RULES AND REGULATIONS

of the

MEDICAL STAFF

PHELPS MEMORIAL HOSPITAL CENTER

Sleepy Hollow, New York

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RULES AND REGULATIONS OF THE MEDICAL STAFF

PHELPS MEMORIAL HOSPITAL CENTER

These Rules and Regulations constitute the Standards of Care for the Medical Staff of Phelps Memorial Hospital Center.

A. ADMISSION OF PATIENTS

1. Only a member of the Medical Staff with admission privileges may admit a patient to the Hospital. All practitioners shall be governed by the official admitting policy of the Hospital.
   a. Order to Admit

      Every patient admitted to the inpatient service shall have an order to admit written by the attending physician or by the Emergency Department physician who evaluated the patient, the latter after consultation with the attending physician.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports on the condition of the patient to the referring practitioner and, when appropriate, to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

3. The primary physician in each case shall record a plan of management at the time of admission and shall update this plan of management in response to clinical data and/or changes in the patient’s condition.

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

5. In any emergency case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.

6. Practitioners admitting emergency cases shall be prepared to justify to the Medical Board that the said emergency admission was a bona fide emergency. The admitting note must clearly delineate the emergency nature of the admission.

7. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend him. Where no such selection is made, a member of the Active Staff on duty in the department or service will be assigned to the patient on the rotation basis where possible. The Director of each department shall provide a schedule for such assignments.

8. a. Each member of the Staff shall be available to attend his patients in an emergency. In the event a Staff member is to be absent from the area, or unavailable for other reasons, and therefore not able to attend his patients in an emergency, he must arrange for adequate
Physicians must be covered by a practitioner of the same specialty for consultations or cases requiring the specialized expertise of their discipline.

b. A practitioner who will be unavailable shall indicate in writing on the order sheet of each of his hospitalized patients, the name of the practitioner who will be assuming responsibility for the care of the patient during his absence. It is the responsibility of each physician to clearly indicate who is responsible for his clinical obligations when coverage arrangements are made. Appropriate sign-out of clinical information to the covering physician is required. Office staff and telephone answering services must also be made aware of coverage arrangements.

c. Should the attending physician be unavailable and/or no provision for coverage has been made, the practitioner of the department to which the absent member belongs who is on-call for the Emergency Department for that day, shall be contacted and requested to attend the patient in need of emergency care. If the physician on-call for the Emergency Department is not available, then the Department Director shall be contacted.

d. If a physician arranges for a colleague to cover his clinical responsibilities, any Emergency Department or service obligations during the period of coverage automatically devolve to the covering physician. It is the responsibility of the physician arranging coverage to inform the hospital operator and the Emergency Department of the change in service coverage.

9. Each clinical department shall develop, and the Medical Board shall approve, categories of medical conditions and criteria for use in the implementation of patient admission priorities.

10. The chief admitting officer will accept for admission patients on the basis of the following order of priorities:

   a. Emergency Admissions

      The attending practitioner shall insure that there is complete documentation of the need for this admission. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be cause for appropriate action.

   b. Urgent Admissions

      This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the Utilization Review Committee to determine priority when all such admissions for a specific day are not possible.

   c. Routine Admissions

      This will include elective admissions involving all services. If it is not possible to handle all admissions, the physician designated by the President of the Medical Staff shall decide the urgency of any specific admission.

   d. Pre-Operative Admissions

      This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the physician designated by the President of the Medical Staff may decide the urgency of any specific admission.
11. Areas of restricted bed utilization and/or assignment of patients shall be as follows:
   a. Pediatric-Adolescent patients.
   b. Obstetrics and Clean Gynecologic patients.
   c. Rehabilitation Unit.
   d. CCU - Cardiac patients.
   e. ICU - Patients in need of intensive therapy.
   f. Psychiatric patients.
   g. Behavioral rehabilitation patients.

Deviations from the above may be made by the President of the Medical Staff, Medical Director, Department Directors or Section Chiefs concerned, Director of Specialty Care Units or their respective designee. When changes are made, the Admitting Clerk will correct these assignments at the earliest possible moment in keeping with transfer priorities.

12. Patient Transfers shall be as follows:
   a. Emergency Room to appropriate patient bed.
   b. From obstetric patient care area (unit) to general care unit or general care area.
   c. From intensive care unit to intermediate care unit or general care area.
   d. From cardiac care unit to intermediate care unit or general care area.
   e. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient. Except in care of urgent necessity, no patient will be transferred without the approval of the responsible practitioner, the Director of the Specialty Care Unit or his designee. These transfers shall have priority over routine admissions.

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

14. For the protection of patients, the Medical and Nursing staffs and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

All suicidal attempts are admitted either to 1-South or to the ICU if medical care is needed. All such patients must have a psychiatric consultation. The psychiatric consultant will decide between the following treatment alternatives: (1) Transfer to 1-South or another psychiatric facility; (2) Remain in ICU; (3) No further psychiatric observation or treatment required; (4) If there are no psychiatric beds available, such a patient, upon recommendation of the psychiatrist, may be admitted or transferred to a medical or surgical unit if continuous surveillance is provided by an appropriate individual.
15. Admissions to Intensive and Cardiac Care Units

a. May be requested by any physician. Final decision for admission will be made by the Director of the Specialty Care Units (as required by JCAHO).

b. Emergency admissions to the CCU and ICU from outside the Hospital must be via the Emergency Department. The admitting physician should speak directly with the Emergency Department physician on duty to coordinate care. Patients admitted to the Units will have whatever diagnostic and therapeutic procedures the clinical situation dictates before leaving the Emergency Department. All cardiac and other potentially unstable patients shall have an intravenous line and cardiac monitoring begun prior to transport from the Emergency Department.

Elective admissions may be admitted directly to the Units with an order from the patient’s physician and with appropriate communication to the Unit, the Emergency Department and Admitting.

c. All cases must meet the admitting criteria of the Specialty Care Unit.

16. Patients admitted by Podiatrists or Dentists to the inpatient service must have a medical history and physical, care plan and admitting orders performed by an appropriately credentialed Internist, Family Physician or Hospitalist with 12 hours of admission. The patient may remain on the Podiatrist’s or Dentist’s service if the primary problem is within that specialty, but the medical physician must see the patient daily during the admission and be responsible for non-Podiatric/Dental clinical issues.

B. EMERGENCY SERVICES

1. Administrative Structure

The Emergency Department shall be under the direction of a Board certified specialist in Emergency Medicine who is an active member of the Medical Staff. The Director has the authority and responsibility of carrying out established policies and of providing overall direction in the continuing operation of the department. The Director of Emergency Services is a Hospital employee with both clinical and administrative responsibilities. The Director shall appoint an Associate Director to act in his/her behalf during periods of absence.

At times when the Director of Emergency Services and Assistant Director are not available, a member of the full-time Emergency Medicine panel will be designated as the acting Assistant Director to insure continuity in the performance of administrative duties.

2. Delineation of Privileges

a. The Director of Emergency Services will define the privileges of each Emergency Medicine physician based on the guidelines of the American College of Emergency Physicians.

b. Privileges granted will be based on education, training, experience, demonstrated competence and continuing medical education. Re-evaluation and renewal of privileges will occur no less frequently than every two years as required by the Medical Staff Bylaws.

3. Patient Care and Admission Policy
a. It is the policy of the Emergency Department to provide for continuous proper functioning, to insure its capability to promptly absorb incoming emergencies, and to insure the safety of patients requiring specific medical and surgical procedures. A physician will evaluate each patient who arrives at the Emergency Department.

b. The Emergency Department will provide required care to all patients who present for treatment. Appropriate consent for treatment will be obtained on all patients able to give such consent. Unconscious patients will be evaluated and treated pending formal consent. Unaccompanied minors will be treated without awaiting full legal permission where there is significant risk that delay might endanger the patient’s life or limb. In such cases, the Administrator on Call shall be notified.

c. The patient’s personal physician of record will be contacted when requested by the patient, or family, or, when in the opinion of the Emergency Medicine physician the patient has a clinically significant condition requiring either hospital admission or a consultant’s attention. Reports of Emergency Department visits and laboratory examinations performed will be sent to the patient’s private on-staff physicians.

d. A patient having a personal physician will ordinarily be referred to that physician for follow-up care. If the patient does not have a personal physician, he/she will be supplied with the names of two or more appropriate physicians practicing in the patient's geographical area and the telephone number of the Phelps Physician Referral Service. All patients treated in and discharged from the Emergency Department will receive appropriate written follow-up instructions in order to reduce the possibility of misunderstanding and to reinforce proper follow-up. The Emergency Department will initiate appropriate follow-up for tests obtained on patients who do not have a private physician.

e. The Emergency Department will maintain two "holdover" beds in order to observe patients who may be candidates for admission but who require a period of observation and/or limited treatment prior to either being admitted or being safely discharged from the Emergency Department. In general, patient disposition will be determined within eight hours. Per New York State Department of Health regulations, in no event can these beds be utilized as a substitute for admitting patients to the Hospital.

f. Transfer of patients directly from the Emergency Department to another hospital shall be effected only if proper care cannot be rendered to the patient at Phelps Memorial Hospital Center, or upon request of the patient, and if, in the judgment of the treating physician, such transfer would not be detrimental to the patient’s health. Such patients shall be stabilized to the maximum extent possible prior to transfer. The receiving facility must first be contacted and agree to accept the patient. This will be documented in the Emergency Department record. A copy of all pertinent laboratory, x-rays, and EKGs will accompany the patient. An appropriate level of ambulance service will be served to insure the patient's safety during transport. All transfers will conform to hospital policy and the requirements of the Emergency Medical Treatment and Labor Act (EMTALA).

g. The evaluation, treatment, and disposition of all patients presenting to the Emergency Department is made on a case-by-case basis and will be based on data from the history, physical examination, laboratory studies, imaging studies and opinion of primary physicians and consultants, as may be needed in each case.
The Emergency Medicine physician 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.

