



## **MEDICAL STAFF RULES AND REGULATIONS**

### **Maine Medical Center**

#### **PART 1: PATIENT ADMISSION**

##### **1.A. PATIENT TYPE**

Maine Medical Center (MMC) accepts patients with both acute and chronic illness for care and treatment, without regard to any protected legal status including race, religion, color, sex, ancestry, age, disability, marital status, veteran status, national origin, ethnic origin, citizenship status, sexual orientation, gender identity, diagnosis, or ability to pay. The admission to MMC and the care of any patient is contingent on the availability of facilities, equipment, and Medical Staff and other personnel adequate to care for the patient.

##### **1.B. PATIENT ADMISSION TO MAINE MEDICAL CENTER**

Except for emergency admissions, no patient shall be admitted without an Attending of record and reason for admission.

Patients shall be admitted to the service appropriate for the established or provisional diagnosis. Admission of patients shall be in accordance with the urgency of their need for care. Bed placement shall be determined by clinical history and infection risk. There may be areas of restricted bed utilization that will affect bed availability.

The Attending is the documented physician of record. Within the policies of the Medical Center, the Attending shall assume ultimate responsibility for all medical, ethical and social aspects of the care of the patient, including completion of the medical record.

For every patient admitted to the Medical Center, there shall always be an Attending available for patient care.

##### **1.C. CENSUS MANAGEMENT**

When bed availability is limited, it may not be possible to accommodate all admissions scheduled for a specific day. During times of constrained capacity, admissions to the Medical Center are guided by the MMC Patient Flow policy as well as the MMC Accepting Inter Hospital Transfers policy.

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**PART 2: GENERAL RESPONSIBILITIES FOR AND CONDUCT OF CARE**

**2.A. GENERAL RESPONSIBILITIES**

Each patient in the Medical Center shall have an Active Physician/Dentist/Podiatrist Medical Staff member with privileges appropriate for the patient's care needs who is responsible for their medical care and treatment.

Each Active Physician/Dentist/Podiatrist shall ensure timely, adequate professional care for hospitalized patients in the Medical Center by being available or, in the event that the Active Physician/Dentist/Podiatrist is unavailable, by designating a qualified alternate Active Physician/Dentist/Podiatrist with whom prior arrangements have been made and who has the requisite clinical privileges at the Medical Center to care for patients. When such designation is absent, or the designated physician is unavailable, the CMO or designee, or the applicable Department Chair, Service Line Chief or Division Chief, has the authority to assign patient care responsibility to any member of the staff with clinical privileges appropriate for the care of the patient.

**2.B. TRANSFER OF RESPONSIBILITIES**

The transfer of patient care responsibilities from one service to another during a hospitalization, requires documentation of the transfer of care by the transferring and accepting services, and requires updating the listed Attending in MMC's Electronic Medical Record (EMR).

**2.C. CARE TEAM RESPONSIBILITIES**

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with dedicated emergency departments to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Medical screening examinations shall be performed by a qualified Active Medical Staff member (either Physician or Advanced Practice Provider - APP). Please refer to MMC Emergency Screening, Stabilization and Management of Patient Transfer (EMTALA) policy.

As an academic medical center, MMC is actively engaged in training medical residents, and medical and other health professional students, in the care of patients. Active Medical Staff members are expected to include students and residents in the care of patients as appropriate.

APPs are required to have and maintain a primary supervising/collaborating physician and secondary supervising/collaborating physicians where available, and Plan of Supervision/Collaboration Agreement. Primary supervising/collaborating physicians and secondary supervising/collaborating physicians are required to be aware of their supervisory arrangements and abide by them.

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**2.D. PATIENT SAFETY RESPONSIBILITIES**

Each member of the health care team has the right to express and is expected to express any good faith concern about a patient safety matter to care team leaders or to MMC clinical leadership. If there should be a question of care being provided, the Safety Stop, Escalation, Using CUS (Concerned, Uncomfortable, Stop), and Chain of Command policy shall be initiated.

It is the policy of MMC to support a culture of safety whereby all who work at MMC or affiliated practices have an obligation and the authority to intervene immediately to protect the safety of a patient. All who work at MMC or affiliated practices also have the obligation to listen and respond when a safety concern is raised by anyone, including patients and their families. In the event an urgent patient issue or significant concern cannot be resolved by instituting the steps in the Safety Stop, Escalation, Using CUS, and Chain of Command Toolkit, employees have an obligation to initiate the Safety Stop, Escalation, Using CUS, and Chain of Command policy. Please refer to the Safety Stop, Escalation, Using CUS, and Chain of Command policy.

**2.E. ON-CALL ROSTER, CONSULTATION FOR HOSPITALIZED PATIENTS, AND OUTPATIENT E-CONSULTATION RESPONSIBILITIES**

Only Active Physician/Dentist/Podiatrist members of the Medical Staff are allowed to participate in call coverage for consultations and, and if granted admitting privileges, are allowed to admit hospitalized patients. While APPs and members of residency programs may participate in on-call responsibilities for hospitalized patients, an Active Physician/Dentist/Podiatrist member of the Medical Staff shall be available at all times. If the Active Physician/Dentist/Podiatrist is on call, they are responsible for that call period. If they are not available for call, they shall make appropriate arrangements for sufficient replacement and notify all necessary staff. Consultation shall be performed in a reasonable period of time as determined by patient condition, unless specified below.

