MEDICAL STAFF

RULES AND REGULATIONS

MEDICAL CENTER OF CENTRAL GEORGIA

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ADMISSION AND DISCHARGE OF PATIENTS

1. Only a member granted admitting privileges by the Medical Staff and who is not currently on the medical records delinquency list may admit a patient to the hospital. All practitioners shall be governed by the official admitting policy of the hospital. This policy includes requirement for providing comprehensive information to the Patient Access department to determine the appropriate level of care required to care for the patient.

2. No patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission, as well as a pertinent treatment plan and orders are provided. The admitting diagnosis should reflect the medical reason for the current admission. The physician is also responsible for communicating any and all co-morbidity's that would ensure appropriate bed placement. All diagnoses will remain confidential as per the hospital confidentiality policy.

3. For all cases, including Medical Observation, outpatient surgery and diagnostic procedures, the admitting physician or designee should contact the Patient Access Department. The Patient Access department is staffed with Registered Nurses who will conduct a screening for medical necessity, check on availability of resources, appropriateness of setting and check on managed care issues. The Patient Access staff will inform the physician of the results of the screening, including any conflict in the requested patient type and the screening criteria to determine the appropriate level of care and the bed assignment. The Patient Access department will make all arrangements for incoming patients from outlying facilities to the Emergency Department and direct admits to a nursing unit from a Nursing Home. The Patient Access Department will not, however, make arrangements for patients being brought to the Emergency Department from physician offices, outlying clinics, urgent care centers, or directly from pre-hospital care scenes. Nor will Patient Access make arrangements for maternal and neonatal transports to Labor and Delivery or to the NNICU from outlying facilities. Patient Access is accessible 24 hours a day and may be reached by dialing 633-1120 or 1-800-647-9111.

   In the event a physician wishes to transfer a patient from another facility to the Medical Center, he/she must contact Patient Access prior to the transfer with the patient information, including the reason for the transfer, the treatment plan and orders. Once the appropriateness of the transfer has been determined based on the availability of resources and bed availability, the Patient Access staff will coordinate the transfer with the transferring facility. Physician orders may be faxed to 633-1811.
   A physician wishing to transfer a trauma case to the Medical Center should contact Patient Access who will contract the Trauma Attending physicians to assess the case for appropriateness of the transfer, bed and resource availability. After receiving approval for the transfer from the Trauma attending, Patient Access will coordinate the transfer

from the transferring facility. The Medical Center will observe and adhere to all EMTALA regulations.

4. Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee of the Medical Staff and the Administration of the hospital that the said emergency admission was a bona fide emergency. The History and Physical must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's medical record as soon as possible after admission, as a hand written note and/or a dictated history and physical within 24 hours.

5. A patient admitted from the Emergency Department or one of the Quick Meds who does not have a private practitioner may request any practitioner in the applicable department to attend him/her. The Emergency Department or Med Center will contact the requested physician or the physician who is on call for the requested physician. In the event the physician is unable to accept the patient or when no such selection is made, a member of the active or associate staff on call in the appropriate department will be contacted to accept the patient. The Chair of each medical staff department shall be responsible for assuring the submission of all call schedules (including all divisions and subdivisions of the department) at least 15 days prior to the effective date of the schedule. The call schedule should be submitted to the Emergency Department and Patient Access. Each department shall develop its rules for taking call and provide them in writing to the Medical Executive Committee and to the Board for approval.

6. Should a patient require readmission within thirty (30) days post discharge for the same or a related condition, the most recent Admitting/Attending physician (or his/her designee) must assume initial responsibility for the care of that patient. This continuity of care requirement does not preclude appropriate specialist consultation at the time of readmission, but does apply to all departments including academic services.

7. Each member of the Medical Staff is responsible for naming an alternate physician who will assume the responsibility of the care of his/her patients who are hospitalized or require admission or consultation when he/she is unavailable to render care. Failure of the attending physician to make advance arrangements may be grounds for corrective action. In case of failure to name such alternate, the chair of the appropriate division, the Medical Director, the Chief of Staff, the Administrator or his/her designee shall have the authority, in that order, to appoint another appropriate member of the active staff.

   Call coverage must be provided by another physician of comparable credentials and privileges who is a member in good standing of the medical staff and who can respond to call in twenty (20) minutes. The on-call physician must be able to be physically present within a reasonable period of time depending on acuity. In most cases, this means that a physician of like specialty training would be required. However, there are instances in which certain subspecialties may appropriately cover for another. Unless

specifically approved by the chairman of the department it would be expected that a colleague provide coverage in the same specialty or subspecialty. Failure of a "covering" physician to respond appropriately will be considered a violation and will be forwarded for peer review. The attending physician will be notified of the failure to respond by the on-call physician.

All responses by physicians must be in a reasonable time. Repeated failure of a physician to respond in a reasonable time will require intervention of the department chair.

If a physician does not respond within the time frames above, the Medical Director, Department Chair, and Chief of Staff have the authority to temporarily suspend that physician's privileges.

The approved method of contact is through the physician's office telephone that should be answered by an answering service and/or answering machine that can be in immediate contact with the physician.

8. It is extremely important that admitting physicians use careful judgment in classifying admissions. Declaring a patient emergency when no physical reason is presented may be detrimental to subsequent emergency cases and is adequate cause for disciplinary action by the Medical Executive Committee.

    1. **Emergency Admissions** – In the opinion of the admitting physician, any delay in admissions and treatment will be or may be detrimental to the physical well being of the patient. Every attempt will be made to make a bed immediately available.

    2. **Urgent Admission** – Those cases that, in the opinion of the admitting physician, any appreciable delay in the admission and treatment (longer than 48 hours) may be detrimental to the physical well being of the patient. Such an admission will be moved to the top of any waiting list of elective admissions, which exist because of a shortage of beds. Patient Access will discuss other urgent cases awaiting admission with the admitting physician to determine priority for his patient. Patient Access will obtain pre-certification for urgent and emergency admissions.

    3. **Elective Admissions** – Those cases that, in the opinion of the admitting physician, a delay in admission and treatment will cause little or no significant risk to the physical well-being of the patient. Pre-certification numbers must be provided to the Pre-Access Center in Patient Access at the time the reservation or request for admission is made.

9. In collaboration with the Nursing Staff, the Patient Access department will determine appropriate bed assignment and utilization based on the patient specific clinical needs and bed availability throughout the hospital.

10. The admitting physician shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatsoever.

11. For the protection of patients and of the Medial and Nursing staffs and the hospital, any patient known to be harmful to himself/herself or others (homicidal or suicidal) may not be admitted to a general medical/surgical area, unless first cleared by a psychiatrist or mental health evaluator. (See suicidal patients)

12. Case Management - The attending practitioner is required to provide the necessary information regarding medical necessity and plan of care when requesting a bed and to document the need for admission and continued hospitalization as identified by the Utilization Management Committee and approved by the Medical Staff. This documentation must contain:

    a. an adequate written record of the reason for admission and continued hospitalization, including signs and symptoms and treatment plan. A simple reconfirmation of the patient's diagnosis is not sufficient.

    b. When ordering electronically, the physician shall enter Initial Status Orders in the Power Plan. Refer to Downtime Policy for paper process related to Initial Status Orders. The screening conducted by Clinical Intake will assist the physician in making the determination of the appropriate level of care. If the patient's clinical condition changes to require a different level of care (from Medical Observation to Inpatient), an order for the status changes must be written.

    Effective October 20, 2009: To facilitate timely determination of the appropriate level of care and registration status, The Medical Center of Central Georgia's Utilization Management Committee utilizes the services of Executive Health Resources (EHR) in lieu of direct involvement by the committee physician membership. **The Transfer Center nurse obtains the clinical information from the admitting physician and applies the appropriate InterQual Inpatient criteria.** If there is insufficient clinical evidence to support Inpatient status, the case will be referred to the E.H.R. physician advisor for determination. The E.H.R physician advisor(s) are considered non-voting members of the UM committee.

    If the admitting physician does not agree with the level of care determination by the E.H.R. physician advisor, the case will be reviewed by a member of UM committee. If this physician agrees with the EHR physician's

determination, the case is considered closed with the level of care deemed appropriate by the EHR and UM physicians. The order for status change will be written by the designated UM physician.

All patients meeting criteria for Medical Observation shall be placed on the Medical Observation Unit. This unit is designed to effectively and efficiently facilitate the diagnostic evaluation to determine the need for further inpatient care. Medical Observation requires more frequent evaluation and documentation of the patient's clinical condition to support the necessity for further care, therefore, the admitting physician will be notified on a frequent basis of the progression of the patient care and condition. It is expected that patients in Medical Observation will progress rapidly to either require inpatient care or may be discharged when the acute illness is ruled out. This rapid progression of care may require more frequent than daily clinical assessment by the attending physician (e.g. 2-3 times per day)

c. acknowledgement of all abnormal test results and plan of care if necessary.

d. The estimated period of time the patient will need to remain in the hospital.

e. Appropriate transition planning needs which are identified shortly after admission and updated regularly to show plans for post hospital care.

Upon request of the Utilization Management Committee, the attending physician must provide written justification of the necessity for hospitalization of any patient when not medically necessary in the opinion of the peer reviewer. This report must be submitted within twenty-four hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Medical Executive Committee for action.

The attending physician is responsible for all issues related to the patient's insurance requirements. This includes providing clinical justification for the treatment plan and length of stay to ensure precertification for all elective and emergency admissions.

13. Patients shall be discharged only on order of the attending practitioner or any authorized provider directly involved in the care of the patient. Should a patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the medical record and a proper release signed by the patient.

14. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within one hour.

It shall be the responsibility of the attending physician to communicate with the family of the patient and to complete the required documentation. In the absence of another designated physician the attending physician is responsible for completing the death

certificate. In the absence of the attending physician, the chief medical officer of the institution may also complete the death certificate.

The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff or his/her designee.

It is the responsibility of the attending physician to make a referral to the state organ procurement facility on all patients deemed appropriate for organ donation, as well as all other deaths, in accordance with the federal regulations on organ donation.

14. It shall be the duty of all medical staff members to secure meaningful autopsies whenever possible. It is the responsibility of the attending physician to obtain the written and signed autopsy permit from the next of kin as defined by the laws of the state of Georgia. The attending physician must complete an autopsy information form. Documentation may be in written or electronic format. All autopsies shall be performed by a hospital pathologist or under his supervision. Hospital autopsies will not be performed on coroner cases. (See criteria for performing autopsy under General Conduct of Care in these Rules and Regulations.)

15. In order to maximize available room space, patients must be discharged before 11:00 a.m.; it shall be the responsibility of the attending physician to discharge patients prior to that time.

16. The admitting physician should discuss Advanced Directives with his/her patient prior to admitting them to the hospital. All patients will be asked for Advance Directives upon admission as required by law and they may initiate one at the time of admission. The physician will initiate the Advanced Directive or Living Will per hospital policy and Georgia law.

