West Hospital

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Owner:	*Shannon Galloway: Supv-Credentialing*
Area:	*Medical Staff*
Tags:	
Applicability:	*Indiana University Health West Hospital*

Medical Staff Rules & Regulations

ARTICLE I. PROFESSIONALISM

1. These rules and regulations are intended to provide comprehensive information to members of the Indiana University Health West Hospital Medical Staff in order for them to fulfill their commitment and responsibility to provide quality and safe patient care. In addition, members of the Medical Staff are obliged to carry themselves in a manner, which exemplifies the utmost respect and professionalism toward patients, families, visitors, staff and employees of Indiana University Health West Hospital.

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ARTICLE II. STAFF PRIVILEGES

1. **Admitting**
   Only physician/dentist who have been duly appointed to membership by the Medical Staff by the IU Health West Hospital Board of Directors or who have been granted temporary privileges, and are in good standing, are eligible to serve as the admitting/attending physician/dentist for patients within the hospital.
2. **Assignment to Observation**
   Only physician/dentists, Nurse Practitioners, or Physician Assistants who have been duly appointed to membership by the Medical Staff by the IU Health West Hospital Board of Directors or who have been granted temporary privileges, are in good standing, and have been granted observation assignment privileges are eligible to assign patients to Observation Status (as defined in Article VII herein).
   1. **Reporting Requirements**
      In addition to reporting requirements at the time of initial application and reapplication to the IU Health West Hospital Medical Staff, all members of the Medical staff are to immediately report to the President of the Medical Staff (or his/her designee when off premises) any circumstances involving the following:
      a. suspension or any action (censure, reprimand, and/or fine) regarding their professional license
      b. loss, suspension or other actions (excludes routine renewal) regarding state or federal prescribing of controlled substances
      c. loss, suspension or limitation (excludes routine non-renewal) of clinical privileges at another health care facility
      d. filing of notice of exclusion/debarment from any federal health care program including Medicare/Medicaid

e. filing of any criminal charge by state or federal authorities (excludes minor motor vehicle accident)

ARTICLE III. INPATIENT CARE

1. **Admission of Patients**
   Active and Associate Medical Staff members may register patients for admission to the hospitals. The physician/dentist who admits the patient will be designated as the attending physician/dentist and will provide the Admitting Section with a provisional clinical diagnosis. The admitting physician/dentist will be considered the attending physician/dentist unless an order is written to transfer care to another physician/dentist who has agreed to accept responsibility for the patient's care management.

2. **Attending Physician/Dentist Requirements**
   Patients admitted to the hospital must be seen within twenty-four (24) hours after admission by the attending physician/dentist. The attending physician/dentist is in charge of the patient's overall care management, including but not limited to review of orders, request of necessary consultations, determination of the patient's resuscitation status, planning for discharge, completion and signing of medical records documentation.

   Hospitalized patients shall be seen daily by the attending physician/dentist or the attending physician/dentist will effectively delegate that responsibility to an associate/partner of the attending physician/dentist. Physicians managing patients in the hospital for "hospice respite or residential" care would be exempt from this requirement; however inpatient hospice patients are to be seen daily.

3. **Patient/Family Complaint Procedures**
   Hospital patients shall be provided with appropriate channels to communicate dissatisfaction with medical care and treatment, safety and security, and be provided a timely and appropriate response upon conclusion of the investigation into the concern. Members of the Medical Staff must fully cooperate in such investigations.

4. **Consultations**
   To promote effective consultation among physician/dentist of various specialties involved in the treatment of patients, it is recommended that the attending physician/dentist, or his/her designee (nurse practitioner, physician/dentist assistant, resident, other physician/dentist partner) directly discuss with a consultant physician/dentist the need to examine, discuss, or otherwise provide an opinion regarding a patient's care management. Consultation should be considered where the diagnosis is obscure, or where doubt exist as to the best therapeutic measures to be taken, including cases where the disorder or complications are not in the field of the attending physicians' practice. Requests for consultation should include the reason for the consultation, extent and involvement in care expected from the consultant and notation that the consultant has been previously contacted by the ordering physician/dentist or his/her designee.

