MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF UPMC MEMORIAL

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I

DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in these Medical Staff Rules and Regulations are set forth in the Medical Staff Glossary.

ARTICLE II

ADMISSIONS AND PATIENT CARE
SERVICES IN THE HOSPITAL

2.A. ADMISSIONS

(1) A patient may only be admitted to the Hospital by order of a Practitioner who is granted admitting privileges. Advanced Practice Professionals may write inpatient admitting orders on behalf of their Supervising/Collaborating Physician, in accordance with the standards of practice outlined in Article 8 of the Credentials Policy.

(2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than 24 hours after admission.

(3) The Admitting Practitioner will provide the Hospital with any information concerning the patient, of which the Admitting Practitioner is aware, that is necessary to protect the patient, other patients or Hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm.

2. B. OBSERVATION STATUS

(1) Observation status is an outpatient status meant to be used as a period of diagnosis and/or treatment prior to or in lieu of an inpatient admission.

(2) All patients placed in observation status must be seen by the Admitting Practitioner or a Responsible Practitioner within the observation period.

2. C. RESPONSIBILITIES OF ATTENDING PHYSICIAN

(1) Any changes to the patient's attending physician will be documented in the electronic medical record ("EMR").

(2) If the Attending Physician is unavailable and alternate coverage has not been arranged, the relevant Department Chair, the Medical Staff President, the VPMA, or the administrator on call will have the authority to call on the on-call physician in the relevant specialty or any other Medical Staff member to attend the patient. The Medical Staff leaders will also confirm the Attending Physician meets the eligibility criteria related to appropriate coverage, as outlined in the Medical Staff Credentials Policy.

(3) Daily Inpatient Rounds: Advanced Practice Professionals may perform daily inpatient rounds in collaboration with a Supervising/Collaborating Physician. The Supervising/Collaborating Physician must provide the appropriate level of supervision and accountability over all care delivered by the Advanced Practice Professionals for inpatients admitted to, or under consultation, by his/her service on a daily basis. Physical presence by the Supervising/Collaborating Physician daily is not required though can be requested by Medical Staff.

All patient records shall be reviewed by the Supervising/Collaborating Physician daily* for patients under the care of the Advance Practice Professional that meet the following criteria as identified by any medical or nursing staff:

- Any unexpected change in patient condition;
- Any unexpected patient admission or readmission to the emergency department or hospital;
- Any patient is not responding appropriately or as expected to the prescribed medical regimen or therapy;
- Any patient experiencing an unexpected reaction to a medication or therapy;
- Any request to the Supervising/Collaborating Physician including but not limited to patient/patient decision maker, any physician involved in the patient's care, hospital leadership, federal, state, or regional regulatory authority; or
- Any patient with a new or changed diagnosis made by the Advanced Practice Professional that is outside of what is normally experienced or expected in the Supervising/Collaborating Physician's practice.

The Supervising/Collaborating Physician must also be available whenever requested by the Hospital or Medical Staff, the patient or the patient's family, and as medically necessary.

* Any of the following can be evidence of the medical record review (that is, during or within 24 hours of the defined need) prompted by this section of the Rules and Regulations:

- Any entry into the record, including a clinical note of any length, check box or attestation of such, or countersignature of a note on that day;
- Login to the patient record using a specific identifier assigned to the supervising physician;

- Notation by any health care worker of Supervising/Collaborating Physician at the bedside or requesting information;

- Verbal or other attestation of record review by Supervising/Collaborating Physician; and/or

- Any audits performed by the site.

ARTICLE III

MEDICAL RECORDS

3.A. GENERAL

(1) A medical record will be prepared for every individual evaluated and treated at the Hospital. Each Practitioner who is involved in the care of a patient will be responsible for the timely and accurate completion of the portions of the medical record that pertain to the care he/she provides.

(2) The medical record shall contain sufficient information to identify the patient, identify the persons treating the patient, and to justify the patient's diagnosis and treatment.

3.B. MEDICAL RECORD ENTRIES

3.B.1. Entries:

(a) Electronic entries will be entered through the EMR and/or Computerized Provider Order Entry ("CPOE") in accordance with Hospital policy. Practitioners are responsible for the accuracy of all such entries, including those dictated through voice recognition software (e.g., M*Modal). The use of disclaimers as a part of a Practitioner's signature is prohibited and does not remove his/her responsibility for the content and accuracy of the entry and any documentation.

(b) Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). Any such written or paper-based entries will be scanned and entered into the patient's EMR in accordance with Hospital policy.

(c) All entries, including handwritten entries, must be timed, dated, and signed.

