Rules and Regulations
of
THE MEDICAL STAFF OF
NORTHERN WESTCHESTER HOSPITAL

Approved by the Medical Board on December 4, 2006
Approved by the Governing Board on January 25, 2007

| Revisions:       | Medical Board: 06/07; 03/08; 10/08; 07/10; 9/10; 07/12; 01/13; 11/13 04/14; 01/15
|                 | BOT: 06/07; 04/08; 10/08; 07/10; 9/10; 07/12; 01/13; 12/13; 05/14
| Anesthesiology  | Medical Board: 02/09; 09/09; 01/10; 05/11; 04/12; 10/14
|                 | BOT: 04/09; 09/09; 01/10; 05/11; 04/12; 10/14
| Emergency Medicine | Medical Board: 09/07; 05/08; 03/09; 04/10; 12/10; 10/11; 12/12; 02/13; 11/13; 01/15
|                 | BOT: 10/07; 05/08; 04/09; 05/10; 12/10; 10/11; 12/12; 03/13; 12/13
| Medicine        | Medical Board: 10/08; 01/10; 11/13
|                 | BOT: 10/08; 01/10; 12/13
| Obstetrics & Gynecology | Medical Board: 05/08; 10/08; 04/12; 06/14
|                 | BOT: 05/08; 10/08; 04/12; 06/14
| Pathology       | Medical Board: 03/12
|                 | BOT: 03/12
| Pediatrics      | Medical Board: 05/08; 06/11
|                 | BOT: 05/08; 06/11
| Psychiatry      | Medical Board: 09/08; 03/13; 11/13
|                 | BOT: 09/08; 03/13; 12/13
| Surgical Services | Medical Board: 09/08; 01/10; 12/10; 11/11; 04/12; 06/12; 02/13; 11/13
|                 | BOT: 09/08; 01/10; 12/10; 12/11; 04/12; 07/12; 03/13; 12/13
GENERAL

The management of Northern Westchester Hospital (NWH) is the responsibility of the Governing Board. The medical care of the patients is delegated to the Medical Board and through the Medical Board to the NWH Medical Staff.

The purpose of these Rules and Regulations is to govern the professional conduct of the Medical Staff, which for the purposes of these Rules and Regulations shall include all physicians, dentists, podiatrists, and allied health professionals who have been granted privileges to attend patients at NWH.

INPATIENT ADMISSION

1. All patients admitted as inpatients to the hospital are only admitted upon referral to and under the care of a licensed and registered practitioner with independent admitting privileges, who assumes the principal obligation and responsibility for managing and coordinating the patient’s medical care, treatment, and services.

2. Patients who are not private patients of members of the NWH Medical Staff and present to the NWH Emergency Department requiring admission to the hospital, or specialty consultation, or follow-up ambulatory care shall be assigned to a member of the NWH Medical Staff, who shall assume professional responsibility for the management of the patient’s care in the hospital and/or a proper plan of care after discharge, regardless of insurance status or ability to pay. The method of such assignment shall be determined by the Chief of each Department and/or Division under the direction and approval of the Medical Board.

3. An order to Admit as Inpatient which includes the medical reason for inpatient admission may be entered by:
   a. an attending physician with admitting privileges who will be the attending of record,
   b. a physician with admitting privileges who is covering for the physician who will be the attending of record,
   c. an Emergency Medicine physician following discussion with and at the direction of an attending physician with admitting privileges, or
   d. a nurse practitioner or physician assistant following discussion with and under the direct supervision of an attending physician with admitting privileges.

4. The attending physician responsible for the care of the patient or his/her covering physician must document in the medical record the medical need for inpatient treatment or evaluation, the reasonably anticipated length of stay (which for inpatient admissions shall generally be at least two (2) midnights), and the anticipated discharge disposition.

5. Each patient must have documentation of a complete history & physical examination in accordance with our Medical Staff Bylaws.

6. If the complete history & physical examination will not be available in the medical record within twelve (12) hours of admission, the admitting practitioner shall document a brief admission note in the medical record indicating the reason for admission, the pertinent history, physical, and laboratory findings, and the plan of care, so that the patient’s status is clear to other health care professionals involved in the patient’s care.

7. Patients admitted with signs or symptoms of recent exposure to communicable diseases shall be isolated and managed in accordance with NWH Infection Control Policies & Procedures.

SHORT STAY

1. Patients seen in the Emergency Department who require additional treatment or evaluation before a decision can be made regarding whether they will require inpatient admission or are able to be discharged from the hospital and it is reasonably expected that such a decision can be made in less than 48 hours, may be observed in an inpatient short stay unit bed under the care of an Emergency Medicine physician or, when approved by a utilization review physician advisor by, an
alternate attending physician. The Emergency Medicine physician should consult all appropriate medical and surgical consultants to assist in the evaluation and treatment of the patient.

2. If it is determined that a patient who is receiving observation services in an inpatient short stay unit bed has a medical reason for inpatient admission because of the results of the evaluation or a change in condition, transfer orders, including an order to Admit as Inpatient shall be entered by one of the practitioners listed in section 3 of “Inpatient Admission” above and care shall be transferred to an attending physician with admitting privileges.

3. Patients who have had an interventional or surgical procedure that is not designated as INPATIENT ONLY may receive ongoing recovery care or monitoring in an inpatient short stay unit bed under the care of the attending proceduralist or surgeon if it anticipated that the need for such care will be for less than 24 hours.

4. If it is determined that a patient who is receiving outpatient services in an inpatient short stay unit bed has a medical reason for inpatient admission because of a change in condition or the need for ongoing postoperative recovery care, the attending proceduralist or surgeon shall enter an order to Admit as Inpatient and will continue to care for the patient as the attending physician.

**DISCHARGE**

1. Patients may only be discharged from the hospital with an order from the responsible attending practitioner, covering attending practitioner, or nurse practitioner or physician assistant under the supervision of the attending practitioner. When a patient insists upon discharging himself/herself from the hospital in the absence of an order from the practitioner, the hospital shall obtain, when possible, a written release from the patient absolving the hospital and the patient’s attending practitioner(s) of liability and damages resulting from such discharge. In the case of a patient discharging himself/herself, the practitioner shall document the circumstances of this self-discharge in the medical record.

2. A discharge order shall only be entered when a patient has a reasonable discharge plan in place, with reasonable availability of any continuing health care services that the attending practitioner determines are medically necessary for the patient.

3. Upon discharge or transfer after an inpatient admission, a summary, which includes the following, shall be documented in the medical record:
   a. Reason for and outcome of hospitalization
   b. Procedures performed and care, treatment, & services provided
   c. Final diagnosis
   d. The patient’s condition & disposition at discharge/transfer
   e. Discharge medications, any pending test results, & a follow-up plan of care
   f. Information to the patient & family, as appropriate

4. Patients must be seen by a Medical Staff practitioner within 24 hours prior to discharge from the Hospital after an inpatient admission.

5. In the event of death, a summary including the first four items in #3 above, as well as whether or not an autopsy was requested and/or performed and whether or not the patient was a suitable organ donor shall be documented in the medical record.

**TRANSITIONAL CARE UNIT**

1. The NWH Transitional Care Unit (TCU) is a short-term sub-acute skilled nursing unit that accepts patient admissions directly from acute Hospital care.

2. All patients admitted to the TCU must have a need for skilled care provided by a licensed nurse and/or physical therapist, such as a need to improve mobility, self-care for activities of daily living,
bladder or bowel management, communication, balance, or safety, reasonably anticipated to be for 5-21 days.

3. All patients admitted to the TCU shall be admitted under the care of an NWH Internal Medicine Hospitalist who will be the responsible attending physician to oversee and coordinate the care.

4. All practitioners with NWH clinical privileges shall automatically have privileges to provide consulting services and perform procedures at the TCU consistent with their NWH clinical privileges.

NOTIFICATION OF DEATH

1. The Attending Physician is responsible for notification of death to the next of kin or legal health care representative. This responsibility is only transferable to an attending physician covering for the responsible attending physician at the time of the death.

2. The Attending Physician shall promptly report all medical-legal deaths by telephoning the Office of the Medical Examiner, prior to requesting permission for an autopsy.

AUTOPSY

1. No autopsy shall be performed without written consent of the legally authorized health care representative, unless so directed under the local jurisdiction guidelines of the Office of the Medical Examiner. When the Office of the Medical Examiner accepts a case, the attending physician should NOT ask for permission from the legally authorized health care representative.

2. The Medical Staff shall be particularly diligent in attempting to secure permission for autopsy in the following cases:
   a. Unusual deaths in which an autopsy may help to explain unknown and unanticipated medical complications to the attending physician
   b. All obstetrical deaths
   c. Deaths at any age when it is believed that autopsy would disclose a known or suspected illness, which may have a bearing on survivors or recipients of transplant organs

3. After obtaining Consent for an Autopsy, the attending physician shall notify Health Information Management or the Administrative Supervisor, who will coordinate arrangement of the autopsy at an outside medical center or, in the case of fetal demise, with our Pathology Department.

4. Coordination and documentation of death, autopsy, notification to the Office of the Medical Examiner, and notification to the New York Organ Donor Network shall be carried out in accordance with the Hospital’s Comprehensive Death Policy & Procedure.

MEDICAL RECORDS

1. The Medical Record shall contain ongoing information to support the working diagnosis, justify the care, treatment, and services, document the course and results of such care, treatment, and services, and promote continuity among practitioners and caregivers.

2. Those authorized to make entries in the Medical Record shall include: Medical Staff Members, Allied Health Professionals, Medical Staff non-members granted clinical privileges, Registered Nurses, Licensed Practical Nurses, Patient Care Associates, Case Managers, Social Workers, Psychiatric Technicians, Therapeutic Dietitians, Speech, Occupational, Physical, Respiratory, Recreation, and Art Therapists, Concierges, Clinical Information Managers (CIMs), and Chaplains.

3. Every Medical Record entry shall be complete, legible, and dated, with the author identified. The following entries must be authenticated by written or electronic signature:
   a. History and Physical Examination
b. Operative Reports
c. Consultation Reports
d. Progress Notes
e. Discharge Summaries

4. The following Medical Record entries made by non-independent practitioners, including Certified Registered Nurse Practitioners (Advanced Practice Registered Nurses), Physician Assistants, and Specialist Assistants, also require authentication by the collaborating or supervising physician:
   a. History and Physical Examination
   b. Operative Reports
   c. Consultation Reports

5. Documentation in the EMR shall accurately reflect the subjective and objective status of the patient on the day of the encounter, an assessment that includes each of the patient’s problems (symptoms, diagnoses, and or possible/likely diagnoses) the documenting practitioner is addressing, and the plan (testing, treatment, specialist consultation) for each problem. Actively cutting and pasting information from one note to another is prohibited. Certain elements of the note, such as a problem list, historical data, and test results may be set to carry forward or autopopulate to improve efficiency and accuracy.

6. Only such abbreviations and symbols approved by the Medical Board may be used in the Medical Record. The final diagnosis may not contain abbreviations or symbols.

7. All Medical Records are the property of NWH and may not be removed without permission of the CEO or his designee, except in accordance with a court order or receipt of a subpoena duces tecum.

8. It is the responsibility of all practitioners to complete their medical records within thirty (30) days of discharge, and the responsibility of the Health Information Management Department to provide necessary assistance to the Medical Staff to facilitate completion of the medical record, which includes providing practitioners and the Medical Board with periodic reports of delinquent medical records. Failure of a practitioner to complete medical records within a timely fashion constitutes professional misconduct under the State Education Law. Incomplete records shall not be filed unless so directed by the Medical Director.

ORDERS

1. Orders for emergency department patients, short stay patients, inpatients, patients undergoing ambulatory surgical procedures, and patients receiving infusion therapy are only acceptable from a practitioner who has been granted such Medical Staff privileges.

2. The following outpatient services may be ordered by any practitioner who is acting within the scope of his/her license recognized in the jurisdiction of the state where he/she sees the patient:
   a. Imaging studies, including those that require injected or oral contrast
   b. Laboratory blood and urine tests, including those that require injected or oral agents (e.g. endocrine stimulation tests)
   c. Pulmonary function tests
   d. Rehabilitation services, including pulmonary rehabilitation, cardiac rehabilitation, medically supervised exercise, physical therapy, occupational therapy, speech and swallowing therapy, and balance testing and treatment
   e. Dietary counseling, including diabetes education

3. All orders shall be authenticated with written signature or electronic signature by the ordering physician, podiatrist, dentist, advanced practice nurse, or physician assistant.

4. Verbal orders are ONLY acceptable when given to a registered nurse, pharmacist, or certified/registered respiratory therapy technician in emergency situations and must be verified by
a “read-back” of the complete order by the person receiving the order. Verbal orders must be
authenticated by the ordering practitioner or a covering practitioner within 48 hours of the order.

5. Telephone orders may be given to a registered nurse, pharmacist, or certified/registered
respiratory therapy technician and must be verified by a “read-back” of the complete order by the
person receiving the order. Telephone orders must be authenticated by the ordering practitioner
or a covering practitioner within 48 hours of the order.

6. Standard Order Sets may be instituted with the approval of the Chief of the relevant Department
or Division and/or the Medical Director. Those order sets that include medications shall also be
reviewed and approved by Pharmacy.

7. Medication orders:
   a. Medication orders shall include the name of the medication, exact dose of the medication,
      and frequency of administration. Dose ranges and frequency ranges are not acceptable.
   b. Medications prescribed on an “as needed” (prn) basis must include the reason for use,
      unless on the Pharmacy & Therapeutics list of exceptions for medications that only have
      one indication for use, as approved by the Medical Board.
   c. Medication orders shall be consistent with the NWH Formulary, as approved by the
      Pharmacy & Therapeutics (P&T) Committee and the Medical Board.
   d. Automatic therapeutic substitutions shall be made for non-formulary medications in
      accordance with the policies, procedures, and guidelines established by the P&T
      Committee and approved by the Medical Board.
   e. The use of non-formulary FDA approved medications requires approval in accordance with
      the policies and procedures of the Pharmacy.
   f. No medications for clinical investigation shall be used without approval from the
      Institutional Review Board and appropriate consent from the patient or authorized
      representative.
   g. Orders for controlled substances shall automatically expire after seven (7) days OR after
      thirty (30) days for a patient who has been chronically stable on the medication for a
      seizure disorder, chronic spasticity, or minimal brain dysfunction.
   h. Orders for antibiotics shall automatically expire after seven (7) days.
   i. Orders for oral vitamin K antagonist anticoagulants shall automatically expire after ten
      (10) days, unless otherwise indicated, and in no case shall be continued longer than thirty
      (30) days without obtaining an INR level.

