

BEAUMONT HOSPITAL, DEARBORN
MEDICAL STAFF RULES AND REGULATIONS
(Revised June 2023)

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10-01-01

Provisional Diagnosis Required on Admission

Except in emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

Approved 11/17/80

10-01-02

Information Required on Admission

Physicians admitting patients shall be held responsible for giving such information as may be necessary to protect other patients from those who are a source of danger.

Approved 11/17/80

10-01-03

Patient Requiring Admission, No Attending Physician

In the case of a patient applying for admission who has no attending physician, he shall be assigned to the member of the Active Medical Staff on call in the service to which the illness of the patient indicates assignment.

Approved 11/17/80

10-01-04

Bed Allocation/Attending-ER

The attending physician calling from his office and the Emergency Room shall have equal access to available beds. Patients shall be admitted on an alternating basis.

Approved 11/17/80

10-01-05

Emergency Patients/Admission to the Hospital

Any patient admitted to the Emergency Department, whose condition warrants immediate admission as an inpatient, should be admitted to the Hospital. Isolation, separation rooms, and treatment rooms can be utilized. The patient can be kept overnight in the Emergency Department, if necessary. The physician attending the patient in the ED is responsible for ascertaining whether the patient's condition warrants immediate admission or whether the patient can be sent home, or if no

beds are available, can safely be transferred to another Hospital. As long as the patient remains in the ED, the care remains the responsibility of the ED physician, unless the care of the patient is transferred to another on-site physician. The care provided will be in consultation with the attending physician and/or consultant.

Procedure for Dr. No Cases

1. Pages to the ED should be answered within 30 minutes. If the first physician on call/resident service (where applicable) cannot be reached, or does not respond within 30 minutes (including second page after 15 minutes), the second physician on call should be paged. If the second physician on call cannot be reached, or does not respond within 30 minutes (including second page after 15 minutes), the Chain of Command should be invoked. See Section 50 06 01 of the Medical Staff Rules and Regulations.

Procedure for Private Patients

1. The Emergency Department physician shall call the private physician or physician to whom the attending has signed out.
2. If the attending or covering physician cannot be reached, or does not respond within 30 minutes, (including second page after 15 minutes), the physician designated will be called. Note: Each member of the Active staff will be given the opportunity to list a designated physician. This name will be listed on the referral cards in the ED.
3. If the designated physician cannot be reached, or does not respond within 30 minutes (including second page after 15 minutes), the Chain of Command should be invoked. See Section 50 06 01 of Medical Staff Rules and Regulations.

Procedure for Clinic and Staff Admissions

1. The attending physician covering a teaching service shall be notified by the resident as per Medical Education Policy on the admission of a patient to the teaching service.
2. If in any situation the attending physician cannot be reached, or does not respond within 30 minutes, (including second call after 15 minutes), the following are called in order for a decision on disposition of the patient.
Program Director/designee
Director of Medical Education

If the above cannot be reached, or do not respond within 30 minutes, (including second call after 15 minutes), the Chain of Command should be invoked. See Section 50 06 01 of the Medical Staff Rules and Regulations.

Revised 05/21/90/Revised 07/15/98/Revised 01/20/03

10-01-06

Emergency Department Admissions

It is the Emergency Department physician's responsibility to determine the necessity for admission when there is a question concerning the admission of a patient to the Hospital, unless an attending physician comes to the Hospital, examines the patient and assumes responsibility for the patient.

Approved 01/19/81/Revised 12/13/96

10-01-07

ED On-Call Availability

Each department shall ensure that a first physician on-call and a second physician on-call (as determined by each department) are provided monthly to the Emergency Department.

Physicians listed on the ED On-call schedule shall be held to the following expectations:

1. On-call Physicians shall ensure that they carry working pagers and/or have left contact numbers with hospital switchboard;
2. Pages to the ED should be answered within 30 minutes. If the first physician on call cannot be reached, or does not respond within 30 minutes (including second page after 15 minutes), the second physician on call should be paged (if exists per specific department). If the second physician on call cannot be reached, or does not respond within 30 minutes (including second page after 15 minutes), the Chain of Command should be invoked. See Section 50 06 01 of Medical Staff Rules and Regulations.
3. If requested by the ED physician to evaluate a patient in person, the consultant should arrive within the timeframe requested by the ED physician, but no later than one hour after the telephone request.
All requests by the ED for consultation should whenever possible be made by telephone call directly physician to physician to ensure that pertinent history and reason for the consultation is clearly communicated. In the event that the ED physician is engaged in critical patient care management and cannot make the call, the ED nurse familiar with the patient should make the call. The reason for the consult must always be directly communicated to the

physician on call, not left with an answering service.

4. Physicians providing on-call coverage to the ED shall be expected to perform any and all duties for which they have been credentialed and received privileges at the time of their appointment or re- appointment.
5. For health reasons and/or upon reaching the age of 60, a member of the active medical staff may be excused from the ED On-Call upon approval of the Chief of Staff.
6. The patient shall be kept in the Emergency Department until a physician has been contacted who will admit the patient.
7. When a specific physician has been notified and contacted successfully by the Emergency Department, the Emergency Department staff shall notify the Admitting Department and the patient unit concerning the final assignment of an attending physician for the patient.

Approved 05/20/85/Approved 01/20/03

10-01-08

Physician Coverage

If a physician is not available for patient coverage, it is the responsibility of the physician to arrange for designated coverage by a physician with equivalent privileges. If the physician is gone for more than four (4) days, it is the responsibility of the physician to notify the Medical Staff Office.

Approved 7/15/98

10-02-01

Standing Orders, Formulation of

Standing orders shall be formulated by conference between the Medical Staff and the Chief Executive Officer of the Hospital. These orders shall be followed insofar as proper treatment of the patient will allow, and when specific orders are not written by the attending physician they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written by the attending physician for the specific patient.

