INTRODUCTION

The Stamford Hospital Medical Executive Committee, with the approval of the Board of Directors, may adopt such rules, regulations and policies governing the medical staff as are consistent with the articles of organization and bylaws of the hospital and the bylaws of the Medical Staff.

MEDICAL STAFF RULES AND REGULATIONS

1. ADMISSION OF PATIENTS

1.1.1. PROVISIONAL DIAGNOSIS. No patient shall be admitted to the hospital or placed on observational status until initial orders have been given by the admitting physician and except in an emergency a provisional diagnosis has been stated.

1.1.2. PATIENT STATUS. All patients in the Hospital must have their status clearly designated by the responsible attending physician (e.g. inpatient, observation, same day care, hospice, etc.).

1.1.3. OBSERVATION STATUS. Observation status generally will last no more than 24 hours, but in special circumstances may be extended to 72 hours.

1.2. SAFETY AND HEALTH OF OTHER PATIENTS. The admitting practitioner shall be responsible for giving all information necessary to assure the protection of patients and others from those patients who are a source of danger. The admitting practitioner shall notify the Admitting office, Nursing Supervisor or Surgery Posting Office of any known contagious disease, suicide risk, behavioral risk or other unusual condition on the part of the patient that may require special attention or treatment.

1.3. TIME FRAMES FOR SEEING PATIENTS. The admitting practitioner or his/her designee must interview and examine the patient within the time frames provided below or within any shorter time frame if the patient's condition requires it:

(a) Patients admitted directly to or transferred into a critical care unit shall be seen WITHIN FOUR (4) HOURS of the decision to admit or transfer.
(b) Patients admitted to a general care area--WITHIN TWENTY FOUR (24) HOURS of the decision to admit by the admitting practitioner.
(c) Elective admissions—WITHIN TWENTY FOUR (24) HOURS after admission to the unit.
(d) All inpatients shall be seen at least once daily by the patient’s attending physician and a progress note written.

2. ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1. ATTENDING PHYSICIAN. There shall be only one attending physician, who shall be responsible for the medical care of the patient, the coordination of care by any consultants or specialists, and the content of the chart. Except in an emergency, physicians other than the attending physician or designee may not enter progress notes and orders, except on the invitation of the attending physician. The attending physician may countersign any verbal order given by another physician on staff for his/her particular patient. Any change of the attending physician shall be clearly documented in the medical record. No medical staff member may withdraw as attending physician until another staff member has agreed to serve as the patient's attending physician and made an entry in the medical record accepting the patient.

2.2. DOCUMENTATION REQUIREMENTS OF ATTENDING PHYSICIAN. The medical record must contain information adequate to justify the admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to treatment.

2.3. COVERAGE. Each member of the medical staff shall arrange for coverage by a practitioner who has appropriate clinical privileges at Stamford Hospital Medical Staff when s/he is not available to provide care for a patient. Physicians arranging coverage must assure that the covering physician(s) have agreed to accept responsibility for all patients with whom the absent practitioner has an ongoing patient-physician relationship or who the absent practitioner is required to provide care for pursuant to a managed care contract.

2.4. STAFF PATIENTS. Staff patients are defined as patients who do not have a personal physician on staff. All staff patients shall be attended by members of the active or provisional staff, and shall be assigned by the department or division concerned with the treatment of the disease, which necessitated admission.

2.5. ON-CALL RESPONSIBILITIES.

2.5.1. Each member of the active or provisional active staff that is required to take call as required by the Medical Staff Bylaws shall participate in a rotational call system for staff patients which is determined by the responsible department or division. When a staff member is the designated practitioner on call, s/he will accept responsibility during the time specified in the published schedule, for providing care to any patient referred to the service for which s/he is providing on call coverage, including referrals for emergency care. If the assigned staff member has a conflict with the published schedule that

precludes call coverage as scheduled, it is the staff member's responsibility to arrange for alternate coverage, and to notify the Department Chair and Emergency Department Chair of such alternate coverage at least 24 hours prior to the scheduled rotation. Physicians on rotational call for the care of staff patients will provide emergency care for all patients regardless of payer type.

