

**Louisiana State University  
Health Care Services Division**

**Lallie Kemp Regional  
Medical Center**

**Medical Staff Rules,  
Regulations and  
Policies**

**LSUHCS D - LKMC MEDICAL STAFF RULES & REGULATIONS**

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**Louisiana State University - Health Care Services Division  
Lallie Kemp Medical Center  
Medical Staff Rules & Regulations and Policies**

**I. General**

- A. All medical staff practitioners will abide by all policies and procedures of Lallie Kemp Medical Center (LKMC) as well as LSU/HCSO policies and procedures.
- B. All medical staff practitioners will uphold patient information confidentiality and as such will not disclose their passwords or personal identification numbers (PIN's) to others in order to access computerized information systems.
- C. All medical practitioners will practice only within the scope of their granted clinical privileges.
- D. All practitioners will abide by guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to patient information confidentiality and accessibility.

**II. Practitioner Health**

All medical staff practitioners will abide by employee health guidelines by completing attestation of practitioner health, regarding history of previous communicable diseases, including tuberculin skin testing, proof of immunization, and/or serologic evidence of immune status for specific diseases, e.g. hepatitis B, varicella, and rubella.

**III. Admission of Patient**

- A. Only those licensed independent practitioners granted admitting privileges may admit patients to the hospital. A patient's general medical condition is managed and coordinated by a physician.
- B. No patient shall be admitted to LKMC until the admitting practitioner has effected a written or verbal order for admission along with the provisional diagnosis or valid reason for admission.
- C. No patient will be admitted with a psychiatric diagnosis as the principal diagnosis.

**1. General Responsibility for Care:**

- a. The attending physician or appropriate covering physician shall be responsible for care, treatment, and services of each patient admitted.
- b. The attending physician shall be responsible for all necessary instructions to hospital personnel regarding care plans, and for the proper care of the patient unless or until proper authentication in the medical records indicates that the care of the patient has been transferred to another member of the medical staff privileged to accept responsibility for the patient's care.
- c. The physician is required to make a clinical visit to each patient hospitalized on a daily basis and document the visit with an appropriate progress note.
- d. The attending physician shall be responsible for the transmitting of patient progress reports to appropriate family members and maintaining an effective communication channel.
- e. The attending physician will be the surgeon of the patient if the patient has gone to the operating room for a major surgical procedure. The patient can be transferred to the

originally-referring practitioner after an appropriate time when mutually agreed upon.

**2. Interdisciplinary Plan of Care:**

- a. The attending practitioner shall collaborate with the interdisciplinary team to plan care that is appropriate to the patient's needs and severity of illness.
- b. The attending practitioner shall review the interdisciplinary plan of care documents and progress summary notes. He/she shall collaborate and coordinate with all team members and the patient's family to modify the plan when appropriate, and ensure that communication occurs with the patient and their family regarding the plan of care.

**3. Bed/Unit Availability:**

Should a shortage of available beds exist in the hospital or in a specific care unit of the hospital, the resolution should be based on medical necessity. Should conflict arise, the Medical Director or his/her designee shall determine the bed occupancy priority after consultation with the appropriate Clinical Department Chairperson.

**4. Discharge of Patient**

- a. A patient shall be discharged only on the written order or telephone/verbal order of the attending physician, except under disaster conditions set forth in the Hospital Emergency Management Plan.
- b. All patients will be given written discharge instructions for follow-up care (exception being patient transferred out). The patient or authorized representative shall sign a receipt acknowledging delivery of said instructions. A signed copy of the general instructions shall become a part of the medical record. Where additional printed standardized or computer generated instructions are given, a notation to that effect should be entered in the record. This also applies to the ambulatory care and emergency services.
- c. Documentation of anticipated discharge date of Medicare inpatients must be entered onto the patient's medical record forty eight (48) hours prior to discharge.

**5. Leaving Against Medical Advice**

- a. Should the patient leave the hospital against medical advice (AMA) of the physician, or without proper discharge, a notation of the incident shall be made in the patient's discharge summary of the medical record. Medications appropriate to the patient's condition may be prescribed at the time of AMA departure.
- b. The Hospital's written policies regarding leaving against medical advice should be consulted and followed whenever a patient desires to leave the hospital, including the Emergency Department, against the advice of any practitioner.

**6. Transfer of Patients**

**a. Transfer of Patient for Logistical Reasons**

A patient may be moved within the hospital for logistical reasons without the approval of the responsible practitioner provided the level of care afforded has not changed.

