



CHRISTIANA CARE

Medical-Dental Staff Rules

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ARTICLE 1
GENERAL

Section 1.1 Medical-Dental Staff Bylaws and Policies and Rules and Regulations:

All Medical-Dental Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical-Dental Staff governance documents. There may be Christiana Care Policies and Procedures and Department or Section Rules and Regulations expanding upon the subject matter contained in these Medical-Dental Staff Rules and Regulations.

Section 1.2 New Member Hospital Orientation(s):

New Medical-Dental Staff Members and Credentialed Health Care Providers should complete a role-based hospital orientation.

ARTICLE 2
EMTALA

Section 2.1 EMTALA Medical Screening Examination:

The following providers are deemed to be “qualified medical personnel”(QMP) authorized to performed medical screening examinations (MSE) at Christiana Care as required by the Emergency Medical Treatment and Active Labor Act (“EMTALA”):

- the Emergency Department (“ED”) physicians (including Emergency Medicine Residents);
- the ED physician assistants and/or advanced practice nurses;
- the Department of Obstetrics & Gynecology physicians (including department residents);
- Certified Nurse Midwives, other Advanced Practice Nurses and Physician Assistants in the Department of Obstetrics & Gynecology
- obstetric nurses

When the disaster plan is implemented or placed on alert, and when warranted by the situation in the ED, the Chief Executive Officer or his designee, the Chief Medical Officer, may designate ED registered nurses as qualified medical personnel authorized to perform medical screening examinations at Christiana Care. In such event, the ED registered nurses may determine whether a patient has an emergency medical condition.

Section 2.2 Patient Stabilization, Movement and Transfer:

- (1) If the MSE reveals an emergency condition, the Emergency Department must stabilize the patient to the extent possible prior to discharge, movement or transfer. [See § 3.5 Transfer of Patients.](#)
- (2) A patient with an incompletely stabilized emergency medical condition may either be:
 - a. Moved to another Christiana Care Department with superior capabilities to stabilize the patient’s emergency medical condition (include more expedient access to the personal services of an on-call physician; or
 - b. Transferred to another facility outside of the Christiana Care Health System, if:

- i) the patient, while understanding the risks and benefits of transfer, provides a written request for transfer despite being informed of the hospital's EMTALA obligations to provide treatment, or
- ii) the treating physician certifies that the benefits of transfer outweigh the risks, and the patient consents to the transfer, or.
- iii) the assigned on-call medical specialist fails or refuses to appear or arrange for movement in accordance with (2) (a) above within the defined timeframe and the requirement of (2)(b)(ii) are met.

Section 2.3 On-Call Responsibilities:

- (1) Under EMTALA, the emergency physician (or other QMP) may request the assistance of any medical specialist, assigned to be on-call to that Emergency Department in the screening, stabilization, movement, treatment, and/or transfer of any patient presenting to that Emergency Department.
- (2) Telephone/Telemedicine consultation may be sufficient to resolve the emergency physician's (or QMP's) query. However, the on-call specialist must either appear personally in the ED when requested to do so by the ED physician or in the alternative, arrange for movement of the patient to another Christiana Care Department where he/she can personally provide further stabilization services at that location. Nothing in this provision shall interfere with the patient's right to request his or her own physician if such a choice is expressed and the physician is on the Christiana Care Medical-Dental Staff with appropriate privileges.
- (3) On-call physicians are expected to respond by telephone within five (5) minutes for STAT calls and fifteen (15) minutes for regular calls. When requested to come to the ED, the physician is required to be personally appear in the ED or arrange for movement to another Christiana Care Department where he/she can personally provide further stabilization services, within forty-five (45) minutes (from request to arrival). This will be monitored.
- (4) The on-call specialist must provide instructions on how to reach him/her immediately. (Group names for on-call rosters are prohibited by EMTALA). If, for some reason, the on-call specialist is unreachable or unavailable, his/her responsibility under EMTALA and the Christiana Care Medical-Dental Staff Bylaws is not diminished. Under such circumstances, the on-call physician should designate a covering physician. Nevertheless, the Chair/designee is ultimately responsible for identifying an alternative physician and/or for setting forth the specific steps to be taken by the ED when the particular specialty is not available for on-call service, or the specialist scheduled for on-call duty cannot respond due to circumstances beyond his/her control (e.g. transportation failures, personal illness, etc.).

ARTICLE 3

ADMISSION AND ASSESSMENT

Section 3.1 General:

Patients shall be assessed in a timely manner based on the patient's diagnosis and special needs, the care being sought, the care setting, the patient's response to previous care and his/her consent to treatment. The evaluation of patients will be made in a timely fashion consistent with the needs of the patient and shall be completed as defined in these [Rules and Regulations, § 11.5](#), but no greater than twenty-four hours (24) after admission.

Section 3.2 Who May Admit Patients:

- (1) A patient may be admitted to Christiana Care only by physicians, oral and maxillofacial surgeons, podiatric surgeons, who have been appointed to the Medical-Dental Staff and who have been granted admitting privileges. See exception below:
 - a. **Podiatrists are permitted** to admit patients and provide care that is within their scope of practice and specifically related to podiatry. An attending physician of the Medical-Dental Staff with admitting privileges will be consulted at the time of admission (co-management) and will supervise required medical care.
 - b. **Certified Nurse Midwives who are credentialed and privileged** by the Department of Obstetrics and Gynecology and have a collaborative agreement with a Christiana Care Medical-Dental Staff member may admit low- risk obstetrical patients as defined in the collaborative agreement.

Section 3.3 Admitting Member's Responsibilities:

- (1) Each patient shall be the responsibility of a designated Medical-Dental Staff Member who shall serve as the attending practitioner.

The attending practitioner is the Medical-Dental Staff member/Certified Nurse Midwife who admits the patient is responsible for:

- a. initial evaluation and assessment of the admitted patient within twenty-four (24) hours of admission;
 - b. completion of the history and physical as outlined in [§ 11.5](#);
 - c. admission diagnosis (in emergency situations, the provisional diagnosis will be documented as soon after admission as possible);
 - d. admission orders, to include countersignature if applicable;
 - e. determining the need for consultation;
 - f. management and coordination of patient care, including direct daily assessment, evaluation and documentation in the medical record by the attending or the designated credentialed provider;
 - g. discharge summary and arrangements for post-discharge care; and
 - h. transfer orders in the medical record after the Medical-Dental Staff member taking over the care of the patient has agreed to accept the patient. [See § 3.5](#)
- (2) In the case of a group practice, the Medical-Dental Staff member who admits the patient shall be considered the responsible, designated Attending practitioner.
 - (3) In the event, the Attending practitioner fails to attend to the patient , the Department Chair/designee may authorize any other qualified member of the Medical Staff to provide such care as necessary. Failure to attend to patients will be subject to peer review.
 - (4) Christiana Care inpatients requiring admission to the Center for Rehabilitation and Psychiatry Services must be discharged from acute care;
 - a. Admissions to the Center for Rehabilitation and the psychiatric unit must have a completed Interagency Discharge Orders Form, including the Medication Reconciliation Order Sheet as defined in Christiana Care [Medication Reconciliation Policy](#) and scheduled follow-up appointments (including the name of the follow-up provider).

- b. Admissions to psychiatric unit must be accepted for admission by the unit Medical Director or on-call psychiatrist. Following acceptance, admission orders will be entered into CPOE by the admitting psychiatrist.