2.5.2. Response to calls should be within fifteen (15) minutes by telephone, and personal presence in the Hospital within forty-five (45) minutes after telephone contact if required by the patient's condition or requested by an emergency medicine physician. These response times may be superseded by more stringent departmental requirements.

2.5.3. Physicians on call may be on call at more than one hospital simultaneously and may post elective cases while they are on call. However, if a physician on call responds to call at another hospital, begins surgery, or otherwise becomes unavailable while on call, the physician must notify the Emergency Department in advance so that the ED is aware of the physician's unavailability.

2.6. AVAILABILITY TO TREAT PATIENTS IN THE HOSPITAL. All physicians who have patients in the Hospital shall make appropriate arrangements to be available, or to have a covering physician available, so that the appropriate physician can be contacted, and can see the patient if necessary, within a reasonable time considering the patient's condition. It is the responsibility of the attending physician to make arrangements which permit the attending physician, or any covering physician, to be contacted directly or through an answering service at all times, and to assure that the nursing staff knows how to contact the appropriate physician. Coverage may only be provided by a member of the Medical Staff with appropriate clinical privileges to provide necessary treatment to the patient. Every physician who is providing care to a patient in the Hospital shall, when requested, return all calls from the nursing staff within thirty (30) minutes.

2.7. HOUSE STAFF. House staff (interns, residents or fellows) is given patient care responsibilities appropriate with the individual level of training, experience, and capability detailed in training protocols developed by the applicable Program Director and medical school authorities. They are supervised in accordance with the Policy on Supervision of Residents at the Stamford Hospital. In all matters of an individual patient's care, house staffs are responsible to the attending physician or the teaching attending, as applicable, who maintains ultimate decision-making and patient care responsibility. House staff performance and recording of histories, physical examinations, daily visits, orders, and progress notes, or carrying out other assigned patient care responsibilities, does not

relieve the attending practitioner of his/her obligation to perform and document any or all of those responsibilities.

3. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1. REQUIREMENT FOR TREATING PRACTITIONER TO BE ON STAFF. No patient may be treated by anyone who does not have clinical privileges at the Hospital. Consultants who will be involved in providing treatment to a patient, writing orders, or otherwise directing care, must obtain temporary privileges following the procedure outlined in the medical staff bylaws prior to treatment of a patient.

3.2. Physicians, dentists, licensed health care providers, scientists, and other individuals having unique or exceptional skills may act as consultants with regard to the care of a particular patient in the Hospital at the request of the patient's attending physician. To the extent permitted by law, consultants may examine patients with the patient's consent, observe and consult on treatment, and review the patient's medical record, but may not actively engage in treatment, write orders, make entries in the medical record or otherwise direct patient care without obtaining temporary privileges. Consultants not providing patient care need not be licensed to practice in the State of Connecticut. Any notes prepared by a consultant does not have temporary privileges shall be delivered to the staff member requesting the consultation and the staff member shall be responsible for placing such portion of the consultant's notes on the patient's chart as the staff member deems appropriate. Any recommendations of a consultant may be implemented only by orders written by a member of the Medical Staff. Consultants shall not be members of the Medical Staff.

3.3. PHYSICIAN SELF TREATMENT OR TREATMENT OF IMMEDIATE FAMILY MEMBERS.

a. No physician will be allowed to admit, write or enter orders, consult, or perform any procedure of a therapeutic or interventional nature on any first-degree family member or significant other. Such individuals include parents, children, siblings, and significant others who have a close and personal association with that physician. The only exception will be for those emergency procedures where obtaining a physician of the required skill and availability would be detrimental to the well-being and stability of the patient.

b. No physician will be allowed in the immediate environment, in a clinical treatment capacity, when a procedure is performed on a first degree relative or significant other. Physicians shall

retain the rights as a family member according to departmental policy.

c. No physician will be allowed to perform an obstetrical delivery on a first degree family member or significant other, and will be allowed to be in the delivery suite only in accordance with existing established policy by the Department of Obstetrics and Gynecology.

d. No physician will be allowed to order any procedure to be done on himself or herself, or on a first-degree family member in an inpatient, ambulatory surgery, infusion center, or Emergency department environment.