4. Medical Records and Reports

See relevant sections in "III. Patient Care and Admission Policies", paragraphs B, C, F, and G.

5. Quality Assurance

The quality and appropriateness of patient care is reviewed daily by the examination of Emergency Department records, x-ray comparison logs, laboratory results, and EKG reports. These results are measured against predetermined standards developed by the Emergency Department.

Equipment and supplies in each room are inspected daily by designated members of the Emergency Department nursing staff. Crash carts are inspected after each use and at the beginning of each shift. Inspection logs are maintained within the department.

A daily review of all records is performed by the physician Director or his designee to ascertain proper documentation and review of care given. Documentation of this review shall be maintained in a log kept in the Emergency Department.

Focused review and Indicator Monitoring is utilized to ascertain the performance of the Emergency Medicine Physician Staff measured against predetermined criteria. Multiple indicators, which are subject to change, are tracked every month and discussed among the Physician Staff. The Nursing Staff also tracks various indicators which are discussed at monthly Co-Joint Staff meetings. The compiled data, conclusions, and actions taken shall be included in a report distributed to the Medical Board.

Monthly Co-Joint staff meetings chaired by the Nursing Director are held. Minutes are kept and submitted to the Quality Assurance Department. This meeting is followed by the monthly Physician Performance Conference chaired by the Director of Emergency Medicine. Consensus is reached regarding: predetermined criteria, evaluation, treatment, and outcomes. Minutes are kept and submitted to the Quality Review Committee. Case reviews of physician practices are incorporated into the Physician Practice Profiles.

The above mechanisms are the most important and frequent sources of problem identification. Areas of improvement are identified via documented data sources that are investigated and an attempt at resolution made. At times, existing policies and procedures are reinforced or changed to insure resolution of identified problems. Other appropriate remedial action may be taken, depending on the circumstances, with staff participation in formulating these changes.

6. Continuing Medical Education

The Emergency Medicine Physician Panel is encouraged to attend the educational programs of the Family Practice Department. They are also required to have successfully completed both Advance Cardiac and Trauma Life Support. Encouragement and support are also given to the Emergency Medicine Physician Panel to attend the wide variety of educational programs available within and outside of the Hospital. Membership in the American College of Emergency Physicians with attendant CME requirement is mandated.

The Emergency Department Policy and Procedures Manual is reviewed and updated as required, but no less than once every three years. A copy of this manual can be found at all times in the Emergency Department and is presented to the Medical Board for approval.

C. DISASTER PLAN: THE MEDICAL STAFF - RESPONSIBILITIES AND INSTRUCTIONS

1. Disaster Medical Chief: The Disaster Medical Chief (DMC) shall be, in order of seniority and availability, one of the members of the Medical Staff. His responsibilities and instructions are as follows:
   a. The DMC is responsible for organizing and overseeing medical and surgical services throughout the hospital during a disaster situation.
   b. By previous endorsement of the Medical Staff Disaster Committee, the DMC has the authority to assign physicians responding to the disaster call to specific areas, as the situation dictates.
   c. The DMC will station himself initially at the Emergency Department and will be identified by a special hat. The DMC will:
      1. Log in arriving physicians.
      2. Receive information regarding the triage disposition of arriving patients.
      3. Be informed of bed availability (will work closely with Admitting). By use of a prepared chart, he will keep track of the location of patients, physician assignments and bed availability.
   d. Requests for additional physician staffing to specific areas will be addressed to the DMC.

2. Triage Officer: The Triage Officer will be the first general surgeon available. The Triage Officer will be stationed at the Emergency Department entrance, and will be in charge of the triage treatment. He will see all patients briefly and will make a quick determination as to the immediate disposition of patients according to the separate instructions for the triage team which will be issued at the time.

3. Other Medical Staff Members: All other members of the Medical Staff responding to the disaster call will report to the DMC, who will be located in the Emergency Department for assignment. Once a physician has completed a given assignment, he should again report to the DMC for possible reassignment. However, if a physician is not needed immediately, he should proceed to the Doctors' Coat Room to await assignment. (Extensions 3375 and 3376.)

D. GENERAL CONDUCT OF CARE

1. Hospital procedure for Informed Consent shall be followed on all occasions.
   a. The general consent form approved by the Hospital, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The charge nurse should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the
b. Prior to the performance of any surgical or special procedure, specific written consent must be obtained from the patient or his legal representative. This consent should indicate that the patient, or his legal representative, has been informed by the attending physician of the nature of the risks inherent in any surgical or special treatment procedure, the risks of not undergoing the treatment or procedure, the alternatives to such procedure, and has been given the opportunity to have any questions answered.

2. Orders for care, treatment or services shall be given in writing. Orders placed via the computer information system are considered to be in writing. Verbal orders and telephone orders are permitted. They are to be used sparingly.

"Telephone orders" are orders given over the telephone. "Verbal orders are those given to another caregiver in direct on-site conversation.

Verbal orders may be used during cardiac arrests, rapid responses, clinical areas during crisis situations, when the practitioner is working in a sterile field or is otherwise gloved and gowned, or when other physical factors prevent orders from being issued in writing.

Any necessary verbal or telephone orders may be accepted by registered nurses. Orders for medications may be accepted by pharmacists. Orders for respiratory therapy medications and treatments may be accepted by respiratory therapists. Orders for physical therapy, EEG, EKG or Radiology procedures may be accepted by technicians in those respective services. Dieticians may accept orders for therapeutic diets or supplements. Speech Language Pathologists are approved to take orders for instrumental swallowing evaluations (MBS and FEESST), bedside swallowing evaluations, changes in diets and speech/language evaluations. All verbal or telephone orders must be entered legibly in the medical record by the individual receiving the order, read back to the provider, include the names of the prescribing practitioner and the individual transcribing the order, the date and time, and not contain any forbidden abbreviations.

Verbal or telephone orders must be signed by the ordering physician or a covering physician as soon as possible, but no later than 30 days after discharge.

3. Do Not Resuscitate (DNR) orders shall follow hospital policy, must be written in the chart and will not be honored until it is documented that the situation has been discussed with the patient and/or family members. No verbal or telephone orders will be accepted. Criteria for obtaining consent for a DNR order and for renewal of such orders shall follow hospital policy.

4. The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written must be rewritten promptly. Orders for treatment will be reviewed by the practitioner weekly to ensure that needed medications are continued and that those no longer needed are discontinued. In compliance with New York State Department of Health regulations, orders for controlled substances are automatically stopped after 72 hours when prescribed in a PRN fashion, and after 7 days for standing and continuing administration. Stop orders for other classes and types of medication shall be approved by the Medical Board, in accordance with established guidelines. These medications and their automatic stops shall be listed within the Policy and Procedures Manual of the Pharmacy and the Department of Nursing. Dose and frequency of administration must be stated in original and renewal orders. Non-
compliance will result in discontinuation of the medication.

5. All previous orders are canceled when patients go to surgery. A complete set of new orders are required post-operatively.

6. Drugs used shall be those listed in the Phelps Memorial Hospital Center's Formulary. Non-Formulary drugs may be requested from among those listed in the United States Pharmacopoeia, National Formulary and New and Non-Official Remedies with the addition of drugs for clinical investigation authorized by the Medical Board. Use of such drugs shall be permitted only with the approval of the Chairman of the Pharmacy and Therapeutics Committee or his designee.

7. Use of Patient's Own Medications: (1) No Formulary medication shall be administered from the patient's own supplies brought into the hospital. (Patient's own medications should not be brought to the hospital, but if they are, should be returned to the family.) (2) If a non-Formulary medication is considered, Formulary equivalents should be utilized where possible. If there is no Formulary equivalent, patient's own medication may be utilized with the following requirements: The order must indicate the name of the medication, strength, frequency and route. The content of the prescription should be verified and/or identified by a Pharmacist before administration. Patient-supplied medications shall be kept in the pharmacy.

8. Investigational Drugs are medications which have not been released by the Federal Food and Drug Administration for general use and are not available commercially.

Principal Investigator: The attending physician authorized by the FDA to evaluate a particular experimental drug or form of treatment. The protocol for use of such drugs (other than those approved under a Compassionate IND) must have been approved by the Investigational Review Board.

a. An investigational drug is used under close supervision of the Principal Investigator who retains control over its use and distribution.

b. The Principal Investigator will submit a request to the hospital’s Institutional Review Board including name of the drug, IND number, and the names of those physicians authorized to prescribe the drug.

b. The Principal Investigator will also inform the IRB of the drug’s indications, source, dosages, toxicities, adverse reactions and required monitoring (if any).

d. A supply of such drugs will be placed in the Hospital Pharmacy for issue only on order of the Principal Investigator or his designated agent(s).

e. The Pharmacy shall maintain adequate records on the disposition of such controlled drugs and shall see that current information on the drug in question is available at the nursing units where it will be administered.

f. The Pharmacy may order investigational drugs provided the Principal Investigator has an authorized IND number and proper control has been filed with the Food and Drug Administration.

g. The Principal Investigator must obtain an Informed Consent permission prior to administration of any particular experimental drug or form of treatment.
h. The Principal Investigator must submit summary results to the IRB of each course of treatment with the investigational drug, as well as reports of all adverse reactions.