(d) Any entry in the medical record should be clear, concise, and objective. Practitioners will not editorialize in the medical record of a patient or enter extraneous comments or criticisms about a patient, a patient's family, or the care provided by other Practitioners or Hospital personnel.

3.B.2. Entries by Advanced Practice Professionals:

(a) Entries by Physician Assistant Advance Practice Professionals will be countersigned by their Supervising/Collaborating Physician in accordance with state law during their first year after graduation and/or their first year of practice in

a new specialty. After that first year, any countersignature requirements that have been specified in the written supervision agreement between the Physician Assistant and his/her Supervising/Collaborating Physician will apply.

(b) Entries by all other Advanced Practice Professionals or Allied Health Professionals only need to be countersigned if a countersignature is required by the written supervision agreement between the Advanced Practice Professional or Allied Health Professional and his/her Supervising/Collaborating Physician.

3.B.3. Authentication:

(a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or CPOE.

(b) The Practitioner will attest that he/she alone will use his/her unique electronic signature code to authenticate documents in accordance with Hospital policy.

(c) Signature stamps are not an acceptable form of authentication for written orders or other medical record entries unless, in accordance with the Rehabilitation Act of 1973, the practitioner has a physical disability and can provide proof to a CMS contractor of his/her inability to provide his/her signature due to his/her disability.

3.B.4. Symbols and Abbreviations:

(a) Only standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used.

(b) The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

3.B.5. Clarity and Completeness:

All entries in the medical record shall be clear and complete so that other members of the health care team are able to understand the entry and the author's intentions.

3.B.6. Correction of Errors:

(a) When an electronic entry requires correction, the author shall enter an electronic addendum to the initial entry. Any error made while entering an order in the CPOE should be corrected by entering another order.

(b) Handwritten entries in the paper record will be corrected by making a single line through the original entry and making any necessary addition/correction. Any addition/correction will be timed, dated, and initialed by the author.

3.B.7. Copying and Pasting/Carry Forward:

Copying and pasting or carrying forward from another entry in the EMR is permissible so long as the posted entry is properly updated (i.e., the Practitioner has verified that the information is accurate for the patient in question).

3.B.8. Completion of Medical Records:

A medical record will not be considered complete until it is completed by the Responsible Practitioner, or it is ordered filed by Health Information Management ('HIM") under the direction of the MEC. Except in rare circumstances, and only when approved by the MEC, no Practitioner will be permitted to complete a medical record on an unfamiliar patient.

3.C. OWNERSHIP, RETENTION, AND ACCESS TO RECORDS

3.C.1. Ownership of Records:

Medical records are the property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

3.C.2. Retention of Records:

The Hospital will retain medical records in their original or legally reproduced form in accordance with Hospital policy.

3.C.3. Access to Records:

(a) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and the Hospital's Health Insurance Portability and Accountability Act ("HIPAA") policy.

(b) A patient or his/her duly designated representative may receive copies of the patient's completed medical record, or an individual report, pursuant to the Hospital's HIPAA policies.

(c) Access to all medical records of patients will be afforded to Medical Staff members for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(d) Subject to the discretion of the Administrative leadership, former Medical Staff members may be permitted access to information from the medical records of their

patients covering all periods during which they attended to such patients in the Hospital.

ARTICLE IV

CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

4.A. CONTENT OF MEDICAL RECORD

4.A.1. General Requirements:

All medical records for patients receiving an evaluation or treatment in the Hospital or at an Ambulatory Care Location will document the information relevant and appropriate to the patient's care, in accordance with state and federal law, as well as Hospital policy.

4.A.2. Progress Notes:

(a) Progress notes will be entered by the Attending Physician or his/her covering Practitioner at least every 24 hours for all hospitalized patients and as needed to reflect changes in the status of a patient in an Ambulatory Care Location.

(b) Progress notes will be understandable, dated, timed, and authenticated. When appropriate, 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 treatments.

4.A.3. History and Physical:

The requirements for histories and physicals, including general documentation and timing requirements, are outlined in Appendix B of the Medical Staff Bylaws.

4.A.4. Consultation Reports:

(a) Consultation reports will be completed in a timely manner and documented in an EMR-generated note or, when the EMR is unavailable, a dictated or legible written note. The consultation report will contain the date and time of the consultation, opinions based on relevant findings and reasons, and recommendations by the Consulting Practitioner.

(b) When non-emergency operative procedures are involved, the Consulting Practitioner's report will be recorded in the patient's medical record prior to the surgical procedure.

4.A.5. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

4.A.6. Informed Consent:

Informed consent will be obtained in accordance with UPMC's Patient Informed Consent Policy and documented in the medical record.