3.4. CONSULTATION. The attending physician is responsible for calling for a consultation from a practitioner with appropriate clinical privileges when the patient's care requires a level of expertise differing from that of the credentialed physician; when requested by the patient or patient's legal representative; when required by clinical practice guideline(s) approved by the Medical Executive Committee; and when requested by the Chair or Chair-Elect of the Medical Executive Committee, the Senior Vice-President for Medical Affairs, the Department Chair, or his/her designee. Satisfactory consultation includes examination of the patient and the record and a documented opinion signed by the consultant, which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, should be recorded prior to operation.

The duration of the consultant's involvement in the care of the patient shall be determined by the attending physician unless superseded by requirements listed above. The Departmental Chairs(s) shall have the ultimate authority in any dispute regarding the appropriateness, duration, or indications for consultation and shall communicate directly with the attending physician in the event of such dispute.

3.5. MANDATORY CONSULTS FOR ICU PATIENTS. All patients admitted to the Medical/Surgical Intensive Care Unit must have a consultation with an appropriately trained specialist, particular one with added qualification and/or board certification in critical care medicine. The decision of whom to call is solely at the discretion of the attending physician. The attending physician may transfer the care of a patient in the ICU to the intensivist, and this is permissible if mutually agreed upon by the attending and consultant physicians.

All patients on ventilators must have a medical or surgical specialist in intensive care consulted in the care of the patient. For open-heart

surgical cases, the cardiac team, led by the cardiac surgeon, will oversee the management of the care of the patient.

3.6. PROCEDURAL SEDATION. Physicians credentialed to provide procedural sedation (also known as conscious sedation) shall comply with the Stamford Hospital Procedural Sedation/Analgesia policy. Informed consent for anesthesia must be obtained for all such procedures.

4. ORDERS

4.1. LEGIBILITY, DATING, TIMING, AND AUTHORITY TO WRITE ORDERS. Only practitioners with clinical privileges may issue orders for inpatient tests or treatment. Orders for inpatient treatment, diagnostic tests or medication must be entered via Computerized Physician Order Entry or, in areas that do not have CPOE available, orders must be documented clearly, legibly, and completely and signed by the practitioner responsible for issuing the orders. Physicians must comply with the Medical Abbreviations Policy of Stamford Hospital.

a. In clinical services where CPOE is not available, all medication, treatment and testing orders must be documented clearly, without the use of unapproved abbreviations, and should include complete medication name, dose, and route of administration as applicable.

b. When appropriate, orders for diagnostic tests must include adequate information indicating the purpose of the test (e.g. chest CT to rule out PE).

c. Electronic documentation is suspended when the computer system is down, and documentation will follow the protocol established by the hospital's "Computerized System Downtime Policy".

4.2. TELEPHONE ORDERS:

a. Telephone orders shall be kept to a minimum and may only be issued by a member of the appointed medical or ancillary staff in emergency situations and rare instances when a physician or ancillary practitioner cannot enter a computerized or written order. All verbal and telephone orders may be taken only by a registered nurse or physician assistant with the following exceptions:

i. Respiratory care orders may also be taken by a registered respiratory technician.
ii. Medication orders may also be taken by a registered pharmacy technician or pharmacist.

iii. Dietary orders may also be taken by a speech therapist or registered dietitian.
iv. Physical therapy orders may also be taken by a physical therapist.
v. Scheduling personnel may accept telephone orders for scheduling outpatient imaging procedures, laboratory tests, and other studies, appropriate for their department.

b. Telephone orders must identify the name of the practitioner who gave the order, the name of the individual who received the order, and the name of the individual who implemented the order.

c. Qualified personnel taking telephone orders will write down the order and then read it back verbatim to the practitioner who initiated it. The practitioner must then confirm that it is correct.

d. All telephone orders on in-patients must be countersigned by the attending physician or person who gave the order as follows: within 24 hours for schedule II narcotics; within 24 hours for telephone orders given to a registered dietician or pharmacist; within 48 hours for all other telephone orders. Delinquent countersignatures of telephone orders will be counted as delinquent medical records pursuant to the Bylaws.

e. Telephone orders may also be faxed to the patient care unit, representing a valid countersignature.