**b. Transfer of Responsibility Between Practitioners**

When primary responsibility for a patient's care is transferred from an attending Practitioner to another Practitioner, a note covering the transfer of responsibility and acceptance of same shall be entered in the progress notes of the medical record. The receiving practitioner shall review all orders and make changes as indicated.

**c. Internal Transfer**

A practitioner's order is necessary prior to any internal transfer between patient care units for a different level of care. The Practitioner shall write a brief summary of the patient's care in the progress notes prior to the patient's transfer, unless in an emergency situation, and shall rewrite all orders.

**d. Transfer to Another Facility**

Patient transfers from Lallie Kemp Medical Center to another licensed hospital/facility or appropriate provider of care shall comply with all applicable federal and state laws and written hospital policies. Patients and/or families shall be fully informed of the transfer and participate in the planning of such transfer to the extent their condition permits. Patient and/or family choice for transfer and/or selection of transfer organization will be accommodated within reason and regulation.

**7. Patient Passes**

Passes to leave the campus are not permitted. The patient will be discharged and readmitted if the condition warrants such action.

**8. Patient Smoking**

No member of the medical staff may give verbal or written orders for permission for any in-patient to smoke inside or outside on the campus of LKMC. For patients who smoke, Nicotine replacement therapy is recommended during the stay unless contraindicated.

**IV. Consultations**

- A. Consultation is obtained when a patient's condition warrants care outside the attending practitioner's expertise and/or clinical privileges.
- B. The practitioner shall use professional judgment and discretion in securing consultations in the care and treatment of his/her patients. All practitioners should abide by the guidelines and recommendations of their respective professional organizations, learned societies, collaborative agreement, if applicable, based on his/her privileges.
- C. The attending practitioner shall remain primarily responsible for the patient's care, unless such care is transferred to another practitioner and accepted in writing on the chart by the successor practitioner except in an emergency or in cases of suspension of privileges as per the Bylaws.
- D. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed but has not been obtained, he/she shall call this to the attention of his/her supervisor who, in turn, may refer this matter to the Director of Nursing. If warranted, the Director of Nursing may bring the matter to the attention of the Department Chairperson, Chief of Staff, and/or Medical Director in that order. When

circumstances are such as to justify the action, any of the above senior medical leaders may request a consultation in writing on the chart.

- E. No consultant shall order a second or further consultation without first obtaining concurrence of the attending physician.
- F. Consultations shall show evidence of the consultant's review of the patient's record, his/her pertinent findings on the examination of the patient, and the consultant's opinion and recommendations.

## **V. Medical Records**

### **A. Documentation Rules**

1. The practitioners shall be responsible for the timely completion, legibility and accuracy of the medical record during the course of the patient treatment in accordance with hospital policy and procedure, regulations, and quality-of-care standards.
2. All entries into the medical record must be in indelible ink and include date (month, day, year) and time.
3. Rubber stamps embossed with a practitioner's signature shall not be permitted to be used in the patient's record. Printed name stamps are permitted and encouraged for legibility in addition to practitioner's written signature.
4. Only approved symbols and abbreviations may be used in the medical record and/or when there is an explanatory legend available to those authorized to make entries in the medical record and to those who must interpret them.
5. Practitioner orders or entries related to medications shall not include abbreviations from the hospital's "DO NOT USE" abbreviations list. Orders containing such will not be carried out until clarification has been received/ obtained from the practitioner.
6. Corrections of the medical records should consist of a line through the material with a notation "error" and date, time, and initials of the corrector. No notation on a medical record may be obliterated or deleted; each entry to be corrected or clarified shall have a single line drawn through it.
7. No record can be updated or modified by preparing entries with dates and times that do not reflect the ACTUAL DATE and TIME that the information was written. Any late entries shall be labeled as such.
8. No member of the medical staff shall be permitted or requested for any reason to complete a medical record on a patient unfamiliar to him/her.
9. Any practitioner who authenticates another practitioner's order or who co-signs a history, physical, or other entry for another person authorized to make such an entry has the legal responsibility for the order or information bearing his/her authentication. Clinical practice groups may agree among themselves to allow each practitioner to authenticate verbal orders

in the group. Likewise, authentication signatures of a member of a group may be permitted in the case of discharge summaries so long as the practitioner signing for the discharging practitioner has actively participated in that patient's care.