   The consultation should be documented in the medical record and include discussion of background information and specific questions about the patient. The consultant must make and sign a report of findings, opinions and recommendations that reflects an actual examination of the patient and review of the patient's medical record. The consultant's report of findings will become part of the medical record.

5. **Delegation of Physician/Dentist Responsibilities**
   In order to insure quality health care to all patients, certain responsibilities must be performed by a physician/dentist or physician/dentist in training and are not to be delegated to non-physician/dentist without proper oversight. These responsibilities are as follows:

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1. Admission of patients to the hospitals.
2. Physician/dentist must obtain and review the history of the present illness and perform the initial physical examination.
3. Dictation of operative notes.
4. Completion of discharge summary and/or death notes.
5. Completion of pre/post anesthesia notes.
6. Performance of surgery, which the physician/dentist has agreed to perform.
7. Signatures of reports, orders or other medical record entries.

6. **Transfer of Care**
   The admitting physician/dentist will be maintained as the attending physician/dentist until writing an order to transfer care to another physician/dentist who has accepted that attending physician/dentist responsibilities. Such transfer of attending physician/dentist status is to occur only after physician/dentist-to physician/dentist discussion of the patient's care and comprehensive discussion of the status of the patient's clinical needs.

7. **Care Management**
   Care Management is a hospital-wide, interdisciplinary process that plans organizes and provides health care services in a timely, cost-effective manner while maintaining quality patient care consistent with the mission of IU Health West Hospital. As an integral member of the team process, physician/dentist support effective and efficient utilization of hospital facilities and services through the following actions:
   1. Communicate with care managers and physician/dentist leaders to help improve inefficiencies in care and safely move the patients to a lower level of care when medically appropriate.
   2. Obtain specialty consultation early and frequently.
   3. Support evidence based medicine such as in the treatment of DVT, pneumonia, surgical care, AMI, stroke and CHF patients.
   4. Review medicines and orders daily:
      a. Discontinue interventions that are not medically necessary (examples: telemetry and Foley catheter)
      b. Change medicines from IV to oral when appropriate (examples: antibiotics and pain meds)
      c. Advance diet and activity when appropriate.
   5. Discuss daily with your patients (and families) those objectives that will need to be accomplished before discharge is possible.
   6. Keep your patient, the family and the interdisciplinary team informed of potential discharge plans and the expected date of discharge.
   7. When patient medically meets criteria for discharge and further testing is needed, discharge patient and finish workup as an outpatient
   8. Consider end of life issues where Palliative care, Hospice or Geriatric services may be appropriate for the patient.
   9. Compare your utilization, LOS and cost performance to your peers and physician advisors (EHR).
   10. Participate in communication between case managers to help resolve concurrent verbal denials for continued hospital stay.

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The Medical Executive Committee, Quality Assessment and Utilization Review Committee, and they are responsible for the review of care including Utilization Management functions. Utilization Management issues will be reported at least quarterly or more frequently as deemed appropriate to these committees. These committees may appoint physician/dentist outside of the committees to perform concurrent or retrospective chart reviews for Utilization Management. The physician/dentist will be available to assist and counsel personnel responsible for utilization functions and to consult with peers to resolve issues. Peer review protection applies in accordance with Indiana Peer Review Statue I.C. 34-4-12.6.1.

8. **Discharge of Patients**
   Patients are to be discharged only by order of the attending physician/dentist or his/her designee. As per Section 3.2, the patient must be seen within twenty-four (24) hours after admission. The patient must also be seen prior to discharge. Telephone orders for discharge may be utilized at the discretion of the attending physician/dentist or designee. The attending physician/dentist or designee is obligated to communicate to the referring physician/dentist all appropriate medical information. In the event that patient is being transferred to another agency or institution, the physician/dentist is to ensure the same information is documented on approved discharge/transfer forms and an immediate discharge summary is dictated.

