RULES AND REGULATIONS
of the
MEDICAL STAFF

St. Joseph's Hospital Health Center
Syracuse, New York

These Rules and Regulations have been developed to implement more specifically the general principles found within the By-Laws of the Medical Staff. Application of the By-Laws of the Medical Staff as well as the Ethical & Religious Directives for Catholic Health Facilities should take precedence in the interpretation of the Rules and Regulations.

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ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the hospital only by a member of the Medical Staff. No patient shall be denied treatment or admission to the hospital because of race, creed, national origin, sex, disability within the capacity of the hospital to provide treatment, sexual orientation or source of payment. All practitioners shall be governed by the official admitting policy of the hospital.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the relatives of the patient. Whenever these responsibilities are transferred to another staff member, the attending transferring the patient must enter an order indicating the change in attending responsibility. The attending physician accepting the case must enter an order noting his/her acceptance of the transfer of responsibility. The transfer of responsibility shall not take place until the order accepting the transfer is entered.

3. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been documented in the medical record. In the case of an emergency such statement shall be recorded as soon as possible.

4. In any emergency case in which it appears the patient will have to be admitted to a hospital, the attending member of the Medical Staff shall, when possible, first contact the admitting department to ascertain whether there is an available bed.

5. Attendings admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

   In the event the admission of an Emergency Room patient to the inpatient service is accomplished by a resident, the resident shall indicate on the Emergency Room record that the attending physician has been contacted and agrees with the admission and plan of care and accepts responsibility for that patient's care. Residents must indicate in the Emergency Room medical record that the attending member of the Medical Staff has been contacted in situations where the patient is pronounced DOA in the Emergency Room.

6. A patient to be admitted on an emergency basis who does not have a private physician will be assigned to the service concerned with the treatment of the disease which necessitated the admission. If the patient specifically requests a private physician, he may select one of his choice or where no selection is made, will be assigned a physician on the attending staff. The Chairperson of each department shall provide a schedule for such assignments on a rotation basis.

   When a particular specialty or subspecialty is not available or the attending on call cannot respond due to circumstances beyond his/her control, the Chairperson of the applicable department may assign another qualified member of the active staff to attend the patient; or, if it is in the patient's best interest, the patient may be advised, in accordance with the hospital's policy on patient transfers, to accept transfer to a facility which can provide the service.

7. Each member of the Medical Staff who admits patients to the hospital shall have an office and a residence within Onondaga County or within twenty (20) miles of the hospital, unless and as long as the Staff person is a member of a group and at least one-half of the group lives within that distance. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is resident in the area who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such associate, the Administrator of the hospital,

Chairperson of the Executive Committee, President of the Medical Staff, or Chairperson of the department concerned, shall have authority to call any member of the active staff in such an event. Each member of the Medical Staff, when off call, must be covered by a practitioner who agrees to provide that coverage, who is a member of the Medical Staff of the hospital and who has essentially equivalent clinical privileges at the Hospital.

8. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof.

9. Patient Transfers

   Transfer priorities shall be as follows:

   Emergency Room to appropriate patient bed;
   From Obstetric patient care area to general care area, when medically indicated;
   From Surgical Intensive Care Unit to general care area;
   From Medical Intensive Care Unit to general care area;
   From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

   No patient will be transferred without notification to the responsible practitioner.

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

11. For the protection of patients, the medical and nursing staffs and the hospital, certain principles are to be met in the care of the potentially suicidal patient:

    Any patient known or suspected to be suicidal in intent shall be admitted to the psychiatric ward of the hospital. If there are no accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital, and, as a temporary measure, suicide precautions shall be enacted. Whenever feasible, such patients shall spend the daytime hours in the area where special observation and therapy is available.

    Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff.

12. Admissions to Intensive Care Units

    If any question as to the validity of admissions to or discharge from the intensive care unit should arise, that decision is to be made through consultation with the appropriately designated member of the attending Medical Staff.

13. For the purpose of Utilization Review, the attending physician's signed and dated progress notes and orders are the only acceptable source of this information. Other sources of information regarding the patient's condition, e.g. nurse's notes, lab reports, x-ray reports, etc., may be used only to substantiate what the attending physician has already written, not in lieu of the attending documentation. The attending is required to document the need for admission and continued hospital stay as identified by this hospital's Utilization Management/Care Management Office, through its working document, the Utilization Review Plan.

    Upon request of the Utilization Management/Care Management Office or its physician advisors, the attending physician must provide written justification for the medical necessity of admission and/or continued hospital stay by documenting such necessity in the medical record in the form of an

attending medical staff member's admission note, appropriate progress notes, or appropriate physician's orders. This written justification must be completed within 24 hours after the attending physician is contacted by a physician advisor. If an attending medical staff member fails to comply with this policy after being contacted by a physician advisor, the Chief Executive Officer shall notify the attending medical staff member by mail that his privileges to admit patients shall be summarily suspended, and such attending medical staff member shall remain suspended until the documentation requirements for the medical necessity of admission and/or continued stay have been completed. In the event of such suspension the attending physician is permitted to continue to treat the patients currently under his care in the hospital. The Admitting Office shall be notified of the suspension of the medical staff member's admitting privileges.

14. Patients shall be discharged only on the order of the attending practitioner. The attending practitioner shall assure that prior to discharge the patient shall receive an appropriate written discharge plan and a written description of the patient discharge review process available to the patient under Federal or State Law. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

15. It shall be the responsibility of the attending practitioner to discharge his patients out in a timely fashion.

16. In the event of a hospital death, the deceased shall be pronounced dead within a reasonable time by the attending practitioner, a post graduate physician trainee, a registered nurse or a physician assistant. It shall not be the responsibility of the registered nurse to request permission for an autopsy.