9. Consultations

The attending physician or dentist should obtain consultation when assistance is required in the care of the patient or when consultation is requested by the patient or members of the patient's family when the patient is unable to make such a request.

The level of consultation should be established from the beginning:

a. A one visit opinion.

b. Continuing cooperative care.

c. Complete transfer of responsibility to the consultant.

A consultant must carefully explain the recommendations to the referring doctor and obtain concurrence for major procedures. The consultant should transfer the patient and proper records back to the primary physician when the consultation is completed. Care must be taken not to undercut the responsibility of the referring physician in the process. One physician must remain in charge of the overall management of the patient. Unless the referring doctor has formally transferred responsibility to a consultant, the ultimate responsibility for the patient's care lies with the referring doctor.

d. Consultation is mandatory:

1. In all cases involving attempted suicide. Consultation must be obtained from a qualified psychiatrist.

2. In the Specialty Care Units where expertise required is beyond the scope of privileges of the physician.

3. By a Cardiologist in all cases of acute myocardial infarction, unstable angina, and serious cardiac arrhythmias.

4. In dental patients, a medical consultation is required preoperatively.

5. Preoperatively, following guidelines established by the Medical Staff.

6. In all cases in which, according to the judgment of the attending physician, the diagnosis is obscure, or there is doubt as to the best therapeutic measures to be utilized, or there is a question of criminal action.

e. It is the duty of the Hospital Staff, through the Directors and Chiefs, to make certain that members of the staff do not fail in the matter of calling consultations as needed. Where this is not done, the Department Director, Section Chief or Medical Director may require such consultation. THE CARE OF THE PATIENT MUST ALWAYS BE PARAMOUNT IN THE CONSULTATION PROCESS.

f. Consultations should be communicated by the requesting physician directly to the consulting physician whenever possible to ensure
timeliness and transfer of appropriate clinical data.

10. The individual staff members must be held accountable for the quality and promptness of care rendered their patients. The patient's medical record should reflect the patient's status and plan of care.

11. Patients shall be discharged only on a written order of the attending practitioner. Should a patient desire to leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and a proper release form signed by the patient or his legal representative. It is the obligation of the attending or covering physician to explain to the patient the risks and consequences of leaving against medical advice. This explanation must be documented. Should the patient or legal representative refuse to sign the release form, the nurse on duty will annotate the release form to that effect and attach it to the patient's medical record.

12. It shall be the responsibility of the attending practitioner to discharge his patients by 11:00 a.m. on the day of discharge whenever possible.

13. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee. The body shall not be released until an entry has been made and signed in the medical record of the deceased and a Death Certificate completed by a member of the Medical Staff or his designee. Policies with respect to release of remains of deceased patients shall conform to the local law.

14. Autopsies

An autopsy is a valuable medical procedure which provides important information for purposes of quality assurance, evaluation of clinical diagnostic accuracy, determining impact of therapeutic regimens, defining new diseases, augmenting clinical and basic research, providing accurate public health data and vital statistical information.

Although something can be learned from every autopsy, it is recognized that it is not possible to perform an autopsy on every patient dying in the hospital.

The following are guidelines for case selection:

a. Medical Examiners Cases

By law, the physician is responsible to report all deaths in Westchester County due to “unlawful act, criminal neglect, violence, casualties, or by sudden and unexplained circumstances.” (See policy for details.) No consent is required.

b. Hospital Cases

Autopsies will only be performed on Hospital patients.

1. Cases where the autopsy should be requested:

   a. Deaths in which the autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

   b. Deaths in which the cause of death is not known with certainty on clinical grounds.

   c. Unexpected or unexplained deaths occurring during or
following any dental, medical or surgical diagnostic procedures and/or therapies.

d. Deaths of patients who have participated in clinical trials approved by institutional review boards.

e. Obstetric deaths.

f. Neonatal deaths.

g. Deaths from rare diseases.

h. Deaths resulting from a genetic disorder.

i. Deaths in which the patient sustained an injury while in the hospital.

2. Limited autopsies

An efficient use of services include limited autopsies or autopsies restricted to organs of interest. For example, in a patient with brain tumor, limit autopsy to the brain. If it is difficult to obtain consent for an autopsy, often the family will consent to a limited autopsy so that the most important questions can be answered.

3. Specialized Studies

Specialized studies such as cytogenetic analysis on stillborn fetuses may be arranged in advance.

4. Requirements for autopsy

a. Legal consent

All hospital autopsies must have a valid consent from the "next of kin." New York State Law (New York Estate and Trust Law, 4-1.1) defines next of kin as all living individuals in each class in the following order:

1. Spouse

2. All children 18 years of age or older

3. All grandchildren 18 years of age or older

4. Mother and father

5. All siblings 18 years of age or older

6. All nephews and nieces 18 years of age or older

7. All grandparents

8. All uncles and aunts 18 years of age or older

9. All first cousins 18 years of age or older

10. All first cousins once removed 18 years of age or older

11. All great grandparents
The consent must specify any restrictions to the postmortem examination.

b. Clinical information and questions

An autopsy consultation form filled out by the requesting physician must be presented to the pathologist before the autopsy begins. This form will include a summary of the patient’s history, hospital course and any particular questions. In this way, we can understand the case, direct our attention to the areas of interest and perform the appropriate studies.

5. Turn-around time

By the following day, a preliminary anatomic diagnosis will be issued. A final report must be completed within sixty (60) days.

6. Where the risks to laboratory personnel outweigh the benefits, autopsies will not be routinely performed in patients with:

a. HIV infection
b. Jacob-Creutzfeldt Disease
c. Meningococcal meningitis

15. Physicians assigned to service coverage must accept responsibility for the delivery of care to all patients regardless of race, creed, color, type of illness, or insurance coverage. Failure of compliance shall be considered a violation of patient rights and requires corrective action by the appropriate chief, but in no case less than two weeks of suspension from all hospital activities.

16. Patients are not permitted to smoke except as specified in the hospital’s Smoking Policy. Orders which do not conform to this policy shall be considered invalid.

17. All orders for restraint shall follow the hospital’s policy and shall be in writing, specifying the time restraints are to be utilized (subject to maxima as listed in the policy). Each use of restraints shall be proceeded by the physician’s evaluation of the patient and documentation of such in the Medical Record.

18. Coverage schedules must be communicated in a timely manner to the Emergency Department and the Medical Staff Affairs Office. Changes in the schedule need to be communicated as soon as possible to prevent delay and misunderstanding.

E. CARE OF PATIENTS IN THE SPECIALTY CARE UNIT

1. General Rules and Regulations

a. No physician may perform a procedure in the specialty care units for which he does not have privileges in his credentials folder. This includes procedures such as cutdown, arterial line insertion, etc.

b. All patients must be seen within a reasonable period of time after admission to the Units consistent with the patient’s acuity.
c. Patients shall be reevaluated as required by the clinical situation. At a minimum, daily visits are required and must be documented with a progress note.

d. The classification of privileges (credentialing) determines what kind of medical problems the physician can treat and when consultation is necessary. HOWEVER, EVEN UNRESTRICTED PRIVILEGES DO NOT OBVIATE THE NEED FOR CONSULTATION IN APPROPRIATE CASES (see 9.d.6. above).

e. The consultant must be called by the physician requesting admission to the Unit.

f. The name of the consultant must be known by the nursing staff at the time of admission in case an emergency situation arises.

g. Responsibility is shared between the primary physician and consultant. As indicated in D(9) above, one physician must be designated as being in overall charge of the patient. Good communication is critical for excellent medical care. Any significant change in orders should be done only with an understanding between the involved physicians.

h. Multiple trauma cases should have a general surgeon as primary physician.

i. Pediatric patients under age 15 must have a pediatric consultation or a pediatrician as primary physician.

j. Respirators must be managed by a pulmonary consultant, an anesthesiologist, or a thoracic surgeon.

k. When signing out, coverage must be by a physician of equal competence and must be credentialed in the same subspecialty. The covering physician should be contacted directly to relay pertinent information concerning the patient. THE NAME OF THE COVERING PHYSICIAN MUST BE MADE KNOWN TO THE NURSING STAFF AND SHOULD BE WRITTEN ON THE ORDER SHEET.

l. The appropriate physician or his designated covering physician must be available at all times for the Units. In the event that the primary physician or the consultant is unavailable, the Director or the Clinical Coordinators may personally intervene, provide the necessary care, or appoint such medical coverage as is deemed appropriate.

m. Patients must meet admitting and discharge criteria. The primary physician will be contacted if the patient meets discharge criteria and there is a need to transfer the patient to a lower level of care.

n. A comprehensive admitting note with a detailed history and physical examination is required at the time of admission.

o. The basic goal of the SCU personnel is excellence of patient care. One of the prime functions of the Director and the Clinical Coordinators is ongoing daily appraisal of patient care. On occasion, the Coordinator or Director may call the primary physician to discuss a specialty care patient so the Coordinator may better understand the goals of therapy.

2. Telemetry - Purpose and Definition
The telemetry unit is designed to provide additional cardiac rhythm monitoring for a select group of patients. Eight telemetry channels are available for patients on 5 South. Patients may be either transferred to the telemetry unit from the SCU or admitted directly by a cardiologist, or alternatively, a vascular surgeon, according to the following guidelines:

a. Patients with a symptom complex possibly secondary to dysrhythmia, but not requiring immediate therapy (e.g. syncope, rule out dysrhythmia).

b. Status post implantation of a permanent pacemaker.

c. Patient with known dysrhythmia not requiring immediate therapy but where close observation is warranted in delineating the extent and significance of the disturbance (e.g. frequent asymptomatic VPDs, Lown Class III or above).

d. Patient with known pre-existing significant dysrhythmia or conduction disturbance requiring observation during adjustment of oral medication (e.g. incomplete trifascicular block, physician beginning oral Quinidine therapy or any other comparable agent).