   Whenever possible, as part of the discharge process, the attending physician/dentist or designee is to identify the physician/dentist who will provide follow-up care after discharge from IU Health West Hospital. Comprehensive communication to the physician/dentist conducting follow-up by the attending physician/dentist or designee is to include the patient's hospital course, medications upon discharge, and need for continuing care.

   It is the responsibility of the attending physician/dentist or designee to ensure discharge of patients in a timely fashion. Discharge planning is multidisciplinary and physician/dentist designees are to engage nursing, care management, and other health care disciplines as needed in the process. Care conferences may be necessary to address challenging patient or family issues that could negatively affect discharge. Physician/dentist is to avail themselves to participate in such conferences or give input when needed.

9. **Leaving Against Medical Advice**
   If a patient desires to leave the hospital against the advice of the attending physician/dentist or designee without proper discharge, the attending physician/dentist or designee will be notified and the patient will be requested to sign the appropriate release form, attested by the patient or legal representative of the patient and a competent third party. Such departure from the hospital is to be noted in the medical record by the attending physician/dentist or designee. Child Protective Services shall be contacted if parents or guardians of minors remove or threaten to remove a patient against medical advice.

ARTICLE IV. CONSENT

1. **Informed Consent Process**
   A separate Consent for Procedure or Consent for Bedside Procedures form should be completed for all operative and other invasive procedures that expose patients to more than minimal risk, including procedures done in settings other than the operating room such as a special procedure unit, endoscopy unit, interventional radiology suite, hospital-based clinics, other outpatient Section of the hospital, or at the bedside. Invasive procedures generally are classified as those procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body. Specific examples of the types of procedures subject to the requirement for completion of a written Consent for Procedure or

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Consent for Bedside Procedure form are listed in policy MS 3.35 Patient Consent.

In addition to discussing the proposed procedures with the patient or surrogate and completing the written Consent for Procedures or Consent for Bedside Procedures form, the treating practitioner should include a note in the patient's medical record to the effect that the physician/dentist spoke with and advised the patient or surrogate of the nature of the proposed care, treatment, services, medications, interventions, or procedures; potential benefits, risks, or side effects including potential problems related to recuperation; likelihood of achieving care, treatment and service goals; reasonable alternatives to the proposed care, treatment and service; relevant risks, benefits and side effects related to alternatives, including the possible results of not receiving care, treatment and services; and when indicated, any limitations of the confidentiality of information learned from the patient. The attestation statement in the Consent for Procedure form may serve as the treating practitioner's written note and must be signed by the Treating Practitioner.

ARTICLE V. MEDICAL RECORDS

1. **Handwritten entries and Use of Abbreviations**
   All entries in the medical record must be legible and in black or blue ink. Pencil entries are not permitted. Entries are to be dated and timed. The date and time of the note will be the date and time of the entry, regardless of whether the content of the note relates to a previous date or time. Documentation throughout the medical record regarding medication orders must be written without the use of unsafe abbreviations.

   Authentication of entries
   All entries in the medical record must be confirmed by written signature or computer signature, identifying the credentials of the author. Reports dictated and transcribed through Health Information Management require attending physician/dentist and/or surgeon authentication by using Cerner's Electronic Signature Authentication. Entries by medical students require countersignature by a physician/dentist. Verbal and telephone orders may be signed by any physician/dentist who provided care to the patient or has knowledge of the patient's care if the ordering practitioner is unavailable and authentication should be completed within forty-eight (48) hours of the order.

2. **Orders**
   Initial admission, diagnostic, treatment and discharge orders may be written by the attending physician/dentist, resident, dentist or podiatrist, nurse practitioner or nurse midwife. The physician/dentist must write an admission status order (inpatient, observation, or outpatient in a bed) for each patient receiving services on a nursing unit; provided, however, that a Nurse Practitioner or Physician Assistant with observation assignment privileges may write an assignment status order for Observation Status in the IU Health West Observation Unit without the need for a separate order by a physician/dentist. Orders may be given verbally to authorized professionals when the medical record or electronic order system is not readily accessible, in emergencies, or by telephone from another location. Verbal orders are to be reserved as much as possible for emergent situations. For further details, please reference IU Health West Hospital Medical Staff Policy on Verbal Orders.