8. Orders for imaging procedures must include the reason for the procedure.

RERAINTS

1. A restraint includes either a physical restraint or a medication that is being used as a restraint. A
   physical restraint is any manual method or physical or mechanical device or equipment that
   restricts one’s freedom of movement or normal access to one’s body, NOT including orthopedically
   prescribed devices, surgical dressings or bandages, protective helmets, arm boards for IV
   administration, and other such therapeutic equipment. A medication used as a restraint is one
   used to control behavior or restrict one’s freedom of movement that is NOT a standard treatment
   for the patient’s medical or psychiatric condition.

2. Restraints for behavior management will be used only to protect the patient, staff member, or
   others from harm. Restraints for acute medical and surgical care (e.g. to prevent removing lines,
   tubes, equipment, and/or dressings) will be used only to improve the patient’s well being.
Restraints for behavior management AND restraints for acute medical and surgical care will be used ONLY when less restrictive interventions have been clinically determined to be inappropriate, ineffective, or insufficient and must be discontinued at the earliest possible time.

3. Restraint orders shall be from an attending physician and specify the type of restraint, purpose of the restraint, and length of time the restraint is to be applied, in accordance with Patient Care Policies & Procedures.

CONSULTATIONS

1. Requests for consultation by specialist physicians should be in accordance with generally accepted standards of patient care with adherence to the specific privileges granted to each practitioner by the Governing Board, except in emergency, potentially life-threatening situations.

2. Consultation is required when the attending physician determines:
   a. a high medical or surgical risk for a complication or adverse outcome
   b. a diagnosis is obscure
   c. there is an unanticipated failure to improve
   d. there is doubt or controversy regarding the best therapeutic plan

3. Consultation with an intensivist is required for patients admitted to the Critical Care Unit, except for patients admitted chiefly for a cardiovascular condition

4. Consultation with a cardiologist is required for patients admitted to the Critical Care Unit for a cardiovascular condition

5. Consultation with a cardiologist is required prior to implantation of a permanent pacemaker

6. Consultation with a psychiatrist is required when a patient has attempted suicide or exhibits severe psychiatric symptoms

7. Consultation is required when a Department or Division Chief or his designee determines that a consultation is indicated for a patient cared for by an attending physician in his Department or Division

8. Consultation is required when so described in the Rules and Regulations particular to any individual Department

9. Nurses and other non-physician practitioners involved in a patient’s care may request a consultation in an emergency situation

10. In determining who to contact for a particular specialist consultation for inpatients or emergency department patients, the following guidelines should be followed:
   - If a patient has an existing relationship with a specialist related to their current condition or a previous unrelated condition, that specialist should be consulted first and given the option of seeing the patient, unless the patient expresses a preference to the contrary
   - If a patient has no existing relationship with a specialist, but has a primary care physician on our staff with a preference for contacting a particular specialist or group, that specialist should be consulted and given the option of seeing the patient
   - If neither of the above applies or if the above consultants are not available to provide a consultation in the appropriate time frame, the specialist on service call for the department or division should be consulted and must be available to provide a consultation in the appropriate time frame, as determined by the consulting attending physician based upon the clinical situation of the patient
In cases where inpatients or emergency department patients have a problem that is specifically related to a procedure performed by a specialist or a condition that is being actively treated by one of our specialists, it is the expectation that the specialist is available to provide consultation or has a covering physician in the same specialty available to provide consultation, as indicated in the section “Medical Coverage” below. An exception to this expectation may be made at the discretion of a particular department or division.

11. The consultant is responsible for documentation of his evaluation of the patient and any recommendations for further evaluation or treatment. If documentation of the complete consultation will not be available in the medical record within twelve (12) hours of the evaluation, the consultant shall document a brief note in the medical record summarizing his impression and recommendations, so that the patient’s status is clear to other health care professionals involved in the patient’s care.

MEDICAL COVERAGE

When any Medical Staff member is temporarily, or for a protracted period of time, away from the area served by the hospital or otherwise not available to care for patients, he shall name a member of the Medical Staff who may be called in his place for the care of his patients. In a case of failure to name such an alternate member of the Medical Staff, the Chief of that Department or Division shall have the authority to appoint such an alternate.

TRANSFER OF CARE

1. In each case of temporary or permanent transfer of the care of a patient from one NWH attending physician to another, such transfer shall be entered as an order as well as noted in the progress note of the patient’s medical record.

2. No patient with an emergency medical condition shall be transferred from the Emergency Room to another hospital unless:
   a. The patient has been stabilized, OR
   b. When the patient has not been stabilized, only under the following circumstances:
      i. after being informed by NWH of the risk of transfer, the patient or legally responsible person acting on the patient’s behalf makes a written request for the transfer, which indicates the reasons for the request and his/her awareness of the risks and benefits of the transfer, OR
      ii. a physician has signed a certification summarizing the risks and benefits of the transfer, which shall include: a statement that the requisite care cannot be provided at NWH, if applicable, AND a statement indicating that the medical benefits of the transfer outweigh the risks to the patient

3. In the case of transfer of a patient with an emergency medical condition to another facility, the following shall be done and documented in the medical record:
   a. NWH has provided medical treatment to minimize the risk to the patient
   b. The transfer is confirmed with the other facility, which includes acceptance from an accepting ED physician, attending physician, or administrator
   c. A copy of the patient’s medical record is sent to the recipient facility
   d. Appropriate equipment and personnel is provided for the transfer

PASSES

1. No passes for inpatients to temporarily leave the hospital will be allowed except when services for the ongoing medical evaluation, diagnosis, or treatment of a patient are not available within NWH are part of the plan of care.

2. In such cases, the senior hospital administrator must be notified and arrangements for the safe transfer and care of the patient must be ensured for the entire period of the leave.
CONTINUOUS PROFESSIONAL PRACTICE EVALUATION

All privileged practitioners will undergo continuous performance review to ensure continued competency in the areas of:

1. Medical knowledge, skill, and judgment
2. Systems based practice: adherence to procedures and systems related to patient safety and appropriate and efficient use of resources
3. Patient Centeredness: effective interpersonal & communication patient care skills and professionalism
4. Peer & coworker relationships: interpersonal & communication skills and professionalism
5. Practice-based learning & improvement: participation in performance improvement committees, meetings, and educational programs

The Medical Board has the ultimate authority and responsibility for Professional Practice Evaluation.

The Professional Practice Evaluation Committee (PPEC) will provide oversight of the continuous performance review process and periodically report to the Medical Board.

As part of the ongoing professional practice evaluation process, all reported concerns/complaints regarding a privileged practitioner's clinical practice or competence are uniformly reviewed and investigated, as described below.

INCIDENT-BASED PEER REVIEW

In addition to systematic continuous performance improvement activities discussed above and described in the annual Quality Management Plan, there shall be an incident-based peer review process under the direction of the Medical Board and coordinated by the Quality Management staff and Chief of each Department, as part of the Hospital’s Patient Safety Evaluation System with the goal of ensuring patient safety and quality of care and improving practitioner performance:

1. All concerns, complaints, and event reports regarding any privileged practitioner’s clinical practice or competence shall be directed to and collected by the Medical Director or her designee. Such concerns, complaints, and event reports may be made directly to the Medical Director or through the computer-based event reporting system.

2. The Medical Director or her designee shall, within forty-eight (48) hours of receiving such complaint or concern, review it.

3. If a concern, complaint, or event raises significant concern that immediate action should be taken in order to protect the life of patient(s) or reduce the substantial likelihood of immediate injury or risk to the health or safety of any patient, employee, or other person present in the Hospital, the Medical Director may immediately recommend to the Chief Executive Officer that summary suspension be imposed, and the summary suspension process in Article VIII of the NWH Medical Staff Bylaws will be followed.

4. In all other situations, the concern, complaint, or event report shall be presented to the Chair of the PPEC who will proceed in accordance with the Professional Practice Evaluation Policy.

5. On the basis of a case review rating, the PPEC may:
   a. Take no further action other than to meet the documentation and reporting obligations listed below
   b. Recommend Focused Professional Practice Evaluation of the relevant privileged practitioner, in accordance with the NWH Medical Staff Rules and Regulations on Focused Professional Practice Evaluations, described below
c. Recommend to the Medical Director corrective action in relation to the applicable privileged practitioner, which shall be addressed by the Medical Board in accordance with Article VIII of the Medical Staff Bylaws

6. Based on the cases reviewed, the PPEC may periodically recommend appropriate system changes to improve patient care and decrease the risk of recurrent adverse outcomes.

7. Those practitioners, staff, and administrators who participate in the professional practice evaluation process shall be afforded protection in accordance with the Federal Health Care Quality Improvement Act of 1986.

8. All information obtained and/or maintained by the PPEC and all reports it produces shall be privileged and confidential pursuant to applicable law, including, but not limited to, New York Education Law §6527, New York Public Health Law §2805-j, and the Federal Patient Safety and Quality Improvement Act of 2005 (Public Law 109-41).

9. Documentation of each concern, complaint, and event report regarding a practitioner’s clinical practice or competence and the disposition of such complaint and/or concern shall be maintained in that practitioner’s file.

FOCUSED PROFESSIONAL PRACTICE EVALUATION

1. A focused professional practice evaluation may be initiated:
   a. Each time a practitioner requests privileges to perform a procedure for which the Hospital has no acceptable documentation of competency to perform such procedure at the Hospital (e.g. new applicants, existing Medical Staff members requesting new privileges)
   b. Whenever a Department or Division Chief, the Chairman of the Medical Board, the President of the Medical Staff, or the Medical Director has a concern regarding the provision of safe, high quality patient care, particularly in the following circumstances:
      i. There is an incident for which the PPEC reviews a case and rates the quality of a practitioner’s performance Level 3
      ii. An overall rate of reported incidents that is greater than that of other practitioners providing similar care or performing similar procedures at the Hospital
      iii. A trend or cluster of complications related to a particular diagnosis or particular procedure performed by the practitioner
      iv. The practitioner is involved in a sentinel event or an event reportable to the New York Patient Occurrence Reporting and Tracking System (NYPORTS)
      v. There is a report of corrective action about the practitioner from the NYS DOH, CMS, other regulatory agency, or other healthcare facility

2. The information collected for focused professional practice evaluation may include chart review, monitoring of clinical practice patterns, simulation, proctoring, external peer review, and/or discussion with other individuals involved in the care of each patient (consulting physicians, surgical assistants, nursing staff) and shall be determined by the Department or Division Chief and the Medical Director. Use of external sources shall be required in accordance with the Medical Staff Bylaws.

3. Each Department shall develop criteria to determine the type of and method for monitoring.

4. Focused professional practice evaluation triggered by a concern regarding the provision of safe, high quality patient care:
   a. Information resulting from the focused professional practice evaluation will be aggregated and provided to the Department or Division Chief and the Medical Director on a monthly basis for a period of six months.
b. Following a six month period, the Department or Division Chief and the Medical Director may do one of the following:

i. Discontinue the focused professional practice evaluation if they are convinced of the practitioner’s ability to provide safe, high quality patient care within the scope of his clinical privileges

ii. Extend the focused professional practice evaluation for an additional six month period if there is an insufficient quantity of information to support the practitioner’s ability to provide safe, high quality patient care within the scope of his clinical privileges

iii. Submit the information from the focused professional practice evaluation to the Medical Board for review and discussion or request for corrective action

5. Focused professional practice evaluation for practitioners on provisional status or non-provisional practitioners requesting new privileges shall be in accordance with the Medical Staff Bylaws section on Initial Appointment and any requirements for the specific privilege requested.

6. Any focused professional practice evaluation that results in limitation of privileges or any other action that would require a report to the New York State Office of Professional Medical Conduct or National Practitioner Data Bank will entitle the privileged practitioner access to the fair hearing and appeal rights described in the Medical Staff Bylaws. All other forms of focused practice evaluation shall not entitle a privileged practitioner to a fair hearing or appeal.

PHYSICIAN ASSISTANTS

Physician Assistants (PAs) are granted privileges at NWH as Allied Health Professionals and are subject to the obligations and restrictions set forth in the Medical Staff Bylaws and Related Manuals, including the applicable Department Rules and Regulations.

Qualifications:

1. Graduate of a national PA program, accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

2. National Certification by the National Commission on Certification of Physician Assistants (NCCPA).

3. Currently registered with the New York State Education Department and licensed to practice in the State of New York.

4. Following initial certification and licensure, each PA must maintain an active New York State license and must maintain their NCCPA certification through 100 hours of CME credit every two years, re-registration as required and re-examination every six years by the NCCPA.

Scope of Practice:

1. A PA practices under the direction of a supervising physician, designated in writing on the PA’s Clinical Privilege Request form.

2. The supervising physician must be an active member appointed to the NWH Medical Staff as an Attending Physician and competent to provide such direction as evidenced by education, training, and/or experience that is related to the work of the PA.

3. A PA may NOT be granted any clinical privileges that are not within the scope of practice and clinical privileges that have been granted to his/her supervising physician.

4. The supervising physician is ultimately responsible for all patient care provided at NWH by any PA who he/she supervises.
5. The supervising physician exercises oversight, control, and direction of the services of a PA, which includes, but is not limited to:
   a. The supervising physician’s continuous availability to provide direction through direct communication in person, by telecommunication, or by electronic communication.
   b. Periodic review of the PA’s medical records to ensure quality patient care.
   c. Delineation of an alternate member of the NWH Attending Medical Staff to provide supervision to the PA in the absence of the supervising physician.

6. No physician may supervise more than six (6) PAs.

7. If any PA is supervised more than one physician, there must be a written delineation of which physician supervisor is responsible for each clinical circumstance and patient.