Section 3.4 Alternate Coverage:

- (1) Each Medical-Dental Staff member shall provide for the medical care of his or her patient(s) in Christiana Care either by being available personally or by having appropriate coverage arrangements with other members of the Medical-Dental Staff in the same specialty and with the same privileges likely to be needed for those times when the covered practitioner will be unavailable.

Section 3.5 Transfer of Inpatients (External and Internal):

- (1) **External:**
 - a. Treatment shall be provided to patients with conditions and diseases for which Christiana Care has appropriate facilities and personnel. When Christiana Care cannot provide the services required by a patient or for any reason Christiana Care cannot care for a particular patient who requires inpatient care, Christiana Care personnel and/or the attending Staff Member, may assist the patient with arrangements for care in another facility.
 - b. A patient shall not be transferred until the patient is satisfactorily stabilized for transports and the receiving facility/physician has consented to accept.
 - c. All available information considered necessary to assure continuity of care shall be placed in the patient's medical records prior to the transfer and shall be provided to the receiving facility at the time of transfer.
- (2) **Internal:**
 - a. In the event of a transfer of care to a different level of care or another physician (regardless of whether initiated by the patient/family or the physician), the transferring physician shall:
 - i) Take reasonable steps to assure continuity of the patient's care;
 - ii) Remain attending physician of record for an inpatient until another physician has assumed the care of the patient;
 - iii) Communicate with the transferee physician regarding the patient's condition and treatment plan;
 - iv) Document an Order for Transfer to the transferee physician.
 - v) Complete a Medication Reconciliation Order Sheet (see Medication Reconciliation Policy).
 - b. The department Chair and/or designee of the transferring physician and Christiana Care Health Services staff will be available to provide assistance as requested by the transferring physician.

Section 3.6 Priorities for Care and Treatment:

- (1) Patients shall be cared for based upon the following order of priorities:
 - a. **Emergency** - includes those patients whose lives are in immediate danger or whose conditions are such that lack of immediate treatment could result in serious or permanent harm and any delay in treatment would add to that harm or danger.
 - b. **Urgent** - include non-emergency patients for whom treatment is considered imperative by the attending member.
 - c. **Elective** - includes non-emergency patients who are already scheduled for surgery or other high-risk procedures or need other clinical services. These patients shall be given an

appropriately scheduled reservation in accordance with Christiana Care’s utilization review plan. If it is not possible to accommodate the patient, the Chair of the pertinent department may decide the priority of any specific patient’s admission.

Section 3.7 Admission Orders:

- (1) Admission Orders will include service admitted to, diagnosis, allergies, nutrition, medications, activities, and condition.
- (2) Admission Orders will include the patient status type (inpatient, or observation) and intended level of care (general floor, stepdown, or intensive care). The patient status and level of care should be based on the patient’s particular condition and consideration should be given to the impact of any pre-existing medical problems or extenuating circumstances that make admission medically necessary.
 - a. If the initial admission order patient status type is inpatient, and the Utilization Review Committee recommends changing the patient status type to Observation because the patient’s condition does not meet the hospital criteria for inpatient status, only the Attending Physician responsible for the care of the patient may write orders to change the patient status to observation.
 - i) Orders for observation must read **“Place in Observation Status”**.
 - ii) If it is determined that an observation patient is in need of inpatient care, the patient’s status can be changed to inpatient at any time. This change requires a physician’s order, which should be written at the time the decision is made.

All admission orders must be signed, dated and timed.

- (3) The order to admit the patient may be written by physicians, oral and maxillofacial surgeons and podiatric surgeons. The order to admit the patient written by Physician Assistants and Advance Practice Nurses at the direction of the supervising/collaborative physician must be countersigned. The Emergency Medicine physician is authorized to issue a temporary or “bridge” inpatient admission order, which is required to be countersigned by the Attending physician.
- (4) Residents may write admission orders at the direction of the Attending Physician, countersignature is required.

ARTICLE 4 **INFORMED CONSENT**

Section 4.1 General:

- (1) Informed Consent is an agreement or permission accompanied by a full notice about care, treatment and/or services that are the subject of the consent. A patient will be apprised of the nature, risks, benefits and alternatives of any invasive medical or surgical procedure or blood administration before the physician or other healthcare professional begins any the procedure. After the patient receives this information then either a consent to, or refusal for must be obtained before initiation of such procedures or treatment. See Christiana Care [Informed Consent Policy](#) for additional information
- (2) Except in emergencies, a failure to include a completed consent form in the patient’s medical record prior to the performance of a surgical or other high-risk procedure shall require cancellation of the procedure.

Section 4.2 Responsibility for Obtaining Informed Consent:

- (1) It shall be the responsibility of the healthcare practitioner who is authorized to perform medical and surgical procedures (“Responsible Practitioner”) or his/her designee, to obtain consent from the patient.
- (2) The nurse may witness the patient’s signature on the form, but is not permitted to obtain consent except for administration of blood or blood products.

Section 4.3 Consent Questions:

- (1) When questions arise regarding patient consent or when unusual circumstances occur not clearly covered by these Rules and Regulations or the Christiana Care [Informed Consent Policy](#), the Responsible Practitioner shall promptly confer with Christiana Care’s Legal/Risk Management Department or the Administrator On-Call concerning such matters.
- (2) Christiana Care will make every effort to assist the Responsible Practitioner in obtaining the required consent and to provide information relative to informed consent. However, it is the ultimate responsibility of the Responsible Practitioner to comply with the requirements contained in these Rules and Regulations.

ARTICLE 5 **CONSULTATION**

Section 5.1 General:

- (1) Requests for consultations shall be entered in the patient's medical record, either by using CPOE or, during a downtime, by handwriting the order on the physician’s order sheet. The ordering provider documents the name of the physician who received the call for STAT consult within the order text
- (2) **A routine consultation** should be completed within twenty-four (24) hours of the request. If the patient’s condition warrants the patient being seen sooner, the requesting physician shall request a STAT consultation and convey the information by speaking directly to the consultant.
- (3) If a specific physician is requested for a consultation but is unavailable, the physician on call for the requested consultant is responsible for assuring the consultation is completed within the required timeframe. Fellows, Residents, Advance Practice Nurses and Physician Assistants may perform initial assessments in order to facilitate the consultation for the consulting physician.
- (4) If a consultation is requested of a specific service, any appropriately licensed professional staff member (practitioner), who is qualified by training and experience, may provide consultation to and direct treatment protocols for the patient. The practitioner performing the consultation will forward his/her consultation report to the collaborating/supervising physician for review and completion of the consultation report. [Refer to Countersignature requirements in Section 11.4.](#) For additional guidance, see the Christiana Care Consultation Policy.

ARTICLE 6
OPERATING ROOM AND SPECIAL AREA PROCEDURES

Section 6.1 General:

Operating Room and Special Procedure guidelines and administrative procedures shall be set forth in departmental policies and manuals approved by the appropriate department(s), the Medical Executive Committee, and the Board, if indicated, and updated as necessary at least every three years. All Staff members and Credentialed Healthcare Providers granted privileges that require use of these areas shall comply with such guidelines and procedures.