All hospital consultations shall be authorized by the patient's Attending or licensed designee and the consultation request shall include the specific question(s) to be addressed by the Consultant. Hospital consults require communication between the requesting provider and the Consultant.

Hospital consultations shall be performed by an Active Physician/Dentist/Podiatrist or licensed designee. If the consulting service declines to provide consultation, there will be direct communication between the Attending and the Consultant to discuss. Any member of the Active Medical Staff who consults on a hospitalized patient shall record a note with initial recommendations at the time the patient is seen. Thereafter, the Consultant's preliminary assessment, including a written evaluation that reflects an examination of the patient and review of the patient's medical record, shall be completed within the next calendar day. The consultation note shall be recorded in the progress notes of the medical record.

2.E.1. Expectations of the provider requesting consultation for a hospitalized patient include:

2.E.1.a. An order for the requested consultation shall be entered into the EMR.

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- 2.E.1.b In a direct communication with the Consultant, the request shall include:
- (i) a statement of the specific reason for consultation and/or question for the Consultant;
  - (ii) a statement whether there is any plan to transfer the care of the patient to the Consultant;
  - (iii) an agreement with the Consultant as to time frame for provision of the consultation and the level of response (by phone, or in person); and
  - (iv) the preferred medium for follow up communication by the Consultant.
- 2.E.1.c. If in the course of discussion associated with the request for consultation, it is determined that the consultation is not indicated or misdirected, then:
- (i) the requesting provider and Consultant shall acknowledge by mutual agreement to abandon the request for consultation; and
  - (ii) the previously entered order for the consultation shall be discontinued in the EMR.
- 2.E.1.d. “Curbside consults” do not satisfy the requirements of this rule. A “curbside” discussion shall be restricted to:
- (i) a question for general information or education; or
  - (ii) a discussion of patient management not associated to the findings on presentation, diagnostic evaluation, or recommendations for a specific patient.
- 2.E.2. Expectations of the Consultant for hospitalized patients include:
- 2.E.2.a. In the direct communication which occurs with the request, the Consultant shall clarify the role of participants (medical student, resident physician, APP, Attending physician), if any, involved the consultation.
- 2.E.2.b. The Consultant’s follow-up communication with the requesting provider shall include the Consultant’s initial impression and recommendations, and an agreement on the role of the Consultant subsequent to the consultation, addressing the following elements, if and as indicated:
- (i) transfer of patient care;
  - (ii) responsibility for order entry;
  - (iii) responsibility for performance of procedures or diagnostic tests;
  - (iv) co-management of patient care;
  - (v) communication with patient and/or family;
  - (vi) involvement in decision-making with patient and/or family; and
  - (vii) anticipated follow-up evaluation and review by Consultant.

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- 2.E.2.c. The formal consultation report for hospitalized patients shall be comprehensively documented in the EMR within a calendar day of the consultation request. Content of the consultation report requires the following:
- (i) reason for consultation;
  - (ii) relevant history;
  - (iii) relevant physical examination;
  - (iv) medical decision making/assessment; and
  - (v) recommendation/plan of care.
- 2.E.2.d. The frequency of on-going Consultant assessment and documentation depends on patient needs. Closed loop communication between requesting providers and Consultants is expected.

**2.E.3. Outpatient E-Consultation**

- 2.E.3.a. E-Consultations are synonymous with inter-professional telephone/internet consultations which are defined as an assessment and management service in which a patient's treating (e.g., Attending or Primary Care) physician/other qualified health care professional requests the opinion and/or treatment advice of a consultant with specific specialty to assist the treating physician/qualified health care professional in the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consultant. This is to distinguish E-Consultations (asynchronous) with Telemedicine (synchronous with active interaction with the patient). For the purpose of these Rules and Regulations, an E-Consultation occurs through the HIPAA-compliant medical record system in an asynchronous fashion without direct or face-to-face specialist-patient contact.

Outpatient E-Consultations shall be performed by an Active Physician/Dentist/Podiatric or designee. If the consulting service declines to provide E-Consultation, there will be direct communication between the Requesting Attending and the Consultant in Epic.

The patient or the patient's authorized representative (in cases where the patient cannot legally give consent) must provide verbal consent for the E-consultation; the requesting provider is responsible for explaining the logistics and purpose of an E-Consultation and for obtaining verbal consent. Only providers who utilize MaineHealth Epic can place E-Consultation orders for their patients. Additionally, the E-Consultant must have an E-Consultation program established within MaineHealth before offering E-Consultations.

If at any time, the requesting provider, the E-Consultant, or the patient/authorized representative wish to convert the E-Consultation to a traditional consultation or a telemedicine consultation, if available, the patient

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will be scheduled for a traditional, in-person or synchronous telemedicine consultation in the usual fashion and within the usual timeframe.