Approved 11/17/80

10-02-02

Standing Order, Newborn Eye Prophylaxis

The application of erythromycin ointment shall be performed in the newborn nursery. The responsibility for ordering the drug lies with the physician. In the event that an order is not written prior to the time of application, erythromycin ointment will be used as a routine standing order.

Approved 08/20/82/Revised 01/15/90/ Revised 11/16/05

10-04-01

Discharge, Order and Record Requirements

Patients shall be discharged only on the order of the physician. At the time of discharge the physician shall complete and sign the records in accordance with the Rules and Regulations of the Medical Staff. Discharge instructions shall be in compliance with all State and Federal Regulations.

Approved 11/17/80/ Revised 03/11/09

10-05-01

Discharge Order for Newborns

All newborns must be seen by a physician prior to discharge.

Normal newborns can be discharged by verbal order of attending physician provided the newborn was seen by a physician within the last twenty-four (24) hours.

Approved 05/19/03/Approved 11/16/05

10-06-01

Emergency Medical Screening Examination – Qualified Medical Personnel

A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act (“EMTALA”) and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under the delegation and supervision of a physician member of the Hospital’s medical staff:

1. Licensed specialty certified nurse practitioners;
2. Licensed specialty certified nurse midwives (obstetrics only); and
3. Physician Assistants.

For nonresident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes required in the Medical Staff Bylaws specifically to include the appropriate Medical Executive Committee ("MEC") and Board approved clinical delineation of privileges form. Actions on membership and privileges shall be subject to MEC and Board approval. Resident physicians may perform the medical screening examination under the supervision of the Emergency Department physician or pursuant to authority granted by the graduate medical education program as evidenced by the resident's progressive responsibility as provided in the residency program's policies and resident documentation.

Approved 12/18/14

20-01-01

Complete Medical Record, Definition of

The attending physician shall be responsible for the preparation of a completed medical record for each patient. The record shall include a relevant history, physical examination, provisional diagnosis, special reports, consultations, progress notes, procedures performed, TNM staging of all analytical cancer cases, condition on discharge, discharge instructions, final diagnosis and any complications as well as dictated discharge summary and autopsy report when available. Use of abbreviations shall be consistent with the hospital's policy on "Use of Abbreviations, Acronyms and Symbols in Clinical Documentation." The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. No Medical Staff member shall be permitted to complete the medical record of a patient who is unfamiliar to him. No medical record shall be filed until it is complete, except on order of the Health Information Management Committee.

All handwritten entries shall be legible and completed in permanent ink and signed, dated, and timed as may be required for compliance with regulatory requirements.

Approved 12/18/95/Revised 09/22/04/ Revised 11/16/05/ Revised 05/13/09

20-01-02

Record Completion for Teaching Patients

The medical record of a teaching patient shall comply with all criteria listed in Section 20-01-01 of the Medical Staff Rules and Regulations. The resident assigned to a teaching patient shall be responsible for completion of the medical record from admission to discharge. Only the attending physician may place final discharge signature to a chart even though the patient is a teaching patient cared for by a resident.

Co-signatures are required for teaching cases as follows: H&P and progress note by the next daily visit and Operative Report, L&D Summary and Discharge Summary within 30 days of discharge.

Approved 08/17/81/Revised 10/15/84/ Revised 09/13/05/Revised 11/16/05

20-02-01

History & Physical, Requirements for

At a minimum, the medical history and physical shall include the chief complaint, history of presenting illness, past medical history, family history (included when deemed contributory by the author) social history, and relevant physical examination, including review of systems.

Inpatient

The physician shall complete the patient's history and physical (H&P) and document it, either by writing legibly in the chart (signed, dated, and timed) or by dictation, within 24 hours of admission and prior to an invasive procedure which places the patient at significant risk and/or for patients who will be receiving moderate sedation. Failure to do so will result in suspension of admitting and consulting privileges until the H&P is complete. If the H&P is dictated, an entry will be made in the chart that the H&P was dictated, and an admission note will be entered that identifies the tentative diagnosis and plan of care. When a patient is readmitted within 30 days for the same or related problem, an interval note reflecting any subsequent changes may be used in the medical record. A history and physical examination may be dictated within, and no more than, thirty days prior to admission. A history and physical dictated within thirty days prior to admission must include a notation by the physician at the time of admission that identifies any subsequent changes or a notation that there are no changes in the history and physical.

Inpatient Monitoring Process/MEC Reporting

When a physician has one or more delinquent history and physical examinations for two consecutive months or two or more in a single month as reported on a monthly audit report, the following action is taken: Physician is notified that he/she must attend the next regularly scheduled Medical Executive Committee (MEC) meeting to discuss the completion of H&Ps. If a physician fails to attend the MEC without prior notification and approval by the Chief of Staff or designee, the MEC will use authoritative discretion on further action, up to and including termination of the physician's privileges. If the physician should receive notification to appear at the next MEC meeting and completes all H&Ps prior to the MEC scheduled meeting, his/her attendance is still required.

Before Surgery

All surgeons shall ensure their patients have a history and physical documented in the chart prior to surgery. If dictated, the transcribed H&P must be on the chart prior to the start of the case. At a

minimum, the signed, dated, and timed H&P should include sufficient patient assessment information to ensure clearance of the patient to proceed with surgery. In an emergency when there is no time to record the complete H&P, a signed, dated, and timed progress note including the pre-operative diagnosis should be written before the surgery.

For Outpatient Procedures Outside of the Operating Room

A brief history and physical is required for outpatients outside of the operating room, who are undergoing invasive procedures which place them at significant risk and/or who will be receiving moderate sedation. The signed, dated, and timed H&P must be completed and on the record prior to the procedure. The history and physical must contain at a minimum, the reason for the procedure, significant medical problems, medications, allergies, vital signs, and examination of the heart, lungs and body system or part where the procedure will be performed.

Admission After Outpatient Procedure

When a patient is admitted to the hospital following an outpatient procedure, the admitting physician shall complete history and physical (H&P - signed, dated, and timed) consistent with the requirement for an inpatient admission.

