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Revised: 6/19/14
A. GENERAL POLICIES

1. In addition to the Rules and Regulations, hereinafter set forth, the New York State Hospital Code, and all federal, state and local statutory and administrative law pertaining to hospitals, Hospital and Departmental policies and procedures, the practice of medicine, dentistry, podiatry and allied health professions shall also govern the actions of the Medical Staff.

2. It is incumbent upon every practitioner to comply with and participate in, the quality management/performance improvement program, which has been established, to maintain quality patient care and insure optimum utilization of hospital beds and medical services.

3. After a finding, in accordance with the procedures of Articles VIII, IX and X of the Bylaws of the Medical Staff, that a Staff member has violated the following Rules and Regulations, the Staff member shall be subject to discipline, including restriction or withdrawal of privileges, denial of promotion and/or the possibility of failure of reappointment.

4. In order to promote the advancement of better medical education and thereby increased quality of care, Medical Staff members are urged, although not required, to participate in the Hospital's teaching programs.

B. ADMISSION AND DISCHARGE OF PATIENTS, INCLUDING EMERGENCY PATIENTS

1. Glen Cove Hospital shall accept patients for care and treatment appropriate to a general and rehabilitation hospital, irrespective of their race, color, creed, sex, national origin, sexual orientation, marital status, age, veteran's status, disability, or the source of payment for their care, except that it may, in non-emergency situations, elect to exclude the prospective patient if: (*100.15, 650.00, 700.01 & 800.01)

a. The capacity of the Hospital has been reached as determined by the President or the CEO, or their designee; or

b. Such patient requires a type of medical service not authorized by the Hospital's Operating Certificate; or

c. The admission of such patient would, in the opinion of the examining practitioner, and concurred in by the Chair of the Department or the Chair's designee, endanger other patients.

2. Categories of medical conditions and criteria to be used to implement patient admission priorities shall be developed by each Clinical Department, submitted to the Medical Board for approval, and be attached to these Rules and Regulations of the Medical Staff.
3. All patients may be included in the teaching program. A practitioner may exclude a patient from the teaching program when he considers such participation to be detrimental to the welfare of the patient or at the request of the patient.

4. A patient shall be admitted to the Hospital only by a member of the Medical Staff with admitting privileges. The admitting practitioner must provide a provisional diagnosis and adhere to the admitting policies and procedures of the Hospital. In the case of an emergency admission, the medical record must clearly justify the patient's emergency medical condition and such findings shall be recorded on the patient's medical record as soon as possible after admission. All podiatric admissions shall be dual admissions by the admitting podiatrist and by a physician. All admissions are subject to review by the respective Department Chair or Chief of Division or Service.

5. The Hospital shall effectively meet the needs of the ambulatory care patient including providing for care in a continuous manner through the goal of assigning the same primary health care practitioner, whenever possible. This health care practitioner shall be responsible for managing the care of the patient including the development of a written plan of treatment. Medical record documentation for patients receiving continuing ambulatory care services shall include a list of known significant diagnoses, conditions, procedures, drug allergies and medications.

6. Each member of the Medical Staff with admitting privileges must sign the New York State required "Notice to Physicians" acknowledgment pursuant to Sec. 405.3 of NYCRR Title 10.

7. Every patient of the Hospital shall have an attending physician who is responsible for the patient's medical care and treatment while the patient is in the Hospital, for the prompt completion and accuracy of the medical record, for any necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered in the progress notes of the medical record.

8. All patients, regardless of source of payment, shall be treated by members of the Active Staff or the Provisional Staff and shall be assigned to the Clinical Department concerned in the treatment of the disease or condition, which necessitated admission.

9. Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm as well as protection of other patients, hospital personnel and visitors from those who are a source of danger from any cause whatsoever.

10. Each practitioner must assure timely, adequate, professional care for his/her patients in the Hospital by being available or having available to his/her office an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of the attending practitioner to meet
these requirements may result in corrective action including, but not limited to, loss of clinical privileges. Coverage arrangements shall ensure that:

a. The patient is able to ascertain who the responsible attending physician is at all times;

b. Medical and nursing staff can easily identify and reach the responsible covering physician; and

c. The covering physician has sufficient knowledge of the patient(s) for whom that physician is responsible to provide appropriate medical care.

Coverage arrangements shall be Department specific.

11. No person who presents for medical care to the Hospital shall be removed, transferred, or discharged for the purpose of effecting a transfer from the Hospital unless such removal or transfer is carried out after a written order made by the attending practitioner that in his judgment such removal or transfer will not create a medical hazard to the person, and that such removal or transfer is considered in the person's best interest, despite the potential hazard of movement. Such removal or transfer shall be made only after prior notification to an appropriate medical facility and only with the consent of the patient or other individual authorized to consent on behalf of the patient. (*650.01)

12. The decision to discharge a patient must be made by the attending practitioner. A member of the Graduate Staff, a physician's assistant or a nurse practitioner may write a discharge order after discussion with the attending practitioner. The discharge note must be written on the day of discharge and shall include the condition of the patient on discharge and instructions given to the patient. Except when special circumstances exist, notice of discharge must be given to the patient at least one (1) day prior to the patient's discharge. At the time of discharge the practitioner shall record the final diagnosis, complete and sign the patient's medical record. Members of the Graduate Staff may complete the applicable final notes or discharge summaries so long any discharge summary completed by a member of the Graduate Staff is appropriately countersigned by the attending practitioner. (*650.01)

13. An unemancipated minor under eighteen (18) years of age shall be discharged only in the custody of his/her parent(s) or his/her legal guardian unless the parent(s), or guardian, shall otherwise direct, in writing on a form approved by Hospital Administration.

