



# **Southern Maine Health Care**

## **Medical Staff Rules & Regulations**



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## **PART 1: DESIGNATED ADMISSION OF PATIENTS**

### **1-1 TYPES OF PATIENTS**

The SMHC hospitals accept for care and treatment patients with either acute or chronic illness without regard to race, religion, age, gender, gender identity, sexual orientation, national origin, disability, or any other basis prohibited by applicable law or ability to pay. The admission of any patient is contingent on the availability of adequate facilities and personnel to care for the patient.

### **1-2 ADMITTING PATIENTS**

Members of the Medical Staff in good standing and with appropriate privileges may admit patients to the Hospital.

For specific details, please refer to the following hospital policy: [Capacity Management & Patient Flow](#).

### **1-3 ADMISSION INFORMATION**

For specific details, please refer to the hospital [Capacity Management & Patient Flow](#) policy.

## **PART 2: ASSIGNMENT AND ATTENDANCE OF PATIENTS**

### **2-1 PARTICIPATION IN THE ON-CALL ROSTER**

Each clinical service develops and distributes an on-call roster. Each member of the Medical Staff agrees to participate in the on-call roster. Providers involved with the call schedule need to have notification and input before finalization. Members of the Medical Staff have an obligation to check the Intranet and be aware of on-call assignments. If a change is made, the provider making the change shall notify the appropriate areas.

When he or she is the designated practitioner on call, he or she will accept responsibility, during the time specified by the published schedule, for providing care to any patient in any unit of the hospital who is referred to the service for which he or she is providing on-call coverage.

A member of the Medical Staff may seek exemption from continued on call roster responsibilities after age 60 if he or she has been a member of the Medical Staff for ten years or more. This request must be made in writing to the MEC, which must seek input from the affected roster members. Approval authority for the exemption will reside with the MEC and Board of Trustees, and, if granted, must be renewed every two years.

### **2-2 Provider Obligations**

Members of the Active Staff have an obligation to share on-call duties. To ensure that the hospital is aware of which physicians, including specialists, are available to provide the treatment necessary to stabilize individuals with emergency medical conditions on a twenty-four hour basis, this on-call policy has been

adopted.

### **2-2.1 Procedure**

#### **A. On-Call Schedule:**

1. Each service line will designate the person responsible for creating the on-call schedule which must be forwarded to the appropriate areas in a timely manner and no later than seven days prior to the beginning of the month.
2. The finalized call schedule will be posted on the Intranet no later than five days prior to the beginning of the month.
3. If there is a change to the published schedule, it is the staff member's responsibility to make provision for change of coverage and to notify the Quality & Safety Service Leader (QSSL), Switchboard, and Emergency Department of such change.
4. If the service line, for unforeseen reasons, has trouble filling the call schedule, the Chief Medical Officer or designee or President of the Medical Staff will be contacted for resolution.

#### **B. Response to Call:**

When an on-call physician is contacted and requested to respond, the physician must:

1. Be immediately available, at least by telephone (within 15 minutes is considered timely for phone response);
2. Respond in person, if so requested, within a reasonable time period. The requesting provider, in consultation with the on-call physician, will determine the appropriate response time;
3. If a dispute arises regarding the need to see a patient in the Emergency Department or the hospital (i.e. the Hospitalist Service), the Emergency Department and/or inpatient providers' recommendation will prevail;
4. If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the requesting provider will determine whether to attempt to contact another specialist on the Medical Staff or arrange for a transfer pursuant to this policy.

#### **C. Concurrent Call/Elective Surgery:**

Notwithstanding an on-call physician's obligation to respond when on call, the on-call physician may perform elective surgery or other patient care services at the hospital while on call, and may be on call at another hospital, provided the on-call physician advises the Chief Medical Officer or designee, for notification and approval.

#### **D. Resignation of Privileges:**

Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibilities. This may be cause for disciplinary action.

