

**RULES AND REGULATIONS  
OF THE MEDICAL STAFF  
OF THE DETROIT MEDICAL CENTER**

**Detroit, Michigan**

**Incorporating all Amendments Approved Through  
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**THE MEDICAL STAFF OF THE DETROIT MEDICAL CENTER  
RULES AND REGULATIONS**

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## **I. ADMISSION, ALTERNATE COVERAGE, TRANSFER, DISCHARGE AND DEATH OF PATIENTS**

### **A. Patients to be Admitted**

Each of the hospitals of The Detroit Medical Center (DMC) shall accept patients for care and treatment in all disease categories for which it is equipped to provide care. No patient shall be admitted to a hospital of The DMC until it is ascertained that a bed is available.

### **B. Professionals Who May Admit and Care for Patients**

A patient may be admitted to a hospital of The DMC only by a practitioner, who is a member of the Medical Staff, with appropriate privileges to manage and coordinate a patient's care, treatment, and services. A physician Medical Staff Member (attending physician) shall be responsible for the general medical care and treatment of every patient admitted to a hospital of The DMC including the supervision of any house staff members. Dental care and treatment may be provided by a dentist who is a Medical Staff Member, podiatric care and surgery may be provided by a podiatrist who is a Member of the Medical Staff, and Allied Health Professionals may provide medical care and treatment as directed by a Member of the Medical Staff.

### **C. Priority of Admissions**

Patients will be admitted according to the following categories:

1. Emergency - any delay in admission could seriously threaten the life or limb or welfare of the patient.
2. Urgent - any delay in admission of more than forty-eight (48) hours could seriously jeopardize the welfare of the patient.
3. Routine - elective admissions on all services. Whenever beds are available, all elective admissions, including those scheduled for surgery, shall be admitted according to the prevailing admitting policies.

The responsibility for determining the categorization of a patient is that of the attending physician. Willful or continued misuse of Emergency admissions will subject the physician to possible disciplinary actions.

### **D. Admission Information Required of Admitting Medical Staff Member**

Within the limits of his/her knowledge regarding the patient's condition, the admitting Medical Staff Member shall be responsible for providing the following information in the patient's medical record:

1. information needed to properly care for the patient being admitted,
2. information needed to protect the patient from self-harm,
3. information needed to protect hospital personnel and others from potential problems or dangers presented by the patient.

### **E. Patients with Psychiatric Disorders and Potentially Harmful Patients**

1. A patient with a primary diagnosis of mental illness or substance abuse shall be admitted to a psychiatric in-patient unit unless he/she has a serious medical condition requiring the care and facilities of a medical or surgical unit of a hospital.
2. For the protection of patients, visitors and staff, when an admitted patient is or is suspected to be dangerous to himself/herself or others, the attending physician shall request a consultation by a Member of the Department of Psychiatry who will promptly see the patient and make a record of the consultation. If the consultation confirms a probability of danger to self or others, the attending physician and the consulting Psychiatrist shall jointly decide the course of the patient's care, including transfer to an

in-patient psychiatric unit if there is a bed available and the patient's medical condition may be suitably managed in such setting.

**F. Admitting Staff Member's Responsibility**

The Member of the Medical Staff who admits the patient shall be responsible for:

1. the medical care and treatment of the patient in the hospital;
2. accurately and promptly completing the medical record;
3. any necessary special instructions; and
4. transmitting reports of the condition of the patient to the referring practitioner and to the family of the patient, as appropriate.

Whenever these responsibilities are transferred to another Member of the Medical Staff, a statement covering the transfer of responsibility shall be entered in the orders of the medical record. The transfer order is not a valid order until the accepting Member concurs through documentation on the order sheet. Physician-to-physician communication is essential to the effective transfer of a patient's care. The Member who admits the patient shall be considered the primary attending physician, unless this responsibility is transferred, as indicated above.

**G. Admitting Diagnosis Required**

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been recorded in the patient's medical record. In the case of an emergency, such statement shall be recorded as soon as reasonably possible.

**G.1. Emergency Department Medical Screening Exam**

A Medical Screening Exam (MSE) shall be performed by a Qualified Medical Person or Qualified Medical Personnel. Qualified Medical Person/Personnel means an individual or individuals determined qualified and consistent with state licensure to perform a MSE. In the Hospital, qualified medical personnel are limited to physicians, physician assistants, nurse practitioners (AHPs), and registered nurses (RN) who have been deemed qualified for these exams. The SIC, Department of Emergency Medicine, shall determine the qualifications of the Qualified Medical Person/Personnel through education, licensure and competency.