- 2.E.3.b. Outpatient E-Consultation Process: Asynchronously, the patient's treating physician/other qualified health care professional orders an E-Consultation in Epic and asks the consultant a focused question. The consultant responds within 3 business days (or another acceptable timeframe that is agreed upon by the requesting provider and the Consultant) by documenting their impression and recommendations in Epic.
- 2.E.3.c. Expectations of the provider requesting E-Consultation include:
- (i) An order for the requested E-consultation is entered into Epic, including a statement of the specific reason for the consultation and/or question for the E- Consultant
  - (ii) Indication that verbal consent was obtained from the patient/authorized representative.
  - (iii) Following E-Consultation, the requesting provider is responsible for communicating the outcome (impression and recommendations) of the E-consultant to the patient/authorized representative.
- 2.E.3.d. Expectations of the E-Consultant include:
- (i) A review of the information available in the EMR, including provider documentation, laboratory and imaging results, etc., in order to render an impression and recommendations to the requesting provider.
  - (ii) The E-Consultant may accept the E-Consultation, decline the E-Consultation, or convert the E-Consultation to a traditional consultation.
  - (iii) If the E-Consultant accepts the E-Consultation, they shall render an impression and recommendations within 3 business days.
  - (iv) A formal, comprehensive E-Consultation report shall be documented in Epic. The content of the E-Consultation report requires the following:
    - Reason for the consult;
    - Relevant history, including labs and other studies;
    - Impression/medical decision-making/assessment; and,
    - Recommendations/plan of care.

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**PART 3: THE MEDICAL RECORD**

**3.A. GENERAL REQUIREMENTS OF THE MEDICAL RECORD**

- 3.A.1. All patients shall have a medical record.
- 3.A.2. All entries in the medical record shall include the date, time, and a signature by the author.
- 3.A.3. Use of any and all symbols and abbreviations is discouraged. The symbols and abbreviations described in MMC policy are prohibited. Please refer to MH Documentation Standards for the Legal Health Record policy.
- 3.A.4. Attendings are responsible for completion of the medical record at the completion of a patient encounter/discharge, including signing orders and cosigning/attesting/addending notes within the time period required by these Rules and Regulations. Failure to complete the medical record components in the required time may result in sanctions, including administrative withdrawal of privileges.
- 3.A.5. The medical record is owned by Maine Medical Center and shall not be removed or transmitted from the hospital except as required by court order, subpoena, or applicable law or by written patient authorization.
- 3.A.6. In the unlikely event that an Attending is unable to complete a patient's medical record, the medical record may be subject to administrative documentation, as outlined in MMC and MaineHealth (MH) Health Information Management (HIM)"Administrative Documentation When Original provider is Unavailable Policy."
- 3.A.7. HIM staff shall determine the completeness of the medical record for all hospital-based, discharged patients.
- 3.A.8. These Rules and Regulations serve to describe the minimum standards required for the members of the Maine Medical Center Medical Staff. Departments, Service Lines, Divisions, and individual groups may set more stringent expectations for medical record content and completion. New and ongoing policies related to Medical Records are expected to undergo an operational assessment prior to implementation by HIM.
- 3.A.9. Emergent/urgent patient, scheduled and unscheduled maintenance of the EMR, and disaster management situations may result in delayed entries into the medical record. These occasions require rectifying the deficiencies as soon as reasonably possible.
- 3.A.10. The Attending or APP who orders a test (laboratory, pathology, or radiology) is responsible for monitoring the receipt of the test results and directing follow-up action based on those results. If a resident orders a test, the Attending is responsible for the result.

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**3.B. ORDERS**

- 3.B.1. All orders for hospitalized patients shall be entered into the EMR, except in the case of an emergency or during maintenance/outage of the EMR at which time downtime procedures apply.
- 3.B.2. Verbal orders shall be an exception; they require “read back” and an electronic signature as soon as possible, but no later than forty-eight (48) hours, as outlined in MMC policy. Active Medical Staff members and residents can enter orders; student orders shall be co-signed by an Active Medical Staff member or a resident physician. Please refer to MMC Verbal Communication of Medical Orders policy.
- 3.B.3. Standing orders are used in well-defined patient populations and/or clinical situations, as described in MMC policy. A licensed professional, typically a nurse or a pharmacist, or a medical assistant, initiates a standing order. Subsequently, these orders REQUIRE a provider signature, such that the timing of the signature is not a barrier to effective, timely, or necessary care. In the outpatient setting, these orders may be referred to as “Protocol Orders, requiring co-signature”. Please refer to MMC Institutional Standing Physician/APP Orders policy.
- 3.B.4. Order sets are available to assist Active Medical Staff members and residents to standardize care for patients in specific circumstances. Order sets are approved, reviewed, and updated by the MaineHealth Order Set Committee and described in MMC policy. Please refer to MMC Order Set Development and Review policy.
- 3.B.5. In limited circumstances, hospitalized patients may be allowed to supply and administer their own medications, as outlined in MMC policy. Certain medications, such as Schedule I drugs, are not allowed to be administered by staff or by patients during their hospitalization, as outlined in Southern Region policy. Please refer to Southern Region Patients’ Own Medications, Practitioner Supplied Medications and Self-Administration policy.
- 3.B.6. Outpatient studies (laboratory and radiology), infusions, and referrals may be ordered by practitioners who have not been granted Medical Staff membership, when the ordering practitioner meets the following requirements:
- (i) They are responsible for the care of the patient.
  - (ii) They are licensed in, or they hold a license recognized in the jurisdiction where the patient is receiving the study or referral.
  - (iii) They are acting within the scope of practice under State Law.