4. 3. VERBAL ORDERS. Verbal orders will be accepted only in emergent situations under the same stipulations as telephone orders.

4.4. AUTOMATIC CANCELLATION OF ORDERS. All previous orders are automatically cancelled when the patient goes to surgery, the delivery room, either into or out of the CCU, or is transferred to another service or another level of care. All orders must be rewritten after surgery, delivery, transfers into or out of the CCU or transfer to another service or level of care. An order to “renew all orders” is not acceptable.

4.5. RESUSCITATION ORDERS. Any patient admitted with no designation concerning whether the patient is to be resuscitated will be treated as a full code. Patients who elect no life-sustaining measures should be designated as "Do not resuscitate" (DNR). The attending physician or his designee will discuss the patient's advance directive with the patient as appropriate, and will follow the patient's wishes as expressed in the advance directive. Patients admitted to the Critical Care Unit must have orders written specifying the patient’s resuscitation status upon

admission to and discharge from the unit. Residents may enter resuscitation orders only after discussion with the attending physician.

4.6. RESTRAINT ORDERS. Orders for patient restraints or seclusion must be signed by a licensed practitioner and must follow the approved Stamford Hospital Restraint and Seclusion Protocol. All such orders must be dated, timed; times limited, and include the type of restraint and the reasons for such restraint. PRN restraint orders are not acceptable.

5. TRANSFER, DISCHARGE, AND MEDICAL SCREENING OF PATIENTS

5.1. TRANSFERS TO AND FROM OTHER HOSPITALS. Non-emergency transfers of patients to Stamford Hospital from other hospitals will be reviewed by the chairman of the Utilization Review Committee or by the appropriate departmental utilization review physician before the transfer takes place. Transfers to or from other institutions will be carried out according to the transfer policy and after the transferring physician certifies that the benefits of transfer outweigh the risks.

5.2. MEDICAL SCREENING EXAMINATIONS. Physicians, Nurse Practitioners, Physician Assistants and Registered Nurses who have been granted appropriate clinical privileges shall be deemed to be Qualified Medical Personnel for purposes of conducting initial screening examinations in accordance with EMTALA.

5.3. DISCHARGES. A patient may be discharged only on the order of an attending physician, resident, APRN or physician assistant (with the approval of the attending physician or his designee). Discharge planning should begin at the time of admission and should be coordinated with case management and social services when appropriate.

a. Discharge documents must include the discharge diagnosis, updated problem list, and the patient's condition. The Patient's Discharge Plan and Medication Reconciliation Form shall be completed prior to the patient's discharge. Discharge summaries must be completed within a reasonable time based on the patient's condition, but in no event more than 30 days after discharge. If the patient will be utilizing Home Health Services a W10 Form must also be completed. Discharge prescriptions will be ordered in the electronic medical record and transmitted electronically to the patient's choice of pharmacy, or will be printed if preferred by the patient, or if the pharmacy does not accept e-prescribing.

b. When a patient is being transferred to another healthcare facility, discharge documents must include the patients' discharge diagnosis, updated problem list and the patient's condition; A Transfer

Summary, Medication Reconciliation Form and a W10 Form must be completed prior to or at discharge.

5.4. PATIENTS LEAVING AMA. When a patient leaves the Hospital AMA or WALKOUT, the attending physician should, to the extent possible, provide the patient with follow up care orders. Should a patient leave AMA or WALKOUT, documentation of the incident shall be made in the patient's record.

6 HOSPITAL DEATHS

6.1. PRONOUNCEMENT. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his designee within an hour, or as soon as possible.