4.A.7. Operative Procedure Reports:

An operative procedure report must be documented in accordance with Article 7 of these Rules and Regulations.

4.A.8. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient's medical record on appropriate paper or electronic forms in accordance with Article 8.

4.A.9. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

4.B. TIMELINESS OF DOCUMENTATION

(1) General Requirements. It is the responsibility of every Practitioner involved in the care of a patient in the Hospital to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies. A medical record is considered delinquent when:

(a) the H&P is not completed and entered into the medical record within 24 hours after admission or registration (but in all cases prior to the procedure);

(b) the full operative procedure report is not documented and entered into the medical record within 48 hours after the procedure;

(c) the post-anesthesia evaluation is not completed and entered into the medical record within 48 hours after the procedure;

(d) an order, including a verbal order, is not signed within seven days of the order;

(e) the results of the medical screening examination are not documented in the medical record within 48 hours of the conclusion of an Emergency Department visit, prior to admission to the Hospital, or, in the case of a transfer, prior to the patient arriving at the receiving hospital, as applicable;

(f) the discharge summary is not completed within 48 hours of the patient's discharge; or

(g) any other required patient reports are not entered, written, documented and/or authenticated within 30 days of the patient's discharge.

(2) Monitoring, notification and enforcement processes are outlined in the UPMC Pinnacle Provider Privilege Relinquishment Policy.

ARTICLE V

MEDICAL ORDERS

5.A. GENERAL

(1) Orders will be entered directly into the EMR by the ordering Practitioner utilizing the CPOE, except when orders are given verbally, by phone, or when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Orders *may not* be communicated by text message. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR as soon as possible, and no later than the time of discharge.

(2) All orders (including verbal/telephone orders) must be:

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering Practitioner, with the exception of a verbal order which may be countersigned by another Practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication*; and

(c) documented clearly and completely. Orders which are improperly entered will not be carried out until they are clarified by the ordering Practitioner and are understood by the appropriate health care provider.

* Orders entered into the EMR are electronically authenticated, dated, and timed.

(3) All orders should be reconciled when a patient is transferred from one level of care to another (e.g., from a procedural area to the floor, the floor to the ICU, etc.). In addition, medication orders will be reconciled in accordance with Section 5.C below.

(4) No order will be discontinued without the knowledge of the Attending Physician or his/her designee, unless subject to protocols or where the circumstances causing the discontinuation to constitute an emergency.

(5) In addition to the requirements outlined in these Rules and Regulations, there may be Hospital policies that dictate the specific requirements for ordering specific tests, treatments, and therapies.

(6) Advanced Practice Professionals may be authorized to issue medication orders as specifically delineated in their clinical privileges. If required by the Advanced Practice Professional's written supervision agreement, any such order will be countersigned in accordance with Section 3.B.2 of these Rules and Regulations.

5.B. ORDERS FOR TESTS AND THERAPIES

(1) Except as otherwise provided in (3) below, orders for tests and therapies will be accepted from Practitioners to the extent permitted by their licenses and clinical privileges.

(2) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering Practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(3) Orders for outpatient services (e.g., laboratory tests, diagnostic tests, etc.) may also be accepted from practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

5.C. ORDERS FOR MEDICATIONS

(1) Orders for medications may only be ordered by Medical Staff members and other authorized individuals with appropriate clinical privileges at the Hospital.

(2) All medication orders will clearly state the administration times or the time interval between doses, route, and the indications for use when appropriate. Each dose of medication shall be recorded in the medical record of the patient after the medication has been administered. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations.

(3) All orders for medications administered to patients will be:

(a) periodically reviewed by the prescriber to assure appropriateness;

(b) reviewed when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

(c) reviewed by a Hospital pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit or when supervised by a licensed independent prescriber). In cases when the medication order is issued when the Hospital pharmacy is "closed" or a Hospital pharmacist is otherwise unavailable, the medication order will be

reviewed by the nursing supervisor and then by a Hospital pharmacist as soon thereafter as possible, preferably within 24 hours.

(4) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(5) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(6) Titration orders may be used so long as the following are specified:

(a) medication name and route;

(b) initial or starting rate of infusion (e.g., dose/min);

(c) incremental units the rate can be increased or decreased and frequency for incremental doses;

(d) maximum range (dose) of infusion; and

(e) objective clinical endpoint for the titration (e.g., RASS score, CAM score, etc.).

5.D. VERBAL ORDERS

(1) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering physician or if a delay in accepting the order could adversely affect patient care.

