RULES AND REGULATIONS

OF THE MEDICAL STAFF OF

THE WILLIAM S. MIDDLETON MEMORIAL VETERANS HOSPITAL
MADISON, WISCONSIN

APPROVED: November 18, 2008

1. Admission to Hospital

a. All patients shall be attended by members of the Medical Staff and shall be assigned at the appropriate level of care to the service or section concerned in the treatment of the disease which required hospitalization or observation care.

b. Upon admission, patients will be interviewed and examined as soon as possible. A complete history and physical examination shall be recorded in the medical record within 24 hours after the admission of the patient. The attending Medical Staff physician is responsible for the preparation and completion of a complete medical record for each patient. This record shall include identification data; chief complaints; history of present illness, relevant past history, social history, and family history; physical examination; and assessment and plan. Special reports such as consultations, clinical laboratory, radiology, and others are found elsewhere in the clinical record and are not expected to be in the admission workup. Dentist members of the Medical Staff are responsible for the dental portion of the medical record.

c. The attending staff must see and evaluate the patient within 24 hours. The Medical Staff physician responsible for the patient must sign the workup if it is prepared by a resident or mid-level provider, and write a progress note or addendum documenting his/her findings, recommendations, treatment plan by the end of the calendar day following admission. Alternatively, if the attending staff is working without a trainee or mid-level provider, he/she should prepare a complete admission workup within 24 hours. If the patient is seen in pre-procedure clinic, the history and physical may be completed and signed by the attending within 30 days of admission. The attending is still required to write a note or addendum whether the admission is through pre-procedure clinic or through direct admission. An update to the history and physical is required by the attending prior to surgery or within 24 hours of admission whichever is earlier.

d. In the event the resident prepares an admission workup, ALL will be retained, but the official workup will be the workup which carries the responsible Medical Staff physician's approval signature. A medical student history and physical does not represent the official history and physical examination. The admission H&P may be delegated to a physician’s assistant or nurse practitioner, although the attending staff must validate and sign the H&P by the end of the calendar day following admission.

e. All patients requiring hospital admission for dental care will be admitted to Medical Service under the care of a medical team and attending physician. Admitted dental patients will receive the same basic medical appraisal by a physician member of the Medical Staff as all other patients admitted to the Medical Service. The patient's dental problems will be managed by a Medical Staff dentist and the patient's medical problems by a Medical Service team with attending oversight. Surgical procedures performed by dentists will be under the overall supervision of the Chief, Dental Service.

f. Other documentation requiring attending staff authentication includes operative reports, consultations, and discharge summaries.

g. The Chief of Staff (COS), in consultation with the Utilization Management Committee, will provide guidance on appropriate completion of medical records. Review of open medical records, specifically a summary of attending documentation of resident supervision responsibility, will be made weekly. When this review determines that an attending has failed to sign a completed admission and/or write a note or an

addendum by the end of the calendar day following admission, the responsible Service Chief or Associate Chief of Staff (ACOS) will issue a notice that the practitioner's practices must improve. If failure to sign a completed admission and/or write an attending note or addendum by the end of the calendar day following admission occurs within 30-days following this notice, the COS will issue a notice that an additional failure within 30 days of receipt of this notice will result in automatic suspension for 30 days. The COS will notify the responsible service chief and Medical Staff member when suspension is to begin and end. The COS, in consultation with the Director and Human Resources Service, and in accordance with applicable VHA rules and regulations, may encumber payments to the staff member for the duration of the suspension.

2. Continuing Stay

For patients in active and acute care beds, there will be a daily progress note. If the progress note is written by someone other than the attending physician, evidence of attending involvement could include a co-signature of the resident's note or the resident may include the discussion with the attending in his/her note.

3. Intensive Care Unit

Because of the high level of acuity for patients in the ICU, attending involvement is expected on admission and on a daily or more frequent basis as evidenced by an attending staff note or co-signature of the resident note. The attending must see the patient and write a note or addendum within eight hours of admission to the ICU.