6.2. REPORTABLE DEATHS. Reporting of deaths to the Medical Examiner's Office and/or appropriate authorities shall be carried out when required by and in conformance with the law. It is the responsibility of the attending physician to contact the Medical Examiner when necessary. Criteria for reporting deaths to the Medical Examiner can be found on the form, "Hospital Report of Death."

6.3. DEATH CERTIFICATE. The death certificate must be signed by the attending physician or his/her designee within 24 hours of the patient's death unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician or his designee issues the death certificate.

6.4. RELEASE OF BODY. The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff. In a Medical Examiner's case, the body may not be released other than to Medical Examiner personnel or to police officers, except upon the receipt of a "Release and Disposition" form issued by the Medical Examiner authorizing the release to someone else. The "Release and Disposition" form is required to be signed by the Medical Examiner in all M.E. cases.

6.5. AUTOPSY. Every member of the staff shall be actively interested in securing autopsies whenever appropriate, according to criteria specified by the department of pathology and adopted by the medical staff. These criteria shall be available for review in the Pathology Department and the Medical Affairs office. No autopsy shall be performed without the documented consent of the responsible relative or other persons authorized by law. All autopsies shall be performed by the hospital

pathologist or by a physician to whom s/he may delegate the duty, or by a physician from another institution who is qualified to perform autopsies. At the request of the legally authorized person, the body may be transferred to another institution for autopsy. In this instance, the person requesting the autopsy shall be responsible for arranging for the autopsy, transportation of the body, and any additional costs incurred. Complete autopsy reports shall be entered in the medical record within sixty (60) days.

7. PHARMACY

7.1. ORDERS. Orders for medications must be specific as to the drug, dosage, route and the time(s) of administration. In-patient orders must be entered via CPOE. In clinical services where CPOE is not available, all medication, treatment and testing orders must be documented clearly, without the use of unapproved abbreviations, and should include complete medication name, dose, and route of administration as applicable.

7.2. COMPLIANCE WITH PHARMACY AND THERAPEUTICS COMMITTEE. Practitioners must comply with all requirements established by the Pharmacy and Therapeutics Committee with regard to drug use, formulary restrictions, substitutions and other policies and regulations of the committee enacted for the effective utilization of drugs and the improvement of patient care.

7.3. AUTOMATIC REVIEW DATE/STOP DATE. The Pharmacy and Therapeutics Committee may from time to time establish automatic review date or stop date policies on certain drugs in accordance with standard medical practice and legal and regulatory considerations. A procedure will be in place to notify the physician when drug orders need to be renewed. At that time the physician must enter a new order rather than extend the existing order.

7.4. ADVERSE DRUG REACTIONS. Suspected adverse drug reactions are to be reported to the pharmacy by the attending physician using the Pemenic system.

7.5. PERSONAL MEDICATIONS. Only under unusual circumstances' should orders be documented allowing patients use of personal medications to be administered by hospital personnel. This would only occur when the medication in question is not on the hospital formulary. If a patient must use personal medication, it must first be sent to Pharmacy for identification and processed by the pharmacy. All patients provided medications will be administered by the nursing staff so that it can be confirmed that the medication was taken and it can be appropriately

documented in the medical record. The practitioner must write complete and specific orders for the medication before it can be administered by nursing services. The practitioner must state in the orders that s/he is allowing the patient to use personal medication and the reason why this is necessary. This rule does not apply to Research Medications.

7.6. INSTITUTIONAL REVIEW BOARD. Clinical trials involving Research drugs and procedures will not be initiated without approval of an Institutional Review Board. In all such cases the policies and procedures of the Institutional Review Board must be followed, including permission to use a central IRB.

7.7. FORMULARY. The Stamford Hospital Formulary is a continually revised compilation of FDA approved pharmaceuticals, which reflect the current clinical judgment of the Medical Staff. Additions and deletions from the formulary require the approval of the Pharmacy and Therapeutics Committee. Medical Staff formulary requests shall be submitted in writing to the Chairman of the P & T Committee or to the director of pharmacy.

