followed.

**K. Disasters:**

The Emergency Physician Director shall assist in planning for emergency service procedures to be properly coordinated with the Hospital's disaster plan, particularly as they pertain to the care of mass casualties.

**III. MEDICAL RECORDS**

**A. Consent for Admission and Treatment:**

The patient or legal guardian shall sign a general consent form for admission and treatment at the time of admission or as soon thereafter as possible.

**B. Informed Consent:**

Physicians shall follow the informed consent policy of the hospital.

**C. Physician Orders:**

A physician's orders must be written clearly, legibly and completely. Orders, which are illegible or incompletely written, will not be carried out until rewritten and/or clarified.

**D. Physician Standing Orders:**

A physician's standing orders, shall be reproduced in detail on the order sheet of the patient's record, dated and authenticated by the physician. Standing orders shall be reviewed / revised and approved annually by the MEC.

**E. Transfer of Patients to Other Areas:**

All previous orders are canceled when patients go to surgery or to and from a special care unit.

- F.** For information on the following topics, refer to the Medical Record Requirements Policy and Procedure:
- a. Contents of medical records
  - b. Physician Orders
  - c. History and Physical Examination
  - d. Operative Progress Notes and Operative Report
  - e. Discharge Summary, Transfer Summary, Final Progress Note, Short Form
  - f. Progress Notes
  - g. Respite Care Unit
  - h. Hospice
  - i. Miscellaneous Requirements

#### **IV. CONSULTATIONS**

- A.** The attending physician is primarily responsible for requesting consultation when indicated. Only practitioners who have been granted staff membership and/or clinical privileges or specified services in their area of expertise may be called upon for consultations. The attending physician will provide written authorization to permit another practitioner to attend or examine his patient except in an emergency.
- B.** Except in extreme emergencies, consultations shall be considered under the following conditions:
1. In any instances in which the patient exhibits severe psychiatric symptoms or for any patient who has attempted suicide or has taken a chemical overdose. Referral services should be documented in the patient's medical record as well;
  2. When requested by the patient and/or family;
  3. When required by the policy of the special care unit.
  4. When the needs of the patient exceed the limits or privileges of the attending physician, a consult with a physician with appropriate privileges is required.
  5. Physicians are encouraged to seek consultations with an appropriate credentialed physician in cases where there is doubt to the clear choice of treatment plan or where the diagnosis is obscure after ordinary diagnostic procedures have been completed. When a consultation is requested, the consulting physician's physician assistant or nurse practitioner may see the patient initially. However, the consulting physician must see the patient within the first 24 hours.

- C. 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. When operative procedures are involved, the consultation note shall, except in emergency situations that are so verified on the record, be recorded prior to surgery.

## V. DRUGS, MEDICATIONS, AND BLOOD TRANSFUSIONS

All drugs and medications administered to patients shall be those listed on the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs of bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Hospital's Drug Standards, Policies and Procedures governing investigation use and all regulations of the Federal Drug Administration.

- A. Investigational drugs, not FDA approved for use in the United States, will only be used when received from an outside primary investigator and will only be used if the patient has been taking the investigational drug under the supervision of an FDA registered primary investigator. A copy of the protocol of the study must be sent to the hospital for inclusion in the patient's chart and for file in pharmacy. The patient's attending physician will be responsible for obtaining this study protocol. The patient must sign a consent form entitled, "Authorization for Use of Investigational Drugs". A patient has the right to refuse to participate in the use of investigational drugs.
- B. All inpatient medication orders will be reviewed and reordered as indicated every Monday and Thursday. A reorder form is posted on the front of each chart; orders are either renewed or discontinued as the physician indicates on the reorder form.
- C. The use of a patient's own supply of medications will be permitted only with the following conditions:
  1. The patient's physician authorizes the use of the medication by writing an order in the medical record.
  2. The medication is non-formulary (Exceptions include multidose products such as an inhaler or eye drops).
  3. The medication is not a controlled substance, and
  4. Pharmacy procedures are followed for identification and dispensing the medication and signed "Consent to Administer Medication Supplied by the Patient" is obtained.

- D. Blood, which has been cross-matched and is being held for a patient will be held for forty-eight (48) hours at which time the order for the blood will be canceled unless reordered for another forty-eight (48) hours.

## **VI. CARDIOPULMONARY THERAPY AND DIAGNOSTIC TESTS**

Cardiopulmonary therapy and testing will be administered according to the attending physician's orders. Duration and mode of therapy will be monitored through the use of a protocol system, which allows for the physician to have the final decision to the type of therapy the patient receives, if any. The protocol system provides for evaluation of the patient's progress every seventy-two (72) hours of therapy.