    The criteria for determining cessation of life are the irreversible cessation of circulatory and respiratory functions. Cessation is recognized by the absence of responsiveness, heartbeat, and respiratory effort. Irreversibility is recognized by persistent cessation of functions during an appropriate period of observation. In clinical situations where death is expected and where the course has been gradual, the period of observation following cessation may be only the few minutes required to complete the examination. When a possible death is unobserved, unexpected or sudden, the examination may need to be more detailed and repeated over a longer period while appropriate resuscitative effort is maintained as a test of cardiovascular responsiveness. It shall be determined that life is extinct by ascertaining that: a) pulsation has ceased in the radial or other arteries; b) heart and respiratory sounds are not heard with the use of a stethoscope.

    The cessation of life shall be documented by a note recorded in the patient's hospital medical record.

    If the cessation of life occurs in the Emergency department, the emergency physician is responsible for signing the death certificate or contacting the Medical Examiner. If cessation of life occurs prior to presentation in the Emergency department and they do not try to resuscitate, the Emergency department will call the Medical Examiner and the Primary Care Physician will be notified to sign the death certificate. The Primary Care Physician may request referral to the Medical Examiner. Cessation of life of an inpatient shall be signed off by the attending physician or resident that holds a current New York state license. Death certificates must be signed electronically within 48 hours.

    The body shall not be released until an entry has been made and signed in the medical record of the deceased. Policies with respect to release of dead bodies shall conform to local and State law.

17. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. The autopsy plays an important role in medical education and in the evaluation of the quality of care; it should be requested in every death.

    Autopsies should be particularly encouraged in the following cases of death:

1. Deaths in which an autopsy may help explain unknown and/or unanticipated medical/ surgical complications.
2. Deaths in which the cause is not known with certainty on clinical grounds, particularly an unexpected death.
3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death.
4. Deaths in patients who have participated in clinical trials.
5. Deaths resulting from high risk infections and contagious diseases.
6. All obstetrical, neonatal and pediatric deaths.
7. Deaths in which an autopsy might disclose information useful to survivors or recipients of transplanted organs.

An autopsy may be performed only with a written consent, signed in accordance with state law or by telephone or telegraphed consent, witnessed by two individuals who sign the authorization as telephone witnesses and followed by a consent in writing. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours and the complete protocol should be made on a part of the record within two months, unless prevented by reasonable circumstances. The attending physician will be notified by the pathologist as to the time an autopsy is to be performed on his/her patient. The Medical Examiner shall be notified concurrently by the attending medical staff member or his/her designee of all deaths which warrant notification of the Medical Examiner.

MEDICAL RECORDS

1. All senior, active, courtesy and consulting Medical Staff must complete training and demonstrate competency in the use of the Hospital's electronic medical record (EMR) and all requirements for coding and documentation at a level determined by the SJLinked Physican training policy, prior to seeing patient once the EMR is active. Members who use their inpatient privileges infrequently (including some courtesy and consulting staff members) must complete designated EMR training and demonstrate competency as determined by SJLinked MD Governance Committee. Members with Community status will not be required to obtain training in the use of the Hospital's EMR. Telemedicine Medical Staff Members do not require EMR training. To expedite credentialing, the completed application of any active, courtesy or consulting medical staff applicant who will need EMR training to exercise privileges may be presented to the Medical Executive Committee and the Board of Trustees with the contingency that approved privileges are not activated until the member has completed EMR training and all requirements for coding and documentation and have demonstrated proficiency.

2. The attending practitioner shall be responsible for a complete and legible medical record for each admitted patient, including the validation and authentication, as appropriate, of any documentation completed by a clinical affiliate, resident or Emergency Department scribe. This record shall include identification data; chief complaint; personal history; family history; history of present illness; pertinent social history; pertinent review of systems; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

3. The attending practitioner must provide justification for the medical necessity of admission and/or continued hospital stay by documenting such necessity in the medical record in the form of an initial progress note, initial physician order, admission note, or within the history and physical documentation. This documentation will be recorded within 24 hours of admission.

   A credentialed attending practitioner's complete history and physical examination shall be recorded

within 24 hours of admission. The history and physical examination shall include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed within 30 days prior to the patient's admission to the hospital, a copy of these reports may be used in the patient's hospital record, provided that an updated history and physical be completed and documented by a licensed practitioner within 24 hours of the patient's admission. The admission physical examination shall also include an offer to screen cervical cytology smear on women 21 to 65 years of age, unless such test is medically contraindicated or has been performed within the previous three years, and palpation of the breast, unless medically contraindicated, for women 21 years of age and older. These examinations shall be recorded in the medical record.

If the patient refuses to allow a history and physical examination to be performed, this refusal must be clearly documented in the medical record. The practitioner must attempt to obtain the history and physical each day that the patient is hospitalized and document the results of the attempt each day in the medical record.

At the time of admission all patients over six months of age who are presumptively susceptible to sickle cell anemia shall be examined for the presence of sickle cell hemoglobin, unless such tests have been previously performed and the results recorded in the patient's medical record or otherwise satisfactorily recorded such as on an identification card.