**3.C. DOCUMENTATION**

**3.C.1. General Requirements**

- 3.C.1.a. Attendings shall co-sign, attest, and/or addend notes from resident physicians and APPs to be compliant with “Part 3: The Medical Record” of these Rules



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and Regulations. Notes that require co-signature, attestation, and/or addendum are considered complete when they are co-signed, attested, or addended by the Attending.

- 3.C.1.b. The note types requiring Attending co-signature, attestation, and/or addendum are: History and Physical Examination (H&P) for hospitalized patients, Discharge Summary, Consult, Operative, Labor and Delivery Summary, Emergency Department Visit, and Anesthesia. Progress Notes for hospitalized patients and Brief Operative Notes do not require co-signatures, attestations, and/or addenda. Ambulatory Office Visit Notes and Procedure Notes may require co-signatures, attestations, and/or addenda, depending on expectations between Attending Physicians and resident physicians/APPs. In some areas, Procedure Notes require co-signatures, attestations, or addenda. These Rules and Regulations do not consider billing implications for signed versus unsigned notes. Individual Attendings may use student documentation as they wish and in accordance with Centers for Medicare & Medicaid Services (CMS) mandates, for billing purposes.
- 3.C.1.c. “Copy-and-Paste” and “Copy-Forward” functions are available in the EMR. These functions require monitoring for accuracy and relevance of entries into the Medical Record and are discouraged if accuracy cannot be ensured and easily monitored.
- 3.C.1.d. These Rules and Regulations do not consider billing implications for documentation purposes.
- 3.C.1.e. Documentation and order entry performed during electronic medical record downtime shall follow established downtime procedures.

#### **3.C.2. History and Physical Examination Notes (H&P) for hospitalized patients**

All inpatients, observation patients, same-day surgery patients, outpatient surgery patients, and obstetrical patients require an H&P that is relevant to their care episode. Active Medical Staff and residents, may document an H&P.

- 3.C.2.a. Inpatients, including Observation-Status Patients: Inpatients shall have a completed H&P in the medical record within twenty-four (24) hours of arrival and admission at the inpatient facility AND before operative/invasive procedures or any general anesthesia, regional anesthesia, or sedation. Initial evaluation of patients is expected within a reasonable time, depending on the acuity of patients and their clinical course. The details of the H&P shall be dependent on the episode of care. At a minimum, the H&P shall include the following patient-specific information:
  - (i) chief complaint/reason for admission or procedure;
  - (ii) history of present illness;
  - (iii) past medical and surgical history;

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- (iv) relevant psych-social history;
- (v) results of physical examination, including positives and negatives by bodily system;
- (vi) medical decision-making/assessment; and
- (vii) plan of care.

Allergies and current medications require review at the time of service and may be entered elsewhere in the medical record.

Within the Electronic Health Record, a Consult note type may satisfy the requirements for a H&P provided it includes all the elements noted above.

An Updated Note that references a prior H&P done within thirty (30) days of admission shall be acceptable. (See Updated Note, section 3.C.2.c.)

- 3.C.2.b. Same Day Procedure/Surgery and Outpatient Procedure/Surgery: All same-day procedure/surgery and outpatient procedure/surgery patients shall have a completed H&P before operative/invasive procedures or any general anesthesia, regional anesthesia, or sedation. This can be done on the day of the procedure or within thirty (30) days of the procedure, as long as there is an Updated Note documented prior to surgery. (See Updated Note, section 3.C.2.c.) The details of the H&P shall be appropriate for the episode of care. At a minimum, the H&P shall include the following patient-specific information:

- (i) chief complaint/reason for admission or procedure;
- (ii) history of present illness;
- (iii) past medical and surgical history relevant to the procedure/surgery being performed;
- (iv) relevant psych-social history;
- (v) relevant physical examination, including cardiorespiratory exam and exam pertinent to the procedure/surgery being performed;
- (vi) medical decision-making/assessment; and
- (vii) plan of care.

Allergies and current medications require review at the time of service and may be entered elsewhere in the medical record.

- 3.C.2.c. Updated Notes: An H&P completed and documented within thirty (30) days of admission/registration shall meet the H&P requirement for hospitalized patients if reviewed, updated, and signed by the Attending. The H&P shall be accessible in the Medical Record and, ideally, linked to the Updated Note. The Updated Note shall be completed within twenty-four (24) hours of admission AND before operative/invasive procedures or any general anesthesia, regional anesthesia, or sedation. The Updated Note shall document the following statement:

- (i) “There were no changes in the H&P”; OR

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(ii) “The following changes were noted . . .”

3.C.2.d. Exceptions to H&P Requirements: Patients undergoing only an outpatient surgery/procedure without anesthesia or an outpatient surgical procedure under infiltrative anesthesia do not require an H&P or a Discharge Summary. However, they do require a Procedure Note (See Procedure Note, section 3.C.10). Examples of these types of procedures include those undergoing lumbar puncture, thoracentesis, paracentesis, renal biopsy, simple skin lesion removal, central line insertion, device removal, and cardiac stress test.