3. Patient Selection of Telemetry - Transfer from SCU

Patients are to be considered as eligible for transfer from SCU to telemetry in the following setting or situation:

a. The patient is not dependent on IV infusion or antiarrhythmic drugs.

b. The patient does not experience symptoms secondary to change in rhythm (e.g. syncope secondary to decreased heart rate).

c. Last day of infarction observation. (Patients who have been essentially stable but need to be observed for ectopy prior to transfer to medical/surgical floor.)

d. Post cardioversion, stable for at least one hour.

e. Arrhythmias which are stable. (Keep under telemetry observation for 12-24 hours.)

f. Cardiac rhythm disturbances requiring monitoring during alteration of drug therapy.

g. Stable external pacemaker awaiting implantation of permanent pacemaker (if not pacemaker dependent).

h. Other individual cases.

4. Discharge from Telemetry Unit

The attending physician will be responsible for discharge of the patient from telemetry. (If a question arises regarding discharge from telemetry, the Physician Coordinator will make the final decision.) If patients meet discharge criteria approved by the Medical Staff, they should be discharged either to a regular medical bed or home.

F. DEPARTMENT OF MEDICINE

1. Administrative Structure
a. The Director of the Department of Medicine shall be responsible for the administration of the Department, shall attend all Hospital and Committee meetings as required by the Medical Staff Bylaws, and shall discharge such other functions as are commensurate with his office.

b. The Director of the Department will nominate one individual to serve as his Associate Director, such nomination to be presented to the Medical Board. The functions of the Associate Director shall include chairing the Medical Mortality Committee and participation in various other functions of the Department as decided jointly by the Director and Associate Director. The function of the Associate Director shall also be to implement, to smooth, and to augment the functions of the Department in the absence of the Director. Finally, the Associate Director will represent the interests of the Department in the absence of the Director.

c. The Department of Medicine is divided into divisions, division chiefs being the appointees of the Director. Division Chiefs are directly responsible to the Director of the Department of Medicine and their functions include the following:

1. Participation in the Quality Assurance program of the Department.
2. Participation in the educational programs of the Department.
3. Participation in the evaluation of new treatments and new procedures in their respective divisions.
4. Development of a regular meeting program schedule within their division; minutes of these meetings shall be maintained and forwarded to the Director of the Department of Medicine.
5. Divisions within the Department of Medicine include the following: Cardiology, Oncology/Hematology, Neurology, Pulmonary Medicine, Nephrology, Dermatology, and Gastroenterology.

d. Members of the Department of Medicine shall adhere to all requirements for patient care, physician coverage, consultation and documentation as required elsewhere in these Rules and Regulations.

2. Delineation of Privileges

The Director of the Department, with the advice of the Chief of Sections, shall recommend for each member of the Department privileges and promotion based on training, experience, and demonstrated competence. Participation in a program of Continuing Medical Education and committee function shall also be considered in this assessment. Such review will take place on a biennial basis.

The Director of the Department will establish a classification of privileges in various categories. The categorization of a member of the Department into such category will depend on qualifications that he or she has obtained through formal training or appropriate and recognized postgraduate education in the specialty and/or subspecialty under consideration. Privilege delineation will include a specification of medical and surgical procedures permitted for each physician. Consultation and assisting requirements will be addressed where applicable. The classification of privileges shall also detail an explanation of the services to be rendered by each physician.
3. Admission Policy

Admission policies are delineated under section "A. Admission of Patients" and "E. Care of Patients in the Specialty Care Units" sections of the Rules and Regulations.

4. Medical Records and Reports

Each patient shall have a Medical Record. This record shall be compiled adhering to the section on Medical Records contained in the Rules and Regulations, "Q. Medical Records".

5. Quality Assurance/Performance Improvement

Departmental meetings addressing Quality Assurance and Performance Improvement issues shall be held on a monthly basis. The compiled data, conclusions and actions shall be included in a report distributed to the Medical Board.

6. Continuing Medical Education

The Director of the Department of Medicine acting in concert with the Chairman of the Continuing Medical Education Committee shall develop an ongoing program of medical education. In part, this will reflect the need to address issues raised in the Quality Review process and which are remediable by an educational process. A schedule of such conferences shall be prepared and distributed on a monthly basis to all members of the Medical Staff.

G. DEPARTMENT OF FAMILY PRACTICE

1. Administrative Structure

   a. The Director of Family Practice shall be responsible for the administration of his department and shall attend all Hospital and Committee meetings as required by Medical Staff Bylaws. The Director shall be responsible for the compliance of his department members with hospital regulations. He shall develop and implement the Quality Assurance/Performance Improvement program of his department.

   b. An Associate Director and Secretary shall be elected at the first departmental meeting of each year. This election shall be determined by a majority vote of the members attending.

   c. The Associate Director of the Department of Family Practice shall perform all administrative duties in the absence of the Director. The Secretary of the Family Practice Department shall function as Medical Education Program Director and shall be responsible for the discharge of administrative obligations in the absence of the Director and Associate Director.

2. Delineation of Privileges

The privileges of each member of the Family Practice Department shall be reevaluated every two years. The privileges in each subspecialty shall be granted in consultation with, and approval of, the respective department Director. These shall be maintained in writing in the appropriate section of the Medical Staff Affairs Office (Practice Profiles).

Consultation shall be obtained by the Family Practice physician as
warranted by the diagnosis and severity of the patient's illness, and with consideration of the physician's experience and training.

The Family Practice physician shall be required to call appropriate consultation for all patients in the Specialty Care area, and a consultative relationship will remain in effect until the patient leaves the Specialty Care area. Ongoing consultative assistance may also be required. The Family Practice physician shall appoint a coordinating physician for all patients in the Specialty Care area. The Family Practice physician may resume primary care when the patient leaves the Specialty Care area.

3. Admission Policy

Criteria for admission are detailed in the Rules and Regulations under section "A. Admission of Patients" and "E. Care of the Patient in the Specialty Care Units".

4. Medical Records and Reports

Each patient shall have a Medical Record. This record shall be compiled adhering to the section referable thereto, "Q. Medical Records".

5. Quality Assurance/Performance Improvement

The department shall meet monthly, and minutes shall be kept of each meeting. At this meeting, discussions of monitoring and evaluation of data shall be presented and discussed. The compiled data, conclusions, and actions shall be included in a report distributed to the Medical Board.

6. Continuing Medical Education

The Secretary of the Family Practice Department shall be responsible for the development of a program of Continuing Medical Education. Topics and speakers will be selected relevant to the needs of the department, and a calendar of such events shall be circulated to all members of the Family Practice Department.

H. DEPARTMENT OF PEDIATRICS

1. Administrative Structure

a. The Director shall be selected by the Medical Board in accordance with Medical Staff Bylaws.

   The Director shall:

   1. Preside at monthly Departmental meetings;
   2. Review the credentials of all physicians with privileges in Pediatrics on a biennial basis;
   3. Supervise the performance of all provisional attending physicians in the Department of Pediatrics;
   4. Make annual recommendations as indicated for changes in staff status of Department members;
   5. Ensure the presence of appropriate and qualified consulting staff;
   6. Nominate an Associate Director to serve in his absence;
7. Supervise the quality assurance process of the Department, and in that regard, shall be an ex officio member of the Pediatric Quality Review Committee; and,

8. Provide appropriate concurrent review of patient care to help ensure a satisfactory outcome, or to monitor a physician's performance when that has been raised as an issue in the Quality Assurance/Performance Improvement process.

2. Delineation of Privileges

a. Classification of privileges will be established in various categories.

b. Each member of the Department of Pediatrics, or a physician seeking privileges in the Department of Pediatrics, shall be placed in one of these categories according to the qualifications obtained through formal training or appropriate, recognized postgraduate courses in Pediatrics and its sub-specialties.

3. Patient Admission Policy

a. All children whose physical/emotional condition warrants shall be admitted to the hospital. All newly admitted patients shall be seen in a time span commensurate with the clinical status of that patient. Well newborns shall be seen within 24 hours. See also "E. Care of Patients in the Specialty Care Unit" (appropriate sections referable to Pediatric patients). In all cases, orders shall be written, a physical examination performed, and admission notes written.

b. The Attending Pediatric physician shall review all written orders with the charge nurse.

4. Medical Records and Reports

Each patient shall have a medical record. This will be compiled according to the section of Medical Records contained in the Rules and Regulations, "O. Medical Records".

5. Quality Assurance/Performance Improvement

The Department of Pediatrics will have in effect a Quality Assurance/Performance Improvement process which is in compliance with requirements and regulations of the Joint Commission on Accreditation of Healthcare Organizations, the New York State Department of Health, the Medical Board of Phelps Memorial Hospital Center, and such other appropriate regulatory bodies. Generally considered in the scope of review of Pediatric care shall be the care rendered to newborns, general Pediatric and adolescent patients, evaluation of surgical referrals, and the initiation of preventative Pediatric medicine. Particularly to be included under aspects of care requiring intensive and ongoing assessment will be the newborn patient population, and specifically the treatment of hyperbilirubinemia, and all premature infants exhibiting respiratory distress and/or failure to thrive. Emergency Department Pediatric services will be included in the Quality Review/Performance Improvement process.

