

**SAINT MICHAEL'S HOSPITAL  
STEVENS POINT, WISCONSIN  
MEDICAL STAFF RULES AND REGULATIONS**

(Approved 05/24/2005)

TABLE OF CONTENTS

A.	GENERAL PROVISIONS AND AUTHORITY .....	1
1.	Staff Rules and Regulations .....	1
2.	Department Rules and Regulations .....	1
3.	Definitions .....	1
B.	ADMISSION AND DISCHARGE OF patients .....	1
1.	Admitting Privileges .....	1
2.	Responsibility for Care .....	1
3.	Provisional Admitting Diagnosis .....	2
4.	Admission Priorities .....	2
5.	Need for Continuing Hospitalization .....	3
6.	Transfer of Patients .....	3
7.	Certification of Death .....	4
8.	Discharge Orders .....	4
C.	MEDICAL RECORDS .....	4
1.	Responsibility .....	4
2.	Inpatient Admission History and Physical Requirements .....	5
3.	Interval History and Physical .....	6
4.	Signatures .....	6
5.	Written and Verbal and Telephone Orders .....	7
6.	Countersignatures .....	7
7.	Symbols and Abbreviations .....	7
8.	Standing (Routine) Orders .....	8
9.	Legibility of Written Orders .....	8
10.	Corrections and Addenda to Medical Records .....	8
11.	Orders Rewritten After Anesthesia .....	8
12.	Radiology Orders .....	8
13.	Progress Notes .....	8
14.	Consultations .....	9
15.	Obstetrical and Newborn Records .....	10
16.	Completion of Medical Records: Disciplinary Action .....	11
17.	Release of Medical Information .....	12
18.	Access to Medical Information .....	12
19.	Removal of Medical Records from the Hospital .....	12
20.	Research Using Medical Records .....	13

21.	Pre-procedural Documentation Requirements.....	13
22.	Operative and Procedure Reports .....	14
23.	Discharge Summary .....	14
D.	GENERAL CONDUCT OF CARE.....	15
1.	General Consent Form .....	15
2.	Drug Formulary.....	15
3.	Dangerous Patients .....	15
4.	Suicidal Patients .....	16
5.	Intensive Care Unit Admissions and Discharges .....	16
6.	Autopsies .....	17
7.	Restraints.....	18
8.	Pre-anesthesia Evaluation .....	19
9.	Examination of Tissue Specimens .....	19
10.	Preventing Fetal Injury .....	19
11.	Diagnostic Imaging Interpretations .....	19
12.	Department Rules and Regulations .....	20
13.	Dispute Resolution: Resolving Disputes Between Hospital Employees, Midlevel Providers or Paramedical Affiliates and Medical Staff .....	20
14.	Medical Staff Behavior .....	20
15.	Advance Practice Nurse Prescribers .....	21
16.	Verification of Critical Test Results .....	21

**A. GENERAL PROVISIONS AND AUTHORITY**

1. Staff Rules and Regulations  
(Reference - Bylaws Section 14.1)

The medical staff shall adopt rules and regulations as may be necessary for the proper conduct of its work and to implement more specifically the general principles set for in these bylaws. Such rules and regulations shall be a part of these bylaws. Rules and regulations may be amended or repealed at any regular meeting of the medical staff by two-thirds (2/3) majority vote of the quorum of the medical staff. Such changes shall become effective when approved by the governing body.

2. Department Rules and Regulations  
(Reference - Bylaws Section 14.2)

Each department shall adopt rules and regulations pertinent to the practice of medicine within their department, and these rules and regulations shall become effective when approved by the medical staff executive committee.

3. Definitions  
(Reference – Bylaws Definition Section)

Terms used in these rules and regulations have the same meaning and definition as those terms are defined in the medical staff bylaws.

**B. ADMISSION AND DISCHARGE OF PATIENTS**

1. Admitting Privileges

A patient may be admitted to the hospital only by an active, courtesy, provisional active or provisional courtesy member of the medical staff with admitting privileges, except that consulting staff may admit patients for observation during a non-surgical treatment, or for chemotherapy, radiation therapy treatment or other procedures, as per Section 4.7(b) and (e) of the medical staff bylaws.