## **B. History and Physical (H & P) Examinations and Required Updates:**

1. All patients admitted to the hospital must have an H&P documented in the medical record within 24 hours of admission. An emergency room assessment for admission can be considered as the initial in-patient admit note pending the full practitioner history and physical exam assessment being placed on the chart.

An H&P that is greater than 30 days old is invalid. In this case a “new” H&P must be done within 24 hours of admission. If a H&P has been done within 30 days of inpatient admission, an update to the patient’s condition must be written within 24 hours of admission, unless the patient will undergo surgery or other procedure that places the patient at risk and/or involves the use of sedation or anesthesia within the first 24 hours, an update H&P must be written prior to the start of the surgery/procedure. *Note: If the H&P and/or update has been dictated, it must be transcribed and entered in the patient’s medical record prior to the surgery/procedure.* An update records any changes since the last H&P was performed. If no changes have occurred, the absence of change must be documented. (Example: “the H&P was reviewed, the patient was examined, and no changes have occurred in the patient’s condition since the H&P was completed.”)

2. Patients admitted to intensive care unit must have a completed history and physical assessment. A short stay summary is not sufficient for intensive care admit H&P.

3. H&P must be documented in the medical record before any surgical procedure and/or invasive diagnostic procedure, except in the event of an Emergency Surgery when such a delay would constitute hazard to the patient. In an emergency, when there is no time to record the complete H&P examination, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded before surgery.

4. The H & P: The completeness of this assessment should be dictated by the complexity and severity of the illness. There shall be a disclaimer statement placed at the top of each dictated history and physical report which states “Pertinent components to this patient’s history and physical are as follows...” This disclaimer statement shall signify that areas of the history and physical that are not addressed should be considered non-pertinent.

The H & P must contain information pertinent to the thorough evaluation of the patient's medical condition and health screening needs. The H & P may include information from the following categories: chief complaint, history of present illness, review of systems, past medical history, past surgical history, medications, allergies, immunizations, social history, family history, test results, physical exam, assessment and plan. The minimal required elements of the H & P should include the history of present illness, physical exam, assessment and plan.

If the patient is readmitted within 30 days for the same or a related problem, a durable, legible copy of this report may be placed in the medical record and any updates to the patient's condition since the H&P are recorded at the time of admission (within 24 hours).

5. The multi-disciplinary assessment form may be used to document the history and physical for patients who are undergoing outpatient surgical/invasive diagnostic procedures or placed in observation status and predicted to be in hospital less than 48 hours. It is the responsibility of the physician to assure that all appropriate portions of this form are completed. "DIRECTED" type H&P A standard History & Physical must be documented for any patient who was originally admitted with the multi-disciplinary assessment form and who remains in hospital for 48 hours or longer.

6. A standard History & Physical must be documented for any patient who was originally admitted with the multi-disciplinary assessment form and who remains in the hospital for 48 hours or more.

7. History and physicals and required updates may be performed by any practitioner who has been granted privileges to do so. H&P's performed by resident physicians must be authenticated by the responsible teaching physician who has been granted H&P privileges. (*Refer to LSUHCS Policy #8510-07 "Physicians at Teaching Hospitals Billing Policy"*)

### **C. Operative, Special Procedures, and Other Requirements**

1. A brief operative note shall be written in the progress notes immediately following surgery (inpatient or outpatient) before the patient leaves the surgery suite or recovery area. The written note must include the following elements:

- a. Name of primary surgeon;
- b. Post-operative diagnosis;
- c. Procedure performed;
- d. Estimated blood loss;
- e. Any complications

2. An operative report (including invasive radiographic and cardiology procedures) shall be dictated for transcription immediately after the procedure. The report should contain:

- a. Principal Surgeon and assistant surgeons if applicable;
- b. Preoperative Diagnosis;
- c. Post Operative Diagnosis;

- d. Operation(s) performed;
- e. Type of anesthesia administered;
- f. Description of the technical procedure performed;
- g. Intra-operative findings;
- h. Intra-operative complications, unusual events including blood loss if applicable;
- i. Specimens removed; and
- j. Post operative state

*NOTE: Invasive radiographic procedures are included although the pertinent Post Operative Report may be found within the text of the radiology report itself.*

3. The writing or dictation of reports required in this section may be delegated to a resident only if the teaching physician was present and directly participating during the entire surgery or procedure. This statement must be clearly documented by the teaching physician indicating he/she was physically present during the surgery or procedure.