8. Clinical privileges for PAs may include:
   a. Taking medical histories and performing physical examinations
   b. Ordering diagnostic tests
   c. Assessment of physical and psychological status, including diagnosis of illness
   d. Implementation of physician-directed treatment plans, including ordering medications and other therapeutic interventions
   e. Implementation of physician-directed pre and postoperative surgical care
   f. Education and counseling patients, including promotion of wellness, discussion of health status, test results, and disease processes, and discharge planning
   g. Provide first, second, or third assist in general surgery and surgical subspecialties
   h. Respond to the Emergency Department for on-call supervising physician, if determined by the responsible Emergency Department Attending Physician to be clinically appropriate
   i. Additional specialty privileges may be granted based on demonstration of education, training, experience, and current competence

9. PA admission history and physical examinations must be countersigned by his/her supervising physician within 24 hours.

ADVANCED PRACTICE NURSES

Advanced Practice Nurses, including Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), and Certified Nurse Midwives (CNMs) are granted privileges at NWH as Allied Health Professionals and are subject to the obligations and restrictions set forth in the Medical Staff Bylaws and Related Manuals, including the applicable Department Rules and Regulations.

Qualifications:

1. Licensed and currently registered by the New York State Education Department to practice as a registered professional nurse

2. Completion of an applicable education and training program as delineated on the applicable Nurse Practitioner, Certified Nurse Anesthetist, or Certified Nurse Midwife Clinical Privilege Request form

3. One of the following Certifications:
   - NPs: National Certification by the American Nurses Credentialing Center (ANCC) of the American Nurses Association or other New York State-approved specialty nursing organization in the applicant’s area of specialty (Acute Care, Adult, Pediatric, Gerontology, Family)
   - CRNAs: Certification by the American Association of Nurse Anesthetists (AANA) Council on Certification
   - CNMs: Certification by the American College of Nurse-Midwives (ACNM) Certification Council

4. Certification above must meet all New York State Board of Education criteria to allow practice of this specialty in the State of New York

Scope of Practice:
1. Advanced Practice Nurses function at NWH in a collaborative practice arrangement under the direction and supervision of a collaborating physician or in the case of CRNAs a supervising anesthesiologist, designated in writing on their Clinical Privilege Request form, and, when applicable, in accordance with a written practice agreement and written practice protocols.

2. The responsible collaborating physician or supervising anesthesiologist must be an active member appointed to the NWH Medical Staff as an Attending Physician and competent to provide such direction as evidenced by education, training, and/or experience that is related to the work of the Advanced Practice Nurse.

3. An Advanced Practice Nurse may NOT be granted any clinical privileges that are not within the scope of practice and clinical privileges that have been granted to his/her collaborating physician or supervising anesthesiologist.

4. The collaborating physician or supervising anesthesiologist is ultimately responsible for all patient care provided at NWH by any Advanced Practice Nurse who he/she supervises. In a circumstance of any disagreement between the collaborating physician or supervising anesthesiologist and the Advanced Practice Nurse regarding a matter of diagnosis or treatment, the physician’s diagnosis or treatment shall prevail.

5. The responsible physician’s collaboration includes, but is not limited to:
   a. Continuous availability to provide supervision and consultation with the Advanced Practice Nurse when needed.
   b. Review of the Advanced Practice Nurse’s patient care activities, including a review of all of his/her medical records for the first month of practice at the Hospital, followed by periodic review of a minimum of 10% of his/her medical records no less than every three (3) months thereafter.
   c. Delineation of an alternate member of the NWH Attending Medical Staff to collaborate with the Advanced Practice Nurse in the absence of the collaborating physician.

6. Advanced Practice Nurse Admission History and Physical Examinations must be countersigned by his/her collaborating physician within 24 hours.

7. CRNA orders must be countersigned by his/her supervising anesthesiologist within 24 hours.
DEPARTMENT OF ANESTHESIOLOGY

LEADERSHIP

1. The Chief of the Department of Anesthesiology shall also serve as the Medical Director of the Operating Room and co-chairman of the Operating Room Committee, which shall meet monthly and include representation from each surgical division, nursing, administration, and quality management, and shall be a member of the Quality Improvement Committee of the Medical Board. The Chief of Anesthesiology shall be a diplomate of the American Board of Anesthesiology.

2. In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Anesthesiology shall be responsible for:
   a. Oversight of the professional and clinical activities in the operating suite for inpatients and the Ambulatory Surgery Center (together with the Chief of Surgical Services)
   b. Oversight of the professional and clinical activities in the Post Anesthesia Care Unit (PACU) to ensure safe and effective monitoring of patients who have undergone procedures and received anesthesia
   c. Working collaboratively with the Administrative/Clinical Director of Surgical Services to oversee the daily scheduling of surgical cases in the operating room and allocation of block time assignments, with the ultimate authority to triage such schedules to provide the most effective, safe, and efficient patient care and to accommodate add-on cases whenever possible
   d. Assignment of appropriate anesthesiology coverage for all procedures requiring an anesthesiologist or CRNA, including those done in the operating room, labor & delivery unit, endoscopy/minor surgery unit, aesthetic institute, interventional radiology suite, cancer center, critical care units, ECT program, and any other areas of the hospital that may from time to time require anesthesiology services
   e. Providing appropriate supervision to all CRNAs administering anesthesia, or delegating such supervision to another anesthesiology physician
   f. Recommendation to the Medical Board and governing body privilege criteria and privileges for all professionals who administer anesthetics, including anesthesiologists, certified registered nurse anesthetists (CRNAs), and non-anesthesiologist physicians, dentists, or podiatrists granted privileges for administration of moderate or deep sedation
   g. Oversight and monitoring of the quality and appropriateness of anesthesia related patient care and ensuring that identified problems are reported to the Quality Management Department and/or Quality Improvement Committee so that they may be addressed and resolved
   h. Developing regulations concerning anesthetic safety and an educational program governing the introduction of newer anesthetic techniques
   i. Ensuring that there is appropriate pre-operative clinical review, medical evaluation, and preparation of all patients undergoing procedures
   j. Oversight of the Pain Management Program, including inpatient and outpatient procedures performed by anesthesiologists and non-anesthesiologist physicians trained and/or certified in pain management
   k. Recommendation to the Medical Board and governing body privilege criteria and privileges for all professionals who specialize in managing pain, including anesthesiologists, physical medicine & rehabilitation specialists, and allied medical professionals including acupuncturists
   l. Delegating responsibility, as indicated, to the Anesthesiology Department Associate Director
STAFFING

1. The Anesthesiology Department shall be staffed by:
   - Physician anesthesiologists who are certified by or eligible to be certified by the American Board of Anesthesiology
   - Certified Registered Nurse Anesthetists (CRNAs), under the supervision of an anesthesiologist who is a member of the Department of Anesthesiology and immediately available as needed. The number of CRNAs supervised by each anesthesiologist will be in accordance with the current prevailing standard of care, and the supervising anesthesiologist shall use sound judgment in initiating other concurrent anesthetic and emergent procedures.

   An anesthesiologist supervising a CRNA is responsible for:
   - Verifying the information from the pre-anesthesia evaluation and repeating and recording essential key elements of the evaluation
   - Prescribing & documenting the anesthetic plan
   - Personally participating in the most demanding procedures of the plan, including induction & emergency situations
   - Following the course of the anesthetic at appropriate periodic intervals
   - Remaining immediately available for diagnosis and treatment of emergencies
   - Providing post anesthesia care

2. The Department will include anesthesiologists with specialized training in areas such as obstetrical anesthesia and pediatric anesthesia to provide input into maintaining the highest quality standards of care in those areas.

3. A “first call” anesthesiologist shall be available on site at the Hospital at all times to respond to cardiopulmonary arrests, the need for administration of anesthesia for emergency procedures, and any other urgent or emergent situation requiring an anesthesiologist.

4. A “second call” anesthesiologist shall be assigned to be available at all times. The second call anesthesiologist will be called into the Hospital in the event that the first call anesthesiologist is administering anesthesia, therefore, at all times having an on site unengaged anesthesiologist available to respond to emergencies.

5. A daily schedule of first and second call anesthesiologists shall be displayed in the Operating Room, Labor & Delivery Unit, and Emergency Department, and provided to the Hospital telecommunications department.

6. The daily anesthesiology assignment schedule shall be arranged so that at least one anesthesiologist is free and available at all times to respond to emergencies in the Operating Room, Labor & Delivery Unit, PACU, Emergency Department, and other areas of the Hospital.

7. The second call anesthesiologist is responsible for informing the Hospital Operator and the first call anesthesiologist of how he/she can be reached at all times.

8. No changes in the call schedule or scheduled assignments shall be made without prior approval from the Chief of Anesthesiology or his designee.

9. Special requests regarding time off from the assignment or call schedule shall be made in writing to the Chief of Anesthesiology no later than ninety (90) days prior to the requested time.
DEPARTMENTAL OPERATIONS

General

1. Anesthesiology is a discipline within the practice of medicine specializing in:
   - The preoperative, intraoperative, & postoperative medical management of patients who are rendered unconscious and/or insensible to pain & emotional stress during surgical, obstetrical, and certain other medical procedures
   - The protection of life functions & vital organs (brain, heart, lungs, kidneys, liver) under the stress of anesthetic, surgical, and other medical procedures
   - The management of problems in pain relief
   - The management of problems in cardiopulmonary resuscitation
   - The management of problems in pulmonary care
   - The management of critically ill patients in critical care units

2. Anesthesiologists are responsible for pre-anesthesia evaluation & treatment, which shall be performed & documented within 48 hours prior to the delivery of the medication used to induce anesthesia, medical management of patients & their anesthetic procedures, and post-anesthesia evaluation & treatment.

3. The same quality of anesthetic care shall be available to meet the needs of all patients receiving diagnostic, therapeutic, invasive, or surgical procedures on an elective or emergency basis, 24 hours a day, 7 days a week.

4. Anesthesia care will only be provided when the appropriate and necessary equipment, personnel, and support are available.

5. The Anesthesiology Department, together with the nursing staff, shall be responsible to ensure adherence to Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery. This includes the processes for:
   - Preoperative verification to ensure that all relevant documents, studies, implants, devices, equipment, antibiotics, fluids, and blood products are available prior to the start of the procedure and have been reviewed and are consistent with each other and with the patient’s expectations and the team’s understanding of the intended patient, procedure, and site
   - Marking the operative site for procedures involving right/left distinction, multiple structures (such as fingers & toes), or multiple levels (such as spinal procedures), and when applicable, the site for regional anesthesia
   - Performance of a “Time Out” immediately before starting the procedure as a final verification of the correct patient, procedure, site, and, when applicable, antibiotic administration and implants, that involves active and attentive communication among all members of the surgical/procedure team initiated by the circulating nurse (or procedural nurse for areas outside of the OR)

Pre-anesthetic Care

1. The anesthesiologist or CRNA is responsible for timely arrival in the operating room to greet the patient & family and review the medical record. The anesthesiologist must be in the ASC by 7:10 AM for patients scheduled for 7:30 AM procedures.

2. The anesthesiology patient evaluation must include:
   - Review and discussion of medical history, including previous experience with anesthesia, drug, and allergy history
   - Patient interview and physical examination, as necessary to assess those aspects of the patient’s physical condition that might affect decisions regarding perioperative risk and management
   - Determination of ASA risk classification and any potential anesthesia problems
   - Notation of any changes in history or physical examination since the preoperative evaluation performed by the patient’s surgeon, primary care, or specialist physician
   - Ordering of any necessary tests, medications, or specialist consultations essential for anesthesia management
Determination of the plan

3. Pregnancy Testing: the knowledge that a woman is pregnant substantially changes perioperative management, which may include a patient’s decision to cancel elective surgery or decide in collaboration with her physicians to undertake a different, lower risk surgery. In addition, there may be risks to the fetus if a pregnancy goes undetected before surgery & anesthesia. Because it is often not possible to reliably exclude pregnancy based on medical history taking alone, reproductive age women will be strongly encouraged to undergo pregnancy testing prior to surgery. In appropriate circumstances and at the discretion of the anesthesiologist and surgeon, a woman’s signed attestation will be accepted in lieu of a pregnancy test.

4. The anesthesiologist will obtain anesthesia consent, including a discussion with the patient, and/or patient representative, of the risks, benefits, and alternatives to the proposed anesthesia plan.

5. When applicable, the anesthesiologist will begin administration of the recommended preoperative dose of antibiotic for surgical site infection prophylaxis, as order by the operating surgeon, and document the drug, dose, route, and time of administration.

Peri-anesthetic Care

1. The anesthetist shall re-evaluate patients immediately prior to anesthesia induction, including an assessment of the airway.

2. The anesthetist shall conduct a routine check prior to administration of anesthesia to ensure readiness, availability, cleanliness, sterility, and working condition of all equipment used in the administration of anesthetic agents.

3. The anesthetist shall appropriately monitor the patient.

4. The anesthetist shall select and administer anesthetic agents to render the patient insensible to pain during the procedure.

5. The anesthetist shall support life functions under the stress of anesthetic, surgical, and obstetrical manipulations.

Post-anesthetic Care

1. The responsible anesthesiologist or CRNA administering anesthesia shall remain with the patient as long as necessary. For obstetrical anesthesia, this includes remaining until the neonate is delivered in cases of vaginal deliveries, and remaining until the second baby is delivered in the case of vaginal twin deliveries. The anesthesiologist or CRNA must communicate directly with the operating surgeon, obstetrician, or physician performing a procedure prior to physically leaving the operating or procedure room.

2. Prior to leaving the patient, the anesthesiologist will inform nursing staff and other members of the PACU team as well as relevant physician consultants of any specific problems presented by each patient.

3. Patients shall be discharged from the PACU or other recovery areas in accordance with policies established by the Department of Anesthesiology.

4. The period of post-anesthetic monitoring and/or observation is determined by the status of the patient and judgment of the anesthesiologist.

5. The anesthetist must perform and document a post-anesthesia evaluation of every patient within 48 hours of the time the patient was transferred to the PACU or other recovery area, and in the case of ambulatory patients, prior to discharge. This evaluation may not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation by answering questions appropriately and performing simple tasks. The post-anesthesia evaluation must include:
Medication Management

1. Prior to administration of anesthesia or intravenous sedation, the anesthetist shall log into Pyxis, remove all medication anticipated for the patient under the patient's name, and secure this medication in the locked anesthesia cart in the procedure room. No medications shall be left in the procedure room unattended by the anesthetist, unless secured in a locked cart.

