

NEUROMEDICAL CENTER
HOSPITAL

MEDICAL STAFF

RULES & REGULATIONS

Approved: _____

TABLE OF CONTENTS

	PAGE
I. DEFINITIONS	4
II. ADMISSION	5
1. Who May Be Admitted	5
2. Who May Admit Patients	5
3. Admitting Physician's Responsibilities	5
4. Alternate Coverage	6
5. Admission Office Procedures	6
6. Priorities for Admission	6
7. Emergency Admissions	6
8. Pre-admission and Post-admission Laboratory Tests	7
9. Laboratory and Radiological Testing by Outside Facilities	7
10. Continued Hospitalization	8
III. MEDICAL ORDERS	8
1. General Requirements	8
2. Who May Write Orders	9
3. Oral Orders	9
4. Orders for Specific Procedures	10
IV. CONSULTATIONS	10
1. Who May Give Consultations	10
2. Required Consultations	10
3. Contents of Consultation Report	11
4. Pathology Consultations	11
5. Psychiatric Consultations	11
6. Surgical Consultations	12
V. SURGICAL CARE	12
1. Scheduling Surgery	12
2. Surgical Records	13
3. Anesthesia Rules and Records	14
4. Dental Patients	15
5. Operating Room Records	15
6. Attire	16
7. Pathology Report	16
8. Unusual occurrences	17
VI. POST ANESTHESIA CARE UNIT	17

1.	Who May Be Admitted	17
2.	Responsibility for Care of Patients	17
3.	Discharge from Post Anesthesia Care Unit	17
VII.	PATIENT TRANSFERS	18
1.	Who May Be Transferred	18
2.	Transporting Patients to another Facility	19
2.	Admissions	19
3.	Transfer from inpatient to hospital	20
4.	Infectious Patients	20
5.	Discharge from inpatient to home	20
VIII.	TREATMENT ROOM	20
1.	Admission to the Treatment Room	20
2.	Transfer of the Treatment Room Patient	20
3.	Determining Unassigned Status	20
IX.	MEDICAL RECORDS	21
1.	General Rules	21
2.	Authentication	21
3.	Contents	21
4.	History and Physical	23
5.	Progress Notes	23
6.	Operative Reports	24
7.	Medical Information from Other Hospitals or Health Care Facilities	24
8.	Discharge Summaries	24
9.	Delinquent Medical Records	24
10.	Possession, Access and Release	25
11.	Filing of Medical Record	26
X.	INFORMED CONSENT	26
1.	Responsibility for Obtaining Informed Consent	26
2.	Definitions	27
3.	Who May Consent	27
4.	Incompetent Patients	28
5.	Unusual Cases	28
6.	Sterilization	28
7.	Refusal to Consent	28
XI.	PHARMACY	29

1.	General Rules	29
2.	Patient's Own Drugs	29
3.	Medication Errors; Adverse Reactions	29
4.	Stop Orders	30
XII.	DISCHARGE	30
1.	Who May Discharge	30
2.	Discharge Planning	30
3.	Transfer of Patients	31
4.	Discharge of Minors and Incompetent Patients	31
5.	Autopsies and Disposition of Bodies	31
6.	Coroner's Cases	31
XIII	MISCELLANEOUS	32
1.	Reports	32
2.	Disaster Plan	32
3.	Research Activities	32
XIV.	AMENDMENTS TO RULES AND REGULATIONS	33
XV.	APPROVED ABBREVIATION LIST	35
XVI.	ADOPTION	59

MEDICAL STAFF

**RULES AND REGULATIONS
OF
NEUROMEDICAL CENTER HOSPITAL**

ARTICLE I.

DEFINITIONS

The following definitions shall apply to terms used in these rules and regulations:

- (1) **“Admission”** means the formal acceptance of a patient by the hospital in order to provide medical care and treatment.
- (2) **“Assistant”** in surgery means a doctor of medicine (M.D.) who is an appointee to the medical staff with clinical privileges to assist a surgeon in surgery.
- (3) **“Authentication”** means evidence of authorship of a written record by a written signature, initials, computer key, if applicable, or rubber signature stamp provided certain hospital requirements are met as to possession and use of the stamp.
- (4) **“Board”** means the Board of Directors of NeuroMedical Center Hospital, who have the overall responsibility for the conduct of the hospital, including the medical staff.
- (5) **“Chief Executive Officer”** means the Administrator of the hospital or his designee.
- (6) **“Executive Committee”** means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board.”
- (7) **“Clinical Privileges”** mean the authorization granted by the Board to an applicant, medical staff appointee or other independent practitioner to render specific patient care services in the hospital within defined limits.
- (8) **“Medical Staff”** means all physicians who are given privileges to treat patients in the hospital.
- (9) **“Physicians”** shall be interpreted to include both doctors of medicine and doctors of osteopathy.
- (10) **“Routine order”** means a directive from a physician nurse or other qualified therapists, examinations, and customary or regular course of medical or other appropriate staff appointee to an individual regarding drugs, treatments, other care to be given to a patient.
- (11) Words used in these rules and regulations shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these rules and regulations.

ARTICLE II

ADMISSION

Section 1. Who May Be Admitted

Admissions to this hospital shall be limited to patients with the following conditions and diseases:

- (a) ENT
- (b) Orthopedics
- (c) General surgery
- (d) Urological conditions and disorders
- (e) Diseases of the breast
- (f) Pediatric surgery up to age twelve (12)
- (g) Plastic and reconstructive surgery
- (h) Podiatry Medicine
- (i) Pain Management

Section 2. Who May Admit Patients

- (a) An individual may be admitted to the hospital only by physicians who have been appointed to the medical staff and who have clinical privileges to do so.
- (b) Individuals in need of care shall be admitted for the treatment of conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or an individual seeking necessary medical care, or for any reason cannot be admitted to the hospital, the hospital or attending physician, or both, shall assist the patient or individual in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.
- (c) Except in an emergency, no individual shall be admitted to the hospital unless a provisional diagnosis has been stated and the consent of the Chief Executive Officer or his delegate secured. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 3. Admitting Physician's Responsibilities

- (a) Each patient shall be the responsibility of a designated appointee to the medical staff, In the case of a group practice, unless the admission sheet clearly shows the admitting physician, the first name listed on the admission sheet in any group practice description shall be considered the responsible, designated medical staff appointee-. Such appointee shall be responsible for the patient's medical care and treatment, the prompt completeness and accuracy of the medical record, necessary special instructions, and transmitting reports concerning the condition of the patient to the referring appointee and to the relatives of the patient.

- (b) Whenever these responsibilities are transferred to another staff appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record. The appointee to whom the patient has been transferred shall acknowledge the transfer by initialing the chart and shall be responsible for the care of that patient until the patient is discharged from the hospital.
- (c) The responsible practitioner shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

Section 4. Alternate Coverage

Each medical staff appointee shall provide assurance of immediate availability of adequate professional care for his patients in the hospital by being available or having available an alternate medical staff appointee with whom prior arrangements have been made and who has clinical privileges at the hospital sufficient to care for the patient. Failure to meet the above requirements may result in loss of clinical privileges.

Section 5. Admission Office Procedures

- (a) An order for an elective or routine admission must be made by the attending physician and presented to the admitting office before the time the patient presents himself for admission.
- (b) No patient shall be admitted until the hospital's consent to treatment form has been signed by the patient or his legal representative.
- (c) At the time of admission or as soon as possible thereafter, each patient shall be fitted with the hospital's means of patient identification.
- (d) A physician shall have the authority to admit a patient to the service of another physician only with the consent of the other physician.

Section 6. Priorities for Admission

In any case in which a patient requires admission, the physician shall first contact the admitting department to ascertain whether there is an available bed. The admitting office will admit patients on the basis of the following order of priorities:

- (a) **Emergency Admissions** - includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. The attending physician shall be required to furnish to the Chairman of the Medical Review Committee or his designee, within forty-eight (48) hours, a signed, complete documentation of need for each admission. Failure to document the need for an emergency admission, or evidence of willful or continued misutilization of this category of admission, shall be brought to the attention of the Executive Committee for appropriate action.

- (b) **Urgent Admissions** - includes non-emergency patients whose admission is considered urgent by the attending physician and the Chairman of the Medical Review Committee, Urgent admissions shall be given priority when beds become available over all other categories except emergency.
- (c) **Pre-operative Admissions** - includes all patients already scheduled for surgery. If it is not possible to accommodate such admissions, the Chairman of the Medical Review Committee may decide the urgency of any specific admission.
- (d) **Routine Admissions** - includes elective admissions involving all services. These patients shall be given an appropriately-scheduled reservation in accordance with the hospital's utilization review plan.

If there is any question concerning the admission of a patient, the Chairman of the Medical Review Committee shall determine the necessity for, or deferment of, the admission.

Section 7. Emergency Admissions

- (a) The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart as soon as possible after admission.
- (b) Emergency admission patients who do not already have a personal physician with admitting privileges will be assigned to a medical staff appointee with appropriate clinical privileges according to the physician "on call" schedule for Treatment Room coverage. The chairperson of each clinical department shall provide an assignment schedule for attendance to such patients. If an assigned appointee is unable to take assignment when scheduled, it shall be that appointee's responsibility to arrange for a qualified substitute.
- (c) Failure of the assigned appointee to respond to an emergency call may result in a professional review action, unless that appointee presents to the Chief of Staff and the Chief Executive Officer, in writing, an acceptable reason for not attending the patient. An unexcused failure to respond to an emergency call shall be reported immediately to the Executive Committee.

Section 8. Pre-admission and Post-admission Laboratory Tests

Pre-admission testing for elective surgical patients shall be within the discretion of the admitting physician.

Section 9. Laboratory and Radiological Testing by Outside Facilities

When preadmission laboratory testing is performed by a laboratory outside of the hospital laboratory, a legible copy of tests performed must be provided on admission by a laboratory that is accredited by the College of American Pathologists (CAP), the Centers for Disease Control (CDC), the U.S. Department of Health and Human Services (Medicare), or a JCAHO hospital laboratory. Renewal of laboratory certification shall be provided in writing to the hospital at two-year intervals. Otherwise, the laboratory work must be repeated at this

hospital within fourteen (14) days prior to admission or upon admission to the hospital. When radiological testing is performed by an outside facility, a legible copy of the radiology report must be provided on admission and must be interpreted and signed by a board-certified or board-eligible radiologist.