4. All pre-sedation or pre-anesthesia assessments and anesthesia care plans must be reviewed and authenticated by a licensed independent practitioner who can be either a:

- Credentialed anesthesiologist or
- The attending physician

NOTE: This does not include doctors of podiatric medicine or dentists.

5. Pre-Induction Assessment: The patient is reevaluated immediately (i.e. on the procedure table, in the moments before the sedation is to be administered) before moderate or deep sedation use and before anesthesia induction and is documented in the record. Documentation of the pre-induction assessment may include vital signs, status of the airway and response to any pre-procedure medications.

6. Anesthesia for podiatric surgery will be performed in accordance with R.S.37:611-628.

#### **D. Progress Notes**

1. Progress notes will be made on each in-patient on a daily basis or more frequently if the patient's condition or situation warrants.

2. Progress notes will give a clear clinical and chronological picture of the patient's progress and will use the "SOAP" format whenever possible, i.e. subjective complaints, objective findings, assessment of condition, and plan of therapy.

#### **E. Completion of Medical Records**

A patient's medical record, resulting from an inpatient stay, outpatient or emergency department encounter shall ALL be completed within thirty (30) days of discharge. This includes listings of all final diagnoses and discharge summaries.

1. A written reminder will be given at least fourteen (14) days prior to the delinquent date.

2. All charts, INPATIENT, OUTPATIENT, and EMERGENCY DEPARTMENT will be considered delinquent at a period of thirty-one (31) days following discharge or date of encounter.

3. It will be considered a violation if a practitioner does not complete his/her records within the allotted time frame and he/ she will be subject to administrative penalties as determined by the CEO.

4. All members of a practitioner group MAY be subject to the penalties placed upon any single member of the practice group.

5. The Attending (supervising) staff physician shall sign or cosign with the House Staff (resident) the attestation sheet and/or the face sheet of the medical record. Neither symbols nor abbreviations may be used on the face sheet or in the final diagnosis, but may be used within the medical record when approved by the Medical Staff.

6. In the event that a House Staff (resident) member fails to complete a medical record in a timely manner, that medical record shall be completed by his/her supervising Academic Staff practitioner and a letter to the sponsoring Graduate Medical Education Program will be sent giving notification of the House Staff (resident) member's failure to comply with the Medical Staff Bylaws, Rules and Regulations, and policies.

#### **F. Filing of the Medical Record**

A medical record shall not be declared complete and filed permanently until it is completed by the responsible practitioner(s) or is ordered to be closed by the Medical Executive Committee on recommendation of the Quality Sub-Committee.

#### **G. Ambulatory Care Medical Records**

1. **Clinic Problem List:** For patients receiving ambulatory care services on a continuing basis, it is the responsibility of the physician seeing the out-patient to assure the maintenance of a "problem list" or "summary list" including the following information:

- Known significant medical diagnoses and conditions
- Known significant operative and invasive procedures
- Known adverse and allergic drug reactions
- Medications known to be prescribed for or used by the patient

2. **Clinic TIC Sheet:** The practitioner must complete his/her own tic sheet with the ICD-9 code.

#### **3. Emergency Department Records**

Appropriate medical screening will be provided and documented by a licensed independent practitioner or other qualified professional with the appropriate clinical privileges, to all individuals seeking emergency services to determine the presence or absence of an emergency medical condition.

- Notes the time and means of arrival
- Notes when a patient leaves against medical advice
- Notes the conclusions at termination of treatment, including final disposition,

- condition at discharge, and instructions for follow-up care.
- A copy of the Emergency Services provided is available to the practitioner or medical organization providing follow-up care.
- Notes any medical care delivered prior to arrival in the Emergency Department.

#### **4. Out-Patient Surgery Department**

It will be the responsibility of the physician performing the diagnostic test/invasive procedure to complete the necessary history and physical examinations and paperwork for the scheduled patient/test. This pertains to any patient whose recovery requires the services of the Out-Patient Surgery Department.

### **H. Release of Medical Information**

Written consent signed and dated by the patient or the patient's legal representative is required for release of any medical information, except for release of medical information for treatment purposes at another facility and processing billing information.

