

**MAINE MEDICAL CENTER  
MEDICAL STAFF RULES AND REGULATIONS**

**PART 1: DESIGNATED ADMISSION OF PATIENTS**

***1-1 TYPES OF PATIENTS***

The Maine Medical Center accepts for care and treatment patients with both acute and chronic illness without regard to race, creed, color, sex, sexual preference, national origin, or ability to pay. The admission of any patient is contingent on the availability of adequate facilities and personnel to care for the patient.

***1-2 ADMITTING PATIENTS***

***1-2.1 Generally***

Only a member of the Attending or Consulting Medical Staff in good standing may admit patients to the Medical Center. All admissions are subject to the official admitting policies of the Medical Center as may from time to time be in effect and to the conditions provided below. The Vice President for Medical Affairs or his designee will submit the names of Medical Staff members not in good standing to the Admitting Office.

***1-2.2 Limitations***

Dentists who have been privileged to perform histories and physical examinations may admit patients to the Medical Center in accordance with current applicable policy.

Dentists not so privileged may admit patients to the Medical Center provided that integral to the admission, a physician member of the Medical Staff with admitting privileges is responsible for the patient. The responsible physician performs a basic medical appraisal (to include a history and physical examination) and an assessment of the overall medical risk and effect on the patient's health of the planned operation or procedure, supervises the patient's general health status during hospitalization and provides care for any medical problem that may be present on admission or that may arise during hospitalization. The dentist is responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the services provided to the patient including a detailed dental history and description of the dental problem necessitating admission and any surgery.

***1-3 ADMISSION CODES BASED ON PATIENT CONDITION***

***1-3.1 Code A - Emergency***

A case may be declared an emergency by the attending practitioner. After communication with the Admitting Office to determine bed availability, such cases may be admitted directly to the Medical Center from the office of the attending physician. Cases declared emergent by the attending Physician after examination in the Emergency Department may be promptly admitted to the Medical Center if beds are available. Under certain circumstances, bed availability may be determined only after consultation with Directors of Special Units, Chiefs of Service, and/or the Vice President for Medical Affairs or designee. In no instance however, shall primary responsibility for the patient awaiting such admission revert from the attending physician to another unless a transfer is effected as prescribed in Part 3-2 of these Rules and Regulations. For each patient admitted as an emergency, the attending practitioner must provide, within a reasonable time after admission: 1) A written note which indicates involvement in the immediate care of the patient, and 2) documentation in the chart sufficient to justify the emergent nature of the admission. Failure to furnish this documentation and information or willful or continued misuse of Code A is grounds for disciplinary action.

**1-3.2 Code B – Urgent**

The attending practitioner having a case which should be admitted to the Medical Center within forty-eight (48) hours must specify as part of his request for urgent admission the reason(s) for such a request. Failure to furnish necessary documentation and information or willful or continued misuse of Code B is grounds for disciplinary action.

**1-3.3 Code C – Semi-urgent**

A case requiring admission to the Medical Center within ten (10) days will be designated semi-urgent. The attending practitioner must specify the reason for such an admission.

**1-3.4 Elective**

This category includes all admissions scheduled in advance and not designated by the attending practitioner as Code A, B, or C.

**1-4 CENSUS MANAGEMENT**

When bed availability is limited, it may not be possible to accommodate all admissions scheduled for a specific day. In that event, the Vice President for Medical Affairs, or designee, will prioritize the cases by condition and will make the ultimate decision regarding admission. In making that decision, the Vice President for Medical Affairs or designee will seek comment from the attending physician, consult with the responsible Chief of service and give due consideration to the inconvenience caused the patient and his family.

**1-5 TIME OF ADMISSION**

Except in emergency cases, the attending practitioner shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same admission day procedures, the attending practitioner must comply with Medical Center policies concerning pre-surgical laboratory tests, documentation, and scheduling.

**1-6 RESTRICTED BED USE AREAS**

Areas of restricted bed utilization and assignment include, but are not limited to, the following:

- A. Special Care Unit (SCU)
- B. Cardiac Intensive Care Unit (CICU)
- C. Neonatal Intensive Care Unit (NICU)
- D. Obstetrics
- E. Pediatrics
- F. Psychiatry
- G. Telemetry Units
- H. Areas designated as "step-down" units
- I. Other such areas as from time to time are designated by the Medical Center as restricted.

The unit or area director or designee, or if there is no such director, the applicable department chairman or nursing supervisor will resolve questions regarding admission to or discharge from any of the above areas.

**1-7 ADMISSION INFORMATION**

Except in an emergency, a patient will not be admitted to the Medical Center (inpatient or outpatient) until a provisional diagnosis or valid reason for admission has been provided by the

attending practitioner with admitting privileges at MMC. The attending practitioner is also responsible for providing applicable patient information concerning communicable disease or infection, behavioral characteristics that would disturb or endanger others, incompetence to sign a consent form and other such information as may influence routine admission policy.