Ambulatory Setting

A history and physical shall be performed consistent with level of service delivered.

***Approved 11/17/80/Approved 04/20/81/Revised 04/21/86/Revised 02/17/92/ Revised 07/10/00
Revised 08/22/01/Revised 09/16/02/Revised 09/22/04/Revised 11/16/05/ Revised 05/13/09
Revised 3/20/23/Approved 3/30/2023***

20-02-02

Verbal Orders

Who Can Accept, Authentication

All orders for treatments or medications shall be in writing.

An order for medications/diet shall be considered to be in writing if given orally by a physician to a Registered Nurse, Registered Pharmacist, Respiratory Therapist, Nurse Midwife, Certified Nurse Practitioner, Certified Nurse Anesthetist, Physician Assistant or Licensed Practical Nurse (as defined in Division of Nursing Medication Administration Policy).

Registered radiographers, sonographers, technologists, physical therapists, occupational therapists, speech therapists, and clinical office assistants (ambulatory) are authorized to accept verbal orders in specific circumstances as it relates to their areas of care only.

An order for treatments shall be considered to be in writing if given orally by a physician to an individual listed above, as well as, a Licensed Practical Nurse. A diet order shall be considered to

be in writing if given orally by a physician to a Dietitian.

Read-back requirement: All authorized personnel taking verbal orders shall repeat it verbatim back to the physician with a verbal confirmation being received from the physician that the order is correct.

All orders shall be transcribed and signed by the individual receiving same and shall include the name of the physician giving the order. The order shall be reviewed, signed, dated and timed by the responsible physician or his physician designee by the next patient visit.

Verbal and telephone orders shall be reserved for unusual or urgent circumstances when the ordering physician is not present on the care unit, and/or unable to write the orders personally. Physician giving verbal or telephone orders shall have the receiving party read back the order to them. Physicians should not give verbal orders if they are on the unit.

House officers are included in the above expectations.

Physician Extenders (physician assistants, certified registered nurse anesthetists, certified nurse midwives, nurse practitioners and clinical nurse specialists) may also give verbal orders/telephone orders according to formulary and applicable laws in the State of Michigan. The order shall be reviewed, signed, dated and timed by the responsible physician extender by the next patient visit.

Reporting of Physicians to the Medical Executive Committee

Physicians receive notification that cumulative unsigned/not dated (“incomplete”) verbal orders are above predetermined percentage that is in accordance with regulatory guidelines and that they be asked to attend Health Information Management Committee. If unsigned/not dated verbal orders continue to be an issue the HIM Committee can refer the physician to the Medical Executive Committee.

Physician is notified that he/she must attend the next regularly scheduled Medical Executive Committee meeting to discuss incomplete verbal orders. If a physician fails to attend the MEC without prior notification and approval by the Chief of Staff or designee, the Medical Executive Committee will use authoritative discretion on further action, up to and including termination of the physician’s privileges. If the physician should receive notification to appear at the next MEC meeting and compliance with verbal order completions improves prior to the MEC scheduled meeting, his/her attendance is still required to discuss his/her verbal order authentication.

***Medical Record Committee 12/10/80/Approved 07/19/82/Revised 06/21/93/Revised 12/13/96
Revised 4/22/97/Revised 7/10/00/Revised 09/16/02/Revised 09/22/04/Revised 11/16/05
Revised 05/13/09 Revised 3/20/23/Approved 3/30/2023***

20-02-03

Inpatient Medical Record Documentation,
by Advance Practice Providers

History & Physical

Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists may perform, write and/or dictate complete history and physical for patients admitted to the service of the supervising physician. The supervising physician will countersign, date and time this within 72 hours and provide the impression and plan.

Rounding

Physician Assistants and Nurse Practitioners may perform daily rounds and write progress notes, which the supervising physician will countersign, date and time within 72 hours.

Order Writing

Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists may write orders for routine laboratory work, diagnostic tests, medications (as allowed by state licensure) and for consultations after prior discussion with their supervising physician. The supervising physician will countersign, date and time within 72 hours. Initiation of medication orders not previously prescribed can only be done as a verbal or written order from the supervising physician.

Discharge Summary

Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists may write and/or dictate comprehensive discharge summaries, which will be countersigned, with date and time, by the supervising physician within 30 days of discharge.

***Approved 09/22/04/Revised 09/13/05/Revised 11/16/05/Revised 07/15/08/ Revised 05/13/09
Revised 4/2023 /Approved 6/29/2023***

20-02-04

Medical Record Documentation,

by Physician Employed/Contracted Registered Nurse

Order Writing

Physician Employed/Contracted Registered Nurse may write nursing progress notes or act as scribe for sponsoring physician progress notes. Sponsoring physician must sign scribed progress notes at the same visit.

Approved 09/22/04/Revised 09/13/05

20-03-01

Removal of Records

All records are the property of the Hospital and shall not be removed except as required by law, a court order, subpoena, or a search warrant. In the case of the readmission of the patient, all previous records shall be available for the use of the attending physician.

Approved 11/17/80/Revised 11/16/05

20-04-01

Operative Procedures, Documentation of

Operative Report: The operative report shall include an account of the findings at operation including the pre-operative diagnosis, post-operative diagnosis, the name of the primary surgeon and any assistants, the procedures performed, specimens removed and the estimated blood loss as well as the details of the surgical technique. The report shall include the estimated blood loss and specimens removed when applicable. Operative Reports must be done within 24 hrs for Outpatients as well as Inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Physicians who are delinquent in dictation of operative reports for more than 24 hrs shall be placed on Full Suspension.

Post - Operative Note: An operative or other high-risk procedure note must be written immediately upon completion of the procedure before the patient is transferred to the next level of care. The note shall include the name of the primary surgeon and assistants, procedures performed, and description of each procedure findings. The note shall include estimated blood loss and specimens removed when applicable.