(2) All verbal orders will be entered into the EMR and will include the date and time of entry into the medical record, identify the names and titles of the individuals who gave, received, and implemented the order, and include the full signature of the individual who accepted the order. Verbal orders will then be authenticated with date and time by the ordering physician or another physician who is responsible for the care of the patient, as authorized by Hospital policy and state law.

(3) The ordering physician, or another physician who is responsible for the patient's care in the Hospital, will countersign a verbal order as soon as practical, but no later than ***seven days*** after the order was given.

(4) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order as the order is entered and alert checking is completed in the EMR. This will serve to eliminate

any errors related to sound-alike drugs and other common discrepancies in transmission and acceptance of verbal orders.

(5) The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:

(a) a registered nurse or a licensed practical nurse;

(b) a nurse practitioner/nurse midwife;

(c) a physician assistant for emergency medications or treatment;

(d) a pharmacist who may transcribe a verbal order pertaining to drugs;

(e) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

(f) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(g) a speech therapist who may transcribe a verbal order pertaining to speech therapy;

(h) an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;

(i) a licensed dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition;

(j) radiologic technicians who may transcribe a verbal order pertaining to diagnostic imaging studies; and

(k) radiology practitioner assistants ("RPAs") and registered radiologist assistants ("RRAs") who may only accept and transcribe verbal orders related to diagnostic imaging studies from their Supervising/Collaborating Physician(s). RPAs and RRAs may not independently issue orders.

5.E. STANDING ORDERS, ORDER SETS, AND PROTOCOLS

(1) The MEC allows the use of pre-printed and electronic standing orders, order sets, and protocols for patient orders when the following criteria are met:

(a) the MEC and the Hospital's pertinent nursing and pharmacy departments must review and approve any standing orders, order sets, and protocols (collectively, "standing orders") that permit treatment to be initiated by an

individual (for example, a nurse) without a prior specific order from the Attending Physician; and

(b) all standing orders must identify well-defined clinical scenarios for when the order is to be used.

(2) The MEC will adopt the findings of the UPMC Electronic Practice Guidelines ("EPG") and/or the UPMC System Pharmacy & Therapeutics Committee, as applicable, confirming that all approved standing orders and protocols are consistent with nationally recognized and evidence-based guidelines. The MEC will also ensure that such standing orders and protocols are reviewed at least annually.

(3) If the use of a standing order has been approved by the MEC, treatment may be initiated (i) by a nurse or other authorized individual acting within his/her scope of practice who activates the order; or (ii) when a nurse enters documentation into the medical record that triggers the standing order.

(4) Standing orders must be dated, timed, and authenticated promptly in the medical record by the individual who activates the order or by another responsible practitioner.

(5) The Attending Physician must authenticate the initiation of each standing order with the exception of those for influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications.

5.F. SELF-ADMINISTRATION OF MEDICATIONS

(1) The self-administration of medications (either hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:

(a) the patient (or the patient's caregiver) has been deemed capable of self-administering medications;

(b) a Responsible Practitioner has issued an order permitting self-administration;

(c) in the case of a patient's own medications, the medications are visually evaluated to ensure integrity; and

(d) the patient's first self-administration is monitored by a Practitioner or nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.

(2) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(3) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.

(4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

5.G. STOP ORDERS

(1) The medication stop order policy shall apply to those medications defined by the Pharmacy and Therapeutics Committee, except for those orders which have:

(a) a specified number of total doses to be administered; or

(b) a specified time period for doses to be administered.

(2) The ordering Practitioner shall be notified in advance of the impending expiration of an order through the patient's medical record. The Practitioner shall renew as a continuing order, renew with indicated stop time or number of doses, change the order by completely rewriting, or discontinue the order.

(3) Drug orders shall not be stopped until there is documented evidence that the ordering Practitioner has been contacted, is aware of the impending expiration of the order, and has had an opportunity to determine if administration of the drug is to be stopped, continued, or altered. Orders may be renewed by telephone.

5.H. ORDERS FOR OUTPATIENT SERVICES

Outpatient orders for physical therapy, respiratory care, rehabilitation, laboratory, or other treatments and services may be ordered by Practitioners who are not affiliated with the Hospital in accordance with Medical Staff policy.

5.I. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

(1) Unless an exception has been granted by the Pennsylvania Department of Health, radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital.

(2) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the indication.

5.J. ORDERS FOR DIETS

(1) Orders for diets, including altering, modifying, or changing, may be delegated to Registered Dietitians by Medical Staff members, residents, interns, and medical associates. A Registered Dietitian initiating/writing an order for a patient's diet shall act under the direction or supervision of a physician member of the Medical Staff. (See UPMC Central PA Policy 100-1.19 Dietitian Order-Writing Privileges.)