GENERAL CONDUCT OF CARE

Do Not Resuscitate

Do not resuscitate (DNR) orders are referred to at the Medical Center as "Resuscitation Status Orders". Since there is no significant ethical or legal distinction between not starting new treatment or stopping treatment that has already been initiated, Georgia law authorizes the restricting of CPR and other medical treatments and grants immunity to any physician, health care facility or its employee, who implements a DNR order as long as compliance with the statute is maintained. Georgia law also grants immunity to individuals or health care facilities that provide CPR to a DNR patient as long as the provider reasonably believes in good faith that the order did not exist or that it had been revoked or canceled.

It is the attending physician's responsibility to:

- Document the patients' resuscitation status using the Resuscitation Status Order sheet.
- Discuss the resuscitation status with the patient or patient's agent.
- Document in the progress note section of the medical record an appropriate summary as to why the patient should not be resuscitated. It should be detailed enough to include diagnosis, prognosis, response to therapy, consultations, and patient's decision-making capacity. The note should reflect any discussion with the patient or patient's agent.
- Notify the members of the health care team involved with the patient.
- Regularly and periodically review the resuscitation status and revise when appropriate.
- Provide the patient or patient's agent with adequate information about his or her condition, prognosis, therapeutic and diagnostic options, so that an informed decision can be made.
- Work with the patient's agent to determine resuscitation status, for those patients who lack decision-making capacity.

Please refer to the Code Blue PALS Policy.

Rounds

Routine rounds by the attending physician should be made daily between the hours of 5:00 AM and 12:00 MN. The attending physician is the physician attending the patient, not necessarily the physician of record.

Restraints and Seclusion

MCCG is committed to preventing, reducing, and eliminating the use of restraint/seclusion when possible. They are only to be used in clinically appropriate and adequately justified situations.

Restraints are defined as the involuntary use of any method physically restricting a person's freedom of movement, physical activity or normal access to his or her body.
Chemical restraint is a medication used to control extreme behavior emergently or to restrict the patient's freedom of movement and that is not a standard treatment for the patient's medical or psychological condition.

Acute Medical/ Surgical Restraints

To be used for patients who are a demonstrated fall risk or those that can't follow directions, or have poor judgment that would interfere with medical intervention.

1. Order must be time specific (not to exceed 24 hours)
2. Order must specify the type of restraints
3. Order must specify the reason for the restraint
4. Verbal or telephone orders must be co-signed by the responsible MD within 24 hours
5. If restraints are required beyond the initial time frame, the MD must reorder them q 24 hours.

Restraints (PHYSICAL AND CHEMICAL) Used for Behavioral Control in any Setting

To be used for patients who are SEVERLY aggressive and violent and pose imminent danger to themselves or others.

1. Order must be time specific not to exceed 4 hours for adults, 2 hours for children and adolescents, 1 hour for children under 9 years.
2. Physician or LIP must make a face to face evaluation within one hour of the initiation of the intervention, document an assessment in the progress notes, and sign, date and time the order sheet.
3. At the end of the specified time period, an RN may assess the need for continuation of the restraints. If they are still needed the nurse MUST contact the MD for an additional 4 hours, 2 hours, or 1 hour depending on age of the patient.
4. At the end of 8 hours (4 hours for children and adolescents, 2 hours for children under 9) the MD or LIP MUST make another face to face evaluation and the process begins again.

The Suicidal Patient

The Emergency Department

If, after medical screening, stabilization, and initial treatment in the ED, the patient's medical status necessitates admission to the hospital, there are five options available.

- If medical status is such that the patient meets the criteria for Critical Care, he/she is to be admitted there under the care of a medical physician. A psychiatric consultation is to be requested by the admitting physician as soon as the patient is responsive and coherent.

- If the patient does not meet the criteria for Critical Care, but is too ill to be transferred to the 6-East Pavilion (or if a bed is not available on 6-East) the patient may be placed on a medical floor on one-to-one observation. This observation is to be done by staff that is

specially trained in dealing with psychiatric observation. The House Coordinator will handle this.

The patient will be under the care of a medical physician but a psychiatric consultation is to be requested ASAP. A comprehensive behavioral assessment is to be done by a mental health evaluator prior to the patient leaving the ED.

- If the patient is stable medically, he/she may be admitted, voluntarily or involuntarily, to the 6-East Pavilion under the direct care of a psychiatrist. The comprehensive behavioral assessment is to be done prior to the patient leaving the ED.
- If the admitting physician judges the patient NOT to be suicidal and documents it, the patient may be admitted to a general area.
- The patient may also be transferred to another health care facility with capabilities to meet their psychiatric needs. The ED physician, in coordination with the mental health evaluator will determine the appropriate disposition. This could include voluntary or involuntary admission.

If the patient does not require admission to the hospital, he/she may be discharged with plans for follow up at an outpatient health center or a psychiatrist's office. The decision for discharge is to be made by the ED physician in consultation with the mental health evaluator and, on some occasions, with a psychiatrist.

The Inpatient Setting

For the protection of patients, the medical staff, and nursing staff and the hospital, certain principles are to be met in the care of patients that have attempted suicide or those who are threatening to harm themselves. Any patient that has made a suicidal gesture or is verbalizing self-harm must have a consultation by a member of the psychiatric medical staff or the Psychiatric Liaison team. As soon as the patient is alert and responsive, the attending is to request a consultation. The psychiatrist may exercise one of the following options:

- If the patient is in the Critical Care unit and is stable medically, he/she may be admitted voluntarily or involuntarily to The Pavilion, under the direct care of a psychiatrist or transferred to another health care facility with capabilities to meet their psychiatric needs.

    - Document that the patient is NOT suicidal or at risk and can be managed on a general area.

    When the level of acute medical care is such that the patient should stay in the medical/surgical area and when the patient represents a suicide risk, the patient may be placed on one to one observation. This one to one is to be done by staff that has been specially trained in dealing with psychiatric observation. The house coordinator will facilitate obtaining this staff.

CRITICAL CARE UNITS

Description

1. Location

The Department of Critical Care is composed of four multipurpose special care-nursing units. Three of the four units have a primary patient focus, but all accept general medical-surgical patients.

The four (4) units are ICU Green (Medical/Surgical/Trauma), ICU Blue (Neurological Medical/Surgical). ICU Tan (Cardiovascular Medical/Surgical), and Coronary Care Unit. The first three ICUs are located in the West Tower, 2nd floor and the CCU is located on the 4th floor in the main building.

2. Patient Placement

Patients requiring intensive care may be admitted to any of the units. Under most circumstances, unit selection will be determined by the physician's order and the unit admission criteria.

During bed or staffing shortage conditions, patients will be overflowed to another of the Critical Care Units.

3. Bed Capacity

The total critical care capacity is 46 (CCU-12/Tan-11/Green-12/Blue-11). The number of beds available at any given time depends on the acuity of the patients, the number of available nursing/support staff and their individual experience/qualifications. The census is established collaboratively by the Medical Director(s) for Critical Care; the Vice President(s), Nursing Director(s), and Clinical Resource Coordinator(s) will be involved in all situations in which patients must be triaged/transferred to another facility/refused admission to Critical Care or when the need for beds exceeds availability.

Medical Director

1. Qualifications

The Medical Director(s) of Critical Care will have demonstrated appropriate education and skill to qualify for board certification in a sub-specialty of Critical Care Medicine as designed by the Specialty Board of Surgery, Medicine, Anesthesia or Pediatrics.

2. Responsibilities

A. In conjunction with the Vice President(s), the Medical Director(s) will share responsibility for assuring credentials and continuing education of all hospital personnel caring for patients in the critical care units. **A Medical Director is available 24 hours a day, seven days a week.**

B. The Medical Directors(s) will have responsibility for the performance improvement in the Critical Care Units. This includes, but is not limited to, policies, protocols, procedures, and admission-discharge criteria.

C. The Medical Director(s) has the authority to establish priority of admission and discharge. In times of reduced bed availability, the Medical Director(s) will have the final authority in admission and discharge to assure proper utilization of definite resources.

D. The patient's attending physician will be responsible for the total medial care of t he patient; however, he/she may delegate authority for all or part of the patient's care to other physicians, including the Medical Director(s).

Critical Care Committee

A standing committee designated as the Critical Care Units Committee is an interdisciplinary group, which is charged with oversight and supervision of the units. This committee meets no less than quarterly and is charged with reviewing, monitoring, and evaluation activities, as well as other critical care concerns.

Critical Care Policies

Circumstances of Admission

1. Admissions to MCCG Critical Care Units from outside facilities or the Emergency Department are expedited by contacting Patient Access. The reservation request is called to the Transfer Center at extension 1120 or 2261. The Transfer Center will provide clinical information to assist the Clinical Coordinator in determining the availability of the Critical Care beds based on the physician determination, prior patients waiting for Critical Care placement in the Emergency Department and the Post-Anesthesia Care Unit and the Critical Care criteria. Issues regarding requests for patient placements that do not meet criteria should be addressed through the Critical Care Medical Director.

2. If a physician thinks his patient might need a bed post-op, the bed must be requested pre-op. Likewise, should the patient not require the Critical Care bed post-op, it is the responsibility of the surgeon to cancel the reservation by

notifying the Transfer Center.

3. In the event no critical care bed is available, elective surgery will be canceled.

Physician Responsibility

1. All new patients are to be seen by the attending physician within four hours of admission to the Critical Care Unit. **EXCEPTIONS:** If the physician has seen the patient:

   a. In the PACU just prior to admission to Critical Care.
   b. In the Emergency Department just prior to admission.
   c. In his/her office just prior to admission.

2. Patients will be seen by the attending physician or the physician acting in his/her stead at least every 24 hours. It is the physician's responsibility to meet this standard. Failure to do so will result in a referral to the Critical Care Medial Director on call and referral to Performance Improvement for review by the appropriate coordinator or medical *staff* department for action.

Change of Patient Condition

The nurse will notify the physician of any significant change in the patient's condition or status. The approved method of contact is through the physician's office telephone, which should be answered by an answering service and/or answering machine, which can be in immediate contact with that physician (or his/her covering physician).

Physician Availability

1. All physicians who have admitted a patient or consulted on a patient at MCCG must be available at all times to the nursing staff or the medical staff concerning those patients (Refer to call coverage for exception.)

2. Call coverage must be provided by another physician of comparable credentials and privileges who is a member, in good standing, of the medical staff. In most cases this means that a physician of like specialty training would be required. However, there are instances in which certain subspecialties may appropriately cover of another. Unless specifically approved by the chair of the department, it would be expected that a colleague in the same specialty provide coverage. Failure of a "covering" physician to respond appropriately will be considered a violation of the obligation, both that the physician and the responsible, i.e., attending physician. All responses must be within a reasonable time.

Transfer/Acceptance of Patients

If the admitting physician feels uncomfortable with coordination and directing the care of a particular patient in Critical Care, he/she should seek to transfer that patient to the care of another physician willing to accept the patient. This transfer of care order should be on the order sheet of the chart. The physician accepting the transfer of the patient to his/her service will document acceptance either on the order sheet or the progress note.