2. Once the patient and practitioners are in the procedure room, the anesthetist unlocks the cart and prepares and labels medication anticipated for the patient.

3. At the end of each case, the anesthetist collects all remaining medications and does the following for each category:
   - Non-controlled substances that are unused and unopened are returned to the Pyxis return bin
   - Controlled substances that are unused and unopened are returned to the Pyxis return bin in the presence of a qualified witness under the appropriate patient's name
   - Non-controlled substances that are opened and/or partially used are disposed of by emptying the contents of the syringe, amp, or vial into the appropriate waste disposal bin, placing syringes into a sharps container, and placing all other containers into the regular garbage
   - Controlled substances that are opened and/or partially used are disposed of by using the Pyxis "waste" function to document the unused quantity under the appropriate patient's name, placing the syringe, amp, or vial along with the Pyxis transaction slip into a bag and then sealing and placing the bag into a secured external waste container — so that it is totally unrecoverable — all in the presence of a qualified witness

4. The anesthesia technician or nursing staff in each area will inspect anesthesia carts between cases and return any medications found not to be secured to the anesthetist for appropriate return or disposal.

5. The Quality Management and Pharmacy Departments will provide periodic reports to the Chief of Anesthesiology regarding each anesthetist's adherence to proper medication management procedures and reconciliation of controlled substances.

Safe Injection Practices for Infection Prevention

1. The following aseptic techniques will be followed when using needles, cannulas, and intravenous delivery systems to avoid contamination of sterile injection equipment:
   - Medications from a syringe will NOT be administered to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single-use items; they should NOT be reused for another patient or to access a medication or solution that might be used for a subsequent patient.
   - Fluid infusion and administration sets (IV bags, tubing, and connectors) will be used for ONE patient only and appropriately disposed of after use. A syringe or needle/cannula is considered contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
   - Single-dose vials for parenteral medications will be used whenever possible.
   - Medications from single-dose vials or ampules will NOT be administered to multiple patients and leftover contents will NOT be combined for later use. Single-dose vials typically lack preservatives; using these vials more than once carries substantial risks for bacterial contamination, growth, and infection.
   - If multi-dose vials must be used, both the needle/cannula AND syringe used to access the multi-dose vial must be sterile and a new sterile needle/cannula AND syringe must be used for
each entry. Only vials clearly labeled by the manufacturer for multiple dose use can be used
more than once.
• Multi-dose vials should NOT be kept in the immediate patient treatment area. They must be
stored in accordance with the manufacturer’s recommendations and discarded if sterility is
compromised or questionable.
• Bags or bottles of intravenous solution will NOT be used as a common source of supply for
multiple patients.

2. A surgical mask will be worn when placing a catheter or injecting material into the spinal canal or
subdural space, including myelograms, lumbar puncture, and spinal or epidural anesthesia.

PATIENT CARE GUIDELINES

NWH Surgical Services provides safe, effective, patient-centered care through clinical expertise,
hardwired safety tools, and advanced technology, enabled by a best-practice model of interdisciplinary
teamwork. All members of the Anesthesiology Department are expected to participate in and adhere
to the standards of the LifeWings patient safety program.

General

These standards apply to all patients who receive anesthesia or intravenous sedation. Such standards
do not apply during the administration of anesthetics only for analgesia, during the administration of
local anesthetics, or during the care of the obstetrical patient in labor unless medically indicated.
Under unusual circumstances, such as extreme emergencies, these standards may be modified. In
such cases, the circumstances shall be documented in the medical record.

Pre-anesthesia Care

1. The anesthesiologist, in concert with the attending physician or surgeon, shall be responsible for
determining the medical status of the patient, developing a plan for anesthesia care, and
acquainting the patient and/or patient representative with the proposed plan based upon the pre-
anesthesia evaluation, including the medical record review, history & physical examination, and
preoperative tests & consultations.

2. The anesthesiologist shall verify that the above has been properly performed and documented in
the medical record.

Anesthetic Monitoring

1. Qualified anesthetists shall be present in the room throughout the conduct of all general
anesthetics, regional anesthetics, and intravenous sedation.
• Because of the possibility of rapid changes in the patient’s status during anesthesia, only
qualified anesthesia staff (anesthesiologists & CRNAs) shall continuously monitor the patient
and provide anesthesia care
• The standard of care is attention to monitoring the patient without distraction, such as phone
calls, non-pertinent conversations, and irrelevant visitations
• In the event there is a direct known hazard (e.g. radiation) to the anesthetist, which might
require intermittent remote observation of the patient, some provision for monitoring the
patient must be made
• In the event that an emergency requires temporary absence of the responsible anesthetist,
the best judgment of the anesthesiologist will be exercised in comparing the nature of the
emergency with the condition of and risk to the anesthetized patient and in the selection of
the person left for anesthetic monitoring during the temporary absence

2. The patient’s oxygenation, ventilation, circulation, and temperature shall be continually evaluated
during anesthesia.
• Oxygenation: to ensure adequate oxygen concentration in the inspired gas and blood during
all anesthetics
Inspired gas: during every administration of general anesthesia using an anesthesia machine, the concentration of oxygen in the patient breathing system shall be measured by an oxygen analyzer, which includes a low oxygen concentration limit alarm.

Blood oxygenation: during all anesthetics, a quantitative method of assessing oxygenation, such as pulse oximetry, shall be used. Adequate illumination & exposure of the patient is necessary to assess the patient’s color.

- Ventilation: to ensure adequate ventilation of the patient during all anesthesia
  - Adequacy of ventilation for patients receiving anesthesia will be continually evaluated. Qualitative clinical signs (chest excursion, observation of the reservoir breathing bag, & auscultation of breath sounds), quantitative monitoring of the CO₂ content, and/or volume of expired gas will be evaluated unless invalidated by the nature of the patient, procedure, or equipment.
  - When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by a clinical assessment & by identification of CO₂ in the expired gas. End-tidal CO₂ quantitative analysis will be monitored throughout the time of endotracheal intubation or laryngeal mask placement.
  - When a mechanical ventilator is used, there shall be a continuous use of an alarm that is capable of detecting a disconnection of any component of the breathing system.

- Circulation: to ensure adequate circulatory function during all anesthesia
  - Every patient receiving anesthesia shall have the electrocardiogram continuously displayed from the beginning of the anesthesia until preparing to leave the anesthetizing location.
  - Every patient receiving anesthesia shall have arterial blood pressure and heart rate determined and evaluated at least every five minutes.
  - Every patient receiving general anesthesia shall have, in addition to the above, circulatory function continually evaluated by at least one of the following: palpation of the pulse, auscultation of heart sounds, monitoring of an intra-arterial pressure tracing, ultrasound peripheral pulse monitoring, or pulse plethysmography or oximetry.

- Body Temperature: to aid in the maintenance of appropriate body temperature during all anesthetics
  - There shall be readily available a means to continuously measure the patient's temperature. The temperature shall be measured when changes in body temperature are intended, anticipated, or suspected.

**Post-anesthesia Care**

1. All patients who received general anesthesia, regional anesthesia, or intravenous sedation shall receive appropriate post-anesthesia management.
   - The PACU, or an area that provides equivalent post-anesthesia care, shall be available to receive patients after surgery & anesthesia. All patients who receive anesthesia shall be admitted to the PACU except by specific order from the responsible anesthesiologist.
   - The medical care in the PACU shall be governed by policies & procedures approved by the Department of Anesthesiology.
   - The design, equipment, and staffing of the PACU shall meet the requirements of the Joint Commission, New York State Department of Health, and any other related accrediting or licensing body.
   - The PACU nursing standards of practice shall be consistent with those approved in 1986 by the American Society of Post Anesthesia Nurses (ASPAN), and as they may be revised and updated from time to time.

2. A patient transported to the PACU shall be accompanied by a member of the anesthesia care team who is knowledgeable about the patient’s condition. The patient shall be continually evaluated and treated during transport with monitoring and support appropriate to the patient’s condition.
3. Upon arrival to the PACU, the patient shall be reevaluated and the member of the anesthesia care team accompanying the patient shall provide a verbal report to the responsible PACU nurse.
   - The patient’s status on arrival in the PACU shall be documented.
   - Information concerning the preoperative condition and the surgical/anesthetic course shall be transmitted to the PACU nurse.
   - The member of the anesthesia care team accompanying the patient shall remain with the patient during emergence in the PACU until the PACU nurse accepts responsibility for the nursing care of the patient, or longer as necessary to meet the patient’s needs.

4. The patient’s condition shall be evaluated continually in the PACU.
   - The patient shall be observed and monitored by methods appropriate to the patient’s medical condition. Particular attention shall be given to monitoring oxygenation, ventilation, circulation, and body temperature. Pulse oximetry shall be employed during the initial phase of recovery.
   - The anesthesiologist shall be responsible for general medical supervision & coordination of the patient’s care in the PACU.

5. A physician is responsible for discharging the patient from the PACU.
   - All discharge criteria standards shall be approved by the Department of Anesthesiology.

**Regional Anesthesia or Analgesia for obstetrical patients**

1. Regional anesthesia should be initiated and maintained only in locations in which appropriate resuscitation equipment & drugs are immediately available to manage procedurally related problems.
   - Resuscitation equipment includes, but is not limited to:
     - Source of oxygen and suction
     - Equipment to maintain an airway & perform endotracheal intubation
     - Means to provide positive pressure ventilation
     - Drugs & equipment for cardiopulmonary resuscitation

2. Regional anesthesia will not be administered until the patient has been examined and the maternal & fetal status and progress of labor have been evaluated by a qualified physician with obstetrical privileges who is readily available to supervise the labor and manage any obstetrical complications that may arise.

3. Regional anesthesia for labor and/or vaginal delivery requires that the maternal vital signs and the fetal heart rate be monitored and documented by a qualified individual. Additional monitoring appropriate to the maternal and fetal condition shall be employed when indicated. When extensive regional blockage is administered for complicated vaginal delivery, pulse oximetry must be applied.

4. Qualified staff, other than the anesthetist attending the mother, shall be immediately available to assume responsibility for resuscitation of the newborn.
   - The primary responsibility of the anesthesiologist is to provide care to the mother. If the anesthesiologist is requested to provide brief assistance in the care of the newborn, the benefit to the newborn must be compared with the risk to the mother.

5. The anesthesiologist shall attend patients brought to the labor and delivery operating room for procedures including suturing, vaginal delivery of twins, dilation & curettage, and post-partum tubal ligations.

**Acupuncture**

1. Traditional Chinese acupuncture directs treatment at the most fundamental cause of disease that can be located, rather than merely seeking to remove or relieve pain or other symptoms without regard to cause. The patient is considered uniquely, rather than being labeled with a disease and then treated like others having the disease. When the patient is treated as an individual, the causative factor or factors in his or her state of health are more easily located and dealt with appropriately.
2. The procedure involves insertion of sterile, single-use, disposable acupuncture needles 0.1 to 0.5 inches into the skin for 5-10 seconds, until the desired effect has been produced on the pulses. Approximately 8-10 needles are used for each treatment, which lasts about 45 minutes long. Treatment may be provided every 2-3 days during a hospital admission. After removed, needles will be disposed of in accordance with NWH policy for needle disposal.

3. Acupuncture at Northern Westchester Hospital will be performed only by a practitioner who has been granted NWH privileges to perform acupuncture, when ordered by an attending physician member of the NWH Medical Staff for appropriate medical indications, which include, but are not limited to:
   - Adjuvant or alternative care of musculoskeletal pain, chronic pain syndromes, post-surgical pain
   - Reduction of pain during labor and delivery
   - Adjuvant to reduce chemotherapy-induced nausea and/or emesis
   - Adjuvant to reduce postoperative nausea and/or emesis
   - Reduction of perioperative anxiety
   - Reduction of constipation, diarrhea, and postoperative or post-traumatic paralytic ileus

4. Prior to the acupuncture visit, the acupuncturist will evaluate and interview the patient, including identification of the following conditions which require precautions:
   1. Acute pain
   2. Heart attack – chest pain, squeezing pressure, pain down left arm, nausea and vomiting, excess sweating.
   3. Shock – unconscious, cyanosis, white clammy skin, rapid breathing, confusion
   4. Seizures
   5. High Blood Pressure
   6. Excessive Blood Loss
   7. Human Bite
   8. Difficulty breathing, severe shortness of breath
   9. Large-mass tumor
   10. High fever, vomiting, extremely painful headache
   11. Symptoms similar to appendix attach, sharp epigastric pain
   12. Vomiting blood
   13. Severe weakness
   14. Not taking prescribed medications
   15. People who are senile
   16. Children under 7 years of age
   17. When patients are intoxicated or heavily sedated from pain medication
   18. Hemophiliacs or patients with clotting disorders
   19. Contraindicated for patients with needle phobia

5. The acupuncturist will describe the procedure and discuss the benefits, risks, and alternatives. The patient will be instructed to eat meals on the day of the appointment. If the patient is fasting, he or she will not be treated. A description of the procedure and the response will be noted in the medical record, including any follow-up recommendations.

MEDICAL RECORDS

Documentation

1. The Anesthesiology Department is responsible for the thorough documentation of the components of the continuum of anesthesia care, including the pre-anesthesia evaluation, intraoperative events, and the post-anesthesia evaluation.

2. The anesthesiologist medical evaluation shall be documented in the medical record and include a medical history, an anesthesia history, a medication history, an appropriate physical examination including an assessment of the patient’s airway, review of objective diagnostic data, assignment of the patient’s American Society of Anesthesiologists physical status (ASA class), and a formulation and discussion of an anesthesia plan with the patient and/or patient representative.
3. The anesthesiologist shall document a time-based record of all pertinent intraoperative events that occur during the induction, maintenance, and emergence from anesthesia, including:
   - Re-evaluation of the patient and check of the equipment, drugs, and gas supply immediately prior to the initiation of anesthesia
   - Monitoring of the patient’s parameters, including blood pressure and pulse
   - Dosage, time, and duration of all anesthetic agents
   - Dosage, time, and duration of other drugs, intravenous fluids, blood, and blood products
   - Techniques used
   - Intraoperative abnormalities or complications
   - The general condition and status of the patient at the conclusion of the anesthesia

4. Documentation of post-anesthesia care shall include:
   - Evaluation of the patient on admission to and discharge from the PACU
   - A time-based record of vital signs and level of consciousness
   - Dosages and administration times of all medications
   - Type and amount of all intravenous fluids, blood, and blood products administered
   - Any unusual events, including post-anesthesia or post-procedural complications
   - For inpatients, a post-anesthesia follow-up evaluation by the anesthetist who administered the anesthesia or an individual qualified to administer anesthesia during the period between three (3) and forty-eight (48) hours following the surgery, which includes the presence or absence of anesthesia related abnormalities or complications and documentation of the general condition of the patient

**Consent**
The anesthesiologist shall ensure that documentation of anesthesia informed consent is completed, signed, and included in the medical record.

