CHRISTIANA CARE

Medical-Dental Staff Rules

TABLE OF CONTENTS

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:
New Medical-Dental Staff Members and Credentialed Health Care Providers shall complete a role-based hospital orientation within 3 months of being granted privileges.

ARTICLE 2
EMERGENCY MEDICAL SCREENING

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;
- the ED physician assistants and/or advanced nurse practitioners;
- 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 and Transfer:

(1) If the MSE reveals an emergency condition, the Emergency Department must stabilize the patient to the extent possible prior to discharge or transfer. See § 3.5 Transfer of Patients.

(2) A patient with an incompletely stabilized emergency medical condition may still be transferred under any of the following circumstances:
   a. 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.
   b. The treating physician certifies that the benefits of transfer outweigh the risks.
   c. The assigned on-call medical specialist fails or refuses to appear within the defined timeframe and without the services of the on-call medical specialist the benefit of transfer outweighs the risks.

Section 2.3 On-Call Responsibilities:

(1) Under EMTALA, the emergency physician (or other QMP) may request the assistance of any medical specialist at Christiana Care in the screening, stabilization, treatment, and/or transfer of any patient presenting to the ED.

(2) Telephone consultation may be sufficient to resolve the emergency physician's (or QMP's) query. However, the on-call specialist must appear personally in the ED when requested to do so by the ED physician. 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 physically present in the ED 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 privileges to admit patients. 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.

(2) The attending practitioner is the Medical-Dental Staff member/Certified Nurse Midwife who admits the patient and 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 physician 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;
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

(3) In the case of a group practice, the Medical-Dental Staff member who admits the patient shall be considered the responsible, designated Attending practitioner.

(4) 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.

(5) 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 Patients (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.

(3) All admission orders must be signed, dated and timed.

(4) Physician assistants may write admission orders at the direction of the Attending Physician. Prior to writing an order for inpatient status, the Physician Assistant must discuss the patient's medical condition with the attending patient responsible for the care of the patient, and the attending physician must agree with the recommendation to place the patient in an inpatient status. These orders will be countersigned as required in §11.4

(5) Advance Practice Nurses may write admission orders at the direction of the Attending Physician, countersignature is not 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 a medical procedure or treatment before the physician or other healthcare professional begins any course of treatment. After the patient receives this information then either a consent to, or refusal for, such procedures or treatment can be made.
See Christiana Care Informed Consent Policy for additional information

(2) Written consent shall also be obtained in all non-emergency situations from the adult patient or the legal representative of any incompetent adult before any surgical or medical procedure is performed.

(3) Whenever the patient's condition prevents the obtaining of consent, every effort shall be made to obtain the consent of the patient's representative prior to the procedure or surgery, and such effort shall be documented in the patient's medical record.

(4) 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 automatically cancel the surgery or procedure.

(5) Whenever the emergency involves a minor or otherwise incompetent patient in which consent for surgery cannot be immediately obtained from parents, legal guardian, durable power of attorney, or appropriate next of kin, these circumstances should be fully explained in the patient's medical record. If possible, a consultation shall be obtained before any procedure or operative procedure is undertaken.

Section 4.2 Responsibility for Obtaining Informed Consent:

(1) It shall be the responsibility of the attending/affiliate Staff Member to obtain consent from the patient for any surgical or high-risk procedure to be undertaken, including ambulatory surgery.

(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 Who May Consent:

(1) A competent adult or emancipated minor may authorize any medical or surgical procedure to be performed upon his or her body, and the consent of no other person shall be required or shall be valid.

(2) Written consent shall be obtained from the parents (who may be minors themselves) or legal guardians of a non-emancipated minor before any surgical or medical procedure is performed on the minor.

(3) Minors may consent for their own care in the following circumstances:
   a. emergencies, provided that an attempt has first been made to obtain the consent of the minor's parent or guardian;
   b. minors over the age of 14 may consent to nonresidential substance abuse treatment; and
   c. minors over the age of 12 may consent to treatment for infectious or communicable disease and care related to pregnancy (except abortion).

Section 4.4 Incompetent Patients:

Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of awareness or reasoning ability. The essential determination to be made is whether the patient has sufficient mental ability to understand his or her condition, the treatment contemplated, and make and communicate decisions as to treatment.