2. Responsibility for Care

A member of the medical staff shall be responsible for the medical care of each patient admitted to the hospital. The patient must be seen by the attending practitioner, the responsible “on call” group practitioner or, where appropriate, the attending psychologist, on a daily basis. The attending practitioner is defined as the practitioner who maintains primary responsibility for determining the patient's continued need for acute care and readiness for discharge, even when the practitioner has consulted other practitioners for specialized treatment. The practitioner who has

admitted the patient will be considered the attending practitioner unless he formally transfers primary responsibility for treatment decisions, continued need for hospital care and readiness for discharge to another practitioner; or unless he is admitting the patient to a member of his clinic group or "on-call" group and clearly notes that on the admitting order sheet, in which case that member will be considered the attending practitioner. When all of these responsibilities are transferred to another staff member, a note regarding the transfer of responsibility shall be entered in the medical record by the transferring physician, after acceptance by the other practitioner. However, temporary transfer of responsibility for care of the patient such as during nights and weekends to "on-call" practitioners from the same clinic or regular call group needs no formal note in the chart regarding such. A printed call schedule shall be available within the various hospital departments and patient care floors so that hospital and other personnel can readily determine which practitioner is responsible for any given patient at any time.

3. Provisional Admitting Diagnosis

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such a statement shall be recorded as soon as possible.

4. Admission Priorities

The patient will be admitted on the basis of the following priorities:

- a. Elective -- The health of the patient is not in danger by delayed admission. Such patients are usually scheduled several days to several weeks before admission. In consideration of the patient, the hospital will make every effort to accommodate the patient's desired date of admission. However, when circumstances dictate, admission of patients in this category can be deferred, as they are the lowest admitting priority.
- b. Urgent -- Delay in admission beyond several hours might threaten the patient's life or well-being.
- c. Emergent -- An immediate threat to the patient's life or well-being exists. This situation warrants the highest admitting priority.

In case of dispute, practitioners admitting emergency cases shall be prepared to justify to the executive committee and the administration of the hospital that the emergency admission was a bona fide one. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on

the patient's chart within a reasonable period of time. The same shall apply to scheduling emergency procedures.

5. Need for Continuing Hospitalization

The attending practitioner is required to document the need for continued hospitalization of a patient if questioned by hospital utilization review personnel, the quality assurance committee, or the executive committee. This report must be submitted within 24 hours and must contain a written justification of the need for continued hospitalization, and an estimated period of time the patient will need to stay in the hospital.

6. Transfer of Patients

Patients who present with an emergency medical condition and who are unstable or in active labor shall be transferred to another facility only when the required medical care cannot be provided at Saint Michael's Hospital and the responsible physician determines the medical benefits of transfer outweigh the risks of transfer, or when transfer is requested by the patient or the patient's legally responsible representative. The attending/transferring practitioner must facilitate a safe, efficient transfer and is responsible for practitioner-to-practitioner communication and for obtaining the receiving facility's agreement to accept the patient in transfer.

No patient shall be arbitrarily transferred to another facility for reasons of inability to pay if Saint Michael's has the facilities to provide the care needed.

All patients will receive stabilizing treatment within the hospital's capacity prior to transfer to another facility so as to minimize the risk to the patient's health. Such stabilization shall include medical evaluation by a practitioner and initiation of treatment to minimize risk to the patient until the transfer is accomplished. All pertinent medical records that are available at the time of transfer will accompany the patient to the receiving facility. The transfer must be effected through qualified personnel and transportation equipment as required, including the use of necessary and medically appropriate life support measures during transfer. Other records not available at the time of transfer will be sent to the receiving facility as soon as practicable after transfer.

Except in emergencies in which the attending/transferring practitioner certifies in writing at the time of transfer that the benefits of transfer outweigh the risk of transfer, the patient will not be transferred without being given a full explanation for the transfer.

An informed consent will be signed by the patient or patient's legally responsible representative when transfer is arranged. If such consent cannot be obtained, either through refusal or inability to sign, the reason for the lack of consent should be documented in the patient's medical record.

If a patient refuses transfer, a statement regarding such shall be placed in the medical record by the attending practitioner or his designee.

For purposes of this rule, a transfer occurs when the patient is transported to another facility, whether or not the patient is scheduled to return. Physician offices, other hospitals, ambulatory surgery centers, long-term care facilities and all other entities not operating under the hospital's provider number and not located on the hospital's main campus constitute other facilities under this rule.