### **I. Safeguarding of Medical Records**

- Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, or specific permission of the hospital CEO and with provisions for continuation of a chain of custody. All records are property of the hospital.
- Free access to patient's medical records may be afforded to members of the medical staff for patient care, performance improvement, special studies, and/or as directed or approved by the Medical Executive Committee or Health Information Management.
- In cases of re-admission of a patient, the practitioner will have all the medical records of previous admissions and outpatient visits available for use. This availability shall apply whether the patient is attended by the same practitioner or by another practitioner.
- Subject to the discretion of the CEO or Medical Director, former members of the medical staff shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the hospital or clinic setting.

### **J. Informed Consent**

1. Upon admission, the hospital will obtain a general consent for treatment during hospitalization. This general consent does not, however, eliminate the need for each Practitioner to obtain informed consent from the patient or the patient's authorized representative for specific treatments or procedures.

- Consents for Surgery, Procedure, Anesthesia, and Treatment Modality: Except in emergency situations, the responsible practitioner shall obtain from the patient or

the patient's lawful representative proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate, including blood transfusion and the use of blood products, in accordance with applicable state law and according to LSU-HSCD'S Informed Consent Policy and Procedure.

- b. Evidence of the informed consent must be obtained and filed in the patient's medical record prior to proceeding with the surgery or other procedure or treatment in accordance with the Informed Consent Policy. Only consent forms approved by the Medical Executive Committee can be used and must include:
  1. An explanation of the nature of the contemplated procedure, treatment, and/or anesthesia, the reason for performing, appropriate alternatives, and respective benefits;
  2. An explanation of the significant risks, complications and alternative options. The patient may be informed that he or she has the right to refuse this explanation;
  3. An explanation of the possible consequences of refusing the proposed treatment or procedure;
  4. The practitioner shall document the need for, risk of, and alternatives to blood transfusions when the use of blood or blood components is considered.
  5. The provisions that all questions of the patient have been satisfactorily answered by the practitioner performing the procedure.
- D. It is the physician's responsibility to indicate the surgical/invasive procedure site and side on the informed consent, as well as the physician order sheet, and all other supporting documentation. All consents will have the appropriate surgical or procedural site, side or level in order to be valid.
- E. Marking of the site is required for procedures involving right/left distinction, multiple structures (such as fingers and toes), or levels (as in spinal procedures).
- F. Emergencies: Consent to surgical or medical treatment or procedure suggested, recommended, prescribed, or directed by a duly licensed and credentialed practitioner will be implied where an emergency exists as defined in the LSU-HCSD Informed Consent Policy and Procedure.

## **K. Patient Education**

While it is understood nursing services is the primary source/person conducting and coordinating patient education, the physician has a responsibility to participate in patient education as deemed necessary and appropriate.

## **L. Death of Patient**

A. In the event of a hospital death of a patient, the practitioner or his/her designee shall pronounce the patient dead. An in-house emergency room physician, when available, may perform this service for the attending Physician.

1. A record of death will be completed and placed in the patient's medical record.
2. Adequate communication with the family and answering their concerns remain a part of the obligation of all physicians dealing with the death of a patient.
3. Release of the deceased shall be in accordance with applicable law.

B. Every deceased patient must be evaluated as a potential candidate for organ and/ or tissue donation. (See LK Policy and Procedure; Organ and Tissue Donation.)

## **IX. Autopsy**

It shall be the duty of all members of the medical staff to secure meaningful autopsies whenever possible after securing consent from all appropriate parties if such an autopsy is otherwise required by civil code.

## **X. Practitioner Orders**

- A. All practitioner orders should be in compliance with Lallie Kemp Medical Center policy and procedures.
- B. All orders and entries should be written clearly, legibly, and completely.
- C. All practitioner orders or entries in the medical record related to medications shall be free of the prohibited (DO NOT USE) abbreviations.
- D. The practitioner's orders and entries must include date (month, day and year and time).
- E. Orders for any diagnostic services or testing services (whether in-patient or out-patient) shall include a clinical diagnosis(es) or ICD-9 code(s) in keeping with compliance regulations in order to establish medical necessity and indicating the reason for the request.
- F. Orders which are illegible or improper will not be carried out until clarified by appropriate personnel.
- G. Physician orders for surgical procedures will remain valid for 60 days or until the procedure has been completed, whichever comes first. Procedures rescheduled in excess of 60 days from the original order date will require new orders to be written.

H. Language such as, “resume all pre-op medications/orders,” “continue home medication,” “renew,” and “repeat” are prohibited without specifying further defining information.