#### **E. Follow-up Care:**

An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition. An on-call physician shall not require insurance information or a co-payment before assuming responsibility for care of the patient.

#### **F. Advanced Practice Providers:**

Advanced Practice Providers may participate in the on-call roster as deemed appropriate by each service line, subject to the service's policy to provide physician back-up.

G. Enforcement:

1. An on-call physician's unavailability when on-call, refusal to respond to a call, or any other violation of this policy is a serious matter.
2. Accordingly, a refusal or failure of an on-call physician to respond in a timely manner shall be reported immediately to the Chief Medical Officer or designee and the CEO, or designee, who shall review the matter. The MEC shall review the matter and determine if there has been a violation of the policy. Confirmed violations of the policy will result in the following disciplinary actions:
  - a) A first violation will result in a letter of reprimand from the CMO or designee;
  - b) A second violation will result in a letter of warning and the immediate suspension of clinical privileges for seven calendar days.
  - c) A third violation indicates an inability and unwillingness to fulfill Medical Staff responsibilities as set forth in the Medical Staff Bylaws and this policy. Accordingly, it will result in the automatic relinquishment of Medical Staff appointment and clinical privileges without the right to a hearing or appeal, after review of the MEC. Automatic relinquishment of Medical Staff appointment and clinical privilege may be reportable to the National Practitioner Data Bank (NPDB).
3. This policy outlines steps that can be taken to address violations under this policy. However, a single violation or pattern of violations may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this policy precludes an immediate referral of a matter being addressed through this policy to the MEC or the elimination of any particular step in the policy.

### **PART 3: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE**

#### **3-1 GENERAL RESPONSIBILITY**

There shall be coordination of the care, treatment, and services among the practitioners involved in a patient's care, treatment, and services. Members of the Medical Staff with admitting privileges shall be responsible for the medical care and treatment of each assigned patient in the hospital, for the accuracy and prompt completion of those portions of the medical record for which he or she is responsible, for special instructions, for transmitting reports concerning the condition of the patient to the referring practitioner, if any. These several responsibilities belong to the assigned physician, except when transfer of responsibility is effected pursuant to Section 3-2.

#### **3-2 TRANSFER OF RESPONSIBILITY**

When the current attending physician intends to transfer the responsibility for a patient's care to another staff member, the transferring physician must document in the record that the second physician has been notified, and has agreed to the transfer of patient care responsibility. The transferring physician must enter an order transferring the care of the patient to the second physician. In complex cases, the withdrawing attending physician, or designee, shall write a comprehensive progress note at the time of transfer.

#### **3-3 ALTERNATE COVERAGE**

### **3-3.1 Inpatients**

Each physician with clinical privileges must assure timely, adequate, professional care for the patients in the hospital by being available or, in the event that the physician is unavailable, by designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for his or her patients. When such designation is absent, or the designated physician is unavailable, the Chief Medical Officer or designee or designee, or the applicable Quality & Safety Service Leader (QSSL), has the authority to assign patient care responsibility to any member of the staff with the requisite clinical privileges.

### **3-3.2 Outpatients**

Each practitioner must assure timely, adequate professional care for the patients in their outpatient practice population by being available or, in the event that the practitioner is unavailable, by designating a qualified alternate practitioner with whom prior arrangements have been made.

## **3-4 INPATIENT CONSULTATIONS**

### **3-4.1 Responsibility**

The good conduct of medical practice includes the proper and timely use of consultation. When indicated or required, the practitioner is primarily responsible for requesting a consultation from a qualified Staff member. Judgment as to the correct diagnosis and treatment or the severity of the illness generally rests with the practitioner.

### **3-4.2 Qualifications of Consultant**

Any qualified physician who has been granted the appropriate level of clinical privileges at this hospital may be called as a consultant, regardless of his/her staff category assignment.

### **3-4.3 General Guidelines for Requesting Consultation**

Consultation with a qualified physician is required in the following cases:

- A. When required by state law;
- B. When requested by the patient or family;
- C. When consultation is a condition attached to the exercise of a particular privilege.