### ***1-8 CLINICAL APPRAISALS AFTER INPATIENT ADMISSION***

The attending practitioner or designee must see and clinically evaluate the patient within twelve (12) hours or within any shorter time frame if warranted by the patient's condition. A physical examination must be performed as part of the clinical appraisal and documented in the medical record within twenty-four (24) hours of admission. Refer to Section 5-2 for specific history and physical examination requirements

## **PART 2: ASSIGNMENT AND ATTENDANCE OF PATIENTS**

### ***2-1 ATTENDANCE OF PATIENTS***

Consistent with the conditions of Section 2-3 below, each patient will be attended by the practitioner of his or her choice provided said practitioner is a member of the Attending or Consulting Medical Staff and has appropriate clinical privileges. A patient presenting for admission who has no personal practitioner may request any practitioner who is a member of the Attending Medical Staff and who has appropriate clinical privileges. When no such request is made or when the requested practitioner chooses not to assume the care of the patient, a member of the Attending Medical Staff with the requisite privileges will be assigned to the patient according to the on-call schedule of the applicable department. Such assignment shall be made without regard to the patient's ability to pay.

### ***2-2 TEACHING SERVICE PATIENTS***

A teaching service patient is managed by a team effort. The attending practitioner is the team leader and retains the ultimate responsibility for the care of the patient. In addition to the attending practitioner, any patient on a teaching service may be seen by the practitioner who is currently designated by the Head of the teaching program as the "teaching attending". Such privileges by the teaching attending are subject to consent of the patient and/or the attending physician and to the observance of customary respect for the physician/patient relationship. House Staff members participate in the patient's care as provided in Section 3-5 of these Rules and Regulations.

### ***2-3 PARTICIPATION IN THE ON-CALL ROSTER***

Each Department develops and publishes an on-call roster. Unless specifically exempted by the Department Chief or his designee, each member of the Attending Medical Staff agrees to participate in the on-call roster. When he or she is the designated practitioner on call, he or she will accept responsibility, during the time specified by the published schedule, for providing care to any patient in any unit of the Medical Center who is referred to the service for which he or she is providing on-call coverage. If there is a conflict with the published schedule, it is the Staff member's responsibility to make reliable and honest provision for change of coverage and to notify the Department Chief and Emergency Division of such change.

### **PART 3: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE**

#### ***3-1 GENERAL RESPONSIBILITY***

Members of the Medical Staff with admitting privileges shall be responsible for the medical care and treatment of each patient in the Medical Center, for the accuracy and prompt completion of those portions of the medical record for which he or she is responsible, for special instructions, for transmitting reports concerning the condition of the patient to the referring practitioner, if any, and for communicating responsibly with relatives of the patient. These several responsibilities belong to the admitting practitioner except when transfer of responsibility is effected pursuant to Section 3-2.

#### ***3-2 TRANSFER OF RESPONSIBILITY***

When the current attending physician intends to transfer the responsibility for a patient's care to another staff member, the transferring physician must document in the record that the second physician has been notified, has agreed to the transfer of patient care responsibility and must enter an order transferring the care of the patient to the second physician. In complex cases, the withdrawing attending physician or designee shall write a comprehensive progress note at the time of transfer.

#### ***3-3 ALTERNATE COVERAGE***

Each practitioner with clinical privileges must assure timely, adequate professional care for his or her patients in the Medical Center by being available or, in the event that the practitioner is unavailable, by designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Medical Center to care for his or her patients. When such designation is absent, or the designated physician is unavailable, the Vice President for Medical Affairs or designee, or the applicable Department Chair or Division Director, has the authority to assign patient care responsibility to any member of the staff with the requisite clinical privileges.

#### ***3-4 DENTISTS***

Dentists may admit patients under the conditions provided in Section 1-2.2 of these Rules and Regulations. Except as provided in Section 1-2.2 of these Rules and Regulations, each dentist shall be responsible for all of those elements of a complete medical record which are required of physician members of the Medical Staff.

#### ***3-5 SUPERVISION OF HOUSE STAFF***

Residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. The teaching staff must determine the level of responsibility accorded to each resident. The attending practitioner may elect to participate in the education program by agreeing to supervise house staff in accordance with the policies of the Department of Medical Education. The attending practitioner retains ultimate responsibility for decision making, patient care and the execution of assigned care responsibilities by members of the House Staff. The teaching attending, with the consent of the attending practitioner, may supervise the care of certain patients on the teaching service. The attending practitioner is not prohibited from writing orders on those patients assigned to house officers on the teaching service.

Medical Staff members have the option of not participating in the education program without jeopardizing their privileges.

### ***3-6 IMMEDIATE QUESTIONS OF CARE***

If any non-physician member of the health care team has reason to question the care being provided to an individual patient by a member of the Medical Staff, he or she shall bring the matter directly to the attention of his or her supervisor, who, in turn, may refer the matter, through channels, to the Division Director, Department Chair, Vice President for Medical Affairs or their designees.

If any non-physician member of the health care team has reason to question the care being provided to an individual patient by a member of the house staff, the non-physician member of the health care team shall bring the matter directly to the attention of his or her supervisor who, in turn, may refer the matter, through channels, to the supervising resident, the teaching attending, the attending physician or their designees.

The aforementioned physician arbitrators may facilitate resolution of the problem by requesting suitable consultation or offering appropriate advice.

### ***3-7 CONSULTATIONS***

#### ***3-7.1 Responsibility***

The good conduct of medical practice includes the proper and timely use of consultation. When indicated or required, the attending practitioner is primarily responsible for requesting a consultation from a qualified Staff member. Judgment as to the correct diagnosis and treatment or the severity of the illness generally rests with the attending practitioner.

#### ***3-7.2 Qualifications of Consultant***

Any qualified practitioner who has been granted the appropriate level of clinical privileges at this Medical Center may be called as a consultant regardless of his Staff category assignment.