**H. Emergency Admissions**

Physicians admitting emergency cases shall document, in the admission note, facts that clearly justify the patient being admitted on an emergency basis. Such findings must be recorded in the patient's medical record as soon as possible after admission.

**I. Emergency Patients Without Admitting Practitioners**

1. A patient who is to be admitted on an emergency basis and who does not have an existing relationship with a physician who agrees to admit the patient may request a physician in the appropriate department or service to attend him. Where no such selection is made or where the physician selected does not accept the patient, the patient will be assigned according to the on-call schedule in effect at the time.
2. An emergency room physician, when he reasonably believes it is necessary, shall have the authority to require that a patient be seen by the admitting physician, or a physician from the department to which the patient is to be admitted, before the patient is formally admitted.
3. Until this admitting physician is identified and notification takes place, and the patient is seen, if required, the emergency room physician shall remain principally responsible for the admitted patient, including supervision of any House Staff who arrive in the emergency room to attend the patient.

**J. Admission to Special Care Units**

Patients shall be admitted to and discharged from special care units in accordance with the current policies of these units.

**K. In-House Transfers**

Transfer priorities for each hospital shall be determined by that hospital and documented in policy.

No patient will be transferred without such transfer being approved by the responsible practitioner.

**L. Coverage for Patients**

1. Each Member of the Medical Staff shall designate another Member of the Active or Affiliate Staff with the same or similar clinical privileges to be called to attend all his/her patients when he/she is not available for more than twenty-four (24) hours.
2. In case of a Member's failure to arrange for coverage, or when neither the Member nor the designee can be located, the Chief of the Service, the Chief of Staff or the Specialist-in-Chief shall have the authority to call upon an appropriate Member of the Staff to care for the patient.
3. Failure to attend a patient, arrange for coverage, or failure on the part of the designee to attend the Member's patients when called may be grounds for disciplinary action.
4. In the event the patient chooses not to be treated by the Member's designee, the patient will be offered the opportunity to select the Medical Staff Member on-call or another Member with suitable training and experience to manage the patient's condition. However, a physician selected in such a manner shall not be obligated to accept the patient. In such case, another Member will be assigned as stated in 2. above.

**M. Teaching Cases**

All patients shall be available for teaching with the exception of those patients who object or whose physician objects. In the event of such objection, the attending physician shall so indicate by an entered order in the patient's chart.

**N. Discharge by Entered Order**

1. Except as listed below, patients shall be discharged only on the authority of the attending physician. Except under extenuating circumstances, the discharge order shall be entered in the patient's chart so as to permit release of the patient by 11:00 a.m. on the day of discharge.
2. The patient's medical record shall be complete within a period of time that is within the guidelines consistent with Joint Commission and CMS requirements, including progress notes, final diagnosis and clinical resume. A final or provisional diagnosis shall be entered on the chart with the discharge order or promptly after final laboratory or other essential reports have been received.
3. No entered discharge order is required in the following circumstances:
  - a. when a patient is removed pursuant to a disaster plan;
  - b. when a patient leaves the hospital against medical advice (AMA).

**O. Patients Leaving AMA**

Should a patient leave the hospital against the advice of the attending physician or without proper discharge, the patient shall be requested to sign a statement releasing the hospital and its Medical Staff Members from responsibility. If the patient refuses to sign such a

statement, this refusal and the facts surrounding the patient's departure shall be documented in the medical record.

**P. Utilization**

The attending physician is required to document the need for admission and continued stay in an inpatient setting. At a minimum, the documentation must contain the following:

1. an adequate reason for continued hospitalization;
2. the estimated period of time the patient will need to remain in the hospital; and
3. plans for post-discharge care.

**Q. Death of a Patient**

In case of a patient's death, the nursing staff shall notify the attending physician. The pronouncement of death shall be made by the attending physician or his/her designate within a reasonable time. The body shall not be released until an entry recording the death has been made and signed in the medical record.

**R. Request for an Autopsy and Securing Organs for Transplantation**

Every Member of the Medical Staff is expected to be actively interested in securing a meaningful autopsy on cases of interest whenever possible and in obtaining organs and tissues for transplantation as defined by state law. An autopsy may be performed only with an entered consent, obtained in accordance with state laws. All autopsies shall be performed by a hospital pathologist unless the death is reportable to the Medical Examiner or as requested by the family. Provisional anatomic cause of death shall be recorded on the medical record within seventy-two (72) hours; and the complete autopsy protocol should be made a part of the record within ninety (90) days following the autopsy.