Section 10. Continued Hospitalization

The attending practitioner is required to routinely document the need for continued hospitalization after specific periods of stay as defined by the Medical Review Committee. This documentation must contain:

- (a) An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
- (b) The estimated period of time the patient will need to remain in the hospital.
- (c) Plans for post-hospital care.

Upon request of the Medical Review Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient, including an estimate of the number of additional days of stay and the reason therefor. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the Executive Committee for appropriate action. Any patient remaining in the hospital over two (2) days must have the stay approved by the Medical Review Committee and by the Chief Executive Officer.

ARTICLE III

MEDICAL ORDERS

Section 1. General Requirements

- (a) Orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until they are rewritten and are understood by the nurse. The use of the terms "renew", "repeat" and "continue" standing alone on orders is not acceptable.
- (b) All previous orders are cancelled when patients go to surgery. Post operative orders may include an order to "resume all pre-operative orders" when written by the surgeon.
- (c) All orders will be completely rewritten when a patient is transferred from one service to another or when medication or treatment is to be resumed after an automatic stop order has been employed.
- (d) Only the abbreviations, signs and symbols listed in Appendix A to these rules and regulations shall be used in the medical record. No abbreviations, signs or symbols may be used in recording the patient's final diagnosis or any unusual complications.

Section 2. Who May Write Orders

- (a) Medical staff appointees and Medical Associates shall have the authority to write orders and only as permitted by their clinical privileges or scope of practice. All orders must be entered in the patient's record, dated, and signed by the responsible practitioner.
- (b) Licensed resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the medical staff appointee responsible for the patient's care. This does not prohibit the patient's attending physician, dentist or podiatrist from writing orders without the agreement of the resident.

Section 3. Oral Orders

- (a) Oral orders (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is impractical for such orders to be given in written manner by the responsible practitioner. Oral orders shall be taken only by qualified personnel who shall transcribe the orders in the proper place in the medical record of the patient. The order shall include the date, time, and full signature of the person taking the order. Verbal or telephone orders must be authenticated (countersigned) by the practitioner giving the order as quickly as possible after giving the order. Hazardous orders shall be authenticated within twenty-four (24) hours of giving the orders. Hazardous orders shall be defined as: Do Not Resuscitate (DNR) orders, orders for restraining and orders for chemotherapeutic agents. All other orders shall be signed upon the next visit of the physician. In the absence of the physician who gave the oral order, the order may be signed or initiated by the physician who next visits or makes rounds on the patient. A countersigned order will not require authentication by the ordering physician. Acceptance of an oral order is limited to only the following personnel, with noted restrictions:
 - (1) A physician, dentist or podiatrist with clinical privileges at this hospital
 - (2) A professional nurse
 - (3) A licensed practical nurse
 - (4) Physician assistants working under supervision and appropriate protocols of the sponsoring/employing physician or department
 - (5) A pharmacist who may transcribe oral orders pertaining to drugs
 - (6) A physical therapist who may transcribe oral orders pertaining to physical therapy regimens
 - (7) A respiratory therapist who may transcribe oral orders pertaining to respiratory therapy treatments

- (8) A dietician who may transcribe oral orders pertaining to his/her field
 - (9) A radiology technologist who may transcribe oral orders pertaining to his/her field
 - (10) A medical technologist who may transcribe oral orders pertaining to his/her field
- (b) All oral orders to discharge a patient shall be countersigned by the physician as soon as possible.

Section 4. Orders For Specific Procedures

- (a) All requests for x-ray and EKCI examinations shall contain a statement of the reason for the examination. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series.
- (b) All orders for therapy shall be entered in the patient's record and signed by the physician.
- (c) Therapeutic diets shall be prescribed by the attending physician in written orders on the patient's chart. Orders for diets must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

ARTICLE IV

CONSULTATIONS

Section 1. Who May Give Consultations

Any qualified practitioner with clinical privileges in this hospital can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the hospital, the Chief Executive Officer, the Chief of the Medical Staff, the department chief, or the appropriate section chairman, shall at all times have the right to call in a consultant or consultants.

Section 2. Required Consultations

- (a) Consultation shall be required in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent. Consultations shall be required as set forth throughout these Rules and Regulations. Consultations are also suggested in all cases in which, in the judgment of the attending physician:
 - (1) The diagnosis is obscure after ordinary diagnostic procedures have been completed
 - (2) There is doubt as to the best therapeutic measures to be used

- (3) Unusually complicated situations are present that may require specific skills of other practitioners
- (4) The patient exhibits severe symptoms of mental illness or psychosis
- (b) The attending practitioner is responsible for requesting consultation when indicated and for utilizing, whenever possible, consultants who exercise Consulting Staff privileges at NeuroMedical Center Hospital.
- (c) Additional requirements for consultation may be established by the hospital as required. It shall be the responsibility of all individuals exercising clinical privileges, to obtain any required consultations, and requests for a consultation shall be entered in the medical record. If the history and physical are not on the chart and the consultation form has not been completed, it shall be the responsibility of the practitioner requesting the consultation to provide this information to the consultant.
- (d) It is the duty of the Credentials Committee, the department chairmen and the Executive Committee, to make certain that appointees to the staff request consultations when needed.

Section 3. Contents of Consultation Report

Each consultation report should be a dictated or handwritten report containing an opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record a limited statement, such as "I concur," does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date and time of the consultation and the signature of the consultant.

Section 4. Pathology Consultations

It shall be the responsibility of both the pathologist performing an operating room consultation and the operating surgeon to have a personal consultation between them during the operation whether the procedure involves a "frozen section" or not. When it is necessary to perform such a consultation at a laboratory located outside the hospital, care shall be taken not to subject the patient to any undue hazards, such as excessive general anesthesia, while awaiting the results of the tissue examination.

Section 5. Psychiatric Consultations

Psychiatric consultation must be obtained for all patients who have been admitted in conjunction with an attempted suicide or who have taken a chemical overdose or other such self-destructive behavior. If psychiatric care is recommended, evidence that such care has at least been offered to such patients must be documented in the medical record.

Section 6. Surgical Consultations

Whenever a consultation is ordered prior to surgery, the anesthesiologist shall ascertain that a consultation was made, and that an adequate notation of the consultation appears in the medical record, if it does not so appear, surgery and anesthesia shall not proceed.

ARTICLE V
SURGICAL CARE

Section 1. Scheduling Surgery

- (a) Members of the operating team shall be appropriately available in scrub suits and the patient in the operating room at the scheduled time for surgery. Up to two (2) support persons may be permitted to observe in the operating room with the permission of the attending physician and patient.

In addition, the following persons may be permitted to observe in the operating room with permission of the attending physician, the patient, the operating room supervisor and the anesthesiologist:

- (1) Registered nurses
- (2) Licensed practical nurses
- (3) Physician's assistants or office nurses
- (4) Medical students
- (5) Nursing students during approved scheduled classes
- (6) Licensed physicians

All other requests to observe in the operating room or delivery suite must be approved by the Chief of Staff Chief Executive Officer and the Director of Nursing for Nursing Service on a case-by-case basis. The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during and after the operation. If the operating surgeon is more than twenty (20) minutes late for any scheduled case without contacting and obtaining the approval of the operating room supervisor or charge person, that case may be cancelled in accordance with medical staff guidelines and the patient returned to his room by the operating room staff. In no case shall general anesthesia be started until the operating surgeon is present in the surgical area. In the case of obstetrical patients under conduction anesthesia, no anesthesia shall be started until the attending physician is appropriately available. Operating time will be released promptly when a case is cancelled or the patient and surgical team are not available on schedule. The operating room will notify the scheduled surgeon(s) when the operating room schedule is delayed more than twenty (20) minutes.

- (b) Specific, contemplated procedures must be designated on the schedule with the name of the patient and the patient's age, diagnosis, and surgical procedure. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case will be done as originally posted or rescheduled. Cases requiring frozen sections should be posted as such at the time the case is scheduled.
- (c) Scheduling of Saturday surgery: all cases are to be scheduled "TO FOLLOW." If a physician wants to schedule a case and that time is open, an estimate of the time of the case will be written on the schedule, but the case will be scheduled as ' FOLLOW." The nurse in charge of the OR on Saturdays is in charge of scheduling. Anyone scheduling surgery after the schedule is complete is to be put at the end of the schedule. If a doctor cannot come at the time of his scheduled case, the doctor after his case is to be moved up in that place. No case should be added in front of anyone unless it is an emergency, and the routine procedure should be followed with the doctor being delayed called first. A physician who voluntarily passes his turn, except for another emergency case, is to be added at the end of the list unless he can make arrangements with another physician on the schedule.
- (d) An emergency case takes precedence over elective surgical cases not in progress. The scheduled cases shall be notified of the delay and, upon completion of emergency surgery, the elective surgical case which was pre-empted shall be immediately rescheduled to allow the pre-empted surgeon the first opportunity to proceed with elective surgery.

Section 2. Surgical Records

- (a) Except in emergencies, the following data shall be recorded in the medical record prior to surgery, or the operation shall be automatically cancelled:
 - (1) Verification of identity of patient
 - (2) Medical history and any supplemental information regarding drug sensitivities and other pertinent facts
 - (3) General physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery
 - (4) Provisional diagnosis
 - (5) Laboratory test results, if applicable
 - (6) Consultation reports, if applicable
 - (7) Signed informed consent obtained and signed by the surgeon and the patient, and an anesthesia consent form signed by the patient and the anesthesiologist or qualified anesthetist
 - (8) X-ray reports, if applicable
 - (9) Dental or podiatric X-ray reports, if applicable

- (10) Other ancillary reports, if applicable
- (b) In an emergency situation, the attending surgeon may orally communicate that delay for recording these requirements would constitute a danger to the health or safety of the patient and that he accepts responsibility for the patient's physical condition before the operation may begin. The physician must enter a notation of such communication on the patient's record within twenty-four (24) hours of the procedure. If the history and physical have been transcribed but not yet entered in the chart, an admission note and statement to that effect may be entered in the chart by the physician. All operations performed shall be fully described by the operating surgeon, who shall record at least the following information immediately after surgery: the pre operative diagnosis, post-operative diagnosis, name of the operation (using standard nomenclature), description of the operation, technique(s) used, and gross pathology observed visually or by palpation.