   Orders occurring prior to a procedure will not be automatically resumed after the procedure. To ensure patient safety, orders must be rewritten after major procedures to ensure changes to the patient clinical status are taken into full consideration.

3. **History and Physical**

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Requirements for History & Physical Examinations can be found in the Appendix of the IU Health West Hospital Medical Staff Bylaws.

4. **Progress Notes**
   Progress notes shall give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition, the results of treatment, and discharge planning.

   Progress notes must be recorded at the time of observation and be sufficient to permit continuity of care and transferability of the patient. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

   Progress notes must be written daily and be authenticated by the practitioner making the note. When residents, fellows, or medical students are involved in patient care, sufficient evidence is documented in the medical record to substantiate the active participation in, and supervision of, the patient's care by the attending physician/dentist.

5. **Operative/Procedure Notes**
   Operative reports must be dictated immediately following any operative or other high risk procedures. The reports must contain the preoperative diagnosis, the postoperative diagnosis, name of the primary surgeon and any assistants, detail the technical procedures used, the description of findings, blood loss, specimens removed, and the condition of the patient at the conclusion of the procedure. The immediate postop note does not need to include specimens and EBL if there is not any anticipated in the procedure.

   For procedures performed under conscious sedation or local anesthesia, the report may be handwritten or electronically generated

   The practitioner must enter an operative progress note in the medical record immediately after the procedure, providing sufficient and pertinent information for any practitioner required to attend to the patient until the operative report is available.

   The complete report must be completed or dictated within forty-eight (48) hours following the procedure and signed by the practitioner.

6. **Tissue and Examinations Reports**
   Tissue removal procedures as directed through IU Health West Hospital Administrative Policy, ADM 1.17 Tissue/Surgical Case Review Policy. All surgery pathology reports prepared by the Pathology Section shall have a code inserted by the pathologist to convey one of the following:

   Code 0: Insufficient clinical information concerning pre-operative diagnosis for coding purposes.
   Code 1: Tissue removed for diagnostic purposes.
   Code 2: Tissue removed for therapeutic purposes with no major discrepancy between the pre-operative (clinical) and post-operative (pathological) diagnosis.
   Code 3: A major discrepancy exists between the pre-operative (clinical) and the post-operative (pathological) diagnosis.
   Code 4: Referral or consultation case originating at another institution.
   Code 5: Failure to review outside diagnostic material prior to treatment (surgery, radiotherapy, bone marrow transplantation or chemotherapy).

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Through audit efforts of Pathology and the Tissue Committee, cases of concern will be channeled for peer review.

7. **Discharge Summary**
   The discharge summary is the responsibility of the attending physician/dentist. The discharge summary must be completed upon discharge of the patient from the hospital. Discharge summary should occur no later than seven (7) days from discharge. The discharge summary must include documentation of the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses established by the time of discharge, significant findings, procedures performed and treatment rendered, condition of the patient on discharge, and specific instructions given to the patient and/or family (especially relating to physical activity, diet, medications, and follow-up care.

8. **Autopsy**
   Physicians are to obtain permission for autopsy from the family or appropriate guardian after death. When one or more of the following criteria are present the medical staff will make a concerted effort to secure autopsy permission:

   a. unanticipated death – all sudden deaths and all deaths in which the admission diagnosis suggests death was not expected;
   b. intraoperative or intraprocedural death;
   c. death occurring within 48 hours after surgery or an invasive diagnostic procedure;
   d. death in an outpatient setting (may not be applicable to the Emergency Section);
   e. death associated with a drug reaction or an adverse event;
   f. death occurring while the patient is being treated under a new therapeutic trial regime (defined as therapies/procedures requiring IRB approval);
   g. maternal death incident to pregnancy or within seven days following delivery;
   h. stillbirth;
   i. death in infants/children when congenital malformations and conditions with possible genetic implications; or
   j. death where the cause is sufficiently obscure to delay completion of the death certificate.