7.8. RESEARCH DRUGS. Physicians requesting the use of research drugs for individual patients, when the drug has been approved by an institutional review board (IRB) of another institution or a central IRB, must comply with the hospital's administration policy R1470, Research Drugs. A copy of the signed IRB approved ICF must be placed in the patients-subject's medical record and a copy provided to the pharmacy. The physician must provide to the nursing and pharmacy departments all information needed in the care of his patient, including the benefits, side effects and monitoring parameters of the research drug and other information as requested. The Pharmacy will ensure that all conditions are met.

7.9. USE OF DRUGS OR CHEMICALS WHICH ARE NOT FDA-APPROVED AND WITHOUT IRB APPROVAL. Only under unusual circumstances and in accord with FDA guidance for the emergency uses of drugs or chemicals, may physicians request or use these agents for individual patients, when they have not been approved by the FDA. Specific documented approval must be obtained from the following: Chairman of the Stamford Hospital Institutional Review Board, Chief Medical Officer, Department Chair, and the Director of the Pharmacy. The physician must provide to the nursing and pharmacy departments all information needed in the care of his patient, including the benefits, side effects and monitoring parameters of the drug or chemical. Emergency use of such non FDA approved drugs or chemicals must be compliance with the Hospital policy on "Emergency Use of Investigational Drugs or Devices."

8. MEDICAL RECORDS

8.1. COMPLETION OF MEDICAL RECORDS.

8.1.1. Any practitioner providing care to a patient is responsible for completing all pertinent medical records within 30 days of the patient's discharge. The failure to complete the medical record within 30 days shall result in automatic suspension of the practitioner's clinical privileges until such time as all medical records the practitioner is responsible for are completed.

8.1.2. While suspended for failure to complete medical records a practitioner:

a. May not admit patients except for cases already scheduled or patients assigned through the Emergency Department while the physician is on call.

b. May not schedule surgical cases.

c. May continue to provide care for patients already in the Hospital.

d. Shall be obligated to provide on call services as scheduled.

8.2. RESPONSIBILITY. The attending physician shall be responsible for the timely preparation of a complete, pertinent, legible medical record for each patient. The content of the medical record shall be sufficient to support the diagnosis, and justify the treatment. All entries in the medical record must be complete, timed, dated and signed. A medical record is considered complete if it contains sufficient information to identify the patient, support the diagnosis/condition, justify the care, treatment, and services, document the course and results of care, treatment and services, and promote continuity of care among providers.

a. When a medical record is incomplete, the responsible physician will receive an email notification twice a week that incomplete records are available for completion by the HIM department. It is the responsibility of the practitioner to assure that practitioner's email address is current with the Medical Staff Office. Department Chairmen will receive a weekly list identifying practitioners in their department with incomplete records.

b. If records remain incomplete 14 days after discharge the Department Chairman will call the responsible physician asking for completion of records; if records remain incomplete 21 days after discharge the Department Chair will send a certified letter to the responsible physician to complete all incomplete medical records.

c. Two or more suspensions in a twelve month period for failure to complete medical records will result in being placed on FPPE, and repeated suspensions may adversely affect the physician's reappointment to the Medical Staff.

8.3. INVOLVEMENT OF MEDICAL STAFF OFFICE.

Records are maintained in the physician's medical staff file of delinquent medical record notices and suspensions.

8.4. RESPONSIBILITY OF SUPERVISING PHYSICIANS FOR HOUSE STAFF AND PHYSICIAN EXTENDERS.

a. It is the responsibility of the Department Chairs to ensure the timely completion of medical records by the House Staff; House Staff failure to complete medical records in a timely manner will result in the Department Chair or residency Program Director removing House Staff from service to complete all incomplete medical records assigned to them, and they will be reinstated upon notification of completion from the Health Information Management Department.

b. It is the responsibility of any physician supervising any Physician Extender to ensure timely completion of medical records for entries by Physician Extenders.

8.5. PROGRESS NOTES. Progress notes should give a pertinent chronological daily report of the patient's course in the hospital and shall contain sufficient content to insure continuity and supervision of care. 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.