*Approved 11/17/80/Revised 12/13/96/ Revised 09/16/02/Revised 11/16/05/ Revised 05/13/09
Revised 04/08/14/Revised 02/21/19*

20-04-02

Emergency Room Record

The Emergency Room Record shall be completed within 24 hours from the time the physician sees the patient in the Emergency Room.

Approved 11/17/80

20-04-03
Circumcisions

All circumcisions shall be noted in the chart.

The physician performing the circumcision must complete a Newborn Circumcision Assessment prior to the procedure if a newborn History and Physical is not already completed and in the medical record. The assessment must minimally include the reason for the circumcision, significant medical history and physical examination of the genitalia.

Circumcisions shall not be performed until the newborn is clinically stable as defined by being able to transfer from the nursery to the mother's room or as deemed so by the attending physician/assigned provider.

Foreskins are exempted tissues and are not sent to the Pathology Department for examination.

If a circumcision was done, the discharge note shall so state.

***Approved 02/15/82/Revised 04/17/89/ Revised 11/16/05/Revised 07/24/07/Revised 09/15/08
Revised 01/07/09/Revised 07/07/10***

20-05-01
Admission Note

An admission note, signed, dated, and timed shall be completed within 24 hours of admission and shall be complete enough to describe the patient's condition. The admitting note shall contain a tentative diagnosis and shall be the responsibility of the physician.

Approved 12/15/80/ Revised 05/13/09

20-06-01

Progress Notes, Requirements for

The attending physician or designated covering physician or physician extender shall see their admitted patients daily and shall document examination in a progress note.

At a minimum, daily progress notes shall include objective physical and diagnostic findings, assessment of the patient's condition and plan. A final discharge note/discharge instruction shall be written stating the final diagnosis and condition on discharge. All medical record entries shall be written legibly, signed, dated, and timed.

Final Progress Note

A final progress note may be substituted for the resume in the case of patients with problem of a minor nature who require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The attending physician must review and countersign the final progress notes that residents write on patients.

The final progress note should include any instructions given to the patient and/or family.

Approved 12/15/80/Approved 2/19/96/Revised 09/16/02/ Revised 05/13/09

20-07-01

Discharge Summary

A clinical discharge summary shall be dictated or written legibly, signed, dated, and timed on all patients hospitalized longer than 48 hours and on all transferred and expired patients. The resume should recapitulate concisely the reason for hospitalizations; significant findings; procedures performed and treatment rendered; the condition of the patient on discharge; and the specific instruction given to the patient and/or family, particularly in relation to physical activity, medication, diet, or follow-up care. The condition on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. All discharge instructions given to the patient must be documented in the medical record. Discharge instructions may be part of the discharge summary, final progress note (when no discharge summary is required) or special form attached to the chart. If the discharge instructions are documented on a separate discharge instruction form, reference must be made to the location of the discharge instructions in the formal discharge summary.

Approved 08/17/81/Revised 11/16/05/ Revised 05/13/09

20-08-01

Incomplete Record, Definition

Inpatient, ambulatory and emergency room records must be completed within 30 days of discharge.

Revised 1/15/96/Revised 8/24/99/Revised 11/16/05

20-08-02

Medical Record Completion System

Inpatient/OPS/Observation Cases/ED Records

Physicians receive notification of all incomplete records available for completion on a weekly basis. When the record remains incomplete 23 days from the first date of availability, the physician will be notified via his/her census information that he/she has 7 more days to complete all medical records (delinquent and non-delinquent). Physicians will also receive a phone call from the HIM Department advising them that all records must be completed within the next seven days.

If a physician does not complete all records within the seven day period, he/she will then receive a letter from the Chief of Staff encouraging the physician to complete all medical records as well as another phone call from the Medical Staff Office. Records are now greater than 30 days old. Failure to complete records during the seven-day grace period shall result in ongoing letters and phone calls.

History & Physicals/Operative Reports:

When an H&P /OR has not been completed within 24 hours, the physician will receive notification. If the H&P/OR is not provided within 24 hours after notification, he/she will receive a phone call or facsimile that an H&P is required. If the H&P is not received within 23 days of first notification a letter will be sent.

Missing Dictations:

If a dictation of a history and physical, discharge summary, consult, or operative report is missing the word of the dictating physician will suffice, however, if the dictations is not retrieved from the system within 24 hours, the physician will be required to re-dictate the report.

Reporting of Physicians to the Medical Executive Committee

If a physician receives three letters due to delinquent charts in a 12-month period, the physician must then attend the next regularly scheduled Medical Executive Committee Meeting to discuss medical record completion.

The MEC will be able to suspend the physician from staff for up to 14 days after reviewing the physician's medical record completion history. Failure to appear before the MEC without prior notification and approval by the Chief of Staff or designee, the Medical Executive Committee

will automatically suspend the physician for a period of 14 days. Appearance before the MEC as well as any action taken by the MEC shall become part of the physician's permanent record and will be considered at the time of reappointment.

Vacation Policy

Vacations are defined as a physician who will be away five or more consecutive days. It is the responsibility of the physician to notify the Medical Staff office, verbally or in writing, of vacation schedules. Physicians on vacation will be allotted one-week post vacation to complete records. Any physician on the incomplete list prior to vacation will remain on the list throughout vacation. Failure to notify the Medical Staff Office of vacation invalidates the one-week grace period.

***Approved 12/19/94/Revised 4/22/97/Revised 1/5/98/Revised 8/24/99/Revised 9/16/02/
Revised 3/14/07***

20-08-03

Death Certificates, Responsibility for Completion

The proper preparation of a death certificate is an important role of the Medical Staff.

Responsibility for completing and signing the death certificate rests with the attending physician, or in the absence of the attending physician, their designated covering physician. Certification of the death, i.e., a completed, signed death certificate, should be provided within the 48 hours immediately following pronouncement of death.