14. No patient shall be detained in the Hospital against his/her will, nor shall a minor under eighteen (18) years of age be detained against the will of his/her parent or legal guardian, except as authorized by law. In no event shall a patient be detained solely for non-payment of the hospital bill or physicians statement for medical services. However it is acceptable to attempt to persuade a patient to remain in the Hospital in the patient's own interest. If there is a concern that the patient lacks capacity due to mental illness, or that
there is a concern that the patient may be a danger to himself/herself or others, the patient may be temporarily detained pending a prompt psychiatric evaluation and determination of the patient's legal rights. If an adult patient lacks capacity for any other reason, and there is no legal guardian or properly designated health care agent, Administration shall be consulted. If a presumptively competent patient insists upon being discharged against the advice of a member of the Medical Staff or the Graduate Staff, the patient shall be requested to sign the form entitled "Release for Leaving the Hospital Against Advice". The physician involved is responsible for documenting the facts and circumstances surrounding the act of the patient leaving the Hospital against medical advice. In the event the patient refuses to sign the form, the patient's refusal must be documented in the patient's chart. (*100.25 & 650.02)

15. Practitioners from outside organ procurement organizations designated by the Secretary, United States Department of Health and Human Services, who are engaged solely at the Hospital in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and the requirements of Section 405.25 of the New York State Hospital Code shall be exempt from the requirements to obtain Medical Staff privileges as outlined in Article III of the Medical Staff Bylaws. (*700.03)

C. INFORMED CONSENT

These Rules and Regulations are a summary of Administration Policy and Procedure 100.23 regarding informed consent. Refer to Policy 100.23 or any other applicable Administration Policy and Procedure that may be promulgated for more specific details on informed consent policies.

1. General Requirements

   a. Upon admission the patient shall be requested to sign a general admission consent form. All consent forms are to be countersigned by a witness. If the patient lacks capacity to provide the general admission consent, then the patient's health care agent (if any), relative, parent (if the patient is a minor) or legal guardian should be requested to sign the general admission consent form. (*100.25)

   b. A properly designated health care agent may make any decision that a patient could make if the patient were capable of giving consent. Any question concerning a health care proxy document shall be referred to Hospital Administration. (*100.25)

   c. Specific informed consent must be obtained by the member of the Medical Staff performing a procedure, for all invasive procedures and/or procedures which bear risk to life or health or which involve anesthesia, analgesia or sedation, or which include the use of blood or blood products or which involve research. The member of the Medical Staff shall document the informed consent discussion in the patient's medical record.
d. The informed consent discussion should include but not be limited to the following:

   (i) The procedure to be performed, which should be explained in simple language, understandable by a layperson. (*100.27)
   (ii) A description of the attendant discomforts and risks, and the possible consequences.
   (iii) A description of the benefits to be expected.
   (iv) A description of the risks, benefits and the alternatives to the administration of blood and blood products, if applicable.
   (v) A description of the risks, benefits and alternatives to the use of anesthetics, analgesia or sedation, which may be utilized in the performance of the procedure.
   (vi) A disclosure of any appropriate alternative procedure(s) and attendant risks of each alternative.
   (vii) A disclosure of the risks attendant to the refusal to agree to the performance of the procedure or the use of anesthesia, analgesia, or sedation and the administration of blood or blood products as the case may be.

e. The Medical Staff member will be responsible for completing any required hospital forms in effect at the time the procedure is contemplated.

f. The informed consent requirement may be waived or modified under the following circumstances:

   (i) In the case of a medical emergency, where in the judgment of the responsible Medical Staff member, the risk of delay is greater than the risk of proceeding, unless the Medical Staff member has knowledge that the patient would have refused the procedure or treatment in question.
   (ii) When the patient assures the responsible Medical Staff member that he would undergo the treatment regardless of the risk involved or the patient indicates to the responsible Medical Staff member that he does not want to be informed of the risks.
   (iii) When the patient assures the responsible Medical Staff member that he would undergo the treatment regardless of the risk involved or the
patient indicates to the responsible Medical Staff member that he does not want to be informed of the risks.

2. Persons Qualified to Consent to Treatment

a. Persons with the capacity to make health care decisions who are eighteen (18) years of age or older may consent to their own treatment. If the responsible Medical Staff member is uncertain about a patient's ability to consent to treatment, a psychiatric evaluation should be obtained.

b. A person with the capacity to make health care decisions who is under eighteen (18) years of age may consent to his/her own medical treatment if that person is a parent, is pregnant, has been married or is married or qualifies as an "emancipated minor". An emancipated minor is a person who has not yet reached the age of eighteen (18), but who has assumed all of the responsibilities of adulthood, e.g., is self supporting, lives apart from parents or pays own living expenses in their parent's home. The "emancipated minor" must be sufficiently mature and intelligent to give informed consent and the Medical Staff member must document the minor's ability to consent to the treatment. A minor may consent to his/her own treatment, which involves birth control, abortion, venereal disease or substance abuse treatment, and the parents should not be notified of such treatment, unless the Medical Staff member is requested to do so.

c. Legal consent to treatment may only be given by a patient, a parent (if the patient is a minor), a properly designated health care agent, a legal guardian or a court appointed guardian. (*100.25)

3. Right to Refuse Treatment

a. An adult with the capacity to make health care decisions and an emancipated minor has the right to refuse treatment. This right includes the ability to refuse or request the withdrawal of life-saving treatment. A psychiatric consultation should be obtained if there is any doubt about a patient's capacity to consent to or refuse treatment.

b. The Medical Staff member must fully document a patient's refusal of treatment in the medical record.

c. A Medical Staff member cannot deny lifesaving treatment to a minor even if a parent refuses to consent to the treatment.

D. HISTORY AND PHYSICAL EXAMINATION

1. Medical Staff members must complete and document a medical history and physical examination for each patient no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or the performance of any procedure requiring anesthesia services. The medical history and physical examination
must be completed and documented by a physician, an oromaxillofacial surgeon or other qualified licensed individual in accordance with law and hospital policy. If a complete history and physical examination has been obtained within thirty (30) days before admission or registration, then a durable, legible copy of this history and physical examination must be placed in the patient’s hospital medical record at the time of, or prior to, any anticipated procedure, and an updated examination including any changes in the patient’s condition or the absence thereof must be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Such updated examination must be completed and documented by a physician, an oromaxillofacial surgeon or other qualified licensed individual in accordance with law and hospital policy. The admission history and physical examination, if recorded by a member of the graduate staff, physician’s assistant, or nurse practitioner shall be reviewed with and countersigned by the attending physician within twenty-four (24) hours of admission and prior to any major diagnostic or therapeutic intervention, but no later than twenty-four (24) hours of admission.