Protocols

Power Plans and Protocols may be instituted on verbal order by physician and must be signed by physician within twenty-four (24) hours of initiation. (In the Coronary Care unit a copy of the CCU standing orders listing medications, emergency and routine procedures a nurse may perform without a physician being present will be placed on the chart of each patient admitted or transferred to the Coronary Unit and instituted unless otherwise ordered.)

Critical Care Direct Admissions

Indications:

1. Operative patient in which the Anesthesiologist, Surgeon, and ICU Nursing Staff agree on the transfer.

2. Cardiovascular patients will be transferred to ICU Tan only.

3. Pre-existing ICU patients

Procedures:

1. The physician is required to request an ICU bed reservation pre-operatively.

2. During the pre-anesthetic period, the patient must demonstrate hemodynamic and respiratory system stability. If not stable, the patient will be transferred to PACU for recovery.

3. The Anesthesiologist, or his designee – i.e., circulatory nurse will notify the receiving ICU of impending transfer approximately thirty (30) minutes before actual transfer time

4. The attending Anesthesiologist and/or anesthetist will personally accompany the patient to ICU.

5. The attending Anesthesiologist and/or anesthetist will personally give report to the receiving ICU nurse.

6. The attending Anesthesiologist will write immediate post anesthetic ventilation orders.

7. The attending Anesthesiologist will document in the progress notes the transfer of care to the surgeon.

8. The Anesthesiologist is responsible for any anesthesia-related problem during the initial hours of admission.

Admission Criteria

Patients are screened for appropriateness of admission to critical care by utilization of a nationally accepted severity of illness and intensity of service criteria (i.e. InterQual)

1. **Priority 1 Patients**: Critically ill, unstable patients in need of intensive treatment such as ventilator support, continuous vaso-active drug infusion, etc. Examples of such admissions may include, but are not limited to, post open-heart patients, post-op craniotomy patients, or patients in septic shock. Priority 1 patients have no limits placed on therapy.

2. **Priority 2 Patients**: Patients that at times of admission are not critically ill but whose condition requires the technological monitoring services of the Critical Care Units. These patients would benefit from intensive monitoring (e.g., peripheral or pulmonary arterial lines) and are at risk for needing intensive treatment. Examples of such admissions may include, but are not limited to, patients with underlying heart, lung, or renal disease who have severe medical illness or have undergone major surgery. Priority 2 patients have no limits placed on therapy.

3. **Priority 3 Patients**: Critically ill or unstable patients whose previous state of health, underlying disease or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from critical care treatment. Examples of such admissions may include, but are not limited to, patients with metastatic malignancy complicated by infection, pericardial tamponade, airway obstruction or patients with end-stage heart or lung disease complicated by a severe acute illness. Priority 3 patients receive intensive therapy to relieve acute complications, but therapeutic efforts might stop short of other measures such as intubation or cardiopulmonary resuscitation.

   ***Detailed information available in Structure Standards Book located in each unit.**

4. **Patients who do not meet routine admission criteria are**:

   A. Patients who have confirmed clinical and laboratory evidenced of brain death (Patients may be admitted if they are potential organ donors, but only for the purpose of life support prior to organ donation).
   B. Competent patients who refuse life supporting therapy.

C. Patients in a permanent vegetative state.
D. Patients whose clinical needs can be met outside of critical care at a comparable level of care.

These patients would be admitted to Critical Care only in unusual circumstances at the discretion of the Critical Care Medical Director and should be discharged if necessary to make room for Priority 1, 2, or 3 patients.

Discharge Criteria

1. Patients are monitored for appropriateness of transfer to the next level of care by utilizing a nationally accepted severity of illness and intensity of service criteria (i.e. InterQual)

2. Priority 1 patients are discharged when their need for intensive treatment is no longer present or when treatment has failed so that short-term prognosis is poor, and there is little likelihood of recovery or benefit from continued intensive treatment.

3. Priority 2 patients are discharged when intensive monitoring has not resulted in a need for intensive treatment and the need for intensive monitoring is no longer present.

4. Priority 3 patients are discharged when the need for intensive treatment is no longer present, but they may be discharged earlier if there is little likelihood of recovery or benefit from continued intensive treatment.

   In consideration of the continuing and often specialized care needs of these patients, arrangements for appropriate non-Critical Care will be made prior to Critical Care discharge.

   ***Additional information available in the Structure Standards book in each unit.**

5. Patients who are NOT likely to benefit from continued Critical Care treatment include:

   A. Patients of advanced age with three or more organ system failures that have not responded to 72 hours of intensive therapy.
   B. Patients who are brain dead or who have non-traumatic coma leading to a permanently vegetative state and a very low probability of meaningful recovery.
   C. Patients who have formal limits placed upon their care indicated by "do not resuscitate" (Status III Resuscitation Order).
   D. Patients with a variety of other diagnoses (advanced COPD, end-stage cardiac disease, or widespread carcinoma) that have failed to respond to Critical Care therapy who's short –term prognosis is also extremely poor and for whom no potential therapy exists to alter that prognosis
   E. Patients with protracted respiratory failure who have not responded to initial aggressive efforts and who are also suffering from hematological malignancy.

F. Physiologically stable patients who are at low risk of requiring unique Critical Care therapy. Examples of such low risk patients may include, but are not limited to, stable surgical patients recovering from aorto-femoral bypass graft and non-operative patients with uncomplicated DKA, self-inflicted drug overdose, concussion or mild CHF.

Individual Unit Description

Coronary Care Unit

1. Purpose

The purpose of the Coronary Care Unit is to provide skilled nursing care twenty-four (24) hours a day for patients with acute myocardial infarctions or cardiac involvement, whose immediate prognosis can benefit from intense observation and treatment.
***Refer to Unit Structure Standards**

2. Consultations

Consultation by either a cardiologist or qualified internist must be obtained on all patients admitted to CCU who meet the following criteria:

a. Suspected myocardial infarction with shock.
b. Suspected myocardial infarction with congestive heart failure.
c. Heart block with or without infarction
d. Rhythm disturbances with or without myocardial infarctions
e. Continued chest pain when the diagnosis is not established within 72 hours.
f. Cardio-pulmonary disease requiring ventilatory support

The committee requests that the Consultant see these patients within twelve (12) hours of the onset of the above complications.

Green Unit (Medical/Surgical, Trauma)

Purpose

The purpose of the Green Unit is to provide comprehensive nursing care twenty-four (24) hours per day for any critically ill or injured adult patient meeting Critical Care criteria. Multiple trauma victims and in-house cardiac/respiratory arrest patients take priority over other patients.
***Refer to the Unit Structure Standards.**

Blue Unit (Neurological/Neuro-surgery)

1. Purpose

The purpose of the Blue Unit is to provide comprehensive nursing care twenty-four (24) hours per day for any critically ill patient with a neurological/ neuro-surgical diagnosis

2. Consultation

Consultation, by either a Neuro-surgeon or a Neurologist, shall be obtained by a physician on all patients admitted to the Blue Unit who meet the following criteria:

a. Shock and/or potential shock due to neurological disorder.
b. Acute head or spinal injuries.
c. Complicated post-op neuro-surgical patients
d. Observation for potential problems related to seizure disorders, neurological deficits and/or those patients who require professional observation for life-threatening situations.

Tan Unit (Cardiovascular Intensive Care)

Purpose

The purpose of the Tan Unit is to provide skilled nursing care twenty-four (24) hours per day for any critically ill or injures adult patient meting Critical Care Criteria. Cardiovascular/Thoracic surgical patients take priority over other patients.
***Refer to Unit Structure Standards**

Mandatory Consults for All Units

1. A nutritional assessment will be done on all patients who are in the Critical Care units more than three (3) days. The assessment will be done twice weekly during the first three (3) weeks while the patient is receiving or enteral nutrition. Then re-assess.

2. Following the recommendation of the American Society of Chest Physicians concerning care of patients on ventilators, all patients with a reasonable expectation of recovery (patients with status IV resuscitation orders being the exception) on ventilator > 48 hours, should have a consultation by an Anesthesiologist, a Pulmonologist, an Intensivist or a Cardiovascular/Thoracic surgeon.

3. Use of the drug, Drotrecogin, must be approved by an authorized Critical Care or Infectious Disease Consultant.

Other Policies for All Units

1. All orders should be reviewed and rewritten by the authorized provider transferring a patient from critical care to a general patient care area. Appropriate medication reconciliation should also occur at this time.
2. Use of restraints
3. Refer to chapter titled "General Conduct of Care" in this document for restraint policy and protocols outline.

4. Overflow to other units

When a patient is overflowed to another unit, standards of care related to diagnosis and treatment will be implemented in the receiving unit. (Example: Neuro patient in Green Unit will have Blue Unit standards of care applied.)

5. Transfer of patients classified suicidal

For the protection of patients, the medical and nursing staff and the hospital, certain principles are to be met in the care of potentially suicidal patients. Any patient known or suspected of significant suicidal intent must have consultation by a member of the medical staff in the Department of Psychiatry (or his/her designee). (Also see The Suicidal Patient in these Rules and Regulations)

The physician may exercise on the following options:

A. Document that the patient is not suicidal or at risk and can be kept on a general area.
B. Order that the patient be discharged from the Critical Care Units and admitted to the Pavilion on 6 East or to a general area with constant observation by designated personnel.
C. Recommend that the patient be involuntarily committed (Central State Hospital).
D. Discharge the patient to a responsible party.

6. Role of Residents and Teaching Staff in Critical Care

The House staff or the Medical/Surgical service may admit patients to the unit under the supervision of their attending physician. The House Staff responds to "Code Blue " emergencies in the units and direct the code until the attending physician is available. When a patient is assigned to staff services, the same policies and procedures designated for the Medical Staff are followed.

Failure to comply with the policy/practice criteria will result in a referral to Performance Improvement and will be reviewed by the appropriate coordinator or department for action. (Also see Graduate Medical Education in these Rules and Regulations)

EMERGENCY SERVICES

1. **On-Call Physicians –** A daily listing of all physicians on-call is maintained in the Emergency Department (ED). It is the responsibility of the Chair of each Medical Staff Department to ensure that the call schedules for each Department, including specialties and subspecialties, are submitted to the Emergency Department at least fifteen (15) days prior to the effective date of the schedule . It is the responsibility of the physician initially scheduled to be on call to notify the Emergency Department **in advance** whenever any changes are made regarding his/her call. Timely response to any call from the Emergency Department is required of the on-call physician, with the expectation that calls will be returned in twenty (20) minutes or less. Specific details of the on call policies for the various Medical Staff Departments are set by those departments for all specialties and subspecialties in collaboration with the Emergency Department.

2. **Medical Screening Exam –** All patients who arrive at the Emergency Department for evaluation or care are required under EMTALA law to have a medical screening exam done and to have stabilizing treatment, if unstable. Medical screening exams in the ED must be done by a physician, nurse practitioner or a physician assistant under the DIRECT supervision of a physician.