From the identified aspects of care referenced above, indicators are selected for monitoring and standards of care are defined. Such indicators shall be selected to evaluate high-risk, high-volume or problem-prone issues. When available, care shall be compared to standards have attained national acceptance and recognition.
Quality Review/Performance Improvement data may be derived from several sources, including indicator monitoring, generic screens, and focused reviews. Departmental meetings addressing Quality Assurance issues shall be held monthly. The compiled data, conclusions, and actions shall be included in a report distributed to the Medical Board. Where opportunities for improved care are demonstrated, corrective action is postulated, and plans made for follow up monitoring. Case review data, mortality review analysis, and other specific practitioner information will be included in the Physician Practice Profile. The Department Director may include other relevant material in the Physician Practice Profile, but the respective practitioner will be so informed in those instances.

6. Continuing Medical Education

The Department of Pediatrics will establish a program of ongoing medical education. Where educational programs are established in a formal fashion, a schedule of those events shall be circulated to the Pediatric and applicable members of the general medical staff.

I. DEPARTMENT OF SURGERY

1. Administrative Structure

a. Director of Surgery

1. The Director will be responsible for the orderly running of the Department, and will serve as a member of the Medical Board, Surgical Services Committee, Quality Review Committee and Surgical Appraisal Committee.

2. The Director will be responsible for reviewing the quality of the work of the Department through the section chiefs and the appraisal committees. The Director will implement an effective quality assurance/performance improvement program in the Department and its sections.

3. Operating Room problems requiring immediate resolution may be referred to the Director for prompt action.

4. All initial appointments, reappointments and promotions must be recommended by the Director.

5. Specific delineation of privileges for new procedures shall be submitted to the Credentials Committee by the Director, including the criteria for training and education.

b. Associate Director of Surgery

1. The Associate Director will be selected by the Director. The Medical Board will be notified of the selection.

2. During the absence of the Director, the Associate Director will assume the responsibilities of the Director.

3. The Associate Director will serve on the Surgical Appraisal and the Surgical Services Committees.

c. Surgical Sections

The sections of the Department are Dental and Oral Surgery, General Surgery, Neurosurgery, Orthopedics, Ophthalmology, Otolaryngology,
2.  Delineation of Privileges

   a.  The Director, with the advice of the section chief, will approve privileges for each physician in the department. Privileges will be reviewed at the time of reappointment.

   b.  Unless otherwise defined, department members at the level of senior, associate, assistant, and visiting attending staff will have independent operating and consulting privileges within their specialty.

   c.  Provisional surgeons will have their work supervised as determined by the chief of the service. In order to be promoted, the provisional attending will undergo review of 15 cases by the chief of that section. The Director of Surgery will present this data to the Credentials Committee in considering advancement of the provisional attending to assistant attending status.

   d.  A consultant to the Medical Staff, as defined in Bylaws 4.4, may render consultations and may scrub as an assistant in operative procedures.

   e.  Courtesy affiliates may render services as outlined in the Bylaws and as delineated by the section chief with the approval of the Director.

3.  Admission Policy

   Admission of patients to a surgical service is at the direction of a surgical attending with admitting privileges. The admission diagnosis should fall within the generally accepted category of the specialty of the admitting surgeon. All multiple trauma patients should be admitted by a general surgeon.

4.  Medical Records and Reports

   a.  Medical Records will be maintained in compliance with the Rules and Regulations of the Medical Staff.

   b.  A brief operative note must be handwritten in the medical record immediately after the procedure before the patient is transferred to the next level of care. This note must include the name(s) of the primary surgeon(s) and his or her assistant(s), the procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. A full operative note must be dictated for each surgical procedure.

   c.  A history and physical examination, and appropriate consultations and laboratory results, must be on the chart prior to each patient's entry to the operating room. In a patient over the age of 45 years, an EKG and CBC are required for general anesthesia (endotracheal and intravenous) administered in the operating room. Other requirements for preoperative testing and consultations may be established by the sections and approved by the Medical Board.

   d.  Properly completed consent forms must be on the chart prior to entry of the patient to the operating room. In addition, a pre-operative note must document informed consent including the nature of the procedure, as well as a reference to indications, risks, benefits, and alternatives.
e. Requirements in Sections C & D may be waived in an emergency. All such cases will be referred to the Director of Surgery and Medical Director for subsequent review.

f. Post-operative orders must be written prior to or upon arrival of the patient in the post-anesthesia recovery area in a timely fashion. All orders written prior to surgery are inactive and must be re-written or activated by the surgeon after the procedure.

5. Quality Assurance/Performance Improvement

a. The Department Director will be responsible for the Quality Assurance program of the Department including Quality Review, assessment, and implementing indicated corrective action.

b. Each section shall establish and maintain an appraisal committee. The Committee will meet with sufficient frequency to review the charts referred or assigned to the Committee. The section chief shall serve as chairman of the Committee. The purpose of the Committee will be to review the quality of the work of the section.

c. If necessary, the Director of Surgery may convene a Department-wide Quality Assurance/Performance Improvement Committee to address issues requiring input from various sections. The membership of this committee shall include section chiefs and other individuals appointed by the Director.

d. Monthly departmental meetings will be held with presentation of quality issues and monitoring results. The minutes of this meeting will be forwarded to the Medical Board and the Quality Assurance Committee.

6. Continuing Medical Education

The Director may appoint a department member to serve as a chairman of the surgical education program. The chairman will arrange an educational program with department members or outside speakers as appropriate. Meeting topics will be circulated to the members of the department in advance.

7. Policies and Procedures

a. All tissue removed at surgery will be sent to the Pathology Department. Proper identification and relevant documentation of this specimen is the responsibility of the surgeon.

b. A surgical assistant is required for designated operative procedures. This list shall be approved by the Medical Board, and may be amended from time to time as recommended by the various sections, consistent with appropriate surgical practice. The list shall be posted in the Operating Room and distributed periodically.

c. Patients must be seen and their progress documented with a frequency appropriate to their level of care [see Q. Medical Records (4), paragraph 2].

d. A surgeon must designate a qualified surgeon to cover the practice when the first surgeon is unavailable; the covering surgeon shall be in the same specialty.

e. Each surgeon will rotate on the Service Coverage roster as assigned by the Department Director or Chief of Service.
f. Appropriate preoperative evaluation is a joint responsibility of the surgeon and the anesthesiologist and must be attested with a preoperative note by both physicians.

g. Departmental Rules and Regulations will be reviewed no less frequently than every three years.

h. The introduction of new equipment brought to the Operating Room must be approved by the chief of the section, the Director of Surgery, and the Operating Room Supervisor.

8. Trauma

a. General Surgery

1. A general surgeon on-call must respond in person to the Emergency Department in the following situations:

a. All obvious general surgical conditions.

b. All multisystem trauma.

c. All trauma assessed by the Emergency Department physician as demonstrating or possessing significant potential for multisystem involvement.

d. At the request of a consulting physician who has assessed the patient.

e. Any patient in shock, pending shock, or demonstrating cardiovascular instability secondary to trauma.

2. All patients admitted with a diagnosis of multiple trauma will be admitted to a general surgeon. The General Surgeon shall serve as coordinating physician for such patients until the patient is stable and care is turned over to another practitioner.

b. Surgical Subspecialties

1. A surgical subspecialist on-call must respond in person to the Emergency Department in the following situations:

a. Condition obviously falling within the subspecialist's scope of practice.

b. Single system trauma in the area of the specialist’s practice, assessed by the emergency physician as lacking potential for multisystem involvement.

c. At the request of an Emergency Department or consulting physician who has assessed the patient.

2. All patients with trauma limited to a single system and requiring hospital admission will be admitted to the appropriate service.

b. Head Injury

1. Head injury with recent or contemporary symptoms assessed by the Emergency Department physician may require a CT Scan of the head. This will usually be ordered by the Emergency Department physician or general surgeon after dialogue with
the attending neurologist or neurosurgeon. CT Scans will be interpreted by members of the Department of Radiology. It is the responsibility of the radiologist on-call to provide a timely interpretation if such physicians are not on site.

2. If a head injury other than concussion is the sole reason for admission to the Specialty Care Unit, a neurosurgeon must be the admitting and coordinating physician.

d. All patients admitted with a primary diagnosis of trauma must have a general surgeon or surgical subspecialist as the coordinating physician while the patient is in the Specialty Care Unit. The sole acceptable exception is a patient admitted for concussion without significant other trauma (i.e. with a negative CT Scan) who may be admitted and attended by a neurologist.

J. AMBULATORY SURGERY

The Phelps Ambulatory Surgery Unit, located on 3-North, consists of Ambulatory Surgery, Endoscopy, Pain Management and the Retinal Diagnostic and Laser Surgery Units. Outpatients receiving blood transfusions, paracentesis and other minor procedures are also cared for in the ASU.

1. Hours of Operation: The unit is open from 7 a.m. to 7 p.m., Monday through Friday. Patients are to report to the Admitting Office at 6:30 a.m. or at times as otherwise approved by the Surgical Services Committee.

2. Pediatric Surgical Patients: Pediatric patients will be boarded on the Pediatric Unit.

3. Medical Staff Coverage

a. Members of the medical staff who hold privileges to perform procedures offered in the Ambulatory Surgical Unit may admit patients to the unit.

b. Only those procedures listed in the Ambulatory Surgery Policy and Procedures Manual (Scope of Services) are appropriate to be performed on ambulatory patients. Any other procedures must be approved by the Director of the Ambulatory Surgical Unit prior to scheduling.

c. The admitting surgeon shall bear the primary responsibility for all aspects of preoperative, intraoperative, and postoperative care of patients in the Unit. The admitting surgeon will also be responsible for completion of all requisite parts of each patient's medical record.

d. The Ambulatory Surgery Unit shall be under the medical direction of a Board Certified or eligible surgeon or anesthesiologist.