**II. ORDERS**

**A. Entered Orders**

All orders for treatment or care shall be entered with date and time recorded, and signed by a Member of the Medical Staff or House Staff, including beeper number. The preferred mechanism for order entry is via the computer, using CPOE (Computerized Provider Order Entry), performed by the ordering clinician. Exceptions are for clinical areas that do not yet have CPOE, during down time, and when the clinician cannot reasonably be expected to have access to a computer with connectivity to the DMC systems. Pharmacists are authorized to write and sign orders under Medical Staff approved protocols. Physician Assistants, Certified Registered Nurse Anesthetists, Certified Nurse Midwives and Nurse Practitioners are authorized to write prescriptive orders according to formulary or approved protocol. Verbal orders from medical staff, house staff member, physician assistant or nurse practitioner may be received by the appropriate personnel as listed in the Medical Staff Rules and Regulations.

Such orders shall be entered in the appropriate section of the medical record and shall include the name of the ordering medical staff, house staff member, physician assistant, or nurse practitioner and signed, timed and dated by the individual receiving the verbal orders. All verbal orders shall be authenticated, signed, timed and dated by the ordering or supervising medical staff within 48 hours.

**B. Persons Authorized to Accept Verbal and Telephone Orders**

The following DMC personnel are authorized to accept verbal and telephone orders:

- a. members of the House Staff;
- b. registered nurses and nurse practitioners;
- c. pharmacists (for medication or therapeutic drug monitoring orders);
- d. dietitians (for dietary and tube feeding orders);
- e. physician assistants, except Schedule 2-5 drugs;

- f. registered respiratory therapist (for respiratory care orders);
- g. physical therapists (for physical therapy orders);
- h. occupational therapists (for occupational therapy orders);
- i. speech therapists (for speech therapy orders);
- j. registered pulmonary function technologist (for pulmonary function tests); and
- k. psychologists (for psychological testing).
- l. Radiation Therapists (for radiation therapy)
- m. Physicists (for radiation therapy)
- n. Dosimetrists (for radiation therapy)
- o. Exercise Specialists (for cardiac rehabilitation)
- p. Laboratory Technologists (for laboratory orders)
- q. Radiologic Technologists (for radiology orders)

**C. Orders for Drugs and Medications**

All orders for drugs and medication shall be reviewed in full and signed, dated and timed by a physician on a regular basis as described in policy.

Orders for antibiotics and other drugs with formulary restrictions will be reviewed in accord with the guidelines established by the Pharmacy and Therapeutics Committee.

**D. Orders for Daily Laboratory Studies**

Orders for daily laboratory studies shall expire automatically after three (3) days unless renewed by the physician. Orders for laboratory studies to be done at specified hourly intervals shall expire after twenty-four (24) hours.

**E. Orders and Care Reconciliation**

The ordering Physician/Allied Health Professional (AHP) is responsible for order and care reconciliation with each encounter, in-house transfer, change of service, or change or level of care. This activity may be completed electronically in the EMR using the current processes available, or via a full review of the medications, patient care orders, problems and diagnoses with the appropriate changes noted in the record. The Ordering Physician shall review and discontinue all entries that are inappropriate for the new level of care. All other existing orders, diagnoses and problems will carry forward in the record and will be active in the patients' profile.

**F. Standing Orders**

Standing Orders, order sets, and protocols for medication orders, requested to be used by a Medical Staff Member shall be approved by the Medical Staff Operations Committee, upon recommendation from the Departmental Advisory Committee and the Medication Use Committee. An order is required before initiation for standing orders to be utilized for individual patients. Copies of standing orders shall be reproduced in the patient's chart in full and signed, dated and timed by the attending physician. These orders shall be followed in so far as proper treatment of the patient will allow, but shall not replace or cancel those orders written for a specific patient.

**G. Restraint Orders**

Restraint orders are time-limited and are valid only for the time periods defined in DMC policy. The continued need for restraints shall be evaluated and documented, and restraints re-ordered if warranted.



### III. DRUGS AND MEDICATION

#### A. Approved Nomenclature

Only those pharmaceutical abbreviations established by the Pharmacy and Therapeutics Committee shall be used in the writing of medication orders. Abbreviations not included on the list must be clarified by the hospital Pharmacy prior to the dispensing of the medication in question.

#### B. Orders

All medications and drugs shall be ordered by name, dosage, route and frequency of administration. Documentation of duration and indication for use is encouraged. If a patient is to take the same medications in the hospital that were taken prior to admission, the attending physician shall continue these medications by name and dosage. Medications brought to the hospital by the patient for the patient's use shall be identified, ordered by name and dosage and not by prescription number, and administered within the framework of the institution's medication distribution system. Unidentifiable medications shall not be given.