3.C.3. Progress Notes for hospitalized patients

Subsequent to the day of admission and each day until the day of discharge, inpatients and observation patients require daily documentation in the form of a Daily Progress Note. Either an Active Medical Staff member, resident, or student shall perform the assessment and enter the Daily Progress Note; if performed and entered by a resident or student, an Attending Physician shall co-sign, attest, or provide an addendum to the resident’s/student’s Note. When Attendings perform and enter an independent Daily Progress Note, the resident/student note does not require co-signature, attestation or addenda.

For patients without acute hospital needs as determined by the Attending Physician, such assessments and Progress Notes may be performed and entered less frequently based on local Utilization Review standards.

3.C.4. Discharge Summaries for hospitalized patients

3.C.4.a. All inpatients and observation patients require a full Discharge Summary. The Attending who discharges the patient is responsible for ensuring the Discharge Summary is completed and signed as soon as possible, and no later than fourteen (14) days after discharge. Students and providers, including resident physicians and APPs, may document the Discharge Summary; however, the Discharge Summary shall be co-signed, attested, and/or addended by an Attending in order for the medical record to be complete. The Discharge Summary shall include the following patient-specific information:

- (i) principal diagnosis;
- (ii) secondary diagnoses/co-morbidities;
- (iii) presence of drug resistant organisms;
- (iv) reason for admission;
- (v) hospital course, including complications and test results;
- (vi) procedures;
- (vii) consultants;
- (viii) discharge medications;
- (ix) pending tests;
- (x) disposition;
- (xi) condition;

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- (xii) follow-up plans - appointments, tests, and post-op/post-hospital care; and
- (xiii) patient instructions - an indication that the patient/caregiver received discharge instructions.

- 3.C.4.b. For same day surgery/procedure patients and outpatient surgery/procedure patients a briefer Encounter Summary, in lieu of a full Discharge Summary, shall be recorded in the medical record at the time of service and no later than fourteen (14) days after the date of the service. The content of the Encounter Summary may be included in another note (i.e. Progress Note, Brief Operative Note, or Operative Note), and need not be separately re-recorded in an Encounter Summary.

An Encounter Summary shall include the following:

- (i) outcome of the care provided;
- (ii) disposition; and
- (iii) follow-up plans.

- 3.C.4.c On occasion, a patient designated an inpatient or observation patient may be discharged directly from the Emergency Department, *prior to admission*. In these instances, a Discharge Summary is not required. Refer to 3.C.6 for the requirements of the Emergency Department (ED) Visit Note type, including the outcome of the care provided, disposition, plan of care, and follow-up plans.

Patients admitted as inpatients or observation patients who are boarding in the Emergency Department and patients admitted as inpatients or observation patients to the CDU (Clinical Decision Unit), must have a Discharge Summary.

### 3.C.5. Operative/High-Risk Procedure Notes

A high-risk procedure involves any procedure that exposes a patient to a greater than minimal risk. Examples include:

1. Any procedure involving opening a body cavity or puncturing a body cavity
2. Any procedure involving incisions beneath the level of the epidermis or manipulation of major organs
3. Excisional or incisional biopsies, excepting superficial skin lesion
4. Cardiac catheterization
5. Endoscopy

- 3.C.5.a. All patients undergoing operative and high-risk procedures require an Operative/High-Risk Procedure Note immediately following the operative/high-risk procedure and before being transferred to the next phase of care. A Brief Operative/High-Risk Procedure Note may suffice until the

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Operative/High-Risk Procedure Note is finalized and signed. No Operative/High-Risk Procedure Note, or Brief Operative/High-Risk Procedure Note may be finalized or signed prior to the completion of the operative/high-risk procedure. See glossary for definition of “Operative Procedure” and “High-Risk Procedure”.

3.C.5.b A Brief Operative/High-Risk Procedure Note shall include the following:

- (i) name of the surgeon or provider performing the procedure;
- (ii) name of assistant(s);
- (iii) name and description of the procedure;
- (iv) findings of the procedure;
- (v) estimated blood loss (must include volume; “minimal” is not acceptable);
- (vi) specimens removed; and
- (vii) post-procedure diagnosis.

3.C.5.c. An Operative/High-Risk Procedure Note shall be finalized and signed within twenty-four (24) hours of the surgery/procedure. Certain content previously documented in the Brief Operative/High-Risk Procedure Note (identified by “\*”, in the list below) need not be re-recorded in the Operative/High-Risk Procedure Note. The Operative/High-Risk Procedure Note shall include the following:

- (i) patient name and identification number;
- (ii) date and time of the operation/high-risk procedure;
- (iii) pre-procedure diagnosis;
- (iv) \*post-procedure diagnosis;
- (v) \*name of the surgeon or provider performing the procedure;
- (vi) name of assistant/s **and their specific tasks during the operation/procedure;**
- (vii) type of anesthesia administered;
- (viii) name and description/technical aspects of the operative/high-risk procedure;
- (ix) \*findings of the procedure;
- (x) \*estimated blood loss (must include volume; “minimal” is not acceptable);
- (xi) \*specimens removed;
- (xii) devices or tissues implanted, transplanted, or graphed; and
- (xiii) complications.