(2) Registered Dietitians require a B.S. degree in nutrition or dietetics. Clinical duties and responsibilities of a Registered Dietitian include:

(a) accurately assess the patient's nutritional status, identify nutritional risk, develop plans of care, and evaluate outcomes;

(b) consult, as needed, with physician and other health care personnel to determine nutritional needs and diet restrictions;

(c) provide nutritional education to patients and their families in nutritional principles, dietary plans, food selection, and preparation;

(d) be accountable as nutrition liaison/expert to assigned unit responding to the needs and initiatives for nutrition care process improvement; and

(e) may engage in research, training and mentoring of dietetic students/interns and supportive personnel.

5.K. RESUSCITATION ORDERS

(1) When a decision has been made by a patient to forgo resuscitation, a DNR order should be documented in the patient's medical record by the patient's Attending Physician.

(2) All resuscitation orders should be accompanied by a progress note justifying the appropriateness of such order and documenting discussions with the patient and/or his/her family resulting in this decision.

5.L. DISCHARGE ORDER

Patients shall be discharged in accordance with Article 11.

ARTICLE VI

INPATIENT CONSULTATIONS

6.A. REQUESTING INPATIENT CONSULTATIONS

(1) Requests for inpatient consultations shall be ordered in the EMR by a Requesting Practitioner and in accordance with the following communication guidelines:

- **Stat Consults** – For emergent consults (e.g., "stat" or similar terminology), the Requesting Practitioner (who should be a ***physician*** unless he or she is unavailable due to patient care responsibilities) will personally speak with the Consulting Practitioner (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the emergent consultation.

- **Routine Consults** – In addition to entering the reasons for the consultation request in the EMR, the Requesting Practitioner (who may be a ***physician or any member of the requesting care team***) will make reasonable attempts to personally contact the Consulting Practitioner to discuss all routine consultation requests.

(2) Failure by a Requesting Practitioner to follow the communication guidelines described in this Section may be reviewed through the appropriate Medical Staff policy.

6.B. RESPONDING TO INPATIENT CONSULTATION REQUESTS

(1) Any individual with clinical privileges can be asked for an inpatient consultation within his/her area of expertise. Practitioners who are asked to provide an inpatient consultation are expected to respond in accordance with the following patient care guidelines, unless (i) another time frame is required under an approved Medical Staff policy, or (ii) another time frame is agreed upon by the Requesting and Consulting Practitioners:

(a) **Stat Consults** – the Consulting Practitioner must see and evaluate the patient within 60 minutes after the request is received and cannot be refused;

(b) **Routine Consults** – for routine consultations, the Consulting Practitioner must see and evaluate the patient within 24 hours of the request.

(2) The Consulting Practitioner may ask an Advanced Practice Professional to respond to a requested inpatient consult in accordance with the standards of practice outlined in Article 8 of the Medical Staff Credentials Policy.

(3) When providing an inpatient consult, the Consulting Practitioner will review the patient's medical record, brief the patient on his/her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the Consulting Practitioner will be directly communicated to the Requesting Practitioner through a note in the EMR or by a phone call or secure text message.

(4) Failure to respond to a request for an inpatient consultation in a timely and appropriate manner will be reviewed under the appropriate Medical Staff policy unless one of the following exceptions applies to the physician asked to provide a consultation:

(a) the requested physician has a valid justification for his/her unavailability;

(b) the patient has previously been discharged from the practice of the requested physician;

(c) the requested physician has previously been dismissed by the patient;

(d) the patient indicates a preference for another Consulting Practitioner; or

(e) any other factors indicate that there is a conflict between the requested physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the requested physician should not provide consultation.

In these situations, it is the mutual responsibility of the Requesting Practitioner and the requested physician to find an alternate Consulting Practitioner. If they are unable to do so, then the Medical Staff President or the appropriate Department Chair can appoint an alternate Consulting Practitioner.

(5) Once the Consulting Practitioner is involved in the care of the patient, the Requesting Practitioner and Consulting Practitioner are expected to review each other's notes in the patient's medical record on a regular basis to assure continuity of care until such time as the Consulting Practitioner has signed off on the case or the patient is discharged.

(6) A Requesting Practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the VPMA, the Medical Staff President, or the appropriate Department Chair.

6.C. RECOMMENDED CONSULTATIONS FOR INPATIENTS

(1) Consultations are recommended in all cases in which, in the judgment of the Attending Physician:

(a) there is doubt as to the best therapeutic measures to be used;

(b) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) complications are present that may require specific skills of other Practitioners;

(d) they are requested by the patient or family, or the patient's representative if the patient is incompetent; or

(e) they are indicated for the clinical specialty in admission to special care units.