In addition, consultation is recommended in the following instances:

- A. Critical illness in which discussion as to the appropriate therapeutic measures to be utilized would be beneficial;
- B. When the risk of surgery requires critical evaluation;
- C. Difficult or equivocal diagnosis or therapy.

### **3-4.4 Documentation of Consultation**

#### **3-4.4.1 Consultation Request**

When requesting consultation, the practitioner must enter an order for consultation into the patient record, including the reason for the request and the extent of involvement in the care of the patient expected from the consultant.



The practitioner is personally responsible for ensuring that the consultant is properly notified by direct one-to-one personal communication. The consultant will be informed of the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

#### **3-4.4.2 Consultant's Documentation**

The consultant must document, sign, date and time a report of his or her findings, opinions, and recommendations which reflects an actual examination of the patient and the medical record. The consultant must expediently conduct the consultation unless the requesting physician notes otherwise. Such report shall become a part of the patient's medical record.

The consultant should document daily notes, unless another frequency is agreed upon with the requesting provider. If daily assessment is not required of the consultant, the note should indicate when the patient will be evaluated again by the consultant. The consultant may sign-off, in agreement with the requesting provider, when their care is no longer needed. Sign-off should be explicitly stated in the consultant's final note. That note should also include instructions for post-hospitalization follow-up if indicated.

### **3-5 TREATMENT OF RELATIVES BY MEDICAL STAFF AND ADVANCED PRACTICE PROVIDERS**

For specific details, please refer to the hospital policy [Employees and Medical Staff Members Providing Treatment to Relatives at SMHC](#).

## **PART 4: ORDERS**

### **4-1 GENERAL REQUIREMENTS**

The practitioner is responsible for entering all orders for treatment or diagnostic tests into the computerized physician order entry (CPOE) module. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for such administration.

In the case of diagnostic tests, the practitioner ordering the test and the clinical department performing the tests are responsible for the appropriate scheduling of such tests. The ordering practitioner is responsible for conveying perceived urgency.

Despite the presence or absence of dictated reports, it is incumbent upon the attending physician to ascertain the test results.

Notwithstanding the foregoing responsibilities of the attending physician, the physician consultant representing the testing facility should contact the attending physician in the event of an unanticipated abnormal finding which may affect the patient's course of care.

### **4-2 CLINICAL SECTION ORDER SETS**

For specific details, please refer to the hospital policy [Order Sets, Standing Orders, and Protocol Orders: Definition and Process for Review and Approval](#).

#### **4-3 VERBAL ORDERS/TELEPHONE ORDERS**

For specific details, please refer to the hospital policy [Orders in the Medical Record](#).

#### **4-4 ORDERS BY ADVANCED PRACTICE PROVIDERS**

An Advanced Practice Provider (APP) may enter orders to the extent specified in the privileges individually defined for him/her. An admission order entered by an APP must be co-signed by the Attending physician.

#### **4-5 BLOOD TRANSFUSIONS**

For specific details, please refer to the hospital policy [Blood Component Administration – Adult/Pediatric](#).

#### **4-6 SPECIAL ORDERS**

##### **4-6.1 Patient's Own Drugs and Self-Administration**

For specific details, please refer to the hospital policy [Use of Medications Brought Into the Hospital by Patients, Families, and Providers](#).

##### **4-6.2 Do Not Resuscitate (DNR)**

For specific details, please refer to the hospital policy [Advance Care Planning and Decisions about Life-Sustaining Treatment](#).

##### **4-6.3 Hospital Standing Physician Orders**

For specific details, please refer to the hospital policy [Order Sets, Standing Orders, and Protocol Orders: Definition and Process for Review and Approval](#).

#### **4-7 FORMULARY AND INVESTIGATIONAL DRUGS**

For specific details, please refer to the hospital policies [Formulary System](#) and [Investigational Drug Trials and Clinical Research Policy](#).