**3.C.6. Emergency Department (ED) Visit Notes**

All emergency department patients shall have an ED Visit Note recorded in the medical record, preferably at the time of service and no later than fourteen (14) days after the date of service. The ED Visit Note shall include the following patient-specific information:

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- (i) chief complaint/reason for visit;
- (ii) history of present illness;
- (iii) past medical and surgical history relevant to the visit;
- (iv) relevant social history;
- (v) relevant physical examination, pertinent to the visit;
- (vi) medical decision-making/assessment;
- (vii) plan of care; and
- (viii) outcome of the care provided at the ED visit, if not addressed in the medical decision-making/assessment or plan of care.

Allergies and current medications require review at the time of service and may be entered elsewhere in the medical record. Patient disposition and follow-up are required at the end of the encounter and may be entered elsewhere in the EMR.

**3.C.7. Ambulatory Office Visit Notes**

- 3.C.7.a. All ambulatory office visit patients shall have an Office Note recorded in the medical record, preferably, at the time of service and no later than fourteen (14) days after the date of service. The Ambulatory Office Visit Note shall include the following:

- (i) chief complaint/reason for visit;
- (ii) relevant history;
- (iii) relevant past medical and surgical history;
- (iv) relevant social history;
- (v) relevant family history;
- (vi) relevant physical examination, pertinent to the visit;
- (vii) medical decision-making/assessment;
- (viii) plan of care; and
- (ix) outcome of the care provided at the ambulatory visit, if not addressed in the medical decision-making/assessment or plan of care.

Allergies and current medications require review at the time of service and may be entered elsewhere in the medical record. Patient disposition and follow-up are required at the end of the encounter and may be entered elsewhere in the EMR.

- 3.C.7.b. Ambulatory Office Visits may be problem-focused visits or annual/comprehensive, primary care visits. Annual/Comprehensive, primary care visits require documentation that is relevant to individual patient's complete care and visit details, as well as a review/update of the patient's history.

- 3.C.7.c. The Ambulatory Office Visit Note may require a co-signature, attestation, and/or addendum, depending on the expectations between Attendings and residents/students/APPs.

**3.C.8. Anesthesia/Sedation Notes**

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All patients receiving general anesthesia/sedation (including moderate and deep sedation) shall have a completed pre-anesthesia/pre-sedation assessment in the medical record prior to the administration of the anesthesia/sedation (except in the case of an emergency) but no more than forty-eight (48) hours prior to the administration of the anesthesia/sedation, and include an American Society of Anesthesiologists (ASA) classification. After receiving general or deep sedation, patients shall have a completed post-anesthesia assessment in the medical record.

#### **3.C.9. Consultation Reports/Notes**

See Part 2.E., “On-Call Roster Consultation for Hospitalized Patients, and Outpatient E-Consultation Responsibilities”, section 2.E.2.c., for the required content of Consultation Reports/Notes.

#### **3.C.10. Procedure Notes**

Procedure Notes shall be used outside of the operating rooms for medical and surgical interventions that are not considered high-risk. The Procedure Note shall include the following:

- (i) name of the procedure;
- (ii) indication for the procedure;
- (iii) description of the procedure;
- (iv) findings of the procedure, if applicable; and
- (v) complications.

These elements listed for “Procedure Notes” are required and may be included in another note type or report.

#### **3.C.11. Death Note**

All patients who expire in the hospital require a Death Note, which shall be completed at the time of death. The Death Note shall include the following:

- (i) provider pronouncing death;
- (ii) date of death;
- (iii) time of death;
- (iv) Medical Examiner case: (Yes or No);
- (v) autopsy requested: (Yes or No);
- (vi) code status at death;
- (vii) CPR performed: (Yes or No);
- (viii) criteria used to declare death;
- (ix) hospital diagnoses;
- (x) operations/procedures;
- (xi) consultants;
- (xii) admission condition;
- (xiii) discharge condition: Deceased;
- (xiv) reason for admission;

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- (xv) hospital course;
- (xvi) last labs;
- (xvii) microbiology;
- (xviii) significant diagnostic studies; and
- (xix) discharge disposition.

#### **3.C.12. Access to Medical Record by providers, auditors, patients**

Role-based access to the Medical Record is available to the healthcare team providing services for the patients under their direct care. Hospital policies governing access to the EMR (i.e. password protection, privacy, and patient confidentiality) shall be followed. Failure to follow MH policy shall result in disciplinary action.

Patients may obtain copies of their complete medical record by written request to the Health Information Management Office, and also may access portions of their medical record electronically if they are registered users of the patient portal of the EMR. Third parties may obtain copies of a patient's medical record through the Health Information Management Office, provided that the patient furnished written authorization to the third party to do so, or as permitted by law. Authorized hospital personnel may require access to patients' medical records for payment and operations as permitted by law, including quality and regulatory activities, safety audits, responding to patient complaints, etc.

#### **3.D. CONSENTS**

##### **3.D.1. Surgical and Medical Procedural Consents and Medical Treatment Consents**

Attendings or their licensed designees shall obtain informed consent from patients or their authorized representative, in accordance with MH policy and with State of Maine law. Please refer to MH Consent to Treat for Procedures, Interventions, and Treatment policy.

