IOWA LUTHERAN HOSPITAL
FAMILY MEDICINE RESIDENCY PROGRAM

Policy: Procedures for Admissions, Discharges, Coverage, and Medical Records

No patient shall be admitted to the hospital until a provisional diagnosis has been stated and is noted in the patient's records. All patients must be admitted to a named attending physician.

The attending physician can only abrogate his responsibility by obtaining the consent of an alternative attending physician.

The responsible physician shall participate in the preparation of a complete medical record for each patient. This record shall include identification, date, history and physical, initial plan of management, progress notes, condition on discharge, final diagnosis, discharge plan, discharge summary and autopsy report when available.

The admission history and physical assessment by the physician describing the need for admission shall be completed within 24 hours. Medical records must be completed within 30 days of patient discharge. No medical record shall be finalized until it is complete except on order of the Patient Care Monitoring Committee.

Physician orders may be received and acted upon by healthcare professionals within the scope of their respective registration/licensure, pursuant to applicable policies and procedures.

All orders shall be entered via the electronic health record. Verbal orders shall be given only in circumstances where a delay would jeopardize patient safety or unreasonably prolong patient discomfort. Orders dictated over the telephone shall be entered into the medical record and signed by the healthcare professional to whom the order was dictated. The attending physician or his alternate shall sign such orders within 24 hours. Each physician must provide the administration with names and credential of all personnel authorized by himself/herself to transmit verbal orders on his behalf.

Only symbols and abbreviations approved by the medical staff may be used in patient records.

Each physician has a responsibility to carefully monitor the length of time a patient receives medication and shall, when possible, include in the order the number of days (or doses) the medication is to be given. At the end of the order period, the patient shall be evaluated by the physician before the drug is reordered. If a number of days or doses has not been specified, then the administration of the medication shall be limited by the automatic stop order policy approved by the medical staff. The justification and rationale for medications should be documented by the physician.

In cases where the diagnosis is uncertain after a reasonable period of evaluation, progress is insufficient, unusual complexity is present and/or problems are outside the attending physician's privileges, appropriate consultation must be obtained.

Each member of the medical staff shall keep on file with the hospital the names of two (2) alternate medical staff members with equivalent privileges whom he has authorized to be called in emergencies to care for his patients when he is unavailable. The attending physician shall not assume that the alternate physician will cover his patients when he is gone. The alternate physician shall only be called when the attending physician cannot be reached after a reasonable period of time.

It is the obligation of the attending physician to see that his hospitalized patients are visited by a physician each day and a progress note is written daily. A completed newborn assessment will satisfy this requirement. Mental health admissions judged stable by the physician must be visited by an attending psychiatrist within 24 hours of admission and every 48 hours thereafter.

Each member of the medical staff must honor all medical staff departmental rules and regulations as well as the policies and procedures developed by units and special areas relevant to the medical regimen prescribed for his patients.

Physicians are notified weekly of all incomplete records and their age. Charts that remain incomplete become delinquent on the 31st day following discharge, whereupon immediate restriction of admissions, consultation and operative scheduling privileges will be invoked. At that time, the physician will be notified in writing by the Chief of Staff that failure to complete the records within two (2) weeks of notification will result in suspension from the medical staff, requiring reapplication for privileges. Vacations and sickness of at least one (1) week will be considered exceptions to the above policy. If the Medical Records Department is notified, the age of the record will be adjusted for the amount of time the physician was unavailable.

Where there is a significant variation identified through the ongoing monitoring and evaluation process, the following procedure will be implemented:

A. The general issues will be discussed at department meeting, without identifying individual(s).
B. The department chairman will personally discuss the issues with the particular physician, and will provide justifying references. The fact that this process took place will be documented in the physician profile as one of the actions taken in response to the audit.
C. The department chairman will submit written complaints to the Chief of Staff if there is resistance to this process.

Residents will be responsible for seeing their admitted patients on a daily basis, writing daily progress notes, and discussing patients with family medicine staff. The responsible residents may arrange to have another resident round on his/her patients and write the daily progress note.

Residents assigned to the family medicine inpatient service will be required to attend teaching rounds with the family medicine faculty.

Each patient shall have a primary physician who is totally responsible for clinical management,

unless total or partial transfer is delegated by written order from the admitting physician.

Operative reports are dictated or typed in the medical record immediately after surgery and will contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis and the name of the primary surgeon and any assistants.

Any patient going to the operating room for surgery must have an H&P present in the medical record. If the H&P is not done by the operating physician, there must be a consult or progress note placed in the medical record by the operating physician prior to surgery, except in the cases of life-threatening emergency.

A medical history and physical examination must be completed no more than seven (7) days prior to admission.

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