8.6. CUTTING AND PASTING. Practitioners are strongly discouraged from cutting and pasting notes from one entry to the next and creating redundancy and repetitive information. Instead, successive notes should document chronological progress and contemporaneous information. Any cutting and pasting must be done in accordance with the medical staff policy relating to cutting and pasting.

8.7. CANCELLATION OF SURGERY WHEN THERE IS NO H & P. There must be a complete history and physical work-up in the chart on every patient prior to any surgery or procedure involving moderate sedation, regional or general anesthesia in accordance with time frames specified in section 8.6. When the history and physical examination is not recorded before the procedure occurs, the procedure shall be canceled unless the

practitioner states in writing that the case is emergent and that such delay would be detrimental to the patient.

8.8. OPERATIVE/PROCEDURE REPORTS. All operations/procedures performed shall be fully described in the medical record. Operative reports shall contain the following minimum information:

a. Name of primary surgeon and any assistants who performed surgical tasks.
b. Date and time of surgery
c. Preoperative and postoperative diagnosis
d. Procedure(s) performed
e. Type of anesthesia administered
f. Description of techniques
g. Findings
h. Estimated blood loss
i. Specimens removed
j. Prosthetic devices, grafts, tissues, transplant, or devices implanted, if any
k. Complications
l. Condition of patient at conclusion of surgery

The operative/procedure report for each operation/procedure shall be dictated or electronically documented immediately after surgery/procedure completion. When the operative report is dictated a postoperative progress note shall be written in the chart immediately after surgery and shall provide sufficient information about the surgical procedure and the patient's condition to facilitate care in the immediate postoperative period. The Postoperative note is not a substitute for the dictated/documented operative report.

A postoperative progress note must include:

a. A pre-operative diagnosis, description of the procedure(s), findings, estimated blood loss, specimens removed, assistants and primary surgeon, and postoperative diagnosis
b. The patient's vital signs and level of consciousness
c. Medications (including intravenous fluids) and blood and blood components administered, anesthesia
d. Any unusual events or complications, including blood transfusion reactions, and the management of those events, and patient condition/disposition.

Failure to dictate the operative/procedure report within 24 hours after completion shall result in the automatic suspension of elective OR booking privileges until such reports are dictated. Continued failure of a practitioner to complete his operative/procedure reports will be

disciplined in conformity with the requirements of the Medical Staff Bylaws pertaining to delinquent medical records. If a resident dictates the operative/procedure report, it must be signed by the attending physician. Tissues, foreign bodies and materials removed during the operation shall be sent immediately thereafter to the department of pathology which shall perform or arrange to have performed such examination as necessary to arrive at a pathological diagnosis.

8.9. ANESTHESIA EVALUATION. The anesthesiologist, or another practitioner credentialed and privileged to administer anesthesia, must document the following:

a. A pre-anesthesia evaluation within 48 hours before surgery, which includes at a minimum the following:
    i. Notation of anesthesia risk (ASA Class)
    ii. Review of the medical history, including Anesthesia, drug and allergy history
    iii. Any potential anesthesia problems identified
    iv. Patient's condition prior to induction of anesthesia

b. A post-anesthesia evaluation of all patients within 24hours after the procedure completion time or prior to discharge whichever time is less. The post-anesthesia report must document, at a minimum, the following:
    i. Cardiovascular function, including pulse rate and blood pressure
    ii. Respiratory function, including respiratory rate, airway patency, and oxygen saturation
    iii. Mental Status
    iv. Temperature, Pain, Nausea and vomiting
    v. Post –op Hydration
    vi. Any follow-up care and/or observations
    vii. Any complications occurring during post-anesthesia recovery
    viii. For outpatients, any follow-up care needed or patient instructions given.

8.10. DISCHARGE SUMMARY. Discharge Summaries must be completed within a reasonable time based on the patient's condition, but in no event more than 30 days after discharge for all inpatients and patients who expired while in the Hospital, and shall contain the following information:

a. The reason for the hospitalization
b. Significant findings
c. Final Diagnosis, secondary Diagnoses
d. Procedures performed and care, treatment, and services provided

e. The patient's condition at discharge
f. Information provided to the patient and family, as appropriate such as medication, diet, activity, and follow-up appointments.