   If transfer of a patient to the Emergency Department is requested/accepted by a private or attending physician, that physician will be responsible for seeing the patient in the ED and for doing the medical screening exam when the patient arrives, unless the patient is unstable on arrival.

   Upon arrival to the Emergency Department, responsive patients will be asked about their private physician, but if unstable, or even potentially unstable, an ED physician will be asked to do the medical screening exam and to begin stabilizing treatment prior to calling the private or attending physician.

   For medical screening exams related to Obstetrical patients refer to "Obstetrics" section of these Rules and Regulations

3. **Admission/Consultation Responsibilities**

   Preassigned patients

   a. For any adult patient who comes to the Emergency Department with an assigned physician and provides that name as their physician, the ED physician will first contact that physician or his/her call partner if a consult or admission is needed.
   b. The physician who is called has a duty to consult on/admit the patient or ask for a particular hospitalist group to take the patient.
   c. If the hospitalist group requested is unwilling or unable to accept the patient for consult or admission, the initial physician called is notified again by the ED and it remains the responsibility of that physician to admit/consult on the patient.

Unassigned Patients

a. If an unassigned patient comes to the ED, the ED physician utilizes the department-specific call policy.
b. When the on-call physician is contacted, it is his/her responsibility to admit/consult on the patient or to ask for a particular hospitalist group (should name the group) to take the patient
c. Should a patient require readmission within thirty (30) days post discharge for the same or a related condition, the most recent Admitting/Attending physician (or his/her designee) must assume initial responsibility for the care of that patient. This continuity of care requirement does not preclude appropriate specialist consultation at the time of readmission, but does apply to all departments including academic services
d. If the hospitalist is unwilling or unable to accept the patient for consult or admission, the initial on-call physician is notified again by the ED and it remains the responsibility of that on-call physician to admit/consult on the patient.

4. **Handling Disposition Disagreements/Disputes** - If, in the rare circumstance that a disagreement occurs over patient disposition between an ED physician and another physician on the medical staff, that medical staff physician is obligated to come to the ED to make disposition on the patient within one (1) hour. If that physician fails or refuses to do so, the ED physician must contact the Chair of the department in which that physician has privileges and the Chair will arrange for further disposition of the patient and discussion with that physician. If the Department Chair cannot be reached, the Senior Vice President of Medical Affairs or the Chief of Staff must be contacted by the ED physician.

5. **Discharge Instructions** - It is the responsibility of the physician discharging any patient from the ED to assure that appropriate discharge instructions are provided to the patient. A copy should be given to the patient and a copy should be retained for the medical record.

6. **Transfers** - All patient transfers to the ED will be handled through the hospital-wide MCCG Transfer Policy. Nursing home patient transfers, MCCG Med Center transfers, Neighborhood Health Center transfers, and Carlyle Place transfers will be handled through the ED nursing coordinator on duty. The ED nursing coordinator will make every possible effort to accept nursing home patients for evaluation in the ED, but, if there are not available beds in the ED or in-house, the ED nursing supervisor will request that the nursing home patient be evaluated at another facility. The nursing home personnel should then arrange a transfer elsewhere. Any patient transferred from the ED to another facility must have a completed transfer form which is the responsibility of the transferring physician (thereby complying with all EMTALA regulations). House officers and students are not to accept transfers.

7. **Dispensing of Medication** - When a patient is being discharged from the ED, physicians should write prescriptions for needed medication. Usually orders should not be written to dispense more than a first dose of prescribed medication to the patient in the ED. No more than three (3) doses of any prescribed medication should be requested by the physician as "take home" medications for the patient. Specific labeling and prescribing instructions must accompany these medications and the physician who is discharging the patient should hand "take home" medications to the patient himself/herself.

8. **Trauma** - Criteria have been established for " Trauma STAT Codes", and for "Trauma Consults". "Trauma STAT Codes" are called to elicit an entire trauma team response based on "major trauma" criteria (per established trauma care protocols).

9. **Thrombolytic Agents, Anticoagulants, Glycoprotein Inhibitors** - Whenever the decision is made that an ED patient is a candidate for any of these agents, the drug chosen will be at the discretion of the ED physician, unless the admitting physician is present in the ED with the patient when that decision is made.

10. **Sexual Assaults** - Alleged sexual assaults are handled per protocol found in the ED Policy and Procedure Manual.

11. **HIV Testing** – HIV testing will not be ordered by ED physicians on patients seen in the ED because of the inability to assure compliance with regulations requiring post-test counseling. If a private physician orders an HIV test on any ED patient, it is his/her responsibility to meet the requirements noted under the section on "HIV Testing and Documentation" under "Laboratory and Radiology Services" in this manual. The exception to ordering an HIV test on an ED patient is when the patient is the "source patient" of a needle stick or significant exposure to a healthcare worker per hospital policy.

LABORATORY AND RADIOLOGY

AUTOPSY (Amended July 2002)

Physicians and families should particularly consider having an autopsy performed whenever someone dies in the following circumstances:

1. When a firm diagnosis has not been made
2. When the death follows unexpected medical complications
3. When death follows use of an experimental drug or device, new procedure or unusual therapy
4. When death follows a medical or surgical procedure done for diagnostic purposes, when the case does not come under the jurisdiction of a medical examiner or coroner. (Deaths in this category clearly come under the jurisdiction of the coroner/medical examiner if something untoward occurred during the procedure which resulted in the death of the patient.)
5. When environmental or workspace hazards are suspected
6. When death is during or after childbirth
7. When there are concerns about a hereditary disease that might affect other members of the family
8. When there are concerns about the possibility of an undiagnosed contagious disease
9. When the patient had been diagnosed as having some unusual disease process which might provide important teaching material for physicians, medical students, and paramedical staff.

The Medical Staff shall attempt to secure autopsies in all deaths that meet the criteria.

The Autopsy Information Form is completed by the physician requesting the autopsy and the data contained therein assists the Pathologist in the performance of the autopsy.

The requesting physician may then answer the following questions on the above referenced form to inform the pathologist if he/she wishes to be:

Notified so he/she may attend complete autopsy?	Yes	No
Notified so he/she may attend organ demonstration?	Yes	No
Notified of the autopsy results only?	Yes	No

In addition to these criteria, it is recommended that the medical record death note include a specific statement as to whether or not an autopsy was requested.

HIV Testing and Results Documentation

HIV testing will be performed only following efforts to obtain consent, appropriate counseling and documentation of both. The purpose is to assure the rights of all patients who may undergo testing for HIV. The policy assists in assuring these individuals understand the implications of the test results and the confidentiality of information related to HIV testing.

1. All patients who are to undergo testing for HIV must be counseled by their physician, a member of their physician's staff or a certified HIV counselor prior to testing.
2. Documentation that such counseling has been accomplished should be recorded on the patient **Consent for HIV Testing** form.
3. An effort must be made following counseling to obtain consent for testing of all patients who are to be tested for HIV.
4. If consent is refused, testing **cannot** be performed **unless** the testing is initiated to determine HIV status of the patient due to exposure of a healthcare provider to the patient's blood or body fluid in such a way that the healthcare provider is at risk of becoming HIV infected if the patient is HIV infected.
5. If consent is refused, documentation of refusal should be recorded on the **Refusal of HIV Testing** form.
6. If a patient has refused testing for HIV to be tested under the exposed healthcare worker provision, approval of two (2) physicians must be obtained and recorded on the **Refusal of HIV Testing** form.
7. All forms and documents related to HIV testing are available from Infection Control and should be placed on the patient's medical record during hospitalization.

Surgical Pathology/Cytology

Prior to the performance of a definitive therapeutic surgical procedure, the initiation of inpatient chemotherapy, or the initiation of inpatient radiation therapy, the microscopic slides on which the diagnosis was made must be reviewed by the MCCG Department of Pathology. This policy does not apply when the surgical or therapeutic procedure has to be performed on an emergency basis.

Respiratory Services

The Respiratory Care Department operates twenty-four (24) hours a day and renders all necessary assistance in the administration of respiratory care to patients throughout the hospital. Both diagnostic and therapeutic services are provided to inpatients and outpatients upon the order of a responsible practitioner. Each physician receives a bound booklet titled "Respiratory Care Services" with detailed information on the proper procedures and appropriate actions to access respiratory services. Additional booklets may be obtained by calling the main office of Respiratory Care at 633-1360.

OBSTETRICS

Medical Screening Exams

All obstetrical patients presenting for evaluation or treatment through the Emergency Department or Obstetrical unit must receive a medical screening examination (MSE) to determine the patient's medical condition and/or labor status. The results of the MSE will indicate whether or not the patient's medical condition is stable or unstable. Those with an unstable condition will receive treatment to stabilize the medical condition to the extent the condition can be treated with available resources. The results of the MSE will indicate whether or not the patient is in active labor.

- **Medical Screening Exams Performed in Emergency Department**
  Patients who present to the Emergency Department in the process of imminent delivery or those who are unstable (i.e., severe vaginal bleeding, severe hypertension, airway compromise, seizure activity), regardless of gestational age, will be seen and treated initially in the Emergency Department by the Emergency Department physician, nurse practitioner, or physician assistant under the direct supervision of a physician.

  OB patients in the first 14 weeks of pregnancy will be seen in the ED. The OB/GYN resident on call should be consulted, if/when deemed necessary by the ED physician (i.e., vaginal bleeding, term/pre-term uterine contractions/pain (labor), ruptured membranes, decreased fetal movement, abdominal pain of unknown etiology, symptoms of preeclampsia/pregnancy induced hypertension such as severe headache/dizziness or peripheral edema associated with elevated blood pressure, eclampsia if not actively seizing, and vomiting chills and fever).

  OB patients who present to the ED > 14 weeks by history, with the exception of gravid trauma patients, who have had their pregnancy confirmed by a positive urine or serum pregnancy test performed in the ED with a pregnancy-related problem will be evaluated in OB Assessment.

  Obstetrical patients who present to the ED as gravid trauma patients will be evaluated by the ED physician, nurse practitioner or physician assistant regardless of gestational age by history. (Refer to the ED OB Assessment Policy)

- **Medical Screening Exams Performed in OB Assessment**
  Patients who present to the Emergency Department in the process of eminent delivery or those who are unstable (i.e., severe vaginal bleeding, severe hypertension, airway compromise, seizure activity), regardless of gestational age, will be seen and treated initially in the Emergency Department by the Emergency Department physician, nurse practitioner, or physician assistant under the direct supervision of a physician.

OB patients in the first 14 weeks of pregnancy will be seen in the ED. The OB/GYN resident on call should be consulted, if/when deemed necessary by the ED physician (i.e., vaginal bleeding, term/pre-term uterine contractions/pain (labor), ruptured membranes, decreased fetal movement, abdominal pain of unknown etiology, symptoms of preeclampsia/pregnancy induced hypertension such as severe headache/dizziness or peripheral edema associated with elevated blood pressure, eclampsia if not actively seizing, and vomiting chills and fever).