#### ***3-7.3 General Guidelines for Requesting Consultation***

Consultation with a qualified practitioner is required in the following cases:

- A. when required by state law;
- B. when requested by the patient or family;
- C. when consultation is a condition attached to the exercise of a particular privilege.

In addition, each attending physician and participating practitioner, as applicable, should request consultation in the following instances:

- A. critical illness in which discussion as to the appropriate therapeutic measures to be utilized would be beneficial;
- B. when the risk of surgery requires critical evaluation;
- C. difficult or equivocal diagnosis or therapy.

### ***3-7.4 Documentation of Consultation***

#### ***3-7.4.1 Consultation Request***

When requesting consultation, the attending practitioner must enter an order for consultation including the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

#### ***3-7.4.2 Consultant's Report***

The consultant must make and sign a report of his or her findings, opinions, and recommendations which reflects an actual examination of the patient and the medical record. The consultant must expediently conduct the consultation unless the requesting physician notes otherwise. Such report shall become a part of the patient's medical record.

#### ***3-7.5 Notification***

The attending practitioner is personally responsible for ensuring that the consultant is notified.

## **PART 4: ORDERS**

### ***4-1 GENERAL REQUIREMENTS***

The practitioner is responsible for all orders for treatment or diagnostic tests. Orders must be clear, legible, and complete. The responsible practitioner must authenticate all orders. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for such administration.

In the case of diagnostic tests, the physician ordering the test and the clinical department performing the tests are responsible for the appropriate scheduling of such tests. The attending physician is responsible for conveying perceived urgency.

Despite the presence or absence of dictated reports, in circumstances where results of these tests might clearly affect the clinical management of the case, it is incumbent upon the attending physician to ascertain the test results, when he or she knows that such tests have been done.

Notwithstanding the foregoing responsibilities of the attending physician, the physician consultant representing the testing facility should contact the attending physician in the event of an unanticipated abnormal finding which, when known, might affect the patient's course of care.

### ***4-2 DEPARTMENTAL ORDER SETS***

Departmental Order Sets, referred to in some Departments as standing orders, may be formulated for routine procedures, specific treatment modalities or diagnoses for any Department, Division, or other clinical unit. The Department Chief, Division Director, or the physician in charge of such clinical unit shall formulate Departmental Order Sets. Assistance in formulating standing orders is available from Nursing Services or the appropriate representative of administration. Standing orders must be reviewed and approved by the Chief of the Department, and the Medical Records Committee prior to implementation and at least every two (2) years for validity and revision, if necessary.

All Departmental Order Sets shall be included in the patient's medical record and must be signed and dated by the responsible practitioner.

#### **4-3 VERBAL ORDERS**

The Medical Center will permit the use of verbal or telephone orders only in certain limited circumstances in accordance with the institutional policy on verbal orders.

##### **4-3.1 Circumstances**

A privileged prescriber may use verbal or telephone orders only when the prescriber cannot reasonably access an MIS terminal. Conditions that would meet the above, but not necessarily be limited to, are the following: (1) codes and similar emergency situations; (2) situations where the prescriber is involved in a procedure or operation where interruption, except in emergent circumstances, would be improper; and (3) the prescriber is not physically present in the hospital.

##### **4-3.2 Authentication**

The responsible practitioner must authenticate telephone or verbal orders within forty-eight (48) hours.

#### **4-4 ORDERS BY ALLIED HEALTH PROFESSIONALS**

An Allied Health Professional (AHP) may write orders only to the extent, if any, specified in the job description developed for that category of AHP and consistent with the scope of privileges individually defined for him.

#### **4-5 AUTOMATIC CANCELLATION OF ORDERS**

Unless a specific order is written otherwise, all previous orders are automatically discontinued when the patient goes to surgery or is transferred to another service or another level of service.

#### **4-6 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS**

Blood transfusions and intravenous infusions must be started by those individuals with requisite training and credentials as set forth by the Transfusion Committee, the Pharmacy and Therapeutics Committee, the Department of Nursing Services, and Maine State Law. Orders for transfusions and infusions must specifically state the rate of administration.

#### **4-7 SPECIAL ORDERS**

##### **4-7.1 Patient's Own Drugs and Self-Administration**

Patients may be allowed to use their own drugs, either administered by the nurse or self-administered, only when the following conditions are met:

- A. the drugs have been identified by a Medical Center Pharmacist, and;
- B. there is a written order for each drug by an authorized prescribing practitioner.

##### **4-7.2 Do Not Resuscitate (DNR) Orders**

The attending physician may write a DNR order, in accordance with established Medical Center policy #1-C-4.

#### ***4-7.3 Institutional Standing Physician Orders***

Licensed health professionals at Maine Medical Center may implement standing physician orders to facilitate patient care delivery, in accordance with established Medical Center policy #1-C-78 Institutional Standing Physician Orders. Institutional standing physician orders are defined as those physician orders which:

1. May be approved for use in more than one clinical division/department.
2. Provide authority and direction for the performance of certain prescribed acts for patients by authorized persons based on defined criteria.
3. Are distinguished from specific physician orders prescribed for a particular patient or individual.

#### ***4-8 FORMULARY AND INVESTIGATIONAL DRUGS***

##### ***4-8.1 Formulary***

The Medical Center Formulary lists drugs available for ordering from stock. All drugs and medications administered to patients, with the exception of agents for bona fide clinical investigation, shall be among those listed in the latest edition of the *United States Pharmacopoeia: New and Non-Official Drugs* or the *American Hospital Formulary Service*.