4. Charting Requirements

All patients shall have an appropriate history and physical examination performed by the surgeon and submitted prior to the procedure. A postoperative note shall be written on each patient.

5. Each post surgery patient shall be observed for postoperative complications for an adequate period of time determined by the attending physician and the anesthesiologist.

6. Detailed verbal and written instructions will be provided to the patient at
K. RULES AND REGULATIONS OF THE OPERATING ROOM

1. Booking of Operations
   a. Operations shall be scheduled by the surgeon directly or by his designee, and the date of booking will be placed in the scheduling book. If the case is not scheduled by the surgeon, the booking will be "tentative" until confirmed by him.
   b. The hours of operation for elective procedures shall be determined by the Surgical Services Committee.

2. Emergency Cases
   a. Emergency cases will be accepted at any time and will be done as soon as possible. When a surgeon schedules an emergency, he must be prepared to perform the operation as soon as the Operating Room can be made available.
   b. The operating surgeon will determine, with both the Operating Room supervisor and the anesthesiologist in charge, whether the schedule shall be interrupted.
   c. The surgeon should notify the Operating Room nurse of the approximate time when the patient will be ready for the Operating Room.
   d. It shall be the responsibility of the surgeon to call the anesthesiologist and Operating Room nurse on first call for any emergency surgery after working hours of the Operating Room.
   e. On Saturdays, Sundays, and holidays, surgery will be limited to emergency cases only and urgent inpatient cases unless elective time is made available by the hospital.

3. General Rules
   a. Other schedules, including surgeons' office hours, must not interfere with the Operating Room schedule; i.e., an emergency case will be done as soon as possible and not when a surgeon finishes his office hours.
   b. Operations should begin at the scheduled time. The surgeon should be in the Operating Room suite fifteen minutes prior to the scheduled time. If the surgeon is not on time, the Operating Room supervisor has the authority to move the case to the end of the schedule. Frequent offenders may be subject to disciplinary action.
   c. Surgeons in the middle or at the end of the schedule are expected to work at their scheduled times.
   d. The operating surgeon should stay in the Operating Room suite with his patient, direct and/or assist in the removal of the patient to the stretcher and accompany the patient to the Post Anesthesia Care Unit, Critical Care units or to the floor.
   e. Assignment of cases for any one Operating Room is flexible. All efforts should be directed to completing the day's schedule as rapidly and efficiently as possible. All reassignments will be at the discretion of the Operating Room supervisor.
   f. The Operating Room supervisor is authorized to contact the Director
of Anesthesia or the Director of Surgery to assist in rearranging the schedule when special problems occur. Cancellation of scheduled cases may be done only by one of the above.

g. Special requests with respect to the anesthesiologist desired or the time of operating will be honored as closely as possible but cannot be guaranteed.

h. Any patient called for by the Operating Room who does not have a history and physical examination recorded on the chart will be placed at the end of the schedule.

i. The anesthesiologist should remain with his patient at all times when the patient is anesthetized, except for a dire emergency.

j. The Operating Room supervisor shall make up the daily schedule and refer the same to the proper anesthesiologist for room assignment.

k. Cancellation of scheduled cases, because of lack of beds or absence of an anesthesiologist, may be done only by the Director of Anesthesia or, in his absence, the the Director of Surgery and/or Director of Obstetrics & Gynecology, if appropriate.

l. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

m. Policies for assisting at surgery shall be established by the Medical Board and approved by the Board of Directors. It shall be the responsibility of the primary surgeon to arrange for assistants.

4. Dental Care

a. A patient admitted for dental care is a dual responsibility involving the dentist and the physician member of the Medical Staff. Medical consultation is required preoperatively on all dental cases. Board Certified oral surgeons, if so credentialed, may perform their own histories and physicals.

b. The dentist is responsible for:

1. A detailed dental history justifying hospital admission.
2. A detailed description of the examination of the oral cavity and a preoperative diagnosis.
3. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and number of fragments removed. All tissue, including teeth and fragments, shall be sent to the hospital pathologist for examination.
4. Progress notes as are pertinent to the oral condition.
5. Discharge summary, if required by the patient’s length of stay.
The physician (or credentialed oral surgeon) is responsible for:

1. Preoperative medical evaluation including medical history, physical examination and evaluation of laboratory data to determine the patient's condition and suitability for anesthesia and surgery.
2. Supervision of the patient's general health status while hospitalized - under the Director of Surgery.

d. The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

5. All tissues removed at the operation shall be sent to the hospital pathologist who shall perform such examinations as are considered necessary to arrive at a tissue diagnosis. The authenticated report shall be made a part of the patient's medical record.

6. All rules and regulations applying to surgical assistants, anesthesia and handling of specimens shall apply to dental and oral surgery patients.
7. Surgeons are required to report in a timely manner any adverse reaction to any implanted tissues, materials or devices.

L. DEPARTMENT OF ANESTHESIOLOGY

1. Administrative Structure

a. The Director of Anesthesiology shall be responsible for the administration of the Department. Clinical and administrative responsibilities of the Director shall be exercised within the Operating Room, the Labor and Delivery Area, the Post-Anesthesia Care Unit, and in such other areas of the Hospital as may be appropriate. An Associate Director will be appointed by the Director, and, in the absence of the Director, will act in his capacity.

b. Scope of Care: An Anesthesiologist must be personally responsible to each patient for the provision of Anesthesia Care. Anesthesia Care is provided by designated Medical Staff members of the Department of Anesthesiology. Anesthesia Care may include the following:

1. The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetric, and certain other medical procedures. This involves the preoperative, intraoperative, and postoperative evaluation and treatment of these patients;
2. The protection of life and vital organ functions under the stress of anesthesia, surgical, and other medical procedures;
3. The management of problems in pain relief;
4. The management of cardiopulmonary resuscitation;
5. The management of pulmonary care; and
6. The management of critically ill patients in the Special Care units.

2. Delineation of Anesthesia Privileges
a. The granting, reappraisal, and revision of clinical privileges shall be in accordance with the Medical Staff Bylaws. As applied to the Department of Anesthesiology, the following classes of privileges are defined:

1. Class I: Local infiltration anesthesia, topical application of anesthetics, and minor nerve blocks without intravenous sedatives and/or narcotics.

2. Class II: Class I privileges and in addition conscious sedation (intravenous sedatives, anxiolytics, and/or narcotics).

3. Class III: Privileges to employ all modalities of Anesthesia Care including spinal, epidural and general anesthesia.

3. Patient Admission Policy

See "K. Rules and Regulations of the Operating Room:...1, a-d, and 2, a-e". (q.v.)

4. Medical Records and Reports

See "K. Rules and Regulations of the Operating Room:...5. (q.v.).

5. Quality Assurance

There will be monthly Departmental meetings. The meetings will be focused on evaluation of quality of anesthesia care rendered, peer review activity, medical education, formulation of anesthesia policies and procedures, and review of communications. The compiled data, conclusions, and actions shall be included in a report distributed to the Medical Board.

6. Continuing Medical Education

The Department will establish standards for Continuing Medical Education. Where educational programs are established, a schedule of those events shall be circulated in advance to applicable segments of the medical, nursing, and allied health staff.

7. Policies and Procedures

The Policies and Procedures Manual of Anesthesia Care is maintained in the Operating Room, the Labor and Delivery area, and the Post-Anesthesia Care Unit.

8. Scheduling of Anesthesia Care

Although members of the Department of Anesthesiology practice as a group insofar as sharing of professional responsibilities, each member retains his individuality as pertains to his relationship to patients and to his peers. Patients and professional colleagues retain the privilege of expressing a preference for a particular anesthesiologist. This preference will be honored if presented to the Operating Room Secretary before finalization of the daily Operating Room Schedule.

M. DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

1. Administration

The Department of Obstetrics and Gynecology is headed by a Director who is appointed and assigned responsibilities in accordance with the Bylaws of
the Phelps Memorial Hospital Center's Medical Staff.

The Director will appoint an Assistant Director who will be responsible for supervising the Department in the absence of the Director.

2. Delineation of Privileges

Professional privileges are defined for each member of the department. Granting of these privileges is based on the education, experience, and demonstrated competence of the physician. Classification of privileges are categorized as follows:

a. Category I: These privileges designate a degree of patient care in which the disease process or usual therapy poses a minimal risk to the life of the patient. Category I privileges include management of the following conditions and procedures:
   1. Normal antepartum and postpartum care.
   2. Normal labor and delivery.
   3. Low forceps delivery.
   4. Episiotomy and repair of second degree lacerations.

b. Category II: These privileges designate a degree of patient care in which there is a major disease process present requiring more complicated therapy, implying an increased risk to the life of the patient. Category II privileges may include the following:
   1. Items in Category I.
   2. Preeclampsia.
   3. Repair of third degree lacerations.
   4. Specified minor gynecologic operations.

c. Category III: These privileges designate a degree of patient care in which the severity of the disease and/or risks of complicated care pose a serious threat to the life of the patient. This category of privileges includes management of most obstetric and gynecologic medical and operative procedures, with the exception of certain specified highly technical or infrequently done procedures.

d. Special Competence: Beyond these three major categories there may be physicians who possess additional special training and demonstrated competence, qualifying them for extended privileges in the management of certain specialized areas involving unusual or complex diagnosis or therapy. These areas will be explicitly delineated in written form by the Director of the Department and must be approved by mechanisms specified in the Medical Staff Bylaws.