OB patients who present to the ED > 14 weeks by history, with the exception of gravid trauma patients, who have had their pregnancy confirmed by a positive urine or serum pregnancy test performed in the ED with a pregnancy-related problem will be evaluated in OB Assessment.

Obstetrical patients who present to the Obstetrical Unit will be directed to the OB Assessment Area. These patients will be triaged and those who have a non-obstetrical problem, regardless of gestational age, will be directed to the Emergency Department as all other Emergency Services patients. Patients who remain in the OB Assessment Area who have a pregnancy related problem will have a medical screening exam performed by a physician or qualified medical professional (QMP) qualified Registered Nurse using medical staff approved criteria. (Refer to Labor and Delivery Policy)

Obstetrical patients who present to the Obstetrical Unit will be directed to the OB Assessment Area. These patients will be triaged and those who have a non-obstetrical problem, regardless of gestational age, will be directed to the Emergency Department as all other Emergency Services patients. Patients who remain in the OB Assessment Area who have a pregnancy related problem will have a medical screening exam performed by a physician or qualified medical professional (QMP) using medical staff approved criteria (Refer to Labor and Delivery Policy).

MCCG-MUSM
Graduate Medical Education
Medical Staff Rules and Regulations

Policy: GME 9.1	**Effective:** July 1, 2011	**Approval**: GMEC 03/10/2011 MEC 05/09/2011

SUBJECT: Supervision of Residents

SCOPE: All Residents and Supervising Teaching Staff

PURPOSE: To ensure oversight of resident supervision and graded authority and responsibility that is appropriate for safe patient care and the educational needs of residents and complies with Medical Staff By-laws/Policies/Rules and Regulations and applicable program requirements .

RELATED ACGME GENERAL COMPETENCY: Patient Care

Supervision of Residents

The Graduate Medical Education Committee provides oversight for all resident education and monitors compliance with ACGME Institutional Requirements and Common Program Requirements. This Committee is comprised of Chief Residents, Program Directors, elected resident representatives from each program, appropriate administrators, the DIO, a member of MCCG Board of Directors and other physicians/faculty as deemed appropriate to the needs of resident education.

Each residency/fellowship program must ensure that qualified supervisors provide appropriate supervision of residents in patient care activities. Each program must classify supervision for specific clinical assignments as "direct"," indirect", and "oversight" in accordance with definitions in ACGME Common Program Requirements (July 2011). All PGY-1's should be supervised either directly or indirectly with direct supervision immediately available.

Each program should maintain job descriptions or promotion criteria, which describe the basic competence level for each resident by year. Clinical responsibilities for each resident must be based not only on the PGY level, but also on patient safety, resident education, severity and complexity of patient illness/condition and available support services. Supervision policies within each program must address at minimum the following components:

1. Resident involvement in transfer of patient from a referring institution
2. Supervision of procedures (bedside, procedural area)
3. Circumstances and events in which residents must communicate with appropriate supervising faculty members (e.g. transfers to higher level of care, end-of-life decisions)
4. Expectations of faculty regarding frequency of bedside rounding and documentation (GME policy 13 regarding Medical Records)

Classification of resident supervision (using the ACGME classifications of direct, indirect, or oversight) in each clinical setting where residents rotate (e.g. OR, clinics, private offices, inpatient, at participating institutions)

Faculty supervision assignments within each program should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

Patients are not admitted to residents since they are not members of the medical staff. As a corollary, residents are not authorized to accept or deny a transfer from outside CGHS. All patients are admitted to a supervising physician on the medical staff who assumes ultimate responsibility and authority for patient care. All supervising physicians abide by Medical Staff By-Laws/Policies/Rules and Regulations.

Specific supervision scenarios involving interaction of residents with MCCG medical staff

1. Emergency Department

All PGY-1 residents are supervised by in-house physicians (either upper level residents or attending physicians depending on specialty-specific requirements). All other residents are supervised either by more senior upper level residents or supervising faculty who are either in-house or immediately available. Immediately available is defined as reachable by telephone or pager and within 30 minutes of the hospital. All patients admitted by residents will be seen within 24 hours of admission by the supervising faculty member. All patient contacts by PGY-1 residents in the Emergency Department or in an ambulatory care setting will be reviewed by a more senior physician prior to final disposition. A "House officer Consultation Form" should be completed on any patient seen by a resident in the ED and discharged from the ED (not admitted to an inpatient or observation bed).

2. Operating Room
   The attending surgeon must be present on all cases for the critical and key portions of the operation and the viewing portion of each endoscopy

3. Outpatient Sites
   For services provided under primary care exemptions, the supervising faculty member may have no other assigned duties during the supervisory period and may supervise no more than four clinical providers.

4. Consultation Requests
   Residents may seek consultation from members of the medical staff outside of their department after discussion and approval by supervising physician

5. Order Writing:
   All residents may electronically enter patient care orders with the exception of orders for chemotherapy. When attending physicians enter orders on a teaching service patient, the respective resident team should be notified.

6. Documentation of Supervision (See GME Policy 13.0 on Medical Record Documentation)
   Documentation that must be countersigned by the attending physician includes the History & Physical, Operative Notes, and Discharge Summary

Additional related information may be found in Academic Departmental *Policies and Procedures* and *Resident Handbooks.*

Supervision of Medical Students

All Medical Students are reviewed and supervised. First and second year students may engage in observational activities only, third and fourth year students may participate in evaluation and management of patient conditions as appropriate for their level of training. All activities are under the direct supervision of a resident or attending MD with the exception of obtaining a patient history and physical exam, which cannot be utilized as the "official" H&P.

When ordering medications, medical students should place orders in a "Saved" status to be reviewed and approved by the resident or attending physician.

Glossary:

Direct supervision
Indirect supervision
Oversight:
Policy Review Responsibility:
DIO/CMO
Supersedes
Medical Staff and GME Resident Supervision Policies prior to 2006
Medical Staff and GME Resident Supervision Policy July 1, 2006

MANAGEMENT OF INFORMATION

1. Medical Staff shall be involved in assuring that the maintenance of the patient medical record is complete, timely, and clinically pertinent.

2. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. The medical record content shall be pertinent and current. The record shall include identification data, complaint, personal history, history of present illness, physical examination, special reports such as consultations, clinical laboratory and radiology services, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition at discharge, summary or discharge note, and autopsy report (when performed).

3. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

4. When a practitioner is designated in electronic order entry roll out as a CPOE provider, he/she will make use of the "Electronic Medications Reconciliation" module between venues of care (admissions, transfers and discharges). They will enter ALL orders electronically, consistent with current hospital policy regarding telephone and verbal orders, document electronically in PowerChart (using PowerNote except for operative note/pre-op H&P, these will/can be dictated) and will use the Electronic Discharge Module when appropriate. All Providers, regardless of CPOE status, will be required to complete medication reconciliation electronically (excludes units documenting in Centricity™).

5. A non-CPOE provider must meet one of the following criteria: 1) A provider granted clinical privileges who does not log into the system at least once every 30 days; OR 2) A provider granted temporary privileges for a limited specified time period not to exceed 30 consecutive days. The Non-CPOE practitioner will continue to hand write orders on paper order sheets, and will continue to dictate certain documents and hand write all other documents.

6. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. Authentication means to establish authorship be written signature, identifiable initials, or computer key. Countersignature refers to physician authorization of medical record entries for Physician Assistants or Advanced Practice Nurses (APN) when applicable. **Rubber stamp signatures are not acceptable for authentication or countersignature at MCCG**.

7. **History and Physical**:

   * A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but always prior to surgery or a procedure requiring anesthesia. If the H&P was completed within 30 days prior to admission or registration, an updated medical record entry must be completed within 24 hours of admission or registration, but prior to surgery/procedure requiring anesthesia

services, except when any significant delay in treatment could possibly jeopardize patient care, safety, or otherwise constitute a hazard to the patient.

* When the H&P is conducted within 30 days before admission or registration by a physician who is not a member of the Medical Staff or does not have admitting privileges, or by a qualified licensed individual who does not practice at the hospital but is acting within the scope of his/her scope of practice under state law or regulation, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital's medical staff to perform an H&P. See Article 13.B.2. of Medical Staff Bylaws for additional requirements.

* The contents of an H&P should include the following elements: chief complaint, history of present illness, past medical history, pertinent review of systems, current medications, allergies, pertinent social/family history, appropriate physical exam, impression, and treatment plan. An abbreviated H&P may be performed prior to newborn circumcision, which should include targeted family history related to clotting disorders and physical exam specific to genitalia.

8. **Progress Notes**:
Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of and/or transfer of care. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment.

9. **Operative Reports**:

* An immediate post procedure note or progress note must be entered in the medical record immediately following the procedure **and** before the patient is transferred to the next level of care.

* This postoperative note must include: the name of the primary surgeon and his/her assistants; postoperative diagnosis/findings; procedures performed and description of each procedure finding; specimens removed and disposition, if applicable; estimated blood loss; and patient condition.

* Operative reports shall be dictated or written within 24 hours following surgery/procedure.

* Operative reports shall include: the name of the primary surgeon and his/her assistants; postoperative diagnosis/findings, procedures performed and description of each procedure finding; specimens removed and disposition, if applicable; estimated blood loss; and patient condition.

10. **Consultation**:
Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinions and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall be recorded prior to the operation except in emergency situations as documented in the record.

11. **Discharge Summary**:

* Discharge summary (clinical resume) shall be entered on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature. The latter exceptions shall be identified by the appropriate committee of the Medical Staff and for these, a final progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

* The content of a discharge summary shall include the following: the reason for hospitalization, procedures performed, care, treatment, services provided, condition at discharge, information provided to the patient and family, and provisions for follow up care.

* A discharge summary is not required when a patient is seen for minor problems or interventions as defined by the Medical Staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow up care.

* For patient stays under 48 hours, the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, provisions for follow up care, and disposition of the care including those cases where the patient expires. All summaries shall be authenticated by the responsible practitioner. In this particular circumstance, if the final progress note, which serves as the discharge summary, is completed by a PA or APN, the note must be countersigned by the sponsoring or other approved designated physician.

12. The patient's medical record shall be completed within 14 days of discharge, including progress notes, final diagnosis, and discharge summary.

13. **Order Sets**

A standard set of evidence based orders that may be initiated by licensed independent practitioners (LIP). These orders are printed or electronic, predefined orders which require the ordering practitioner to make selections. These may not be initiated without prior LIP approval! Example: Admission Order set for a patient with CHF.