A complete history and physical must be performed and documented by a licensed practitioner within 24 hours of admission. With respect to outpatient operative and other procedures, a history and physical examination appropriate to the planned procedure must be performed no more than thirty (30) days prior to the procedure date or within twenty four (24) hours after admission or registration, but prior to surgery or other procedure requiring anesthesia services and placed in the patient's medical record within twenty four (24) hours after admission. The history and physical must be in the medical record prior to any high-risk procedure, surgery or other procedure requiring anesthesia services. The update must be performed by a licensed practitioner or his designee with privileges to perform history and physicals. The updated history and physical examination must address changes in the patient's current status, an update of any components of the physical exam that have changed, confirm that the necessity for the admission, procedure or care is still present, and be written or otherwise recorded on, or attached to, the previous history and physical, or written in a progress or consult note.

4. It is the responsibility of the attending practitioner to make certain that justification for the medical necessity of admission and/or continued hospital stay and the complete history and physical are documented prior to the proposed surgery procedure. In the case of a severe emergency, the history and physical may be recorded after the procedure.

5. Attestations by attending physicians of resident progress notes are for the purpose of indicating attending concurrence with the plan of care, and are to be done daily. Every resident progress note does not require an attending countersignature, but concurrence in the plan of care must be evident. No specific time frame is suggested, but attending physician documentation at admission and periodically during the hospital course (at a minimum anytime there is a change in diagnosis and/or the plan of care or a procedure is performed) is required.

6. Pertinent progress notes shall be recorded sufficient to permit continuity of care and transferability. 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 recorded by the attending physician of record (or midwife) or his/her covering physician at least daily. The initial progress note shall be recorded within 24 hours of admission and the final note no earlier than 24 hours prior to discharge. Patients on alternate care shall not require a daily progress note. Normal, stable newborns whose prolonged hospital stay is due to a prolonged maternal hospitalization shall require progress notes at a frequency consistent with the needs of the newborn.

7. A brief operative note shall be written in the progress notes immediately following operative and other procedures if a detailed operative note has not been completed. This note shall include the name of the operating practitioner, assistants; procedure performed, preoperative and post-operative diagnoses, findings, specimens, and estimated blood loss.

   A detailed operative report shall be dictated within 24 hours following surgery for outpatients as a well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. The dictated operative report shall include a detailed account of the findings at surgery as well as the details of the surgical technique.

8. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative and other procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

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

10. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

11. Symbols and abbreviations may be used only in accordance with policies and procedures of the hospital. https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=13146 https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=17764

12. For outpatient medical records, the diagnosis and procedures, if applicable, shall be recorded in the record prior to the scheduled procedure or diagnostic test. The final diagnosis shall be recorded on the progress note or the face sheet of the medical record without the use of symbols or abbreviations and must be signed and dated by the attending physician.

13. A discharge summary shall be completed on all medical records of inpatient hospitalizations, regardless of length of stay, except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. For these exceptions, the final discharge note must be completed at the time of discharge or no earlier that 24 hours prior to discharge. The discharge summary (which includes the discharge instruction sheet) concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, and the condition of the patient on discharge. Also, the final diagnosis shall be listed and the cause of death, if applicable. All summaries shall be authenticated by the attending medical staff member.

14. Medical staff members and clinical affiliates may not intentionally access or review any record that you normally would not receive or review during the course of providing patient care, without proper authorization from the patient approved by the Health Information Management Department other than as permitted by the confidentiality policies and procedures of the hospital. Any release of information obtained from the medical record to parties other than the patient must be conducted through the Health Information Management Department. Promptly forward any requests for medical information to the Health Information Management Department.

15. Written consent of the patient is required for release of medical information to persons not authorized to receive this information. Records, including both computer and manual, may be removed from the hospital's jurisdiction only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed, accessed or

duplicated in any fashion without permission of the President or his/her designee.

In the case of readmission of a patient, all previous records shall be available for the use of the attending medical staff member. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the hospital or unauthorized access to computerized medical information is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

16. Access to computerized medical information and use of electronic signatures shall be controlled through the use of individual computer passwords. Passwords are confidential and must never be shared with anyone, for any reason. Medical Staff members including clinical affiliates will be held responsible for any system usage that occurs with their password if they directly allow another to use their password or if they are negligent in keeping their password confidential. Access to computerized medical records and use of electronic signatures are subject to the same confidentiality policies as paper medical records and inappropriate access of such records shall give rise to the same possible sanctions as inappropriate access to paper medical records.

17. A medical record shall not be permanently filed/archived until it is completed by the responsible practitioner or is ordered filed/archived by the Health Information Management Committee.

18. At the time of discharge, the inpatient's medical record shall include final diagnosis, discharge instructions and after visit summary. Where this is not possible, because final laboratory or other essential reports have not been received at the time of discharge, the patient's medical record will be placed in the physician's deficiency work list. It is the responsibility of the physician to access the work list and complete all medical records in a timely manner. If the patient's medical record remains incomplete 30 days following discharge, regardless of the availability of reports, the Administrator shall notify the practitioner that his privileges to admit patients shall be suspended, and such practitioner shall remain suspended until the records have been completed. The Admitting Office shall be notified of this action.