(1) When a patient has been declared incompetent by a court, a consent form signed by the court appointed legal guardian shall be obtained.

(2) In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the patient's legal representative shall be obtained.

Section 4.5 Verbal/Telephone Consents:

(1) Verbal consents including telephone consent shall be permissible when a delay in obtaining consent on behalf of an incompetent individual or a minor would result in harm to the individual, or where it is impractical to obtain a written consent to convey the information necessary to make an informed consent in person.
   a. In such a case, the physician who will perform the procedure or provide the treatment shall, in the presence of at least one (1) witness who is on the line with the physician, convey the information via telephone.
   b. If telephone consent is given, the physician giving the information must document in the medical record exactly what was told to the patient's representative and must date/time and sign such notation. The witness shall sign the note as well, certifying that he or she heard the information being transmitted by the physician and also heard the patient's representative give consent.
   c. If telephone consent is granted, immediate steps should be subsequently undertaken to procure confirmation of the consent in writing.

Section 4.6 Obstetrical and Gynecological Procedures:

Prior to all invasive gynecological procedures on women of childbearing age, the attending Member must make every reasonable effort to rule out unsuspected pregnancy and a notation of said efforts shall be documented in the medical record.

Section 4.7 Refusal to Consent:

(1) A patient or, if incompetent, the patient's representative retains the right to refuse medical treatment, even in an emergency situation.

(2) If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form should be executed, and, if possible, signed by the patient. Such form(s) shall be kept in the patient's medical record.

(3) Any patient with psychiatric problems who refuses to consent to care may be held at Christiana Care in an appropriate observation or treatment area if such hold is determined to be in the best interest of the patient and meets applicable state law/regulation criteria.

Section 4.8 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 attending/affiliate Staff member shall promptly confer with hospital legal/risk management concerning such matters.

(2) Christiana Care will make every effort to assist the attending practitioner in obtaining the required consent and to provide information relative to such matters. However, it is the ultimate responsibility of the attending Member 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 handwriting the order on the physician's order sheet

(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 an **urgent or 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, Advance Practice Nurses and Physician Assistants may perform initial assessments in order to facilitate the consultation. The physician on call is responsible for assuring the consultation is completed within the required time frame.

(4) Any appropriately licensed professional staff member who is qualified by training and experience, may provide consultation to include treatment (upon request). Refer to Countersignature requirements in Section 11.4

Section 5.2 Indications for Consultation:

(1) A consultation may be indicated for cases in which the diagnosis remains uncertain, where complications arise, or where specialized knowledge, treatments or procedures are required.

Section 5.3 Contents of Consultation Report:

(1) Each consultation report shall include:

a. A brief impression and treatment recommendation documented on a consultation form; and

b. a fully documented opinion by a consultant that ,when appropriate, reflects an examination of the individual and the individual's medical record(s).

(2) The brief impression and treatment recommendations shall be documented immediately by the consulting physician, resident, or appropriately privileged designee.

(3) A full opinion by a consultant that reflects, when appropriate an examination of the individual and the individual's medical records(s) shall be dictated following the consultation or documented on an approved Christiana Care form;

a. Consultations shall be signed by the author and if necessary and countersigned by the consulting physician.

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. 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 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 § 3.3.5 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 (except in an emergency when time does not permit.) unless the ordering physician controls the ordering, dispensing, and administration of the drugs.

(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. This requirement generally applies to patients participating in studies at other institutions who are admitted for inpatient care to Christiana Care.

ARTICLE 10

MEDICAL ORDERS

Section 10.1 General Requirements:

(1) The metric system of weights and measures 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) Orders by physician assistants shall be countersigned within 72 hours barring extraordinary events or circumstances by the supervising physician as required by the Delaware law.

(8) 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. See Christiana Care Policy: Abbreviations in the Medical Record.

(9) Orders for diagnostic procedures (e.g., x-ray or EKG) must state the reason for the order.

(10) 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.

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) **Titrating 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 approved by the Medical-Dental Staff and may be instituted by nursing without a separate physician order unless the RN determines the action would be contraindicated.