ARTICLE 7
DISCHARGE

Section 7.1 Who May Discharge:

Patients shall be discharged only on order of the attending Staff Member or by a Certified Nurse Midwife who has a collaborative agreement with a Christiana Care attending Staff Member. In the Emergency Department, the patient may be discharged by the emergency department physician or the consultant physician. Should a patient leave Christiana Care against the advice of the attending Staff Member, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign Christiana Care's "Departure Against Physician's Advice " form as described in Christiana Care [Discharge, Adult and Departure Against Medical Advice Policy](#).

Section 7.2 Discharge Planning:

Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine no discharge planning is necessary in a particular case, that conclusion shall be noted on the medical record of the patient. [See § 11.9 for required discharge documentation.](#)

Section 7.3 Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in *loco parentis*, or another responsible party unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

Section 7.4 Discharge of Patients requiring Rehabilitation or Psychiatry Services:

Inpatients requiring admission to the Center for Rehabilitation or Psychiatry Services must be discharged before admitted for these services. [See § 3.3.\(4\)for admission requirement.](#)

ARTICLE 8 **DEATHS AND AUTOPSIES**

Sections 8.1 Deaths:

- (1) The attending physician of record is responsible for completion of the death certificate at the time of death or no later than seventy-two (72) hours following death. The death certificate shall indicate the cause of death.
- (2) The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until
 - a. death has been officially pronounced by a physician, and
 - b. the concurrence of the parent, legal guardian or responsible person has been obtained; and
 - c. the medical examiner has approved disposition (if the death falls under medical examiner jurisdiction; and
 - d. the event adequately documented in the patient's medical record within a reasonable period of time by the attending Member or another designated Medical-Dental Staff Member

Section 8.2 Autopsies:

- (1) It shall be the duty of all Medical-Dental Staff Members to secure consent to meaningful autopsies whenever possible.
- (2) An autopsy may be performed only with proper consent in accordance with state law and hospital policy.
- (3) All autopsies shall be performed by Christiana Care pathologist, his/her designee or the Delaware Medical Examiner.
- (4) Consent for an autopsy shall be effective only by inclusion of such notation on the appropriate hospital form signed by the appropriate legal representative of the patient.
- (5) A copy of the autopsy report shall be forwarded to the patient's attending Staff Member and included in the patient's medical record.
- (6) Provisional anatomic diagnoses shall be recorded on the medical record, with the complete protocol entered into the medical record. For additional guidance see Christiana Care [Autopsy Policy.](#)

Section 8.3 Medical Examiner's Case:

- (1) It is the responsibility of the attending Staff Member or designee to notify the Medical Examiner of any

cases considered a medical examiner's case.

- (2) In cases under the jurisdiction of the Medical Examiner, autopsies performed at Christiana Care shall be performed by the Medical Examiner or a pathologist duly deputized by him/her.
- (3) Any death that is unexpected and/or unexplained must be referred to the Medical Examiner, this includes all deaths related to:
 - a. violence, injury, suicide, homicide, overdose, etc.;
 - b. death occurring in an adult, child or infant in apparent good health;
 - c. diagnostic or therapeutic procedures, intraoperative deaths, and any death occurring under anesthesia;
 - d. individuals in custody, including prisoners and involuntarily committed psychiatric inpatients;
 - e. suspicious circumstances, including individual with unknown identity or bodies found in unusual locations;
 - f. potential neglect (infant, children, elderly, or otherwise disabled); and
 - g. suspected communicable diseases or otherwise posing a potential threat to public health.

ARTICLE 9

PHARMACY

Section 9.1 General Rules:

- (1) All inpatient medications shall be:
 - a. cancelled automatically when the patient goes to an intensive care unit (ICU); and
 - b. reviewed by the pharmacist before the initial dose of medication is dispensed unless a licensed independent practitioner controls the ordering, preparation, and administration, of the medication or when a delay would harm the patient in an urgent situation.
- (2) The pharmacist may dispense the generic equivalent drug which has been accepted for the formulary by the Pharmacy and Therapeutics Committee when a trade drug name is prescribed, but is not in the hospital formulary. A Staff member may object to the use of the generic equivalent for a particular patient and may request the specific product by writing "Do Not Substitute" or "Dispense as Written."

Section 9.2 Self-Medication by patients:

Self-medication by patients is not permitted unless approved via a standing protocol for patient self-administration. Self-medication is approved for respiratory therapy patients being advanced to self-care via department protocol. Patients may self-administer insulin, under nursing supervision, without a physician's order.

Section 9.3 Use of Investigational/Unapproved Medications:

- (1) Christiana Care Health System study protocols involving investigational drugs must:
 - a. Be approved, in writing by the Christiana Care Health System Institutional Review Board and
 - b. Have a copy of the signed approved research participant informed consent obtained by the principal investigator(s) or authorized individual.

- (2) When a patient enters the system already on a medication that is associated with a research protocol that was not approved by the Christiana Care Institutional Review Board, the admitting physician must assure the following before an order to continue the investigational medication can be implemented:
 - a. A copy of the study protocol must be placed on the chart
 - b. A copy of the patient-signed consent form for the study must be placed on the chart.
 - c. The non-Christiana Care study medication must be managed by the Pharmacy service.
- (3) Use of an Unapproved Medication Outside of a Study Protocol
 - a. When a patient enters Christiana Care taking a medication that the FDA has not approved outside of an IRB-approved study protocol, the Investigational New Drug (IND) approval letter with IND number must be provided to the Pharmacy and a copy of the signed patient consent must be placed on the patient's chart before an order to continue the medication can be implemented.

ARTICLE 10

MEDICAL ORDERS

Section 10.1 General Requirements:

- (1) The metric system of weights and measures for select demographics of height and weight, shall be used exclusively in Christiana Care for medical orders, prescriptions, and medication administration records.
- (2) Any drug order written in another system shall be converted to the metric system, if possible, either by a pharmacist or under the direction of the pharmacist.
- (3) For pediatric inpatients, weight-based dosing in accordance with Formulary Guidelines is required
- (4) In patient care areas where CPOE has been implemented, orders must be entered using CPOE. In other areas, handwritten orders are acceptable.
 - a. If handwritten, the order(s) shall be documented clearly, legibly, in metric measure and signed, dated, and timed.
- (5) Orders that are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner.
- (6) Orders must be countersigned by the supervising or collaborating attending practitioner when required by the practitioner's scope of practice.
- (7) Only those abbreviations, signs and symbols authorized by Christiana Care shall be used in the medical record. However, no abbreviations, signs or symbols shall be used in recording the patient's final diagnosis or any unusual complications. Unacceptable abbreviations as defined in [Christiana Care Policy: Abbreviations in the Medical Record](#) are not to be used.
- (8) Orders for diagnostic procedures (e.g., x-ray or EKG) must state the reason for the order.
- (9) Orders for "daily" tests shall state the number of days.