## **PART 5: THE MEDICAL RECORD**

### **PREFACE:**

It is the policy of Southern Maine Health Care that all providers will be required to independently utilize all currently implemented components of the electronic medical record, and such additional components that are implemented in the future.

Demonstrated continued competence, either through frequent independent use of the electronic record, or successful completion of further training, is a requirement for maintenance of Medical Staff privileges.

Failure to comply with this policy will be addressed through the Disruptive Physician policy and/or the Corrective Action & Fair Hearing Manual.

## **5-1 REQUIRED CONTENT**

For specific details, please refer to the hospital policy [Legal Health Record](#).

## **5-2 HISTORY AND PHYSICAL EXAMINATION**

The purpose of a medical history and physical examination is to determine whether there is anything in the patient's overall condition that would affect the planned course of the patient's treatment. The content should be pertinent, relevant, and include sufficient information to address the patient's condition, care, and needs. There may be additional documentation guidelines for billing purposes which are not addressed here.

### **5-2.1 Admitted Patients**

A history and physical examination is required to be completed for all admitted patients within twenty-four (24) hours after admission. When a patient is re-admitted to the Hospital within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings documented within 24 hours of the patient admission may be used provided the original information is readily available.

Content should include the chief complaint, details of the present illness, relevant medical, social, and family histories, any relevant review of systems, pertinent physical examination findings, an assessment and a plan.

The history and physical examination must be performed by a physician with privileges to do so or may be delegated to an Advanced Practice Provider provided the responsible physician reviews and countersigns the documentation. The APP H&P satisfies the immediate documentation requirement when signed by the APP. It will be co-signed by the supervising physician before the medical record is finalized.

### **5-2.2 Procedure Patients**

A documented history and physical examination is required to be completed for all patients prior to undergoing procedures involving the use of general, spinal, or epidural anesthesia, moderate or deep sedation, or having a procedure performed in the operating room. A history and physical examination is not required for outpatients undergoing incisions, insertions, or punctures not involving the above listed types of anesthesia.

The history and physical examination may be performed up to 30 days prior to the procedure. If performed more than 24 hours prior to procedure, a documented update to the H&P is required to be completed prior to the procedure indicating that the physician has reviewed the chart and examined the patient. In the event of emergency, the practitioner may document the history and physical examination immediately after the emergency surgery has been completed.

Content of the history and physical examination may be service line-specific and must contain, at minimum, the chief complaint and indication for the procedure, significant medical/surgical history, and examination of the body system or part where the procedure will be performed. The record will also contain medications, allergies, and vital signs. Documentation of the update must include any additions to the history and documentation of any or no changes in the physical findings subsequent to the original report.

The history and physical examination and any update may be performed by a physician with privileges to do so or may be delegated to an Advanced Practice Provider provided the responsible physician reviews and countersigns the documentation prior to the procedure.

The history and physical examination may also be completed by a qualified, licensed non-privileged practitioner acting within his/her scope of practice under State law if a privileged provider reviews the document, assesses for and completes any missing information, evaluates and updates a physical examination, and signs an attestation that the updated or revised document is current and accurate. Generally, this occurs with an H&P completed in advance by a primary care provider without Medical Staff membership or privileges.

### **5-2.3 Pre-Operative Anesthesia Evaluation**

The anesthesiologists (or other licensed independent professional responsible for the patient's anesthesia care), must conduct and document in the record a pre-anesthetic evaluation of the patient including pertinent information relative to the choice of anesthesia for the procedure anticipated, pertinent drug and allergy history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiology patient status classification, condition of the patient prior to anesthesia, and orders for pre-operative medication within forty-eight hours of inpatient or outpatient general, spinal or epidural anesthesia, moderate or deep sedation. Except in cases of emergency, this evaluation will be recorded before pre-operative medication has been administered and prior to the patient's transfer to the operating area. A re-evaluation of the patient is documented immediately before moderate or deep sedation and before general, spinal or epidural anesthetic induction.