##### **3.D.1.a. The following medical procedures require written consent of the patient or authorized representative:**

- (i) surgical procedures involving incisions beneath the level of the dermis or manipulation of major organs;
- (ii) general anesthesia, regional anesthesia, or sedation, excluding infiltrative anesthesia;
- (iii) procedures in which general anesthesia, regional anesthesia, or sedation is used;
- (iv) excisional or incisional biopsies, excluding skin lesions;
- (v) invasive monitoring;
- (vi) electro-cardioversion;
- (vii) cardiac catheterization;
- (viii) cardiac treadmill test;
- (ix) endoscopic procedures;
- (x) certain radiology procedures, including but not limited to, angiography,



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- percutaneous transabdominal cholangiography, radiation therapy and radioactive ablation therapy, percutaneous drainage and nephrostomies;
- (xi) blood product transfusion (if not otherwise covered by a procedural consent form);
- (xii) organ donation;
- (xiii) certain non-surgical treatments or procedures that involve unusual risks for the patient, such as lumbar puncture, central line placement, arterial line placement, circumcision, paracentesis, thoracentesis, arthrocentesis, injections (such as BOTOX, steroids, other pain relieving injections);
- (xiv) voluntary inpatient psychiatric treatment;
- (xv) electroconvulsive therapy;
- (xvi) oncologic treatments;
- (xvii) sterilization;
- (xviii) pregnancy termination;
- (xix) pediatric patients (less than 18 years of age) receiving medications (hormone treatment and/or pubertal blockers) to treat gender dysphoria; and
- (xx) dialysis.

#### 3.D.2. The Consent Form

One of the final steps in the informed consent process is documentation, including a provider's and patient's signature on a *consent form*. At the time of the medical treatment, surgical/medical procedure, or intervention, the provider offering the treatment or performing the procedure/intervention shall ensure that all the patient's concerns are addressed, even if a consent form was signed prior to the time of the procedure/intervention or medical treatment.

- 3.D.2.a. Consent forms shall be signed prior to procedures or treatments except in extraordinary or emergent circumstances. Faxed consent forms are acceptable when they are scanned into the EMR.
- 3.D.2.b. Consents for one-time procedures/interventions, treatments, and anesthesia are valid for 6 months. Beyond 6 months, the informed consent process shall be repeated. In addition, if the procedure/intervention, treatments, or anesthesia changes or the patient's status/risk changes, a new consent shall be reviewed and signed.
- 3.D.2.c. All consent forms shall include the following in legible, non-medical terms, with adaptations when necessary based on the patient's co-morbidities and with attention to language, cultural, and health literacy of the patient or authorized representative:
  - (i) patient identification (including name, date of birth, medical record number, and location of care);
  - (ii) name of the procedure;

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- (iii) indication that the benefits of the procedure were discussed;
- (iv) risks of the procedure;
- (v) indication that alternatives to the procedure were discussed, including risks, benefits of the alternatives and of receiving no care;
- (vi) provider signature, time, and date and provider name in legible print;
- (vii) patient or \*authorized representative signature, time, and date;
- (viii) hospital witness signature, time, and date if the patient is unable to sign due to a physical limitation, or if the consent is obtained by telephone; and
- (ix) language interpreter's identifying information if a language interpreter is required for either in-person or for phone consents.

*\*If a patient is a minor, has a guardian, is incapacitated, or is otherwise unable/unauthorized to provide informed consent, a parent, guardian, or other authorized representative may provide informed consent on the patient's behalf. Please refer to the MH Consent to Treat for Procedures, Interventions, and Treatment policy.*

**3.D.3. Serial Consents**

Serial Consents are used when the same procedures/interventions, treatments, or anesthesia are repeated for the duration of a medical or psychiatric treatment course, for instance: repeat casting in the operating room, repeat endoscopy for esophageal dilations, repeat anesthesia for electroconvulsive therapy, repeat cystoscopy, repeat blood products for anemia, dialysis, etc. If the procedure/intervention, treatments, or anesthesia changes or the patient's status/risk changes, a new serial consent process shall be undertaken and an appropriate consent form shall be reviewed and signed. Serial consents for procedures/interventions, treatments, and anesthesia are valid for 6 months.

**3.D.4. Photographic and Video Documentation**

Photographic and video documentation shall be undertaken only in accordance with MMC policy. Patient consent is not required when such imaging is deemed essential to the patient's care, or when such imaging may be necessary to comply with law (e.g., reporting of alleged physical abuse in child protective cases). Retention of any the photos/videos as part of the EMR is permissible when they are entered directly into the EMR from an EMR app on an approved phone or tablet.

**3.D.5. Consent for Research**

Patient consent to participation in medical research requires a separate consent process and the use of consent form provided by the research investigators group.

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**PART 4: DEATHS AT THE MEDICAL CENTER**

**4.A. PRONOUNCEMENT**

The Attending or Attending's licensed designee shall pronounce and record the death of a deceased patient who was hospitalized within a reasonable period of time after death is confirmed. If pronouncement is performed by a licensed designee, that licensed designee shall notify the Attending as soon as possible. In the case of the death of a patient covered by a valid Do Not Resuscitate (DNR) Order, a registered nurse may make the pronouncement of death and record entry.