Section 10.2 Types of Orders:

- (1) **Hold Orders:** must specify the length of time or number of doses for withholding the medication (e.g., a length of time, number of doses), or “until completion/cancellation of a specified procedure or occurrence of a specified event, otherwise the medication will be discontinued.
Note: The procedure or event must be described clearly in the order
- (2) **Range orders** should NOT be used,
(Please note, that if a range order is written, the following criteria will be applied)
 - a. If a time range order is written, the shorter time interval will be used for medication administration.
 - b. If a dose range order is written, the lower dose will be administered first with an additional dose (to total maximum dose) can be administered.
- (3) **PRN or As-Needed** orders must have all the elements of a medication order plus the reason (indication) for administration.
- (4) **Blanket Medication Orders:**
 - a. Orders such as “Resume orders” or “Continue previous medications” are unacceptable and will not be honored.
 - b. Medications are not discontinued when a patient goes to the operating room. All pre-op medications are automatically continued unless modified or discontinued by the physician. Physicians must carefully review the medication list when writing post-op medication order.
 - c. Post- Procedure/Post- Cardiac-Catheterization: Previous medication orders are automatically continued unless modified or discontinued.
- (5) **Tapering Orders** must include (in addition to all required elements of an order) a defined duration for each step in the tapering process (i.e. “prednisone 10mg po daily for 4 days followed by prednisone 5 mg po daily for 4 days, followed by 2.5 mg po daily for 4 days then discontinue prednisone).
- (6) **Titration Orders** must include the monitoring parameter that will be used as the basis for dose changes. The order should include a defined dose increment, a defined time interval for making the change, and a maximum dosage.
- (7) **Standing Orders by Protocol** are pre-approved, pre- printed orders or electronic protocols approved by the Medical-Dental Staff and may be initiated by nursing or other qualified staff if the patient meets the clinical criteria, unless the staff determines the actions would be contraindicated.
 - a. Only Influenza and Pneumococcal polysaccharide vaccine Standing Orders by Protocol are exempted from the authentication requirement. [See CCHS Policy- Standing Order by Protocol](#)
 - b. Standing Orders by Protocol developed for use only in the Ambulatory Practices may be approved by The Medical Executive Committee of The Medical Group of Christiana Care Health Services.
- (8) **Automatic Stop Orders:** New orders must be written when a patient transfers into an intensive care unit (ICU). All orders previous to the transfer will be automatically discontinued.
 - a. Upon discharge from an intensive care unit, the attending practitioner or designee will write orders as appropriate to the patient’s condition.
- (9) **Conditional Orders:** Medication and Discharge orders that are conditional on the approval of another physician before they can be implemented are unacceptable and will not be honored.

Section 10.3 Medication Reconciliation:

- (1) Inpatients will have medications reconciled within 24 hours of admission, at transfer, and at discharge by entering into CPOE or if not available an approved paper form.
- (2) The attending practitioner shall reconcile medications within 24 hours of admission.
- (3) Transfer and discharge reconciliation will be in conformity with hospital policy: [Medication Reconciliation](#)

Section 10.4 Elements of Complete Medication Orders:

- (1) Medication orders must include at least the following elements:
 - a. Patient name (plus another unique identifier such as medical record number, date of birth)
 - b. Age, height, and weight of the patient, when appropriate;
 - c. Drug name;
 - d. Dosage form (e.g., tablet, capsule, inhalant), when appropriate;
 - e. Exact strength or concentration, when appropriate;
 - f. Dose, frequency, duration (when appropriate) and route;
 - g. Clearly indicate which enteral route is appropriate [example NG, PEG, J tube, etc.] PO/PEG or PO/NG tube is not acceptable - the route must be patient specific)
 - h. Purpose or indication for PRN medications;
 - i. Specific instructions for use;
 - j. Prescribing practitioners' signature and printed name or identification number; and,
 - k. Date and time.

Section 10.5 Who May Write Orders:

The following categories of practitioners are permitted to write orders as permitted by their licenses and clinical privileges or scope of practice:

- (1) Attending Members of the Medical-Dental Staff, appropriately privileged Affiliate Staff , and Christiana Care Residents or Fellows;
- (2) Christiana Care Pharmacists (when pertaining to the substitution or clarification of medication orders, use of laboratory markers during monitoring of medication therapy or ordering of parenteral nutrition under the guidance of the Medical Director);
- (3) Advanced Practice Nurses privileged to perform duties in collaboration with a physician or group of physicians;
- (4) Physician Assistants privileged to perform duties under the supervision of a physician or group of physicians;
- (5) Registered dietitians when orders pertain to nutrition therapy and are consistent with the scope of practice for registered dietitians;
- (6) Respiratory Therapists when orders pertain to protocol order changes; and

- (7) Medical Students (although orders cannot be implemented until countersigned by an attending physician, resident or fellow).

Section 10.6 Verbal Orders for Medication or Treatment:

- (1) A verbal order for medication or treatment shall be honored in emergency situations or during an invasive procedure when the originator is physically unable to write the order down. Verbal orders may be given by the following authorized individuals:
- a. Attending members of the Medical-Dental Staff and appropriately privileged Affiliate Staff;
 - b. Residents and Fellows;
 - c. Advanced Practice Nurses privileged to perform duties in collaboration with a physician or group of physicians; and,
 - d. Physician Assistants privileged to perform duties under the supervision of a physician or group of physicians.
- (2) A verbal order may be accepted and documented by only authorized qualified personnel, listed below:
- a. Christiana Care Registered and Licensed Practical Nurses;
 - b. Christiana Care Respiratory Therapists (when pertaining to respiratory care procedures);
 - c. Christiana Care Pharmacists (when pertaining to substitution or clarification of medication orders, use of laboratory markers during monitoring of medication therapy or ordering of parenteral nutrition under the guidance of the Medical Director)
 - d. Christiana Care Physical Therapists, Occupational Therapists, Speech Pathologists and Audiologists (when pertaining to their specialty after consulting with a physician);
 - e. Christiana Care Radiology Technician (who may document a verbal order pertaining to radiological procedures);
 - f. Christiana Care Registered Dietitians (when orders pertain to the nutritional care of a patient);
 - g. Advanced Practice Nurses who are privileged to perform duties in collaboration with a physician or group of physicians;
 - h. Physician Assistants privileged to perform duties under the supervision of a physician or group of physicians; and,
 - i. Registered Nurses and Licensed practical nurses employed by a member of the Medical-Dental Staff and who are privileged to perform duties under the supervision of a physician or group of physicians.
 - j. Christiana Care Medical Assistants in ambulatory practices are authorized to accept such orders by practice protocol or policy, excluding medications except as expressly authorized in approved practice protocol or policy.
- (3) A verbal order shall be entered into CPOE or the medical record (and include the date, time, full name of the person who gave the order, and full name and signature of the person to whom the verbal order has been given). Verbal orders for medications, diagnostic tests and treatments shall be “read-back” or “repeated-back” as defined in [Christiana Care Read Back Policy](#). Verbal medication orders shall include the following additional special content:
- a. Drug name and spelling;
 - b. Dose, frequency, and route (NOTE: numbers must be verbalized as single digits (e.g., 50 mg “five zero milligrams”);
 - c. Designation as “VO” (verbal order)
- (4) All verbal orders must be countersigned by the practitioner who gave the order or, when that practitioner is not available, another Medical-Dental Staff Member or an appropriately privileged Advanced Practice

Nurse who is attending the patient, as soon as possible after the order was given, but not more than 72 hours thereafter.

- (5) Chemotherapy orders may not be given verbally, but may be initiated by fax.

Section 10.7 Telephone Orders:

Telephone orders are defined as orders given to a recipient by telephone and should be used only when absolutely necessary. Telephone orders will be countersigned within 72 hours.