#### C. Formulary, Investigational and Non-Formulary

1. Drugs used in the DMC shall meet the standards of the United States Pharmacopoeia National Formulary or New Drugs Evaluated by American Medical Association Council on Drugs, and shall come under the purview of the Pharmacy and shall be classified as Formulary, Investigational, and Non-Formulary.
2. A Formulary drug is a therapeutic or diagnostic agent that is well established as suitable for use in patient care and is stocked in the Pharmacy.
3. Restricted drugs are those for which the Pharmacy and Therapeutics Committee establishes criteria to assure appropriate and efficient care.
4. An investigational drug is one which:
  - a. has not been approved by the Federal Food and Drug Administration (FDA) for general use in humans but has been approved for investigational purposes, or
  - b. has been approved by the FDA for human use for a specific therapeutic purpose but is being used in a research protocol for a purpose not approved by the FDA.

All investigational drugs shall be dispensed by the Pharmacy following approval by the Institutional Review Board (IRB). In emergency circumstances, such drugs may be dispensed, as ordered by the attending physician, without prior approval by the IRB provided such approval is obtained within forty-eight (48) hours, or the drug shall be discontinued. The informed written consent of the patient, parent or legal guardian, as appropriate, shall be obtained before an investigational drug is used. The use of investigational drugs shall be subject to review by the Institutional Review Board.

5. A Non-formulary drug is any drug other than those classified as formulary or investigational, or any brand of a formulary drug not stocked at the time of dispensing. Such a drug shall be obtained by the Pharmacy only when a Member of the Medical Staff requests such in writing to the Pharmacy. In such case, alternative formulary drugs will be considered.

### IV. MEDICAL RECORDS

#### A. Physician's Responsibility

The attending physician shall be responsible for the preparation of a complete, timely and legible medical record for each of his/her patients. All entries shall be authenticated, dated and timed within the timeframe approved by the MEC and noted in applicable Medical Staff Policy.

The medical record's contents shall be clinically pertinent and current. This record shall include:

- (a) the patient's name, address, date of birth and the name of any legally authorized representative;
- (b) the legal status of any patient receiving mental health services;
- (c) emergency care provided to the patient prior to arrival, if any;
- (d) the record and findings of the patient's assessment, including documentation of known allergies;
- (e) conclusions or impressions drawn from the medical history and physical examination;
- (f) the diagnosis or diagnostic impression;
- (g) the reasons for admission or treatment;
- (h) the goals of treatment and the treatment plan;
- (i) evidence of known advance directives;
- (j) evidence of informed consent, when required by hospital policy;
- (k) diagnostic and therapeutic orders, if any;
- (l) all diagnostic and therapeutic procedures and test results;
- (m) all operative and other invasive procedures performed, including procedures performed at the patient's bedside, using acceptable disease and operative terminology that includes etiology, as appropriate;
- (n) progress notes made by the medical staff and other authorized individuals;
- (o) all reassessments and any revisions of the treatment plan;
- (p) clinical observations;
- (q) the patient's response to care;
- (r) consultation reports;
- (s) every medication ordered or prescribed for an inpatient;
- (t) every medication dispensed to an ambulatory patient or an inpatient on discharge;
- (u) every dose of medication administered and any adverse drug reaction;
- (v) all relevant diagnoses established during the course of care;
- (w) any referrals and communications made to external or internal care providers and to community agencies;
- (x) conclusions at termination of hospitalization;
- (y) discharge instructions to the patient and family; and
- (z) clinical resumes and discharge summaries, or a final progress note or transfer summary.

**B. Approved Entries and Forms**

No entry shall be made in the medical record by any person unless he is authorized to make entries in medical records by the MEC. No form should be used unless such form has been approved by the MEC.

**C. Emergency Treatment Notes**

The notes should reflect the reason for the visit, any care and treatment provided, diagnoses, and patient disposition (discharged, admitted, transferred, expired).

**D. History and Physical**

Medical History and Physical shall include, at minimum, chief complaint, history of the present illness, relevant past social and family histories, past medical/surgical history, allergies, medications, review of body systems, physical examination, an assessment and plan of care. A complete H&P shall be performed for inpatients, and for any procedure, that requires anesthesia service, without regard to the patient's inpatient or outpatient status. In Outpatient Hospital Based Facilities where patients receive continuing treatment and care by a medical staff member, the H&P will be completed.

**E. Pre-procedure Evaluation**

No major diagnostic or operative procedure may begin in the absence of an appropriate medical evaluation of the patient. The content of the evaluation is to be appropriate to the risk of the procedure to be performed, the anesthesia/sedation to be used and the condition of the patient and should be adequate to determine the patient's physical, mental and neurological status and needs, the appropriate level of post-procedure care, and the need for additional diagnostic data. Patients presenting for procedures who are not admitted to the hospital (non-inpatients) require at a minimum, a focused review that includes relevant aspects of the patient's history, vital signs, and pertinent physical examination including cardiac and respiratory evaluation, allergies, and medications.