7. Certification of Death

In the event of a hospitalized patient's death, he shall be pronounced dead by the attending practitioner or by his designee within a reasonable time. A hospice nurse may pronounce (but not certify the cause of) the death of a hospice patient who was under the care of a physician at the time of death and the death was anticipated. The body shall not be released until an entry has been made in the medical record of the deceased by a member of the medical staff or his designee, and by filling out the "Record of Death" form.

8. Discharge Orders

Patients shall be discharged only on the verbal or written order of the attending practitioner or his designee. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge order, notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign a refusal of treatment form. If the patient refuses to sign, the refusal should be documented in the medical record.

**C. MEDICAL RECORDS**

1. Responsibility

The attending practitioner, or a substituting practitioner or health care provider with clinical privileges to do so, shall be responsible for the preparation of a timely, accurate, legible and complete medical record for each patient. The medical record will include, as appropriate, a history and physical examination, provisional diagnosis, plan of action, clinical laboratory results, radiology services results, other diagnostic services

results, consultation reports, medical and/or surgical treatment, operative reports, pathological findings, daily progress notes, autopsy report (when performed), discharge summary, definitive final diagnosis and anatomical gift information. Only members of the medical staff or other professional personnel authorized by the medical staff shall record and authenticate entries in the medical record. Other professional personnel, include, but are not limited to ancillary departments, rehab, nutrition services, spiritual services, students and Ministry Behavioral Health.

2. Inpatient Admission History and Physical Requirements

A complete history and physical examination shall be dictated no more than 7 days prior to or within 24 hours of inpatient admission. This record shall include identification data, chief complaint or reason for admission, history of the present illness, past medical history including medications, allergies and past surgeries, personal, social and family history, review of systems, physical exam, statement of conclusions or impressions, and action planned. This report must be recorded by a member of the active, courtesy, consulting or limited medical staff (or provisional members in these categories), or by another licensed health care provider granted privileges to do so. A different set of requirements exist for obstetrical and newborn patients; see "Obstetrical and Newborn Records." (Note: Medicare Conditions of Participation requires the history and physical to be performed no more than 7 days prior or 48 hours after admission. JCAHO requires H&P within 24 hours of admission)

Outpatient Admission History and Physical Requirements

For patients admitted on an outpatient or observation status, see Pre-  
Procedural Documentation Requirements

3. Interval History and Physical

INPATIENT ADMISSION: If a patient is readmitted as an inpatient within 30 days of inpatient discharge for the same or related condition, then a copy of the history and physical exam recorded from the initial admission may be used provided an appropriate assessment, which shall include a physical examination of the patient to update any component of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, was completed within 7 days prior to inpatient admission or 24 hours after inpatient admission confirming that the necessity for the care is still present and the H&P is still current; AND the physician or other individual authorized to perform the H&P writes an update note based on that assessment addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status. The update note must be on or attached to the H&P; AND the H&P, including all updates and assessments, must be included within 24 hours after inpatient admission in the patient's medical record for this admission.

OUTPATIENT ADMISSION: If a patient is being admitted as an outpatient for a procedure or surgery and has had a History and Physical examination performed within 30 days prior to the outpatient admission, a copy of that H&P may be used provided an appropriate assessment, which shall include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, was completed within 7 days prior to the outpatient admission confirming that the necessity for the procedure is still present and that the H&P is still current; AND the physician or other individual authorized to perform the H&P writes an update note based on that assessment addressing the patient's current status and/or any changes in the patient's status, regardless of whether there were any changes in the patient's status. The update note must be on or attached to the H&P; AND the H&P, including all updates and assessment, must be included in the patient's medical record, except in emergency situations, prior to surgery.

4. Signatures

All clinical entries in the patient's medical record shall be legible, permanently recorded, time-dated and authenticated with the name and title of the person making the entry. A signature stamp shall be used only when a practitioner files a certificate with the medical staff office attesting to the fact that he and only he is authorized to possess and use the stamp.

5. Written and Verbal and Telephone Orders

Orders for diagnosis and treatment may be given in writing or by spoken word by a practitioner or other individual authorized by the medical staff within the scope of his practice (see Midlevel Provider Policy with Ordering and Countersignature Requirement grid). All outpatient orders must include the medical diagnosis or indication, along with the date, time and the name and title of the ordering practitioner or midlevel provider. All verbal and telephone orders shall be written in the orders section of the medical record and read back to the ordering practitioner or midlevel provider by the appropriately authorized person to whom dictated, and then signed by the authorized person along with date, time and the name and title of the practitioner or midlevel provider giving the orders. Appropriately authorized person means a registered nurse, licensed pharmacist, physical or occupational therapist, dietician, respiratory therapist, or social worker.