Section 3. Anesthesia Rules and Records

- (a) The surgeon shall identify his patient prior to administration of the anesthetic and shall remain in the operating room area in operating attire during induction. He may be asked to assist or supervise the position of his patient on the operating table and must be available in the event of an emergency.
- (b) The anesthesiologist shall verify that there has been a recent preoperative physical examination with appropriate laboratory data in the clinical record on all patients referred to him. The pre-anesthesia evaluation must include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. This evaluation must include the patient's previous drug history, other anesthetic experience and any potential anesthetic problems.
- (c) The anesthesiologist shall review the patient's condition immediately prior to induction of anesthesia.
- (d) A record shall be maintained of all events taking place during the induction of, maintenance of and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fractions,
- (e) The findings of a pre-anesthesia assessment by an anesthesiologist shall be recorded within forty-eight (48) hours of surgery. Post-anesthesia follow-up findings shall be recorded by an anesthesiologist or nurse anesthetist within twenty-four (24) hours after surgery.
- (f) The recording of post-anesthetic visits shall include at least one note describing the presence or absence of anesthesia-related complications. A note made in the surgical or obstetrical suite, or in the post-anesthesia care unit (or nursing floor anesthesia recovery phase when there is no such unit), does not ordinarily constitute a visit. While the number of visits will

be determined by the status of the patient in relation to the procedure performed and anesthesia administered, a visit should be made early in the post-operative period, and once after complete recovery from anesthesia. Complete recovery is determined by the clinical judgment of the anesthetist or the discharging surgeon/obstetrician. Each post-anesthesia note shall specify the date and time. It is recommended that a post-anesthesia medical record entry be made by a physician or, when appropriate, a qualified oral surgeon. However, all anesthesia personnel are encouraged to make pertinent post-anesthesia entries in the medical records of patients to whom they have administered anesthesia. When the post-anesthetic visit and record entry by anesthesia personnel are not feasible because of early patient release from the hospital, the physician or dentist who discharges the patient from the hospital should be responsible for meeting the requirements. General anesthesia for surgical procedures shall not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

Section 4. Dental Patients

There will be no elective scheduling of dental surgery. Dental surgery is limited to patients desiring dental work while already under anesthesia for other surgery done at this hospital. Such a patient is the dual responsibility of the attending dentist and physician.

- (a) Dentist's responsibilities:
 - (1) A detailed description of the examination of the oral cavity and preoperative diagnosis
 - (2) A complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination
 - (3) Progress notes pertinent to the oral condition
 - (4) Clinical summary or statement
 - (5) Discharge order
- (b) Physician's responsibilities:
 - (1) Medical history pertinent to the patient's general health
 - (2) A physical examination to determine the patient's condition prior to and suitability for anesthesia and surgery
 - (3) supervision of the patient's general health status while hospitalized

Section 5. Operating Room Records

- (a) A roster of physicians and dentists currently possessing surgical privileges, with a delineation of the surgical privileges of each, shall be maintained in the surgical suite and available to the operating room supervisor. There shall be an on-call schedule of physicians established and posted at each patient unit or other area where surgical patients are admitted or the communications center of the hospital to ensure that there is twenty-four (24)-hour emergency care or post-operative follow-up care, or both, available.
- (b) An operating room register shall be provided and maintained on a current basis. The operating room log or register shall contain the date of each operation, name and number of the patient, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre-operative and post-operative diagnosis, type of surgical procedure and the presence or absence of complications in surgery.

Section 6. Attire

Anyone entering the Operating Room suite will wear a scrub suit, a cap which completely covers the hair, a mask worn over the nose and mouth, and shoe covers (optional). Shoe covers and masks should not be worn throughout the hospital.

Section 7. Pathology Report

- (a) All tissues or exudates removed during a surgical procedure, except those specimens enumerated in paragraph (b) of this Section, shall be properly labeled and sent to the laboratory for examination by the pathologist who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnosis. The pathologist shall sign his report which becomes a part of the patient's medical record.
- (b) Those specimens that should not be sent to the laboratory include the following:
 - (1) Foreskins from circumcision of newborns
 - (2) Tissue/fluid from suction lipectomy
 - (3) Arthroscopy shavings
 - (4) Old scars
 - (5) Grossly normal skin and subcutaneous tissue removed during cosmetic/reconstructive surgical procedures, excluding tissue from breast reduction
 - (6) Vascular/peritoneal access device

Section 8. Unusual Occurrences.

When an unusual incident occurs in the operating room, a report must be made to the Operating Room Supervisor or designate at once containing the following information: time, place, and circumstances of the incident, persons involved, any witnesses, condition of patient, and signature of surgeon.

ARTICLE VI

POST ANESTHESIA CARE UNIT

Section 1. Who May Be Admitted

- (a) Surgical patients shall be admitted to the PACU following general, regional anesthesia or monitored anesthesia care.
- (b) The following patients shall not be considered for admission to the PACU:
 - (1) Surgical patients who have not received general, regional or monitored anesthesia care.

Section 2. Responsibility for Care of Patients

- (a) The surgeon shall remain in the operating room area until his/her patient is admitted to the Post Anesthesia Care Unit. Post operative orders must be written by the surgeon or his designated resident before the patient leaves the operating room suite. The anesthesiologist will be responsible for care and treatment of the patient while in the PACU and will provide orders to be carried out while in PACU. The anesthesiologist will assess any patients with complications or those patients not meeting discharge criteria per the Revised Aldrette scoring system.
- (b) At least one registered nurse and one ancillary staff member will be present in the PACU when there are patients present. One additional registered nurse will be immediately available, Additional personnel shall be provided to meet the needs of each patient.

Section 3. Discharge from the Post Anesthesia Care Unit

Patients receiving general, regional or monitored anesthesia may be discharged when she is stable and obtains a Revised Aidrette score of >9.

ARTICLE VII
PATIENT TRANSFERS

Section 1. Who May be Transferred

- (a) Patients to be considered for transfer to an Acute Care Hospital shall include:
1. Acute MI- for stabilization
 2. Suspected MI
 3. Acute pulmonary edema
 4. Acute respiratory failure (rate > 35 and sustained and/or pO₂ < 50 on 50% O₂)
 5. Life threatening arrhythmias
 6. Shock
 7. Post CPR
 8. Pulmonary embolism
 9. Hypertensive crisis
 10. Status epilepticus
 11. Toxic overdose with potential for cardiac arrhythmias
 12. Status asthmaticus
 13. Massive bleeding with hemodynamic instability
 14. DKA or hyperosmolar coma
 15. Laryngeal edema or other acute upper airway obstruction
 16. Severe pre-eclampsia/eclampsia
 17. Need for continuous cardiac monitoring to rule out myocardial infarction, arrhythmias, Chemotherapy protocol requiring monitoring
 18. Post-op extensive surgical procedures with need for hourly vital signs and/or continuous O₂ saturation monitoring
 19. Those who in the consideration of the attending physician involved are:
 - (i) Recovering from surgical procedures of great magnitude
 - (ii) Recovering from procedures requiring a tracheotomy
 - (iii) Undergoing extensive or complicated surgical procedures with significant medical conditions

- (iv) In postoperative shock
 - (v) In severe electrolyte imbalance
 - (vi) Recovery from prolonged anesthesia and require the skilled personnel to maintain airway and supervise complicated drainage apparatus
- 20. Post operative complications occurring after patient is in a medical unit in a hospital.
 - 21. Severe complications of obstetrics
 - 22. Miscellaneous, i.e., any acute surgical emergency that in the opinion of the attending physician warrants admission.

Section 2. Transporting Patients to another Facility

- (a) If an unstable patient is transferred to another facility, their services must be transferred to that facility.

Section 3. Admissions

All admissions to the surgical inpatient floor will be made at the request of the attending physician. In the event of a bed shortage, if there is not an agreement among physicians, further consultation with the Medical Director will be necessary. A decision will be made by the Medical Director and attending physician.

- (a) Treatment Room — Need for admission to the inpatient from the Treatment Room will be determined by the physician examining the patient in the Treatment Room. Admission to the unit will be made directly from the Treatment Room with the proper information being conveyed to the Admitting Office and the Treatment Room.
- (b) In extenuating circumstances when shock, severe pain or gross arrhythmias are evident, a patient may be admitted to the unit with out first being examined by the attending physician per verbal phone orders from the attending physician. The patient then will be seen by the attending physician as soon as possible, and that physician assumes total responsibility for the patient's medical care.
- (c) From the Operating Room — Patients admitted to the inpatient directly from the operating room or from PACU before the first stage of recovery is completed, will obtain from the anesthesiologist on duty, an order to discharge the patient from anesthesia care when the first phase of recovery is completed. In the event that the patient is unstable at the end of this period, the attending physician will be notified of the patient's condition. The attending physician can order an anesthesiology consult.

Section 4. Transfer from Inpatient to Hospital

As soon as the patient's condition warrants, he must be transferred to one of the general medical or surgical units in the hospital. The attending physician will inform the AICU personnel and the admitting office will be notified as soon as that attending physician determines that such a transfer may be accomplished. Notice to the AICU personnel will enable them to prepare for additional admissions, while notice to the admitting office will enable it to find an appropriate bed for the patient.

Section 5. Infectious Patients

When an infectious patient is admitted in AICU the nurse will consult with the Infection Control nurse and the patient will be placed in appropriate isolation.

Section 6. Discharge from the Inpatient to Home

In the unusual event that a discharge is made directly from the Inpatient it will be processed in the same manner as discharges from other hospital departments.

ARTICLE VIII

TREATMENT ROOM

Section 1. Admission to the Treatment Room

- (a) If any individual comes to the Treatment Room and requests examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within its capabilities to determine whether an emergency condition exists.
- (b) Patients who present for treatment but do not appear to have an emergency situation will be triaged. Patients with complaints that are clearly beyond the scope of our capabilities, but require emergency treatment will be stabilized and transferred.