- (1) Direct nurse/Staff member communication is encouraged whenever possible. When this is not feasible, telephone orders may be given by the following authorized individuals: [\(Exception: Chemotherapy Orders- refer to § 10.9\)](#)
- a. Attending Members of the Medical-Dental Staff and appropriately privileged Affiliate Staff;
 - b. Residents and Fellows;
 - c. Advanced Practice Nurses privileged to perform duties in collaboration with a physician or group of physicians;
 - d. Physician Assistants privileged to perform duties under the supervision of a physician or group of physicians; and
 - e. Christiana Care Pharmacists when pertaining to substitution and clarification of medication orders.
- (2) In patient care areas where CPOE has been implemented, the recipient of a telephone order must enter the order into CPOE. In other areas, handwritten orders are acceptable.
- a. If handwritten, the telephone order(s) shall be documented clearly, legibly, in metric measure, dated and signed.
- (3) Telephone clarification for written parenteral cytotoxic agents may only be received by a pharmacist. A registered nurse or pharmacist may take telephone clarifications for non-cytotoxic components of the chemotherapy regimen and oral cytotoxic drugs.
- (4) Telephone order shall include the full name of the individuals who gave, and received the orders.
- (5) In addition to content requirements for written orders, telephone medication orders shall include the following additional special content:
- a. Drug name and spelling;
 - b. Dose, frequency, and route (numbers should be verbalized as single digits (e.g., 50 mg= “five zero milligrams) ;
 - c. Designation as “TO” (telephone order); and
 - d. Full name and title of the individuals who gave the order and received it.
- (6) Telephone orders may be accepted and documented by the following authorized individuals:
- a. Christiana Care Registered and Licensed Practical Nurses;
 - b. Christiana Care Respiratory Therapists (when pertaining to respiratory care procedures);
 - c. Christiana Care Pharmacists (when order pertains to substitution or clarification of medication orders, use of laboratory markers during monitoring of medication therapy or ordering of parenteral nutrition under the guidance of the Medical Director);
 - d. Christiana Care Physical Therapists, Occupational Therapists, Speech Pathologists and Audiologists (when pertaining to their specialty after consulting with a physician);
 - e. Christiana Care Radiology Technician (who may accept a telephone order pertaining to radiological procedures);

- f. Christiana Care Registered Dietitians (when order pertains to the nutritional care of a patient);
- g. Advanced Practice Nurses who are privileged to perform duties in collaboration with a physician or group of physicians;
- h. Physician Assistants privileged to perform duties under the supervision of a physician or group of physicians; and,
- i. Registered Nurses and Licensed practical nurses employed by a member of the Medical-Dental Staff and who are privileged to perform duties under the supervision of a physician or group of physicians.

Section 10.8 Faxed Orders (For Non-CPOE Areas Only):

- (1) Faxed orders are permitted only in those areas where CPOE has not been implemented.
- (2) Practitioners authorized to write orders may transmit orders to non-CPOE patient care units via the use of a Christiana Care fax form.
- (3) Fax orders shall comply with all requirements regarding written orders and shall include both the patient's first and last name plus one of the following: medical record number, financial number (FIN) or social security number.

Section 10.9 Chemotherapy Orders:

- (1) Chemotherapy orders, regardless of the indication, will be written on a Chemotherapy Order Form (an approved regimen-specific preprinted form of MD5156).
 - a. **Exception:** Oral chemotherapy agents that are not part of a multi-drug chemotherapy regimen will be ordered via CPOE.
- (2) Chemotherapy orders may not be given verbally, but may be initiated by fax. Faxed orders must include the patient's first and last name, and one other unique identifier. See section 10.8 (3) above.
- (3) Telephone clarification of a written order is permitted.
 - a. Registered nurse or pharmacist may take telephone clarifications for non-cytotoxic components of the chemotherapy regimen and oral cytotoxic agents.
 - b. Only a pharmacist may receive telephone clarification for parenteral cytotoxic agents.
- (4) Physicians are required to provide the following patient specific information on all chemotherapy orders:
 - a. diagnosis;
 - b. therapeutic intention (induction, maintenance, pre-bone marrow transplant);
 - c. height, weight, and body surface area (BSA);
 - d. medication(s) ordered including dose per m² or kg; route, frequency, duration;
 - e. investigational protocol or regimen; and
 - f. dose adjustment (if any, documenting intentional deviation from protocol use).
- (5) Orders written by Residents or Fellows shall be countersigned by the attending Hematologist, Medical Oncologist or Gynecologic Oncologist prior to implementation.
- (6) If the order form is incomplete in any respect, a call will be initiated from the nurse or pharmacist to the prescribing physician for clarification. If this information is unobtainable, the Chemotherapy will be held until the information is acquired.
- (7) If the orders cannot be substantiated by an available protocol or regimen, they must be reviewed and

approved by the Hematology, Medical Oncology or Gynecologic Oncology Section Chief.

- (8) Inpatient chemotherapy orders must be received and clarified as needed by Pharmacy and Nursing by 15:00 hours to allow sufficient time for same day processing. Orders not received or orders that are unable to be clarified by 15:00 will not be dispensed until after 08:00 the following day.
- (9) Refer to the Christiana Care [Chemotherapy Medication Management Policy](#) for additional information.

Section 10.10 Restraint and/or Seclusion Orders:

- (1) Restraint or seclusion may be used only when clinically justified and when it has been determined that less restrictive alternatives have not been, or would not be, effective. These methods may only be used as a means to protect the immediate physical safety of the patient, staff, or others and must never be used as a means of coercion, discipline, convenience or retaliation.
- (2) Orders are never PRN or Standing, must be time-limited and written in conformance with Christiana Care Policy. See Christiana Care Policies: [Restraint \(Non Violent\)](#) and [Restraint \(Violence\)](#).

Section 10.11 Do Not Resuscitate (DNR) Orders:

- (1) The responsible physician will have a full and sufficient discussion with the patient or his/her decision maker concerning the nature of the illness, the prognosis, the options for treatment including palliative/supportive care and possible treatment limitations.
- (2) Documentation of Treatment Limitations/DNR – The responsible physician, Physician Assistant or Advance Practice Nurse will complete the Treatment Limitations Order/DNR Order form and document the following on this form:
 - a. The patient’s current medical condition and prognosis;
 - b. Statement of the patient’s decision-making capacity; and
 - c. Discussion between the responsible physician and patient or decision-maker.
- (3) Residents may write treatment limitation orders after consultation with and the concurrence of the responsible physician. The discussion with the responsible physician will be documented on the Treatment Limitations/DNR order.
- (4) The responsible physician will communicate to the nurse caring for the patient that an order to limit treatment/DNR has been created. See Christiana Care [Do Not Resuscitate/Decision to Limit Treatment Policy](#).

Section 10.11 Transfusions:

- (1) Any order to transfuse red cells includes the collection of a specimen for type and cross matching if such a specimen is not already in the Blood Bank within the past seventy-two (72) hours.
- (2) Additionally, an order to transfuse must include the IV start.