4. Consultations

a. Request for Consultations: Any member of the Medical Staff may request consultation. Other licensed professionals may request a consult if hospital policy or individual non-LIP privileges provide for this. Consultation is urged for the following situations:

(1) When the patient is not a good risk for an operative procedure.
(2) When the diagnosis remains obscure after ordinary diagnostic procedures have been completed.
(3) When there are significant differences of opinion as to the best choice of therapy.
(4) In unusually complicated situations where specific skills of other practitioners may be helpful.
(5) When specifically requested by the patient or his family and with concurrence by the attending physician.
(6) For all patients who have attempted suicide or who have had self-administered chemical overdoses, psychiatric consultation will be ordered electronically.

b. Performance of Consultation: A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The status of the consultant is determined by the Medical Staff in the privileging process on the basis of an individual's training, experience, and competence. A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in an emergency, shall be reported prior to the operation.

Nursing assessments may result in referrals to Physical Medicine and Rehabilitation Service, Nutrition, Speech and Audiology, and Social Work Services. These referrals are based on screening criteria established by respective disciplines.

5. Discharge from Hospital

a. Patients shall be discharged only on written order of a member of the Medical Staff or a physician trainee (house officer). A note will be written regarding the patient's condition at the time of discharge. At time of dictating the final summary, the responsible member of the Medical Staff shall review the medical record to

ensure that documents therein pertain to his/her patient and contain accurate data. He/she shall review and sign the final summary within 30 days following discharge of the patient.

b. Completion of discharge summaries is the responsibility of the Medical Staff member responsible for the direct care or supervision of care for the patient. The responsible Medical Staff member may delegate dictation or computer entry of the summary to a physician trainee, another member of the Medical Staff, or to an appropriately trained psychologist or Registered Nurse. In all cases, standardized templates shall be used for discharge summaries to assure their quality. However, the attending Medical Staff member is responsible for the content of the discharge summary which he/she reviews and electronically signs. The appropriate ACOS or Service Chief, in cooperation with the COS, shall monitor weekly the number of discharge summaries which are delinquent for Medical Staff signature. A summary shall be considered delinquent when a typed summary has not been signed in ink or electronically within 30 days following the discharge of the patient. The staff member found to have over six charts delinquent by over 30 days, three charts delinquent over 60 days, or one chart delinquent over 100 days shall receive a written notice from his or her supervising Chief or ACOS indicating that all delinquent summaries must be completed within 14 working (Monday through Friday) days. If completion of the summaries does not occur, the COS office shall issue a notice to the staff member indicating that no discharge summaries assigned to the practitioner should remain delinquent after the following 14 working days. If the practitioner does not comply with this notice, his or her privileges shall be suspended on the fifteenth working day and shall remain suspended until all delinquent discharge summaries assigned to the staff member have been dictated and signed. The COS, in consultation with the Director and Human Resources Service, and in accordance with applicable VHA rules and regulations, may encumber or eliminate payments to the staff member for the duration of the suspension.

c. When the rate of delinquent discharge summaries for a quarter exceeds 50% for a given clinical service, it will be the responsibility of the service chief to assure that the rate for that service becomes less than 50% within 14 working days of notification of this problem. Summaries that are awaiting final review for signature and charts awaiting dictation must be processed within that time frame in order to accomplish this goal. If staff responsible for the delinquent discharge summaries fail to make sufficient progress to decrease the delinquency rate, the service chief shall be responsible for completing enough records to bring the service delinquency rate to less than 50%.

6. Short Stay Admission

An abbreviated medical record may be used in lieu of a complete workup in certain treatment and diagnostic cases of a minor nature where it is anticipated the stay will be less than 72 hours. In order for the record to be acceptable, it must contain sufficient information to support the diagnosis(es) and adequately reflect treatment and results as well as an abbreviated discharge summary.