### **1. Verbal Orders**

- a. Telephone and verbal orders should be reserved for urgent or emergent situations and for other circumstances when the prescriber is unable to be physically present to write the order.
- b. All telephone, verbal orders, and critical results shall be verified by read back procedures, whereby all information regarding the order is read back to the prescriber including patient identification information and critical patient data.
- c. All verbal orders must be authenticated by the ordering physician or by another practitioner authorized by the ordering physician within 48 hours of the verbal order or within legal time frame specified by law. Practitioners who are not prepared to authenticate orders within this time period should make arrangements with their practice colleagues for authentication.
- d. Telephone or verbal orders for medications and treatment may be accepted and transcribed by a duly authorized person functioning within his/her scope following hospital policy and procedure for verbal orders.
- e. Acceptance of a verbal order is limited to only the following personnel:
  1. Registered Nurses
  2. Licensed Practical Nurses
  3. Certified Registered Nurse Anesthetists
  4. Pharmacists
  5. Licensed Physical, Speech and Occupational Therapist
  6. Certified Registered Respiratory Therapist
  7. Licensed Dietitians
  8. Registered Radiology and Registered Nuclear Medicine Technologist
- f. Verbal orders cannot be given for “do not resuscitate” orders or “do not code” orders unless personal evaluation for terminal and irreversible condition has been effected and documented in the progress note section of the patient record.
- g. Verbal orders will be accepted only from the practitioner and not from a third party such as an office secretary or office nurse.

### **2. Automatic Cancellation of Orders**

- a. All previous orders are canceled when a patient goes to surgery. Orders must be rewritten legibly and completely. The exception to this is a patient who undergoes an endoscopy procedure only.

- b. All previous orders are canceled when a patient is transferred to or from a unit of a different level of care. Orders must be rewritten legibly and completely.

### **3. Pre-printed Order Sets, Protocols, and Clinical Guidelines**

Pre-printed order sets, protocols, and clinical guidelines will be coordinated through the Hospital Quality Resource Department. These documents will be reviewed and approved by the MEC annually and as needed.

## **XI. Response Time**

- A. Each member of the Medical Staff needs to be capable of physical response of 60 minutes.
- B. If such a response time cannot be met, a specified member of the Medical Staff with similar privileges must be named by the practitioner to act in his/her place. Such information shall be left with the nursing supervisor.
- C. All members of the medical staff are expected to participate in the hospital's disaster call-out plan as assigned and notified.

### ***On-Call Obligations:***

- A. When beyond the control of the on-call physician, response cannot be made for an emergency case for an Emergency Department patient; the emergency physician shall determine whether to attempt to contact another such specialist on the medical staff or immediately arrange for a transfer.
- B. When beyond the control of the on-call physician, response cannot be made for an emergency case for an inpatient, the medical director or designee will be notified to arrange alternatives.
- C. In all cases, the on-call physician is responsible for arranging for a replacement or back-up when response delays are anticipated. In the event that all resources are exhausted, the medical director will be notified for a decision regarding the diversion of that service.
- D. When a practitioner is paged, call back is required within 15 minutes. Refer to policy "On-Call Duty."

## **XII. Infection Control Measures**

- A. Members of the Medical staff shall comply with all infection control regulations to prevent the transmission of infection.
- B. Infection Control (through its leader, or the medical director or designee) has the authority to institute appropriate control measures or studies when it is reasonably felt that the danger to patients, visitors, or personnel exists. This includes the unilateral institution of isolation precautions. In such circumstances, the level of care afforded cannot be changed.

### **XIII. Pharmacy Procedures**

- A. All practitioners will abide with all pharmacy policies including those on generic and therapeutic equivalents, automatic stop, as well as drug restrictions requiring special credentialing requirements or because of resistant nosocomial outbreaks.
- B. Sample drugs will be handled according to hospital policy.

### **XIV. Investigational Drug Use**

- A. Drugs administered under an approved protocol for investigational or experimental drug use shall be used only under the supervision of the principal investigator or designee who shall be a member of the medical staff.
- B. The protocol including consent forms for use of an investigational drug or an approved drug used for new indications under an investigational protocol shall have been submitted to the LSUHCSD institutional review board (IRB) with a favorable response. Consent forms and protocols need to be sent to the Hospital Research Committee for approval. Refer to LSUHCSD Policy and Procedure.
- C. A copy of the authorized consent form signed by the patient will be kept in pharmacy as well as on the patient's chart. The pharmacy will be responsible for the storage, labeling, and dispensing of all investigational drugs in accordance with the written orders by the physician investigator.
- D. Nursing staff administering such drugs must be able to show competence by being knowledgeable of reported side effects (acute and chronic) and adverse reactions of the medication.