ARTICLE 11
MEDICAL RECORDS

Section 11.1 General Rules:

- (1) The medical record is the mechanism for defining, capturing, analyzing, transforming, transmitting and reporting patient-specific information related to care processes and outcomes for every individual assessed or treated at Christiana Care
- (2) A medical record shall be maintained for each patient who is evaluated or treated by Christiana Care providers and contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.
 - a. The content of an inpatient medical record reflects:
 - i) The patient's condition on arrival,
 - ii) Diagnoses,
 - iii) Test results,
 - iv) Therapy,
 - v) Condition and in-hospital progress, and
 - vi) Condition at discharge.
 - b. Medical records for inpatients or outpatients who had a high risk or operative procedure will be deemed incomplete when the following are absent or incomplete:
 - i) History and physical,
 - ii) Discharge summary. and
 - iii) Operative reports, when appropriate.
- (3) The medical record may be created and maintained in either electronic or paper formats.
- (4) All references to the "medical record" in Article 11 apply to all components of the medical record.
- (5) Each entry in the medical record shall be in compliance with [Documentation in the Medical Record Policy](#) and documented legibly, dated, timed and authenticated by the individual providing the care, treatment or service
- (6) Only forms that have been approved by either the Forms Management Committee or the Functional Documentation Committee may be used in the medical record. [Exception: History and Physical (H&P) documents completed in the physician's office].
- (7) For any dictations that become part of the medical record, the dictator shall supply at least the following: type of report dictated, patient name, account number (FIN) or admission and/or discharge date, and providers to be copied.
- (8) Use of abbreviations, signs and symbols in the medical record shall be limited as defined in Christiana Care Policy: [Abbreviations in the Medical Record](#).
- (9) As applicable, the attending physician is required to document in accordance with the Centers for Medicare and Medicaid Services Teaching Physician Documentation Guidelines

Section 11.2 Individuals Authorized to Document in Medical Records:

- (1) Only authorized individuals may make entries in the medical record.
- (2) The following members of the workforce are authorized to make entries in the medical record:
 - a. Medical-Dental Staff members and Credentialed Healthcare Providers involved in the patient’s care as permitted by their clinical privileges and scope of practice;
 - b. Health care professionals employed by Christiana Care;
 - c. Non-employed personnel who are authorized to write entries;
 - d. Students in approved Christiana Care clinical placements; and,
 - e. Entries by other personnel are subject to the specific departmental policies determining the appropriate content and location of these entries
- (3) Entries by other personnel are subject to the specific departmental policies determining the appropriate contents and location of these entries.

Section 11.3 Authentication:

- (1) Each entry will be individually authenticated by date, time and the legible signature of the individual making the entry.
- (2) In addition to authentication, the authors printed name and title are required.
- (3) Electronic signatures are acceptable when using Christiana Care approved electronic medical record systems.
- (4) Signature stamps are acceptable only when used to supplement the written signature.
- (5) Pre-printed or electronic Standing Order by Protocol are dated, timed and authenticated as soon as possible by the ordering practitioner or another practitioner responsible for the care of the patient.

Section 11.4 Treating Provider Documentation Requirements:

- (1) The responsible Attending Staff Member will document as required below:

Provider	Record Element	Attending/Consultant Documentation and Timeframe
Emergency Medicine Physicians	Admission Orders	Co-signature as soon as possible, but by the time of discharge
Physician Assistants	Admission Orders	Co-signature as soon as possible, and before the discharge order or before any operative procedure.
	Dictated Operative Report	Co-signature within 48 hours of transcription
	Consults	Review and/or provide supervision attestation when appropriate within 72 hours of completion.
	Discharge Orders	Co-signature within 72 hours of discharge
	Discharge Summary	Co-signature within 7 days of discharge

Advance Practice Nurse: [Exception: CNM with collaborative agreement with Christiana Care attending Staff member may admit and discharge low risk obstetrical patients]	Admission Orders	Co-signature as soon as possible, but by the time of discharge
	Discharge Orders	Co-signature within 72 hours of discharge
	Discharge Summary	Co-signature within 7 days of discharge
	Consults	Review and/or provide supervision attestation when appropriate within 72 hours of completion.
Residents and Fellows	Admission Order	Co-signature as soon as possible, but by the time of discharge.
	H&P	Co-signature within 72 hours of admission
	Dictated Operative Report	Co-signature within 48 hours of transcription
	Discharge Orders	Co-signature within 72 hours of discharge
	Discharge Summary	Co-signature within 7 days of discharge
	Consults	Review and/or provide supervision attestation when appropriate within 72 hours of completion.
	Chemotherapy Orders	Co- signature by Attending Hematologist, Medical Oncologist, or Gynecologic Oncologist prior to implementation

- (2) For Consult reports refer to the Consultation Policy for specific guidelines.
- (3) Countersignatures are required by the time of discharge for all verbal admission orders entered by a Registered Nurse.

Section 11.5 History and Physical (H&P) and Assessment of Patients:

(1) General

- a. Completion of the history and physical and the update to the history and physical may be delegated to a Resident Physician, Advance Practice Nurse (APN) or a Physician Assistant (PA).
 - i) If the update is completed by a Resident Physician, APN or PA, any change will be reported to the attending physician.
- b. A H&P completed by a physician who is not a member of the medical-dental staff and does not have admitting privileges is acceptable for a surgical patient but is subject to the same standards as outlined in this article.

(2) Inpatient Admissions

- a. Patients will have a history and physical examination (H&P) documented in the medical record within twenty-four (24) hours after admission to an inpatient unit and before surgery or invasive procedure requiring anesthesia or titrated (moderate or deep) sedation.
[Exception: For emergency procedures, the complete H&P may be documented after the completion of the emergency procedure, but in no case more than 24 hours later. [Please see Section 11.7. 2 for requirements prior to the emergency procedure.](#)]
]
- b. The H&P should be dictated using the hospital system or created within a pre-approved electronic medical record system and must contain: chief complaint, history of present illness (HPI); relevant past medical history (PMH); review of systems (ROS) relevant social and family histories; a pertinent physical examination; pregnancy or lactation status (as applicable) conclusions or

impressions from the exam; the diagnosis or diagnostic impression, and the goals of treatment and the plan of care.

- c. **A H&P performed within thirty (30) days before admission must be updated**, using the approved form, by a physician or the appropriately qualified licensed provider within 24 hours after admission and before performance of any surgery or invasive procedure requiring anesthesia or titrated (moderate or deep) sedation.
- d. **Dentists** are responsible for the part of their patient's history and physical examination that relate to dentistry. Inpatient admissions and the completion of the history and physical will be the responsibility of an Attending Physician of the Medical Staff. The Attending Physician will be responsible for the care of the patient during hospitalization.
- e. **Oral and Maxillofacial** surgeons may perform the required history and physical. Medical consultation should be obtained if deemed appropriate by the surgeon.
- f. A history and physical examination of the patient admitted for **Podiatric Surgery** will be completed by an Attending Physician in collaboration with the Podiatric Surgeon who will complete that portion of the history and physical that relates to podiatry.

(3) **Outpatient: Operative, Invasive and High Risk Procedures**

- a. H&Ps must be completed prior to any operative, invasive, high-risk diagnostic or therapeutic procedure or procedures requiring or titrated (moderate or deep) sedation regardless of setting.
 - i) A H&P that is performed within thirty (30) days of the procedure may be updated within 24 hours after registration but prior to the outpatient surgery and/or high-risk/invasive procedure using an approved Christiana Care H&P update form.
 - ii) The H&P will contain: chief complaint, history of present illness (HPI); relevant past medical history (PMH); review of systems (ROS); relevant social and family histories; a pertinent physical examination; pregnancy or lactation status (as applicable) conclusions or impressions from the exam; the diagnosis or diagnostic impression, and the goals of treatment and the plan of care.
- b. **Dentists** are responsible for the part of their patient's history and physical examination that relate to dentistry. The remaining portions of the history and physical will be performed by an attending Staff member or the patient's primary care physician who may or may not be a member of the Medical-Dental Staff.
- c. **Oral and Maxillofacial surgeons** may perform the required history and physical. Medical consultation should be obtained if deemed appropriate by the surgeon.
- d. **Podiatrists** are responsible for the part of their patients' history and physical examination that relates to podiatry. The remaining portion of the history and physical will be performed by an attending Staff member or the patient's primary care physician who may or may not be a member of the Medical-Dental Staff.