      The following **deaths must also be reported to the coroner**; however, a coroner's forensic autopsy will not necessarily be performed:

   k. any medically unexpected death
      1. occurring coincident with a therapeutic or diagnostic procedure,
      2. of a child (possible SIDS), or
      3. involving unexplained coma;
   l. death of a child or adult where abuse, neglect or trauma is a possibility;
   m. death following disease or injury in the workplace;
   n. death of an inmate or a person in official custody;
   o. death involving the suspicion of criminal abortion;
   p. all homicides; suicides and accidents; or

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q. any suspicious, unusual or unnatural death.

ARTICLE VI. URGENT/EMERGENT PATIENT CARE

1. **Emergency Care**
   Individuals who "come to the dedicated emergency Section" (as defined within 42 CFR §489.24) will receive a medical screening examination appropriate to their presenting signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This screening shall occur regardless of the patient's ability to pay and shall be conducted in whole or in part by the following individuals designated as "Qualified Medical Personnel" (QMPs) within the statutory definition:

   - Credentialed Physicians or Dentists
   - Credentialed Allied Health Practitioners
   - Emergency Section Triage Nurses
   - Labor and Delivery Nurses

   When non-Credentialed staff members assist with or perform the medical screening examination, their assessments are consistent with established policies and protocols or are in collaboration and consultation with appropriate Credentialed practitioners as necessary.

   The patient's primary physician/dentist, if applicable, will be notified of the patient's condition. If, based on the patient's condition, the Emergency Section physician/dentist determines that consultation of a specialist is required; the Emergency Section physician/dentist will contact a specialist in accordance with the primary care physician/dentist's normal referring pattern.

   Patients received in the Emergency Section without referral by or not under the care of a private physician/dentist will be assigned to a physician/dentist on-call as deemed appropriate by the Emergency Medicine Physician/dentist. The Emergency Section physician/dentist will contact an appropriate primary/specialty care physician/dentist guided by the on-call schedule established by each Service.

2. **On-Call Responsibilities**
   Members of the Medical Staff are expected to meet the obligation to cover emergency services in a manner outlined by the clinical service line.

   Complete on-call rosters, which include the name of the specific practitioner on call, are to be forwarded to the Emergency Section by the clinical service. On-call records must be kept by the Emergency Section for seven (7) years. If an effective call schedule cannot be maintained by the clinical service, physician/dentist with active or provisional privileges will be required to take an equal share of such emergency call responsibility. Physician/dentist is responsible to either fulfill his/her assignment or, if that is not possible, find a suitable replacement and notify the service co-chief, in writing, who will be replacing him/her on the schedule.

   When covering on-call services at the hospital, the physician/dentist on call is required to respond promptly to all pages. The physician/dentist on-call must be physically within a reasonable distance from the hospital in order to promptly report to the hospital when needed.

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3. **Response to Urgent Situations**
   It is the responsibility of all members of the Medical Staff who provide patient care at IU Health West Hospital to quickly and accurately resolve immediate and urgent clinical concerns. If a clinical concern is not resolved, the healthcare professional will follow the chain of command until the issue is resolved, including contact of administrative leaders up through and including the President. If circumstances surrounding the inability to reach a physician/dentist or member of the Medical Staff merit, the case will then be forwarded the appropriate section chief or physician/dentist leader for peer review.

ARTICLE VII. OBSERVATION

1. **Definition**
   Observation Status is the unscheduled use of an IU Health West Hospital bed to evaluate an outpatient's condition to determine the need for inpatient admission or discharge to home or another provider.
2. **Criteria for Observation Status**
   Patients may be assigned to Observation Status by any physician/dentist, Nurse Practitioner, or Physician Assistant who is a Member of the IU Health West Hospital Medical Staff, provided that the Nurse Practitioner or Physician Assistant must have been granted observation assignment privileges. Patients assigned to Observation Status must meet the following criteria:
   - **The patient's diagnostic evaluation requires more prolonged services than what is typically accomplished in the Emergency Department or outpatient setting; or**
   - The patient requires monitoring or treatment beyond the usual recovery time due to an unexpected occurrence or complication following an outpatient procedure (for example: abnormal bleeding, uncontrolled pain, vomiting, delayed recovery from anesthesia, etc).

