The following list has been developed in order to summarize and highlight aspects from the Medical Staff Bylaws, Rules and Regulations and Policies that apply to everyday physician practice in the hospital.

All Medical Staff members should be aware of these and will be asked to sign a statement that they will abide by these as part of their medical staff role.

1. **Call Coverage:** Each Medical Staff member must have on file in the Medical Staff Office the name(s) of at least one appropriately qualified Staff member or call group who has agreed to serve as his/her alternate.

2. **Advanced Directives, Code Status:** Physicians should make reasonable efforts to ascertain the wishes of their patients regarding resuscitation in the event of cardiac or respiratory arrest (e.g. code status, Advanced Directives) and document this information in the chart.

3. **ED Back-up Responsibilities:** All practitioners are expected to respond to requests from the ED to assume care of patients to the extent of their privileges. If the care is beyond the scope of their privileges, the practitioner is responsible for arranging for an appropriate provider to assume care. Decisions to transfer patients to other facilities must be made according to departmental guidelines and hospital policies/regulations. Refusal to respond to the ED without personally evaluating the patient is considered a violation of the Medical Staff Bylaws.

4. **Timely evaluation of patients:** The attending physician or designate must evaluate all new patients within 24 hours of admission. Inpatients must be rounded on daily with a progress note made to document that visit. The Attending Physician is ultimately responsible for the care of the patient. Upon admission to the Critical Care Unit, the Attending physician will be notified immediately. The Attending should see the patient within a period of time commensurate with the medical needs of the patient. If there is any significant change in the patient condition, the attending physician should be called immediately.

5. **Physician Documentation:** All physician documentation must be legible. Physician signatures must either be legible or followed by the physician’s hospital number or printed version of the physician’s name.
   a. **History and Physicals:** All patients admitted to the hospital as either inpatients or outpatients must have a history and physical available to be placed on the chart within 24 hours after admission. A previously dictated complete H&P may be used for this purpose if it has been dictated within 30 days of the patient’s admission. If this H&P is used, though, an interval note updating the patients condition, meds, etc. must be written or dictated and placed on the chart in conjunction with the previously dictated complete H&P. The only exception to this is when the complete H&P has been dictated within 24 hours of the patient’s admission.
   b. **Pre-operative or pre-procedure H and P’s:** A valid H&P must be on the chart prior to any procedure being performed. When emergency surgeries or procedures are performed, a brief pre-op note or the Emergency Department note may suffice. Immediately after the procedure, the full H&P should then be written/dictated.
   c. **Discharge Summaries:** A complete discharge summary must be written or dictated on all inpatients and outpatients. Patients undergoing outpatient procedures must have a brief summary written on their chart in the event that the patient requires re-evaluation prior to the dictated note being available. The Day of Discharge Form should be filled out on all inpatients prior to discharge for the same reason. If a patient is being transferred to a Skilled Nursing Facility or other healthcare facility, the discharge summary must be written/dictated prior to transfer.
   d. **Post-operative notes:** A post-procedure note must be written in the progress notes immediately upon completion of the procedure. Key elements to be included in the note include pre- and post-operative diagnoses, names of surgeon and assistants, type of procedure, complications or significant findings, and estimated blood loss. A complete operative report must then be dictated within 24 hours of the procedure.
   e. **Documentation of co-morbidities, secondary diagnoses, and complications:** All physicians should perform accurate documentation of all aspects of the patient’s care. Utilization management personnel may place prompts in the chart when they feel that the documentation is not consistently supporting the level of care the patient is receiving. Physicians are expected to respond to these prompts. Charts will be held as delinquent if this is not done.

6. **Dictation:**
   a. All PRMCE related dictations may be done through the hospital’s dictation service.
   b. Regular dictations will have a turn-around time of 24 hours. Stat dictations will have a turn-around time of 2 hours. Appropriate work-type, patient account number and spelled patient name, and physician(s) name must accompany all dictations.
7. **Informed Consent:**
   a. Documentation of Informed Consent by the physician must be on the chart prior to procedures or operations.
   b. Informed consent must be obtained prior to any invasive and/or operative procedure and, if risks, benefits and alternatives are not specifically addressed in the informed consent, the discussion between the physician and patient must be documented in the H&P, or progress notes.

8. **Physician Orders:**
   a. All orders for treatment shall be in writing. Transcription of orders dictated by telephone shall include the name of the dictating practitioner plus the name of the authorized person transcribing the orders. The ordering prescriber for Class II controlled substances must sign all verbal orders within 5 days.
   b. All orders written prior to surgery will be canceled at the time the surgery is performed.
   c. Only practitioners holding a currently valid DEA (Drug Enforcement Agency) Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category.
   e. All preprinted orders require approval by appropriate Hospital and Medical Staff committees prior to use.
   f. Orders for restraints shall be per Hospital policy.

9. **Consultations:**
   a. Any practitioner with privileges in the Hospital may be called upon for consultation within his/her area of privileges as sanctioned by the respective Divisions/Sections and the Credentials Committee. It is preferable for consultation requests to occur through physician-to-physician contact.
   b. Emergencies excepted, consultation is required when: (1) the diagnosis is obscure; (2) a question exists as to whether or not a specific surgical procedure or proposed method of therapy is appropriate, or (3) the patient has failed to respond to therapeutic measures over an extended period of time.
   c. It is recommended that physicians admitting patients to the NICU or ICU/CCU consult with the appropriate specialist (cardiologist, neonatologist/ARNP or intensivist/hospitalist) when there is any question as to the appropriate diagnosis or treatment.
   d. Consultations should be conducted within 24 hours of request. Following evaluation of patient and dictation of consultation note, the consultant should continue to follow the patient. The decision to discontinue consultative services should be reached by agreement between the primary attending and the consultant.

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Signature                      Date

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Print Name