(4) **Outpatient: Low risk procedures**

- a. Prior to performance of other outpatient, low risk procedures, that do not involve titrated moderate or deep sedation, a progress note that includes an examination of the body area(s) relevant to the safe performance of the procedure, as well as a review of pertinent laboratory tests and other relevant diagnostic tests shall be completed.

(5) **Obstetrical History and Physical**

- a. The Obstetrical Record History and Physical form will be completed as outlined in § 2A above, as required by Department of Obstetrics and Gynecology.

(6) **Office-Based Initial Assessments**

- a. Initial Assessments are required within 24 hours after registration in all office-based clinics and will include: chief complaint, history of present illness (HPI); relevant past medical history (PMH); review of systems (ROS); relevant social and family histories; a pertinent physical examination;

pregnancy or lactation status (as applicable) impression/diagnostic impression and plan for treatment.

- b. The problem summary list is initiated by the third visit and updated whenever there is a change in diagnoses, medications or allergies to medications, and whenever a procedure is performed. The problem summary list includes:
 - i) Any significant medical diagnoses and conditions;
 - ii) Any significant operative and invasive procedures;
 - iii) Any adverse and allergic drug reactions; and
 - iv) Any current medications, over-the-counter medications, and herbal preparations

(7) Emergency Department

- a. Each patient encounter will be documented on the appropriate Emergency Department form and will include: chief complaint, history of present illness (HPI); relevant past medical history (PMH); relevant social and family histories; review of systems (ROS); pertinent physical examination; pregnancy or lactation status (as applicable) conclusions or impressions from the exam; the diagnosis or diagnostic impression, and the goals of treatment and the plan of care
- b. Completion of the H&P, along with the discharge instructions, will be the responsibility of the Attending Emergency Department physician.

Section 11.6 Progress Notes:

(1) Inpatient Progress Notes

- a. The attending physician or designated credentialed provider will record a daily progress note, or more frequently, based on the condition of the patient and the severity of the patient's illness, on each patient's medical record.

(2) Office- Based Progress Notes

- a. A pertinent progress note shall be recorded within 24 hours of the patient visit.

Section 11.7 Operative, and High-Risk Procedures: Required Documentation:

- (1) Operative and high-risk procedures are defined as surgeries and procedures occurring in but not limited to the operating rooms (main and ambulatory), cardiac catheterization laboratories, interventional radiology suites, infusion services, dental clinics, radiation therapy, endoscopy suites, bronchoscopy suites and outpatient rehabilitation which require the use of anesthesia services to include moderate sedation.

(2) Pre Procedure Documentation:

- a. The following information will be recorded in the patient's medical record by the responsible Attending Medical-Dental Staff member prior to surgery or high-risk procedure or the operation/procedure:
 - i) A current history and physical; and
 - ii) Relevant laboratory and radiology results; and
 - iii) Pre-operative diagnosis; and
 - iv) A properly executed and witnessed informed consent, signed, dated and timed by the patient and surgeon.
- b. In emergencies, the surgeon shall document the following in a progress note:
 - i. Reason for the emergency status;
 - ii. Pre-operative diagnosis;
 - iii. Indications for procedure, including physical findings; and
 - iv. Planned procedure

(3) **Post-Procedure Documentation (Brief Operative Note):**

- a. A brief operative note will be entered into the patient's medical records after the operation or procedure, before the patient is transferred to the next level of care. This note will include:
 - i. Name(s) of the surgeons(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
 - ii. Post-operative diagnosis;
 - iii. Surgical procedure(s) performed;
 - iv. Estimated blood loss
 - v. A description of techniques, findings, and tissues removed or altered

Additional information can be added based on patient condition, type, and surgeon preference

(4) **Post Procedure Documentation (Full Operative or High-Risk Procedure Report):**

- a. A full operative or high-risk report shall be created by the attending physician who performed the procedure or his/her designee within 48 hours following the procedure. This report shall be authenticated by the attending physician who performed the procedure as soon as possible and no longer than 30 days after the procedure(s). In addition to the elements identified in Section (3) above, the report will include the condition of the patient upon conclusion of the procedure.

(5) **Failure to complete Operative and High-Risk Procedure Reports**

- a. If a full operative or high-risk procedure report is not created within 48 hrs (two (2) calendar days) following the procedure, the attending physician who performed the procedure and the physician's Department Chair will be notified that the report must be created to avoid administrative suspension of elective procedural scheduling privileges.
- b. Elective procedural scheduling privileges shall be administratively suspended seven (7) calendar days from the date of the notification provided in (4) a. above unless the provider has established support for a justifiable delay as defined and outlined in Section 11.10, (2) of these Rules.
- c. The operative or high-risk procedure report must be authenticated by the attending physician who performed the procedure within 30 days of procedure.
- d. Additional penalties for not completing operative or high-risk procedure reports in a timely fashion are defined in Section 11.10 of these Rules.

Section 11.8 Anesthesia and Deep Sedation:

- (1) All anesthesia services provided at Christiana Care Health Services are under the direction of the Chair, Department of Anesthesiology. The physician who holds this position will be an experienced administrator and leader with a demonstrated record of clinical and administrative achievement to include proven commitment to the advancement of excellence in clinical care, ability to work collaboratively with other departments and the hospital, and must meet the requirements for appointment as an Attending physician on the staff of Christiana Care Health Services.
- (2) Administration of anesthetic agents designed to induce Deep Sedation are considered by regulatory standards to be Anesthesia and as such, requires documentation as described in this section.
 - a. **Pre-Anesthesia Evaluation** should be performed within 48 hours prior to any inpatient or outpatient surgery or diagnostic or therapeutic procedure requiring anesthesia, by an appropriately privileged provider.
 - b. **Intraoperative Anesthesia Record** will be completed for each patient who receives general, regional, or monitored anesthesia.

- c. **Post-Anesthesia Evaluation** must be completed and documented by an appropriately privileged provider, within 48 hours after surgery or a procedure requiring anesthesia services. The individual performing the post-anesthesia evaluation need not be the same individual who administered the anesthetic.

(3) All documentation requirements are found in the relevant Department of Anesthesia policies.