The responsible provider should authenticate by signature verbal and telephone orders within 24 hours, if at all possible, but no later than 72 hours after entry into the patient's chart.

Orders must be permanently recorded in black or blue ink. Orders recorded in pencil or in any color ink than black or blue shall not be acceptable at any time.

6. Countersignatures

The attending practitioner shall countersign the history and physical examination, all progress notes, and the discharge summary when they have been recorded by a physician assistant or advanced practice nurse in inpatient records. Requirements for countersignatures for lab, x-rays, electrocardiograms, physical therapy and drug orders are required for circumstances set forth in the Midlevel Provider Policy (see Ordering and Countersignature Requirements for Midlevel Providers grid).

Histories and physicals must be countersigned within 24 hours if possible, but no later than 72 hours from the time of the entry into the patient's chart; progress notes and discharge summaries must be signed or countersigned within 30 days of discharge.

7. Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of the approved abbreviations shall be kept on file in the record room.

8. Standing (Routine) Orders

A practitioner's routine, standing, or pre-written orders, when applicable to a given patient, shall be placed on the orders compartment of the patient's medical record, then signed and time-dated by the practitioner if used.

9. Legibility of Written Orders

A practitioner's orders must be permanently recorded and written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten, or understood by the person authorized to execute the order.

10. Corrections and Addenda to Medical Records

A charting error is corrected by drawing a single line through the incorrect portion so the error remains legible. "Delete" is written with the date and time of the correction and the author's initials next to the error. The correct information is written as applicable. Corrections made in a limited space are lined out with "delete" written and an arrow drawn to the margin or closest available space to write the correct information. Scribbling out, write-overs, erasing or use of white-out or any other form that renders the original writing illegible are not acceptable for correcting medical record documentation.

Any addendum shall be denoted as such and time-dated as applicable to reflect when the addendum was actually written, with references, where appropriate, to the date or dates of the chart entries to which the addendum applies.

11. Orders Rewritten After Anesthesia

All orders shall be cancelled prior to and rewritten after general, spinal or epidural anesthesia.

12. Radiology Orders

An order for a radiology examination by the attending practitioner or another individual with privileges to do so shall contain a concise statement of the reason for the examination, along with the name and title of the ordering practitioner.

13. Progress Notes

Daily progress notes shall be recorded in sufficient detail to permit continuity of care and transferability by practitioners and by other individuals who provide direct services to patients. Each of the patient's

clinical problems should be clearly identified and discussed in the context of specific tests, treatments, and outcomes. Progress notes should be recorded not greater than 24 hours following patient assessment.

14. Consultations

Consultation is encouraged when diagnostic studies fail to identify the nature of the patient's problem or when the results of a treatment plan deviate substantially from the range of anticipated results. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise. The attending practitioner or his designee must order the consultation and the reason for the consultation must be documented in the patient's chart.

The attending practitioner or his designee is primarily responsible for requesting consultation when indicated, except in an emergency.

Consultation is required when requested by a mentally competent patient or by the legally responsible party for a patient who is incapacitated or not competent.

Consultation is required for each active medical problem or procedure for which the requesting practitioner does not hold clinical privileges.

If a nurse or other hospital health care professional believes that appropriate consultation is needed and has not been obtained, he shall bring the matter in question to the attention of his immediate supervisor who shall then refer the question to the attending practitioner or his designee. If the matter remains unresolved, it may be referred to the chairperson of the department(s) wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the chairperson of the department may then himself request the consultation.

It is expected that notification of the consultant is to be provided by personal contact between the attending practitioner and the consultant. At the time of such contact, the purpose and urgency of the consultation is to be communicated to the consultant. In addition to giving personal notification, the attending practitioner or his designee shall enter time-dated notice of such consultation and its purpose on the order section of the patient's medical record.

In instances in which the time of consultative evaluation is wholly elective in that its timing has no potential to adversely affect the safety, well-being or the future health of the patient, consultant notification may be given by the ward staff at the direction of the attending practitioner or his designee. Hospital protocols specifically set up for these elective communicative purposes shall be followed.

Completion of a consultation shall occur with a timeliness appropriate to the seriousness and urgency of the problem being addressed. In all cases, consultation notes shall be dictated within 24 hours of the time the consultation has been performed.