3. Consultations

a. Consultation must be obtained from a physician with privileges to treat the particular illness involved.

b. Consultation is required as follows:
   1. In categories of complexity exceeding the listed category of privileges of the attending physician.
2. In areas of gynecological surgery in which there exists risk of injury or disease to adjacent structures such as bowel, bladder and ureter, by gynecologists lacking the appropriate special skills. (Gynecologists with appropriate training may perform diagnostic and therapeutic urologic procedures in the lower urinary tract.)

c. Consultation is required of Physicians who do not have Category III privileges:

1. In every case wherein a patient has been in active labor within the Hospital for a period of twelve hours or with membranes ruptured for twelve hours.

2. In every case requiring use of parenteral oxytocics for induction of potentiation of labor.

3. In every case of multiple pregnancy.

4. In every case of abnormal presentation including breech presentation or decomposition of the breech or breech extraction.

5. In every case of toxemia.

6. In every case of hemorrhage, manual removal of the placenta, and packing of the uterus.

7. Prior to all vaginal operations, with the exception of episiotomy or outlet forceps.

8. Prior to all destructive operations.

9. In all cases involving pregnant or puerperal patients with major medical, surgical or obstetric complications.

10. In all cases involving patients with intrapartum fever.

11. In all cases of previous Cesarean Section.

4. Medical Records

Each obstetrical patient should have a medical record that includes both antepartum and in-hospital care data.

5. Anesthesia

The anesthesiologist on-call should be informed in advance if a complication with the delivery is anticipated. Anesthesia information discussed during the patient’s prenatal care should be reviewed with the patient, including information regarding the advantages, disadvantages, and risks associated with various forms of anesthesia.

6. Adoptions

Private adoptions are permissible as long as they are in accordance with State Law and hospital policy. The adoption procedure is outlined in the Hospital's Administrative Manual.

7. Quality Assurance/Performance Improvement

Monthly meetings will document review of a representative number of both
gynecological and obstetrical cases. In addition, indicators and other sources of data will be reviewed. Findings, conclusions and recommendations shall be forwarded to the Quality Review Committee.

N. DEPARTMENT OF PATHOLOGY

1. Administrative Structure

   a. The Director of Pathology/Director of Laboratories is a member of the medical staff and is appointed as a medico-administrative officer. The Director is responsible for the proper functioning of the Laboratory and the Pathology Department both medically and administratively in accordance with New York State Law.

   b. In the absence of the Director, the senior Associate Pathologist functions as Acting Director.

2. Delineation of Privileges

   Privileges are recommended for members of the Department by the Director based on education, training, experience and/or documented competence.

3. Medical Records and Reports

   Standards for format and completeness of reporting are maintained for the Department. Target turnaround times are set for surgical, cytology and autopsy reports. Written reports are rendered and copies of all reports are retained.

4. Quality Assurance/Performance Improvement

   The Director shall be responsible for the Quality Assurance/Performance Improvement program. Departmental meetings are held on a monthly basis. The agenda for these meetings will include case review and indicator monitoring. The compiled data, conclusions, and actions shall be included in a report distributed to the Medical Board.

5. Continuing Medical Education

   Pathologists participate in continuing medical education so as to maintain current CAP Standards and meet AMA Physician Recognition Award criteria. The Department is committed to assisting with ongoing educational efforts through interdepartmental conferences.

6. Policies and Procedures

   Additional policies and procedures are contained in separate manuals maintained within the Laboratory.

O. DEPARTMENT OF RADIOLOGY

1. Administrative Structure

   a. The Medical Director of the Department of Radiology is appointed and assigned responsibilities in accordance with the Bylaws of the Medical Staff of Phelps Memorial Hospital Center. The Director also serves as Director of the Nuclear Medicine and Radioimmunoassay Division of the department, in accordance with New York State Law.

   b. Associate Directors for divisions within the Department of Radiology may be appointed by the Director.
c. In the absence of the Director, in the event of illness or vacation, a senior staff radiologist designated by the Director will temporarily perform directorial duties.

2. Delineation of Privileges

a. Professional privileges are defined for each member of the department by the Director, based on training and education, experience, and continued competence.

b. Classifications of privileges are as follows:

1. Category I. General Diagnostic Radiology: This category includes the supervision and interpretation of imaging procedures by a general radiologist or general diagnostic radiologist:
   - Radiography; Fluoroscopy; Ultrasound; Computerized Tomography; Nuclear Medicine and Radioimmunoassay; Other noninvasive imaging procedures proved clinically useful.

2. Category II. Interventional Radiology and Special Procedures: Invasive procedures for diagnostic and/or therapeutic patient management. These procedures require additional training of the radiologist during residency years and/or on a fellowship basis. Periodic review of physician proficiency and competency will be performed. Crossover privileges for a limited number of non-radiologist physician specialists who provide documentation of their expertise fall into this category. Privileges for such procedures will be recommended by the Director of Radiology.

3. Category III. Special Competence: Subspecialty training and/or postgraduate work is required where the severity of disease and/or the risks of complicated medical care require a greater degree of medical expertise. Privileges will be granted to those who qualify.

4. Category IV. Radiation Oncology: Privileges delineated in accord with training, hospital equipment resources and community need.

5. Consultants or courtesy appointments may be made as recommended by the Director of Radiology and approved according to the Medical Staff bylaws.

6. An individual will be appointed as Radiation Physicist as an Associate to the Medical Staff.

3. Records and Reports

All radiological examinations require transcribed reports to be expeditiously distributed to referral areas. A copy of all reports is retained by the department.

4. Quality Assurance/Performance Improvement

Concurrent and retrospective review of departmental imaging and interventions are carried out on an ongoing basis. Information from indicators and other studies will be obtained and reviewed. Compiled data are forwarded to the Quality Review Committee quarterly.

Complete rules and regulations for radiological services are found in the Policies and Procedures Manual of this department.

P. DEPARTMENT OF PSYCHIATRY

1. Administrative Structure

a. The Director of Psychiatry serves as the full-time salaried Director of all of the Mental Health inpatient and outpatient services. His/her appointment is through the Medical-Administrative process specified in the Bylaws. Responsibility for the attending staff and all matters of professional performance require reporting to the Medical Board. Administrative responsibilities, including the operation of the Mental Health Center, require reporting to Administration. An Associate Director shall be appointed by the Director. There is a unit Chief for each inpatient unit who reports to the Director of Psychiatry.

In his/her absence, supervisory duties for the inpatient unit and other hospital areas involving attending staff will be assumed by the Associate Director; clinical and administrative responsibilities for the outpatient programs will be delegated to appropriate salaried Mental Health Center staff.

b. The comprehensive Mental Health Center includes inpatient units, outpatient units located on the Phelps campus and outpatient units located in the community.

A Table of Organization of the Mental Health Center is attached (see Appendix A).

c. Hospital Consultations

Salaried staff psychiatrists of the Mental Health Center provide emergency on-call services 9:00 a.m. to 5:00 p.m., Monday through Friday. Requests for consultations may be handled privately. The Department of Psychiatry provides on-call services between 5:00 p.m. and 9:00 a.m., and on weekends. Psychiatrists on call are expected to return calls promptly and provide consultations in a timely manner consistent with a high standard of medical care.

d. Mental Health Center Staffing

Inpatient - A multidisciplinary treatment team that works with the attending psychiatrists includes nurses, social workers, and activities therapists pursuant to Office of Mental Health regulations.

Outpatient - The professional and clinical staffing is in compliance with the appropriate licensing agency (Office of Mental Health or Office of Alcoholism and Substance Abuse Services) and may include psychiatrists, psychologists, psychiatric social workers, nurse practitioners, certified alcoholism counselors, psychiatric nurses, recreational therapists, occupational therapists, rehabilitation counselors, occupational therapy assistants and community aides.

2. Delineation of Privileges

a. The Chief of Psychiatry makes recommendations to the Credentials Committee as to the privileges to be held by a prospective or
current member of the Department. The specific privileges must be in areas where the Department member has adequate training and demonstrated competence. In general, the routine functioning of attending psychiatrists will include admitting patients to One South and 4 North, providing psychiatric treatment (including psychotropic medications) and coordinating medical treatment on One South and 4 North. They will also provide psychiatric consultation to the Emergency Department, Specialty Care Units, and Medical/Surgical floors.

b. Special procedures, such as ECTs, are specifically credentialed in accordance with the Bylaws of the Hospital.

c. Psychologists may be credentialed as Associates to the Medical Staff. Training and experience must include inpatient work. These Associates are credentialed to perform psychological testing and, under the supervision of a psychiatrist, to treat selected patients on the inpatient psychiatric unit. Associates who wish to exercise the latter privilege must attend at least two Departmental meetings a year.

3. Admission Policy

a. Inpatient admissions are largely on a voluntary basis. Involuntary patients may be admitted if they are safely manageable on unit. Patients must be 13 years of age or older (patients between 13 and 16 years of age can be admitted with the approval of the Director), must carry a DSM-IV diagnosis, must be able to benefit from treatment, and be able to be treated safely on One South.

b. Criteria for admission to the various inpatient and outpatient programs are described in the Policies and Procedures Manual.

c. All psychiatric patients admitted to Critical Care must be evaluated by a psychiatrist for appropriate disposition prior to transfer from the unit.