19. The patient's outpatient medical record for One Day Surgery, Emergency Department, Diagnostic Services, and Dialysis visits shall be complete at the time the service rendered for that visit is completed. Where this is not possible because final laboratory or other essential reports have not been received at the conclusion of the treatment visit, the patient's incomplete medical record will be placed in the physician's deficiency work list, located in the Med Rec Tab of the Portal. It is the responsibility of the physician to access the work list and complete all medical records in a timely manner. Emergency Department records must be completed in the EMR for electronic transmittal to HPF where it is stored as the legal health record. If a scribe is used to assist with documentation, the scribe must complete all documentation and the attestation by the end of the shift. The Emergency Department physician must complete all documentation and the attestation within 36 hrs following the patient's discharge. If the record still remains incomplete 30 days after all essential reports have been received and placed on the record, the Administrator shall notify the practitioner by mail that his privileges to admit patients to the hospital and/or the dialysis unit shall be suspended, and such practitioner shall remain suspended until the records have been completed. The Admitting Office shall be notified of this action.

20. Procedure following Three (3) Consecutive Occurrences of Administrative Suspension or Six (6) Cumulative Occurrences of Administrative Suspension:

Step I. The Health Information Management Manager or designee will bring the name of the practitioner to the attention of the President of the Medical Staff, the Chairperson of the appropriate Clinical Department and the President of the Hospital.

Step II. The President of the Medical Staff will forward a certified/return receipt letter to the practitioner. The letter of notification will specify that:

A. He/She will have (seven) 7 days from the day the letter was received to complete all delinquent and incomplete medical records.

B. If he/she fails to complete the medical records by the end of the seven (7) day period, he/she will automatically be placed on Summary Suspension with a complete loss of privileges. A registered or certified letter signed by the President of the Medical Staff will then be sent notifying the practitioner of Summary Suspension.

C. If placed on Summary Suspension, he/she must provide to the President of the Medical Staff in writing or in person an explanation of his/her failure to comply and request removal from Summary Suspension. Upon approval of the President, his/her privileges will be reinstated.

D. A letter with a timeline of listed occurrences and actions taken will then be forwarded to the President of the Medical Staff for placement on the agenda of the next Medical Executive Committee meeting.

E. All documentation/written communications pertaining to this event will be filed in the practitioner's credentialing file.

Step III. When any practitioner is placed on Summary Suspension for a second time during any Medical Staff year for failure to complete medical records, the practitioner's Medical Staff membership shall be revoked subject to the practitioner's rights under Article VIII. Upon completion of all delinquent and incomplete medical records, the practitioner will be eligible to reapply for membership to the Medical Staff.

21. Use of Copy and Paste. Copy/Paste means a documentation assist feature in electronic health record systems that enable the user to select information from one source/location and replicate it in another location. The copy/paste feature may also be referred to as: copy and paste, copy forward, carry forward, pull forward, brought forward, re-use, and cloning. Cloned documentation means documentation that is identical or unreasonably similar to the previous entries for a patient or to other patients. The Medical Staff shall be responsible for following the policy, Use of Copy/Paste Functionality in the Electronic Health Record. Use of Copy/Paste Functionality in the EHR

GENERAL CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer shall notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

   The patient shall receive information necessary to give informed consent prior to the start of any non-emergency procedure or treatment or both unless expressly waived by the patient. This shall include, as a minimum, the specific procedure or treatment or both, the reasons for it, the reasonably foreseeable risks and benefits involved, and the alternatives for care or treatment, if any, as a reasonable practitioner under similar circumstances would disclose. Documented evidence of such informed consent shall be included in the patient's medical record.

   The patient has the right to refuse treatment to the extent permitted by law and to be informed of the reasonably foreseeable consequences of such refusal.

   The patient has the right to receive from the responsible practitioner or designated hospital representative, information necessary to give informed consent prior to the withholding of medical care and treatment.

   Furthermore, patients must be informed about the outcomes of their care, particularly when there are unanticipated outcomes. The pertinent member of the medical staff must provide adequate and

timely information to the patient, or family member when appropriate, whenever there is an event associated with temporary patient harm, permanent patient harm, or death.

Whenever an error may have caused or contributed to an unanticipated outcome of patient care, the Hospital Policy for "Communicating with Patients and Families about Health Care Injury" must be followed.

2. All orders for treatment and medication shall be entered into the medical record. Orders can be generated by physicians, dentists, podiatrists, midwives, advanced practice nurses and physician assistants consistent with their privileges.

   A verbal/telephone order may be considered if communicated to a pharmacist, registered nurse, physician assistant, respiratory therapist, imaging technologist, or registered dietician. Verbal/telephone orders for narcotics and benzodiazepines are acceptable only in emergency situations. Verbal/telephone orders may not be given for chemotherapeutic agents. All verbal/telephone orders shall be signed by the pharmacist, registered nurse, physician assistant, respiratory therapist, imaging technologist, or registered dietician to whom dictated with the name of the medical staff member or clinical affiliate per his or her own name, excepting emergency situations, verbal/telephone orders may not be enacted until the authorized individual receiving the verbal/telephone order has completed a "read-back" verification with the ordering practitioner. The individual or supervising physician who gave the verbal/telephone order shall authenticate and sign all orders for drugs and biologicals within 30 days. Excepted from this policy are outpatient verbal/telephone orders for controlled substances which must be authenticated within 48 hours.

   Radiological, ultrasound, MRI, and nuclear medicine technologists are permitted to accept verbal/telephone orders for imaging studies and/or required contrast media, or radiopharmaceuticals related to their discipline.

   Respiratory therapists may only accept verbal/telephone orders related to respiratory care treatments/medications, ventilator management, and supplemental oxygen. Registered dieticians are permitted to accept verbal/telephone orders for food and enteral nutritional products.

3. The practitioner's orders must be clear and complete. Orders which are improperly entered will not be carried out until corrected and understood by the nurse. The use of "Renew," "Repeat," and "Continue Orders" are not acceptable.