Each member of the Medical Staff assents to the use of the Formulary as approved by the Pharmacy and Therapeutics Committee. The use of non-Formulary drugs should be reserved for infrequently encountered clinical settings or unique circumstances where there are no Formulary drugs that are appropriate.

##### ***4-8.2 Investigational Drugs***

Use of investigational drugs must be in full accordance with all regulations of the Food and Drug Administration and must be approved by the Institutional Review Board and the Executive Committee of the Medical Staff. Investigational drugs shall be used only under the direct supervision of the principal investigator and in accordance with existing nursing policy. The principal investigator shall be responsible for obtaining all necessary consents and for completing all necessary forms. He or she shall prepare and clarify directions for the administration of investigational drugs as to:

- A. untoward symptoms;
- B. special precautions and administration;
- C. proper labeling of the container;
- D. proper storage of drug;
- E. methods of recording doses when indicated; and,
- F. method of collecting and recording specimens of urine and other specimens.

### **PART 5: THE MEDICAL RECORD**

#### ***5-1 REQUIRED CONTENT***

A medical record shall be maintained for every individual who is evaluated and treated at the Medical Center. Each practitioner providing services to a patient is responsible for preparing such portions of the medical record which are appropriate and necessary to the services provided.



The record shall include:

- A. Identification data;
- B. Personal and family medical histories;
- C. Description and history of present complaint and/or illness;
- D. Physical examination report;
- E. Diagnostic and therapeutic orders;
- F. Evidence of appropriate informed consent;
- G. Treatment provided;
- H. Progress notes and other clinical observations including results of therapy;
- I. Special reports when applicable;
- J. Final diagnosis;
- K. Condition on discharge. The record at discharge should reflect the final diagnosis, discharge medications and instructions, and disposition of the case;
- L. Clinical resume;
- M. Autopsy report when appropriate.

## ***5-2 HISTORY AND PHYSICAL EXAMINATION***

### ***5-2.1 Generally***

A history and physical examination is required for all inpatients and for outpatients undergoing procedures involving the use of general, spinal, or epidural anesthesia, moderate or deep sedation, or those procedures involving an incision into or puncture of a body cavity, even in the absence of moderate or deep sedation or anesthesia. A history and physical examination is not required for outpatients undergoing incisions or insertions that are limited to the skin and subcutaneous tissue or for the placement of catheters or devices in tubular epithelial structures (e.g. esophagus, urethra, anus, nose, bronchus)

If a history and physical is required, the responsible attending practitioner with admitting privileges at MMC must dictate or record in the chart a complete history and physical examination within twenty-four (24) hours after admission of the patient or before surgery or procedure, whichever may come first. The history and physical examination may be delegated to a physician assistant, nurse practitioner, or resident provided the responsible attending practitioner reviews and countersigns the documentation.

### ***5-2.2 Comprehensive History and Physical Examination***

A comprehensive history and physical examination is required for all inpatients whose condition is not of a minor nature, and whose hospital stay is expected to exceed 48 hours. The documentation of the history and physical examination should include the chief complaint, details of the present illness, all relevant medical, social, and family histories, the patient's emotional, behavioral, and social status when appropriate, all pertinent findings resulting from the physical examination and appropriate review of systems, , a diagnostic/therapeutic assessment and a plan. A pediatric history must also include developmental assessment.

### ***5-2.3 Short Form***

The attending practitioner may use a short history and physical examination form in lieu of a comprehensive history and physical examination, as outlined in Section 5-2.2, for:

1. Outpatient procedures involving the use of general, spinal or epidural anesthesia, moderate or deep sedation, or those procedures involving an incision into or puncture of a body cavity, even in the absence of moderate or deep sedation or anesthesia for patient's whose intended postop stay will not exceed 48 hours.
2. Patients with problems of a minor nature whose hospital stay is not expected to exceed forty-eight (48) hours.

A short history and physical examination form may be Department-specific and must contain, at minimum, the indication for the procedure, significant medical/surgical history, medications, allergies, and appropriate physical examination.

If the patient remains hospitalized over forty-eight (48) hours, additional required elements of the comprehensive history and physical examination as per Section 5-2.2 must be documented in the medical record.

#### ***5-2.4 Use of Reports Prepared Prior to Current Admission***

A. External to Medical Center: If a member of the Maine Medical Center Medical Staff with admission privileges has obtained a history and has performed a physical examination within thirty (30) days prior to the patient's admission to the Medical Center, a legible copy of the report may be used in the patient's medical record, provided that a written admission update includes all additions to the history and any changes in the physical findings subsequent to the original report. The history and physical examination and corresponding update completed within 24 hours of admission or prior to surgery or procedure must be signed or countersigned by a physician with admitting privileges at MMC.

B. During prior admission: When a patient is re-admitted to the Medical Center within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used provided the original information is readily available.

#### ***5-3 PRE-OPERATIVE DOCUMENTATION***

##### ***5-3.1 History and Physical Examination & Re-Assessment***

In addition to the history and physical examination, the chart shall also show documented evidence that the operating practitioner or designee has reviewed the chart, examined the patient and recorded findings and recommendations, including the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, and allergies known to be present, within twenty-four (24) hours of the surgery or procedure and must be authenticated by the responsible attending practitioner. This re-assessment by the attending practitioner within 24 hours of surgery meets the history and physical update requirements outlined in Section 5-2.4 above.