2. If the admission history and physical for an operative or invasive procedure is performed by a physician who is not a member of the Hospital's medical staff, the Hospital shall independently confirm that the physician has a New York State license and is currently registered to practice medicine in the State of New York and that the physician has an affiliation with a New York State licensed hospital. The Hospital shall maintain documentation of such confirmation. The attending physician shall review and countersign the history and physical examination before the operation or procedure.

3. Such physical examination shall include a screening uterine cytology smear on women twenty-one (21) years of age and older, unless such test is medically contraindicated or has been performed within the last three (3) years, and palpation of the breast for all women over twenty-one (21) years, unless such test is medically contraindicated. These examinations shall be recorded, or included, in the medical record. Insofar as it is possible to identify patients who may be susceptible to sickle cell anemia, all such presumptively susceptible patients, including infants over six (6) months of age, shall be examined for the presence of sickle cell hemoglobin unless such tests have been previously performed and the results recorded in the patient's medical record or otherwise satisfactorily recorded, such as on an identification card.

4. When obtaining the admission history, the admitting physician shall inquire about the patient's recent exposure to communicable diseases. Whenever there are positive findings, the physician shall take appropriate measures relative to the care of the patient and the protection of other patients and staff, which may include isolation of the patient.

5. When the history and physical examination, appropriate diagnostic tests, or informed consent (*100.23) are not completed before a surgical procedure, or any potentially hazardous diagnostic procedure, or if the history and physical examination is required to be countersigned and such requirement has not been met, such. Procedure shall be canceled, unless, in the judgment of the surgeon or attending physician, it is determined that the risk of delay is greater than the risk of proceeding in the absence of conformity
to such requirements and such determination is recorded on the patient's chart and signed
by such surgeon or attending physician.

6. Physicians, dentists or podiatrists admitting patients for treatment of malignant lesions,
including in situ carcinoma based upon pathology reports prepared by pathologists not
on the Medical Staff of the Hospital must submit the pathology data (including slides of
tissue sections) on which the results were based. The pathology data must be submitted
to the Hospital’s Department of Pathology for review by the Hospital’s pathologists
prior to elective surgery or other major intervention (e.g., chemotherapy, radiation
therapy). Exceptions to this rule must be justified in the chart by the responsible
attending physician, dentists, or podiatrist and approved by the Chair of the Department
of Pathology.

7. Physicians, dentists or podiatrists admitting patients for treatment based upon studies
must provide a copy of the written report which accompanies such studies which will be
included as part of the patient's medical record. In lieu of the written report, the
physician, dentist or podiatrist shall be required to document in the patient's medical
record prior to elective surgery or other major intervention a description of the report,
including the study which was performed, the name of the party who performed the
study and who issued the report, the date the study was performed and the findings and
recommendations. Exceptions to this rule must be justified in the chart by the
responsible attending physician, dentist or podiatrist and noted in the patient's chart.

8. All physicians, dentists and podiatrists admitting patients must include in the record a
summary of the indications for elective surgery or other major intervention.

9. A licensed independent practitioner shall perform a medical history and physical
examination on a non-inpatient in accordance with the Hospital Department’s Policy and
Procedure.

E. MEDICAL RECORDS

1. The physician, dentist or podiatrist of record shall be responsible for ensuring that the
medical record accurately reflects the patient's medical condition (whether inpatient,
outpatient, emergency or home care). The contents of the record shall be pertinent and
current.

2. The medical record shall contain: identification data, chief complaint, present illness,
past history, allergies, current medications, family history, physical examination,
provisional diagnosis, clinical laboratory reports, x-ray reports, consultations, medical
and surgical treatment, tissue report, progress notes, final diagnosis, discharge summary
and autopsy findings, if performed.

3. The physician, dentist or podiatrist of record is responsible for ensuring that the entries
in the medical record reflect that the physician, dentist or podiatrist of record is directly
involved in the overall care of the patient. Pertinent progress notes shall be recorded at
the time of observation, sufficient to permit continuity and transferability of care. Each
of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written at least daily on acutely ill patients and every three days on patients whose status is alternate level of care, or more often if there is difficulty in diagnosis or management of the clinical problem.

4. Entries in the medical record must demonstrate that the physician, dentist or podiatrist of record was directly involved in the overall care of the patient. All clinical entries in the patient's medical record shall be accurately dated, timed and signed (signatures shall consist of the full last name and first initial of the recording person). The printed name of the practitioner must accompany all signatures. If the entry reflects a prior encounter with the patient, the date and time of such encounter should be reflected in the medical record.

5. Symbols and abbreviations may be used only when they have been approved by the Medical Board. An official record of approved abbreviations shall be kept on file in the Health Information Management Department, and on each nursing unit.

6. A practitioner's routine orders, when applied to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.

7. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and shall be dated, and signed by the responsible practitioner at the time of discharge of all patients. (*650.01)

8. Any entries made in the medical record by medical or dental students shall be countersigned within twenty-four (24) hours by the attending physician, dentist or podiatrist of record (as applicable) or by an appropriately credentialed physician.

9. Members of the Graduate Staff and Allied Health Professional Staff (who are appropriately credentialed and privileged: physician's assistants, nurse practitioners and nurse midwives) may dictate discharge summaries, provided that such summaries are reviewed and countersigned by the appropriate attending physician of record. Nurse midwives may dictate a labor and delivery report, provided that such report is reviewed and countersigned by the appropriate attending physician of record. Nothing contained in this Section shall be interpreted to in any way change the attending practitioner’s ultimate responsibility for the patient's care and the contents of the patient's medical record.

10. Members of the Graduate Staff must be supervised by the attending practitioner of record or a designee. The attending physician or dentist is responsible for countersigning the history and physical written by a member of the Graduate Staff within thirty days of discharge. Further documentation in the medical record must evidence the level of involvement by the attending physician or dentist of record. Merely countersigning the notes written by a member of the Graduate Staff is not sufficient documentation of the attending's involvement and supervision.
11. Notwithstanding the fact that a member of the Medical Staff may employ or otherwise supervise, in accordance with law, an individual who is a member of an allied health profession, such individual allied health professional may not have any patient care responsibilities for any Hospital patient nor make any entries in the medical record with respect to any Hospital patient unless such individual is separately and appropriately credentialed and privileged as a member of the Allied Health Professional Staff. Members of the Allied Health Professional Staff shall not act outside of the scope of their delineated clinical privileges, which shall be consistent with the legal authority governing their scope of practice. Physicians, dentists or podiatrists who supervise or collaborate with members of the Allied Health Professional Staff shall not delegate to these individuals responsibility for activities which are not consistent with their delineated clinical privileges as approved by the Hospital's Board of Trustees.