## **5-3 PROGRESS NOTES**

### **5-3.1 Generally**

The attending physician or the designated Advanced Practice Provider is responsible for creating pertinent daily progress notes. Notes must be timed and dated at the time of observation. Notes should contain sufficient information to permit continuity of care and provide an accurate description of the patient's progress. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders/tests/treatments. Electronic documentation of notes (typed or dictated into the EMR) is required because it allows for remote access to the notes during the hospitalization.

Progress notes can be documented by an Advanced Practice Provider working under the supervision of a physician.

Progress notes shall be documented currently and shall be sufficient so that the clinical course can be followed from the record. Minimum requirements are for daily physician notes in the case of patients classified as acute care; and notes as needed, but no less than monthly, in the case of patients classified as sub-acute care (e.g., patients awaiting placement to a long term care facility).

It is the physician's responsibility to create a daily progress note for patients who are critically ill. The Advanced Practice Provider may perform rounds on these patients, but such rounds do not satisfy or change the supervising physician's responsibility to make daily rounds and record progress notes. For patients whose diagnosis or management is difficult, the physician should consider creating a separate progress note.

## **5-4 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS**

### **5-4.1 Operative and Special Procedure Reports**

A full operative or special procedure report must be documented within 24 hours following the procedure, and promptly authenticated by the primary performing physician.

A full operative or special procedure report must contain, as applicable:

- A. The name(s) of the licensed independent practitioner(s) who performed the procedure, and his or her assistant;
- B. The name of the procedure performed;
- C. A description of the procedure;
- D. Findings of the procedure;
- E. Any estimated blood loss, if clinically relevant;
- F. Any specimen(s) removed;
- G. The post-operative diagnosis

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure (i.e., dictation awaiting transcription), a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note must contain:

- A. The name(s) of the primary surgeon(s) and his or her assistant(s);
- B. The procedure performed and a description of each procedure finding;
- C. Estimated blood loss, if clinically relevant;
- D. Specimens removed; and
- E. Post-operative diagnosis.

The medical record must also contain the following postoperative information:

- A. The patient's vital signs and level of consciousness;
- B. Any medications, including intravenous fluids and any administered blood, blood products, and blood components;
- C. Any unanticipated events or complications (including blood transfusion reactions) and the management of those events.

The medical record must contain documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria.

### **5-4.2 Tissue Examination and Reports**

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy, shall be properly labeled, and packaged in preservative as designated, identified in the Operating Room or Special Procedures Suite at the time of removal as to patient and source, and sent to the Pathologist. The Pathologist shall document receipt, and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the pre-operative and post-operative diagnoses. An authenticated report of the

pathologist's examination shall be made a part of the medical record.

## **5-5 OBSTETRICAL RECORD**

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the responsible practitioner's office or clinic record, provided that the record contains all pertinent information as defined in Section 5-2.1. Such record may be transferred to the hospital before admission, but an interval admission note must be written which includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 5-2 and 5-3 of these Rules and Regulations.

## **5-6 ENTRIES AT CONCLUSION OF HOSPITALIZATION**

### **5-6.1 Diagnoses and Procedures**

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure, any additional procedures must be recorded in full in the medical record and must be signed, dated, and timed by the responsible practitioner at the time of discharge. The following definitions are applicable to the terms used herein:

- A. Principal diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- B. Secondary Diagnoses (if any): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the responsible practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
- C. Co-morbidities (if any): A condition that co-existed at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one (1) day for about seventy-five percent (75%) of patients.
- D. Complications (if any): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one (1) day.
- E. Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.
- F. Additional Procedures (if any): Any other procedures, other than the principal procedure, pertinent to the individual's stay.