### **XV. Credentialing (Initial Appointment/Reappointment) and Granting of Clinical Privileges**

#### **A. General**

- 1. Applications and processes for applications and re-appointment applications and granting of clinical privileges will be effected in compliance with the Bylaws and Policies of the Medical Staff, which have been approved by the MEC and Board.
- 2. All members of the medical staff acknowledge the hospital's performance improvement plan and the medical staff competency process, which form the basis for the credentialing process.
- 3. Failure to comply with the standards of performance improvement may result in evaluation by the Medical Executive Committee, fines, reprimands, withholding of salary, suspension, removal from the staff with cancellation of contracts to work or any combination therein.
- 4. All Advanced Practice Registered Nurses who are members of the Medical Staff

must provide for a valid collaborative practice agreement with a physician annually, as required by the Louisiana State Board of Nursing.

**B. Confidentiality of Credentialing Information**

It shall be the policy of this organization to maintain the confidentiality of all records, discussions and deliberations relating to credentialing and focused practitioner review (peer) and improvement activities. Disclosure of the aforementioned shall be permitted only as described in the policy.

1. **Location and Security:**

All records shall be maintained under the care and custody of this hospital's authorized representative(s). The office and file cabinets where credentialing records are stored shall be kept locked, except when an authorized representative supervises access. Records stored electronically shall be protected by passwords and read/write controls.

2. **Access to records:**

All requests for access to credentialing records shall be presented to an authorized representative, who shall keep a record of requests made and granted.

Unless otherwise stated, an individual permitted access under this section shall be afforded a reasonable opportunity to inspect the records and to make notes regarding the requested records in the presence of an authorized representative. In no case shall an individual remove or make copies of any records without express permission.

3. **Access by Individuals Performing Official Functions:**

The following individual's may access credentialing records to the extent described:

- a. Authorized representatives and staff members may have access to all records as needed to fulfill their responsibilities.
- b. Consultants or attorneys engaged by this hospital may be granted access to records that are necessary to enable them to perform their functions.
- c. Representatives of regulatory or accreditation agencies may have access to records.
- d. Authorized representatives from organizations for whom this hospital performs delegated credentialing services may have access to records pertaining to their applicants or participating providers provided that each applicant or participating provider has completed a satisfactory authorization and release form.
- e. An applicant or participating provider in an organization for whom this hospital performs delegated credentialing services shall have access to records with the exception of confidential evaluation or references, which shall be released to the

subject of the evaluation or reference only with the express written consent of the person, who have the evaluation or reference.

- f. An individual practitioner may review his or her credential file under the following circumstances:
  - (1) The request is approved by the medical director, chief executive officer, credentials chair, or department chair.
  - (2) The review of the file is accomplished in the presence of the quality resources/medical staff affairs supervisor or designee, officer of the staff, or member of the credentials committee
  - (3) The practitioner understands that he or she may not remove items from the credentials file.
  - (4) The practitioner understands that he or she may add an explanatory note or other document(s) to the file.
  - (5) The practitioner understands that he or she may not review confidential letters of reference received during the initial appointment or any subsequent reappointment.
  - (6) No items may be photocopied without the express written permission of the chief executive officer.
4. Each individual described in (1) and (2) above shall be permitted access to records, provided that he or she has signed and dated the confidentially agreement. The original agreement shall be retained in this hospital.
5. The hospital will release reports received from the National Practitioner Data Bank only to those organizations that have officially designated representatives of this hospital as their official querying agents.
6. All subpoenas pertaining to records shall be referred to the authorized representative, who shall first consult with legal counsel regarding appropriate response.
7. Records that are requested by persons or organizations outside of this hospital shall be provided upon approval of the authorized representative.
8. **Sanctions:** Violation of this policy is grounds for termination of employment.