12. The medical record discharge face sheet for a patient must be reviewed for accuracy and signed by the attending physician, dentist or podiatrist of record.

13. The following types of cases do not require a dictated final summary to complete the medical record:

- Normal Newborns
- Normal Deliveries
- Admissions for less than a 48 hours stay, except those involving transfers, death and major morbidity
- Ambulatory Surgery Cases
- Ambulatory Endoscopy Cases
- Chemotherapy - less than 48 hour stay
- Intravenous Gammaglobulin Cases - less than 48 hour stay
- Uncomplicated surgery cases-less than 48 hour stay

Nonetheless, the medical record for such procedures shall not be deemed complete unless it includes an appropriate entry by the responsible physician containing a discharge note with outcome of hospitalization, the disposition of the case, any provisions for follow-up care, and a final diagnosis.

14. All practitioners shall comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Hospital's policies and procedures governing patient confidentiality and the release of patient information. (*100.20, 100.41, 100.42 & 200.00 to 200.06)

15. Medical records may be removed from the Hospital's jurisdiction and safe-keeping only in accordance with a court order, subpoena, or statute. All records are the property of the Hospital and shall not be removed from the Hospital without permission of the Vice-President/Administration, or designee. In case of readmission of a patient, all previous records shall be available for the use by the practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of
charts from the Hospital by Staff members shall be grounds for corrective action, including, but not limited to, suspension of Medical Staff privileges.

16. Nothing contained in a patient's medical record shall be removed from the chart. If an alteration needs to be made to an entry in a patient's medical record, the practitioner who made the entry shall strike through, but not obliterate the erroneous notation and a fully explanatory new entry shall be made to correct or alter a previous entry. If a physician wishes to revise a note previously written by a member of the Graduate staff or a member of the Allied Health Professional Staff who is under his supervision, then the physician should enter a separate note, which outlines his own findings.

17. Medical records must accompany the patient at all times while the patient is in the Hospital.

18. All members of the Medical Staff and Allied Health Professional Staff shall maintain the confidentiality of their patients' records and respect the confidentiality of the records of all patients of the Hospital. They shall not access any patient information through paper records, the Hospital's health information systems and/or patient databases ("Hospital's information systems") unless required to access such information in connection with their obligation to provide medical care to the patient or for bona fide research or educational purposes consistent with preserving the confidentiality of patient information. (*100.20, 100.41, 100.42 & 200.00 to 200.06)

19. Each member of the Medical Staff, Graduate Staff and Allied Health Professional Staff shall be given a password or other means of user identification ("Password"), which will allow the practitioner access to the Hospital's information systems. No practitioner shall give or disclose to another person, or allow another person to use the practitioner's password(s), whether or not such other person is an authorized user on the Hospital's information system. The assigned personal password constitutes the practitioner's legal signature and the practitioner accepts full responsibility for all actions taken as a result of the use of the practitioner's password. In the event that any practitioner reasonably suspects or becomes aware of any unauthorized disclosure or use of the practitioner's password, the practitioner shall immediately report such unauthorized use or disclosure to the Vice President/Information Services, Chief Information Officer of the Hospital who shall take appropriate action. Each member of the Medical Staff and Allied Health Professional Staff shall log off the Hospital's information systems, or password protect the computer screen, to ensure that a computer session cannot be accessed by any other individual when the computer is left unattended or at the conclusion of the computer session.

20. No practitioner shall print, copy or download patient information from the Hospital's information systems to any hard drive, diskette, tape or other storage device or otherwise copy any paper record for purposes other than to provide medical care to the patient or for bona fide research or educational purposes, and such practitioner shall be solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded. (*100.20, 100.41, 100.42 & 200.00 to 200.06)
21. The Medical Staff Departments where electronic and computer transactions and authentications are utilized will work in conjunction with the Management Information Services Department of the North Shore-Long Island Jewish Health System and the Health Information Management Department of the Hospital to develop and implement criteria and procedures that ensure appropriate and confidential use of electronic or computer transactions and authentications, including the identification of those categories of practitioners and hospital personnel who are authorized to utilize electronic or computer generated transmissions.

22. Delinquent Medical Records

a. Definitions:

(i) Medical records of discharged patients shall be completed within thirty (30) days of such discharge.

(ii) A medical record shall ordinarily be considered complete when the required contents are assembled and authenticated, including dictation of a final summary (when indicated) and all appropriate signatures.

(iii) Special time considerations:
• Operative reports must be dictated immediately after the procedure.
• Practitioners will be notified of their incomplete medical records by the twentieth (20) day after discharge.
• Medical records are considered delinquent if not completed within thirty (30) days after discharge.

b. Process:

(i) If a medical record is delinquent, the practitioner will be notified by the HIM Department. A copy of the notice will also be sent to the appropriate Department Chair.

(ii) If the record remains delinquent for the next 30 days, notification will again be sent to the practitioner and his/her Department Chair. Notice will also be sent to the Senior Vice President for Medical Affairs who will send a letter to the practitioner requesting completion of all delinquent charts within 14 days. Failure to comply could lead to disciplinary action including suspension or termination.

(iii) If non-compliance leads to suspension, notification of the suspension will be sent to the practitioner as well as his/her Department Chair, members of the Medical Board, the Senior Vice President for Medical Affairs, the Executive Director and the Directors of Admitting, Emergency Department and Perioperative Services.
(iv) Suspended practitioners must transfer patient care to an appropriate practitioner in good standing.

(v) Medical record suspensions will be considered administrative, catalogued accordingly and kept in the practitioner's Quality Assurance file.

(vi) The Director of Health Information Management (HIM) will remove the practitioner from the suspension list after certification of completion of the medical record(s).

(vii) Notification of removal from the suspension list will be sent to the practitioner as well as his/her Department Chair, members of the Medical Board, the Senior Vice President for Medical Affairs, the Executive Director and the Directors of Admitting, Emergency Department and Perioperative Services.