It is appropriate that preliminary findings and the recommendations be summarized in a written note on the medical record at the time the patient is seen and/or be communicated directly to the referring practitioner, depending on the urgency and severity of the patient's problems.

Consultation notes shall include patient identification data, requesting practitioner, date and time of the consultation, pertinent items from the history of the present illness and past medical history, a directed physical examination if appropriate, pertinent hospital study results, a statement of conclusions or impressions, and recommendations. When potentially hazardous or dangerous procedures are involved, the consultation note shall be written or dictated before any such procedure.

15. Obstetrical and Newborn Records

The prenatal record, or a legible copy thereof on the approved hospital form, shall serve as the history and physical examination on patients having normal term deliveries. An interval admission note should be written that updates pertinent additions to the history and physical exam.

Each obstetric patient shall have a complete hospital record which shall include:

- a. Prenatal history and findings, including complications, Rh determination, and other matters essential to adequate care;
- b. Labor and delivery record, including anesthesia;
- c. The practitioner's progress record;
- d. The practitioner's order sheet;
- e. A medicine and treatment sheet, including nurses notes;
- f. Any laboratory or x-ray reports;
- g. Any medical consultant's notes;
- h. An estimate of blood loss.

Each newborn infant shall also have a complete hospital record which shall include at least:

- a. Record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth;
- b. A record of physical examinations;
- c. A progress sheet recording medicines and treatments, weights, feedings and temperatures;
- d. The notes of any medical consultant.

The discharge data summary form may serve as the discharge summary in the case of normal newborn infants and uncomplicated obstetrical deliveries, but that summary form must meet the content requirements of a discharge summary.

16. Completion of Medical Records: Disciplinary Action

Admission history and physical examination reports, operative and other procedural reports and consultation notes shall be dictated within 24 hours. A hand-written operative or procedural note shall be entered in the medical record immediately after the event and before the patient is transferred to the next level of care. Failure to meet these specific time frames will be trended by the medical records department and monitored by the Medical Staff Quality Assurance Committee. Habitual noncompliance may be a basis for disciplinary action.

All medical records, including discharge summaries, must be completed and signed within 30 days of discharge or death, after which time they will become delinquent. Discharge summaries on deaths where an autopsy was performed shall be completed within 30 days of availability of the final autopsy report. The medical record department will remind practitioners of an incomplete record on or about 15 days after discharge or death and specify the date 30 days after discharge when the record would become delinquent. One week before the impending delinquency, the Medical Staff President will send via special notice a letter with his signature notifying the practitioner that failing to complete the medical record(s) by the specified date, suspension will take place at 5:00 pm on the date specified and shall be in effect until completion of the records. If the record remains incomplete at the end of 30 days, a suspension of clinical privileges shall occur. The suspension shall take the form of withdrawal of the practitioner's clinical privileges, except the suspension will not affect the privileges to administer to patients already in the hospital under the care of that practitioner at the time of the automatic suspension.

Three such suspensions of privileges within any 12 month period may be sufficient cause for permanent suspension of the practitioner's clinical privileges or other corrective action deemed appropriate by the executive committee.

The medical record shall not be permanently closed until it is completed by the responsible practitioner or is ordered closed and filed by the quality assurance committee.

17. Release of Medical Information

No individual may view or have access to a patient's record unless the performance of their professional duties requires access. The patient's medical record, including all computerized medical information, shall be kept confidential and released only as allowed or required by law. The patient, his legally responsible representative, or any legally authorized person shall have access to the patient's medical record. Written consent of the patient or legally responsible party is required for release of medical information to persons not otherwise authorized to receive this information. Accessing patient health care information in violation of this rule is a violation of professional ethics.

18. Access to Medical Information

Practitioners and other health care professionals will sign a confidentiality statement before being given on-line access to patient health information. Practitioners and other health care professionals will be assigned unique passwords and access menus. Passwords are confidential and shall not be disclosed or shared with other users. Practitioners and other health care professionals are permitted to access records only in accordance with applicable legal and ethical standards. Computers are not to be left unattended after entry of the password until proper computer terminal sign-off procedures have been followed. When a practitioner loses or resigns clinical privileges or medical staff membership (or is suspended), password and access codes will be immediately deactivated. In the same manner, when other health care professionals resign their position, their password and access codes will also be immediately deactivated.