Section 2. Transfer of the Treatment Room Patient

- (a) Transfer of patients requiring emergency treatment that is beyond the scope of NeuroMedical Center Hospital capabilities may be transferred by ambulance or EMS.
- (b) The decision to transfer must be made by the physician or qualified medical person in consultation with the physician.
- (c) If transfer to another hospital indicated by the situation, the appropriate transfer forms should accompany the patient.

Section 3. Determining Unassigned Status

- (a) A patient who presents to the Treatment Room without a physician will be considered unassigned.

- (b) If the patient is currently under the care of a physician or has recently been treated by that physician the patient is not unassigned unless the patient refused to see that physician.
- (c) If the patient has not seen a physician within a reasonable period of time nor has an appointment to see that physician or group, the physician may choose to accept the patient or have the patient become unassigned.

ARTICLE IX

MEDICAL RECORDS

Section 1. General Rules

The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient under his care. This responsibility cannot be delegated. The contents of the medical record shall be pertinent and current. A single attending physician shall be identified in the medical record as being responsible for the patient at any given time. A physician's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, but must be dated and signed by the attending physician. Symbols and abbreviations may be used in the medical record only when there is a legend to explain them. Only the abbreviations, signs and symbols listed in Appendix A of these Rules and Regulations shall be used in the medical record. Errors should be corrected by drawing a single line through the error, writing in the correct notation immediately above, and initialing and dating the correction.

Section 2. Authentication

All entries in the record shall be dated and authenticated by the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry must be individually authenticated by the signature or initials of the individual making the entry. A signature stamp is acceptable, provided the individual whose signature the stamp represents places in the administrative offices of the hospital a signed statement to the effect that the individual is the only one who has the stamp and is the only one who will use it.

Section 3. Contents

A complete medical record shall include:

- (a) Identification data, including the patient's name, address, the date of birth, the next of kin or a legally authorized representative, as well as a single unit number that identifies the patient and the patient's medical record
- (b) The patient's legal status for patients receiving mental health services
- (c) Date of admission and discharge
- (d) History, including:
 - (1) Chief complaint

- (2) Details of the present illness
- (3) Relevant past, social and family histories
- (4) Menstrual and obstetrical history
- (5) An inventory by body system
- (e) Provisional admitting diagnosis
- (f) Emergency care provided to the patient prior to arrival, if any
- (g) Physical examination (a durable, legible original or reproduction of the office or clinical records is acceptable)
- (h) The record and findings of the patient's assessment
- (i) A statement of the conclusions or impressions drawn from the admission history and physical examination
- (j) Diagnosis or diagnostic impression
- (k) The reason for admission or treatment
- (l) The goals of treatment and the treatment plan
- (m) Evidence of known advance directives
- (n) Evidence of appropriate informed consent
- (o) Diagnostic and therapeutic orders
- (p) Clinical observations, progress notes, nursing notes, consultation reports
- (q) Reports of procedures, tests and the results:
 - (1) Preoperative diagnosis and operative report
 - (2) Pathology reports
 - (3) Clinical laboratory examination reports
 - (4) Radiology and nuclear medicine examination and treatment reports
 - (5) Anesthesia records
- (r) All diagnostic and therapeutic procedures and tests performed and the results
- (s) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate
- (t) Clinical observations, progress notes, nursing notes, consultation reports
- (u) All reassessments, when necessary
- (v) The response to the care provided
- (w) Every medication ordered or prescribed for an inpatient
- (x) Every dose of medication administered and any adverse drug reaction

- (y) Every medication dispensed to or prescribed for an ambulatory patient or an inpatient or discharge
- (z) Final diagnosis, condition on discharge, summary or discharge note
- (aa) All relevant diagnosis established during the course of care
- (bb) Any referrals/communication made to external or internal care providers and to community agencies
- (cc) Autopsy report, when performed

Section 4. History and Physical

- (a) A complete history and physical examination shall be recorded and signed within twenty-four (24) hours of admission by a physician on the medical staff. This report shall reflect a comprehensive current physical assessment. If a complete physical examination has been performed within thirty (30) days prior to admission, a durable, legible copy of this report may be used in the patient's hospital medical record, providing these reports were recorded by a physician on the medical staff and there has been no change subsequent to the original examination or the changes have been recorded at the time of admission. A durable, legible original or reproduction of the office or clinic prenatal record is acceptable.
- (b) When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.
- (c) The medical record shall document that a current, thorough physical examination has been performed prior to the performance of surgery. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending physician states in writing that an emergency situation exists.

Section 5. Progress Notes

Progress notes made by the medical staff should give a pertinent chronological report of the patient's course in the hospital. Progress notes shall be legible, recorded and dated at the time of observation, and shall contain sufficient content to insure continuity of care if the patient is transferred. Wherever 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. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem. Progress notes for all other patients, except normal newborns whose hospital stay extends beyond three (3) days, must be written at least every third day. Pertinent progress notes shall also be made by others such as house staff, individuals who have been granted clinical privileges, and specified professional personnel.

Section 6. Operative Reports

Operative reports shall be dictated or written in the medical record immediately after surgery and shall contain a description of (a) the findings, (b) the technical procedures used, (c) the specimens removed, (d) the postoperative diagnosis, (e) the complications encountered, and (1) the name of the primary surgeon and any assistants. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When there is a transcription and/or filing delay, a handwritten operative progress note should also be entered in the medical record immediately after surgery in order to provide pertinent information for use by any practitioner who is required to attend the patient.

Section 7. Medical Information from Other Hospitals or Health Care Facilities

The Medical Records Department shall transmit a written request and the patient's written authorization to other hospitals or healthcare facilities requesting data concerning the patient's previous admissions, record name, birth date and dates of previous hospitalization. Information received in response to said request shall not become part of the patient's medical record at this hospital unless authorized and authenticated by the attending appointee as part of the current medical record.

Section 8. Discharge Summaries

- (a) All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and complications, shall be recorded on the face sheet, using acceptable disease and operative terminology. The face sheet shall be signed by the attending physician at the time of discharge.
- (b) A clinical discharge summary shall be included in the medical records of all patients except those with minor problems who require less than a forty-eight (48)-hour period of hospitalization. A final progress note may be substituted for the discharge summary for these patients, which should include any instructions given to the patient or family.
- (c) The discharge summary shall include the reason for hospitalization, the significant findings, any complications, the procedures performed and treatment rendered the condition of the patient on discharge, and any specific instructions given to the patient or family, as pertinent. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission. When preprinted instructions are given to the patient or family, the record should so indicate and a copy of the instruction sheet used should be on file in the medical record department. All summaries shall be authenticated by the attending physician.

Section 9. Delinquent Medical Records

- (a) Failure to complete medical records fifteen (15) days after discharge shall require a notification from the Medical Records Department advising the

medical staff appointee that his surgical posting privileges are relinquished. Privileges shall automatically be relinquished at the time that the medical record becomes delinquent, and reinstated at the time the medical record is completed.

- (b) If the medical staff appointee has failed to complete the delinquent medical record(s) that caused relinquishment of clinical privileges within forty-five (45) days after the discharge, the appointee will receive a third and final written notice from the Medical Records Department. Privileges shall be automatically relinquished at the time that the medical record becomes delinquent, and reinstated at the time the medical record is completed.
- (c) Failure to complete the medical record(s) that caused relinquishment of clinical privileges sixty (60) days from the date of the first notification by the Medical Records Department shall constitute automatic relinquishment of all clinical privileges and voluntary resignation from the medical staff.
- (d) When privileges and staff appointment are relinquished because of delinquent medical records, the individual shall be eligible to reapply for staff appointment and clinical privileges and the application shall be processed in the same manner as if it were an initial application.
- (e) No medical staff appointee shall be permitted to complete a medical record on a patient unfamiliar to him in order to retire that record.
- (f) Records of deceased patients shall be reviewed by the Medical Records department. When an autopsy is performed, provisional anatomic diagnosis shall be recorded in the medical record within three (3) days, and the complete protocol shall be made part of the record within ninety (90) days.

Section 10. Possession, Access and Release

- (a) All medical records are the physical property of the hospital and shall not be taken from the confines of the hospital. Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending physician. Unauthorized removal of a medical record from the hospital by an appointee shall constitute grounds for a professional review action.
- (b) No patient record shall be removed from the Medical Records Department except for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, and/or as needed by the Chief Executive Officer or a designee.
- (c) Upon written approval of the Chief Executive Officer, access to the medical records of all patients shall be afforded to medical staff appointees for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients.

Subject to the discretion of the Chief Executive Officer, former staff appointees shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Any publication of compiled data from the hospital's patients' medical records is forbidden without written approval of the Chief Executive Officer.

- (d) Written consent of the patient is required for release of medical information to those not otherwise authorized to receive this information.
- (e) Any record taken out of the Medical Records Department for the purpose of patient readmission shall be returned with the current record by the charge nurse on the unit upon discharge of the patient.

Section 11. Filing of Medical Record

A medical record shall not be permanently filed until it is completed by the attending physician or is ordered filed by the Medical Review Committee. When reports, e.g. laboratory, radiology, etc., are received in the Medical Records Department after discharge of the patient, that medical record, with the recently received reports flagged, will be available for the physician to review to assure that he sees such reports before the record is permanently filed.

ARTICLE X

INFORMED CONSENT

Section 1. Responsibility for Obtaining Informed Consent

- (a) The hospital's "Consent to Treatment" form shall be signed by every patient upon admission to the hospital; however, it shall be the physician's responsibility to obtain the patient's informed consent. The informed consent may be documented on procedure-specific forms, forms prepared by the Louisiana Medical Disclosure Panel or any other form which sufficiently documents that the patient has been advised of:
 - (1) The nature and purpose of the procedure
 - (2) The known risks and benefits of the procedure
 - (3) The alternative methods of treatment
 - (4) The possible need to administer blood and/or risks, if applicable
 - (5) The Anesthesia Plan options with attendant risks, if applicable
 - (6) The common and uncommon and/or percentage for specific operative risks
- (b) The patient must also acknowledge that the foregoing information has been disclosed to her, that she has been given the opportunity to ask questions, and that any questions have been answered in a satisfactory

manner. The document must be signed by the patient for whom the procedure is to be performed or, if the patient for any reason lacks legal capacity to consent, by a person who has legal authority to consent on behalf of such patient in such circumstances.