The attending physician or designee must complete and document the pre-procedure evaluation, confirming the findings, conclusions, pre-procedure diagnosis and assessment of risk, before beginning an operative procedure or a major diagnostic procedure. A copy of a recent (within 30 days) history and physical exam may be used for documentation, if it is included in the procedural documents AND updated on the day of the procedure, prior to the beginning of an operative procedure or a major diagnostic test. There must be a written update note reflecting the H&P was reviewed and the patient was examined for any changes, and the changes documented, or indicating there has been no change in the patient's condition since the H&P was performed that might be significant for the planned course of treatment. Alternatively, a shortened procedural history and physical form may be used. Examples of areas where pre-procedural evaluation is required are endoscopy, cath lab, interventional lab, DMC-owned outpatient facilities and surgical centers.

These requirements may be waived in an extreme emergency.

**F. Progress Notes**

Pertinent progress notes shall be recorded daily, and shall be authenticated, dated and timed by the person writing the note. These shall be sufficient to permit continuity of care. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

**G. Daily Patient Visits**

All patients admitted to acute care hospitals shall be visited at least daily by his/her attending physician. Evidence of these daily visits shall be recorded in the patient's medical record.

**H. Operative Reports**

The complete operative report ("Operative Report") shall include detailed accounts of procedures. The Operative Report includes at a minimum: Patient name and hospital identification number, date and time of the procedure, the primary surgeon and any assistant(s), name of the surgery/procedure performed, findings of the procedure, details of the surgical procedure/techniques, any specimen(s) removed or altered, estimated blood loss as applicable, the pre and post-operative diagnosis, type of anesthesia administered, and if any complications, prosthetic devices, grafts, tissues, transplants or devices implanted. The Operative Report shall be fully entered into the medical record within 72 hours following the procedure. In addition to the Operative Report, a post-procedure progress note shall be entered in the medical record immediately after the procedure, before the patient is transferred to the next level of care, in order to provide pertinent information necessary for individuals required to attend the patient. The immediate post-procedure progress note includes name(s) of primary surgeon and assistant(s), procedure performed and description of each finding, estimated blood loss, specimens removed and post-operative diagnosis. The completed report, when entered by a member of the house staff or advanced practice professional, shall be authenticated by the proceduralist or operating physician.

**I. Anesthesia Report**

A report of preanesthetic assessment, reassessment, intraoperative anesthetic management, and postanesthesia care shall be entered in the patient chart. The anesthesia report shall include written documentation of anesthesia services provided including at least the following:

1. the pre-anesthesia evaluation including a review of patient systems, social history, previous drug history and anesthesia experience, allergies, physical assessment, code status, any potential anesthesia problems or risks relating to anesthesia, the modality of anesthesia planned, and evidence that informed consent for the anesthetic plan has been acknowledged by the patient;
2. a review of the patient's condition immediately prior to induction of anesthesia, and documentation of the actual OR time (day of surgery and exact arrival and departure times);
3. a record of all events taking place during induction of, maintenance of and emergence from anesthesia; the graphic display of the anesthetic entries includes dosage and duration of anesthetic agents, medications, intravenous fluid, blood or blood components, a chronological display of patient vital signs, and responses to the delivery of anesthesia care;
4. immediate post-anesthesia assessment of the patient's condition, continuum of care, and condition prior to discharge;
5. summary of post-anesthetic condition within the first 24 hours following surgery, including reference to the presence or absence of anesthesia-related complications and, documentation of actual recovery time.

**J. Consultations on Hospitalized Patients**

1. The patient's physician shall be responsible for requesting consultations via the medical record from appropriately qualified Medical Staff Members when indicated. The consultation request must include the reason for the consultation and whether the request is for consultation only, consultation and management of a problem, and/or transfer of the patient. All requests for consultation must be documented in the medical record.
2. Consultations shall be defined as emergency (STAT) or routine. An emergency consultation requires immediate attention (within four (4) hours) and shall be verbally communicated by physician-to-physician communication. Routine consultations should be answered within twenty-four (24) hours.
3. The consultant must record a summary of his findings, including a review of the patient's record, pertinent findings on examination of the patient, his opinion and recommendations. This report shall be signed by the consultant and made a part of the patient's record. When operative procedures are involved, the consultant's recommendation and findings shall be recorded prior to the operation, except in an emergency.