**EDUCATION AND CONFERENCES**
The Anesthesiology Department Attending Physicians and CRNAs shall attend periodic Departmental meetings, when applicable, and are responsible for remaining informed of all Departmental policies & procedures.
DEPARTMENT OF EMERGENCY MEDICINE

LEADERSHIP

1. The Chief of the Department of Emergency Medicine shall also serve as the Emergency Department Director, and shall be a diplomate of the American Board of Emergency Medicine with current certification in Advanced Cardiac Life Support (ACLS) or the equivalent.

2. In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Emergency Medicine shall be responsible for:
   a. Supervision and control of the Emergency Department
   b. Recruitment and scheduling of Emergency Medicine Attending staff to ensure continuous coverage of the Emergency Department
   c. Serving as the collaborating or supervising physician for Emergency Department Advanced Practice Nurses or Physician Assistants
   d. Oversight of medical control and direction of pre-hospital emergency medical services (EMS)
   e. Delegating responsibility, as indicated, to the Emergency Department Associate Director

STAFFING

1. Emergency Department staffing shall at all times include at least one qualified Emergency Department Attending Physician who has been granted NWH Emergency Medicine privileges, and may at times include a second Emergency Department Attending Physician and/or a Nurse Practitioner.

2. Emergency Department Attending Physicians and Nurse Practitioners shall maintain certification by the American Heart Association in Basic Cardiac Life Support (BCLS) and Advanced Cardiac Life Support (ACLS) Certification or the equivalent training.

3. A monthly schedule of Emergency Department Attending Physicians and Nurse Practitioners will be posted prior to the first of each month.

4. No Emergency Department Attending Physician or Nurse Practitioner shall be scheduled for more than twelve consecutive hours of work.

5. Emergency Department Attending Physicians are members of the NWH Primary Stroke Team, and must continue ongoing education in this field as required by New York State Department of Health.

DEPARTMENTAL OPERATIONS

Procedure

1. The NWH Emergency Department shall provide medical care to all patients presenting for treatment. This care shall include evaluation and initial management and treatment or recommendation for admission or transfer to another facility that can provide definitive treatment, in accordance with the Medical Staff Rules & Regulations regarding transfer of care.

2. All medical care shall be provided under the direction and control of the Emergency Department Director or designated Emergency Department Attending Physician.

3. The flow of patients presenting to the Emergency Department shall be under the direction of the Emergency Department Flow Coordinator, who shall be a registered professional nurse.
4. Patients whose signs and symptoms suggest a level of care considered urgent or emergent, who are likely to require admission to the Hospital, who may require a prolonged diagnostic and therapeutic intervention, who are unexpectedly returning to the department for the same complaint as a previous visit, or who request an evaluation by a physician in place of a nurse practitioner, must be seen by an Emergency Department Attending Physician.

5. All cases of suspected child abuse or neglect shall be treated and reported immediately to the New York State Central Register of Child Abuse and Maltreatment pursuant to Social Services Law.

**Ambulance Diversion**

1. The Emergency Department shall request ambulance dispatcher services to divert patients with life threatening conditions to other hospitals only when the Emergency Department Director or designated Attending Physician AND the Hospital CEO or designated Administrator determine that acceptance of an additional critical patient would endanger the life of that patient or another patient.

2. The need for diversion shall, at a minimum, be re-evaluated at each shift.

**Consultants**

1. Each NWH Medical Staff Department or Surgical Division with sufficient practitioner staffing shall submit to the Medical Affairs Department a monthly schedule of Attending Physicians to provide emergency coverage to the Emergency Department 24 hours a day, seven days a week, in accordance with patient needs.

2. The Emergency Department Attending or Nurse Practitioner may request on-site consultative evaluations on patients in the Emergency Department when deemed necessary. The consultant has the obligation to arrive in the Emergency Department within a reasonable time to perform an evaluation and make clinical recommendations. If the consultant selected by the Emergency Department practitioner and/or patient is not available within a reasonable time frame, it is the responsibility of the on-call specialist for the pertinent specialty to be available within the appropriate timeframe, in accordance with Medical Affairs Policies and Procedures for Emergency Department Consultation.

3. The Medical Staff shall ensure availability of consultants for emergencies in times of inclement weather and other adverse or disaster conditions that may impact patient care as follows:

   a. If inclement weather or other adverse or disaster conditions are forecasted or predicted, the CEO, Chief Medical Officer, Chief of Emergency Medicine, Chairman of the Medical Board, and President of the Medical Staff, or their respective designees shall discuss and determine to the best of their ability the likelihood of how the storm will impact patient care and consultant availability.
      i. NWH Category A Condition: a potential significant increase in patient volume, a potential for interference in communication, a potential impact on the ease of travel by consultants
      ii. NWH Category B Condition: a significant impact on the ease of travel by consultants making it highly likely that they will not be able to arrive at the hospital to care for patients in a reasonable amount of time

   b. NWH Category A Condition: Under the direction of the Chief of Emergency Medicine, Emergency Department staff will contact the on-call physician from each specialty to discuss the potential impact, develop a communication plan, and confirm the specialists ability to travel to the Hospital if necessary to care for a patient.

   c. NWH Category B Condition: Under the direction of Senior Administration and Physician Leadership, staff will contact the on-call physician from each specialty, as described for a Category A Condition. In addition, Senior Administration and Physician Leadership may mandate the continued availability of an on-call specialist for each of the following Departments and Divisions on site at the Hospital: Gastroenterology, Critical
Care/Pulmonary Medicine, Interventional Radiology, Pediatric Hospitalist, Neonatology, General Surgery, Neurosurgery, Orthopedic Surgery, Otolaryngology, Urology, Vascular Surgery, Obstetrics, and Psychiatry. If the on-call specialist is unable to provide on-site availability, he/she is responsible for contacting the Department/Division Chief to arrange for an alternative specialist to provide on-site coverage.

4. For surgical consultations in patients with problems following and possibly related to specific surgical procedures, whenever possible, the surgeon who did the initial procedure should be contacted.

5. When general surgery consultation is needed:
   a. the general surgeon on-call should be contacted for patients age sixteen (16) and older or for emancipated minors (young teenagers who are pregnant, have children, or are living independently)
   b. the pediatric surgeon on-call should be contacted for patients from birth up until their sixteenth (16th) birthday or for problems that are unique to pediatric surgery (e.g. congenital esophageal atresia)

6. Injuries:
   a. The on-call orthopedic surgeon should be contacted for consultation and/or follow-up for patients with fractures of spine, shoulder, pelvis, and upper and lower extremities, including wrist, foot, & ankle fractures and for suspected compartment syndrome of extremities
   b. The on-call plastic surgeon should be contacted for consultation and/or follow-up for patients with skin & soft tissue injuries, including burns that do not require referral to a designated burn center
   c. For those dates in which a hand service physician is assigned to providing 24 hour coverage, he/she will be responsible for bony injuries of the metacarpals and phalanges of the hand, and soft tissue injuries distal to the elbow. When there is no designated hand service physician on call, the on-call orthopedic surgeon is responsible for bone injuries and the on-call plastic surgeon is responsible for skin and soft tissue injuries, as outlined in sections a and b above.

**PATIENT CARE GUIDELINES**

**General**

1. Patients should be treated in the order of seriousness of the emergency.

2. Patients presenting to the Emergency Department for care should be treated promptly and, when practical, with a goal of seeing a practitioner within thirty minutes of the patient’s arrival.

3. The Emergency Department Flow Coordinator will assign each patient to a clinical team including an attending physician or nurse practitioner, at least one registered or licensed professional nurse, in some cases an Emergency Department technician, and a Business Associate.

4. The Emergency Department clinical team will coordinate the diagnostic and therapeutic care of each patient under the direction of the Attending Physician or Nurse Practitioner.

5. During the hours from 8:00 AM – 5:00 PM on Monday thru Friday and at other times when a Pediatric Hospitalist may be present in the Hospital, the Emergency Department Flow Coordinator will call the Pediatric Hospitalist to evaluate any patient under age 16 years, who has been waiting to see the ED Attending Physician or Nurse Practitioner for greater than one (1) hour if the ED practitioner will most likely not be able to see that child for another thirty (30) minutes. In such cases, the Pediatric Hospitalist will be assigned a computer in the ED and integrated into the ED team responsible for caring for the child.
6. No patient shall remain under evaluation and observation in the Emergency Department for
greater than eight hours. If additional time is required to determine a diagnosis and treatment
plan, the patient should be admitted to the Hospital for observation or inpatient services.

**Radiological Examinations**

1. Except in immediately life-threatening situations, no females of child-bearing potential will
undergo a radiological examination without an evaluation for pregnancy, which may include, at the
discretion of the Emergency Department Attending Physician or Nurse Practitioner, either a urine
or serum HCG test or a Pregnancy Declaration form signed by the patient indicating that she is not
pregnant.

2. Emergency Department Attending Physician and Nurse Practitioners reviewing plain radiographic
examinations shall document a brief interpretation in the “Notes” section of the PACS system,
unless the radiologist’s review and interpretation is already present in the electronic medical
record.

**Follow-up Care**

1. The Attending Physician or Nurse Practitioner treating the patient in the Emergency Department is
responsible for advising the patient of the recommended follow-up care.

2. The practitioner shall provide the patient with:
   a. Printed discharge instructions that include the names and contact information for any
      physicians to whom they are being referred
   b. A list of any new medications, reconciled with their previous medications, when applicable
   c. Prescriptions for medications, when applicable

3. Patients shall be referred back to their community primary care physician for follow-up care. If
the patient has no physician in the community and requires or requests primary care follow-up, he
or she will be referred to a physician on the NWH Medical Staff, based on the pertinent on-call
schedule.

4. Patients requiring follow-up with a specialist will be referred to the appropriate on-call specialist,
who shall be professionally responsible for care of the problem for which the patient sought
emergency treatment, regardless of insurance status or ability to pay.

**Admissions**

*Medical and Telemetry Admissions*

1. Emergency Department Attending Physicians will obtain general and symptom-specific baseline
diagnostic data and perform an assessment sufficient to develop a working diagnosis and the
appropriate disposition for the patient, prior to consulting an admitting internal medicine
physician.

2. If an Internal Medicine Hospitalist accepts the patient for admission to a medical or telemetry unit,
the Emergency Department Attending Physician will provide holding orders which include diet,
activity, intravenous fluids, medications for pain and other symptoms, and vital sign monitoring,
so that the patient can be transported to the medical or telemetry care center. In such cases, the
Hospitalist will assume responsibility of the patient’s care as soon as the patient leaves the
Emergency Department, and will evaluate the patient on the unit within 90 minutes of accepting
the patient for admission.

3. If an Internal Medicine Hospitalist is uncertain of the need for admission of the patient, the
Hospitalist will evaluate the patient in the Emergency Department within 30 minutes of receiving
notification from the Emergency Department Physician. In such cases, the Internal Medicine
Hospitalist may do one of the following:
a. Evaluate and admit the patient within one hour
b. Evaluate and discharge the patient within one hour with an appropriate follow-up care plan
c. Consult an intensivist or other specialist to admit the patient
d. Coordinate additional evaluation and therapeutic trial, which in no case shall last longer than two hours, before coming to a disposition decision

4. If the patient’s private internal medicine or family medicine physician accepts the patient for admission, the private physician may give telephone admission orders or attend to the patient in the Emergency Department within the appropriate time frame. Once admission orders are given, the private internal medicine or family medicine physician assumes the responsibility for the patient’s care.

Critical Care Admissions

1. Emergency Department Attending Physicians will order general and symptom-specific baseline diagnostic data and perform an assessment sufficient to determine that the patient is in need of critical care and contact the on-call Intensivist.

2. The on-call Intensivist will respond to the Emergency Department in accordance with the Medical Affairs Critical Care Program Policy.

Surgical Admissions

1. Patients who require admission for a surgical problem shall be admitted under the care of the appropriate surgical attending physician.

2. After 7:00 PM, if the admitting surgeon indicates the need for a routine perioperative medical evaluation, the Emergency Department may contact the on-call NWH or MKMG internal medicine hospitalist to inform them of the request. The surgeon is responsible for evaluation of the patient prior to 9:00 AM the following day and available any time prior should the patient’s symptoms or condition progress. If the patient has a unique medical or surgical condition, the admitting surgeon is responsible for directly contacting and communicating with the internal medicine hospitalist to discuss the patient’s plan of care and the anticipated arrival time of the surgeon.

Determination of admitting service

1. In general, patients should be admitted to the service that cares for the primary problem causing the need for admission. Additional specialists are available as consultants and to provide ongoing care of co-existing medical problems.

2. In cases of differing opinion among attending physicians, the Emergency Department Attending has the ultimate authority to determine the appropriate admitting service. A Medical Staff attending physician may appeal the decision of the Emergency Department Attending AFTER performing an evaluation of the patient, by contacting his/her Department or Division Chief, the Emergency Department Director, or the Hospital’s Chief Medical Officer.

3. Guidelines for adult patients admitted for abdominal pain are as follows:

   General Surgery
   - Acute abdominal pain with signs of peritonitis or perforation
   - Small bowel obstruction with signs of air outside the bowel
   - Pancreatitis secondary to cholelithiasis
   - Acute cholecystitis

   Medicine
   - Diverticulitis without signs of perforation
   - Pancreatitis secondary to alcohol or other toxins
   - Uncomplicated small bowel obstruction or abdominal pain of unclear etiology without clinical or radiographic signs of peritonitis or perforation (general surgeon must be in as a consultant to
evaluate and examine patients admitted overnight before 12:00 PM of admission day one and available at any time prior should the patient’s symptoms progress)
MEDICAL RECORDS

Documentation
1. All ED visits will have appropriate documentation (dependent on the presenting complaint) recorded in the ED record, including the patient’s history and physical examination. ED Staff Practitioner evaluations will be recorded on the appropriate electronic documentation template.