   Residents may enter patient care orders. Such orders will be in keeping with the plan of care of the attending member of the Medical Staff. This does not preclude a member of the attending medical staff from entering orders.

4. All previous orders are canceled when patients go to surgery, except for those procedures deemed exceptions by the Surgical Services Committee.

5. All drugs and medications administered to patients shall be those listed in the latest edition of: <u>United Stated Pharmacopoeia</u>, National <u>Formulary</u>, <u>American Hospital Formulary Service</u> or <u>A.M.A. Drug Evaluations</u>. Drugs for bona fide clinical Investigations may be exceptions. These shall be used in full accordance with the <u>Statement of Principles Involved in the Use of Investigational Drugs in Hospitals</u> and all regulations of the Federal Drug Administration.
   All practitioners may prescribe medications appropriate to their training, education, current competency and delineated privileges.

6. Consultations shall be obtained at the discretion of the attending practitioner. It is the duty of the hospital staff, through its Departmental Chairpersons and Executive Committee, to see that members of the staff do not fail in the matter of calling consultants as needed. A consultant must be well qualified to give an opinion in the field in which his opinion is sought. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant

which is made part of the record. If critical orders are necessary, orders should be written by consultant or communicated to the primary provider or provider requesting the consultation to determine who should complete the order. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation.

7. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Residents, Physicians, and Clinical Affiliates may call on behalf of the attending practitioner. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise. Consultations will be seen within 24 hours of the request for consult unless a timeframe is mutually agreed upon between the Attending and Consulting Physicians. In the case of an emergency consultation, the requesting physician will discuss the patient's clinical status with the consultant, who will then respond within a timeframe appropriate to the clinical problem, as mutually agreed upon by the requesting and consulting physicians. If the initial consult done by a Clinical Affiliate, the Attending must also see the patient and participate in the consult.

8. If a nurse, pharmacist or other allied health professional, after he/she has consulted with the attending physician, dentist or midwife, has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who, in turn, may refer the matter to the Director of a Clinical Service or Administrative superior. If warranted, the Director or the Administrative superior may bring the matter to the attention of the Chairperson of the department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chairperson of the department may themselves request a consultation.

9. In an effort to ensure an environment conducive to the delivery of quality patient care, it is imperative that both Medical Staff and Hospital Staff conduct themselves in a professional, collaborative manner which is not abusive or harassing. Any behaviors inconsistent with this goal should be reported and addressed immediately.

   The following behaviors are not acceptable in the workplace which, if exhibited, will result in disciplinary action:

   - Breaching patient confidentiality;
   - Creating a hostile environment (by offensive language or other behavior) for
   - patients, staff or Medical Staff members;
   - Stealing or other forms of dishonesty;
   - Threats or intimidation;
   - Violation of Hospital and Medical Staff Code of Conduct;
   - Violation of Patient Bill of Rights;
   - Violation of Sexual Harassment Policy;
   - Violation of the Drug Free Workplace Policy.

   Disciplinary actions for Medical Staff include:

   - Verbal counseling and warnings by the Department Chair and Vice President for Medical Affairs;
   - Issuance of a letter of reprimand and potentially a recommendation for reduction, suspension or revocation of privileges pursuant to Article VII of the By-Laws of the Medical Staff.

10. Policy Regarding Sexual Harassment

All members and affiliates of the Medical Staff are responsible for assuring that the workplace is free from sexual harassment. The Hospital will not tolerate offensive or inappropriate sexual behavior at work. It is expected that all members and affiliates of the Medical Staff will avoid any action or conduct that could be viewed as sexual harassment.

PROCEDURE

*Complaints of sexual harassment by a member or affiliate of the Medical Staff are handled in accordance with the Code of Conduct of the Medical Staff. Employees may file complaints of sexual harassment as outlined in the Employees Handbook. https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=19502

GENERAL RULES REGARDING SURGICAL CARE

1. Except in severe emergencies, the preoperative diagnosis, required laboratory tests, complete history and physical, and consultation notes when indicated, must be recorded on the patient's medical record prior to any operative and invasive procedure. It is the responsibility of the attending surgeon to make certain that the attending note is on the chart prior to the procedure.

2. a. Dentist members of the Medical Staff shall be eligible for privileges to admit, manage and discharge their patients.

   b. The Attending Dentist shall be responsible for the admission, management and discharge of dental patients inclusive of all related written documentation.

   c. The admission history and physical examination for dental patients shall be completed by a dentist qualified to perform a history and physical examination on his/her own patients or by another member of the medical staff. A dentist qualified to perform a history and physical examination shall mean a dentist who:

      1. has successfully completed a program of postgraduate study incorporating training and physical diagnosis at least equivalent to that received by one who has successfully completed a postgraduate program of study in oral and maxiofacial surgery accredited by a Nationally recognized body approved by the United States Department of Education; and

      2. as determined by the Medical Staff through its credentialing and Performance Improvement Programs, is currently competent to conduct a complete history and physical examination to determine a patient's ability to undergo a proposed dental procedure or other dental care.

   d. Dental patients with medical problems present upon admission or arising during hospitalization shall be referred to appropriate medical staff for consultation and/or management.

   e. Additional Dentists' responsibilities are:

      1. A detailed dental history justifying hospital admission;

      2. A detailed description of the examination of the oral cavity and a preoperative diagnosis;

      3. A complete operative report, describing the finding and technique. In the 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 hospital pathologist for examination;

      4. Progress notes as are pertinent to the oral condition;

      5. Clinical resume (or summary statement).

3. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

4. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

5. Unless exempted by Medical Staff policy, all tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

6. In those surgical cases where there are unusual hazards to life based upon preoperative risk assessment and complexity of the proposed procedure, there shall be present and scrubbed as first assistant a physician credentialed to assist in major surgical procedures.