19. Removal of Medical Records from the Hospital

Medical records may be removed from the hospital jurisdiction in safekeeping only in accordance with a court order, statute, or by permission of the designated administrative officer or his designee. Minutes or other documents pertaining to peer review activities, conferences, medical audit activities, or other quality assurance mechanisms are not considered to be part of the medical record and are not to be released from the hospital and/or medical staff jurisdiction.

20. Research Using Medical Records

If waiver of individual patient authorization has been approved by the applicable institutional review board or a privacy board in accord with federal privacy regulations and the researcher has made the representations required under the privacy regulations, access to all medical records of all patients shall be afforded to members of the medical staff for a bona fide research study consistent with preserving the confidentiality of personal information concerning the individual patients, unless the patient has filed a written objection with the hospital. All such projects shall be approved by the executive committee before records can be studied. Subject to the discretion of the designated administrative officer and the conditions specified above for current members of the medical staff, former members of the medical staff shall also be permitted access to information from the medical records of their patients for bona fide research study covering all periods during which these patients were in the hospital.

21. Pre-procedural Documentation Requirements

- a. For patients undergoing invasive or potentially hazardous procedures without anesthesia; under topical, local, or regional anesthesia; or with any sedation not used intravenously, the following data elements must be in the chart prior to the procedure:
  - Indications for the procedure;
  - Medications list;
  - Medicine allergies and intolerances;
  - Physical exam to include assessment of mental status, vital signs and an examination specific to the procedure and existing co-morbid conditions;
  - Consent signed by the patient or legally responsible party; with documentation of the pre-procedural discussion regarding indications, potential benefits, potential risks, potential complications, and alternatives, after which such informed consent was obtained;
  - A statement about the patient's general medical condition, with an interpretation of significant abnormal findings as they relate to the patient's risk for the planned procedure and anesthetic;
  - Results of indicated diagnostic tests;
  - Diagnosis or impression; and
  - Verification with the patient of the type of procedure and body part involved (e.g., right eye).
- b. For procedures done with intravenous sedation, or under general, spinal, or epidural anesthesia or analgesia, the data requirements

are the same as above in paragraph "a", plus an examination of heart and lungs by auscultation shall be done and documented.

- c. For elective procedures, the above data elements should be completed no more than 7 days before the planned procedure, with any history and physical findings updated pursuant to Rule C.3 on "Interval History and Physical."
- d. In emergency situations where there is inadequate time to record the above elements, a brief note including the pre-procedural diagnosis, indications and plan will be recorded prior to such procedure.
- e. When the above documentation requirements are not on the chart before the procedure, it shall be canceled unless the practitioner states in writing that such delay would be detrimental to the well-being of the patient.

## 22. Operative and Procedure Reports

Operative or procedure reports should be dictated immediately after an operation or other potentially hazardous procedure. This report shall contain documentation of the patient's informed consent, the title or name of the procedure, the names of the operator and assistants, the indications or preoperative diagnosis, the findings or postoperative diagnosis, a detailed account of what was done, what biopsies or specimens were taken or removed, complications, estimated blood loss, patient's condition, and the disposition of the patient.

If the operative report is not placed in the medical record immediately after surgery due to transcription or filing delay, then an operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This operative progress note should contain at a minimum comparable operative report information. These elements include: name of primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis as well as estimated blood loss.

**Immediately after surgery** is defined as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver.

## 23. Discharge Summary

A discharge summary should be dictated at the time of discharge on all hospital inpatients except for uncomplicated obstetrical deliveries and

normal newborn infants. This summary shall include the dates of admission and discharge, reason for admission, significant findings, procedures, complications, consultations, treatments and outcomes, condition on discharge, disposition of the patient, primary diagnoses and secondary diagnoses addressed during the hospitalization, and instructions given to the patient including diet, activity, medications, and plan for follow-up. All summaries shall be dictated by the attending practitioner or another licensed health care practitioner privileged to do so.

A countersignature on the discharge summary is required if the person dictating is not a member of the active or courtesy staff (or provisional members in these categories).

For outpatient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care.

All discharge summaries shall be completed (dictated and signed) within 30 days of discharge and must include a final diagnosis.