2. All ED Practitioner documentation must be dated, timed, and signed.
   - All electronic entries into the EMR will automatically capture the date and time.
   - All paper documentation, including consent forms, MOLST forms, behavioral health emergency admission forms, and any other paper documents, must be dated, timed, and signed by the practitioner.

3. The diagnosis and disposition of all ED patients must be recorded in the EMR.

4. Discharge Instructions will be documented in the EMR for each ED patient who is treated and released from the ED.

5. Patients transferred from the NWH ED to another facility for any reason must have an EMR Transfer Order, which includes the appropriate checklist and documentation.

6. For patient admitted to the Hospital, the Emergency Department record shall be integrated into the inpatient record.

Consent
1. Every patient seen in the Emergency Department will sign a form indicating consent for treatment and acknowledgement of HIPAA notification.

2. In the case of a minor or patient who lacks capacity, the parent or legal representative must sign the document.

3. In the case of a life-threatening condition, where postponement of treatment would be hazardous to the patient’s health, the Attending Physician will take the responsibility of treatment without consent, after a reasonable effort is made to contact a responsible party. A note outlining the situation shall be documented in the Medical Record by the Attending Physician.

4. At any point in care, non-minor patients who have capacity to understand the advice of the Emergency Department practitioner regarding diagnosis or treatment, but refuse to accept such advice should be asked to sign a refusal or Leaving Hospital Against Advice form. If the patient is, for any reason, not willing to sign any forms, the Attending Practitioner shall document this in the medical record.

EDUCATION AND CONFERENCES
1. Emergency Department Attending Physicians must complete each year a minimum of four hours of continuing medical education pertinent to the care of patients with acute stroke.

2. The Emergency Department Attending Physicians and Nurse Practitioners will meet at least on a quarterly basis to discuss and update departmental policies and procedures to improve the quality of patient care, communicate Hospital-wide updates, review Emergency Department quality measures established by the Quality Management Committee of the Medical Board, and review and evaluate the medical care of selected cases.
DEPARTMENT OF MEDICINE

LEADERSHIP

In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Medicine shall be responsible for:

a. Oversight of the Internal Medicine Hospitalist Program, in conjunction with the Medical Director of the Program and the Chief Medical Officer (CMO) of the Hospital

b. Oversight of any programs within medicine subspecialty Divisions, including the Critical Care Program and Stroke Program, in conjunction with the designated Division Chief or program director and the CMO of the Hospital

STAFFING: ON-CALL

1. Members of the Department of Medicine will be assigned, on a rotating basis, to an internal medicine emergency on-call schedule, and will be available to provide care to internal medicine patients (age 18 and older) who are not private patients of members of the Department and present to the NWH Emergency Department with a need for follow-up ambulatory care.

   a. The internal medicine emergency on-call schedule will include physicians in the Department of Medicine who are not members of a subdivision, as well as those physicians in the following subdivisions: Endocrinology, Rheumatology, and Family Practice

   b. Family Practice Physicians will participate in the internal medicine on-call schedule and the pediatric on-call schedule on a rotating basis

   c. Internal Medicine Physicians whose practice is limited to Allergy & Immunology will be excused from the internal medicine emergency on-call schedule

2. The Chief of each of the following Divisions of the Department of Medicine shall provide the Medical Affairs office with a monthly schedule of on-call physicians to provide continuous coverage for emergency care:
   
   - Cardiology
   - Critical Care/Pulmonary Medicine
   - Dermatology
   - Gastroenterology
   - Neurology
   - Oncology

3. Attending Physicians in the Internal Medicine Hospitalist Program will provide care to and assume professional responsibility for patients age 18 and over who are not private patients of members of the Department and present to the NWH Emergency Department requiring inpatient admission to the hospital for medical care or medical consultation.

4. Upon discharge of patients who do not have a primary care physician, the Internal Medicine Hospitalist attending will arrange for patients to have follow-up and ongoing care with either the Open Door Family Medical Clinic or the internal medicine physician who was on-call on the day the patient was admitted to the Hospital, or an internist in the community who accepts the responsibility of assuming medical care.
DEPARTMENTAL OPERATIONS

Internal Medicine Hospitalist Program

1. The Internal Medicine Hospitalist Program is available to provide care to Department members’ private patients for:
   - Admissions through the Emergency Department
   - Direct admissions from physicians’ offices
   - Medical Consultation to the Emergency Department, Surgical Services, Obstetrical Service, and Behavioral Health Unit

2. All members of the Department of Medicine who choose to have their patients admitted to the NWH Internal Medicine Hospitalist service are expected to:
   - Work collaboratively with the Internal Medicine Hospitalists toward providing high quality clinical care to patients
   - Maintain ongoing communication with the Internal Medicine Hospitalist regarding the care of their patients
   - Be available to be involved in medical care decisions at the request of the patient and/or family or representative
   - Provide the necessary follow-up care to their patients in the appropriate time frame after discharge from the Hospital, or make other coverage arrangements for such follow-up
   - Remain in compliance with all Medical Staff Rules & Regulations and Policies & Procedures, including timely completion of Medical Records

3. When private patients of members of the Department of Medicine are admitted to the Internal Medicine Hospitalist Program, the Hospitalists shall:
   - Promptly notify the primary care physician (or designated covering physician) about the admission
   - Update the primary care physician following any significant changes in the patient’s condition, as well as at discharge
   - Provide a comprehensive discharge summary to the primary care physician, ideally within 48 hours following discharge
   - Request inpatient consultations in accordance with the preferences of the patient’s primary care physician

4. The Internal Medicine Hospitalists shall serve as members of the NWH Rapid Response Team.

5. In the rare event that inpatient and Emergency Department care cannot be carried out by the Internal Medicine Hospitalist Program due to extreme and unforeseen causes leading to the inability to meet the needs of patients, the Chief of Medicine and/or the CMO will be notified. After review of the circumstances and if no other option is available, the Chief of Medicine and/or CMO shall:
   a. Assign the responsibility for care of internal medicine patients in the Emergency Department and/or in the Hospital who are not private patients of members of the Department to the on-call internist
   b. Communicate to all members of the Department the need for them to assume care and professional responsibility for their own private patients who are in the Hospital or who present to the Emergency Department in need of consultation or admission
Critical Care Program

1. The NWH Intensivist Group will provide continuous care to patients admitted to the Critical Care Unit, in accordance with the Critical Care Program Policy.

2. For Medical patients admitted to the Critical Care Unit:
   - The Primary Care Internist/Hospitalist will be the Attending Physician and the Intensivist will be the consultant for patients admitted to the Critical Care Unit
   - The Intensivist will assume primary responsibility for each Medical patient while he/she is in the Critical Care Unit
   
   Exception:
   The Attending Cardiologist shall assume primary responsibility for patients admitted to the Critical Care Unit chiefly for a cardiovascular condition, unless the cardiologist requests otherwise. The Intensivist shall not provide consultation or care to these cardiovascular patients unless specifically requested by the Cardiologist.

3. For Surgical patients admitted to the Critical Care Unit:
   - The Attending Surgeon shall continue primary responsibility for surgical and postoperative care
   - The Intensivist shall provide mandatory consultation and ongoing medical care while the patient is in the Critical Care Unit

Proctoring for Medical Procedures

1. Attending Physicians in the Department of Medicine with provisional privileges within a particular Division may only perform the following procedures with another non-provisional attending member of the Division, acting as a proctor:
   - Upper Endoscopy, until completion of at least three (3) cases at NWH
   - Colonoscopy, until completion of at least five (5) cases at NWH
   - Endoscopic Retrograde Cholangiopancreatography (ERCP), until completion of at least five (5) cases at NWH
   - Transesophageal Echocardiography, until completion of at least two (2) cases at NWH
   - Bronchoscopy, until completion of at least two (2) cases at NWH

2. The number of procedures required to be performed with another non-provisional attending member of the Division may be extended at the discretion of the proctor, the Division Chief, the Department of Medicine Chief and/or the CMO.

3. The Chief of each Division of the Department of Medicine shall, from time to time, develop proctor or preceptor policies and rules for performing new procedures, based upon education, training, and certification requirements and the complexity of the new procedure. Such policies and rules shall be approved by the Chief of the Department of Medicine and the Medical Board.

PATIENT CARE GUIDELINES

General
Members of the Department shall provide patient care in accordance with generally accepted standard of medical practice. Each division shall, from time to time, develop or adopt consensus-basis practice guidelines from organizations such as the American College of Physicians, the American College of Cardiology, the American Heart Association/American Stroke Association, the American College of Gastroenterology, the American College of Chest Physicians, and other professionally recognized organizations.
Inpatient Admissions

1. Patients admitted to the Medical Service must have a complete history & physical examination within twenty four (24) hours of admission by the responsible or covering internal medicine or family medicine attending physician or Internal Medicine Hospitalist.

2. The attending or covering internist must visit patients on a daily basis throughout the course of their hospitalization, with a daily notation entered in the patient’s medical record.

Consultations

Consultation shall be obtained by the appropriate medical specialist when patients present with complex problems beyond the scope of practice or clinical privileges of the internal medicine attending or Hospitalist.

EDUCATION AND CONFERENCES

All Department of Medicine Attending Physicians shall attend Departmental meetings and Division meetings, when applicable, and remain informed of all Departmental and Division policies & procedures.
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

LEADERSHIP

In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Obstetrics & Gynecology shall be responsible for:

a. Oversight of the professional and administrative activities in the Labor & Delivery Unit, the Maternity Unit, the Operating Room, and the Prenatal Clinic, each of which he/she may delegate to the Associate Chief for Gynecology, Medical Director of the Prenatal Clinic, and/or any Division Chief within the Department of Obstetrics & Gynecology.

b. Collaboration with the medical & administrative leadership of the Department of Pediatrics and the Division of Neonatology to ensure effective newborn care and a high quality of care and communication in the Hospital’s NY State designated Level III Perinatal Care Program.

STAFFING: ON-CALL

1. Members of the Department of Obstetrics & Gynecology will be assigned, on a rotating basis, to provide care to and assume professional responsibility for patients who are not private patients of members of the Department and present to the NWH Emergency Department requiring admission to the hospital for obstetrical or gynecological care, or specialty consultation, or follow-up ambulatory care.

2. The rotation of assignment will be for a period of one month at a time, and a copy of such schedule will be provided periodically to the Medical Affairs Department for distribution to the Hospital and Emergency Department.

3. If an obstetrical or gynecological attending of record for a private patient wishes to make arrangements for coverage of his/her patients, he/she will make arrangements with another qualified obstetrician and/or gynecologist with clinical privileges at NWH. It is the responsibility of the attending physician to notify the members of the patient care staff caring for the patient.

DEPARTMENTAL OPERATIONS

Gynecological Surgery

The Rules and Regulations that apply to the Department of Surgical Services shall be applicable to all Gynecological Surgery, except where specifically noted.

Provisional Privileges

1. Attending Physicians in the Department of Obstetrics & Gynecology with provisional privileges are required to consult with a non-provisional attending obstetrician for the following conditions:
   - Preterm labor or delivery prior to thirty-four (34) weeks gestation
   - Preterm premature rupture of the membranes prior to thirty-four (34) weeks gestation
   - Multiple birth if anticipating a vaginal delivery
   - Severe pre-eclampsia
   - Any major antenatal or postpartum complication

2. Attending Physicians in the Department of Obstetrics & Gynecology with provisional privileges may only perform the following procedures with another non-provisional attending member of the Department:
• Major gynecological surgery, until completion of five (5) cases at NWH
• Operative laparoscopy, until completion of five (5) cases at NWH
• Cesarean section until completion of ten (10) cases at NWH, five (5) of which are to be
  with the assistance of an attending physician who is not a member of the provisional
  attending physician’s practice.

3. For the purpose of the above requirement, “non-provisional attending members of the
Department” includes those attending physicians whose privileges are limited to assisting.

4. The above requirements may be adjusted on the basis of previous experience and clinical
performance at the discretion of the Department Chief.

PATIENT CARE GUIDELINES

General

1. All members of the Department are expected to actively participate in the NWH Managing
Obstetrical Risk Efficiently (MORE-OB) patient safety program.

2. Members of the Department shall provide patient care with adherence to the standards set forth
by the American College of Obstetricians & Gynecologists (ACOG) and in accordance with NY State
public health law.

3. Attending Physicians in the Department of Obstetrics & Gynecology will administer only local and
pudendal anesthesia, unless specifically credentialed to do otherwise by the current Chief of
Anesthesiology and with approval by the Governing Board.

4. Women shall be provided the opportunity to make an informed choice with regard to options for
treatment, care, & technological support that are expected to be available at the time of labor &
delivery.

5. Obstetrical patients have the right to request and receive a primary cesarean section. Patients
requesting a primary cesarean section who are in labor or with ruptured membranes shall be
treated as urgent, rather than elective cases, and be done in a timely fashion. In such cases, the
attending obstetrician shall document that the patient has requested a primary cesarean section,
and the attending anesthesiologist will discuss and document any anesthetic concerns or risks.

Admissions

1. Patients admitted to the Labor & Delivery unit without complications or contraindications who have
had pre-natal care may have an initial pelvic examination by qualified nursing staff to evaluate
labor status & the imminence of delivery. The nursing staff shall inform the responsible attending
or covering obstetrician or certified nurse-midwife of her status. Qualified nursing staff includes
registered professional nurses who have met the Patient Care Department competency
requirements for obstetrical nurses, including electronic fetal monitoring interpretation.

2. Patients admitted to the Labor & Delivery unit who have had no pre-natal care or are in an acute
state such as preterm labor or preterm premature rupture of the membranes must be evaluated
by her attending or covering obstetrician within sixty (60) minutes of his/her being notified of the
patient’s arrival to the Labor & Delivery unit.

3. Patients admitted to the Labor & Delivery unit with active vaginal bleeding, pre-eclampsia, or any
unstable medical problem must be evaluated by her attending or covering obstetrician within thirty (30)
minutes his/her being notified of the patient’s arrival to the Labor & Delivery unit.