(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 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 accepted only under circumstances when it is impractical for such order to be given in writing by the responsible health care provider. 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; or,
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.

(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" 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 48 hours thereafter.

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. Faxed orders are preferred whenever possible.

(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:

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 order shall include the full name of the individuals who gave, and received the orders.

(4) 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);

d. Full name and title of the individuals who gave the order and received it

(5) 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 (Limited Use Only):

(1) While the preferred method for transmitting orders is direct computer physician order entry (CPOE), faxed orders can be used only if the provider is unable to enter his or her orders electronically.

(2) Practitioners authorized to write orders may transmit orders to 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 and birth date plus one of the following: date of birth, medical record number, financial number (FIN) or social security number.

Section 10.9 Chemotherapy Orders:

(1) All orders for chemotherapy agents will be in compliance with Christiana Care Comprehensive Chemotherapy Policy.

(2) Only those prescribers identified in the Christiana Care Comprehensive Chemotherapy policy are authorized to prescribe injectable or oral chemotherapy.

(3) Intravenous chemotherapy will not be administered at Wilmington Hospital

(4) Injectable Chemotherapy:

a. If the medication is ordered to treat a hematologic or oncologic condition, only a Hematologist, Medical Oncologist or Gynecologic Oncologist may prescribe/countersign. This includes clarification of orders.
   Exceptions:
   i) urologist for intravesicular administration
   ii) interventional radiologist for chemoembolizations, and
   iii) surgeon for intraperitoneal chemotherapy instillation or placement of Gliadel wagers.

(5) The prescribing of select oral chemotherapy agents is restricted as defined by the Christiana Care Chemotherapy Medication Management Policy.

(6) Chemotherapy orders, regardless of the indication, will be written on a Chemotherapy Order Form (an approved regimen-specific pre-printed form or MD5156)

Exception: Oral chemotherapy agents that are not part of a multi-drug chemotherapy regimen will be ordered via CPOE

(7) In order for parenteral chemotherapy to be initiated on the day prescribed, orders must be received and clarified as needed by Pharmacy and Nursing by 15:00. 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.

(8) All patients scheduled to receive parenteral chemotherapy should be admitted to the medical-oncology unit or the bone marrow transplant unit. If however, a patient who needs injectable chemotherapy must be admitted to the higher level of care, a chemotherapy-competent nurse will be responsible for administering the chemotherapy regimen.

(9) Refer to the Christiana Care Chemotherapy Medication Management Policy for procedures governing the prescribing, evaluation, preparation, dispensing, administration and monitoring of chemotherapy

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 Restraints and Seclusion Policy.

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. The responsible physician shall co-sign within twenty-four (24) hours.

(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
   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.

(4) 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.

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; and
   b. Health care professionals employed by Christiana Care; and
   c. Non-employed personnel who are authorized to write entries; and
   d. Students in approved Christiana Care clinical placements
   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.

Section 11.4 Counter-Signature Requirements:

(1) The responsible Attending Staff Member will counter-sign documents as required below:

Provider	**Record Element**	**Timeframe of Attending Co-Signature**
Physician Assistant:	H& P (including the update)	Within 72 hours
	Progress Notes	Required only if a new diagnosis or procedure is described in the note. If required, within 72
	Dictated Operative Report	Within 72 hours of transcription
	Consults	Within 72 hours
	Discharge Summary	Within 30 days of discharge
	Orders	Within 72 hours of entry
Advance Practice Nurse: [Exception: CNM with collaborative agreement with Christiana Care attending Staff member]	Discharge Summary	Within 30 days of discharge
	Progress Notes	Required only if a new diagnosis or procedure is described in the note. If required, within 24 hours
	Consults	Within 72 hours
Residents and Fellows	H&P	Within 72 hours of admission
	Dictated Operative Report	Within 72 hours of transcription
	Discharge Summary	Within 30 days of discharge
	Consults	Within 72 hours
	Treatment Limitation/DNR orders	Within 24 hours

(2) In addition to countersignature, a statement of level of involvement from the attending physician is required.

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); 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 physician 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); 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 a**re 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); 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

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; 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. 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 Medical Staff member designee 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. This requirement is in addition to daily progress notes entered by Residents and/or Physician Assistants or Advance Practice Nurses.