Except in an emergency, documented by the operating practitioner in the chart, surgery or any other potentially hazardous procedure, which includes those involving the use of general, spinal or epidural anesthesia, moderate or deep sedation, shall not be performed until after the preoperative diagnosis, history and physical examination have been recorded in the chart. In case

of emergency, the responsible practitioner must enter a note regarding the patient's condition prior to induction of anesthesia and start of the procedure. This note must include critical information about the patient's condition, including pulmonary status, cardiovascular status, blood pressure and vital signs. The practitioner shall record the history and physical examination immediately after the emergency surgery has been completed.

### ***5-3.2 Diagnostic Tests***

Appropriate diagnostic tests must be performed prior to surgery and must be current. Results of such tests must be available prior to the induction of anesthesia. Except in an emergency documented by the operating practitioner, surgery or any other potentially hazardous procedure shall not be performed until the appropriate diagnostic tests results have been recorded in the chart or are readily available (such as radiologic films).

### ***5-3.3 Pre-operative Anesthesia Evaluations***

The anesthesiologists (or other licensed independent professional responsible for the patient's anesthesia care), must conduct and document in the record a pre-anesthetic evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent drug and allergy history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiology patient status classification, condition of the patient prior to anesthesia, and orders for pre-operative medication within forty-eight hours of inpatient or outpatient general, spinal or epidural anesthesia, moderate or deep sedation. Except in cases of emergency, this evaluation will be recorded before pre-operative medication has been administered and prior to the patient's transfer to the operating area. A re-evaluation of the patient is documented immediately before moderate or deep sedation and before general, spinal or epidural anesthetic induction. This re-evaluation typically includes vital signs, status of airway and response to pre-procedure medications.

## ***5-4 PROGRESS NOTES***

### ***5-4.1 Generally***

The attending practitioner is responsible for recording pertinent progress notes which must be timely and dated at the time of observation. The attending practitioner is responsible for progress notes which contain sufficient information to permit continuity of care and provide an accurate description in the medical record of the patient's progress. Each of the patient's clinical problems must be clearly identified in the progress notes, correlated with specific orders and with the results of tests and treatment. The Attending physician or designee must write daily progress notes on acutely and critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem.

### ***5-4.2 By Attending Practitioner When House Staff Involved***

At appropriate intervals during hospitalization, the attending practitioner will personally write a note indicating involvement in the care of the patient, as required by regulatory and licensing agencies and as may be amended from time to time. If the patient's condition warrants, more frequent notes by the attending practitioner are expected.

The supervising physician must document review of House Staff entries. This may be accomplished by: (1) countersigning a note written by a member of the House Staff indicating that the supervising physician concurred with the observations recorded by the member of the House Staff; (2) an independent note by the supervising physician indicating review of the House Staff entries in the medical record.

## **5-5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS**

### **5-5.1 Operative and Special Procedure Reports**

Operative and Special Procedure Reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens recovered, the post-operative diagnosis, and the name of the primary performing practitioner and any assistants. The complete report must be written or dictated immediately following the procedure, and promptly authenticated by the primary performing practitioner. If the report is dictated, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient.

### **5-5.2 Tissue Examination and Reports**

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy of the Operating Room Committee, shall be properly labeled, packaged in preservative as designated, identified in the Operating Room or Special Procedures Suite at the time of removal as to patient and source, and sent to the Pathologist. The Pathologist shall document receipt, and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the pre-operative and post-operative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

## **5-6 OBSTETRICAL RECORD**

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending practitioner's office or clinic record, provided that the record contains all pertinent information as defined in Section 5-2.1. Such record may be transferred to the Medical Center before admission, but an interval admission note must be written which includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 5-2 and 5-3 of these Rules and Regulations.

## **5-7 ENTRIES AT CONCLUSION OF HOSPITALIZATION**

### **5-7.1 Diagnoses and Procedures**

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure, any additional procedures must be recorded in full in the medical record and must be dated and signed by the attending practitioner at the time of discharge. The following definitions are applicable to the terms used herein:

- A. Principal diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the Medical Center for care.
- B. Secondary Diagnoses (if any): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.

- C. Co-morbidities (if any): A condition that co-existed at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one (1) day for about seventy-five percent (75%) of patients.
- D. Complications (if any): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one (1) day.
- E. Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.
- F. Additional Procedures (if any): Any other procedures, other than the principal procedure, pertinent to the individual's stay.

### ***5-7.2 Clinical Resume***

- A. General: A clinical resume must be recorded for all inpatients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, treatment rendered, the condition of the patient on discharge, discharge diagnoses and the disposition of the patient.
- B. Exceptions: A final progress note may be substituted for the clinical resume for the following categories of patients:
  - 1. Those with problems of a minor nature who require less than forty-eight (48) hours of hospitalization;
  - 2. Normal newborn infants;
  - 3. Patients having uncomplicated vaginal deliveries.

### ***5-7.3 Instructions to Patient***

The clinical resume or final progress note must indicate any specific instructions given to the patient and/or significant others relating to physical activity, medication, diet, and follow-up care. Alternatively, the chart must contain documentation of instructions given to the patient and/or significant others in the form of a standard instruction sheet. If no instructions were required, a record entry must be made to that effect.

### ***5-8 AUTHENTICATION***

All clinical entries in the patient's records must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.