**K. Obstetrical Records**

The obstetrical record shall include a complete prenatal record, including history of past pregnancies, laboratory data, past medical and social history, physical findings and office visits. The prenatal record shall be a durable, legible copy of the attending practitioner's office record, transferred to the hospital before admission in a form approved by the MEC. In such instances, interval admission notes shall include pertinent additions to the history and any subsequent changes in the physical findings.

**L. Final Diagnosis**

The final diagnosis shall be recorded in full, on the discharge summary, using a recognized system of disease nomenclature. The final diagnosis shall be dated, timed and signed by the practitioner responsible for the patient at the time of discharge.

**M. Discharge Summary**

A discharge summary shall be entered on every patient unless the patient was discharged within forty-eight (48) hours **of admission** and the stay was uncomplicated. For these exceptions, a final summary progress note or brief discharge note shall be sufficient. A discharge summary shall be entered on every patient expiration.

For all patients, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment. All summaries shall include diagnosis; pertinent laboratory, X-ray and physical findings; medical and/or surgical treatment rendered and patient's response to such treatment; patient's physical condition upon discharge; discharge disposition; and instructions that were given to the patient/family for further care.

**N. Symbols and Abbreviations**

Only symbols and abbreviations that have been approved by the MEC may be used when recording patient information. An official record of approved abbreviations shall be maintained by Health Information Management.

**O. Inappropriate Entries**

Documentation in the medical record shall be objective. All inappropriate entries shall be referred to the practitioner's Specialist-in-Chief and may result in a Professional Review Action in accordance with the Medical Staff Bylaws.

**P. Authentication and Corrections**

All clinical entries in the patient's medical record shall be dated, timed and authenticated by the appropriate practitioner. When the practitioner signs an entry in the medical record, he certifies that the entry is accurate. Any change, correction or addition in a record shall be clearly marked as a change or addition and initialed, dated and timed by the practitioner.

It is never appropriate to obliterate an entry in the medical record, to make a change not clearly marked as a change or to remove or rewrite any page or form in the medical record. Any such action shall be immediately referred to the MEC for review and may constitute grounds for a Professional Review Action as set forth in the Medical Staff Bylaws.

**Q. Consent Forms**

Except in the case of life, limb or organ threatening emergencies, or patient incapacitation, every patient treated shall sign a general consent form. After an emergency situation has ceased to exist, the patient or his legal representative shall document consent on such form. In addition, all specific consents appropriate to the proposed treatment or procedure shall be documented prior to the treatment. General and informed consent shall be obtained in accordance with Michigan law and hospital policy and documented only on forms approved by the MEC.

**R. Code Status and Advance Directives**

Code status and advance directive, if known, must be designated on all patients when admitted, in accord with DMC Policy. In the event of a code change, documentation must be present to indicate the reason for the change.

**S. Medical Record Completion and Enforcement Procedure**

The records of patients shall be completed timely and consistent with Medical Staff Rules and Regulations, Medical Staff Policy, and Joint Commission and CMS requirements. Medical record entries will be considered delinquent according to the criteria in the Medical Records

Documentation and Completion Policy (1 MS 015). That policy also governs enforcement of Medical Records Suspension and associated voluntary resignation (**1 MS 040**).

**T. Filing Incomplete Records**

A medical record shall not be permanently filed until it is completed by all responsible practitioners or until it is ordered filed "incomplete" by the Division Chief of Staff of the responsible practitioner who has not completed his portion of the chart.

**U. Release of Information**

Written authorization of the patient or the patient's legal representative is required for release of medical information to persons not otherwise authorized by law to receive this information. Releases of information shall otherwise comply with DMC policy.

**V. Release of Original Records**

All original patient records are the property of the hospital and shall not be taken from the hospital premises except upon a court order, subpoena or legal statute. Removal of a chart from the hospital by a practitioner is grounds for a Professional Review Action including suspension and/or termination of membership.

**W. Access to Charts**

In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner, to the extent permitted by applicable law, in accord with DMC policy. This shall apply whether the patient was attended by the same practitioner or by another.

Access to medical records of patients shall be afforded to Members of the Medical Staff and other healthcare professionals involved in the care of the patient, and for the purposes of research, education and activities associated with monitoring and evaluation of quality and appropriateness of patient care. Research and study projects must provide safeguards for preserving the confidentiality of personal information concerning the individual patients. Subject to the approval of the Chief of Staff and the Administration, a former Member of the Medical Staff may be permitted access to information from the medical records of his patients covering all periods during which he attended such patients in the hospital.

**V. EMERGENCY SERVICES AND ON-CALL SCHEDULES**

Each Departmental Advisory Committee shall be responsible for establishing emergency department and other specialty coverage programs. The Specialist-in-Chief or his designee shall furnish the Department of Emergency Medicine of each hospital, in a timely fashion, monthly rosters of on-call physicians for his respective Department.