For patients who are hospitalized for less than 48 hours, or in the case of a normal newborn or obstetrical patient, a discharge note may be substituted for a full discharge summary.

Copies will be sent to referring physicians as directed.

8.11. ABBREVIATIONS. Use of abbreviations in the medical record should be kept to a minimum. A list of abbreviations that cannot be used by the medical staff is maintained on each nursing unit. Only abbreviations approved by the Medical Executive Committee may be used.

8.12. OWNERSHIP OF MEDICAL RECORDS. All records are the property of the hospital and shall be removed only under court order or with the authorization of the Vice President for Risk Management or the Senior Vice President for Medical Affairs. In case of readmission of a patient, all previous records shall be made available for the practitioner's use.

8.13. CONFIDENTIALITY OF MEDICAL RECORDS. Access to medical records is only permissible when the practitioner seeking access is involved in the care of the patient or is engaged in peer review, risk management, medical staff credentialing or other appropriate activity. This requirement applies regardless of the form in which medical records are maintained or stored, and therefore applies equally to information stored in hard copy form or on computer diskettes, tapes or hard disk.

9. INFORMED CONSENT

9.1. GENERAL RULES, EMERGENCY TREATMENT. No procedure, operation, transfusion or anesthesia (except for local anesthesia) shall be undertaken without the consent in writing of the patient or authorized representative in accordance with the Administrative Informed Consent Policy.

9.2. DOCUMENTATION. No procedure, or operation, transfusion, or anesthesia, including procedural sedation, shall be undertaken until the physician performing the procedure or operation, or ordering the transfusion, or administering the anesthesia, has documented in the patient's record that "informed consent" of the patient has been obtained through a satisfactory explanation of the course of action which the physician contemplates.

9.3. LATERALITY POLICY. Surgeons shall conform to the laterality policy approved by the operating room committee and incorporated into the institutional Policy and Procedure manual.

10. MISCELLANEOUS

10.1. MEDICAL STAFF MEETINGS. Regular meetings of the medical staff shall be held on the second Tuesday of March, June, September and December. Special meetings may be called by the Chair of the Medical Staff. The Medical Executive Committee Chair shall give ten days' notice to each member. The December meeting of the staff shall be considered as the annual meeting. Members of the consulting, courtesy, affiliate and honorary staffs shall not be required to attend meetings.

10.2. DEPARTMENTAL MEETINGS. Regular departmental meetings at which a record of attendance and proceedings are kept shall be held for each department and reported as they occur to the Medical Executive Committee. Time and place of meeting will be at the discretion of the Department Chair. A secretary for these departmental meetings may be appointed by the chief or elected. Each department shall meet regularly to review and analyze on a peer-group basis the clinical work of the department and to discuss quality assurance and performance improvement activities ongoing in the department. Members of the consulting, courtesy, affiliate, and honorary staffs shall not be required to attend meetings.

10.3. DUES. Staff dues shall be paid to and collected by the Medical Staff Office within 30 days of notice to the medical staff member. The Medical Staff Office shall submit an annual report of delinquencies to the Medical Executive Committee. Applications for reappointment will be considered to be incomplete and will not be processed if the practitioner has not paid any dues that are currently due.

10.4. MEDICARE ACKNOWLEDGMENT STATEMENT. Upon appointment to the medical staff, practitioners must sign the Medicare acknowledgment statement.

10.5. CPR TRAINING. CPR training for recertification will be available on a voluntary basis.

11. AMENDMENT OF RULES AND REGULATIONS. The rules and regulations of the staff may be amended by a majority vote of the Medical Executive Committee consistent with the Article XVI of the Medical Staff Bylaws.

12. REVIEW OF DEPARTMENTAL RULES AND REGULATIONS. The rules and regulations of all clinical departments will be reviewed by the Medical Executive Committee every 3-years, or sooner if changes are proposed.

Approval Dates:
MEC: 8/2012, 9/8/15
Medical Staff: 9/25/15
Board of Directors: 9/2012