7. In those cases attended by an anesthesiologist, the operating physician shall concurrently inform the anesthesiologist of potentially vasoactive drugs and local anesthetics administered directly by the surgeon. This will include the medication, strength, dosage, quantity and route of administration.

8. The operating surgeon and anesthesiologist shall collaborate throughout the operative period so as to provide optimal patient care. Should an unexpected and untoward event occur during the operative period, the physician with the greater expertise in diagnosing and treating the problem shall have primary responsibility for that aspect of care.

9. OR Attire will follow the CMS State Operations Manual, Regulations and Interpretive Guidelines for Hospitals. https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=19436

EMERGENCY SERVICES

1. Each clinical Chairperson shall be responsible for the assignment of appropriate members of the Medical Staff to provide coverage of the emergency service.

   The assigned member of the Medical Staff must respond by phone as soon as possible, but no longer than thirty (30) minutes from a call from the Emergency Department attending. A conversation will then take place between the attending emergency physician and the medical staff physician on-call in which the need for further evaluation and stabilization of a patient with an emergency medical condition will then be described. The assigned member of the medical staff must present in person, when requested by the Emergency Department attending, as soon as possible but no more than sixty (60) minutes from the time of verbal notification of the on-call physician by the Emergency Department physician to provide the above-described evaluation and treatment. If there is a disagreement about the need to come to the Emergency Department, the assigned member of the Medical Staff must come to the Emergency Department and render care. Any disagreement may be addressed at a later time with the appropriate Department Chairpersons.

   Whenever the assigned member of the Medical Staff cannot respond due to circumstances beyond his/her control, including but not limited to, sudden illness, automobile accident, involvement in a surgical procedure or medical emergency, the Chairperson of the applicable department may assign another qualified member of the active staff to attend the patient; or, if it is in the patient's best interest, the patient may be advised, in accordance with the hospital's policy on patient transfer, to accept transfer to a facility which can provide the service.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be

incorporated in the patient's hospital record, if such exists. The record shall include:

a. Adequate patient identification;
b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;
d. Diagnosis;
e. Treatment given;
f. Description of significant clinical, laboratory and imaging findings;
g. Condition of the patient on discharge or transfer; and
h. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

3. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

4. There shall be a periodic review of Emergency Room records by the Medical Records Department and by appropriate clinical departments to evaluate quality of emergency medical care.

5. The hospital's Disaster Plan shall be considered as part of these Rules and Regulations.

6. The working conditions and hours of physicians and post-graduate trainees assigned to the Emergency Department shall meet the requirements of the New York State Department of Health. Specifically, post graduate trainees and attendings shall not be assigned to be on duty more than 12 consecutive hours in the emergency department.

7. The organization general policies and procedures, staffing and patient care policies shall meet the requirements of the New York State Department of Health.

8. A medical screening examination will be provided for all individuals presenting to the hospital for emergency care. The purpose of this examination is to determine whether or not a medical emergency exists. Furthermore, the medical screening examination may require reassessment at intervals appropriate to the patient's clinical condition and duration of stay. This medical screening examination will be provided by an attending with privileges appropriate to the clinical situation or by his/her designee with attending supervision. The designee may be a physician assistant, nurse practitioner, or resident physician.

   In the case of a pregnant patient, a medical screening examination may be necessary to determine if there is active labor. This examination may be performed by an attending with obstetrical privileges, an emergency department physician or licensed midwife. Resident physicians, nurse practitioners and physician assistants may perform the examination under the direction of a credentialed physician. In the case of a low risk pregnancy, the examination may be performed by an obstetrical nurse under the direction of a practitioner privileged in obstetrics. However, when a pregnant patient is experiencing contractions, only a physician may make the determination that there is no active labor.

CLINICAL AFFILIATES

1. Members of medically related professions who play a significant role in the program of patient care at St. Joseph's Hospital Health Center may be appointed as Clinical Affiliates of the Hospital. Clinical Affiliates of the Medical Staff shall include audiologist, clinical nurse specialists, clinical pharmacists, neurophysiology technologists, nurse anesthetists, nurse practitioners, physician assistants, psychologists, podiatrists and registered nurse first assistants.

2. Clinical Affiliates may function only under conditions outlined by the Chairperson of the pertinent

department and approved by the Executive Committee of the Medical Staff and the Board of Trustees. Such conditions shall be consistent with the licensing and registration requirements of the New York State Department of Health, State Education Department, and other governmental agencies where applicable.

3. Clinical Affiliates are appointed by the Board of Trustees of the Hospital upon recommendation of the Executive Committee of the Medical Staff and are assigned to an appropriate clinical department. Each Clinical Affiliate shall have a sponsoring physician for credentialing purposes ("Sponsoring Physician for Credentialing") who shall assist the Clinical Affiliate with Appointment, Reappointment, Corrective Actions, Hearings and Appellate review under the By-Laws of the Medical Staff. For nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and registered nurse first assistants, appointment and reappointment shall include consideration of an evaluation and recommendation from the Chief Nursing Officer or designee.