### **5-6.2 Discharge Summary**

- A. General: A discharge summary must be recorded for all inpatients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, treatment rendered, the condition of the patient on discharge, discharge diagnoses and the disposition of the patient.
- B. Exceptions: A final progress note may be substituted for the discharge summary for the following categories of patients:
  - 1. Those with problems of a minor nature that require less than forty-eight (48) hours of hospitalization;

2. Normal newborn infants;
3. Patients having uncomplicated vaginal deliveries;
4. Outpatients.

### **5-6.3 Instructions to Patient**

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant others relating to physical activity, medication, diet, and follow-up care. Alternatively, the chart must contain documentation of instructions given to the patient and/or significant others in the form of a standard instruction sheet. If no instructions were required, a record entry must be made to that effect.

## **5-7 AUTHENTICATION**

All clinical entries in the patient's records must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.

## **5-8 USE OF SYMBOLS AND ABBREVIATIONS**

For specific details, please refer to the hospital policy [Abbreviations and Symbols](#).

## **5-9 FINALIZING**

No medical record shall be finalized until it is complete and properly authenticated and closed. In the event that a chart remains incomplete by reason of the death, resignation, or other inability or unavailability of the responsible physician to complete the record, the Chief Medical Officer or designee shall consider the circumstances, may enter such reasons in the record and order it finalized.

## **5-10 OWNERSHIP AND REMOVAL OF RECORDS**

All original patient medical records, including x-ray images, pathologic specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena, statute, or in accordance with established procedure designed to facilitate continuing or follow-up patient care. Unauthorized removal of a medical record or any portion thereof from the hospital including its outpatient offices is grounds for disciplinary action.

## **5-11 ACCESS TO RECORDS**

Members of the Medical Staff shall not access any patient information through health information systems and/or patient databases unless required to access such information in connection with their obligation to provide medical care to a patient or for bona fide research or educational purposes consistent with preserving the confidentiality of patient information. No member of the Medical Staff shall give or allow another to use his or her password or other user identification, whether or not such individual is an authorized user. Each member of the Medical Staff understands that his or her password or other user identification shall constitute his or her legal signature and shall be accountable for all actions taken as a result of the use of such password or other user identification. In the event that members of the Medical Staff reasonably suspect or become aware of any unauthorized use or disclosure of their password or other

user identification, they shall immediately change such password or other user identification, and immediately report such unauthorized use or disclosure to the Chief Information Officer. Each member of the Medical Staff shall log-off the health information systems and/or patient databases or password protect his or her computer screens, regardless of where the screens are located, to ensure that a computer session cannot be used by any other individual when left unattended. No member of the Medical Staff shall print, copy or download patient information from the health information systems and/or patient databases to any hard drive, portable memory device, tape or other storage device for purposes other than to provide medical care to a patient or for bona fide research or educational purposes. Unauthorized removal of a medical record or any portion thereof from the hospital, including its outpatient offices, is grounds for disciplinary action.

Each member of the Medical Staff shall become solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded.

#### **5-11.1 By Patient**

Any patient may, upon written request, have access to all information contained in his or her medical record, unless access is specifically restricted by the responsible practitioner for medical reasons. An inpatient may, upon oral request, review the record with consent of, and in the presence of, the attending physician. The attending physician may waive the condition requiring his or her presence.

#### **5-11.2 By Third Parties**

Written authorization by the patient or his or her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section, 5-12, or by law to receive this information. Release of information shall be in accordance with the existing policy of the HIM Department as may from time to time be established.

#### **5-12.3 For Statistical Purposes and Required Activities**

Patient medical records shall also be made available to Medical Staff members or authorized personnel with an official hospital-approved interest in order to facilitate:

1. Automated data processing of designated information;
2. Activities concerned with assessing the quality, appropriateness, and efficiency of patient care;
3. Clinical unit/support service review of work performance;
4. Official surveys for hospital compliance with accreditation, regulatory and licensing standards;
5. Approved educational programs and research studies;
6. Continuing care by another physician or health care provider.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification. Confidential personal information extraneous to the purposes for which the data is sought shall not be used.