(viii) If chronic non-compliance leads to termination of Staff appointment, notification to the suspended practitioner will be made ten (10) days prior to the impending termination of Medical Staff appointment.

c. Exceptions:

   Upon recommendation of the Director of HIM and the Chair of the Medical Records Committee, any medical record may be deemed complete (for the purposes of filing) by the Medical Records Committee.

d. Declaration:

   Any action, whatsoever, pursuant to this section (E 22) shall not give rise to the due process rights granted to Medical Staff or Allied Health Professional Staff Members under Articles VIII or X of the Bylaws of the Medical Staff.

23. Quality of Medical Records

All medical records must be maintained as described above. Identified quality issues are to be reported to the Department Chair and the Quality Management Department.

F. GENERAL CONDUCT OF CARE

1. Orders

   a. All orders for treatment shall be in writing, include the date and time and be signed on the Order Sheet by an appropriately credentialed practitioner. The printed name of the practitioner must accompany all signatures. Written orders may be issued by a Medical Staff member, a graduate staff member, a physician's
assistant, nurse practitioner, certified registered nurse anesthetist, and nurse midwife.

b. A physician’s assistant may write medical orders, including those for controlled substances, for inpatients under the care of the physician responsible for his or her supervision. Countersignature of such orders may be required if deemed necessary and appropriate by the supervising physician or the Hospital, but in no event shall countersignature be required prior to execution.

c. Telephone orders shall be used sparingly when the practitioner who is authorized to issue an order is not readily available on-site, and shall not replace an appropriate medical assessment. Practitioners who are authorized to issue telephone orders shall include Medical Staff members, Graduate Staff members, nurse practitioners, certified registered nurse anesthetists (CRNA), physician's assistants, and nurse-midwives. A dietician, registered professional nurse (RN), a pharmacist, a respiratory therapist or a member of the Allied Health Professional Staff can transcribe a telephone order when the order is within the scope of their practice or their clinical privileges, whichever the case may be. An order so transcribed may be carried out by a nurse.

d. Verbal orders shall be issued only during an emergency by a member of the Medical Staff, a member of the Graduate Staff, or a nurse-midwife. Verbal orders can be accepted by a member of the Allied Health Professional Staff, a pharmacist, an RN, a respiratory therapist when the order is within the scope of their practice or their clinical privileges, whichever the case may be.

e. Telephone/verbal orders for treatment must be authenticated by the prescribing practitioner or another practitioner responsible for the care of the patient as soon as possible, but no later than 48 hours after issuing the order.

f. The metric system shall be used in ordering and prescribing medication.

g. It is desirable that the generic name of a medication as stated in the Hospital's Formulary be used. When a practitioner prescribes a medication by trade name, he does so with the clear understanding and agreement that the Hospital Pharmacist may dispense a generically equivalent drug.

h. The Anesthesiology Department alone is responsible for ordering preanesthetic medication for surgical patients; including, but not limited to, narcotics, barbiturates, benzodiazepines, belladonna drugs and other related preanesthetic drugs. The Anesthesiology Department is not responsible for preoperative orders, which are unrelated to the anesthetic management of the patient.

i. All medications orders must be rewritten every thirty (30) days unless the original medication order specifies a different duration of therapy, or the medication order is subject to another exception, such exception having been approved by the Pharmacy and Therapeutics Committee and the Medical Board and described in the Pharmacy Department Policy and Procedure Manual. All
orders for controlled drugs must be rewritten every three (3) days without exception.

j. Requisitions for blood and blood products for transfusion shall include the indications for transfusion.

k. All orders for diagnostic testing must include an appropriate diagnosis and be in compliance with all governmental regulations.

l. In the event that the attending physician, dentist or podiatrist will not be available for a given period of time, (i.e., over seventy-two (72) hours), the attending must document the following in the progress notes:

(i) The name of the physician, dentist or podiatrist who will be covering in the attending's absence, and will therefore be responsible for supervising the patient's care; and

(ii) A statement confirming that both the patient and the member(s) of the Graduate Staff caring for the patient have been informed of the name of the covering attending.

This provision shall not apply to members of a formal, established medical group as recorded in the Medical Staff Office, which routinely provides for on-call coverage of the group's patients by the members of such group.

The covering attending physician, dentist or podiatrist who is temporarily responsible for the direct supervision of the patient's care shall assume all of the duties of the attending physician, dentist or podiatrist and must document the following in the progress notes:

(i) All relevant patient care data and/or amendments to the treatment plan; and

(ii) At the conclusion of the period of coverage, that the practitioner has relayed all pertinent information to the original attending upon that attending's resumption of responsibility for the patient.

2. Research Programs; Publications

a. The North Shore Long Island Jewish Health System’s Office of the Institutional Review Board (IRB) shall function as the institutional review board for Glen Cove Hospital for the protection of human subjects in research in compliance with applicable Federal and State statutes and regulations. All research programs (including clinical investigation activities) undertaken or to be undertaken at Glen Cove Hospital and all applications for research grants by members of the Hospital's Medical Staff or any Adjunct Staff of the Hospital shall require the approval of the IRB. The IRB shall also clear before publication all Hospital-
associated manuscripts prepared by members of the Hospital's Medical Staff/Adjunct Staff in such manner not to unduly delay the publication thereof. All such research programs (including clinical investigation activities), applications for research grants, and Hospital-associated manuscripts shall first be submitted by the Medical Staff or Adjunct Staff member to Department Chair for review and shall require the Department Chair's approval prior to being submitted to the IRB. All rules, regulations, policies and procedures of North Shore University Hospital with respect to clinical investigation and scientific research shall apply to clinical investigation and scientific research undertaken by members of Cove Hospital's Medical Staff and Adjunct Staff, except that references in the rules, regulations, policies and procedures of North Shore University Hospital to "Administration" or "President" or "Medical Board" for purposes hereof shall be deemed to refer to Administration, President or the Medical Board, as the case may be, of Glen Cove Hospital. (*100.06 & 700.05)

3. Surgical Services

a. The Surgeon shall ascertain that a record of the following appears in the patient's chart:

   (i) A medical history and physical examination including the indication(s) for the procedure recorded within seven (7) days prior to the procedure.

   (ii) A preoperative diagnosis and appropriate diagnostic tests.