- (1) The treating physician or physician's designee shall obtain the patient's consent to any surgical procedure to be undertaken, including ambulatory surgery.
 - (2) The physician performing the procedure or physician's designee shall obtain the patient's consent to all non-routine or high-risk medical procedures.
 - (3) The anesthesiologist, or physician administering anesthesia, shall obtain the consent of the patient to the administration of anesthesia
- (c) The informed consent of the patient shall be provided to the hospital at the time of admission for inclusion in the patient's medical record. If for any reason the attending physician has not obtained the patient's informed consent prior to admission, informed consent must be documented in the patient's record prior to any surgical procedure.
 - (d) Except in emergencies, a failure to include an informed consent form in the patient's chart prior to the performance of the procedure shall automatically delay the procedure until informed consent is obtained.
 - (e) If a second operation is required during the patient's stay in the hospital, a second informed consent must be obtained by the physician.

Section 2. Definitions

The following definitions shall be applied when obtaining the patient's consent to treatment in the hospital:

- (a) **Informed Consent** - Consent obtained from the patient after being informed of the nature and risks of the proposed treatment and of the possible alternatives by the attending physician or surgeon.
- (b) **Emergency** - A situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent could jeopardize the life, health or safety of the patient.
- (c) **Emancipated Minor** - A person who, although he has not yet reached the age of 18, has been judicially emancipated (if age 16 or older) or has been or is married.

Section 3. Who May Consent

- (a) A competent adult or emancipated minor may authorize any medical or surgical treatment or care upon his body, and the consent of no other person is required or valid an emancipated minor can consent to care and procedures on himself and for his children.

- (b) Written consent shall be obtained from the parents or legal guardian of a minor before any surgical or medical procedure is performed on the minor, except in the following cases in which minors may consent for their own care:
 - (1) Emergencies
 - (2) minors seeking treatment for an illness or a disease including, but not limited to, infectious, contagious or communicable diseases or substance abuse
 - (3) pregnant minors seeking care related to their pregnancy
- (c) Written consent shall also be obtained, in all non-emergency situations, from the legal representative of any incompetent adult before any surgical or medical procedure is performed.

Section 4. Incompetent Patients

Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a patient has been declared incompetent by a court, a consent form signed by the court-appointed guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the person's next-of-kin shall be obtained; under certain circumstances, reference may be made to the hospital's policies regarding advance directives and/or Do Not Resuscitate ("DNR") orders.

Section 5. Unusual Cases

Where questions arise or unusual circumstances occur not clearly covered by these rules and regulations regarding patient consent, the attending physician shall promptly confer with hospital management concerning such matters. The hospital will make every effort to assist the physician in obtaining the required consent and providing information relative to such matters. However, it is the ultimate responsibility of the attending physician to satisfy himself that he has complied with the requirements contained in these rules and regulations.

Section 6. Sterilization

No consent will be accepted for a surgical procedure resulting in sterilization other than from the patient. Before consenting to a sterilization procedure, the patient must be informed and understand that the restoration of fertility is unlikely.

Section 7. Refusal to Consent

A patient or, if incompetent, the patient's representative retains the right to refuse medical treatment, even in an emergency situation. A second medical opinion should be recommended and obtained when the patient refuses treatment. If the

patient continues to refuse such treatment, after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form should be executed, and, if possible, signed by the patient. Such form(s) shall be kept in the patient's medical record.

ARTICLE XI

PHARMACY

Section 1. General Rules

- (a) Drug protocols established by the CQI and Medical Executive Committee shall serve as guidelines for all medical staff appointees concerning the use, administration and storage of drugs in this hospital.
- (b) All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service" or "A.M.A. Drug Evaluations," with the exception of drugs for bona fide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and approved by the Medical Executive Committee.
- (c) A pharmacist may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the medical record of the patient and properly signed after the drugs have been administered.

Section 2. Patient's Own Drug

If patients bring their own drugs to the hospital, these drugs shall not be administered unless they are identified and the attending physician has written an order for their administration. If the drugs are not ordered by the attending physician, they shall be packaged, sealed and returned to the patient at the time of discharge from the hospital. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall not be returned to the patient without approval of the attending physician.

Section 3. Medication Errors: Adverse Reactions

Any medication error or apparent drug reaction shall be reported immediately to the physician who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the medical record of the patient. Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible, in order to notify everyone treating the patient throughout the duration of his hospitalization of the drug sensitivity and thereby prevent a recurrence of adverse reaction.

Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the physician and to the director of pharmaceutical services.

Section 4. Stop Orders

A “STOP” order drug policy shall be in effect and shall apply, among others, to depressant and stimulant drugs and antibiotics. Orders are automatically discontinued on all oxytoxics after twenty-four (24) hours, anticoagulants, antineoplastics, hypnotics, sedatives and controlled drugs after five (5) days and antibiotics after seven (7) days. Inhalation Therapy treatments shall also automatically be discontinued after three (3) days. Orders for tests or procedures stated as “daily” shall be reviewed after three (3) days. At the end of the stated time, if indicated, any order to be automatically discontinued must be rewritten in the same format that it was originally recorded. No order shall be discontinued without the attending physician having been notified. All medications and treatments for all patients shall be reviewed by the attending physician at least weekly to assure discontinuance when no longer needed.

ARTICLE XII

DISCHARGE

Section 1. Who May Discharge

Patients shall be discharged on a written or verbal order of the attending physician. Should a patient leave the hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient’s medical record, and the patient shall be asked to sign the hospital’s release form.

Section 2. Discharge Planning

Discharge planning shall be an integral part of the hospitalization of each patient and shall come as soon as possible after admission. When hospital personnel determine no discharge planning is necessary in a particular case, that conclusion shall be noted on the medical record of the patient. All Medicare patients shall be interviewed by appropriate social service personnel to determine the adequacy of discharge planning. Discharge planning shall include, but need not be limited to, the following:

- (a) Appropriate referral and transfer plans.
- (b) Methods to facilitate the provision of follow-up care.
- (c) Information to be given to the patient or patient’s family or other persons involved in caring for the patient on matters such as the patient’s condition, health care needs, the amount of activity the patient should engage in, any necessary medical regimens including drugs, diet, or other forms of therapy, sources of additional help from other agencies, and

procedures to follow in case of complications. The attending physician shall be responsible for overseeing that this information is provided.

Section 3. Transfer of Patients

A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient. Pursuant to the laws of this state, patient transfer shall be executed only upon physician referral from the transferring medical facility to another physician at the receiving medical facility.

Section 4. Discharge of Minors and Incompetent Patients

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

Section 5. Autopsies and Disposition of Bodies

- (a) The remains of any deceased patient, including a fetal death or a neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician, the event adequately documented within a reasonable period of time by the attending physician or another designated medical staff appointee or resident and only with the consent of the parent, legal guardian, or responsible person. Death certificates are the responsibility of the attending physician and must be completed within twenty-four (24) hours of death or birth in the case of fetal death.
- (b) It shall be the duty of all medical staff appointees to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only with proper consent in accordance with state law and hospital policy. All autopsies shall be performed by the hospital pathologist or a designee. Provisional anatomic diagnoses shall be recorded on the medical record within forty-eight (48) hours and the complete protocol shall be made a part of the medical record within ninety (90) days.

Section 6. Coroner's Cases

It is the responsibility of the attending physician or a designee to notify the coroner of any cases considered a coroner's case. The following are classified as coroner's cases in East Baton Rouge Parish:

- (a) All cases, even with physician care, which suggest that death was violent, suspicious in nature, or was the result of other than natural causes.
- (b) All cases of death from suicide, homicide, poisoning, or criminal abortion.

- (c) All deaths from accidents of any type (auto, industrial, home, burns, shock, etc.) where the death occurs within a period of one (1) year and one (1) day following the accident.
- (d) All cases of criminal assault, or any cases in which external violence acted as a contributing cause and where death occurred within a period of one (1) year and one (1) day after such violence.
- (e) Any death occurring in the operating room or within twenty (24) hours of an anesthetic.
- (f) All cases where the cause of death is under reasonable suspicion or in which a definitive diagnosis cannot be made with reasonable certainty.
- (g) Any newborn infant dying within twenty-four (24) hours.
- (h) Any death which has occurred without medical attendance, including DOA's.
- (i) Deaths occurring within twenty-four (24) hours after admission.

ARTICLE XIII
MISCELLANEOUS

Section 1. Reports

It shall be the responsibility of each appointee to the medical staff to report, in writing, to the Medical Director or the Chief Executive Officer any conduct, acts or omissions by appointees to the medical staff of which he is aware which he, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the hospital, or which violate professional ethics.

Section 2. Disaster Plan

The plan for the care of mass casualties shall be rehearsed twice a year by key hospital personnel, including appointees to the medical staff. Each appointee to the staff shall be responsible for familiarizing himself with the plan. All staff appointees shall be assigned to posts, either in the hospital or elsewhere, and it is their responsibility to report to their assigned stations. The Chief of the Medical Staff and the Chief Executive Officer will work as a team to coordinate activities and give directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the Chief of the Medical Staff or the Chief Executive Officer, or their respective designees, will authorize the movement of patients.

Section 3. Research Activities

- (a) Participation in research projects by medical staff appointees is encouraged. To ensure adequate compliance with any applicable guidelines and laws, medical staff appointees shall consult with the

Research Institute and obtain the necessary approvals regarding any research projects in which they propose to participate.

- (b) A letter or a copy of the research projects/proposals, including the protocol to be used in conducting the research and specific goals of the study, will be submitted to a Research Coordinator in the.
- (c) The Research Coordinator shall submit the protocol to the Research and Development Council for consideration and approval. Appropriate subcommittees will be formed from this committee when a more extensive review of a protocol is deemed necessary.
- (d) Unless the proposed study fits the Office of Protections from Research Risks (OPRR) criteria for exemption from Institutional Review Board approval, the Research Coordinator will submit the proposed study and the patient information/informed (when applicable) to the
- (e) Any clinical research involving investigational new drugs or investigational devices must have proof of the FDA registration number for the product. Research proposals involving investigational new drugs must be initially approved by the NeuroMedical Center Hospital Director of Pharmacy before IRB submission.
- (f) The results of all research projects, clinical, statistical or other wise, as well as all proposed publications written or provided by a member of the medical staff, shall be submitted to the Research and Development Council for approval to publication. This council will forward the study to the CEO for final approval.

