Community Fairbanks Recovery Center

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MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff, in collaboration with the Board of Directors, shall adopt such rules and regulations as may be necessary to implement more superficially the general principles found within the Medical Staff Bylaws. The rules and regulations relate to the proper conduct of Medical Staff organizational activities and embody the specific standards and levels of clinical practice that are required of each Medical Staff Member and other designated individuals within the organization. The Rules and Regulations may be amended or repealed at any regular meeting of the Medical Staff and Board of Directors at which a quorum is present, and without previous notice.

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A. ADMISSIONS/DISCHARGE/TRANSFER

a. Community Fairbanks Recovery Center (CFRC) may accept and treat patients suffering primarily from addictive disorders, emotional/behavioral complications and existing medical conditions suitable for treatment in its facilities.
b. CFRC may admit all cases that present for admission by virtue of the patient's/legal guardian's signature.
c. All patients shall be notified of their rights on admission.
d. Patients shall be admitted only with a physician order.
e. Patients shall be attended by a physician member who shall be responsible for the diagnosis, medical care and treatment and for the prompt completeness and accuracy of the medical record. The term physician refers to the treating physician or the physician chosen to act as their designee.
f. Each member of the Staff shall designate another member of the Medical Staff who may attend to their patients in the event of absence and/or when they cannot be physically present for more than three (3) hours or will be unavailable by phone more than sixty (60) minutes.
g. CFRC, in agreement with the physician, reserves the right to refuse admission or to remove a patient whose needs and treatment cannot be adequately performed at CFRC.
h. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.
i. Patients will be admitted on the basis of current guidelines established by the American Society of Addiction Medicine (ASAM) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).
j. No patient shall be admitted to CFRC until a provisional diagnosis or valid reason for admission has been stated.
k. Patients may be discharged and transferred on the order of a medical provider.
l. When patients elope from CFRC and cannot be brought back by the staff voluntarily, CFRC staff will contact the patient's family in regard to the elopement if consent is present. If it is felt the patient is either a danger to himself or to other staff members, notification will be made to the Community Health Network Police Department, the local and/or state authorities and any person believed to be a potential victim.
m. If a patient chooses to leave CFRC against medical advice (AMA), a staff member will attempt to obtain the patient's or guardian's signature on the AMA form. A notation of the occurrence will be entered into the patient's medical record by the staff member.

B. PHYSICIAN ORDERS

a. An order must be given to admit, discharge or transfer a patient to another facility.
b. All orders for treatment shall be entered into the Electronic Medical Record (EMR) and shall follow established policies for content of orders.
c. Medication errors and adverse drug reactions shall be documented in the medical record.
d. A history and physical examination shall be completed within 24 hours of admission.

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e. An order may also be dictated to a licensed nurse/pharmacist and authenticated by the ordering practitioner or, if dictated over the phone, read back by the nurse/pharmacists and authenticated by the nurse/pharmacist to whom the order was dictated with the name of the ordering physician.
f. A practitioner shall authenticate the date and time of all verbal and telephone orders per policy.
g. Verbal telephone orders may be authenticated by a practitioner, other than the ordering practitioner, if the practitioner is an active member of the Medical Staff and has reviewed the order prior to authentication.
h. Routine orders and/or protocols are allowed and must be approved by the Medical Executive Committee.
i. If the patient's condition precludes completion of the history and physical examination within 24 hours, an entry shall be recorded in the medical record indicating the reason for inability to complete the examination.
j. If within 30 days of admission, a complete history and physical examination has been performed by a member of Medical Staff, a copy of the report may be considered to constitute an appropriate examination if the attending physician indicates the presence of any physical changes since the date the exam was performed.
k. The following procedure will be implemented in the event there is a difference of opinion between the attending physician and the licensed nurse:
    i. Upon receipt of a questionable order from physician, the license nurse shall first review the order with the physician;
    ii. If the nurse still questions the order, they shall call the following for clarification: pharmacists, Nurse Manager, Medical Director or designee.

C. RESPONSE TIMES

a. Physicians who are on-call must respond to non-emergency pages within thirty (30) minutes; emergency pages immediately.
b. If a physician does not respond in the specified timeframe, another physician will be called.
c. In the event of an emergency, the physician-on-call will be notified.
d. If the physician on-call is not available, the Medical Director shall be notified. If the Medical Director is unavailable, another member of the active Medical Staff shall be notified.