**VI. GENERAL RULES REGARDING SURGICAL CARE**

**A. Commencement of Operation**

Surgeons shall be in the operating room and ready to commence operating at the assigned time. The case may be cancelled if the surgeon is not ready to begin within fifteen (15) minutes of the scheduled time of the operation.

**B. Surgical Specimens**

Tissue specimens removed at operation and all foreign bodies needing identification and documentation, as described in hospital policy, shall be sent to the Department of Pathology where a pathologist shall determine the extent of the examination necessary to arrive at a complete diagnosis. The surgeon shall be responsible for the completion of a pathology referral form to indicate the nature of the specimen, the operation performed, the pre- and post-operative diagnoses, and any clinical information necessary for the pathologic evaluation of the specimen. A report of operating room consultations shall be provided in writing by a pathologist at the time of surgery.

### **C. Dental Patients**

1. A patient admitted for dental care is a dual responsibility which involves the dentist or oral surgeon and a physician Member of the Medical Staff. Dentists shall be limited to the diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region as specified for each individual in his delineation of privileges.
2. The dentist shall be responsible for recording a detailed dental history which justifies the hospital admission, a detailed description of the examination of the oral cavity and preoperative diagnosis, a complete operative report, and such progress notes as are pertinent to the oral condition.
3. A physician on the Medical Staff shall be responsible for the care of any medical problems that may arise during the hospitalization and his name shall be entered on the medical record at the time of admission by the dentist. Consultation with a physician on the Medical Staff shall be required whenever medical complications are present. Prior to surgery, the dentist shall ensure that a physician on the Medical Staff or House Staff conducts an adequate medical evaluation of the patient and that the report is entered in the medical record and signed.
4. This requirement for a medical evaluation by a physician does not apply to patients admitted by qualified oral surgeons who have been granted clinical privileges to perform history and physical examinations. Oral surgeons should assess the medical risks of the proposed surgical procedure. Consultation with an appropriate physician shall be required in all cases with complex or serious medical conditions.

### **D. Podiatric Patients**

1. A patient admitted for podiatric care is a dual responsibility which involves the podiatrist and a physician Member of the Medical Staff. Podiatrists shall be limited to the diagnosis, the surgical and adjunctive treatment of diseases, injuries and defects of the foot as specified for each individual in his delineation of privileges.
2. The podiatrist shall be responsible for recording a detailed podiatric history which justifies the hospital admission, a detailed description of the examination of the foot and preoperative diagnosis, a complete operative report, and such progress notes as are pertinent to the podiatric condition.
3. A physician on the Medical Staff shall be responsible for the care of any medical problems that may arise during the hospitalization and his name shall be entered on the medical record at the time of admission by the podiatrist. Consultation with a physician on the Medical Staff shall be required whenever medical complications are present. Prior to surgery, the Podiatrist shall ensure that a complete History and Physical is provided. The History and Physical may be done by the Podiatrist for low risk patients (a normal healthy patient or a patient with mild systemic disease – classified as an ASA (American Society of Anesthesiologists) Score of I, II or III). The complete History and Physical of a high risk patient (ASA score of IV or greater) must be provided by a physician on the day of surgery. Updates to an out-patient History and Physical must be provided by a member of the Medical Staff on the day of surgery.

## **VII. HOSPITAL BASED FACILITIES**

- A.** An appropriate medical record shall be created for every outpatient. A Clinic Note, outlining the services and treatment provided, along with any relevant History and Physical information as deemed appropriate, shall be completed and authenticated for every patient seen by a physician or advanced practice professional. The contents of such medical record shall be in accordance with guidelines established by the Medical Executive Committee. The Medical

Staff, through its Departmental Advisory Committees, may develop appropriate policies and procedures governing the care of outpatients.

- B. A summary list must be initiated for the patient by his or her third visit for patients that receive continuing ambulatory care services. The summary list must contain the following: any significant medical diagnoses and conditions, any significant operative and invasive procedures, any adverse and allergic drug reactions, any current medications, over the counter medications and herbal preparations. The summary list is updated whenever there is a change in diagnosis, medications, allergies to medications and whenever a procedure is performed. Summary list must be readily available.