   Observation Status is not acceptable for:
   - Routine prep or recovery period to or following diagnostic or surgical services;
   - Custodial care and/or as a convenience to patient, family, hospital, or physician;
   - Physical medicine and rehab care;
   - Patients receiving therapeutic services (chemotherapy, dialysis, blood transfusions not associated with acute blood loss) routinely provided in the outpatient setting;
   - Determining the labor status of a maternity patient; or
   - Patients requiring critical care treatment and monitoring.
3. Other Requirements

   Patients shall not be scheduled for Observation Status. A patient may only be scheduled as an outpatient or an inpatient. The admitting/attending physician/dentist may decide after an outpatient procedure that a patient meets criteria for Observation Status.

   Documentation must provide a description of the medically unstable condition for which the patient is being observed, the patient's signs and symptoms, the treatment provided and the response to treatment.

   Changes of patient from observation to inpatient must be documented in the Medical Record to indicate the reasons.

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ARTICLE VIII. QUALITY/PATIENT SAFETY

1. **Quality Measurement and Improvement**
   Participation in quality activities of the clinical service for which the physician/dentist practices is required. Trending of aggregate data on clinical processes and outcomes, professionalism, administrative and utilization data is to occur through each clinical service of the Medical Staff. Physician/dentist is expected to examine their individual performance as compared to peers among their service in order to identify opportunities for improvement in their clinical practice. Physician/dentist will at intervals be asked to participate on performance improvement teams.
2. **Peer Review Activities**
   Assessment of individual episodes of patient care management is triggered through various mechanisms, such as routine quality reviews, care management, medical staff committee activities and risk management activities. Peer review will be conducted as part of quality improvement efforts of the Medical Staff. Physician/dentist is to respond promptly to queries from peer physicians/dentists regarding interventions for individual episodes of care.
3. **Root Cause Analysis (RCA) and Risk Management Activities**
   Physician/dentist may be requested to participate in at intervals in activities to promote patient safety and reduce risk to patients and improve processes throughout IU Health West Hospital. Root causes analysis (RCA) sessions will be conducted on any sentinel event, serious event with the systems implication of a sentinel event, or a near miss event. The Risk Management Section, or in some cases, the Clinical Excellence Section, will contact the physician/dentist to determine a meeting time to conduct a systems review. Physicians/dentists are asked make attendance at such meetings a priority.

   Additionally, physicians/dentists are to promptly report patient errors or other patient-related safety issues to the Risk Management Section by completing an occurrence report or by contacting the hospital patient representative.

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ARTICLE IV. GENERAL RULES/EXPECTATIONS

1. **Confidentiality**
   In keeping with state and federal laws as well as IU Health West Hospital policy, all medical records, patient-specific information, peer review materials, risk management materials, credentialing records and files, minutes of relevant Medical Staff and hospital meetings, are the property of IU Health West Hospital.

   Access to confidential materials by Medical staff is permissible only when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, credentialing or other authorized activity. This requirement applies to information in electronically stored or hard copy format.
2. **Adherence to IU Health West Hospital Policy and Procedures**
   All members of the Medical Staff are expected to adhere to established policies and procedures for IU Health West Hospital. This includes adherence to all health care regulatory and accreditation requirements. Breach of policies, standards or regulations by individual physician/dentist will be handled through peer review mechanisms of the IU Health West Hospital Medical Staff.

ARTICLE V. REVISIONS

This document may be revised as outlined in Article 8 Section B (4) of the IU Health West Hospital Bylaws.

ORIGINAL APPROVAL DATES:

Medical Staff Executive Committee:
Medical Staff:
Board of Directors:

AMENDED APPROVAL DATES:

Date Revised:
Medical Staff:
Board of Directors:

Date Revised:
Medical Staff Executive Committee:
Board of Directors:

Attachments:

Applicability

Indiana University Health West Hospital

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