D. CONSULTATIONS

a. Orders for consultation shall indicate the reason for the consultation.
b. The consultant shall enter a response to the request and address the issues that required the consultation.

E. MEDICAL RECORDS

a. Patient records containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is rendered shall be maintained on each patient.
b. When appropriate, the data in the patient record shall be used in training, research, evaluation, and performance improvement programs.
c. Patient records shall contain documentation that the right of the patient are protected. Patient and family member involvement in the patient's treatment program shall be documented in the patient record.

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d. Patient records shall be directly accessible to the clinicians caring for the patient.
e. Patient records shall contain identifying data that is recorded in standardized formats.
f. This identifying data shall include: full name, home address, home telephone number, date of birth, age, sex, race or ethnic origin, next of kin, education, marital status, type and place of employment, date of initial contact or admission to CFRC, legal status including relevant legal documents, referral source, date the information was gathered and the electronic signature of the staff member gathering the information.
g. Symbols and abbreviations shall be used only if they have been approved by the Medical Staff.
h. Rubber stamps may not be used in lieu of handwritten signatures. Entries in the medical record must be legible and recorded in permanent ink. Upon implementation of the Electronic Medical Record (EMR), an electronic signature/computer key may be used in lieu of handwritten signatures.
i. Access to medical records shall be afforded to members of the Medical Staff for bona fide research and study consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved by the Medical Executive Committee before records can be studied and in accordance with Community Health Network policy and process.
j. Medical Staff having access to patient records shall be required to abide by the written policies regarding confidentiality of patient records, disclosure of information in the records as well as all applicable federal, state and local laws, rules and regulations.
k. An admission assessment shall be completed, signed and dated by the physician.
l. The patient record shall contain both physical and emotional diagnoses using either ICD and/or DSM classification systems.

F. DIAGNOSIS

a. A provisional or admitting diagnosis on every patient shall be provided by the physician before or at the time of admission.
b. The final diagnosis shall be provided by the medical provider before or at the time of patient discharge.
c. The medical provider shall electronically sign the discharge summary.

G. DISCHARGE SUMMARY

a. The discharge summary shall be entered into the patient's record within thirty (30) days following discharge and shall be electronically signed by the practitioner.
b. The discharge summary shall include: reason for admission, pertinent history and physical findings, admitting diagnoses, pertinent laboratory, x-ray or other diagnostic testing results. A clinical resume shall summarize the following: significant findings, course and progress of the patient in regard to each identified problem, clinical course of the patient's treatment, final assessment including the general observations and understandings of the patient's condition initially, during treatment, and at discharge.
c. The summary shall also include: complications during hospitalization, condition at discharge, plans for care post discharge, including prescribed medications at the time of discharge, any special diet, any activity restrictions, and arrangements for further treatment. Final diagnoses shall be recorded.

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d. If the inpatient's length of stay was less than 48 hours, a final progress noted may be entered in lieu of a discharge summary.
e. If an inpatient dies, a summation statement shall be entered in the record in the form of a discharge summary. The statement shall include the circumstances leading to death and shall be electronically signed by the physician. If an autopsy is performed, a complete report shall be requested of the coroner and, if received, made part of the record within sixty (60) days, if possible.

H. TREATMENT PLANNING

a. The physician and the treatment shall ensure that an individualized treatment plan is developed for each patient based on assessment of the patient's clinical needs.
b. The physician shall attend all team conferences and case reviews according to the program schedule.
c. Treatment plans are to be electronically signed by all members of the treatment team.

I. PROGRESS NOTES

a. Progress notes shall be dated, timed and signed (handwritten or electronically) by the individual making the entry.
b. Progress notes shall be entered into the patient's record and shall include: documentation of implementation of the treatment plan, documentation of all treatment rendered to the patient, chronological documentation of the patient's clinical course, description of changes in the patient's condition, and description of the responses of the patient to treatment, the outcome of treatment, and the response of significant others when clinically appropriate.
c. The physician/designee shall visit each patient:
    i. Detoxification patients: daily, 7 days per week;
    ii. Rehabilitation patients: as clinically indicated;
    iii. Residential: as clinically indicated;
    iv. Partial Hospitalization: as clinically indicated.
    v. A progress note shall be entered into the record at the time of each visit.
    vi. Progress notes involving subjective interpretation of the patient's progress should be supplemented with a description of the actual observed behavior.
    vii. The policies and procedures related to patient care can be found on-line and are accessible to all staff and members of the Medical and Allied Health Professional Staff.