(A) Protocols

An evidenced based interdisciplinary plan and or standard of care as approved by Medical Executive Committee (MEC) used to manage defined patient care problems.

a. Follows an IF this then THAT format and direct specific care when criteria for implementation are met.
b. These printed or electronic predefined orders are developed to manage specific patient conditions in order to prevent barriers to effective emergency response, timely and necessary care, or other patient safety advances.
c. Provide specific parameters for management of a condition based on objective, measurable criteria and do not allow the ordering practitioner to make selections, thus not requiring nurses or others carrying out the order to make a choice of care paths dependent on clinical judgment.

d. May be initiated without prior provider approval but the practitioner must be notified when they are used and they must be authenticated by the provider at the earliest time possible.
    i. Example: Stroke Protocol, Chest Pain Protocol, CAUTI Protocol, OSA Protocol, Hypoglycemia Protocol, Heparin Protocol, Pneumonia Protocol.
    ii. Exception: Nurse initiated administration of influenza and pneumococcal polysaccharide vaccines do not require prior LIP approval or authentication.
e. These orders are Medical Executive Committee (MEC) approved and will route to the physician's Inbox for co-signature.

(B) Power Plans

Groups of orders that may be entered by an authorized provider in a "Planned" (Future) status or in an "Initiated" (Active) status.

a. "Planned" PowerPlans- This status should only be used for patients not yet admitted OR if admitted, when the orders are intended for future use. In the latter case, when the Plan is to be Initiated (activated), the ordering provider is responsible for "Initiating" the Plan. If a RN or RRT has to initiate the PowerPlan, the provider will be required to stay on the phone until the order entry process is complete to address all alerts.

(C) Care Sets

Groups of orders that may be entered by an authorized provider

Telephone/Verbal Orders

* All telephone and verbal orders must be verified/authenticated within 14 days after discharge and must include the date and time of authentication.
Exception: Restraint orders must be authenticated in accordance with hospital policy.

* Only licensed practitioners may accept and transcribe verbal or telephone orders in accordance with state law, their level of licensure, and scope of practice for use in their specialty as approved by the Medical Staff and outlined in department policy and procedure manuals.

* The following licensed practitioners are authorized by hospital policy to accept verbal and telephone orders:

- Physician, Physician Assistant, Advanced Practice Nurse
- Registered Nurse
- Physical Therapist, Speech Therapist, Occupational Therapist,
- Radiology Technologist, Registered Dietician, Registered Pharmacist, Respiratory Therapist

* Social workers are authorized to accept non-treatment verbal/telephone orders (i.e. patient type changes, durable medical equipment, palliative care consult)

14. **Specific countersignature requirements for Physician Assistants (PA)**:
All entries made by the PA in the medical record must be countersigned by the supervising physician in a timely manner but no later than 14 days after discharge. Such entries include

but are not limited to the H&P, H&P update, discharge summary, progress notes, all verbal, written or electronic orders, and consults.

15. **Specific countersignature requirements for Advanced Practice Nurses (APN)**:

* Discharge summaries delegated to the APN must be countersigned by the delegated sponsoring or other approved designated physician within 14 days.

* All written, verbal, or electronic orders initiated by the APN must be within the scope of practice defined by the nurse protocol agreement and do not require countersignature by delegated sponsoring or other approved designated physician.

* All other medical record entries made by the APN such as H&P, H&P update, progress notes, and consultations do not require countersignature by the delegated sponsoring or other approved designated physician.

* Verbal and telephone orders received by the APN from a delegated sponsoring or other approved designated physician require read back and verification (R&V) and physician countersignature.

16. **Specific countersignature requirements for Residents**:
The H&P, operative report, and discharge summary must be countersigned by the attending physician.

17. **Dependent Practitioner (DP)** means those allied health professionals who are permitted to practice in the hospital only under the direct supervision of a practitioner appointed to the Medical Staff and who function pursuant to a defined scope of practice. The supervising practitioner is responsible for the actions of the Dependent Practitioner in the hospital.

18. **Advanced Dependent Practitioner (ADP)** means those allied health professionals who are licensed or certified under state law, are granted clinical privileges, and function in the hospital under the supervision of a practitioner appointed to the Medical Staff. The supervising practitioner is responsible for the actions of the Advanced Dependent Practitioner.

19. In accordance with the Americans with Disabilities Act, a credentialed provider may submit a request to the Credentials Committee to utilize a scribe. Requested duties to be performed by an authorized scribe will be reviewed and approved on a case by case basis.

The chart entry must be concurrent with physician presence and/or clearly document physician presence in the performance of physical exam and procedures and evidence that documentation is based on physician's verbal dictation of content.

20. Standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designation may be used. Our list of prohibited abbreviations, acronyms, symbols, and dose designations includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d., qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MgSO4. The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

21. A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

22. **Release of Information**:

* Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive the information.

* Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of medical records from the hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

23. **Access to the Medical Records**:
Access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study, research, quality, and utilization review consistent with preserving the confidentiality of personal information concerning the individual patients.

24. **Completion of Medical Records**:
Practitioners are required to complete all available medical records as outlined in the Health Information Management Record Completion Policy.

25. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Utilization Review and Health Information Management Committee.

INVESTIGATIONAL STUDIES

The Institutional Review Board will establish and monitor procedures which assure the protection of all human subjects involved in research projects at the Medical Center of Central Georgia in accordance with Department of Health and Human services, Federal Drug Administration and other federal and state statures and regulations. This applies to research conducted by anyone using facilities at the Medical Center and to research conducted elsewhere by faculty, students, staff or other representatives of the Medical Center using Medical Center resources or patients I the investigation.

1. The hospital Institutional Review Board will review all proposed investigational studies and research projects to be conducted at the hospital or utilizing hospital resources.
2. The Board will approve only those projects, which are well designed and offer reasonable opportunity for benefit when weighed against the cost and risks.
3. The Board will approve only those projects, which demonstrates an appropriate procedure and document for consent. (See Policy Number 1-400 Institutional Review Board.)
4. All patients asked to participate in a research project are given a description of the expected benefits, potential discomforts and risk.
5. All patients asked to participate in a research project are given a description of alternative services that might also prove advantageous to them.
6. All patients asked to participate in a research project are given a full explanation of the procedures to be followed, especially those that are experimental in nature.
7. All patients asked to participate in a research project are told that they may refuse to participate and that their refusal will not compromise their access to service
8. All consent forms pertaining to investigational studies indicate the name of the person who provided the information and the date the form was signed; and address the participant's right to privacy, confidentiality and safety as outlined throughout this chapter.

PHARMACEUTICAL CARE

1. **Formulary:** The Medical Center operates under a closed formulary of accepted medications. Only those medications approved by the Pharmacy and Therapeutics Committee and listed in the hospital formulary are routinely purchased and stocked by the pharmacy. Medications are selected for the formulary because of efficacy, safety, and cost effectiveness and to avoid unnecessary duplication.

2. **Pharmacy and Therapeutics (P&T) Committee:** The P&T Committee is a standing committee of the medical staff and serves as an organizational line of communication between the medical staff and the pharmacy. It is a policy recommending body to the medical staff and hospital administration related to the therapeutic use of drugs. The P&T Committee evaluates the clinical use of drugs, develops policies for managing drug use/administration, and manages the formulary system. This committee is composed of physicians, pharmacists, and other health care professionals appointed by the Chief of Staff. The primary purposes of the P&T committee are: Policy Development, Monitoring Drug use for Safety and Efficacy, Education, and Costs Management.

3. **Generic Drugs:** Only one brand of a given drug is stocked by the pharmacy. When medication is ordered by brand name, a different brand or generic equivalent, identical in active ingredients and bioavailability, may be dispensed.

4. **Non-Formulary Drug Requests:** Only formulary drugs are routinely available for patient care. Non Formulary drug use may result in an additional expense to the patient and a delay in initiation of therapy, depending on the source and availability of the drug. If a non-formulary agent is required, the physician is encouraged to contact the pharmacist, in advance of placing a CPOE order or writing the order, to coordinate drug procurement. If a non-formulary drug is ordered without advanced coordination, a pharmacist will notify the physician and may suggest alternatives that are on the formulary. If alternatives are unacceptable, the drug will be obtained and dispensed, but there will be an associated delay.

5. **Therapeutic Alternatives:** The P&T Committee has approved a number of medications as therapeutic class representatives to be dispensed when other class agents are requested. Examples include potassium supplements, cephalosporins, laxatives, etc. Therapeutic alternatives are listed in the formulary and a list is available from the Pharmacy Drug Information Center or Pharmacy Administration.

6. **Medical Center Information System:** Medication therapy is managed using a computerized information network system. The Powerchart component is used to order medications. The pharmacy component, PharmNet-Medmanager, is used to verify

medication order entry, to schedule and dispense medications, and to produce medication administration records (MARs) for use in documenting medication administration.

7. **Source of Medications:** All medications administered to patients shall be approved by the U.S. Food and Drug Administration (FDA) and shall be issued from Pharmacy. Only drugs listed in official compendia, such as the Pharmacopoeia, A.M.A. Drug Evaluations or the American Hospital Formulary Service, and purchased from reputable manufacturers will be stocked in the Pharmacy.

   a. Medication samples will **NOT** be administered to inpatients unless labeled and dispensed by the Pharmacy in a P&T Committee approved therapeutic trial.

   b. Patient's medications from home are **NOT** to be used routinely for hospital treatment. The Medical Center is responsible for the patient during hospitalization and cannot allow drugs of unknown source, potency, purity, or cleanliness to be administered. Exception to this policy is allowed for oral contraceptives packaged in the manufacturers calendar pack, eye drops and other topical medications. In an emergency, when an equivalent medication is not available and patient care would be adversely affected, a patient's own medication may be used. The medication must be identified by a pharmacist or a physician prior to use. A note stating that the medication has been identified will be entered into the medical record and the patient will not be charged for the medication.

8. **Investigational Drugs:** Non-approved drugs may be prescribed only if part of an investigation approved by the FDA, P&T Committee, and the Institutional Review Board. Only principal or co-investigators may prescribe investigational drugs. These drugs will be stored and dispensed by the pharmacy. Information necessary for safe and effective use of the drugs shall be provided to the pharmacy and nursing staff.

9. **Automatic Stop Orders:** The Automatic Stop Order policy is directed by the Pharmacy and Therapeutics Committee to protect patients from unintended prolonged duration of therapy. The policy applies only when the physician does not specify the duration of therapy for certain drugs. Medications in the following classes will automatically stop after the time period indicated:

Antimicrobials	7 Days
Schedule II Oral Drugs	7 Days
Schedule III Drugs for Pain	7 Days
Hypnotics	7 Days
Schedule II Injectable Drugs	7 Days
Ketorolac	5 Days
Neuromuscular Blocking Drugs	2 Days

10. **Adverse Drug Reaction:** An Adverse Drug Reaction is defined as "a response to a drug that is noxious and unintended, and that occurs at doses used in humans for prophylaxis, diagnosis, or therapy, excluding failure to accomplish the intended purpose". Adverse reactions involve not only hypersensitivity reactions, but all body functions including changes in renal, cardiovascular, gastrointestinal, respiratory, neurologic, and musculoskeletal systems. Spontaneous reporting by physicians provides valuable information about adverse reactions that might otherwise go undetected. Reports may be submitted by telephone to Pharmacy or through the Risk Management CQIR process.