## **XVI. Compliance Plan Specific Rules**

- A. All medical practitioners will abide by the hospital's medical compliance program in keeping with all state and federal regulations and directives.
- B. Medical Staff members are responsible for adherence to facility compliance policies and plans, federal and state law, as well as federal, state, and private payer health care program requirements.
- C. Such policies include, but are not limited to the following:

1. All ordered procedures and tests must be medically necessary based either on history and/or physical assessment or on medically approved protocols.
2. The medical record must contain sufficient documentation that supports the medical necessity of the hospital and/or test or procedure code.
3. Documentation in the medical record and/or in the charge submission forms must be accurate and recorded daily (inpatient) or by each visit (outpatient).
4. If the practitioner is requesting an admission, a test, or a procedure that will not be covered by Medicare, he/she must notify the patient through a Non-Covered Services form or an Advanced Beneficiary Notice form.
5. Documentation in time studies, time logs, or time cards must be accurate.
6. Adherence to the facility's Rules of Conduct, Bylaws, and these Rules and Regulations and Policies.
7. All Medical Staff members will receive:
  - a. The facility Compliance Plan and policies applicable to their function.
  - b. The Rules of Conduct.
  - c. It is the responsibility of the practitioner to be thoroughly familiar with these documents.
8. If the practitioner is found to be willfully in violation of the compliance plan and/or policies, or the hospital's Rules of Conduct, the practitioner will face disciplinary action as mentioned in the Medical Staff Bylaws.
9. In instances without major institutional jeopardy, the disciplinary action, up to or including suspension or termination of medical staff privileges, will be subject to the fair hearing process.

## **XXVII. Conflict Resolution**

All members of the medical staff are obliged to conform with principles of conflict resolution:

- A. If a practitioner has a conflict regarding another practitioner he or she is encouraged to attempt resolution by direct communication always maintaining the precept of respect for others.
- B. If the problem cannot be resolved, it should be addressed with the department chairperson the Chief-of-Staff.

- C. If the practitioner has conflict with hospital personnel (nursing or others) the problem should be addressed through the appropriate hospital senior management person, viz., CEO, COO, CNO. Disruptive, aggressive, or other non-constructive behavior which makes for poor communication among the health care team will be considered a violation of this rule.
- D. If the practitioner has conflict with a patient, resolution of that conflict should be attempted by direct communication between the practitioner and the patient and family. Inability to achieve resolution should prompt the department chairperson of the service or Chief-of-Staff to intervene.

### **XVIII. Swing bed**

Only those practitioners granted admitting privileges by the hospital may admit patients to a skilled care/swing bed.

#### **A. Admission of Patient to Swing Bed**

To admit the patient to swing bed the attending practitioner must:

- Write orders to discharge the patient from acute care.
- Complete a discharge summary as customary.
- Write admission orders for skilled care/swing bed.

#### **B. History and Physical Documentation Requirements:**

A copy of the acute care history and physical and the discharge summary from the acute care stay to which the physician has added the data for the initial physician progress note will serve as the history and physical for the swing bed admission. For direct admit patients from other facilities, the history and physical is to be completed within 72 hours.

#### **C. Documentation requirements for physician visits:**

The physician making clinical rounds should document in the progress notes:

- All diseases affecting the care while in the swing bed
- Status of medical issues
- Outcome of treatment plan

#### **D. Frequency of visits:**

The frequency of clinical visits by the attending practitioner is determined by the condition and needs of the patient.

1. Initial on-site (clinical rounds): On-site (clinical) rounds are to be made by the attending practitioner within 48 to 72 hours from admission to swing bed/skilled care as long as there are admission orders to care for the patient.
2. At a minimum, clinical rounds are to be made weekly.
3. The practitioner must document in the medical record the reason to support the need to see the patient.

#### **E. Discharging Patients from Swing bed/skilled care bed**

1. The attending physician will write the order to discharge patient from swing bed/skilled bed care.

2. The discharging physician should write discharge progress notes upon discharge form the swing bed in lieu of a formal discharge summary.

**F. Certification/Recertification Form:**

The attending physician signature is required on the certification/recertification form as follows:

1. Admission certification: upon admission to swing bed.
2. Recertification form: continued skilled inpatient care on or before the 14<sup>th</sup> day.
3. Second (2<sup>nd</sup>) Recertification: continued skilled inpatient care on or before the 44<sup>th</sup> day. (30 days after the first recertification)
4. Third (3<sup>rd</sup>) Recertification: on or before the 74<sup>th</sup> day of skilled inpatient care.

**XIX. Amendments**

Amendments to the Rules and Regulations may be made by the medical executive committee as necessary.

**XX. Approval**

- A. Approval of amendments of rules and regulations is via simple majority vote of the voting members of the medical executive committee.
- B. Amendments to rules and regulations will be communicated to all members of the medical staff in writing.