4. Any physician member of the Medical Staff may medically supervise a Clinical Affiliate ("Supervising Physician") as long as the scope of activities is within the clinical affiliate's granted privileges, education training and experience. Furthermore, a Supervising Physician may only supervise a clinical affiliate engaging in activities for which the physician has privileges and is within the scope of Supervising Physician's practice. Pursuant to 10 NYCRR Section 94.2(f), the Supervising Physician shall remain medically responsible for the medical services performed by a physician assistant whom such Supervising Physician supervises. Members of the Medical Staff shall abide by the Medical Staff's *Guidelines for Working with Clinical Affiliates.* ..\..\Policies and Procedures\Guidelines for working with Clinical Affiliates ratified July 2017.pdf

5. Clinical Affiliates are subject to the terms and conditions of the By-Laws of the Medical Staff including, but not limited to, "Procedure for Appointment and Reappointment", "Corrective Action", and "Hearing and Appellate Review Procedure".

6. Licensed Physician Assistants (P.A), Nurse Practitioners (N.P.), Certified Registered nurse anesthetists (C.R.N.A.) and Podiatrists (D.P.M.) applying and reapplying for membership on the Clinical Affiliate Staff must achieve and maintain certification by their specialty board. This requirement may be waived by the Medical Executive Committee upon recommendation by the Department Chair and upon approval by the Board of Trustees. Criteria for such waiver shall be training, service and experience which demonstrate excellence equivalent to that of a Board Certified physician. A temporary waiver may be granted by the Medical Executive Committee, upon recommendation by the Department Chair and approval by the Board of Trustees, to allow an unsuccessful candidate to re-challenge a certification or recertification examination. A temporary waiver may be granted by the Medical Executive Committee, upon recommendation by the Department Chair and approval by the Board of Trustees, in case of illness or other personal hardship. Such temporary waivers shall be for one year, and may be renewed if appropriate in the judgment of the Department Chair, Medical Executive Committee and Board of Trustees.

PODIATRISTS

Privileges may be granted to licensed podiatrists as Clinical Affiliates depending on their professional training, experience, demonstrated competence and professional qualifications.

1. Appropriate accreditation and education requirements must be submitted, including: graduation from an accredited post-graduate School of Podiatric Medicine, successful completion of the National Board of Podiatry Examiners and licensure by the State Education Department.

2. Podiatrists, if properly credentialed, will be allowed to diagnose, treat, operate and prescribe for any disease, injury, deformity, or other condition of the foot and will be permitted to operate on the bones, muscles or tendons of the feet consistent with their delineated privileges.

3. Podiatrists will be allowed to administer local anesthesia for therapeutic purposes and will be

allowed to treat under general anesthesia administered by authorized persons. Podiatrists will also be allowed to use non-narcotic postoperative sedatives and, if certified by the State Education Department and Drug Enforcement Administration, will have the right to administer or prescribe narcotics.

4. Podiatrists will not treat any other part of the human body nor treat fractures of the malleoli or operate upon the malleoli.

5. Podiatrists have admitting privileges and shall be responsible for their part of their patient's history and physical examination that relates to podiatry. The hospital internist / family physician or hospitalist shall be responsible for the rest of the history and examination of medical and psychiatric conditions as part of a mandatory medical consultation.

6. Podiatrists are appointed by the Board of Trustees of the Hospital following the recommendation of the Executive Committee of the Medical Staff.

7. Podiatrists shall be under the supervision of the Department of Surgery's Section Chief of Orthopedics who will recommend the Delineation of Privileges for each podiatrist based on the podiatrist's accreditation and experience.

POST-GRADUATE TRAINEES (RESIDENTS)

St. Joseph's Graduate Medical Education Program will comply with all applicable laws, rules and regulations and ACGME standards (and all other accrediting entities as applicable) regarding work hour limitations of post graduate trainees and supervision requirements. Work hours will be restricted, monitored and managed as provided in the Resident Work Hour Limitations Policy.

1. Post-graduate trainees shall have their work hours and conditions comply with the following guidelines:

   a. Post-graduate trainees shall not be assigned to be on duty more than 12 consecutive hours in the emergency department.
   b. Post-graduate trainees with inpatient care responsibilities shall not be assigned to a workweek averaging in excess of 80 hours per week over a four week period nor more than 24 consecutive hours.
   c. Post-graduate trainees shall have at least eight (8) hours of non-working time between scheduled times on duty.
   d. Post-graduate trainees shall have at least one 24-hour period of scheduled non-working time per week.
   e. Exempted from requirements B. and C. are those residents whose documented night calls are infrequent and rest time is adequate.

2 Members of the medical staff shall take all reasonable efforts to ensure compliance with the requirements set forth in 1, and shall not assign duties and responsibility to post-graduate trainees which exceeds their capabilities based upon their level of training and demonstrated competency.

3. Residents, including supervising residents, shall consult with and be directed by a member of the Medical Staff with regard to diagnostic and therapeutic decisions, invasive procedures and changes in patient status. Direct patient care may be provided by residents and medical students within their permitted scope of responsibility and privileges with supervision as consistent with the responsibilities as outlined in the Housestaff Manual. Whenever a resident has any question about the diagnosis, prognosis or treatment of a patient, it is his/her obligation to seek advice from a more senior resident or an attending. A member of the Medical Staff may not supervise and direct a resident or medical student in clinical activities for which the member of the Medical Staff does not

have privileges granted in accordance with the By-Laws of the Medical Staff. Occurrence of urgent or emergent situations may preclude the attending or admitting physician from direct participation in decision-making regarding patient care. In such instances, the supervising resident shall concur in the decision and the attending member of the Medical Staff shall be notified as soon as possible.