As the death certificate is not an autopsy report, the attending physician shall use their sound medical judgment to complete the certificate based on what is known to them. In the event that the patient expired prior to the attending physician seeing the patient, this information may be obtained from the electronic medical record or consultation with the patient's primary care physician (if they are not the attending). It is the responsibility of the attending physician of record to complete the death certificate regardless of whether or not they saw the patient during the hospitalization in which the patient died.

Regardless of where the patient expires, all deaths that meet pre-defined criteria are reported to the Medical Examiner. Depending on the circumstances of the patient's death, the ME may sign the death certificate, or they will refer the matter back to the patient's attending physician.

Cases in which the attending physician is available but refuses to sign the death certificate will be immediately referred to the Department Chief. The matter may be escalated up the chain of

command, if necessary.

Refusal by the appropriate attending physician to sign a death certificate will automatically result in removal of that physician from the ER call schedule. Additional corrective action by the Medical Staff may also be considered.

Approved: 06/16/16

30-01-01

Consultation, Requirements for

The OHS Standard for timely response to requests for physician consultations shall be 1) STAT and urgent consults: consulting physician to respond to call from ED physician in 30 minutes and then to evaluate patient within the time frame felt to be necessary by the requesting physician, but in any case, not to exceed 4 hours; 2) Routine consults: physician to evaluate patient within 24 hours.

All consultation requests shall include the reason for the consultation and the acuity level of the request, i.e., STAT or Routine.

All STAT consultation requests should be made by telephone call directly physician to physician to ensure that pertinent history, reason for the consultation, and the timeframe in which the consultant needs to be present at the bedside are clearly communicated. In the event that the requesting physician is engaged in critical patient care management and cannot make the call, the call may be made by a nurse, but must be directly communicated to the consulting physician.

All Routine requests will be communicated to the physician per their self-identified calling preference and within sufficient time for the physician to evaluate the patient within 24 hours.

All OHS Physicians shall ensure that they carry working pagers and/or have left contact numbers with hospital switchboards while on call.

Consultations shall be dictated or written legibly within 24 hours of the time the consultant sees the patient. The consultation report shall contain a written opinion by the consultant that reflects an actual examination of the patient and the patient's medical record.

Consultations may be used as the admitting H&P provided they contain the elements of a complete history and physical as defined by the Rules and Regulations of the medical staff.

Approved 07/17/78/Revised 09/16/02/Revised 07/15/08/Revised 05/13/09

30-01-02

Consultation in Case of Potentially Suicidal Patient

If a physician considers a patient potentially suicidal and writes an order for "SUICIDE PRECAUTIONS", an immediate mental health consultation shall be obtained.

IMMEDIATE CONSULTATION--The referring physician shall not delay consultation through the usual channels of communication but contact a psychiatrist personally and obtain assurance of prompt response. If the member of the department requested is not available, the psychiatrist on first call for the department shall respond to these urgent calls.

Approved 12/15/80/Revised 12/18/14

30-01-03

Intensivist Consults and Critical/Intensive Care Medical Management

ICU, CCU, CVCU Areas

All Critical/Intensive Care (ICU, CCU and CVCU) patients shall have a **mandatory** consult by an Intensivist trained and board certified/eligible in Critical Care Medicine. Consultations in these areas for an Intensivist will be completed within at least four (4) hours – or sooner as clinically needed – of the consult being placed. In the interest of patient safety, and as clinically appropriate, the Critical Care Medical Director (CCMD) will intervene if a consult is not completed within this timeframe.

ED, OR Areas

Consultations in Pre Op/OR/Post Op and ED for an Intensivist who is trained and board certified/eligible in Critical Care Medicine will be completed within at least four (4) hours – or sooner as clinically needed – of the consult being placed. In the interest of patient safety, and as clinically appropriate, the Critical Care Medical Director (CCMD) will intervene if a consult is not completed within this timeframe.

3S, 3E, 3N, 3W

For all patients admitted to these units (3S, 3E, 3N, 3W), it is **strongly recommended** that the attending physician consults an Intensivist who is trained and board certified/eligible in Critical Care Medicine. The CCMD will track initial impact of this voluntary approach within 3-6 months of go live to determine if a suggested edit to the Rule and Regulation should be presented to medical staff leadership. Consultations for an Intensivist in these areas will be completed within at least four (4) hours on these units or sooner as clinically needed.

All Areas

The CCMD or their designee shall determine what patients are appropriate for admission (per admission and discharge criteria) to the Critical/Intensive Care and Step-Down units. These criteria should be developed and published by the CCMD within 90 days of go live of this Rule and Regulation.

Additionally, when a patient no longer requires the level of service provided on such unit, the CCMD shall have the authority to:

1. Discharge the patient to the appropriate setting for the patient's continued care, and,
2. Notify the patient's attending physician of the decision to discharge (also notify the surgeon of record if a surgery occurred during the same admission to the hospital).

Any differences of clinical opinion will be referred to the appropriate Department Chief or Chief of Staff for resolution, per the Medical Staff's Chain of Command.

Approved 06/16/16

30-01-04

Consultations in the Nursery

Consultations shall be obtained as needed (if a physician does not have appropriate privileges)

1. Premature infants under four pounds
2. Bilirubin over 15 mg. Percent
3. Newborns with sustained temperatures of 101°F. or over for 14 hours and unstable temperatures
4. Persistent cyanosis
5. Persistent vomiting
6. Abdominal distention
7. Respiratory difficulty
8. Convulsions
9. Abdominal bleeding

Approved 12/15/80

30-02-01

Autopsies

Every member of the Medical Staff shall be actively interested in securing autopsies whenever possible.

- Unanticipated death or unknown complications may have caused death
- Deaths of participants in clinical trials or when a patient is being treated under a new therapeutic trial regiment
- Intra-operative or intra-procedure death
- Death occurring within 48 hours after surgery or an invasive diagnostic procedure

Beaumont Hospital, Dearborn
Rules and Regulations

- All deaths on a psychiatric service
- Deaths due to accidents in the hospital
- Obstetrical deaths or death incident associated with pregnancy within 7 days following delivery
- Neonatal and pediatric deaths, including those with congenital malformations.