(2) The Medical Staff President, the VPMA, and the appropriate Department Chair shall each also have the right to call in a Consulting Practitioner where a consultation is determined to be in the patient's best interest.

6.D. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide) or who are determined to be a potential danger to themselves or others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

6.E. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the Consulting Practitioner, including relevant findings and reasons, must appear in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the surgeon states in writing that an emergency situation exists.

ARTICLE VII

SURGICAL SERVICES

7.A. PRE-PROCEDURAL PROCEDURES

Except in a documented emergency situation, the following will occur before an operative procedure or the administration of anesthesia occurs:

(1) the Attending Physician (i.e., surgeon) is in the Hospital;

(2) the Attending Physician will thoroughly document in the medical record:

(a) the provisional diagnosis and the results of any relevant diagnostic tests;

(b) the consent of the patient or his/her legal representative; and

(c) a complete and appropriately updated history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room;

(3) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(4) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(5) a pre-anesthesia evaluation is performed in accordance with Section 8.B of these Rules and Regulations; and

(6) the Universal Protocol will be carried out in accordance with Hospital policy.

7.B. POST-PROCEDURAL PROCEDURES

(1) Full Operative Report. A full operative procedure report must be completed and entered within 48 hours after an operative procedure. The operative procedure report will include, as applicable:

(a) the patient's name and Hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) indications for the procedure;

(e) the name of the Operating Physician(s) and assistant surgeon(s) responsible for the patient's operation;

(f) procedure(s) performed and description/technique of the procedure(s);

(g) description of the specific surgical tasks that were conducted by Practitioners other than the Operating Physician;

(h) findings, where appropriate, given the nature of the procedure;

(i) estimated blood loss, where applicable;

(j) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(k) the type of anesthesia/sedation used;

(l) specimen(s) removed, if any;

(m) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(n) the signature of the Operating Physician.

(2) Post-Operative Progress Note. If the Operating Physician is unable to complete a full operative report at the time the operative procedure is completed, a post-operative progress note must be entered in the medical record immediately after an operative procedure and before the patient is transferred to the next level of care. The post-operative progress note will include, as applicable:

(a) the names of the physician(s) responsible for the patient's care and physician assistants;

(b) the name and description/technique of the procedure(s) performed;

(c) findings, where appropriate, given the nature of the procedure;

(d) estimated blood loss, when applicable or significant;

(e) indications for the procedure;

(f) specimens removed; and

(g) post-operative diagnosis.

7.C. PATHOLOGY REPORTS AND DISPOSITION OF SURGICAL SPECIMENS

All significant tissues removed during any surgical procedure shall be sent to the Hospital pathologist where they shall be examined as necessary to arrive at a tissue diagnosis. The Hospital pathologist's authenticated report shall be made a part of the patient's medical record.

ARTICLE VIII

ANESTHESIA SERVICES

8.A. GENERAL

(1) Anesthesia may only be administered by the following qualified Practitioners:

(a) an anesthesiologist;

(b) an M.D. or D.O. (other than an anesthesiologist) who has been granted clinical privileges to administer anesthesia in a specific patient care area or for a specific procedure (e.g., Emergency Department and GI procedures); or

(c) a CRNA who is supervised by an anesthesiologist or a directing/supervising physician (other than an anesthesiologist) who is immediately available.

(2) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation, including epidurals/spinals, and other nerve blocks. "Anesthesia" does not include topical or local anesthesia or minimal or moderate ("conscious") sedation.

(3) Because it is not always possible to predict how an individual patient will respond to minimal or conscious sedation, a qualified Practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

8.B. PRE-ANESTHESIA PROCEDURES

(1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

(2) The following elements of the pre-anesthesia evaluation must be performed within the 48 hours immediately prior to an inpatient or outpatient surgery or procedure requiring anesthesia services:

(a) a review of the medical history, including anesthesia, drug and allergy history; and

(b) an interview, if possible, preprocedural education, and examination of the patient.

(3) The following additional elements of the pre-anesthesia evaluation may be performed up to 30 days prior to an inpatient or outpatient surgery or procedure requiring anesthesia services, but must be reviewed and updated as necessary within 48 hours of the surgery or procedure:

(a) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(b) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway as identified through an airway examination, any ongoing infections, limited intravascular access);

(c) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(d) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

Per the Centers for Medicare & Medicaid Services Conditions of Participation, under no circumstances may these elements be performed more than 30 days prior to surgery or a procedure requiring anesthesia services.