#### **D. GENERAL CONDUCT OF CARE**

##### **1. General Consent Form**

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

##### **2. Drug Formulary**

All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia or American Hospital Formulary Service and approved by the Pharmacy and Therapeutics Committee. Investigational drugs must have a protocol approved by the Federal Drug Administration. Controlled drugs, antibiotics, anticoagulants and corticosteroids ordered without a time limit will be subjected to a stop date approved by the Pharmacy and Therapeutics Committee. Drugs shall not be stopped without notifying the practitioner.

##### **3. Dangerous Patients**

The admitting practitioner shall be held responsible for giving such known information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever he

reasonably believes the patients might be a source of danger from any cause whatsoever.

4. Suicidal Patients

- a. Any patient considered suicidal on admission shall have a consultation by a member of the psychiatric staff or their designee(s) within 24 hours of admission.

If a patient is discovered to be suicidal in ideation after admission, the psychiatric consultation shall be done within 24 hours of that time.

- b. Any patient known or suspected to be suicidal shall be placed under routine special precautionary protocols by attending practitioner order, no matter where in the hospital the patient is placed.

5. Intensive Care Unit Admissions and Discharges

- a. A patient may be admitted or transferred to the intensive care unit by any member medical staff as permitted by their staff category designation and privileges. Specific ICU admitting privileges are not required; however, when the patient requires care beyond the scope of practice or privileges of the admitting physician, the responsibility for care must be transferred to another member of the medical staff qualified and privileged to provide the care required or request that such a member consult on and follow the patient while in the ICU.
- b. Questions as to the advisability of admission or transfer to the intensive care unit or the discharge therefrom shall be resolved through discussions between the attending practitioner and the chair of the intensive care unit committee. Should the chair of the intensive care unit be absent, any physician in the hospitalist program may replace him in that function.
- c. Should the intensive care unit be full, priorities for admission, transfer or discharge of patients shall be resolved by discussions between the attending practitioner and the chair of the intensive care unit. Should the chair of the intensive care unit be absent, any physician in the hospitalist program may replace him in that function.

6. Autopsies

Autopsies shall be obtained under two circumstances:

- a. Cases in which the attending practitioner (or his designee) and/or the patient's family desires one after a written consent from the "next-of-kin" is obtained by completing the Autopsy Permission/Request Form, in accordance with State law.

In these cases, the autopsy order shall be considered a consultation request of the pathologist, and handled in the same manner as any other consultation request.

Suggested criteria for autopsies requested by physicians and/or family members include, but are not limited to:

- 1) deaths which are not anticipated;
- 2) deaths in which the cause is not known with certainty on clinical grounds;
- 3) unexpected or unexplained deaths during or following any diagnostic or therapeutic procedure;
- 4) deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards;
- 5) obstetric, neonatal or pediatric deaths;
- 6) deaths known or suspected to have resulted from environmental or occupational hazards;
- 7) deaths in which an autopsy might disclose a disorder which may have a bearing on survivors or recipients of transplant organs.

- b. In those cases fulfilling the criteria of "Coroner's Autopsies" under State law, including:

- 1) deaths in which there are unexplained, unusual or suspicious circumstances;
- 2) all homicides and suicides;
- 3) all deaths during or following an abortion;

- 4) all deaths following a poisoning;
- 5) all deaths following an accident;
- 6) when a physician will not sign a death certificate;
- 7) in all indeterminate or questionable cases.

The attending physician or his designee shall contact the Coroner of Portage County who shall determine if an autopsy shall be performed and then contact the appropriate pathologist.

Upon completion of the macroscopic portion of the postmortem examination the pathologist shall contact the requesting physician with a verbal preliminary anatomical diagnosis. A written preliminary anatomical diagnosis shall be recorded in the medical record within three working days of the completion of the macroscopic autopsy procedure. A complete report shall become a part of the medical record of the deceased within three months.

## 7. Restraints

Patients have a right to be free from restraints that are not medically necessary. Restraint devices or seclusion protocols can be used when clinically indicated to improve the patient's well being or when warranted to prevent a patient from injury to self or others when less restrictive interventions are ineffective or inadequate. Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular part of such procedures do not constitute restraints.