It is the responsibility of the Nursing Department to see that Form 11-70, "Authorization for Autopsy", is completed in duplicate before an autopsy may be performed. The attending physician or house officer or on-call physician is responsible for obtaining the autopsy permission and completing the form noting if the autopsy is subject to any restrictions. The form must be signed by the appropriate party. The following priority should be followed in obtaining the signature:

The spouse, an adult son or daughter in order of age, either parent, an adult brother or sister, legal guardian of the person of the decedent at the time of death, or any other person authorized or under obligation to dispose of the body.

This signature must be witnessed by a physician or Oakwood staff member. The physician filling out the form must also sign it. In questionable instances, one of the Hospital pathologists should be consulted. All autopsies shall be performed by the Hospital pathologist or by a physician to whom he may delegate the duty.

Approved 12/15/80/Revised 01/17/89/Revised 05/18/05

30-03-01

Tissues Removed at Operation

All tissues removed at operation shall be sent to Hospital pathologist who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis.

Approved 12/15/80

30-03-02

Tissues, Examination of Gross Specimens

The following specimens shall be examined by gross examination only in the Department of Pathology:

Cataracts
Foreign bodies
Loose bodies
Bunions
Bunionettes
Spurs
Accessory navicular
Bone pins & nuts, etc
Toenails
Hammer toes
Nasal septum
Teeth
Stones (kidney, ureter and gallbladder)
Pacemakers
Intra-uterine devices

Although these specimens are only examined grossly, this does not change the regulation, which requires that all specimens from the operating room be submitted to Pathology for examination.

Approved 12/15/80

30-06-01

Dispensing Medications/Metric Measures

The Metric System shall be used in the ordering and dispensing of all medications at Oakwood Hospital.

Approved 07/19/82

40-01-01

Promptness in the Operating Room

Surgeons must be in the operating room and ready to commence operation at the time scheduled, and in no case will the operating room be held longer than fifteen minutes after the time scheduled.

Operating Room Committee 6/2/8/Approved 06/02/81

40-02-01

Swan Ganz Catheters, Insertion

1. Any physician granted the privilege may perform the procedure in Oakwood Hospital.
2. The physician performing the procedure must have clinical responsibility for the patient, as the attending, or as the consultant at the request of the attending physician.
3. When more than one physician with appropriate privileges is involved in the care of the patient, that physician with the immediate need shall determine the particular device which satisfies this need and perform the procedure.
4. The physician performing the procedure shall be responsible for the proper technique, as well as management of any and all complications that may result.
5. The physician performing the procedure shall be responsible for any requisite studies (i.e. X-rays to determine catheter position and absence of complications) prior to scheduled time of surgery in the event that surgery is to be performed.
6. The procedure may be performed by a resident-in-training, under the direct supervision of the responsible physician, satisfying the prior criteria.

Approved 03/18/86

50-01-01

Reporting of Medical Staff Action to the Chief Executive Officer

After each meeting of the General Medical Staff, the Secretary of the Medical Staff shall transmit to the Chief Executive Officer of the Hospital such reports and recommendations as the Medical Staff may wish to make to him or through him to the Governing Board.

Approved 01/19/81

50-02-01

Director of Medical Education, Appointment of

The Director of Medical Education, a member of the Active Staff, shall be appointed by the Executive Committee subject to the approval of the Governing Board.

Approved 01/19/81

50-03-01

Quality Assurance Activities of the Medical Staff

All quality assurance activities of all Medical Staff committees will be reported to the Quality Assurance Committee and then to the Executive Committee for forwarding to the Board of Trustees.

Approved 10/20/80/Approved 04/21/86

50-03-02

Quality Management Committee, Medical Staff Responses to

When a physician fails to adequately respond in writing or in person to a written query by the Quality Management Committee for additional information within thirty (30) days, the following action is taken:

Physician is notified that he/she must attend the next regularly scheduled Medical Executive Committee (MEC) meeting to discuss the Medical Staff member accountability for quality management. If a physician fails to attend the MEC without prior notification and approval by the Vice Chief of Staff or designee, the MEC will use authoritative discretion on further action, up to and including termination of the physician's privileges. If the physician should receive notification to appear at the next MEC meeting and adequately responds to the Quality Management Committee prior to the MEC scheduled meeting, his/her attendance is still required

Approved 8/22/01

50-04-01

Medical Staff Meetings/Excused Absences

As stated in the Medical Staff Bylaws: Article XI, Section 4

Excused absences are given in response to:

- A. Written notice of illness
- B. Vacation notice indicating the physician is out of town

Excused absences are to be noted on attendance records. No telephone excuses are to be accepted.

Approved 11/17/80

50-05-01

Medical Staff Dues, Collection

Dues are assessed for each medical staff membership category as provided for in the Medical Staff By-Laws, with specific amounts determined after periodic review and approval by the Medical Executive Committee. Dues assessments will be:

- Active category members: \$300. Annually
- Affiliate category members: \$400. Annually
- Consulting category members: \$200. Annually
- Ambulatory category members: \$200. Annually
- Limited category members: \$200. Annually

Failure to pay dues within three (3) months from first notice will result in the loss of all clinical privileges for the physician. The appropriate procedure to be followed by the Medical Staff Office will be:

1. Initial letter, signed by the Vice Chief of Staff, notifying physician of the amount of dues to be paid shall be sent to the physician at his/her designated mailing address thirty (30) days prior to the due date of April 1st.
2. A second follow-up letter will be sent in thirty (30) days from initial notice to the physician at his/her designated mailing address, clearly stating "2nd Notice" and advising physician that failure to pay by the date specified in the letter would result in suspension with loss of all clinical privileges.
3. A final letter will be sent in sixty (60) days from initial notice, by certified mail to the physician at his/her designated mailing address, clearly stating "Third and Final Notice" advising the physician that he/she must pay his/her dues by the date specified in the letter or it would be considered a voluntary resignation from the Medical Staff effective on the specified date.