7. Outpatient Care

a. Outpatient Clinics: The outpatient record shall reflect the appropriate workup relevant to the specific clinic whether a primary care or specialty clinic. The record shall contain the chief complaint, history of present illness, focused exam, assessment, and plan. The attending physician shall be responsible for ensuring that elements of evaluation and management present in records of outpatient visits match the level of evaluation and management specified for that patient encounter.

b. Ambulatory Care Procedures Requiring Conscious Sedation: For patients undergoing procedures in the Ambulatory Surgery and Procedures area, the minimum workup will be an evaluation of heart and lungs and notation of procedure to be performed. The ASA score will also be noted immediately prior to the start of the procedure.

8. Ordering Practices

a. Standard Practice: All medical and dental orders for treatment shall be in writing, using either electronic medium or ink and paper. Electronic ordering shall be the preferred practice standard for this hospital.

b. Verbal Orders: Verbal orders (including telephone orders) are generally discouraged; however, they are accepted by R.N.s, respiratory therapists, dietitians, physical therapists, pharmacists, and occupational therapists within their area of practice when it clearly is in the best interests of patient care and efficiency. Additional staff may be authorized to receive verbal orders based on Hospital Memorandums (including Patient Record, 136-03) and protocols/memorandums approved by the COS. A verbal order may be declined if the recipient believes it is in the best interest of the patient for the licensed independent practitioner to see the patient prior to issuing orders. The recipient of the verbal order is responsible for indicating to the issuing provider if they are not authorized to accept verbal orders or if the particular order exceeds their scope of practice. The provider should not knowingly issue verbal orders to an unauthorized person. When a verbal order is given, the order must be directly entered into CPRS or written down by the recipient onto an order sheet and then read back. The practitioner should then verbally confirm that the correct patient has been identified and the order has been received correctly. In an emergency situation the order may be repeated back and documented after implementation. Verbal medication orders are handled as outlined in the Hospital Memorandum on Medication Use, 11-15. All verbal orders must be signed by the attending licensed independent practitioner or his/her house-staff designee as soon as possible and within 24 hours. Inappropriate issuing of verbal orders may result in loss of privileges. Verbal orders for antineoplastic agents are not permitted.

c. Orders Written on Progress Notes: The COS may empower clerical staff to enter certain orders into the computer which have been written by a privileged practitioner. This will be accomplished by a memorandum from the COS to the appropriate service chief indicating that certain orders may be entered "by policy" into the electronic medical record system by specified staff. In general, this will only be allowed where the non-practitioner staff may have information on scheduling services for the patient essential to assuring patient care. Routine outpatient orders for laboratory tests and patient supplies required for a future appointment which are recorded by a physician on clearly formatted outpatient paper or electronic routing sheets are an example of orders which are candidates for transcription into the electronic record on behalf of the physician.

d. IRMS (Information Resources Management Service) may develop electronic order templates with specific guidance from members of the Medical Staff or their designee. Templates shall be revised whenever practitioners determine changes in practice make this necessary.

9. Medication Prescribing/Ordering

a. All drugs used in the hospital must be on the Hospital Formulary or meet the criteria for use approved by the Therapeutic Agents and Pharmacy Reviews and Standards Committee. Investigational drugs that have been approved by the Research and Development Committee may be used.

b. All drugs, both formulary and investigational, used in the hospital will be stored and dispensed by the Pharmacy.

c. Drug orders will expire in the following manner:

(1) Inpatient orders for Schedule II Substance and Schedule III Narcotics will be rewritten every seven (7) days. If a patient has chronic pain requiring narcotics, the physician may write for an order to be active up to 30 days if the order states that it is for chronic pain.

(2) Outpatient controlled substance prescriptions expire according to federal law.

(3) Outpatient medication orders expire after one year and are reviewed by the practitioner at least yearly. Pharmacy may renew prescriptions for three months after expiration. Following that three months, the licensed independent practitioner must re-write the prescriptions.

(4) All PRN orders require an indication for use.