4. Chemical induction or augmentation of labor may be initiated only after the attending obstetrician,
or qualified certified nurse-midwife in collaboration with the attending obstetrician, has evaluated
the woman, determined that induction or augmentation is medically necessary for the woman or
fetus, recorded the indication, and established a prospective plan of management acceptable to
the woman. During the entire time of the infusion of oxytocin (or other substance used to induce
or augment labor), the attending obstetrician, a qualified certified nurse-midwife in collaboration with the attending obstetrician, or another physician who has assumed responsibility for the patient’s care, shall be immediately available and within the grounds of the hospital to manage any complications that may arise.

5. The attending or covering obstetrician, gynecologist, or certified nurse-midwife must visit patients on a daily basis throughout the course of their hospitalization, with a daily notation entered in the patient’s medical record.

6. Patients on the Obstetrical or Gynecological service must be seen by the attending obstetrician or gynecologist or covering practitioner on the day of or evening prior to discharge.

Consultations

1. Patients who are pregnant and require hospital admission primarily for medical or surgical problems that are not obstetrical or gynecological conditions will be admitted to the service that will provide care for the condition necessitating admission, but will have consultation by an attending obstetrician within 24 hours, or sooner if requested by the admitting physician. Such patients will be placed on the patient care unit best able to provide care for the patient, as determined by the attending physician and nursing leadership.

2. Patients who are pregnant being admitted for urinary tract infection, abdominal pain without clear etiology, or conditions pertaining to pregnancy, delivery, or the puerperal period will be admitted to the maternity unit on the service of their attending obstetrician, who may consult the appropriate specialist(s).

3. If a patient develops a major complication, the attending obstetrician or gynecologist will seek consultation with the appropriate specialist(s).

4. In the event of a major complication, the Chief of Obstetrics & Gynecology, or his designee, shall be notified.

MEDICAL RECORDS

Documentation

1. Attending obstetricians shall, in a timely manner, provide the Hospital Labor & Delivery unit a copy or abstract of an obstetrical patient’s prenatal record, if existing, including a maternal history & physical examination as well as results of maternal & fetal risk assessment and ongoing assessments of fetal growth & development & maternal health.

2. Information regarding the woman’s HIV counseling and HIV status must be included as part of her medical history and provided to the Hospital Labor & Delivery unit.

3. It is expected that operative reports and the summary of labor and delivery will be completed or dictated immediately after the surgery or delivery. The dictated report shall in no case be completed later than twenty-four (24) hours after the surgery or delivery.

EDUCATION AND CONFERENCES

All Obstetrics & Gynecology Department Attending Physicians shall attend a minimum of fifty percent (50%) of Departmental meetings and remain informed of all Departmental policies & procedures.
DEPARTMENT OF PATHOLOGY

LEADERSHIP

In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Pathology shall be responsible for:

1. Proctoring all new department members for a minimum of three months, six months for newly trained pathologists, and longer when necessary as determined by the Chief

2. Review of activities will include the following performance indicators:
   - Real time review of all frozen sections prior to report
   - Review of all new malignant diagnoses prior to report
   - Real time review of all clinically significant diagnoses prior to report
   - Review of all signed reports for clarity, coherence, and conformance to department standardized reporting manual
   - Random review of 10% of completed cases
   - Review of cases submitted for intradepartmental consultation with individual’s provided diagnosis

STAFFING

All members of the Department of Pathology & Laboratory Medicine must be competent to perform all categories of practice delineated by the chief, which include:

1. Surgical pathology, cytopathology, and autopsy pathology

2. Clinical consultation regarding anatomic pathology services

3. Provision of medical direction and technical supervision to the clinical laboratory, blood bank and transfusion service

4. Performance of interpretation of diagnostic laboratory tests with consultation services for clinicians regarding patient test results
DEPARTMENT OF PEDIATRICS

LEADERSHIP

In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Pediatrics shall be responsible for:

1. Oversight of the Pediatric Hospitalist Program, in conjunction with the Medical Director of the Program and the Chief Medical Officer (CMO) of the Hospital.
2. Collaboration with the medical & administrative leadership of the Department of Obstetrics and Gynecology and the Division of Neonatology to ensure effective newborn care and a high quality of care and communication in the Hospital’s NY State designated Level III Perinatal Care Program.
3. Collaboration with the pediatric subspecialty programs to ensure that the programs are meeting the needs of our pediatric patient population.

STAFFING: ON-CALL

1. Members of the Department of Pediatrics will be assigned, on a rotating basis, to an emergency on-call schedule, and will be available to provide care to pediatric patients (age less than 18) who are not private patients of members of the Department and present to the NWH Emergency Department with a need for follow-up ambulatory care.
2. The Pediatric Hospitalists will provide care to and assume professional responsibility for patients under age 18 who are not private patients of members of the Department and present to the NWH Emergency Department requiring admission to the hospital for pediatric care or pediatric consultation.
3. In the rare event that pediatric inpatient and Emergency Department care cannot be carried out by the Pediatric Hospitalist Program due to extreme and unforeseen causes leading to the inability to meet the needs of pediatric patients, the Chief of Pediatrics and/or the CMO will be notified. After review of the circumstances and if no other option is available, the Chief of Pediatrics and/or CMO shall:
   a. Assign the responsibility for care of pediatric patients in the Emergency Department and/or in the Hospital who are not private patients of members of the Department to the on-call pediatrician
   b. Communicate to all members of the Department the need for them to assume care and professional responsibility for their own private patients who are in the Hospital or who present to the Emergency Department in need of consultation or admission

DEPARTMENTAL OPERATIONS

Pediatric Hospitalist Program

The Pediatric Hospitalist Program is available to provide hospital care to Department members’ private patients:

1. Pediatric patients referred to the Emergency Department will be evaluated by the Emergency Department attending physician. The Emergency Department attending may then contact the Pediatric Hospitalist, if indicated, for consultation, further evaluation, or admission.
2. During the hours from 8:00 AM – 5:00 PM, patients may be admitted directly to the Pediatric Unit if all of the following have been met:
   a. The patient has been seen on the day of admission by his/her pediatrician
- The patient’s pediatrician has communicated and exchanged information with the Pediatric Hospitalist
- The Pediatric Hospitalist is in agreement with the need for admission
- The patient is clinically stable
- The nursing staff can accept the patient and there is an available bed on the unit
- Any infant with hyperbilirubinemia may be directly admitted to the Pediatric Unit

PATIENT CARE GUIDELINES

General

1. Members of the Department shall provide patient care with adherence to the standards set forth by the American Academy of Pediatrics (AAP) and in accordance with NY State public health law.

2. Newborns shall receive eye prophylaxis, vitamin K administration, and screening tests in accordance with NY State public health law.

3. Newborns who require extraordinary care shall be cared for in the neonatal intensive care unit and attended by a neonatologist.

4. All patients under 100 pounds in guarded condition (such as status epilepticus, status asthmaticus, anaphylaxis, croup, bacterial tracheitis, bronchiolitis, diabetic ketoacidosis, meningitis, overdose) will have a pediatric emergency profile completed and signed by a registered nurse at the time of admission. The card will be taped to the patient’s medical record and will include the patient’s weight, dosages for emergency drugs, defibrillation dose, and ET tube size.

Admissions

1. Newborns admitted to the Nursery must be examined within twenty four (24) hours of birth by the responsible or covering pediatric attending physician.

2. Nurse Practitioners who have NWH clinical privileges in the Department of Pediatrics may do the initial examination of well newborns; however, the collaborating pediatrician must also examine the newborn within twenty four (24) hours of birth. Follow-up care by nurse practitioners shall otherwise be in accordance with their clinical privileges and the General NWH Medical Staff Rules and Regulations.

3. All patients admitted to the Pediatric Unit must be seen by the attending pediatrician or Pediatric Hospitalist within sixty (60) minutes of the admission, unless the attending pediatrician has already evaluated the patient in an office or emergency room. If a patient is not seen within the above timeframe, the nurse manager or her designee will notify the responsible attending. If the response is unsatisfactory, the nursing supervisor will be called and will contact the Pediatric Department Chief.

4. The admitting physician service must visit patients on a daily basis throughout the course of their hospitalization, with a daily notation entered in the patient’s medical record.

5. Patients under age 18 admitted to the Pediatric Unit by a surgical attending for greater than 24 hours are required to have a consultation by the patient’s attending pediatrician or the Pediatric Hospitalist.

6. Patients under age 18 who require admission to the critical care unit will only be admitted if a discussion among the pediatric hospitalist, intensivist, and nursing administration determines that we can provide the appropriate care to the specific patient. Otherwise the patient will be transferred to an appropriate tertiary care facility.

7. Patients under age 18 who require postoperative monitoring and observation in the Surgical Step Down Unit must be evaluated by the Pediatric Hospitalist prior to going to the Surgical Step Down Unit. Such patients may only be cared for in the Surgical Step Down Unit if the Pediatric
Hospitalist, Anesthesiologist, and Nursing Leadership agree that they are medically stable and not in need of critical care, and they will be co-managed by the surgeon and the Pediatric Hospitalist.

8. Infants admitted to the neonatal intensive care unit for perioperative care shall be admitted by the neonatologist with surgical co-management.

9. All nursery and pediatric patients must be seen by the responsible attending pediatrician or covering practitioner on the day of discharge.

Consultations

1. Consultation shall be obtained by the appropriate pediatric specialist when patients present with complex problems beyond the scope of practice or clinical privileges of the attending pediatrician or Pediatric Hospitalist/Neonatologist.

2. When pediatric patients are admitted with upper respiratory problems, such as croup, epiglottitis, or tracheitis, and are at risk for obstruction, an otolaryngologist and/or anesthesiologist must be notified of the admission and possible need for their consultation.

3. Admission of pediatric patients with serious acute psychiatric disorders who are in need of medical care:
   - If it is determined that safety of concern, pediatric patients with serious acute psychiatric disorders in need of admission for medical care will have a psychiatric evaluation prior to admission to determine if there is a concern for imminent danger to self or others or a potential risk for elopement.
   - If the patient is to be transferred to NWH from an inpatient psychiatric care facility, documentation regarding their current psychiatric status from the physician at the referring facility shall be faxed to NWH prior to admission to determine the appropriate safe level of observation. Of particular concern is any documentation related to a risk of suicide or violent behavior.
   - Pediatric patients with serious acute psychiatric disorders who do not need acute medical care shall not be admitted to the Pediatric Unit.

4. When the attending pediatrician, Pediatric Hospitalist, or neonatologist requires consultation in a specialty for which there is no representation on the NWH Medical Staff, temporary privileges may be granted, in accordance with Article VI, section 7 of the NWH Medical Staff Bylaws. In such circumstances:
   - The Chief of the Department of Pediatrics is notified to review the appropriateness of the need for the consultation
   - The Medical Affairs office is notified of the need for granting temporary privileges
   - The Medical Affairs office notifies the responsible attending physician and nurse manager, or her designee, when temporary privileges have been granted

MEDICAL RECORDS

Documentation

1. Pediatric patients must have documentation in the medical record of information regarding their present illness, past history, allergies, immunizations, and family history within 24 hours of admission.

2. Medical records must include documentation of the patient’s weight on admission.

3. Pediatric patients undergoing surgery must have documentation of a complete history and physical examination prior to going to the operating room, except in emergency situations in which an admission note detailing the present illness and pertinent components of the past history, such as allergies, shall suffice.
4. Medical records of newborns must have documentation by the nurse or attending pediatrician of a physical assessment, including APGAR scores, presence or absence of three cord vessels, description of maternal-newborn interaction, ability to feed, vital signs, and accommodation to extra-uterine life.

5. All pediatric patients shall have a final discharge progress note. Nursery patients shall also have documentation of a discharge physical examination.

EDUCATION AND CONFERENCES

All Pediatric Department Attending Physicians shall attend Departmental meetings and remain informed of all Departmental policies & procedures.
DEPARTMENT OF PSYCHIATRY

LEADERSHIP

1. The Chief of the Department of Psychiatry shall also serve as the Medical Director of the NWH Behavioral Health Unit, and shall be a diplomate in Psychiatry by the American Board of Psychiatry & Neurology.

2. In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Psychiatry shall be responsible for:
   a. Supervision and control of the Behavioral Health Unit
   b. Recruitment and scheduling of Psychiatry Attending staff to ensure continuous coverage of Behavioral Health
   c. Serving as the collaborating or supervising physician for Advanced Practice Nurses or Physician Assistants in the Psychiatry Department

STAFFING

1. The Chief of Psychiatry, along with his/her hospital-based associate Attending Psychiatrists, advanced practice nurses, and clinical social workers, shall be responsible for caring for patients on the Behavioral Health Unit and provide psychiatry consultative services to the Emergency Department and inpatients admitted to other Hospital Departments:
   - Weekdays from 9AM – 5PM on site
   - Evening/Night shifts 5PM – 12AM on site and available by phone for emergencies from 12AM – 9AM
   - Weekends and Holidays – on site adequate time to see all patients and available by phone at all times

2. The Attending Staff of the Psychiatry Department shall provide coverage of the service in accordance with the above schedule from time to time as needed.

3. Psychiatry Attending Physicians shall qualify to be designated by the Director of Community Services as examining physicians in accordance with Section 9.37 of New York State Mental Health Code.

DEPARTMENTAL OPERATIONS

1. Patients age 18 and older may be admitted to the Behavioral Health Unit through the Emergency Department, transferred from another Hospital service, or accepted as a direct transfer from another Emergency Department or facility.

2. Patients may only be accepted for a direct transfer from another Emergency Department or facility after review and approval by the Psychiatry Department Chief or his/her designee. In such cases, the patient must have also had an adequate medical evaluation at the other facility by an Emergency Medicine, Internal Medicine, or Family Practice physician. The Psychiatry Department Chief or designee will discuss concerns regarding any potential medical issues with the NWH Hospitalist, PRIOR to accepting the patient for transfer.

3. Patients sent to NWH from psychiatrists’ or therapists’ offices will first be evaluated in the Emergency Department by the Emergency Medicine Physician, who will consult the Attending Psychiatrist when indicated.
PATIENT CARE GUIDELINES

1. Patients who come to the Emergency Department or who are sent to the Hospital by their psychiatrist or therapist will initially be evaluated by an Emergency Medicine Attending Physician for a screening medical examination.