Approved 11/18/85/Revised 11/28/01/ Revised 03/11/09/Revised 07/17/12

50-05-02

Legal Assessment

All newly appointed Active and Affiliate Medical Staff members will be required to pay a one-time legal assessment of \$100.00. New members will be billed for the legal assessment upon their acceptance to the Medical Staff. Failure to pay the assessment will be handled with the same procedure as the Medical Staff Dues.

Approved 04/20/87

50-06-01

Medical Staff Chain of Command

In the best interest of quality of care and patient safety, the Chain of Command establishes a clear procedure to be followed to ensure the medical direction of patient care in the event that an attending/consulting physician is unable or unavailable to manage his/her patient. The Chain of Command may also be invoked when issues cannot be resolved with a medical staff member(s) directly, to resolve conflicts in the management of patient care, or when other conflicts or unexpected situations arise.

The Chain of Command is as follows:

Chief of Department
if unavailable, Vice Chief of Department
or designee
Chief of Staff
if unavailable, Vice Chief of Staff
or designee

Approved 03/19/03

50-07-01
Medical Protocols, approval of

The Medical Executive Committee and the appropriate standing committee of the medical staff must approve all medical protocols.

Approved 01/26/05

60-01-01
Leave of Absence

Leave of absence may be granted to members of the Medical Staff on recommendation of the respective Department Chiefs. The physician shall submit a written application for leave of absence to his Department Chief who will forward it to the Credentials Committee, through the Executive Committee and to the Board of Trustees. Leaves of absence shall be granted for a period of up to three years. An extension beyond that time will be granted only for unusual and extenuating circumstances.

The Medical Staff member shall request reinstatement of his or her privileges by submitting a written request to his Department Chief for transmittal to the Credentials Committee. A written summary of the staff member's pertinent activities during the period of leave of absence shall accompany the request. The Credentials Committee shall make a recommendation to the Executive Committee and the Executive Committee will make a recommendation to the Board of Trustees concerning the reinstatement of the member's privileges.

Approved 05/18/87

60-02-01
Affiliate Status

Determination of eligibility for Active Status, as follows:

1. That we continue to abide by the ruling that any person on the Active staff who has twelve or more admissions annually is not eligible for transfer to the Affiliate Staff except under extenuating circumstances.
2. That in the Department of Pediatrics, care of newborns is considered the same as admissions for purposes of this ruling.
3. That Hospital consultations shall not be considered as admissions.
4. That clarification of our rules be made in regard to persons who are on the Affiliate Staff and exceed twelve admissions annually. At the time the twelfth admission is accomplished, the staff member shall be advised that he now has twelve admissions for the current year and that if he wishes to continue admitting more patients, he must apply for transfer to the Active staff.

Approved 01/19/81

60-04-01
Transfer to Active Staff

Any member of the Medical Staff requesting a transfer from Affiliate Staff to Active Staff due to patient activity exceeding the maximum level for an Affiliate member (per policy), is not required to complete an application and follow the already established interviewing procedures within that particular department. They may request a transfer of staff status via letter to their department chief.

Medical Staff transfer request to Active Staff, from any other staff status and for any other reason, must complete a new application and follow already established interviewing procedures within that particular department, as well as being processed as any other new applicant.

Approved 07/16/84/Approved 03/14/07

60-07-01
Application, Staff Membership

Beaumont Hospital, Dearborn
Rules and Regulations

Within sixty days of the receipt of the completed application by the Beaumont Hospital, Dearborn, Medical Staff Office, (as defined in the Medical Staff Bylaws, Article 2, Section 3 and Section 4, A & B), the Credentials Committee will forward their findings and recommendations (acceptance, rejection, deferral) to the Executive Committee for action. Applications for physicians who are joining practices of physicians currently on staff at Corewell Health East, Dearborn Hospital, and applications for physicians who are active members of Corewell Health System affiliate hospitals will be given priority status during the review of their application.

Approved 06/16/86 Revised 1/5/98 Revised 3/20/23

60-07-02

Medical Staff Appointment/Reappointment

Each applicant for medical staff appointment and reappointment to the Medical Staff and initial, renewed, or revised delineation of clinical privileges must include the following information, if applicable:

- (1) previously successful or currently pending challenges to any licensure or registration, or voluntary or involuntary relinquishment of such licensure or registration;
- (2) voluntary or involuntary termination of medical staff membership, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another Hospital; and/or
- (3) involvement, if any in a professional liability action, including all final judgments or settlements involving the individual.

Approved 12/13/96

60-07-03

DEA, Requirements for,

All members of the medical staff shall maintain a current Federal Drug Enforcement Agency (DEA) certificate (if applicable) with Schedules 2-5, including 2n and 3n.

Limited staff members shall maintain a current Federal Drug Enforcement Agency (DEA) certificate (if applicable), as appropriate to scope of practice.

Approved 09/22/04

60-08-01

Credentials Committee: Applicant's Request for Privileges

The Chief of each department shall advise the Credentials Committee in writing that he has reviewed and approved/disapproved the applicant's requested privileges and that some correspondence be included in the applicant's file when it is presented to the Credentials Committee for action.

Approved 11/20/89

60-09-01

Credentials Committee: Applicant's Liability Coverage

The Chief of the Departments are responsible for reviewing not only the qualifications and privileges of all candidates but also any aberrant liability information provided by the Medical Staff Office and Risk Management before they write the letters of recommendations to the Credentials Committee.

Approved 2/19/90

60-10-01

Computer Training

A practitioner granted clinical privileges must complete computer (i.e. EPIC) training within three months of appointment to the Medical Staff or granting of clinical privileges, whichever is sooner. Failure to complete training within the prescribed timeframe will be considered a voluntary resignation from the Medical Staff and relinquishment of all clinical privileges.