Section 11.9 Discharge Summaries:

- (1) The attending physician of record, or his/her credentialed designee, is responsible for electronically entering the discharge summary or the final progress note where appropriate, see section 4 below. The discharge summary or the final progress note must be entered within 7 days of discharge.
- (2) The attending physician of record (or the CNM caring for the low-risk obstetrical patient) will authenticate the discharge summary or final progress note within 7 days of discharge.
- (3) A discharge summary shall include:
 - a. the reason for hospitalization and the final diagnosis;
 - b. significant findings;
 - c. complications, if any;
 - d. the care, treatment and services provided to include procedures performed;
 - e. the outcome of the hospitalization and the condition of the patient on discharge;
 - f. any specific, pertinent instructions given to the patient or the patient's representative, including instructions relating to physical activity, medication, diet, and follow-up care; and
 - g. shall be consistent with the information provided in the patient's discharge instructions.
- (4) A final progress note may be substituted for the discharge summary for patients who require a period of hospitalization of forty-eight (48) hours or less and for normal newborn infants, normal vaginal deliveries, uncomplicated tubal ligations, and scheduled normal C-Sections (length of stay <96 hours).
 - a. The final progress note shall contain: reason for hospitalization, the outcome of hospitalization, any diagnoses identified, including the final diagnosis, disposition of the case, provisions for follow-up care, the patient's condition at discharge, and discharge instructions to the patient or family.
- (5) In the case of an inpatient death, an electronically entered discharge summary is required regardless of the length of stay.
- (6) Discharge Instructions for hospitalized patients shall be documented through the electronic discharge workflow. For surgical outpatients, a discharge instruction form shall be completed. The discharge instructions shall include at a minimum: Physical activity/limitations; Medications; Diet; Special Care Instructions; Reasons to contact physician; and Plan for follow-up care.
- (7) Failure to complete a discharge summary or the final progress note
 - a. If the discharge summary or final progress note is not completed and authenticated within seven (7) days after discharge, the attending physician of record (or the CNM) and the respective Department Chair will be notified of the delinquency.
 - b. Following 1st notification, the provider has 14 days to complete the discharge summary or final progress note prior to being administratively suspended unless the provider has established support for a justifiable delay as defined and outlined in Section 11.10, (2) of these Rules.

- c. Additional penalties for not completing the discharge summary or final progress note in a timely fashion are defined in Section 11.10 of these Rules.

Section 11.10 Delinquent Medical Records (Acute Care Only):

- (1) Failure to complete a discharge summary or operative report in accordance with these Rules and Regulations shall result in a \$200.00 fine and the administrative suspension of the Medical-Dental Staff member's clinical privileges, upon notification by the Chief Medical Officer. The suspension of clinical privileges shall continue until the Medical-Dental Staff member has satisfactorily completed all delinquent entries including signatures, and has paid the \$200.00 fine.
 - a. While on suspension, the Medical-Dental Staff Member may continue to provide care for current patients, but is not permitted to:
 - i) take on-call duties
 - ii) admit new patients; or
 - iii) schedule new elective surgeries or other new procedures until all delinquent entries have been completed and the suspension has been lifted.
 - b. The suspended Medical-Dental Staff member is responsible for arranging coverage for his/her on-call obligations.
- (2) Medical-Dental Staff members are required to notify Health Information Management Services (HIMS) in the event of a justifiable delay, including any time the provider is taking an extended vacation. A justifiable delay, resulting from extenuating circumstances requires approval by the CCO.
- (3) Physicians who have received repeated suspensions due to delinquent medical records (have received three [3] within any twelve [12] months) will be referred to the appropriate departmental chair for Peer Review.

Section 11.11 Possession, Access and Release of Medical Records:

- (1) All medical records are the property of Christiana Care and shall not be removed from Christiana Care. The original medical record may be removed from Christiana Care's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute
- (2) Unauthorized removal of medical record or protected health information from Christiana Care by a Medical-Dental Staff member shall constitute grounds for a professional review action.
- (3) No patient record shall be removed from the Health Information Services (HIMS) except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the Chief Executive Officer or a designee.
- (4) Refer to Christiana Care Institutional Review Board (IRB) for guidance for publications, studies and research.
- (5) Records are confidential and shall only be available pursuant to Christiana Care Privacy and Information Security Policy and in accordance with Federal and State laws and regulations.

ARTICLE 12
POPULATION SPECIFIC CARE

Section 12.1 Obstetrical Patients

- (1) The safe management of a pregnant patient requiring inpatient admission for medical (non-obstetrical) care requires communication and collaboration by members of the healthcare team.
- (2) General guidelines:
 - a. Trauma patients or patients with life-threatening conditions will be managed as currently defined by the Access Center
 - b. Patients who are in labor or labor is considered imminent, will be transferred to Labor & Delivery.
 - c. Admissions to Wilmington Hospital (other than for services indicated below) are strongly discouraged.
- (3) For patients coming through the Emergency Department (ED), an outside provider's office or another facility, referrals will be managed as currently defined by the Access Center and:
 - a. The ED provider will contact the appropriate attending (Department of Obstetrics & Gynecology (OB/GYN) or Family & Community Medicine Physician with Obstetrical privileges) to determine the appropriate type and site of care; then,
 - b. The OB/GYN or Family Medicine attending may decline to admit the patient to his/her service, but is responsible for discussing the patient with the attending from the identified appropriate service to determine placement for the patient; then,
 - c. The accepting attending physician contacts the ED provider or other referring physician in a timely fashion.
[Please note: 3a. through 3c. are applicable for patients presenting to the ED regardless of arrival/referral source]
- (4) For admissions to Psychiatry/Center for Rehabilitation or inpatient admissions for Ophthalmology or Oral and Maxillofacial services (Wilmington Hospital services):
 - a. The admitting attending and the attending OB/GYN will collaborate to determine the most appropriate site of care.
- (5) Wilmington Hospital
 - a. In the event a hospitalized patient enters active labor, the attending physician will immediately contact the patient's obstetrician to determine whether transfer to Christiana Hospital is possible.
 - i) If the attending obstetrician is not available, the attending physician shall contact the OB/GYN on-call to assist in the decision and plan for transport.
 - ii) If the patient cannot be safely transported to Christiana Care for delivery, the patient will be moved to Wilmington Emergency Department and assessed.

ARTICLE 13
PATIENT SAFETY

All members of the Medical-Dental Staff are expected to comply with all guidelines/policies related to National Patient Safety Goals and other patient safety initiatives. These policies include but are not limited to:

- [Abbreviations in the Medical Record](#)
- [Critical Test Results](#)
- [Chaperone Policy](#)
- [Hand Off](#)
- [Medication Reconciliation](#)
- [Patient Identification](#)
- [Universal Protocol for Surgery and Invasive Procedures](#)
- [Read Back Policy](#)
- [Standard Precautions and Hand Hygiene](#)
- [Transmission-Based Precautions \(when indicated\)](#)

ARTICLE 14 **EMERGENCY OPERATIONS**

Section 14.1 Emergency Operations Plan:

In the event of a disaster as defined in the [Emergency Operations Plan](#) of Christiana Care Health Services, Inc., it is the duty of every person to participate in accordance with the provisions of this plan.

When the Christiana Care Emergency Operations Plan has been activated and the immediate needs of patients in the facility cannot be met, the CCO or the President of the Medical-Dental Staff or designate may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners and physician assistants. See Credentials Manual: Disaster Privileges.

In the case of an emergency declared by the Hospital or Federal or State government and when existing resources of the Hospital or Medical-Dental Staff have been or are likely to be exhausted, the CCO or the President, Medical-Dental Staff or his/her designee may grant Disaster Privileges to volunteer practitioners in accordance with Christiana Care Emergency Operations Plan. Disaster privileges will terminate immediately upon identification of any adverse information about the practitioner, and/or in accordance with the Emergency Operations Plan and [Christiana Care Credentials Policy](#). In any case, privileges will be granted only for the duration of the emergency.

ARTICLE 15 **AMENDMENTS**

These rules may be changed with the approval of the Bylaws Committee, the Medical Executive Committee, and the Board of Directors as outlined in the Medical-Dental Staff Bylaws.

ARTICLE 16 **ADOPTION**

These Rules and Regulations are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all other Medical-Dental Staff rules and regulations, Medical-Dental Staff policies, manuals or department rules and regulations pertaining to the subject matter herein.