#### **5-11.4 For Re-Admission**

In the case of re-admission of a patient, the responsible physician or designee(s) shall have reasonable access to all previous records.

#### **5-11.5 To Former Medical Staff Members**

Subject to the approval of the Chief Medical Officer or designee and with appropriate reason, former



members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods for which they attended such patients in the hospital.

#### **5-12 STANDARDS FOR COMPLETION**

The appropriate practitioner must complete or sign the medical records within fourteen (14) days of discharge. A record is considered complete when the discharge summary or discharge note, history and physical, consultative report, operative note, catheterization report, other procedure report, and final diagnoses are assembled and authenticated. Additional documentation to facilitate hospital billing or accreditation may also be required; examples of such documents including cancer staging forms or billing queries. Records remaining incomplete thirty (30) days after being made available to the appropriate practitioner shall be considered delinquent.

#### **5-13 ADMINISTRATIVE WITHDRAWAL OF PRIVILEGES**

Should a delinquent record exist, a practitioner's privileges to admit or perform elective surgical or medical procedures shall be suspended until all delinquent records are complete. The practitioner may continue to provide services to current inpatients. This suspension shall be termed an administrative withdrawal of privileges. For all legal and medical practice purposes, the practitioner shall continue to retain all clinical privileges, but shall be deemed to have agreed not to exercise any such retained privileges until the administrative withdrawal shall be terminated.

##### **5-13.1 Notification**

Seven (7) days prior to an incomplete record being considered delinquent, the practitioner will be notified in writing by the HIM Department of the existence of potential delinquent records and the projected date of the withdrawal of privileges.

Forty-eight (48) hours prior to the anticipated suspension of privileges, the practitioner's office will be notified by telephone by the HIM Department of the availability of records and the anticipated suspension of privileges.

##### **5-13.2 Withdrawal**

Should records remain incomplete as described above, the practitioner or representative will be notified, on the morning of the day in which the records become delinquent by the office of the Chief Medical Officer or designee, that if the records are not completed by 5:00 p.m. that afternoon, the practitioner's privileges will be withdrawn. Should records not be completed by that afternoon, the HIM Department will notify the Admitting Office, the ASU, the Endo Suite, the Cardiac Cath Lab and the Operating Room (and other sites that may be identified from time to time) and the physician's office that admitting, elective surgery, and medical procedures privileges have been withdrawn.

##### **5-13.3 Appeal**

The affected practitioner may appeal the imposition of such administrative withdrawal to the Chief Medical Officer or designee with no further right of Fair Hearing. If the practitioner demonstrates, to the satisfaction of the Chief Medical Officer or designee or designee, justifiable reasons for the delinquent records which caused the administrative withdrawal or other extenuating circumstances, then the Chief Medical Officer or designee will immediately rescind or modify the withdrawal. Justifiable reasons for delinquent records shall include, but not be limited to:

1. The practitioner or any other party necessary for completion of the record was ill, on vacation, or otherwise unavailable; or,
2. The practitioner was waiting for the results of a late report and the record is otherwise complete except for the final diagnosis or discharge summary or both.

#### **5-13.4 Non-Compliance**

If a practitioner shall exercise any retained clinical privileges during such administrative withdrawal, he shall be subject to the processes related to questions of professional behavior as provided for in the Medical Staff Bylaws.

### **PART 6: CONSENT TO MEDICAL TREATMENT**

#### **6-1 GENERAL REQUIREMENT**

Obtaining and recording informed consent before major diagnostic, therapeutic, and invasive procedures is a physician's professional and legal obligation. Patients have the legal right to grant or withhold informed consent, either personally or through lawful representatives.

For specific details, please refer to the hospital policy [Informed Consent](#).

### **PART 7: HOSPITAL DEATH AND AUTOPSIES**

#### **7-1 HOSPITAL DEATHS**

##### **7-1.1 Pronouncement**

The attending physician, Advanced Practice Provider, or registered nurse, in accordance with hospital policy, must pronounce the death of the patient within a reasonable period of time.