### ***5-9 USE OF SYMBOLS AND ABBREVIATIONS***

The use of symbols and abbreviations shall be limited to those approved by the Medical Records Committee. An inventory of approved symbols and abbreviations is available at each Nursing Station and in the Medical Records Department.

### **5-10 FILING**

No medical record shall be filed until it is complete and properly authenticated. In the event that a chart remains incomplete by reason of the death, resignation, or other inability or unavailability of the responsible practitioner to complete the record, the Vice President for Medical Affairs or designee shall consider the circumstances, may enter such reasons in the record and order it filed.

### **5-11 OWNERSHIP AND REMOVAL OF RECORDS**

All original patient medical records, including x-ray films, pathologic specimens and slides, are the property of the Medical Center and may be removed only in accordance with a court order, subpoena, statute, or in accordance with established procedure designed to facilitate continuing or follow-up patient care. Unauthorized removal of a medical record or any portion thereof from the Medical Center is grounds for disciplinary action.

### **5-12 ACCESS TO RECORDS**

Members of the Medical Staff shall not access any patient information through health information systems and/or patient databases unless required to access such information in connection with their obligation to provide medical care to a patient or for bona fide research or educational purposes consistent with preserving the confidentiality of patient information. No Member of the Medical Staff shall give or allow another to use his or her password or other user identification whether or not such individual is an authorized user. Each Member of the Medical Staff understands that his or her password or other user identification shall constitute his or her legal signature and shall be accountable for all actions taken as a result of the use of such password or other user identification. In the event that Members of the Medical Staff reasonably suspect or become aware of any unauthorized use or disclosure of their password or other user identification, they shall immediately change such password or other user identification, and immediately report such unauthorized use or disclosure to the Associate Vice President, Information Systems. Each Member of the Medical Staff shall log-off the health information systems and/or patient databases or password protect his or her computer screens regardless of where the screens are located to ensure that a computer session cannot be used by any other individual when left unattended. No Member of the Medical Staff shall print, copy or download patient information from the health information systems and/or patient databases to any hard drive, diskette, tape or other storage device for purposes other than to provide medical care to a patient or for bona fide research or educational purposes. Each Member of the Medical Staff shall become solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded.

#### **5-12.1 By Patient**

Any patient may, upon written request, have access to all information contained in his or her medical record, unless access is specifically restricted by the attending practitioner for medical reasons. An inpatient may, upon oral request, review the record with consent and in the presence of the attending physician. The attending physician may waive the condition requiring his or her presence.

#### **5-12.2 By Third Parties**

Written authorization by the patient or his or her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 5-12 or by law to receive this information. Release of information shall be in accord with

the existing policy of the Medical Records Department as may from time to time be established.

**5-12.3 For Statistical Purposes and Required Activities**

Patient medical records shall also be made available to Medical Staff members or authorized personnel with an official hospital-approved interest in order to facilitate:

- A. Automated data processing of designated information;
- B. Activities concerned with assessing the quality, appropriateness, and efficiency of patient care;
- C. Clinical unit/support service review of work performance;
- D. Official surveys for hospital compliance with accreditation, regulatory and licensing standards;
- E. Approved educational programs and research studies;
- F. Continuing care by another physician or health care provider.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification. Confidential personal information extraneous to the purposes for which the data is sought shall not be used.

**5-12.4 For Re-admission**

In the case of re-admission of a patient, the attending practitioner or designee(s) shall have reasonable access to all previous records.

**5-12.5 To Former Medical Staff Members**

Subject to the approval of the Vice President of Medical Affairs and with appropriate reason, former Members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods for which they attended such patients in the Medical Center.

**5-13 STANDARDS FOR COMPLETION**

The appropriate practitioner must complete or sign the medical records within fourteen (14) days of availability. A record is considered complete when the clinical resume or discharge note, history and physical, consultative report, operative note, catheterization report, other procedure report, and final diagnoses are assembled and authenticated. Records remaining incomplete fourteen (14) days after being made available to the appropriate practitioner shall be considered delinquent.

**5-14 ADMINISTRATIVE WITHDRAWAL OF PRIVILEGES**

Should a delinquent record exist, a practitioner's privileges to admit or perform elective surgical or medical procedures shall be suspended until all delinquent records are complete. The practitioner may continue to provide services to current inpatients. This suspension shall be termed an administrative withdrawal of privileges. For all legal and medical practice purposes, the practitioner shall continue to retain all clinical privileges, but shall be deemed to have agreed not to exercise any such retained privileges until the administrative withdrawal shall be terminated.

**5-14.1 Notification**

Seven (7) days prior to an incomplete record being considered delinquent, the physician will be notified in writing by the Medical Record Department of the existence of potential delinquent records and the projected date of the withdrawal of privileges.

Forty-eight (48) hours prior to the anticipated suspension of privileges, the physician's office will be notified by telephone by the Medical Record Department of the availability of records and the anticipated suspension of privileges.

**5-14.2 Withdrawal**

Should records remain incomplete as described above, the physician or representative will be notified, on the morning of the day in which the records become delinquent by the office of the Vice President for Medical Affairs, that if the records are not completed by 5:00 p.m. that afternoon, the practitioner's privileges will be withdrawn. Should records not be completed by that afternoon, Medical Records Office will notify the Admitting Office, the ASU, the Endo Suite, the Cardiac Cath Lab and the Operating Room (and other sites that may be identified from time to time) and the physician's office that admitting, elective surgery, and medical procedures privileges have been withdrawn.