11. **Parenteral Nutrition Orders (PN, Hyperalimentation, and TPN):** Parenteral Nutrition (PN) solutions should be ordered using preprinted, standardized order forms. Formulation ingredients may be specified daily or, when changes are not anticipated, in 3 day increments (please check box on form). New and/or updated or revised orders must be received in the pharmacy by 14:00. Pharmacy services will prepare a 24-hour supply for administration between 17:00 and 19: 00. If PN is not addressed by 14:00, pharmacist will automatically renew the solution as previously ordered, adjusting electrolytes to reflect current lab results. PN solutions are complex formulations requiring many safety checks and double check in preparation and administration. For this reason, PN solution formulation changes cannot be made on and emergency basis. No additions are permitted to a formulation after administration has begun. Fine electrolyte adjustment should be made via a peripheral line until formulation changes can be incorporated into the next solution. If PN is interrupted, Dextrose 5% (peripheral) or 10% (central) will be administered at the same rate as the PN solution.

12. **Intravenous Sedatives and Muscle Relaxants:** Drugs which require continuous monitoring of vital signs and/or cardiac rhythm must be administered in approved areas only. Examples of such medications include intravenous sedatives, neuromuscular blocking agents, etc. Intravenous use of such drugs is permitted only in those patient care areas where the level of professional monitoring and specialized equipment is in place to ensure patient safety.

13. **Medication Order Requirements:** Medication orders must meet the requirements set forth in medication management policy "Medication Ordering and Transcribing 4-609".:

    a. Date and time written
    b. Print name and beeper number (or contact number) of prescriber
    c. Write with ball point pen (no felt tip pens)
    d. Write full drug name – Do not abbreviate
    e. Spell out – DO NOT ABBREVIATE:
        - Microgram
        - Units
    f. Do not write a trailing zero after a decimal when specifying a drug dose. Example:

DO NOT WRITE: 1.0mg --- Write **as: 1mg**

g. Always write a zero before a decimal. Never leave the decimal "naked". Example:
DO NOT WRITE: digoxin .2mg -- **Write as: digoxin 0.2mg**

h. For Pediatric Orders Only:

1. Write Dose as:
(Dose per weight or BSA) X (weight or BSA) = Final Dose (or maximum or age appropriate dose)
Example: Ceftriaxone (50mg/Kg) X 5Kg = 250mg every 24 hours

2. Co-sign House Staff High Risk orders for:
   - IV Digoxin
   - IV Vasoactive agents (norepinephrine, epinephrine, dopamine, dobutamine, and phenylephrine)
   - IV Potassium
   - Chemotherapy
   - Insulin
   - Magnesium Sulfate
   - Calcium gluconate

14. **Questions Regarding Medication Order(s):** When questions arise regarding medication orders (or prescriptions), the pharmacist will contact the prescriber. Questions may involve drug selection, doses, frequency, or route of administration, etc. If the question(s) cannot be resolved between the pharmacist and the prescriber, the pharmacist will contact the prescribing physician's Department Chair for resolution. This procedure provides the mechanism for pharmacists and physicians to resolve those issues critical to patient safety with regards to medication use.

15. **Verbal Orders:** Verbal orders are not accepted for Chemotherapy or TPN.

SURGERY CENTER

Operating Room

All members of the Medical Staff who perform surgery in the Operating Room of the Medical Center of Central Georgia must comply with all applicable Surgery Center standards as reviewed and approved by the Practice Committee, Assistant Vice President of the Surgery Center, and Medical Director of the Surgery Center. The Medical Director will have complete authority over all members of the Medical Staff providing services in the Surgery Center.

Standards of Practice

1. All surgical cases shall be scheduled and posted in compliance with the standard entitled "Operating Room Schedule, Posting and Implementation Of".
2. Approved surgical attire shall be worn in accordance with the standard entitled "O.R. Attire".
3. Entering, moving throughout and exiting the operating room area shall be in accordance with the standard entitled "Traffic Patterns in the Surgical Suite".
4. All surgical scrubs shall be completed in compliance with the standard entitled "Surgical Hand Scrubs".
5. All sponges, small items, sharps and instruments shall be strictly accounted for in accordance with the standard entitled "Sponge, Small Items, Sharps and Instrument Counts".
6. Basic principles of aseptic technique shall be followed in accordance with the standard entitled "Aseptic Technique and Asepsis".
7. General safety practices shall be followed in accordance with the standard entitle "Perioperative Safety".
8. Pneumatic tourniquet safety practices shall be followed in accordance with the standard entitled "Use of the Pneumatic Tourniquet".
9. Electrosurgery safety practices shall be followed in accordance with the standard entitled "Electrosurgery".
10. Laser safety practices shall be followed in accordance with the standards " Guidelines for Argon Laser", "Guidelines for CO_2 Laser", and "Guidelines for Yag Laser".
11. Preoperative skin preparation procedures shall be followed in accordance with the standard entitled "Skin Preparation of Patients".
12. Universal precautions shall be followed in accordance with the standard entitled "Universal Precautions".
13. Preoperative/pre-procedural validation of operative sites shall be followed in accordance with the standard entitled "Surgical Site Verification".

Residents

Attending surgeons shall not instruct nor allow any resident to commence any operative procedure until they (the attending surgeon) are physically present in the Surgery Center.

Consents

The surgeons are responsible for obtaining an "Informed Consent" and any other surgical consent. These consents are to be signed by the patient or the person acting as guardian in the case of a minor or the patient's agent if the patient is incompetent. This written and signed informed consent is to be obtained prior to the operative procedure.

EXCEPTIONS: In those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the patient's condition.

Emergency Cases

- In emergencies involving a minor or an unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained in the patient's medical record.
- As time permits, a consultation with at least two (2) other physicians in such instances may be desirable before the emergency operative procedure is done.

Second Operation

- If a second operation is required during the patient's hospitalization, a second consent specifically worded shall be obtained. If two or more specific procedures are to be performed at the same time, and the procedures are know in advance, the operative procedures may be described on one (1) consent form.

Pathological Specimens

1. All tissues removed during a surgical procedure are sent to the hospital laboratory for pathological examination.
2. The surgeon is responsible for proper completion of the laboratory requisitions either by writing or entering electronically the necessary clinical information and/or providing the necessary information to the circulating nurse, who completes the required laboratory requisitions.
3. The circulating nurse is responsible for proper labeling and disposition of the specimens.

Post Anesthesia Care Unit (PACU)

Medical Direction

- The anesthesiologist will assume complete responsibility for entering all orders and for the medical care of the patient while in PACU. He/she is responsible for keeping the surgeon informed of any change in the patient's condition with the assistance of the PACU nurse.
- In the event the anesthesiologist desires to transport a patient directly from the O.R. Suite to a Critical Care Unit, the Critical Care Direct Admissions Policy will be followed. (A copy may be found in the Critical Care Units section of this book.)
- Open-heart patients are transported directly from the O.R. Suite to the appropriate Critical Care Unit. Exceptions may be made with bed availability and "Fast Track" heart cases.

Attending Physicians

- The attending physician/surgeon shall be available for consultation with the anesthesiologist and/or PACU nurse regarding patient problems or post-operative orders on patients admitted to PACU.

THE CHILDREN'S HOSPITAL

Location:

The Children's Hospital inpatient units are all located on the third floor of the hospital. There are two medical/surgical nursing care areas for general pediatric admissions – 3 West is located on the west wing and 3 East Peds on the east wing, north corridor; the Pediatric Intensive Care Unit (PICU) is also located on 3 West, and the Intensive Care Nursery (ICN) on the main building. When census allows patients who are followed by pediatric sub-specialists or primary physicians who exceed the 16 year age limit may be admitted to 3 West, allow for continuity and appropriate developmental care.

There is a Pediatric Residency program and House staff is available 24/7.

Description

3 West is a 19-bed unit with six hard wired monitored beds for centralized cardio-respiratory and pulse oximetry monitoring. 3 East Peds is a 10-bed unit, which has centralized cardio-respiratory and pulse oximetry monitoring. All rooms are private rooms. There is a treatment room available on each unit so that the pediatric patients can have procedures done outside of their rooms. Nursing staff is based on acuity and census.

PICU is a 12 bed pediatric intensive care unit with 7 private rooms and 3 semi private rooms. All rooms have centralized monitoring capability. The purpose of the PICU is to provide skilled nursing care twenty-four (24) hours per day for any critically ill or injured pediatric patient meeting Critical Care criteria. Pediatric multiple trauma victims and in-house cardiac/respiratory arrest patients take priority over other patients.
*Refer to the Unit Structure Standards.

Admission and Discharge of Patients to Children's Hospital

I. General Pediatric Medical/Surgical Patient Placement:
   A. Admission to 3 West and 3 East Peds: Admission may be directly from a physician office, from Children's Health Center, the Surgery Center, the Emergency Department or from the Registration Area. Admissions are accomplished through Clinical Intake and all MCCG rules and regulations apply.
   B. Bed Capacity: The total general pediatric bed capacity is 29. At times general peds patients may be housed as "overflow" patients in the PICU. If all pediatric rooms are full, and more beds are needed, pediatric patients will be placed in the adult med-surgical areas according to age, weight and diagnosis. All placements outside of Children's Hospital will be coordinated with the Attending Physician, the Clinical Resource Coordinator, and the Charge Nurse or the Director of the Children's Hospital.
   C. Discharge from 3 West and 3 East Peds will be accomplished according to MCCG Medical Staff rules and regulations.

D. The Pediatric Standard of Care requires the physician to visit the pediatric patient within six (6) hours of admission.
E. All Pediatric patients (16 and under excluding normal newborns) admitted to other services, who are not primary care providers, will have a consultation performed by either a pediatric resident or private pediatrician.

II. Patient Placement in the PICU:

A. Patients age 0 – 16 years who require intensive care or continuous monitoring may be directly admitted to the PICU from the Emergency Department or Surgery Centers, from the general peds areas, from an outside referral source – usually directly admitted via ambulance transport or via the pediatric or neo-natal transport team.
B. Bed Capacity: The total critical care bed capacity is 12. The number of beds available at any given time depends on the acuity of the patients, the number of available nursing/support staff and their individual experience/qualifications. The census is established collaboratively by the Medical Director for PICU, the Intensivist on call, and the Director, who will be involved in all situations in which patients must be triaged/transferred to another facility/refused admission to Critical Care or when the need for beds exceeds availability.

Medical Director

A. QUALIFICATIONS

The Medical Director of PICU will have demonstrated appropriate education and skill to qualify for board certification in Pediatric Critical Care Medicine as designated by the Specialty Board of Pediatrics.

B. RESPONSIBILITIES

1. In conjunction with the Vice President(s), the Medical Director will share responsibility for assuring credentials and continuing education of all hospital personnel caring for patients in the critical care units. **The Medical Director, or his designee, is available 24 hours a day, seven days a week.**

2. The Medical Director will have responsibility for the performance improvement in the Critical Care Unit. This includes, but is not limited to, policies, protocols, procedures, and admission-discharge criteria.