##### **7-1.2 Reportable Deaths**

For specific details, please refer to the hospital policy [Medical Examiner Cases](#).

##### **7-1.3 Death Certificates**

The Attending Physician or his or her physician designee must sign the death certificate, unless the death is a Medical Examiner's case, in which event the death certificate can be issued only by the Medical Examiner. When a reported case is not accepted by the Medical Examiner, the attending physician issues the death certificate.

##### **7-1.4 Release of Body**

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the Medical Staff or his or her physician designee. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel except upon the receipt from the Medical Examiner of authorization to release the body. All other policies with respect to the release of dead bodies shall conform to state law.

#### **7-2 AUTOPSIES**

It is the responsibility of every member of the Medical Staff to secure autopsies whenever indicated. Proper consent for an autopsy shall be in accordance with applicable state law. Autopsies should be considered in those deaths that meet, but are not limited only to, the following criteria:

- A. Unanticipated deaths;
- B. Death occurring while the patient is being treated under a new therapeutic trial or regimen;
- C. Intra-operative or intra-procedural death;
- D. Death occurring within forty-eight (48) hours after surgery or an invasive procedure;
- E. Death incident to surgery or an invasive diagnostic procedure;
- F. Any death on the psychiatric service;
- G. Death where the cause is significantly obscured to delay completion of the death certificate;
- H. Death in infants and children with congenital malformation;
- I. Death in which the autopsy may help allay concerns of the family and/or the public regarding the death;
- J. Natural deaths which were subject to, but waived by, forensic medical jurisdiction such as, but not limited to, death on arrival at the hospital, death occurring within twenty-four (24) hours of admission, death in which the patient sustained, or apparently sustained, an injury while hospitalized;
- K. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs;
- L. Cancer patients in who there is no prior tissue diagnosis, or the site of origin of the primary tumor is unknown;
- M. Obstetric (maternal and fetal) and pediatric deaths, according to state law.

All autopsies shall be performed by a hospital pathologist or by qualified designee. The provisional anatomic diagnoses must be recorded on the medical record within seventy-two (72) hours, and the preliminary report in thirty (30) working days. The complete protocol shall be made a part of the medical record within ninety (90) days. These rules do not apply to cases which, according to law, must be referred to the Medical Examiner's Office.

### **7-3 ORGAN DONATIONS**

It is the responsibility of any member of the Medical Staff to discuss the possibility of organ donations with family members when appropriate and otherwise comply with the Maine Uniform Anatomical Gifts Act and hospital policy.

For specific details, please refer to the hospital policy [Organ/Tissue Donor Program](#).

## **PART 8: MEDICAL EDUCATION**

### **8-1 MEDICAL STAFF PARTICIPATION**

Members of the medical staff may, by mutual consent, serve in a teaching and/or supervisory capacity in any Medical Staff-approved educational programs for which the hospital has a contract with Maine Medical Center for residents in an approved program. Medical Staff members have the option of not participating in the education program without jeopardizing their privileges or staff membership.

**8-2 SUPERVISION OF RESIDENT PHYSICIANS**

Residents must be supervised by the responsible physician in accordance with the terms outlined in the contract between MMC and SMHC.

**PART 9: ENFORCEMENT**

Violations of any of these general Rules and Regulations or referenced hospital policies by a member of the Medical Staff may constitute grounds for initiation of the processes relating to questions of professional competence or conduct provided for in the Medical Staff Bylaws, which states that these processes may be initiated by the President of the Medical Staff, the Chief Medical Officer or designee or the leader of the relevant service line.

**PART 10: AMENDMENT**

These General Rules and Regulations may be amended, or repealed, in whole or in part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

Approved MEC: 9/19/19  
Approved Board: 10/7/19  
Revised: 9/1/20  
Approved MEC: 9/17/20  
Approved Board: 10/5/20