Residents may perform procedures either under the direct, in person supervision of a credentialed member of the Medical Staff or credentialed resident. As determined by the applicable Residency Program Director, a resident at the appropriate level of training and with evidence of the necessary education, knowledge and current competency, may be granted privileges to perform procedures with limited supervision (i.e., attending is on-call and available to respond in a timely fashion).

Excepted are those procedures performed in the operating rooms; an attending member of the Medical Staff must be present to provide direct, in-person supervision.

The Director of Medical Education shall maintain privilege lists for all residents, which shall be available in the Clinical Services office at all times.

Furthermore, the Residency Program Director may grant residents graduated patient care responsibilities, including the supervision of other residents, based upon demonstration of adequate training, education, knowledge and current competence in accordance with criteria set forth by the Director.

GUIDELINES FOR HELPING THE SICK OR IMPAIRED PRACTITIONER

The Medical Staff of St. Joseph's Hospital Health Center desires to set up guidelines for the identification of and assistance to sick or impaired members of its professional staff, and a procedure for the protection of its patients from any such sick or impaired members. A standing committee of the Medical Staff named the Health Committee shall be appointed consisting of two psychiatrists, one member of the Department of Medicine and one member of the Department of Family Practice, none of whom are members of the Executive Committee of the Medical Staff. The Committee will elect its own Chairperson. Any complaints or information concerning a sick or impaired member of the professional staff may be brought to the attention of the Chairperson or any of the members of the Health Committee. Those submitting information or complaints should be willing to appear before the committee to document their charges. All information including names will be held privileged and confidential.

The Health Committee's focus shall be rehabilitation, rather than discipline, to encourage referrals including self referral by a practitioner. For individuals eligible to participate in the Committee for Physicians Health program of the Medical Society of the State of New York, enrollment and compliance with the program obviate the need for Steps I and II.

STEP I

a. Upon receipt of a complaint, the Health Committee will be convened within three working days. The involved practitioner will subsequently be contacted and interviewed concerning the information received. Records of such meetings will be kept and procedures instituted to limit access of this information.

b. The Health Committee shall make known its recommendations to the involved practitioner. Their recommendations shall consider the protection of patients both in and outside of the hospital and the best interests of the practitioner, including recommendations for evaluation and care of the sickness or impairment which optimize the likelihood that the practitioner can safely re-assume or continue their clinical duties and responsibilities, when appropriate.

c. If the practitioner accepts and acts upon the recommendation of the Health Committee, the

investigation shall be terminated.

d. The Health Committee shall monitor the future activity of the practitioner in a manner which is appropriate to the complaint, and which safeguards the physician from prejudicial or harassing supervision.

STEP II

Failure of the involved member of the hospital Medical Staff to act upon the recommendations of the Health Committee shall cause the problem to be referred without delay to the Executive Committee of the Medical Staff which will hold appropriate hearings as called for under Articles VII and VIII of the Medical Staff By-Laws and will make recommendations to the member of the staff, or will determine other corrective action. These recommendations or decisions for corrective action will also be transmitted to the Chairperson of the Health Committee who will be responsible for monitoring compliance.

In the event that the involved member of the Medical Staff refuses to accept the recommendations of the Health Committee, and the Health Committee believes any delay might endanger the welfare of the patients or the hospital, the Committee will promptly inform the President of the Medical Staff and the Administrator of the hospital and recommend that temporary suspension of the practitioner be affected.

It is the obligation of the Health Committee to continue to monitor the condition of the affected practitioner, and in the event that he wishes to have his privileges reinstated after suspension, to make recommendations to the Executive Committee, which will promptly, in accordance with the By-Laws, act on the reinstatement of the rehabilitated professional.

I. Each member of the Medical Staff granted admitting and clinical privileges and Clinical Affiliate Staff granted clinical privileges shall maintain professional liability insurance in the minimum amounts of $1,300,000/$3,900,000.

Alternatively, in the event that a member of the Medical Staff seeks to satisfy the obligation to maintain professional liability insurance by means of participating in a Risk Retention Group, such member of the Medical Staff shall meet all requirements requested by the Medical Executive Committee including, but not limited to, the following:

1. The policy limits should be no less than $2 million per claim and $6 million in the aggregate. In situations where these limits are unobtainable, a request to the Medical Executive Committee may be made to approve a lesser amount.

2. The Medical Staff member shall provide yearly proof of the AM Best rating of "A" or better from the Risk Retention Group for any re-insurance carriers. No re-insurance carrier with a rating lower than "A" will be accepted.

3. The Medical Staff member shall provide annual audited financial statements of the Risk Retention Group for each year of participation in the Risk Retention Group.

4. The policy provided by the Risk Retention Group shall provide that defense costs shall be in addition to the limit of liability and shall not exhaust that limit.

5. The policy shall contain an endorsement covering liability as a result of sexual molestation.

6. The policy shall provide for an automatic 60 day tail in the event that coverage is ended or not renewed.

7. The Medical Staff member seeking to provide coverage through a Risk Retention Group must agree to pay all of the costs incurred by the Medical Staff in connection with their review of the

request to meet the professional liability insurance requirements through the use of a Risk Retention Group.

8. The policy provided by the Risk Retention Group must be approved by the Hospital.

ADOPTED:

President, Medical Staff — August 31, 2018

Secretary, Board of Trustees — August 31, 2018