   (iii) A written, signed informed consent consistent with the requirements of Section C of these Rules and Regulations. Written consent shall be obtained prior to the operative procedure except in those situations where the patient's life is in jeopardy and suitable signature cannot be obtained. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from a parent or guardian or next of kin, the circumstances shall be fully explained in the patient's medical record.

b. A preanesthesia assessment shall be made to include medical history, co-morbid conditions, prior anesthetics, allergies, medications, pertinent laboratory tests, physical findings and baseline vital signs. The admitting history and physical will provide information for this assessment.

A determination shall be made whether or not the patient is a suitable candidate for the proposed procedure and anesthesia. It is understood that all laboratory data may not be available at the time of initial assessment and that the patient will be reassessed on the day of the procedure by the care team for completeness of preparation and any change in patient status.

c. The surgeon shall, prior to commencing surgery, verify the patient's identity and the site and side of the body to be operated on.
d. The Hospital's separate specific regulations for preoperative prep and scrub techniques shall be strictly observed.

e. All preoperative orders are automatically canceled upon operation and new post-operative orders must be written immediately.

f. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation, intra-operative management, and postanesthetic follow-up of the patient's condition.

g. All operative or other high-risk procedure reports shall be dictated or written in the medical record by the operating surgeon immediately (upon completion of the operation or procedure, before the patient is transferred to the next level of care) following surgery. Operative or other high-risk procedure reports shall contain the name of the primary surgeon and assistants, indications for surgery, technical procedure(s) performed and description of the procedure(s), findings, estimated blood loss, complications, specimens removed or altered, general condition of the patient and postoperative diagnosis. The exception to this requirement is when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full operative or other high-risk procedure report can be written or dictated within twenty four hours of the operation or other high-risk procedure.

h. All anatomical parts, tissues, and devices removed at operation, except as approved by the Medical Board, shall be delivered to the Hospital Pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. A report of the Pathologist's findings shall be filed in the patient's chart and copy of such report shall be available to the Surgical Case Review/Tissue Committee.

i. The anesthesiologist shall have overall responsibility for patient supervision in the Post Anesthesia Care Unit, subject to the post-operative orders of the patient's surgeon, who is responsible for being on call for any emergent complications. The anesthesiologist is responsible for determining when a patient is sufficiently recovered to permit the patient's transfer to his or her room and for ordering such transfer.

4. Dental Patients

a. A patient admitted for dental care is the responsibility of the dentist.

b. The dentist's responsibilities shall include, but shall not be limited to:

   (i) A detailed dental history;
(ii) A detailed description of the examination of the oral cavity and a preoperative diagnosis;

(iii) A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Hospital Pathologist for examination;

(iv) Progress notes as are pertinent;

(v) Clinical resume or summary statement.

c. If the patient's medical condition is such that involvement of a physician member of the Medical Staff is required, then the dentist shall make the appropriate referral. Thereafter, the responsibilities of the physician shall include, but shall not be limited to:

(i) Medical history pertinent to the patient's general health;

(ii) A physical examination to determine the patient's condition prior to anesthesia and surgery;

(iii) Supervision of the patient's general health status while hospitalized.

5. Podiatric Patients

a. All podiatric in-patients shall be co-admitted by a podiatrist and a physician member of the Medical Staff. The discharge of the patient shall be on the written concurrence of both the podiatrist and the physician involved. (*650.01)

b. The responsibilities of the podiatrist shall include, but shall not be limited to:

(i) A detailed podiatric history and physical examination to justify hospital admission; and

(ii) Completion of all appropriate elements of the patient's medical record, including any orders for medication and treatment consistent with law and the policies of the Medical Staff, and the recording of such progress notes as are pertinent to the podiatric condition.

c. The responsibilities of the physician shall include, but shall not be limited to:

(i) Medical history pertinent to the patient's general health;

(ii) A physical examination to determine the patient's condition prior to the podiatric procedure or treatment; and
(iii) Supervision of the patient's general health status while hospitalized.

6. Consultations

a. Except as otherwise provided for by the Medical Board, any qualified practitioner with clinical privileges in this Hospital may be called for consultation within his or her area of expertise.

b. The attending practitioner is primarily responsible for requesting the consultation when indicated and for calling in a qualified consultant. The request for consultation and the consultation report itself shall be made upon the Hospital's form for this purpose, which is available at each Nurse's Station and shall then be incorporated into the patient's medical record.

c. The consulting or covering physician must initiate the consultation within twenty-four (24) hours, unless otherwise specified. In emergent or urgent situations, physician-to-physician communication is required and the consultation must be initiated in a timely fashion based on the physicians’ discussion. If no consulting physician is available, the on-call physician for that service must be contacted to perform the consultation. The different types of consultations are defined as follows:

- Consultation only – report to referring physician.
- Consultation with orders - report to referring physician and written treatment plan.
- Consultation and manage defined condition - report to referring physician, written treatment plan and concurrent follow up care of the patient.

d. Except in an emergency, consultation is indicated in the following situations, but shall not be limited thereto:

(i) In cases where the scope of care needed by the patient is beyond the delineated clinical privileges of the practitioner;

(ii) In unusually complicated situations where specific skills of other practitioners may be needed;

(iii) In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms;

(iv) For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health;

(v) When requested by the patient or the patient's family; or
(vi) Those situations specifically designated elsewhere in these Rules and Regulations, or in the Regulations of the various Clinical Departments or Special Care Units.

e. Consultations by physicians, dentists or podiatrists not on the Medical Staff must have the prior permission of the pertinent Department Chair (or designee thereof) and the Vice President/Administration. Such permission must be recorded in the patient's medical record. Whenever possible, the attending physician, dentist or podiatrist of record or a designee shall be physically present during such consultation. In addition, the consultation and its results should be legibly noted in the patient's chart.