2. All patients admitted to the Behavioral Health Unit will have a history and physical examination by an internal medicine or family practice physician within 24 hours of admission.

3. The Psychiatrist admitting the patient will notify the appropriate internal medicine physician IMMEDIATELY upon admitting the patient from the Emergency Department or IMMEDIATELY upon arrival of patients accepted for a direct transfer from another Emergency Department or facility.
   a. The Mount Kisco Medical Group (MKMG) on-call internal medicine hospitalist or covering physician shall be called if the patient’s primary care physician is a member of MKMG
   b. The NWH Internal Medicine Hospitalist shall be called for all other patients

4. Patients admitted to the Behavioral Health Unit will have a daily evaluation by the assigned Attending Psychiatrist, Nurse Practitioner, or covering psychiatrist for the first five days of admission and thereafter at a minimum of three times each week. Evaluations may be more frequent when clinically indicated. Patients who are on 1:1 observation require a daily evaluation for as long as they are on 1:1 observation.

5. Patients admitted to the Behavioral Health Unit will be cared for by a multidisciplinary team of social workers, art therapists, and nursing staff in conjunction with the Attending Psychiatrist. The multidisciplinary team will meet each weekday morning at 9:00 AM to review and discuss the care & treatment plan of the patients on the unit.

6. Psychiatrists who are not part of the hospital-based Psychiatry Attending Staff, attending their private patients on the Behavioral Health Unit must attend a minimum of two treatment multidisciplinary team meetings each week. If an Attending Psychiatrist is unable to meet with the multidisciplinary treatment team, a hospital-based Psychiatry Attending may be designated to attend the patient.

MEDICAL RECORDS

Attending Psychiatrists shall document in each patient’s medical record an admission psychiatric assessment, which is part of a multidisciplinary assessment, and ongoing goals & objectives, which are part of each patient’s multidisciplinary treatment plan.

EDUCATION AND CONFERENCES

1. The Behavioral Health Quality Improvement Committee will meet once each quarter to review clinical care and performance indicators, including physical & medication restraints, seclusion, aggressive or self-destructive behavior, transfers to other acute care services within 24 hours of admission, unplanned readmissions within fifteen (15) days of discharge, and other performance indicators as developed from time to time by the Quality Improvement Committee of the Medical Board.

2. The Behavioral Health Quality Improvement Committee in addition may hold special reviews at other times when necessary to review specific incidents such as aggressive or self-destructive behavior, suicide, homicide, or elopements.

3. Psychiatry Department meetings will be at least every six months to review and update the staff on administrative and clinical issues, provide education, and address any issues or concerns. All Psychiatry Department Attending Physicians shall attend Departmental meetings and remain informed of all Departmental policies & procedures.
DEPARTMENT OF SURGICAL SERVICES

LEADERSHIP

In addition to the responsibilities of the Chief of each Department described in Article VII Section 2 of the NWH Medical Staff Bylaws, the Chief of Surgical Services shall be responsible for:

a. Oversight of the professional and clinical activities in the operating suite for inpatients and the Ambulatory Surgery Center.

b. Serving as the co-chairman of the Operating Room Committee, which shall meet monthly and include representation from each surgical division, anesthesiology, nursing, administration, and quality management.

c. Delegation of administrative, quality management, ongoing professional practice review, and performance improvement functions to the applicable chief of each surgical Division within the Department of Surgical Services.

STAFFING: ON-CALL

1. Emergency on-call policies shall be established by each Division of the Department of Surgical Services, consistent with the Bylaws and General Rules and Regulations of the NWH Medical Staff.

2. The Chief of each Division of the Department of Surgical Services shall provide the Medical Affairs office with a monthly schedule of on-call physicians to provide continuous coverage for emergency care.

3. The following applies for emergencies in General and Pediatric Surgery:

   The Pediatric Surgeon on-call is responsible for patients from birth up until their sixteenth (16th) birthday, when a surgical evaluation is needed emergently.

   The General Surgeon on-call is responsible for patients age sixteen (16) and older, when a surgical evaluation is needed emergently.

   Exceptions:
   - General Surgeons should be contacted for emancipated minors (e.g. young teenagers who are pregnant, have children, or are living independently)
   - Pediatric Surgeons should be contacted for problems that are unique to pediatric surgery (e.g. congenital esophageal atresia)
   - For surgical problems related to specific surgical procedures (e.g. small bowel obstruction due to post-procedure adhesions), whenever possible, the surgeon who did the initial procedure should be contacted

DEPARTMENTAL OPERATIONS

Operating Room

1. Operations shall be scheduled in accordance with the Surgical Services Scheduling Process Policy & Procedure, including use of the appropriate forms and order sets.

2. The surgical schedule shall begin each day at 7:30 AM and subsequent scheduled cases shall follow thereafter in sequence. Surgeons are expected to be present for the first case each day at 7:20 AM.

3. No patient shall receive an anesthetic unless the surgeon is present in the surgical suite.
Assistants

1. The first assistant during a surgical operation should be able to participate and actively assist the surgeon in completing the operation safely and expeditiously by helping to provide exposure, maintain hemostasis, and serve other technical functions. The qualifications of the person in this role may vary with the nature of the operation and the surgical specialty.

2. Surgeons serving the role as first assistant do so under the supervision and guidance of the operating surgeon. The surgeon serving as an assistant is ideally in the same specialty as the operating surgeon, but may be in a related specialty based on availability. Other appropriately credentialed physicians and allied health professionals, including registered nurse first assistants (RNFAs) and physician assistants (PAs), may also serve as first assistants if they have been granted such privileges by the NWH Governing Board or are employed by the Hospital in such capacity.

3. The operating surgeon is responsible for determining the need for and role of assistants for each surgical procedure in accordance with any delineated privileges specified by their particular surgery division. If the need for and/or appropriate qualifications of an assistant are not clear, the operating surgeon and surgical division may refer to the American College of Surgeons Assistant at Surgery Consensus as a resource. Generally, the following shall be taken into account in determining the training and role of assistants:

- Complexity and duration of the planned procedure
- The nature of the underlying disease, potential complications, and likelihood of the need for multiple procedures
- Risk factors and co-morbid conditions of the individual patient
- Size and body habitus of the individual patient

4. Unless otherwise approved by a Department or Division Chief, the following procedures must be performed with a qualified assistant:

- Major Spine Surgery
- Craniotomy Procedures
- Computer-enhanced Laparoscopic Surgery (using the Da Vinci Robotic System)
  i. Attendance at an approved course in computer-enhanced laparoscopic surgery OR
  ii. An on-site educational session regarding the technology AND participation in at least three (3) cases as a second assistant with an NWH physician preceptor OR
  iii. Documentation of participation in a minimum of five (5) cases as a first assistant during an approved residency or fellowship program

5. Attending physicians in the Department of Surgery with provisional privileges must select surgical first assistants in accordance with any proctoring policies or delineated privileges specified by their particular surgery Division, except under life threatening emergency situations.

6. Assistants who are not members of the NWH Medical Staff are not permitted unless granted patient-specific temporary privileges by the Medical Director and Department or Division Chief in advance of the procedure in accordance with the NWH Medical Staff Bylaws.

Proctors and Preceptors

1. Preceptoring is a form of training whereby an experienced surgeon scrubs in or directly supervises a procedure with the intention of guiding the surgeon and assisting in the acquisition of new skills during the steep part of a learning curve. The preceptor provides feedback to the surgeon and attempts to transfer skills to the surgeon by an active, hands-on approach. A preceptor is the primary person responsible for the well-being of the patient and can readily take over a surgical procedure if the situation so demands.

2. Proctoring involves observation by another, more experienced surgeon, during the initial phase of the learning curve for a new procedure or of a new surgeon, to assess knowledge and skills in the use of a technique or equipment. The proctor is responsible for observing surgeon performance and competence in performing a surgical procedure safely and effectively. The proctor reports findings and recommendations to the Department/Division Chief to assist in determining whether the surgeon shall be granted privileges for a particular procedure or requires further training or preceptoring.

3. The Chief of each Division of the Department of Surgical Services shall develop proctor and preceptor policies and rules for surgeons granted provisional clinical privileges or surgeons
performing new procedures, based upon education, training, and certification requirements and the complexity of the procedure. Such policies and rules shall be approved by the Medical Board.

4. In the absence of a specific exception approved by the Division Chief and the Medical Board, proctors and preceptors shall meet the following criteria:
   a. Board Certification in the same specialty as the surgeon performing the procedure
   b. Approved in advance by the Division Chief as qualified and proficient in the procedure for which he/she is serving as a proctor or preceptor
   c. If not a member of the NWH Medical Staff, granted temporary NWH clinical privileges, with documented New York State license and professional liability insurance
   d. Proctors and preceptors both have the authority and responsibility to intervene and take definitive action when necessary to ensure the well being of the patient and may take over the procedure if the situation so demands, in the interest of patient care and safety
   e. Proctor will provide a report back to the Division Chief regarding the surgeon’s performance

Complications

1. All complications of surgery performed on inpatients and ambulatory surgery patients shall be identified, recorded in the patient’s medical record, and referred to the Quality Management Department. Such events will then be managed in accordance with the incident-based peer review process described in the General Rules & Regulations of the Medical Staff.

2. All infections of clean surgical cases shall be recorded and reported to the Hospital’s Infection Control Practitioner.

3. Complications of surgery performed, including infections, shall be discussed with the patient and/or patient representative in accordance with the Patient Care Services Disclosure of Unanticipated Outcomes Policy & Procedure.

PATIENT CARE GUIDELINES

NWH Surgical Services provides safe, effective, patient-centered care through clinical expertise, hardwired safety tools, and advanced technology, enabled by a best-practice model of interdisciplinary teamwork. All members of the Surgical Services Department are expected to participate in and adhere to the standards of the LifeWings patient safety program.

1. Informed consent shall be obtained from each patient and/or patient representative for each inpatient or ambulatory operation or procedure performed, except under life-threatening emergency situations, in which case notification shall be made to the Hospital Medical Director or on-call Administrator. Informed consent shall include a discussion of the risks and benefits of the planned procedure and alternatives to the planned procedure.

2. Prior to the start of the procedure, the operating surgeon must document obtaining consent from the patient and/or patient representative or Hospital Medical Director or on-call Administrator.

3. Prior to surgery, each patient shall have a timely history and physical examination appropriate to the patient’s condition and planned surgical procedure in accordance with the NWH Medical Staff Bylaws and General Rules & Regulations for Admissions.

4. Prior to surgery, each patient shall have the preoperative testing in accordance with the Preoperative Evaluation Guidelines approved by the Medical Board and the Department of Anesthesiology.

5. Each operating surgeon shall be responsible for participating in each element of the Joint Commission Universal Protocol (UP.01.01) and New York State Surgical & Invasive Procedure Protocol, including pre-procedure verification, marking of the procedure site, and performing a time out immediately prior to starting the procedure.
6. Surgeons shall encourage professional and collaborative teamwork and communication, holding all members of the team responsible for cross checking other members of the team and respectfully bringing forward any quality or patient safety concerns to the surgeon or circulating nurse.

7. All tissue removed during an operation, with the exception of a normal placenta, circumcised prepuce, or arthroscopy shaving, shall be sent to the Hospital Pathology Department, who shall perform such examinations considered necessary in accordance with standard of care. The operating surgeon shall provide the Pathology Department with sufficient and relevant clinical information to enable an accurate analysis of the specimen.

8. Instrument, sponge, and needle counts shall be done in compliance with the Policies & Procedures of the Operating Room Department, approved by the Operating Room Committee.

9. The operating surgeon and attending anesthesiologist shall determine the adequate time period for observation following surgery for each patient undergoing an operation or procedure, which shall in no case be less time than indicated in Patient Care Services Policies & Procedures.

10. Following an operation, if a patient is subsequently admitted to the Hospital or was an inpatient and is remaining in the Hospital, the operating surgeon or his/her designee is responsible for reviewing the patient’s preoperative medications & other orders and indicating with transfer/postoperative orders which of the preoperative medications & other orders are to be continued, and adding any new medications or other orders to the transfer/postoperative orders.

11. At the time of discharge following an inpatient admission for surgery, the attending surgeon is responsible for entering documented discharge instructions in the medical record that includes at least:

- Information about complications that may arise and symptoms to look out for
- Telephone number(s) to be used should complications or questions arise
- Date, time, and location of any follow-up care
- A list of all medications that the patient will continue after leaving the Hospital, reconciled with the medications that the patient was taking prior to and during the hospital stay
- In cases where the patient is being managed by the surgeon along with consultation by an internist, the surgeon is responsible for determining, documenting, and prescribing any antibiotics, analgesics, anticoagulants, antiplatelet agents, and any other medications specifically related to the surgical procedure and the internist is responsible for determining, documenting, and prescribing medications related to underlying chronic medical problems or new medical problems discovered during hospital admission. The timing of discontinuation, continuation, or resumption of anticoagulants and/or antiplatelet agents may often require direct communication between the surgeon and the internist.

12. At the time of discharge following an ambulatory operation or procedure, each patient shall be provided with detailed verbal instructions, confirmed by printed instructions approved by the Medical Board, that includes at least:

- A list of short term medications that the patient will continue after leaving the Hospital
- An updated chronic (long-term) medication list IF any new chronic medications are being added or any changes are being made to any of the patient’s current known chronic medications
- Information about complications that may arise
- Telephone number(s) to be used should complications or questions arise
- Date, time, and location of any follow-up care
- Instructions to go to the NWH Emergency Department in the event of an emergency
MEDICAL RECORDS

Operative Notes
1. A brief note must be entered into the medical record after each operative or other high risk procedure upon completion of the operation or procedure, before the patient is transferred to the next level of care, to ensure that pertinent information is available to the next caregiver, including the following:
   - Procedure performed and description of the procedure
   - Name of surgeon and assistant(s)
   - Findings
   - Estimated blood loss
   - Specimens removed
   - Postoperative diagnosis

2. It is expected that an operative report fully describing the operation or procedure performed shall be completed or dictated by the operating surgeon immediately after the operation or procedure. The report shall in no case be completed or dictated later than twenty-four (24) hours after the surgery or procedure.

EDUCATION AND CONFERENCES

Attending surgeons shall attend meetings of their specific surgical Division and remain informed of all policies & procedures of their Division and of the Department of Surgical Services.