- A. Requisition forms for diagnostic tests shall be filled out completely including pertinent clinical data to justify the need for the exam requested. A nurse may take the necessary data from the order sheet or progress notes.
- B. All female patients of childbearing age will be asked if there is a possibility that they may be pregnant before a radiographic procedure is done. If so, the radiologist will be consulted. When the examination is deemed necessary, the abdominal region must be shielded with a lead apron.

## **VII. GENERAL CODE OF CONDUCT**

- A. When physicians have inpatients, they shall:
  - 1. Respond within 30 minutes of being notified, and if the situation warrants, be at the hospital within an additional 30 minutes; or
  - 2. Designate in writing who shall be responsible for their inpatient(s) should they be unavailable.
- B. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she or he shall call this to the attention of her or his supervisor who in turn may refer the matter to the CNO. If warranted, the CNO may bring the matter to the attention of the attending practitioner, the Chairman of the appropriate department, or the Chief of Staff.
- C. For writing DNR orders, physicians shall abide by the DNR policy of the hospital.
- D. Physicians shall abide by the official restraint policy of the Hospital.

- E. Physicians shall abide by the official conscious sedation policy of the hospital.
- F. Physicians are required to wear an AMC identification badge while treating patients in the hospital.

## **VIII. AUTOPSIES**

It is suggested that autopsies be considered in the following circumstances:

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 the family and/or the public regarding the death, and to provide reassurance to them regarding same.
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 which are apparently natural and not subject to a forensic medical jurisdiction.
7. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at hospital (b) deaths occurring in hospitals within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
8. Deaths resulting from high-risk infectious and contagious diseases.
9. All obstetric deaths.
10. All perinatal and pediatric deaths.
11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
12. Deaths known or suspected to have resulted from environmental or occupational hazards.

Physicians should consider medical examiners statutes and refer to medical examiners appropriately. When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within three days and the complete protocol is included in the record within 60 days.

## **IX. NOTIFICATION OF STATUS CHANGES**

Practitioners who have medical staff or allied health privileges at AMC shall immediately report any of the following instances to the Chief of Staff or Administration:

1. Revocation, suspension, reduction or failure to renew privileges at any other hospital or institution in which the practitioner practices or provides treatment to patients.
2. Any change in mental or physical ability which could or might affect his or her professional performance in the care of patients within the Hospital.
3. Any change in professional liability insurance coverage.
4. Any conviction or plea of guilty or nolo contendere to any criminal offense.
5. Any suspension or termination of state license or any change in eligibility for payment by third party payers or for participation in Medicare on a reimbursable basis, including any notification of sanctions imposed or recommended by the Federal Department of Health and Human Services or any state program.

## **X. SURGERY/ANESTHESIA**

### **A. Anesthesia:**

The anesthetist / anesthesiologist is responsible for conducting a pre-anesthesia evaluation and documenting this evaluation in the patient's medical record prior to the patient's transfer to the operating area and before pre-operative medication is administered. Patient is reassessed prior to the procedure. This note shall include an evaluation of the patient including drug and anesthesia history and a risk assessment and the choice of anesthesia for the surgical or obstetrical procedure anticipated. In the absence of the anesthesiologist, the surgeon is responsible for reviewing and co-signing the pre-anesthesia plan.

The anesthetist / anesthesiologist is responsible for maintaining a complete record of the anesthetic event including notation of the patient's condition at the conclusion of the case. An anesthetist is responsible for writing a post anesthesia recovery care note after the patient has completed post anesthesia care, which includes at least acknowledgement of the cardiopulmonary status, level of consciousness and the presence or absence of anesthesia related complications. In the case of post anesthesia complications, a plan of care shall be outlined. Each anesthesia entry shall be dated, signed and authenticated by the responsible anesthetist / anesthesiologist.

### **B. Surgical Care:**

A history and physical examination including the indication for surgery, the surgery planned, preoperative diagnosis, appropriate consents for the procedure / anesthesia, laboratory and radiology reports assessments of risks/benefits of the procedure, assessment of the need or potential need to administer blood, and consultations when requested, must be recorded on the patient's medical record prior to any surgical procedure except in the case of an extreme emergency. In the case of an extreme emergency (a non-elective procedure with serious threat to life or function) where any or all of the above entries have not been made in the medical record, the surgeon shall state in writing that a delay would be detrimental to the patient prior to induction of anesthesia or the start of surgery. The history and physical examination shall include documentation of a chief complaint: history of present illness, relevant past, social and family histories, review of systems, physical examination, conclusion, impression or admission diagnosis, and a plan or course of action planned for the patient.