**5-14.3 Appeal**

The affected practitioner may appeal the imposition of such administrative withdrawal to the Vice President for Medical Affairs with no further right of Fair Hearing. If the practitioner demonstrates, to the satisfaction of the Vice President for Medical Affairs or designee, justifiable reasons for the delinquent records which caused the administrative withdrawal or other extenuating circumstances, then the Vice President for Medical Affairs will immediately rescind or modify the withdrawal. Justifiable reasons for delinquent records shall include, but not be limited to:

- A. the practitioner or any other party necessary for completion of the record was ill, on vacation, or otherwise unavailable; or,
- B. the practitioner was waiting for the results of a late report and the record is otherwise complete except for the final diagnosis or clinical resume or both.

**5-14.4 Non-Compliance**

If a practitioner shall exercise any retained clinical privileges during such administrative withdrawal, he shall be subject to the processes related to questions of professional behavior as provided for in Article 7 of the Medical Staff Bylaws.

**PART 6: CONSENT TO MEDICAL TREATMENT**

**6-1 GENERAL REQUIREMENT**

The practitioner or designee is responsible for obtaining the informed consent in accordance with Medical Center policy prior to performing any procedures or treatments involving anesthesia, surgical or other invasive procedures, use of experimental drugs, radiation therapy or chemotherapy and other procedures set forth in Section 6-2 below. The form shall provide a reasonable person under all surrounding circumstances with a general understanding of:

- A. the nature and purpose (including potential benefits) of the intended procedures or treatments, and



- B. the usual and most frequent risks and hazards inherent in the proposed procedures or treatments, and
- C. when appropriate, any medically significant and acceptable alternatives, including, when appropriate, the usual risks and hazards inherent in those alternatives.

Such physician performing any procedure or treatment for which informed consent is required represents to the Medical Center by the undertaking of such procedure or treatment that he or she has previously obtained informed consent as required by this rule.

### **6-2 CONSENT FORM REQUIRED**

The practitioner is responsible for obtaining a properly signed, hospital-approved informed consent form. This form shall be completed in a manner consistent with the general requirement above. An executed copy of such form shall be placed in the medical record prior to undertaking any of the following treatments and procedures performed in the Medical Center:

- A. all surgical procedures in the operating room, ambulatory surgical unit and minor procedures room;
- B. use of general, spinal or epidural anesthesia or conscious sedation;
- C. abortions;
- D. excisional or incisional biopsies, excepting superficial skin lesions;
- E. all cardiac catheterization procedures, including elective Swan-Ganz lines;
- F. electrocardioversion;
- G. cardiac treadmill tests;
- H. elective subclavian and jugular catheterization;
- I. all endoscopic procedures;
- J. the following radiology procedures: angiography, percutaneous transabdominal cholangiography, procedures using venous injected contrast media, radiation therapy and radioactive ablation therapy, percutaneous drainage and nephrostomies;
- K. electroconvulsive therapy;
- L. blood transfusion (separate specific consent form)
- M. organ donation.

When a series of such procedures is to be performed as part of a course of therapy, then one executed consent form may be used for all procedures performed pursuant to the course of therapy described in such executed consent form.

Alternatively, certain specified divisions have created specific consent forms which have been approved and authorized for use within that division. These consent forms may be used in place of the standard form.

### **6-3 EXECUTION OF CONSENT FORM**

The consent form required by the Medical Center shall be signed by the patient or, for incompetent patients, by his or her spouse, parent, guardian, nearest relative, or other person authorized to give consent. The form must be completed, dated and signed. The form may be witnessed by the physician or designee providing the information and obtaining the informed consent. If he or she relies on a designee for any part of the process, the physician shall assume responsibility for determining the sufficiency of information supplied

by the designee and the capacity of the patient or his or her representative to execute the form. When necessary, the practitioner may obtain telephone consent from an authorized representative as listed above if properly witnessed by a third party, and such consent is documented on a standard consent form.

**6-4 HOUSE STAFF PARTICIPATION IN INFORMED CONSENT**

Members of the House Staff may execute informed consent forms subject, however, to the provisions of Section 3.5 of the Medical Staff Rules and Regulations governing the responsibility of attending physicians in assigning patient care functions to house staff.

**6-5 TIME FOR PLACING CONSENT FORM IN THE RECORD**

The fully executed form shall be appended to the medical record, as specified under 6-2 above, before the patient is given pre-operative sedation, local or general anesthesia.

**6-6 FACSIMILE COPIES**

Facsimile (FAX) copies may be obtained of fully executed forms, photocopied, and the photocopy appended to the medical record in order to satisfy the requirements of this rule.

**6-7 EMERGENCIES**

If circumstances exist where the performing physician determines that probable health hazards or increased risk of harm will result from delayed treatment or procedures even for the time reasonably anticipated to obtain informed consent from the patient or his or her authorized representative in accordance with the general requirement, then he or she may proceed with the procedure or treatment. The physician must document such circumstances in the medical record.

**6-8 COMPLIANCE WITH OTHER INFORMED CONSENT REQUIREMENTS**

The provisions of this rule are in addition to other Medical Center policies governing the requirements and process for obtaining informed consent, with or without specific consent forms, which policies include abortions, autopsies, photography, treatment of minors, medical treatment orders, obstetrical services, sterilization, mental health services, radiology, anesthesiology, and HIV testing.