(4) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

8.C. MONITORING DURING PROCEDURE

(1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor the patient per current ASA standards.

(2) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented in an intraoperative anesthesia record, including at least the following:

(a) the name and Hospital identification number of the patient;

(b) the name of the Practitioner who administered anesthesia and, as applicable, any directing or Supervising/Collaborating Physician;

(c) the name, dosage, route, time, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

8.D. POST-ANESTHESIA EVALUATIONS

(1) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).

(3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(b) cardiovascular function, including pulse rate and blood pressure;

(c) mental status;

(d) temperature;

(e) pain;

(f) nausea and vomiting; and

(g) post-operative hydration status.

(4) Patients will be discharged from the recovery area by a qualified Practitioner according to criteria approved by the ASA, using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

(6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient and responsible designated adult, if any.

8.E. MINIMAL OR CONSCIOUS SEDATION

All patients receiving minimal or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained Practitioner in accordance with applicable Hospital policies. However, such procedures are not subject to the requirements regarding a pre anesthesia evaluation, an intraoperative anesthesia report or a post-anesthesia evaluation described in this Article.

8.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing, and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE IX

PHARMACY

9.A. GENERAL RULES

(1) Orders for medications are addressed in the Medical Orders Article.

(2) Adverse medication reactions and errors in administration of medications will be documented in the patient's medical record and reported to the Attending Physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients and is to be administered for the same purpose and in the same manner unless otherwise specified by the ordering physician (e.g., "brand name necessary").

(4) Except for investigational or experimental drugs in clinical investigations, all drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluation, or otherwise approved by the Pharmacy and Therapeutics Committee. Drugs for clinical investigations shall be used in accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Food and Drug Administration, and the use of such drugs shall require approval of the Institutional Review Board.

(5) Drugs for bona fide clinical investigations may be excepted from this requirement, provided they are used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the FDA and their use is approved by the IRB.

(6) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to Medical Staff members, Allied Health Professionals, and other Hospital personnel.

9.B. PATIENT'S OWN MEDICATION

Any medication and/or drug brought to the Hospital by a patient being admitted will be collected by the nursing personnel and held at the Nurses Station in proper storage until the patient is discharged unless the Staff member directs otherwise.

9.C. MEDICATION THERAPY MANAGEMENT

(1) Medication therapy management services are provided by a clinical pharmacist and supplemented by staff pharmacists. These services may include, but are not limited to, dosing and monitoring of antibiotic therapy when appropriate, dose adjustments, monitoring of parenteral nutrition therapy, IV to oral conversion (using guidelines approved by the Pharmacy and Therapeutics Committee and MEC), electrolyte monitoring with appropriate therapeutic adjustments, and ordering of serum concentrations of those agents potentially requiring dose adjustments for maximum therapeutic efficacy (using guidelines and/or protocols approved by the Pharmacy and Therapeutics Committee and the MEC). Orders for laboratory tests or other diagnostic agents/tests related to the Pharmacy and Therapeutics Committee and MEC-approved medication therapy management protocols can be initiated by a pharmacist. Examples include, but are not limited to, measures of coagulation, medication levels, iron studies, and thyroid function tests.

(2) These activities may be undertaken without direct interaction with the attending or prescribing physician. However, the physician may terminate any of these activities at any time.

9.D. STORAGE AND ACCESS

(1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.

(a) All medications and biologicals will be kept in a secure area and locked unless under the immediate control of authorized staff.

(b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(c) Only authorized personnel may have access to locked or secure areas.

(2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the Hospital President.

ARTICLE X

EMERGENCY SERVICES

10.A. GENERAL

Emergency services and care will be provided to any person who comes to the Emergency Department, as that term is defined in the EMTALA regulations, whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's insurance status, economic status, or ability to pay for medical services.

10.B. MEDICAL SCREENING EXAMINATIONS

(1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel ("QMP") who can perform medical screening examinations in the Emergency Department within applicable Hospital policies and procedures are defined as:

(a) Emergency Department:

(i) Medical Staff members with clinical privileges in Emergency Medicine; and

(ii) appropriately credentialed Medical Staff members and Allied Health Professionals.

(b) Labor and Delivery:

(i) Medical Staff members with OB/GYN privileges;

(ii) Certified Registered Nurse Midwives with OB privileges; and

(iii) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

(2) The results of the medical screening examination must be documented in the medical record.

10.C. ON-CALL RESPONSIBILITIES

It is the responsibility of the scheduled on-call physician to respond to calls from the Emergency Department in accordance with Hospital policies and procedures.