Approved 6/21/18

70-01-01

Health Information Management Committee

The Health Information Management Committee shall consist of members of the Active Medical Staff representing the various departments and the Administrator or his designate and shall be of sufficient number to cover the prescribed duties. The HIM Administrator shall be a member of this subcommittee. The duties of the HIM Committee are as follows:

It shall require that medical records meet applicable requirements in reflecting patient care and historical validity.

The committee shall meet monthly and submit items for approval to the Quality Council..

The HIM Committee shall assure that the regulatory requirements for medical records have been satisfied.

Approved 01/19/81/Revised 11/16/05

70-03-00

Utilization Committee

The Utilization Committee shall be composed of members representing all departments in sufficient numbers to perform all the tasks assigned to it.

Functions of the Committee:

1. The Utilization Committee shall review admission practices of the Medical Staff, reviewing specific cases as needed to identify improper admission practices. Regular reports shall be made to the Quality Assurance Committee.
2. The Committee shall survey length of stay statistics to determine criteria for average stay and apply these criteria to ongoing reviews to assure the proper use of facilities. Regular reports shall be made to the Quality Assurance Committee.
3. The Utilization Committee shall also review medical records for analysis of quality of care provided and shall refer cases of suspected failure to render acceptable quality care to the Quality Assurance Committee.
4. Within its review procedures, the committee shall establish standards of utilization and assist in educating the Medical Staff in the proper utilization of Hospital facilities.
5. The Committee shall serve the function of evaluating the need of extended stay for particular patients when requested by appropriate authorities. Before reaching a final decision that extended stay in a particular case is not warranted, it shall allow the attending physician involved to present his position, and must so inform him of its decision before sending its final decision to the Quality Assurance Committee and Executive Committee.
6. The Committee shall prepare and maintain an up-to-date plan of utilization review and shall have this plan available for review at all times by accreditation bodies. It must be specific in detail and meet the requirements of all applicable Federal and State laws.

Approved 01/19/81/Revised 04/21/86

70-06-00

Cancer Committee

The Cancer Committee is a standing committee. The membership shall include representatives from Surgery, Internal Medicine, Gynecology, Pediatrics, Diagnostic and Therapeutic Radiology and Family Medicine. It may also include non-voting members from Hospital Administration, Nursing Service, Social Service, Rehabilitation and Cancer Registry.

The Committee shall be concerned with all aspects of care for the cancer patient and that patients have access to consultation services in all disciplines. It shall be responsible for educational programs having to do with cancer. It shall participate in audits encompassing adequacy of work-up, staging and care. It shall be responsible for supervising the Cancer Registry. The committee shall meet at least quarterly.

Approved 1/16/84/Revised 11/16/05

80-01-01

Complete Order, Respiratory Therapy

All respiratory therapy treatment orders must include the following:

1. Treatment modality
2. Frequency
3. Duration
4. Medication as appropriate
 - a. concentration
 - b. dosage
 - c. type and dosage of diluent
5. Oxygen concentration as appropriate
6. Incentive spirometry--designate administration by:
 - a. Respiratory Care personnel
 - b. Nursing staff

All oxygen therapy orders must contain:

1. Type of oxygen administration device
2. Oxygen concentration (%oxygen) (F102)
3. Oxygen liter flow, if applicable
4. Duration of therapy, where appropriate

Approved 07/19/82/Revised 06/21/93

80-01-02

Evaluation of Respiratory Therapy Services

- A. Therapeutic Objectives: Continuing assessment of the effectiveness of Respiratory Therapy modalities should be appropriately documented in the patient's medical record by Respiratory Therapist and physician.
- B. Arterial Blood Gases or Ear Oximetry should be performed to validate the adequacy and effectiveness of continued use of oxygen therapy.

Approved 07/19/82

80-01-03

Standing Orders, Respiratory Therapy

- A. Therapeutic Modalities

If any part of the physician's order is missing, the following order will be used in its place:

1. Frequency: QID
2. Medications: 0.5 cc albuterol (albuterol sulfate) and 2.5cc normal saline (unit dose).
3. Mode: Aerosol Updraft

The physician will be notified as soon as possible.

- B. Oxygen Therapy/Emergency Oxygen Administration

In the event of a patient experiencing labored respiration or shortness of breath or cyanosis, emergency administration of oxygen may be instituted (by R.N. or Respiratory Care personnel) at 2 l/min via nasal cannula.

The attending physician or house officer will be notified immediately after the oxygen therapy is initiated.

Approved 07/19/82/Revised 06/21/93

80-01-04

Automatic Stop Procedure, Respiratory Therapy

(This policy may be superseded by SPECIAL CARE UNIT policies)

- A. Therapeutic Modalities

There is a 2 day (48 hour) stop order on all treatments.

B. Oxygen Therapy

1. All oxygen therapy equipment that has not been used for 48 hours will be discontinued.

C. Notification Process for Automatic Stop Orders.

1. The therapist/technician places a notification on the patient's chart 24 hours prior to discontinuance.

Approved 07/19/82/Revised 06/21/93

80-01-05

Automatic Stop on Patient Transfer

The treatment of any patients going to O.R., or transferred into or out of either I.C.U. or C.C.U. will be discontinued unless reordered after their transfer.

Approved 07/19/82

80-01-06

Investigational Drugs, Respiratory Therapy

When an investigational respiratory drug treatment is ordered, a complete investigational drug consent form must be obtained from pharmacy and signed by the patient before the treatment is begun.

Approved 07/19/82

08-01-07

Arterial Blood Gas Sampling

The Medical Director of the Respiratory Care Department shall have the authority to validate the skill of a Certified Respiratory Therapy Technician and Respiratory Therapist to perform the following special procedure:

Draw arterial blood gases (adult). The therapist who draws the sample will take the sample to the lab and personally report the results to a physician.

Approved 07/19/82/Revised 06/21/93