Nursing, inpatient or outpatient, will routinely check all surgical charts for H&P. If there is no H&P, the surgeon will be notified thirty (30) minutes to one (1) hour prior to the scheduled surgery time. Patients will receive pre-op medication as scheduled and will remain in the inpatient or outpatient room. If the surgeon does not provide the H&P, surgery will be moved to the end of the surgery schedule per the anesthesiologist. In cases where patients are referred to surgeons for consults, the attending physician will be responsible for the H&P.

Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he may be referred to the Chairman of the Department of Surgery for disciplinary action.

Surgeons shall abide by the scheduling policy of the Operating Room.

1. The following information is required to post a case:

The patient's full name, age, sex, phone number, planned surgical procedure, requested type of anesthesia, operating surgeon and time of length of procedure.

Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parent, guardian or next of kin, these circumstances should be fully documented on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time

permits. The anesthesiologist / anesthetist is responsible for obtaining anesthesia consent.

Pre-operative laboratory and radiographic evaluation shall be at the discretion of the operating surgeon(s) and anesthesiologist / anesthetist.

Sterilization, male or female, will not be done without the fully informed consent of the patient as evidenced by a signed consent form.

Patients are discharged from PACU by a licensed practitioner or by established criteria.

**C. Assistant at Operation:**

If, in the opinion of the operating surgeon and/or the Chief of Surgery, there is in any surgical procedure an unusual hazard to life, there shall be present and scrubbed, as first assistant, a qualified physician.

**D. Surgical Specimens:**

Tissue / specimens removed at the operation shall be sent to the hospital pathologist to arrive at a tissue diagnosis. Each specimen shall be accompanied by the necessary information including pre-op diagnosis, description of tissue and brief pertinent clinical data. Exemptions from pathological examinations are listed in the policies and procedures of the hospital. The pathologist's report shall be made a part of the patient's medical record.

**E. Preceptorship/Supervision Status:**

A staff appointee who is classified in a preceptorship or supervisory status for specified surgery privileges must have present his preceptor or qualified assistant for these specified surgery procedures.

**F. Surgeries Performed by Oral Surgeons, Dentists or Podiatrists:**

A patient admitted for dental / podiatric care is the responsibility of the dentist / podiatrist and active medical staff member.

1. The dentist / podiatrist shall arrange for admission to the hospital through an active medical staff member, schedule surgery and complete a detailed dental / podiatric history, a pre-operative diagnosis, a complete operative report describing the findings and techniques, progress notes as are pertinent to the oral / foot condition and discharge summary.
2. The active medical staff member shall be responsible for the medical history and physical pertinent to the patient's general

health, a physical examination to determine the patient's condition prior to anesthesia and surgery, and supervision of the patient's general health status while hospitalized.

\*Medical H&P and physical examination may be performed by an oral surgeon who has been granted medical staff privileges pursuant to these Bylaws Rules and Regulations.

3. No podiatric or dental procedure requiring general or regional anesthesia shall be performed without the presence of an anesthesiologist in the surgery suite.

## **XI. OBSTETRICAL CARE**

- A.** The current obstetrical records shall include a complete prenatal record. The prenatal record may be a legible copy of the attending physician's office record.
- B.** The prenatal record may serve as the H&P. A progress note on important or new physical findings since her last physical examination on the pregnancy record shall be documented.
- C.** A final progress note may be substituted for a discharge summary in the case of normal newborn infants and uncomplicated obstetric deliveries.
- D.** Oxytocic drugs shall be used in the following manner:
  1. Intravenous oxytocin shall be initiated only with the physician readily available or immediately accessible by phone to the LDR unit.
  2. The reason for induction labor shall be stated in the history or progress notes.
  3. No more than two elective inductions shall be scheduled at one time.
- E.** Informed consent for the delivery shall be obtained on the patient's arrival to LDR area.
- F.** All previous orders are cancelled after Cesarean section or postpartum tubal ligation unless the physician writes an order to continue previous orders.
- G.** Medically indicated terminations of pregnancy will be handled in the following manner:
  1. The reasons for the termination of pregnancy must be clearly documented in the medical record.
  2. All terminations of pregnancy done will be reviewed through the Surgical Care Review process.
  3. Terminations of pregnancy will be done for fetuses at risk of fetal anomalies or maternal health factors only.
- H.** Diagnostic dilation and curettage will not be performed unless the medical record reflects a preoperative negative pregnancy test or documentation of a previous sterilization procedure.

- I. Medical screening examinations in the Labor and Delivery unit on obstetrical patients will be performed as outlined in the “Medical Screening Examinations” policy.

**XII. NEWBORN CARE**

- A. All newborn orders must be itemized, including orders for formula and care of the newborn and signed by the attending physician.
- B. A physical examination shall be recorded in the medical record of all newborns.
- C. PKU testing will be done at the direction of the MD according to North Carolina guidelines.