(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: Documentation Required:

(1) Pre Procedure Documentation Required:

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

(2) 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. Pre-operative and post-operative diagnosis;
   iii. Surgical procedure(s) performed;
   iv. Estimated blood loss and replacement, if any;
   v. IV fluids received, if any;
   vi. Anesthesia administered;
   vii. Complications, if any;
   viii. A description of techniques, findings, and tissues removed or altered; and
   ix. Implants, if any.

(3) Post Procedure Documentation (Dictated Operative Report):

a. An operative report shall be dictated within 24 hours following surgery by the appropriately privileged provider, and shall be authenticated by the attending surgeon as soon as possible. In addition to the elements identified in Section (1) above, this will include the condition of the patient upon conclusion of the procedure.

Section 11.8 Anesthesia and Deep Sedation:

(1) 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 anesthestic.

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

Section 11.9 Discharge Summaries

(1) The attending physician of record, his/her designee, is responsible for dictating the discharge summary or completing the final progress notes at the time of the patient's discharge.

(2) All discharge summaries or final progress note(s) are authenticated by the attending of record or the CNM caring for the obstetrical patient.

(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 normal newborn infants, normal vaginal deliveries, uncomplicated tubal ligations, and scheduled "normal C-Sections (length of stay <96 hours) or for patients who require a period of hospitalization of forty-eight (48) hours or less.
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, a dictated discharge summary is required regardless of the length of stay.

(6) Discharge Instructions shall be documented on a discharge instruction form and shall include at a minimum: Physical activity/limitations; Medications; Diet; Special Care Instructions; Reasons to contact physician; and Plan for follow-up care.

Section 11.10 Delinquent Medical Records (Acute Care Only):

(1) Each medical record shall be completed in full within thirty (30) days following the discharge of the patient. The Attending of record at the time of patient's discharge shall be responsible for the completion of the medical records.

a. If a medical record is incomplete fifteen (15) days after discharge, the Health Information Management Services (HIMS) Department shall notify the Attending/Affiliate Staff Members and CNMs of record of the delinquency and inform the Attending/Affiliate Staff Member and CNMs that the record must be completed within fifteen (15) days from the date on the notification.

b. If the medical record remains incomplete thirty (30) days following the date of discharge without justified delay, the Chief Medical Officer shall notify the Medical-Dental Staff Member in writing that his or her clinical privileges have been automatically suspended.

(2) Failure to complete medical records in accordance with these Rules and Regulations shall result in a monetary 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 appropriately completed all of the delinquent records and has paid the $200.00 fine.

a. The Medical-Dental Staff Member shall remain responsible for obtaining coverage for his or her on-call obligations. The member may continue to provide care for current patients, but are not permitted to:

i) admit new patients; or

ii) schedule new surgeries or other new procedures until the records have been completed and the suspension has been lifted

(3) Medical-Dental Staff members are required to notify Health Information Management Services (HIMS) in the event of a justifiable delay. A justifiable delay, resulting from extenuating circumstances will be approved by the CMO.

(4) 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 Chief Medical Officer for action.

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 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 safety transported to Christiana Care for delivery, the patient will be moved to Wilmington Emergency Department and assessed.

Section 12.2 Solid Organ Transplant Patient

(1) The safe management of Solid Organ Transplant patients requiring inpatient admission requires consultation & collaboration by transplant educated physicians.

(2) General guidelines for Solid Organ Transplant patients:

- At the time of presentation and/or admission, the Emergency Department physician/Admitting Physician and/or Nurse practitioner should notify the original transplant center to discuss medication reconciliation and to address possible need for transfer to their facility.
- If unable to contact the original transplant center, the Christiana Care identified expert physician should be consulted in a timely fashion.
- Accurate Medication Reconciliation is paramount at the time of admission and discharge. These medications carry a high risk for known drug interactions, require skilled management and are preventable if recognized.
- With the exception of kidney transplant patients, admissions to Wilmington Hospital (except for Psychiatry/Center, Rehabilitation or inpatient admissions for Ophthalmology or Oral and Maxillofacial services) are strongly discouraged.

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 CMO 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 CMO 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.