A practitioner's order is necessary for restraint or seclusion protocol initiation by hospital personnel, and the order may not be made on a standing or PRN basis. If restraint or seclusion is ordered for behavior management, a practitioner must evaluate the patient within one hour after initiation of the seclusion or restraint. Orders for such restraints are limited to 4 hours for adults, 2 hours for children ages 9 through 17, and 1 hour for children under age 9, but may be renewed for similar time periods for up to a total of 24 hours, at which time the practitioner must again see and assess the patient before issuing a new order to continue the restraint. A new order for continuation of such restraint if desired may be written after 24 hours. The chart will be stamped with a renewal request in such cases. Orders for restraints will contain specific time limits for use of the restraints in compliance with Joint Commission standards, federal law and hospital policy.

Patient's rights, dignity and well being are protected during restraint use. The least restrictive safe and efficient restraint method is employed.

8. Pre-anesthesia Evaluation

Every patient about to have general, spinal or epidural anesthesia shall have a preanesthetic evaluation by a person qualified to administer anesthesia, with findings recorded within 48 hours before surgery, a preanesthetic visit by the person administering the anesthesia, and an anesthetic record and post anesthetic follow-up examination, with findings recorded within 48 hours after the procedure by the individual who administered the anesthesia. If a general anesthetic is used and a physician (MD/DO) is not a member of the operating team, a physician shall be immediately available in the hospital to assist in emergency situations.

9. Examination of Tissue Specimens

All tissues removed at any procedure shall be sent to the hospital pathologists, except those specimens listed as exempt by the medical staff and department of pathology (Sue-check to see if we have an exempt list). The pathologists shall make such examinations as they consider necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

The medical staff and the pathology department together shall determine which tissue specimens require macroscopic examination and which require both macroscopic and microscopic examination.

10. Preventing Fetal Injury

Female patients of child-bearing age shall be evaluated for possible pregnancy before the administration of any drugs, or before the performance of any tests, procedures or treatments which might be potentially harmful to the fetus.

11. Diagnostic Imaging Interpretations

Interpretations of x-rays and other diagnostic imaging studies shall be written or dictated and shall be done and signed by a qualified practitioner authorized by the medical staff to interpret diagnostic imaging studies.

12. Department Rules and Regulations

Rules and regulations, and policies for each clinical department or section are included by reference only and are determined by those departments and sections individually.

(REFERENCE - Bylaws Section 15.2)

All individual clinical department or section rules and regulations and policies, along with any proposed changes or revisions thereto, shall be reviewed by the bylaws committee, then adopted or rejected by the executive committee.

(REFERENCE - Bylaws Sections 15.2 and 16.4)

13. Dispute Resolution: Resolving Disputes Between Hospital Employees, Midlevel Providers or Paramedical Affiliates and Medical Staff

If a hospital employee, midlevel provider, or paramedical affiliate has reason to dispute either the professional conduct of or delivery of patient care by a medical staff member, the matter should be brought to the attention and discussed with the medical staff member if possible. If the matter remains unresolved after it has been brought to the attention and discussed with the medical staff member, or if the employee or paramedical affiliate is unable to discuss the matter directly with the medical staff member, he shall bring the matter to his immediate supervisor who may in turn refer the matter to the appropriate hospital vice president (or his designee). If warranted, the hospital vice president or his designee may bring the matter to the attention of the chairperson of the medical staff member's department, or in the absence of the chairperson, or where the chairperson is the subject of the concern, to the President of the medical staff. In the absence of the applicable hospital vice president or designee, the supervisor may take the matter to the department chairperson. The vice president and the chairperson of the department will jointly consider the issue and make any appropriate recommendations to the medical staff member. If the issue remains unresolved, the issue may be referred to the executive committee or the designated administrative officer for appropriate action.

14. Medical Staff Behavior

No medical staff member shall harass, verbally or physically threaten or harm or act in a manner which is demeaning to each other, hospital staff, patients or visitors. Dispute resolution procedures should be followed in the event of a violation of this rule.

15. Advance Practice Nurse Prescribers

An Advance Practice Nurse Prescriber may prescribe or order any patient treatment that is authorized for and in the manner provided in Wisconsin Administrative Code N 8.06.

16. Verification of Critical Test Results

When critical test results are relayed orally to the ordering or attending practitioner, the person receiving the results must record the results and read back the results so recorded to the person who relayed the results.

**ADOPTED** by the active medical staff of Saint Michael's Hospital of Stevens Point, Inc.

\_\_\_\_\_  
Medical Staff President

May 5, 2005  
Date

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Medical Staff Secretary/Treasurer

**APPROVED** by the governing body of Saint Michael's Hospital of Stevens Point, Inc.

May 24, 2005  
Date

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Secretary of the Board