## VIII. HOUSE STAFF AND ALLIED HEALTH PROFESSIONALS

- A. Each Affiliate House staff appointee and each allied health professional shall comply with the requirements of the Medical Staff Bylaws, Rules and Regulations and Policies that would logically apply to such individuals.
- B. The House Staff shall consist of physicians who are in training in a Detroit Medical Center graduate training program as residents or fellows. This is meant to include those residents from extramural programs who are at the DMC for the purposes of training. Each House Staff member shall participate in patient care under the direction of physicians whose clinical privileges are appropriate to the activities in which the House Staff member is engaged. House Staff members shall be responsible in their clinical activities to the Chief of Service and Department Chair. The duties of a House Staff member will be determined in the context of the respective professional graduate training program requirements. With the exception of the order to admit the patient to the hospital, House Staff may write independent patient care orders without countersignature by a supervising Licensed Independent Practitioner. Medical students, however, may not write independent orders of any kind. Termination or summary suspension of members of the House Staff shall not entitle such member to the procedures rights specified in Article XII of the Bylaws of the Medical Staff. Members of the House Staff are entitled to due process under the Fair Hearing Procedures of the Graduate Medical Education Program.
- C. **Affiliate House Staff**  
Affiliate House staff status is limited to those physicians (including non-DMC residents and fellows) who are employed by the hospital or contract practice group and practice within a limited scope of privileges as defined by the individual department. These individuals will be credentialed according to established DMC policies and procedures and are bound by the Medical Staff Bylaws, Rules and Regulations. As Affiliate House Staff, they are limited to the care and treatment of patients in the hospital and can not independently admit patients. Affiliate House Staff will not vote or hold office and are not required to pay Medical Staff dues.
- D. **Allied Health Professionals (AHP)**  
Allied Health Professionals (AHP) include employees of the DMC and non-DMC employed practitioners. AHPs are not members of the Medical Staff but may request certain privileges through the Medical Staff structure. Any AHP desiring to provide services to patients that are customarily provided by the Medical Staff must be credentialed through the Medical Staff credentialing process. Ongoing performance shall be monitored under the ongoing professional practice evaluation process. AHPs are entitled to due process under DMC Policy 1 MS 007. Associated details can be found in the DMC Medical Staff Policies.

## IX. CONFLICT RESOLUTION

- A. In the event a Member of the Medical Staff or allied health professional or hospital professional employee becomes concerned that the diagnosis, treatment or care of a patient by a Medical Staff Member may be inadequate or inappropriate, the concerned person shall



attempt to notify and communicate his concerns and perceptions to the patient's attending physician.

- B.** In the event the attending physician cannot be reached or the person, after communicating his concerns with the attending physician, believes further consideration and/or action is warranted:
  - 1. if the concerned person is not a Medical Staff Member, the nursing or appropriate clinical supervisor shall be notified of the concerns.
  - 2. if the concerned person is a Medical Staff Member, the Chief of Service or Specialist-in-Chief shall be notified of the concerns.
- C.** In the event the nursing or appropriate clinical supervisor has been notified, and after consideration of pertinent facts, there is the belief that further medical review is warranted, the Chief of Service or Specialist-in-Chief shall be notified.
- D.** In the event the Chief of Service or Specialist-in-Chief has been notified of such concern by the nursing or clinical supervisor or by a Member of the Medical Staff, the Chief of Service or Specialist-in-Chief shall, upon reviewing the situation and possibly examining the patient and/or communicating with the patient's attending physician, take one of the following actions:
  - 1. recommend to the Chief of Staff that an immediate administrative consultation take place to resolve the concern; or
  - 2. advise the Chief of Staff that no further administrative action need be initiated.
- E.** If an appropriate resolution is not forthcoming following notification of the Chief of Service or specialist-in-Chief, the Chief of Staff shall be notified.

## **X. GENERAL RULES**

### **A. Universal Precautions**

All Members of the Medical Staff and allied health professionals shall treat all patients using the current Universal Precautions Guidelines and shall follow appropriate Clinical and Infection Control policies, including Influenza Vaccination (DMC Policy 1 CLN 058).

Standard Precautions by the Centers for Disease Control and Prevention includes the practice of Universal Precautions for blood and body fluids in the care of all patients.

Failure to comply with either the Universal Precautions and/or Influenza Vaccination Policy is justification for temporary suspension, following consultation with the site Chief of Staff and its Vice President of Medical Affairs. The temporary suspension shall be removed immediately upon remediation of the violation, but cannot remain in effect for more than 20 days. A violation not remediated within 20 days shall require action in accordance with the Fair Hearing Process contained in the Medical Staff Bylaws.

### **B. Reporting and Compliance**

The Medical Staff shall comply with all reporting requirements and all other applicable regulations as stated in DMC and/or hospital policy and State or other law.

### **C. Disaster**

In case of a disaster situation, all members of the Medical Staff specifically agree to cooperate with the Chief of Staff and the Disaster Committee to facilitate transfer and discharge of appropriate patients.