**6-9 REPORTING LACK OF INFORMED CONSENT FORM**

If the performing physician attempts to perform procedures or treatment without filing an executed informed consent form when required, Medical Center personnel aware of both the attempt and the lack of an executed form shall report the matter to the performing physician. If the properly executed informed consent form is not immediately provided, the Medical Center personnel shall report the matter directly to his or her supervisor, who, in turn, may refer the matter, through channels, to the Division Director, Department Chair, Vice President for Medical Affairs or their designees.

## PART 7: MEDICAL CENTER DEATH AND AUTOPSIES

### **7-1 MEDICAL CENTER DEATHS**

#### **7-1.1 Pronouncement**

The Attending Physician or designee must pronounce the death of the patient within a reasonable period of time. In the case of the death of a patient covered by a valid Do Not Resuscitate Order, a Registered Nurse may make the pronouncement of death.

#### **7-1.2 Reportable Deaths**

Reporting of deaths to the Office of the Medical Examiner shall be carried out when required by and in conformance with state law, which upon the adoption of these rules provides that the following deaths are medical examiner cases:

- A. Deaths by violence or poisoning;
- B. Suddenly when a person is in good health and with no specific natural diseases sufficient to explain death;
- C. During diagnostic or therapeutic procedures under circumstances indicating gross negligence or when clearly due to unrelated trauma or poisoning unrelated to the ordinary risks of those procedures;
- D. Death of a person under arrest or in custody at a governmental facility;
- E. Death of a person while a patient or resident of a Department of Mental Health or residential care facility unless certified by the attending physician as due to natural causes;
- F. Death suspected of being due to a threat to the public health, and the medical examiner is needed to study the case for public health reasons;
- G. Death involving bodies brought into the state and buried remains uncovered unless by legal exhumation;
- H. Deaths suspected of being medical examiner cases certified by other than medical examiners;
- I. SIDS deaths and all other deaths of children under the age of 18 unless clearly certifiable by an attending physician as due to specific natural causes unrelated to abuse or neglect;
- J. Whenever human remains are discovered not properly interred or disposed of; or
- K. Deaths by any cause without an attending physician capable of certifying the death as due to natural causes.

#### **7-1.3 Death Certificates**

The Attending Physician or his or her physician designee must sign the death certificate unless the death is a Medical Examiner's case in which event the death certificate can be issued only by the Medical Examiner. When a reported case is not accepted by the Medical Examiner, the Attending Physician issues the death certificate.

#### ***7-1.4 Release of Body***

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the Medical Staff or his or her physician designee. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel except upon the receipt from the Medical Examiner of authorization to release the body. All other policies with respect to the release of dead bodies shall conform to state law.

#### ***7-2 AUTOPSIES***

It is the responsibility of every member of the Medical Staff to secure autopsies whenever possible. Proper consent for an autopsy shall be in accordance with applicable state law. Autopsies should be considered in those deaths that meet, but are not limited only to, the following criteria:

- A. Unanticipated deaths;
- B. Death occurring while the patient is being treated under a new therapeutic trial or regimen;
- C. Intraoperative or intraprocedural death;
- D. Death occurring forty-eight (48) hours after surgery or an invasive procedure;
- E. Death incident to pregnancy or an invasive diagnostic procedure;
- F. Any death on the psychiatric service;
- G. Death where the cause is significantly obscured to delay completion of the death certificate;
- H. Death in infants and children with congenital malformation;
- I. Death in which the autopsy may help allay concerns of the family and/or the public regarding the death;
- J. Natural deaths which were subject to, but waived by, forensic medical jurisdiction such as, but not limited to, death on arrival at the hospital, death occurring within twenty-four (24) hours of admission, death in which the patient sustained, or apparently sustained, an injury while hospitalized.
- K. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.

All autopsies shall be performed by a Medical Center pathologist or by qualified designee. The provisional anatomic diagnoses must be recorded on the medical record within seventy-two (72) hours and the preliminary report in thirty (30) days. The complete protocol shall be made a part of the medical record within ninety (90) days. These rules do not apply to cases which according to law must be referred to the Medical Examiner's Office.

**7-3 ORGAN DONATIONS**

It is the responsibility of any member of the Medical Staff to discuss the possibility of organ donations with family members when appropriate and otherwise comply with the Maine Uniform Anatomical Gifts Act and the Maine Medical Center Procedure on Organ Procurement for Clinical Transplantation.

**PART 8: ENFORCEMENT**

Violations of any of these General Rules and Regulations by the Medical Staff may constitute grounds for initiation of the processes relating to questions of professional competence or conduct provided for in Article 7 of the Medical Staff Bylaws, which states that these processes may be initiated by the President of the Medical Staff, the Vice President for Medical Affairs or the Chief of the relevant department.

**PART 9: AMENDMENT**

These General Rules and Regulations may be amended, or repealed, in whole or in part by a resolution of the Executive Committee recommended to and adopted by the Board.

Revised MEC 3-1-02  
Revised Full Medical Staff 4-1-02  
Revised Board of Trustees 4-11-02  
Revised MEC 10-5-05  
Revised Board of Trustees 11-2-05  
Revised MEC 11-3-06  
Revised Board of Trustees 12-6-06  
Revised MEC 7-29-08  
Revised Board of Trustees 8-6-08  
Revised MEC 8-15-14  
Revised Board of Trustees 9-3-14