**4.B. REPORTABLE DEATHS**

Reporting of deaths to the Office of the Medical Examiner shall be carried out when required by and in conformance with state law, and in accordance with the Medical Examiner Act, which as of the date of the adoption of these Rules and Regulations provides that the following deaths are medical examiner cases:

- 4.B.1. Death is suspected of having been caused by any type of physical injury, including poisoning, regardless of whether the suspected manner of death is homicide, suicide or accident;
- 4.B.2. Sudden death when a person is in good health and with no specific natural diseases sufficient to explain death;
- 4.B.3. Death during diagnostic or therapeutic procedures under circumstances indicating gross negligence or when clearly due to unrelated trauma or poisoning unrelated to the ordinary risks of those procedures;
- 4.B.4. Death of a person under arrest or in custody at or in transit to a governmental facility;
- 4.B.5. Death of a person while a patient or resident of a Department of Mental Health or residential care facility unless certified by the Attending as due to natural causes;
- 4.B.6. Death suspected of being due to a threat to the public health, and the medical examiner is needed to study the case for public health reasons;
- 4.B.7. Death suspected of not being certified, including bodies brought into the state and buried remains uncovered unless by legal exhumation;
- 4.B.8. Death suspected of being medical examiner cases which may have been improperly certified or inadequately examined;
- 4.B.9. Sudden Unexpected Infant Death Syndrome (SUIDS) deaths and all other deaths of children under the age of 18, unless clearly certifiable by an Attending as due to specific natural causes unrelated to abuse or neglect;

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4.B.10. Whenever human remains are discovered not properly interred or disposed of; or

4.B.11. Death by any cause without an Attending capable of certifying the death as due to natural causes.

4.C. DEATH CERTIFICATES

The Attending or licensed designee shall complete an electronic death certificate, unless the death is a Medical Examiner's case reportable to the State. The electronic death certificate process can be accessed within the EPIC Provider Discharge Navigator. When a case reported to the State is not accepted by the Medical Examiner, the Attending shall issue the death certificate.

4.D. RELEASE OF BODY

The body shall not be released from the Medical Center until a Death Note has been made and signed in the deceased's medical record by an Attending or licensed designee. In a Medical Examiner's case, the body shall not be released to anyone other than Medical Examiner personnel except upon the receipt from the Medical Examiner of authorization to release the body. All other policies with respect to the release of dead bodies shall comply with state law.

4.E. AUTOPSIES

Proper consent for an autopsy shall be in accordance with applicable state law, and documented in the EMR. The Attending shall be notified when an autopsy is performed. Autopsies shall be considered in those deaths that meet, but are not limited only to, the following criteria:

4.E.1. Unanticipated deaths;

4.E.2. Death occurring while the patient is being treated under a new therapeutic trial or regimen;

4.E.3. Intraoperative or intraprocedural death;

4.E.4. Death occurring forty-eight (48) hours after surgery or an invasive procedure;

4.E.5. Death incident to pregnancy or an invasive diagnostic procedure;

4.E.6. Any death when the patient has been admitted with a primary psychiatric diagnosis;

4.E.7. Death where the cause is significantly obscured to delay completion of the death certificate;

4.E.8. Death in infants and children with congenital malformation;

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- 4.E.9. Death in which the autopsy may help allay concerns of the family and/or the public regarding the death;
- 4.E.10. Natural deaths which were subject to, but waived by, forensic medical jurisdiction such as, but not limited to, death on arrival at the hospital, death occurring within twenty-four (24) hours of admission, death in which the patient sustained, or apparently sustained, an injury while hospitalized; or
- 4.E.11. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.

All autopsies shall be performed by a pathologist who is an Active Physician member of the Medical Staff or by a qualified licensed designee. The provisional anatomic diagnosis shall be recorded on the medical record within forty-eight (48) business hours. The final anatomic diagnosis shall be made a part of the medical record within sixty (60) business days. This paragraph does not apply to cases which according to law shall be referred to the Medical Examiner's Office or complicated post-mortem diagnoses requiring outside second opinions.

4.F. ORGAN DONATIONS

It is the responsibility of any member of the Active Medical Staff to notify the contracted Organ Procurement Organization (OPO) of a potential organ or tissue donor. The OPO shall communicate with the next of kin regarding potential donation. If needed, the OPO shall communicate directly with the Medical Examiner to obtain verbal authorization to proceed with donation. This authorization shall include restrictions pertinent to cause of death of the potential donor. Medical Staff shall otherwise comply with the Revised Maine Uniform Anatomical Gifts Act and the Maine Medical Center Procedures on Organ and Tissue Donation and Organ Donation Following Cardiac Death.

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**PART 5: ENFORCEMENT**

Violations of any of these Rules and Regulations by Medical Staff members may result in corrective action in accordance with the Medical Staff Bylaws.

**PART 6: AMENDMENT**

These Rules and Regulations may be amended, or repealed, in whole or in part by a resolution of the Medical Executive Committee (MEC) recommended to and adopted by the Board.

Revised MEC 3-1-02  
Revised Full Medical Staff 4-1-02  
Revised Board of Trustees 4-11-02  
Revised MEC 10-5-05  
Revised Board of Trustees 11-2-05  
Revised MEC 11-3-06  
Revised Board of Trustees 12-6-06  
Revised MEC 7-29-08  
Revised Board of Trustees 8-6-08  
Revised MEC 8-15-14  
Revised Board of Trustees 9-3-14  
Revised MEC 6-16-17  
Revised Board of Trustees 8-2-17  
Revised MEC 10-19-2020  
Revised Local Board 11-4-2020  
Revised MEC 2-16-24  
Revised Local Board 4-3-24