3. The Medical Director has the authority to establish priority of admission and discharge. In times of reduced bed availability, the Medical Director will have the final authority in admission and discharge to assure proper utilization of finite resources.

PICU Committee

A standing committee designated as the PICU Committee is an interdisciplinary group, which is charged with oversight and evaluation of the unit. This committee meets no less than quarterly and is charged with reviewing, monitoring, and evaluation activities, as well as other critical care concerns.

PICU Admission Policies

A. Circumstances of Admission

1. The decision for admission to the PICU and for bed utilization rests with the pediatric intensivist on call or assigned to the unit. Bed assignment will be based on patient acuity. If any question, the intensivist will determine acuity in collaboration with both the Charge Nurse and the Clinical Resource Coordinator and a joint decision will be made.

2. If a physician thinks his patient might need a bed post-op, the bed must be requested pre-op. Likewise, should the patient not require the Critical Care bed post-op, it is the responsibility of the surgeon to cancel the reservation.

3. In the event no PICU bed is available, elective surgery will be canceled.

B. Physician Responsibility

1. All new patients will have orders on admission and are to be seen by the attending physician or supervisory resident within four hours of admission to the PICU. **EXCEPTIONS:** If the physician has seen the patient:

   a. In the PACU just prior to admission to Critical Care.
   b. In the Emergency Department just prior to admission.
   c. On 3 West or 3 East Peds just prior to admission.

2. Patients will be seen by the Attending physician or the physician acting in his/her stead at least every 24 hours. It is the physician's responsibility to meet this standard. Failure to do so will result in a referral to the Medical Director.

C. Change of Patient Condition

The nurse will notify the Intensivist or supervisory resident of any significant change in the patient's condition or status. The approved method of contact is through the house pager. The respiratory therapist assigned to the patient is also responsible for notifying the Intensivist or resident of significant changes in respiratory status of the patient or major ventilator changes.

D. Attending Status in PICU

The Attending Physician will be clearly identified in the Admission/Transfer orders. The Admitting Office will be so notified, and the Attending Physician of record will be noted and changed if necessary. If not included in the orders, the RN will obtain MD orders designating Attending Physician.

1. Mandatory Attending by Intensivist (Critical Care Service). With the following conditions, the Intensivist will be the Attending Physician unless otherwise designated by the Intensivist.

- All patients with unstable respiratory physiology requiring respiratory interventions hourly or more frequently.
- All patients with acutely obtained artificial airway support, including endotracheal tube, tracheostomy, and nasopharyngeal tube. Patients with stable tracheostomy are excluded.
- All patients on mechanical ventilation.
- All patients in circulatory shock.
- All patients requiring vasoactive infusions, including adrenergics, IV antihypertensives, or IV vasodilators.
- Patients requiring complex (2 or more drugs) parenteral sedatives or tranquilizers for acute states of agitation or delirium.
- Coma of any etiology.

2. Surgical Patients - Unless designated otherwise by the Intensivist, the Intensivist will Attend children who meet the criteria in (1) with other participant physicians serving as consultant except as noted below.

- Children 12 years old or less and <u>not</u> meeting the criteria in (1) will be attended by the Intensivist or by a surgeon with specific pediatric specialty or subspecialty eligibility or certification. (I.e. Pediatric surgeon, pediatric neurosurgeon, pediatric orthopedic surgeon.)
- Patients 13 or older and not meeting the criteria in (1) will be on either Surgical or Critical Care Service as determined by communication between MD's.
- Patients requiring > 72 hours postoperative care in the PICU require critical care consultation or specific approval by the Intensivist for continued stay and may be candidates for transfer to the Critical Care Service.

3. Trauma Service: While the child is in the Emergency Department the trauma surgeon is the Attending Physician. The Intensivist is available to the trauma team to serve in specific roles (i.e. airway management or sedation for radiological procedures), or to accept Attending responsibilities at the discretion or the trauma Attending. When the patient is admitted to the PICU and meets the criteria

established in (1), the intensivist will be Attending Physician. Patients 13 or older and not meeting the criteria in (1) will be on either Surgical or Critical Care Service as determined by communication between MD's.

4. Medical Patients not meeting the criteria in (1) will be attended by a pediatrician.

- Medical patients requiring > 72 hours in PICU require specific approval by the Intensivist for continued stay and may be candidates for transfer to the Pediatric Critical Care Service. The Attending Physician will submit charges as primary treating physician and other participants submit charges as consultants or with modifiers.

Admission Criteria

A. Priority 1 Patients: Patients with severe or potentially life-threatening pulmonary or airway disease, severe, life-threatening, or unstable cardiovascular disease such as shock or life threatening dysrhythmias; actual or potential life-threatening or unstable neurologic disease such as seizures, altered sensorium, post-op neuro surgery patients; unstable hematologic or oncologic disease such as severe coagulopathy; severe DKA, unstable metabolic disease such as sever hypo or hypernatremia or severe metabolic acidosis; severe GI bleeding; postoperative patients who require frequent monitoring and intensive intervention; renal failure and other potentially fatal conditions such as toxic ingestions.

Priority 1 patients have no limits placed on therapy.

B. Priority 2 Patients: Patients who, at times of admission may not be critically ill but whose condition requires the technological monitoring services of the PICU. These patients may have conditions that necessitate the application of special technologic needs, monitoring, complex intervention, or treatment including medications associated with the disease that exceed general patient care policy limitations. These patients would benefit from intensive monitoring (e.g., peripheral arterial lines, central venous pressure monitoring – or continuous cardio-respiratory monitoring) and are at risk for needing intensive treatment. Examples of such admissions may include, but are not limited to, patients with underlying heart, lung, or renal disease who have severe medical illness or have undergone major surgery.

Priority 2 patients have no limits placed on therapy.

C. Priority 3 Patients: Critically ill or unstable patients who's previous state of health, underlying disease or acute illness, either alone or in combination, severely reduces the likelihood of recovery and benefit from critical care treatment. Examples of such admissions may include, but are not limited to, patients with metastatic malignancy complicated by infection or patients with end-stage heart or lung disease complicated by a severe acute illness. Priority 3 patients receive intensive therapy to relieve acute

complications, but therapeutic efforts might stop short of other measures such as intubation or cardiopulmonary resuscitation.

D. Patients who do not meet routine admission criteria are:

1. Patients who have confirmed clinical and laboratory evidenced of brain death (such patients may be admitted if they are potential organ donors, but only for the purpose of life support prior to organ donation).
2. Patients in a permanent vegetative state - unless the parents or guardians have chosen to pursue Status I Resuscitation, in which case the patient would meet the criteria for Priority 1.

These patients would be admitted to Critical Care only in unusual circumstances at the discretion of the Critical Care Medical Director and should be discharged if necessary to make room for Priority 1, 2, or 3 patients.

***Additional information available in the structure standards in the unit.**

Discharge Criteria

A. Priority 1 patients are discharged based on the following criteria: Stable hemodynamic parameters, stable respiratory status, minimal oxygen requirements, no inotropic, vasodilator, or antiarrhythmic drug are needed; ICP monitoring equipment has been removed, neurologically stable with control of seizures, no hemodynamic monitoring catheters, stable or mature artificial airways (tracheostomies) who no longer require excessive suctioning. Discharge may occur when the health care team and the patient's family have determined that there is no benefit in keeping the child in the PICU or that the course of treatment is medically futile.

Priority 2 patients are discharged when intensive monitoring has not resulted in a need for intensive treatment and the need for intensive monitoring is no longer present.

Priority 3 patients are discharged when the need for intensive treatment is no longer present, but they may be discharged earlier if the Health care team and the patient's family has determined that there is little likelihood of recovery or benefit from continued intensive treatment.

In consideration of the continuing and often specialized care needs of these patients, arrangements for appropriate non-Critical Care will be made prior to PICU discharge.
***Additional information available in the Structure Standards book in each unit.**

B. Patients who are not likely to benefit from continued Critical Care treatment include:

1. Patients with three or more organ system failures that have not responded to 72 hours of intensive therapy.
2. Patients who are brain dead or who have non-traumatic coma leading to a permanently vegetative state and a very low probability of meaningful recovery.
3. Patients who have formal limits placed upon their care indicated by "do not resuscitate" (DNR).
4. Patients with a variety of other diagnoses (advanced lung disease, end-stage cardiac disease, or widespread carcinoma) who have failed to respond to Critical Care therapy whose short –term prognosis is also extremely poor and for whom no potential therapy exists to alter that prognosis.
5. Patients with protracted respiratory failure who have not responded to initial aggressive efforts and who are also suffering from hematological malignancy.
6. Physiologically stable patients who are at low risk of requiring unique Critical Care therapy. Examples of such low risk patients may include, but are not limited to, stable surgical patients recovering from abdominal or orthopedic procedures and non-operative patients with uncomplicated DKA, or concussion.

Mandatory Consults/Policies - PICU

A. A nutrition assessment will be done on all patients who are receiving enteral or parenteral nutrition. Reassessment will be done twice weekly while the patient is receiving nutrition support

B. All PICU patients will have a mandatory Pediatric Social services assessment. Families may be seen one time only for an assessment or may be seen on an on-going basis.

C. The interdisciplinary health care team will meet at least weekly to discuss transitional care planning for the PICU patients.

D. Transfer of patients classified suicidal

For the protection of patients, the medical and nursing staff and the hospital, certain principles are to be met in the care of potentially suicidal patients. Any patient known or suspected of significant suicidal intent must have consultation by a member of the medical staff in the Department of Psychiatry (or his/her designee). The physician may exercise on the following options:

1. Document that the patient is not suicidal or at risk and can be kept on a general area.
2. Order that the patient be discharged from the PICU and admitted to an appropriate psychiatric facility for the appropriate age and development.
3. Discharge the patient to a responsible party.

E. Role of Residents and Teaching Staff

The Pediatric House Staff or the Medical/Surgical service may admit patients to the unit under the supervision of the Intensivist or Attending. The House Staff responds to Code PALS emergencies in the unit and directs the code until the Intensivist or an Attending Physician is available.

F. **Non-PICU patients**. On occasion the only available location for placement of a general pediatric patient is the PICU. Admission will be accomplished through Clinical Intake with a pediatrician or pediatric sub-specialist as Attending (if primary Attending is not a pediatrician, then the Pediatric Teaching Service or the Intensivist may take on the role of the Attending while the patient is housed in the PICU. The Intensivist should be advised of the admission of these patients in a timely manner. Should that bed be required for a PICU admission then other arrangements will be made to house the non-critical patient and that patient will be transferred from the PICU.

Failure to comply with the policy/practice criteria will result in a referral to Performance Improvement and will be reviewed by the appropriate coordinator or department for action.

The Rules and Regulations of the Medical Staff of the Medical Center of Central Georgia have been reviewed and updated pursuant to Article 15.B. of the Medical Staff Bylaws.

Adopted by the Medical Executive Committee - March 10, 2014.

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Chief of Staff

Approved by the Board – March 27, 2014.

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President/CEO