10. Clinical Patient Record System (CPRS)

a. Electronic medium shall be the preferred mechanism for recording all information pertinent to a patient's care. All medical records are confidential and the property of the hospital and shall not be removed or transmitted electronically from the premises without permission. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records on file shall be available for the use of the physician or dentist.

b. If any member of the Medical Staff finds it necessary to send photocopies of a medical record to a professional who is not a member of the Medical Staff or an employee of this VA Hospital in order to assess the quality of care rendered, the COS office must be notified of the intended external review. When the COS believes it is appropriate, procedures shall be used to redact the name and identifying numbers of the patient from the photocopied material in order to protect the patient's confidentiality.

c. Free access to all medical records of all patients shall be afforded to Medical Staff members for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient.

d. Secure electronic signatures and handwritten signatures are to be used in medical records. Signature stamp use for medical records is not acceptable.

e. Practitioners should strive to use symbols and abbreviations in Progress Notes which are commonly recognized by fellow practitioners. In CPRS (Clinical Patient Record System) ordering system, the hospital shall use symbols and abbreviations which have been incorporated into the program by VHA Headquarters, because these have been selected to minimize any misinterpretation of resultant orders. Free text orders in CPRS and orders written on paper should use abbreviations allowed in Hospital Memoranda. In addition, there is a list of non-approved abbreviations which pose a potential risk if used. The use of abbreviations on paper should follow guidelines established in the following Hospital Memoranda: Medication Use, 11-15; Patient Records, 136-03; Verification of Correct Surgical/Procedural Site, 11-14.

f. No portion of the medical record will be copied onto portable electronic storage devices such as Blackberries, flash drives, or CDs.

11. Procedure Guidelines

a. Staff physicians under the guidance of the Service Chief must closely supervise the workup of patients, scheduling of cases, assignment of case priorities, the pre-procedure preparation, intra-procedure, and post-procedure care of the patients. This supervision must include a pre-procedure note confirming the resident's findings, diagnosis, and plan of treatment so that ultimately the choice of procedure to be performed is prospectively approved in writing by the staff physician.

b. Except in an emergency, no patient may go to the operating room without a complete history and physical examination recorded in his/her chart plus recorded results of admission lab work and x-rays.

c. A surgical operation or invasive procedure shall be performed only with informed consent of the patient or his legal representative, except in emergencies. Other procedures requiring informed consent and this process (how this is done and who is responsible) for obtaining informed consent are outlined in Hospital Memorandum 11-07, Informed Consent for Clinical Treatments and Procedures.

d. All operations performed shall be briefly described in the progress notes of the patient's electronic medical record immediately after the procedure. The immediate post-operative note shall contain the pre-operative diagnosis, post-operative diagnosis, attending staff, resident staff, procedure performed and description of procedure, findings, anesthesia, estimated blood loss, specimens removed, and complications. The operative report is dictated as soon as possible after the procedure and while the patient is still in the anesthesia recovery phase regardless of location, and before the patient is transferred to another level of care. The operative report is transcribed and available for authentication by the attending within 24 hours of dictation. The attending staff authenticates the dictated operative record within seven calendar days. For other invasive procedures, a post–procedure note shall contain the name of the licensed independent practitioners involved, the diagnosis, the procedure performed, and the post-procedure condition of the patient.

e. Emergency surgery should be performed by house staff only after consultation with a staff surgeon and may be started prior to the immediate availability of a staff surgeon only if the situation is critical.

f. The operating surgeon shall have a qualified assistant at all operations.

g. When a tissue or object is removed from a patient during an operation, the operating surgeon should exercise reasonable judgment in assuring the tissue or object is examined by a hospital pathologist when this is indicated. The following is a list adapted from the UW Health Policies and Procedures on Pathology Specimen Care and Handling, June 2005, of specimens which may be exempt from the requirements to be examined by a pathologist:

(1) Specimens that by their nature or condition are removed only to enhance operative exposure.
(2) Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements.
(3) Foreign bodies (e.g. bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives.
(4) Specimens known to rarely, if ever, show pathological change, and removal which is highly visible post-operatively, such as the foreskin from a circumcision.
(5) Teeth, provided the anatomic name or anatomic number of each tooth or fragment of each tooth is recorded in the medical record.
(6) Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary.
(7) Normal skin, adipose tissue (including liposuction fat), mucosa, cartilage and bone removed during plastic/cosmetic surgical procedures for non-neoplastic disease purposes other than mammoplasty.
(8) Skin or normal tissue removed during cosmetic or reconstructive procedure, e.g., blepharoplasty, abdominoplasty, syndactyl repair, provided it is not contiguous with a lesion and the patient does not have a history of malignancy.
(9) Normal toenails and fingernails.
(10) Scars excised during re-operation of non-malignant disease.
(11) Arthroscopic debridement, menisci, bunionectomies, sesamoid bones, and hammer toes.
(12) Intervertebral disc material.
(13) Bone donated to the bone bank, bone segments removed as a part of corrective or reconstructive orthopedic procedures, e.g., rotator cuff repair, synostosis repair, spinal fusion, falciform ligaments, tendons.

(14) Middle ear ossicles. The surgeon is responsible for determining whether specimens will or will not be sent to pathology.

12. Autopsy

It is VHA policy that permission to perform an autopsy must be requested in every instance when a patient dies while an inpatient, during an outpatient or emergency care visit, or during an ambulatory care procedure. Information about deaths requiring notification of the coroner may be obtained from the Patient Administration Service. The physician provider responsible for the patient at the time of death has the primary responsibility to request permission for an autopsy from the next of kin. Clinicians need to take into consideration any special medical or prior military service-related conditions, the need for accuracy of the death certificate, immediate and long-term contributions to medical knowledge, and the value of findings to the next of kin. Directed or partial autopsy examinations are considered the same as complete autopsies.

The request for autopsy must be documented in the patient's medical record including notation of the participants in the discussion and whether the permission was granted or denied. When permission is denied, the reasons for the denial are to be recorded in the medical record. Whenever possible, the patient's family is given the results of the autopsy, both verbally and in writing, by the Chief of Service.

13. Clinical Service Responsibilities

a. Each clinical service shall conduct at least quarterly meetings to review deaths, complications, infections, significant problem cases, and any other relevant aggregate performance improvement results. These meetings may be held in conjunction with the Medical School department or division. Full-time and part-time Medical Staff members are encouraged to attend at least 50 percent of the meetings of their services. Service Chiefs will assure that important decisions from these meetings are communicated to their staff.

b. All physicians and dentists must be familiar with the hospital disaster plan and know their particular hospital assignment.

c. All Medical Staff members shall participate in their own individual programs of continuing education in order to keep themselves informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh themselves in various aspects of their basic education. Medical Staff members are responsible to see that their own participation in continuing education programs and conferences both in and outside this hospital can be periodically documented.

d. In addition, all Medical Staff will participate in mandatory training as directed by Leadership.

14. Restraint and Seclusion

Patients have a right to be free from physical restraint and seclusion. When restraint and seclusion is considered, either in an emergency or another setting, practitioners should consider whether other alternatives may actually be safer for the patient. Seclusion or restraint may be used only when less restrictive measures are ineffective or not feasible and shall be used for the shortest time possible. All orders for restraint or seclusion must be time limited. Medical Staff and house-staff physicians are responsible for assessing the need for use of restraint or seclusion. Appropriate consultation should be sought and the Hospital Memorandum on this subject followed. Hospital Memorandum 116A-1, "Behavioral Health Restraint and Seclusion Policy", and Memorandum 118-9, "Medical-Surgical Care Restraint Policy", contain expanded specifics on the hospital restraint and seclusion policy.

15. Applicable VHA and Hospital Memoranda

a. The Medical Staff Rules and Regulations on supervision of residents is guided by VHA Handbook, 1400.1, "Resident Supervision", and by Hospital Memorandum 11-16, "Resident Supervision."

b. Medical Center memoranda are considered an extension of the Rules and Regulations. They are available to all staff through the Intranet or from service chiefs. They are available to prospective staff for review upon request.

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Reviewed, revised, and approved by the Medical Executive Committee for the Medical Staff on November 18, 2008.

Approved by the Director for the Governing Body on November 18, 2008.