G. REGULATORY REQUIREMENTS

1. **Medical Examiner** - The physician of record is responsible for reporting to the Medical Examiner's Office all deaths that might fall under the purview of the Nassau County Medical Examiner. The Nassau County Medical Examiner shall be contacted if there is any question as to whether a case is reportable. It is the responsibility of the attending physician, dentist or podiatrist to notify the family that the patient's death was reported to the Medical Examiner. Permission for autopsy should not be sought until it is determined that the death is not reportable to the Medical Examiner. (*100.13 & 700.04)

2. **Infection Control** - The Infection Control Practitioner, supported by the NSUH Department of Medicine, Division of Infectious Diseases, is responsible for meeting the infection control requirements of regulatory agencies for the Hospital. Members of the Medical Staff, the Graduate Staff, the Allied Health Professional Staff, the Infection Control Practitioner and the NSUH Department of Medicine, Division of Infectious Diseases serve as a resource to the Medical Staff to facilitate infection prevention efforts. The Medical Staff, the Graduate Staff and the Allied Health Professional Staff shall comply with all infection control and prevention regulations to identify infections and implement measures to prevent the transmission and development of infection. Members of the Medical Staff are mandated, as per the New York State Department of Health and local Health Departments to report infectious diseases which pose a risk to the health of the public. In addition, all Class I and Class II surgical site infections identified by a practitioner following discharge shall be recorded and reported to the Infection Control Practitioner for further investigation.

3. **Safe Medical Device Reporting** - The members of the Medical Staff, the Graduate Staff, and the Allied Health Professional Staff will comply with the Hospital's Medical Device Reporting Program, which was established to identify medical device related incidents in order to initiate corrective action and comply with the reporting requirements of the Safe Medical Devices Act of 1990. The members of the Medical Staff, the Graduate Staff, and the Allied Health Professional Staff shall report any such potentially reportable incident to the Department of Quality Management. (*100.36)
4. **Department of Health Incident Reporting** - The members of the Medical Staff, the Graduate Staff, and the Allied Health Professional Staff will assist the Department of Quality Management to ensure compliance with the New York State (NYS) Health Code requirement that certain types of incidents be reported to the NYS Department of Health. (*100.05)

5. **Child Abuse and Neglect** - Members of the Medical Staff and Graduate Staff and the Allied Health Professional Staff shall be responsible for reporting suspected abuse and/or neglect of children as soon as possible to the Child Protective Services, Central Registry for Mandated Reporters. The Hospital Department of Social Work should be contacted to facilitate this reporting. (*100.10)

6. **EMTALA** - The Hospital and the Department of Emergency Medicine have developed and implemented detailed policies-and procedures to ensure compliance with the Emergency Treatment and Active Labor Act (EMTALA). (*700.01)

   If a physician who is on the on-call roster does not adhere to the above time frames or fails to respond, that fact, along with any other violations of EMTALA, will be reported to the responsible Department Chair for appropriate action. Failure of the on-call physician to adhere to these requirements may result in corrective action, including but not limited to, loss of clinical privileges.

**H. MISCELLANEOUS HOSPITAL AND PATIENT CARE REGULATIONS**

1. **Transfer of the care of a patient** from one member of the Medical Staff to another must be indicated in the medical record by a signed note certifying the consent of the involved members of the Medical Staff. The Admitting Office shall be notified of such transfers. (*650.01)

2. **The use of restraints, or the placement of a patient in seclusion**, may only be accomplished by physician order. The order must be written to comply with Patient Care policies and procedures, where applicable, and the policies and procedures promulgated by the Department of Psychiatry.

3. **Medical Staff members** are expected to refer their patients who may need social service assistance, alternate level of care placement, or home care assistance to: Social Work Department.

4. **Except for patients in the Department of Psychiatry**, no patient shall be permitted to leave the Hospital on pass.

5. **When a patient dies**, the patient shall be pronounced dead by the attending practitioner or designee. The attending practitioner, or designee, is responsible for making the appropriate entry in the patient's medical record, for completing the death certificate and for notifying the next of kin. If the attending practitioner, or designee, is unable to contact the next of kin within twelve (12) hours of the patient's death, the attending shall notify Hospital Administration.
6. The Medical Board has defined those types of cases in which an autopsy is indicated for diagnostic purposes, quality monitoring, or education. In all such cases, Medical Staff members must attempt to secure consent for autopsy form the legal next of kin, and all such attempts shall be documented in the medical record. Whenever autopsy consent is refused by the next of kin, the responsible medical staff member must document that a request for autopsy was made and that consent was refused. (*100.23 & 700.04)

7. Hospital supplies and equipment are exclusively for the use of registered patients and are not to be removed from the Hospital without the approval of Hospital Administration.

8. Members of the Medical Staff, Graduate Staff, and the Allied Health Professional Staff are expected to cooperate with the Hospital’s Disaster Plan in any emergency or local disaster requiring the presence of the Medical Staff, Graduate Staff, and the Allied Health Professional Staff.

9. Diagnosis or other clinical data shall not be discussed in elevators, corridors, or any other public place where such conversations may be overheard. (*200.00)

10. The Hospital has been designated as a "Smoke Free" hospital. The rules of the Hospital in regard to "No Smoking" shall be observed by all members of the Medical Staff. (*100.21)

11. Consistent with the Hospital's policy of respect for the individuality and dignity of its patients, the Medical Staff endorses those "Patient's Bill of Rights" as promulgated by the New York State Department of Health, and the New York State Office of Mental Health. (*100.11)

12. No physician shall be required to give advice regarding termination of pregnancy nor shall the physician be required to participate in the performance of this procedure. However, the physician shall be required to assist in transferring the patient to another physician who will provide the requested services.

13. The primary mechanism to address patients’ and staff needs for resolution of issues relating to the ethical and caring treatment of the patient shall be the responsible Medical Staff member in consultation with the patient and/or family and, if necessary, with his or her Department Chair. Additional counsel of the Ethics Committee may be sought at the discretion of the Department Chair. (*100.39 & 800.02)

I. HOME CARE PROGRAM

1. A written plan of care shall be developed for each patient who is a candidate to receive home care services after hospital discharge. This plan will be based upon assessment of the patient's post hospital home care needs by the appropriate staff and the physician who has primary responsibility for the patient. (*100.26)
2. During the patient's hospital stay, this plan shall be periodically re-evaluated by home care program staff in collaboration with the patient's primary physician. The essentials of the written plan of care shall be made part of the patient's medical record.

3. Patients may choose to receive home care services from any provider for reasons of preference, insurance coverage, or residence outside of the home care department's catchment area. Notwithstanding sections I.1 and I.2, the assigned clinical care coordinator shall make the necessary home care arrangements to reflect the patient's choice.