Specific protocols to be followed in the case of pharmaceuticals shall be submitted to the Pharmacy and Therapeutics Committee.

ARTICLE XIV

AMENDMENTS TO RULES AND REGULATIONS

Rules and regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in NeuroMedical Center Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards.

- (a) Particular rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions, or repeals are appropriately disseminated to the medical staff and made available to all members of the Executive Committee fourteen (14) days before being voted on and further provided that all written comments on the proposed changes by persons holding current appointments to the medical staff be brought to the attention of the Executive Committee

before the changes are voted upon. Adoption of and changes to the rules and regulations shall become effective only when approved by the Board.

- (b) All proposed amendments of these rules and regulations initiated by the medical staff shall, as a matter of procedure, be referred to the Executive Committee. The Executive Committee shall report on them either favorably or unfavorably at the next regular meeting of the medical staff; or at a special meeting called for such purpose. They shall be voted upon at that meeting provided that they shall have been posted on the medical staff bulletin board at least fourteen (14) days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the voting staff who are present at the time of such vote and who do vote. Amendments so adopted shall be effective when approved by the Board.
- (c) The Executive Committee shall have the power to adopt such amendments to these rules and regulations as are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the medical staff or the Board within sixty (60) days of adoption by the Executive Committee. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee. Immediately upon adoption, such amendments shall be sent to the Chief Executive Officer and posted on the medical staff bulletin board for fourteen (14) days.

ARTICLE XV
APPROVED ABBREVIATION LIST
NEUROMEDICAL CENTER HOSPITAL

<u>A</u>	
a	before
@	at
aa	of each
AA	Alcoholics Anonymous
A & P	Anterior and posterior
abd	abdomen; abdominal
ABG's	Arterial blood gases
a.c.	before meals
AC	antecubital
ACL	anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
AD	right ear
ad lib	freely as desired
adm	admit
ADA	American Dietetic Association
ADH	antidiuretic hormone
ADL	activities of daily living
AFB	acid fast bacilli
A Fib	Atrial Fibrillation
AIDS	Acquired Immune Deficiency Syndrome
A-K	above the knee
alk	alkaline
Alk. phos	alkaline phosphatase
A.M., am	before noon
A.M.A.	against medical advice; American Medical Association
amb	ambulatory; ambulate
A.M.I.	Acute Myocardial Infarction
amp	ampule; amputation; ampere
Amt	amount
Anes	anesthesia
ant	anterior
ant. ax. line	anterior axillary line
ante	before
anti HBc	antibody to hepatitis B core antigen
anti HBe	antibody to hepatitis Be antigen

anti HBs	antibody to hepatitis B surface antigen
A & P	auscultation & percussion
A-P	anterior - posterior
A.P. and Lat	anterior, posterior, and lateral
approx.	approximately
aq	aqueous; water
ARD	Acute Respiratory Disease
AS	left ear
ASA	aspirin
ASAP	as soon as possible
ASCVD	arteriosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
as tol	as tolerated
asst	Assistant
A-V	atriovenous; Atrial-ventricular; audio-visual
A/V Diss	Atrioventricular Dissociation
1° A/V HB	first degree A V Heart Block
2° A/V HB	second degree A V Heart Block
3° A/V HB	third degree A V Heart Block
A/V Node	Atrioventricular Node
Ax	Axilla; Axillary; Axis
B	
Ba	barium
bact	bacteria
baso	basophile
BB	bier block
BBB	bundle branch block; blood-brain barrier
BBS	bilateral breath sounds
b.i.d.	two times a day
b.i.n.	two times a night
Bil	bilateral
B-K	below the knee
bkfst	breakfast
Bld	blood
BM	bowel movement
BMR	basal metabolic rate
BOM	bilateral otitis media

BP (B/P)	blood pressure
BPH	benign prostatic hypertrophy
BRGHC	Baton Rouge General Health Center
BRGMC	Baton Rouge General Medical Center
BR	bathroom
BRP	bathroom privileges
B.S.	blood sugar
BSOM	bilateral serous otitis media
BTM	bilateral tympanic membrane
BUN	blood urea nitrogen
Bx	biopsy
C	
C°	Centigrade; celsius degrees
c	with
C/= or C/E	clear and equal
C-1 to C-7	cervical vertebrae 1 through 7
Ca	carcinoma; calcium
CAB	coronary artery bypass
CAD	Coronary artery disease
cat	cataract
CAT	computerized (axial) tomography scan
cath	catheter, catheterized, catheterization
CBC	complete blood count
CBS	chronic brain syndrome
CCU	Coronary Care Unit / Critical Care Unit
C/D/B	cough, deep breathe
CDC	Center for Disease Control
C-gram	cystogram
C/D/I	clean, dry, intact
CHB	complete heart block
CHD	coronary heart disease
CHF	congestive heart failure
CHO	carbohydrates
CH O	formaldehyde
chol	cholesterol
circ	circulation
CIT	cauterization inferior turbinates
Cl	chlorine

cm	centimeter
CMS	circulation, movement, sensation
CNS	central nervous system
C/O	complaint of
CO	carbon monoxide
CO2	carbon dioxide
contra	against
cont'd	continued; continue
COPD	chronic obstructive pulmonary disease
CPK	creatinine phosphokinase (same as CK)
CPR	cardio-pulmonary resuscitation
CPT	chest physiotherapy
C&S	culture and sensitivity
CRNA	certified registered nurse anesthetist
CRNFA	certified registered nurse first assistant
C-section	Cesarean section, cesarean section
CSF	cerebrospinal fluid
C-Spine	Cervical Spine
CST	Certified Surgical Technologist
CTR	carpal tunnel release
cu	cubic; copper
cult	culture
CVA	cerebrovascular accident
CVP	Central Venous Pressure
cysto	cystoscopy
D	
Discharge	Do not use abbreviations
Discontinue	Do not use abbreviations
D&C	dilation and curettage
DDD	Degenerative Disc Disease
DDS	Doctor of Dental Surgery
Defib	Defibrillation
D/I	dry, intact
Dia	diathermy
dil	dilation; dilatation
DIC	Disseminated Intravascular Coagulopathy
diff	differential (blood count); difficulty
Dip	distal interphalangeal
DJD	degenerative joint disease

dl	deciliter
DM	diabetes mellitus
DNA	deoxyribonucleic acid
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DP	dorsalis pedis
DPT	diphtheria, pertusis, tetanus
Dr.	doctor
dr	dram
DSG	dressing
DST	dexamethasone suppression test
DT	delirium tremens
D.T.	Diphtheria Tetanus, Diet Technician
DTR	deep tendon reflexes
D/W	dextrose in water (D5W)
Dx	diagnosis
<u>E</u>	
E	Eye
EBV	Epstein-Barr virus
ECCE	extra capsular cataract extraction
ECG or EKG	electrocardiogram; electrocardiograph
ECHO	echocardiogram
EEG	electroencephalogram; electroencephalograph
EENT	eye, ear, nose, throat
e.g. or i.e.	for example
elix	elixir
endo	endoscopy/endoscopic
ENT	ears, nose, throat
EOM	extraocular movement
eos	eosinophils
EPF	endoscopic plantar fasciotomy
ER	emergency room
ESI	Epidural steroid injection
ESR	erythrocyte sedimentation rate
ET	endotracheal, endo
ETA	estimated time of arrival
etiol	etiology
exc	excision
Exer	exercise

Exp	exploration
Exp. Lap.	exploratory laparotomy
F	
F	female; Fahrenheit; field of vision formula
FA	folic acid assay; fatty acid
F.B.	foreign body
FBS	fasting blood sugar
FDP	fibrin degradation products
Fe	iron
fem	femoral
FESS	Functional Endoscopic Sinus Surgery
ff	force fluids
FH	family history
fl. oz. or fld. oz.	fluid ounce
FOB	foot of bed
FS	face shield
F.S.	frozen section
FSH	follicle stimulating hormone
FSP or FDP	fibrin split or degradation products
Ft	foot, feet
FUO	fever of undetermined origin
f. waves	flutter waves
Fx	fracture
G	
g	gauge
GB	gallbladder
GC	gonococcus
Gen/GEN	general anesthesia
GFR	glomerular filtration rate
GG	gamma globulin
GGT	gamma glutamyl transferase
GI	gastrointestinal
glob	globulin
glu	glucose
gm	gram
GP	General Practitioner
gr	grain
Grav. 1	primigravida
gt	drop (gutta)

gtt	drops (guttae)
GTT	glucose tolerance test
GU	genitourinary
GYN	gynecology
H	
HA	Hepatitis A ; headache
HAA	hepatitis Australian antigen (same as HBsAg)
HA Ag	hepatitis A antigen
HB	hepatitis B; Heart Block
HOB	head of bed
Hgb	hemoglobin
HBcAg	hepatitis B core antigen
HBe	hepatitis Be
HBeAg	hepatitis Be antigen
HBF	fetal fraction of hemoglobin
HBP	high blood pressure
HbS	abnormal hemoglobin (S)
HBsAg	hepatitis Bs antigen
HCHO	formaldehyde
HCO3	bicarbonate standard
Hct	hematocrit
HCVD	Hypertensive cardiovascular disease
HEENT	head, eyes, ears, nose, throat
HGH	human, growth hormone
H&H	hemoglobin and hematocrit
HNP	herniated nucleus pulposus
H&P	history and physical
hr	hour; hours
HR	heart rate
hs	hour of sleep; at bedtime
HSCBR	HEALTHSOUTH Surgery Center of Baton Rouge
HSV	herpes simplex virus
ht	height
HT	heart tones
HTN	hypertension
H 2 O	water
hypo	hypodermic
Hx	history
I	