10.D. EMTALA TRANSFERS

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable policy and in compliance with all applicable state and federal laws, such as EMTALA.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.A. WHO MAY DISCHARGE

(1) Patients will be discharged only upon the order of the Attending Physician or another Practitioner acting as his/her designee. Patients may not be discharged without a written discharge plan completed by the Attending Physician and/or designee.

(2) At the time of discharge, the discharging Practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(3) Should a patient leave the Hospital against the advice of the Attending Physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign an "Against Medical Advice" form.

11.B. DISCHARGE PLANNING

(1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The Responsible Practitioner is expected to participate and collaborate in the discharge planning process, which includes updates of the expected discharge date in the EMR throughout the patient's stay.

(2) Discharge planning will include determining the need for continuing care in an acute care setting, treatment, services after discharge or transfer, and services which can be obtained in an outpatient vs. inpatient setting.

11.C. DISCHARGE SUMMARY

(1) A concise discharge summary will be created in the medical record by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries must be completed as soon as possible and will include the following:

(a) reason for hospitalization;

(b) significant findings;

(c) procedures performed, and care, treatment, and services provided;

(d) final principal diagnosis, including the primary and secondary diagnoses;

(e) the patient's condition and disposition at discharge;

(f) information provided to the patient and family, as appropriate;

(g) provisions for follow-up care; and

(h) discharge medication reconciliation.

(2) A short stay form or final summary progress note may be used as defined and approved by the Medical Staff to document short hospitalizations for minor problems or interventions as long as the note or form contains the outcome of the stay, disposition of the case, and provisions for follow-up care.

(3) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

11.D. DISCHARGE OF MINORS AND INCAPACITATED PATIENTS

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

ARTICLE XII

HOSPITAL DEATHS AND AUTOPSIES

12.A. DEATH CERTIFICATES

(1) The determination of death, including brain death, will be made in accordance with governmental regulations and accepted medical principles.

(2) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the Attending Physician or his/her designee within a reasonable time frame. Death certificates should be completed within ***24 hours*** of when the certificate is available.

12.B. RELEASE OF BODIES

(1) Bodies shall be released from the Hospital in accordance with Hospital policy.

(2) The Medical Examiner will be notified of any medical examiner cases as required by Hospital policy.

12.C. AUTOPSIES

The Medical Staff should attempt to secure autopsies in accordance with Hospital policy and state and local laws.

12.D. ANATOMICAL DONORS

The Hospital will identify potential anatomical donors in accordance with 20 Pa. C.S.A. § 5471. This includes potential donors of organs, tissues, and eyes, as well as hands, facial tissues, limbs, or other vascularized composite allografts. All Practitioners will cooperate fully in this effort.

ARTICLE XIII

MISCELLANEOUS

13.A. ORIENTATION

All new Practitioners will be provided an overview of the Hospital and its operations (e.g., the EMR system) to help them have a successful practice at the Hospital.

13.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS, COLLEAGUES, AND CO-WORKERS

13.B.1. Self-Treatment:

(a) Practitioners are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) Practitioners should never write prescriptions for controlled substances for themselves.

13.B.2. Guidelines for Treatment of Immediate Family Members, Colleagues, and Co-Workers:

(a) Generally, Practitioners should refrain from the following activities in the Hospital:

(1) admitting or consulting on immediate family members (i.e., a parent, spouse, child, or anyone else residing in the same household); or

(2) being involved in the care of a family member with complex or potentially serious symptoms or diagnoses.

When considering these guidelines, factors such as the availability of other Practitioners to provide the needed care, patient acuity, and the patient's right to direct his/her own medical care should also be considered.

(b) Practitioners should never write prescriptions for controlled substances for family members.

(c) As it relates to colleagues and co-workers in the Hospital, Practitioners should refrain from:

(1) treating any individual without first performing an appropriate assessment and creating a proper medical record; or

(2) writing a prescription for any individual in the absence of a formal Practitioner-patient relationship.

13.C. INFECTION PRECAUTIONS

All Practitioners will abide by Hospital infection control policies.

13.D. HIPAA REQUIREMENTS

All Practitioners will:

(1) adhere to the security and privacy requirements of HIPAA and the Hospital's HIPAA policies, meaning that only a Responsible Practitioner may access, utilize, or disclose protected health information; and

(2) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.

ARTICLE XIV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XV

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, or manuals of the Medical Staff pertaining to the subject matter thereof.

Medical Staff/MEC: May 20, 2022; September 22, 2022

Board of Directors: May 27, 2022; September 23, 2022