4. After the patient is discharged from the Hospital into a home care program, a visiting nurse shall maintain regular contact with the primary physician to report on the patient's progress. The primary physician, in consultation with the home care staff shall be responsible for the home care services plan and for the decision to discharge the patient from home care. Additionally, the primary physician will collaborate with the visiting nurse to develop a post home care plan when home care services are terminated.

J. SUPERVISION OF THE GRADUATE STAFF

1. Postgraduate trainees are given patient care responsibilities commensurate with their individual level of training, credentialing, experience and capability as determined by the chiefs of the respective clinical departments. In all matters of an individual patient's care, the attending physician is always responsible for the performance of residents. Physical examinations, daily visits, orders, progress notes, recording of histories or other assigned medical care responsibilities performed by residents does not preempt the attending physician's ultimate responsibility for the care of each patient.

2. Attending physicians, dentists and members of the Graduate Staff who are in their third year of graduate training shall provide supervision to the Graduate Staff Members in the same specialty as such attending physicians, dentists or senior Graduate Staff Members. There shall be a sufficient number of such supervising physicians or dentists (as the case may be) present in person in the Hospital twenty-four (24) hours per day, seven (7) days per week to supervise the Graduate Staff and to meet reasonable and expected demand. When it can be documented that the patient's attending physician or dentist is immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by members of the Graduate Staff who are in their penultimate year of post-graduate training, or who have completed at least two (2) years of post-graduate training.

3. The attending physician or dentist (as the case may be) is responsible to ensure that all decisions and determinations as to patient care are reflected in the treatment plan as written in the progress notes of the patient's medical record. The treatment plan is the written vehicle through which communication among those attending physician(s), dentist(s) and members of the Graduate Staff involved in the patient's care is enabled. Therefore, all relevant information must be clearly and thoroughly documented. The following additional requirements apply to treatment plans:
a. The treatment plans and any significant modifications must be discussed with the members of the Graduate Staff responsible for the patient's care and approved by the attending physician(s) or dentist(s). This approval shall be documented in the patient's medical record.

b. The treatment plan must be reviewed in accordance with the patient's condition and can only be amended by the written authorization of the attending physician or dentist. A member of the Graduate Staff may only amend the treatment plan without consulting with the responsible attending when he or she determines that an emergency exists. The amendment must be documented in the medical record, and the attending physician notified as soon as possible.

c. In the event that the attending physician or dentist will not be available for a given period of time, (i.e., the weekend), he must document the following in the order sheet and progress notes:

(i) The name of the physician or dentist (as the case may be) who will be covering in the attending's absence, and who will, therefore, be responsible for supervising the patient's care; and

(ii) A statement confirming that both the patient and the member(s) of the Graduate Staff caring for the patient have been informed of the name of the covering physician or dentist.

This provision shall not apply to members of a formal, established medical group as recorded in the Medical Staff Office, which routinely provides for on-call coverage of the group's patients by the members of such group.

d. The covering attending physician or dentist who is temporarily responsible for the direct supervision of the patient's care shall assume all of the duties of the attending physician or dentist and must document the following in the progress notes:

(i) All relevant patient care data and/or amendments to the treatment plan; and

(ii) At the conclusion of the period of coverage, the covering attending physician or dentist (as the case may be) must document that all pertinent information regarding the patient's care and status has been relayed to the primary attending upon that attending's resumption of the care of the patient.

4. Supervision by an attending surgeon of the care provided to surgery patients by members of the Graduate Staff must be documented and include at least the following:

a. Personal supervision of all surgical procedures performed by members of the Graduate Staff requiring general anesthesia or an operating room procedure; and
b. Pre-operative examination and assessment by the attending surgeon; and

c. Daily post-operative examination and assessment by the attending surgeon.

5. Within the context of the residency training program, documentation in the patient's medical record shall reflect the following requirements:

a. When minor procedures are performed by members of the Graduate Staff, documentation by the attending surgeon in the patient's medical record must reflect that the attending surgeon was present for the entire procedure.

b. When complex surgery or high risk procedures are performed by members of the Graduate Staff, documentation by the attending surgeon in the medical record must reflect that the attending surgeon was physically present during the key portion of the performance of the surgery or high risk procedure. Documentation must also reflect that the attending surgeon was immediately available to furnish services during the entire surgery or procedure.

c. When endoscopic procedures are performed by members of the Graduate Staff in a teaching setting, the attending physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device, and the documentation in the medical record by the attending physician must reflect this fact.

d. When radiologic procedures are performed by members of the Graduate Staff, documentation must reflect that the physician personally performed the interpretation of the test or reviewed the resident's interpretation with the resident. Countersignature is not adequate documentation of attending physician supervision.

6. The Program Directors of the Hospital's Graduate Medical Education programs are responsible for ensuring compliance by Medical Staff Members with the supervision requirements of these Rules and Regulations and with the regulations applicable to supervision of Graduate Staff members. The Program Directors are also responsible for monitoring patient care services provided by graduate trainees to assure provision of quality patient care services within the scope of privileges granted to such trainees and responsibility for assuring corrective measures and/or disciplinary action when such services provided exceed the scope of privileges granted. They, in turn, are accountable to their Department Chair. Any questions regarding this Section J should be referred to the appropriate Department Chair.

K. ADDITIONAL REFERENCE MATERIALS

1. In addition to the Bylaws, Rules and Regulations promulgated herein, the members of the Medical Staff, the Graduate Staff and the members of the Allied Health Professional Staff are bound to comply with all other policies and procedures that are currently in
effect or that may hereinafter be developed by the Hospital, including those developed
by their Department Chair. The following is a list of documents, which are readily
available on the nursing units and should be sought when questions related to their
subject matter arise.

a. Administration Policy and Procedure Manual
b. Patient Care Policy and Procedure Manual
c. Infection Control Policy and Procedure Manual
d. Safety Manual
e. Fire and Disaster Plans
f. Clinical and Ancillary Departmental Manuals, i.e., Pharmacy, Dietary.

THESE RULES AND REGULATIONS HAVE BEEN ADOPTED BY THE MEDICAL
BOARD OF GLEN COVE HOSPITAL

_________________________________
Chairman of the Medical Board

_________________________________
Vice Chairman of the Medical Board