I	Iodine
ICU	Intensive Care Unit
ICS	Intercostal space
I&D	incision and drainage; irrigation and debridement
ID	immunodiffusion
IM	intramuscular; infectious mononucleosis
IMP	impression; impaction/ impervious
IMV	Intermittent Mandatory Ventilation
Inc. Ab	incomplete abortion
indep	independent
IDD	Intervertebral disk disorder
inj	injection
inst	instruction
I&O	intake and output
Int. Med	Internal Medicine
IOP	intraocular pressure
IOL	intraocular lens
IQ	intelligence quotient
IPPB	intermittent positive pressure breathing
ITP	idiopathic thrombocytopenic purpera
Unit	do not abbreviate
IUD	intra-uterine device
IV	intravenous
IVP	intravenous push; intravenous pyelogram
IVPB	intravenous piggyback
IVR	Idioventricular Rhythm; IV regional anesthesia
<u>J</u>	
<u>K</u>	
K	potassium
K Cl	potassium chloride
kg	kilogram
KMNO4	potassium peremanganate
K/O	keep open
KUB	kidneys, ureters, bladder
KVO	keep vein open
<u>L</u>	
L	left; liter; length; lumbar; lethal
lb	pound

lg	large
L to L	lumbar vertebrae 1 through 5
lab	laboratory
lat	lateral
LAUP	Laser assisted uvulopalatopharyngoplasty
LBBB	Left Bundle Branch Block
LBP	low back pain
LD	learning disability
LDH	lactic dehydrogenase
LE	lupus erythematosus
LFC	lateral femoral condyle
LFS	liver function studies
LIHR	left inguinal hernia repair
LH	luteinizing hormone
Lig	ligament
LKS	liver, kidney, spleen
LLQ	left lower quadrant (abdomen)
LLT	left lateral thigh
L/M	liters per minute
LMP	last menstrual period
LOA	leave of absence
LOC	local anesthesia
L.O.C.	level of consciousness
LOM	left otitis media
LP	lumbar puncture
LPN	Licensed Practical Nurse
L/R	lactated ringers
Lt.	left
Lt. UL (LUL))	left upper lid
Lt LL (LLL)	left lower lid
LUG	left upper gluteal
LUL	left upper lobe (lung)
LUOG	left upper outer gluteal
LUQ	left upper quadrant
LV	left ventricle
LVG	left ventral gluteal
LVH (RVH)	left ventricular hypertrophy (right)
<u>M</u>	
M	male; meter; myopia; muscle; thousand
MAC	monitored anesthesia care

MA-1	respirator
m	minim; meter
MAE	moving all extremities
MAR	medication administration record
mcg	microgram
M.D.	Medical Doctor
Meds	medications; minimal effective dose
mEq	milliequivalent
mEq / L	milliequivalent per liter
MFC	medial femoral condyle
mg	milligram
MH	malignant hyperthermia
MI	myocardial infarction
MICU	Medical Intensive Care Unit
MP	Metacarpal Phalangeal
ml	milliliter
mm	millimeter
mm/hr	millimeter per hour
mmHg	millimeter of mercury
mod	moderate
MOM	Milk of Magnesia
Morphine Sulfate	(spell out the word it may be mistaken with MSO4/ spell all drug names out)
MRI	magnetic resonance imaging
M.T.	Medical Technologist
mV	millivolt
MVP	Mitral valve prolapse
<u>N</u>	
N	nitrogen; normal
Na	sodium
NA	nasal antral (windows)
N/A	not applicable
NaCl	sodium chloride
NaHCO	sodium bicarbonate
NAD	no appreciable disease
NB	new born
N/C	nasal cannula
NCV	nerve conduction velocity
neg	negative
neuro	neurology / neurological
N/G	nasogastric

NH	nursing home
NKA	no known allergies
NKDA	No Known Drug Allergies
noct	night; nocturnal
NPO, n.p.o.	nothing by mouth (non per os)
N/S	normal saline
NSD	Nasal Septal Defect or Nasal Septal Deformity
NSR	normal sinus rhythm
N&V	nausea and vomiting
N v/s	neurological vital signs
<u>O</u>	
∅	none; no
O ₂	oxygen
OB	obstetrics
OBS	organic brain syndrome
OCP	ova, cysts, parasites
oint	ointment
OJ	orange juice
OK	within normal limits
OLOLRMC	Our Lady of the Lake Regional Medical Center
OM	otitis media
O.O.B.	out of bed
OP	operation
O.P.	outpatient
Ophth.	ophthalmology
OR	operating room
ORIF	open reduction internal fixation
Ortho	orthopedic
OS	left eye (oculus sinister)
OT	occupational therapy
O ₂ Sat	oxygen saturation of arterial blood
OU	each eye; (oculus uterque)
oz	ounce
<u>P</u>	
p	after
P	pulse; pupil; phorphorus
PA	physician's assistant
P-A; P/A	posterior-anterior
P&A	percussion and auscultation

PAC	Premature Atrial Contraction or Beats
PACU	post anesthesia care unit
Pap test	Papanicolaou smear
Para I, II, III	unipara, bipara, tripara
PAS, PASA	para aminosalicylic acid
PAT	paroxysmal atrial tachycardia
path	pathology
PBI	protein-bound iodine
pc	after meals
pCO ₂	carbon dioxide pressure
PCP	primary care physician
PEEP	positive end-expiratory pressure
PDR	physicians desk reference
PE tubes	polyethylene tubes
PE	pulmonary embolus; physical exam
Ped	pediatric
Pedi-RM	pediatric room
PEG	pneumoencephalography
per	through
PERL	pupils equal and reactive to light
PERRLA	pupils equal, round, regular, reactive to light and accommodation
Phaco	phacoemulsification
PI	peripheral iridectomy
PID	pelvic inflammatory disease
PKU	phenylketonuria
PJC	premature junctional contraction
PM; pm	evening; postmortem
PMI	point of maximal impulse
PMS	premenstrual syndrome
PNC	Premature Nodal Complex or Beats
P.N.D.	Paroxysmal Nocturnal Dyspnea
PND	post nasal drainage
PO, p.o.	orally (per os)
pO ₂	oxygen pressure
pop	popliteal
poss.	possible
postop	postoperative
pp	postprandial
PPB	positive pressure breaths
PPD	purified protein derivative (TB Test)
PPK	partial penetrating keratoplasty

ppm	parts per million
Pr	presbyopia; prism
PRBC	packed red blood cells
preop	before surgery
Pre-Op	preoperative room
p.r.n., PRN	as required (pro re nata)
pro time	prothrombin time
PROM	passive range of motion
psych	psychiatric
PSVT	paroxysmal supraventricular tachycardia
pt	pint; patient
PT	physical therapy; prothrombin time; posterior tibial
P	pulmonic second sound
PTH	parathyroid hormone
PTT	partial thromboplastin time
PUD	peptic ulcer disease
Pulm. T.	pulmonary toiletry
pulse ox	pulse oximeter
PVC	premature ventricular complex, contraction, or beats
Q	
q	every
QA	Quality Assurance
QA & I	Quality Assessment and Improvement
every day	no abbreviation write out "every day"
q.h.	every hour
q.i.d.	four times daily
nightly	no abbreviation write out "nightly"
qns	quantity not sufficient
every other day	no abbreviation write out "every other day"
q.o.n.	every other night
qs	quantity sufficient
qt.	quart
R	
R	right; respiration
RA	rheumatoid arthritis; room air
RAIU	radioactive iodine uptake
RBBB	right bundle branch block
RBC	red blood cell
RDA	recommended dietary allowance

R.D.	Registered Dietitian
re	regarding
Resp.	respirations; respiratory
Retic	reticulocyte
RF	rheumatoid factor
RIHR	right inguinal hernia repair
RLL	right lower lobe (lung)
RLQ	right lower quadrant (abdomen)
RLT	right lateral thigh
rm	room
RM	respiratory movement
RML	right middle lobe (lung)
RN	registered nurse
R/O	routine order; rule out
ROM	range of motion
ROS	review of systems
RR	respiratory rate
RSR	regular sinus rhythm
RT	respiratory therapy; reading test
RT3	radio T3 uptake test
Rt. UL (RUL)	right upper lid
Rt. LL (RLL)	right lower lid
RUG	right upper gluteal
RUL	right upper lobe (lung)
RUOG	right upper outer gluteal
RUQ	right upper quadrant (abd.)
RVG	right ventral gluteal
RVH	right ventricular hypertrophy
Rx	prescription
<u>S</u>	
s	without
S	Sacral
SA Block	sinoatrial block
SA Node	sinoatrial node
SaO ₂	oxygen saturation of arterial blood
SBE	subacute bacterial endocarditis
SCBR	Surgi-Center of Baton Rouge
sec	second
SBO	small bowel obstruction
sed rate	sedimentation rate

SGOT	serum glutamic oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SICU	Surgical Intensive Care Unit
sm	small
SMR	submucous resection
S & O	salpingo-oophorectomy
SOB	shortness of breath
sol	solution; dissolved
sp. gr., or SG	specific gravity
spec	specimen
SR	side rails
one half or 1/2	no abbreviation write out one-half or 1/2
sss	sick sinus syndrome; specific soluble substance
septo	septoplasty
staph	staphylococcus
stat	immediately (statim)
strep	streptococcus
ST	sinus tachycardia, Surgical Technologist
S.T.S.	serologic test for syphilis
SVT	supra-ventricular tachycardia
Subcutaneous or sub cut	no abbreviations ok to write "sub cut" or write out "subcutaneous"
surg	surgery
Sx	suctioned; suction; symptom
S/S	signs & symptoms
<u>T</u>	
T	temperature; Thoracic
T3	3,4,3-Triiodothyronine
T4	Thyroxin
T7	calculated free thyroxin index
T & A	tonsillectomy and adenoidectomy
tab	tablet
TAB	triple antibiotic
TAH	total abdominal hysterectomy
TAT	tetanus antitoxin; toxin-antitoxin
TB	tuberculosis; tuberculin; tubercle bacillus
Tbsp	tablespoon
TCDB	Turn, cough, deep breathe
Tech	Technologist
temp	temperature
TIBC	total iron binding capacity

TIA	transient ischemic attack
TKO	to keep open
TID	three times a day
TLM	torn lateral meniscus
T&M	type and match
TMJ	temporomandibular joint
TMM	torn medial meniscus
TFNR	total functional nasal reconstruction
TNS	transcutaneous nerve stimulation
TPR	temperature, pulse, respirations
T&S	type and screen
TSH	thyroid stimulating hormone
tsp	teaspoon
TT	T tube
T.T.	tetnus toxiod
TUR	transurethral resection
TURP	transurethral resection of prostate
tx	treatment
<u>U</u>	
Unit or Uranium	no abbreviations write out "unit" and "Uranium"
UA	urinalysis; uric acid
ug	microgram
UGI	upper gastrointestinal
umb	umbilicus
uppp	uvulopalatopharyngoplasty
URI	upper respiratory infection
Urol	urology
u/s	ultrasound
USP	United States Pharmacopoeia
UTI	urinary tract infection
<u>V</u>	
V.A.	visual acuity
VD	venereal disease
VDRL	venereal disease research laboratory (STS)
vf	ventricular flutter
VF	ventricular fibrillation
vit	vitamin
VO	verbal order
Vol	volume

Vol%	volume percent
VP	venous pressure
VS	vital signs; volumetric solution
VT	ventricular tachycardia
VW	vessel wall
<u>W</u>	
w/	with
Wall neb	wall nebulization treatment
WBC	white blood count
W/C	wheelchair
w/d	warm & dry
WFE	William Flexion exercises
wk	week
WN	well nourished
WNL	within normal limits
w/o	without
WPRBC	washed packed red blood cells
WPW	Wolfe-Parkinson white syndrome
WSR	Westergran sed rate
Wt	weight
wts	weights/watts
<u>XYZ</u>	
X-ray	Roentgen ray

INJECTION SITE ABBREVIATIONS

<u>2/15/03</u>	
LAT	Left Anterior Thigh
RAT	Right Anterior Thigh
LUOQ	Left Upper Outer Quadrant
RUOQ	Right Upper Outer Quadrant
LG	Left Gluteal
RG	Right Gluteal
RD	Right Deltoid
LD	Left Deltoid
RUG	Right Upper Gluteal
RUOG	Right Upper Outer Gluteal
LUG	Left Upper Gluteal
LUOG	Left Upper Outer Gluteal
RLT	Right Lateral Thigh

LLT	Left Lateral Thigh
LVG	Left Ventral Gluteal
RVG	Right Ventral Gluteal

MEDICAL RECORDS

Addendum ABBREVIATIONS FOR ORTHOPEDIC PROCEDURES

2/15/03

A
Active

A-1
is not abbreviation

AA
Active Assistive

ABDQ
Abductor Digiti Quinti

ADQM
Abductor Digiti Quinti Minimi

AFB
Acid Ast Bacillus

AIMNT
Anterior Intramuscular Nerve Transposition

APB
Abductor Pollicis Brevis

APL
Abductor Pollicis Longos

AVN
Avascular Necrosis

B

BR
Brachioradialis

C

CAP
Capsulotomy

CBC
Complete Blood Count

CC
Cylinder Cast

CDA
Common Digital Artery

CDN
Common Digital Nerve

CEO
Common Extensor Origin

CHLT
Capitate Hamate Lunate Triquetral

CMC
Carpometacarpal

CR
Closed Reduction

CRPP
Closed Reduction Percutaneous Pinning

CTR
Carpal Tunnel Release

CTS
Carpal Tunnel Syndrome

D

DBS
Dorsal Blocking Splint

DC
Dorsal Compartment

DCG
Dorsal Carpal Ganglion

DCP
Dynamic Compression Plate

DeQ
DeQuervains Syndrome

DIN
Dorsal Interosseous Nerve

DIP
Distal Interphalangeal

DJD
Degenerative Joint Disease

DRSN
Dorsal Radial Sensory Nerve

DRUJ
Distal Radial Ulnar Joint

DSBUN
Dorsal Superficial Branch of the Ulna Nerve

E

ECRB
Extensor Carpi Radialis Bervis

ECRL
Extensor Carpi Radialis Longus

ECU
Extensor Carpi Ulnaris

EDU
Extensor Digitorum Communis

EDL
Extensor Digitorium Longus

EDM
Extensor Digiti Minimi

EDQP

Extensor Digitorum Quintis Proprius

EIP

Extensor Indicis Proprius

EPB

Extensor Pollicis Brevis

EPI

Epicondylitis / Epicondylectomy

EPL

Extensor Pollicis Longus

EUA

Examine Under Anesthesia

F

FCC

Fibral Cartilage Complex

FCR

Flexor Carpi Radialis (tendon)

FCU

Flexor Carpi Ulnaris

FDP

Flexor Digitorum Profundus

FDS

Flexor Digitorum Superfundus

FES

Functional Electrical Stimulation

FPL

Flexor Pollicis Longus

FSG

Flexor Sheath Ganglion

FTG

Free Tendon Graft

FTSG

Full Thickness Skin Graft

FX
Fracture

G

GCT
Giant Cell Tumor

GSW
Gun Shot Wound

H

H & P
History and Physical

HTFPF
Hyopothernar Fat Pad Flap

I

I & D
Irrigation & Debridement

IF
Index Finger

INTR
Intrinsic Release

IP
Interphalangeal Joint

J

K

L

LAC
Laceration

LACN
Lateral Antibrachial Cutaneous Nerve

LAS
Long Arm Splint

LATSC
Long Arm Thumb Spica Cast

LDO
Long Dorsal Outrigger

LF
Long Finger

LT
Lunate Triquetrum (Triquetral)

M

MACN
Medial Antibrachial Cutaneous Nerve

MC
Metacarpal

MCE
Medicare

MCD
Medicaid

MF
Middle Finger

MP

Metacarpal Phalangeal

N

O

ORIF
Open Reduction Internal Fixation

P

P₁
Proximal Phalanx

P₂
Middle Phalanx

P₃
Distal Phalanx

P
Passive

PCB
Palmar Cutaneous Branch

PCBRN
Palmar Cutaneous Branch Radial Nerve

PIN
Posterior Interosseous Nerve

PIP
Proximal Interphalangeal Joint

PL
Palmaris Longus

PP
Percutaneous Pinning

PQ
Pronator Quadratus

PRC
Proximal Row Carpectomy

PT
Pronator Teres

PVNS
Pigmented Villionodular Synovitis

Q

R

RA
Rheumatoid Arthritis

RC
Radial Capitate

RC tear
Rotator Cuff Tear

RCL
Radial Collateral Ligament

RDN
Radial Digital Nerve

RF
Ring Finger

RN
Radial Nerve

ROH
Removal of Hardware

ROM
Range of Motion

RSD
Reflex Sympathetic Dystrophy

RSN
Radial Sensor Nerve

RTR
Radial Tunnel Release

S

SBRN
Superficial Branch Radial Nerve

SCUNT
Subcutaneous Ulnar Nerve Transposition

SDO
Short Dorsal Outrigger

SF
Small Finger

SLAC
Scapho Lunate Advanced Collapse

SLCH
Scapho Lunate Capitate Hamate

SMUNT
Submuscular Ulnar Nerve Transposition

SORL
Spiral Oblique Retinacular Ligament

S/P
Status Post

SQ
Subcutaneous

STPF
Subtotal Palmar Fasciectomy

STS
Stenosing Tenosynovitis

STSG

Split Thickness Skin Graft

STT

Scapho Trapezio Trapezoid

I

T

Thumb

TCL

Transverse Carpal Ligament

TEA

Total Elbow Arthroplasty

TENS

Transcutaneous Electrical Nerve Stimulation

TER

Total Elbow Replacement

TFCC

Triangular Fibra Cartilage Complex

TFR

Trigger Finger Release

TOS

Thoracic Outlet Syndrome

TRL

Transverse Retinacular Ligament

U

UCL

Ulnar Collateral Ligament

UDN

Ulnar Digital Nerve

UE

Upper Extremity

UN
Ulnar Nerve

V

VCG
Volar Carpal Ganglion

VP
Volar Plate

VRC
Volar Retinacular Cyst

VRG
Volar Retinacular Ganglion

W

WFC
Wrist Flexion Crease

XYZ

Symbols:

i
Thumb

ii
IF

iii
MF

iv
RF

v
SF

SYMBOLS

2/15/03

P, Q, R, S T, U	Any combination of these may be used in conjunction with wave or interval.
2:1 ₊ - 3:1	any ratio of heart block
♀	Female
♂	male
greater than	no symbol for greater than write out "greater than"
less than	no symbol for less than write out "less than"
-	negative
+	positive
m	murmur
↑	raised; elevated; above
↓	decrease, lower, below

oz	ounce
△	
	changed or change
=	equal
#	number / pounds
÷	divided
*	special note
c	with
s	without
L	left
R	
	right
↑→	flat and erect
1°	First degree
2°	second degree
3°	third degree
~	
	approximately
ā	
	before
-	
p	
	after

**** NOTE: Do not use a terminal zero for values expressed in whole numbers. For example: Use 2 not 2.0
Use a leading zero when value is less than a whole unit.
For example: Use 0.5 not .5**

**NEUROMEDICAL CENTER HOSPITAL
BATON ROUGE, LOUISIANA
CHEMICAL ABBREVIATIONS**

Ag	Silver
AgNO ₃	Silver Nitrate
Ba	Barium
Ca	Calcium
Co	Cobalt
CO ₂	Carbon Dioxide
Cl	Chloride
F	Fluoride
Fe	Iron
H	Hydrogen
He	Helium
Hg	Mercury
H ₂ O	Water
H ₂ O ₂	Hydrogen Peroxide
I	Iodine
K	Potassium
KMnO ₄	Potassium Permanganate
Kr	Krypton
Mg	Magnesium
MgSO ₄	Magnesium Sulfate
N	Nitrogen
Na	Sodium
NaHCO ₃	Sodium Bicarbonate
NaCl	Sodium Chloride
O ₂	Oxygen
P	Phosphorus
Pb	Lead
Ra	Radium
S	Sulphur
Si	Silicone
Zn	Zinc

Origination Date: 02/03

Reviewed: 02/03

ARTICLE XV

ADOPTION

The present rules and regulations of the medical staff are hereby readopted and placed into effect insofar as they are consistent with these bylaws, until such time as they are amended in accordance with the terms of these bylaws.

Adopted by the Medical Staff on:

(Date)

Approved by the Board of Directors on:

(Date)