4. Medical Records

a. Inpatient medical records must reflect the care of the patient and must conform to all hospital requirements.

b. Outpatient records are kept by each program. Closed charts that remain inactive are stored centrally.

5. Quality Assurance/Performance Improvement

a. The Director shall appoint a Quality Appraisal/Performance Improvement Committee to review appropriate clinical cases, indicators and other quality data. Findings, conclusions and recommendations are referred to the Director of Psychiatry and forwarded to the Quality Review Committee.

b. Program Evaluation for all Mental Health Center programs. A variety of forms are used to collect data that is summarized periodically by each Division Chief. This data is analyzed with the objective of improving quality of care. These reports assess hospital programs, not medical staff, and are available to Administration and to regulatory agencies such as the Office of Mental Health.

c. A Utilization Review Committee reviews all outpatient cases in a
thorough manner. This review serves not only to determine if proper levels of care are being provided, but also to identify areas where quality of care might be improved.

d. Incident Review: Special Review Committee - Meets quarterly to review untoward incidents involving the Mental Health Center patients. Ad hoc meetings are called to review very serious incidents in order to expeditiously identify possible corrective action. All findings are included in the Quality Review/Performance Improvement process.

e. In the monthly meetings of the Department, the Attending Staff reviews trends and serious deficiencies reported from various sources (Special Review Committee, Quality Assurance Committee, Indicators, other Hospital departments, Office of Mental Health, etc.) and, where applicable, proposes corrective action.

6. Continuing Medical Education

Each member of the Department is expected to participate in Continuing Medical Education so as to maintain up-to-date clinical expertise. In cases of identified individual educational need, the Director may refer that person for appropriate learning. Identified collective educational needs will be addressed through discussions, presentations, or lectures at required meetings of the Department.

7. Restraint or Seclusion

Special treatment procedures that require justification include restraint or seclusion. A physician’s order is required for each use of restraint or seclusion. A physician must see and evaluate the patient, and confirm in writing within thirty (30) minutes, an emergency application of a restraint or order for seclusion. An order for restraint or seclusion requires the reason for the, the type of restraint, and the duration of the order, which may not exceed four (4) hours, unless the patient is asleep. If continuing restraint/seclusion is indicated beyond four (4) hours, another order is required, as well as supporting documentation. If protective restraint is required beyond twenty four (24) hours, written approval from the Director of Psychiatry is required.

Q. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. This record shall include:

   a. Chief complaint;
   b. Present illness;
   c. Family history;
   d. Past history;
   e. Review of systems;
   f. Physical examination;
   g. Provisional diagnosis;
   h. Medical or surgical treatment rendered;
   i. Operative report;
j. Pathology reports with tissue or specimen diagnosis;
k. Progress noted;
l. Final diagnosis;
m. Condition on discharge;
n. Discharge note or discharge summary;
o. Instructions to the patient regarding post-discharge care;
p. Autopsy report, when performed.

2. A complete history and physical examination shall be recorded within 24 hours of admission. Such examination shall, for women 21 years of age or older, include palpation of the breasts and a screening uterine cytology smear, unless this test is medically contraindicated or has been performed within the previous three years.

3. A complete history and physical examination, appropriate laboratory data and imaging studies, preanesthesia note, consent for surgery and any required consultations must be present in the record prior to surgery. These may be waived in an extreme emergency.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written as often as necessary to pertinently describe the clinical condition of the patient and progress of care and must justify the level of care rendered.

5. Operative notes shall include a detailed account of the findings at surgery, as well as the details of the surgical technique. Operative reports shall be written or dictated immediately after the surgical procedure and the report promptly signed by the surgeon and made a part of the patient's current medical record. A brief operative handwritten note is required after surgery if a full note is dictated, in compliance with JCAHO standards.

6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on the examination of the patient, the consultant's opinion and recommendations.

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

8. The psychiatric record, when relevant, shall address, in a manner consistent with Joint Commission requirements, the treatment modalities for restraint, seclusion, electroconvulsive therapy, psychosurgery, and behavior modifications procedures. These specific requirements shall be delineated in detail in the Policies and Procedures Manual of the Department of Psychiatry.

9. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication means to establish
authorship by a written signature. Computer authentication is acceptable to the extent allowed by state law and regulation.

10. Entries in the medical record must not contain any abbreviations that are listed as “forbidden” by the Medical Board.

11. Final diagnosis shall be recorded in full on the face sheet, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients, unless reports from ancillary sources are pending.

12. The face sheet of all medical charts should be completed in full and signed by the attending physician at the time of discharge. A discharge clinical summary shall be written or dictated on all medical records of those patients hospitalized over 48 hours, except for normal obstetrical deliveries and normal newborn infants. When the hospital stay is less than 48 hours, a final summation-type progress note shall be sufficient.

It is required that all charts be completed within 30 days of discharge, or for outpatient services, within 30 days of the service. Incomplete charts will be placed in the physician’s Medical record file and notification of these will be given to the responsible physician. Privileges will be suspended for any physician failing this requirement.

Physicians whose privileges have been suspended four (4) times in one calendar year may be demoted by one rank by the Medical Board.

13. Information contained in the medical record shall be released only as stated in the Phelps Memorial Hospital Center's policy on the release of medical information, which is on file in the Medical Records Department.

14. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner in the hospital. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of any portion of medical records, including but not limited to X-ray film, pathology specimens and slides, and electrocardiography records from the hospital, may be grounds for suspension of the practitioner for a period to be determined by the Medical Board.

15. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research projects consistent with preserving the confidentiality of personal information concerning the individual patients. All such research projects shall be approved by the Medical Board before records can be studied.

Subject to the discretion of the President of the Hospital, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

16. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Records Committee.

17. Access to and entries into the Medical Record will be limited to those credentialed practitioners with Medical Staff privileges, clinical/technical employees of Phelps Memorial Hospital Center, and agencies contracted by Phelps Memorial Hospital Center to provide patient care services and who are directly involved with the care, treatment, and testing of a particular patient.
Access shall be granted to employees (technical/clerical) conducting business on behalf of the Hospital for the purpose of Utilization Review, Quality Assurance, and administration of patient rights as required by the New York State Department of Health 405 Regulations.

Other individuals seeking access to the Medical Record must request administrative approval through the Director of Medical Records.

18. Guidelines for Out Patient Prescriptions and Documentation

a) All prescriptions for diagnostic testing require a written diagnosis or symptom that provides evidence of medical necessity for the test.

b) It is preferred that the ordering physician writes out the condition rather than providing a diagnostic code. “Rule out, probable, possible” diagnoses are not acceptable as evidence of medical necessity.

c) If a patient registers with a prescription that does not meet the requirement for medical necessity documentation, the physician will be called to provide the appropriate information. Physicians must respond in a timely manner.

d) If the prescription lacks appropriate medical necessity justification, the patient will be required to sign an Advance Beneficiary Notice, indicating that they understand that they may be responsible for the cost of the test. The hospital will take appropriate steps to obtain the proper documentation before billing the patient.

e) The hospital will maintain as a quality indicator a record of prescriptions that do not meet criteria for medical necessity as well as physician responsiveness to requests for information. For physicians credentialed at the hospital, the information will be available for Ongoing Professional Practice Evaluation and reappointment.

19. Guidelines for Inpatient Documentation

a) All notes and orders should be entered in the hospital’s electronic record and signed as soon as possible.

b) When documenting procedures, an appropriately detailed description of the procedure and findings must be included.

c) The clinical diagnosis made from test results must be written out, rather than using an arrow or other symbol (example: “hyponatremia”, not “↓Na”).

d) All inpatient stays must have a detailed discharge summary prepared as soon as possible after discharge but no later than 30 days after discharge.

e) The discharge summary must include the principal diagnosis, all other diagnoses and treatments provided during the stay. Discharge summary should not include a new diagnosis that was not documented throughout the chart.

f) “Rule out, probable, possible” diagnoses are acceptable on inpatient cases.

g) The attending physician or the hospitalist who is discharging the patient is responsible for preparing the discharge summary.
R. RULES AND REGULATIONS OF THE CREDENTIALS COMMITTEE

1. Protocol for New Applicants
   a. All inquiries for new staff appointments will be referred to the Medical Staff Coordinator.
   b. The candidate will be referred to the appropriate Department Director or Section Chief who will arrange a meeting with the candidate, the Medical Director, the President of the Medical Staff, and himself/herself (or surrogates for the last two). If at the time of this interview, the candidate appears to comply with the Bylaws requirements, he/she will be instructed to complete an information sheet. This meeting may be waived by the Medical Director and the President of the Medical Staff. References will be promptly confirmed by telephone whenever possible by the Director and/or Section Chief.
   c. Upon its receipt, the information sheet will be reviewed by the President of the Medical Staff, the Chairperson of the Credentials Committee, and the Medical Director. If these three agree that the applicant appears to qualify for staff appointment, the Medical Staff Coordinator will be instructed to send an application. If all three agree that the applicant does not qualify, the Credentials Committee Chairperson will prepare a letter to this effect to so inform the applicant; and will report this action to the Credentials Committee at its next scheduled meeting. If there is a division of opinion, the issue will be presented to the Credentials Committee for a determination.
   d. Applications that are submitted with the required supporting documentation will be reviewed within 7 days by the Medical Staff Affairs Office and necessary information pursuant to Section 405.6 of the New York State Health Code will be solicited by mail within that time. Applications are deemed to be complete when they contain all of the information required under Section 405.6. Completed applications will be presented to the Credentials Committee within 60 days. Recommendations of the Credentials Committee must be presented to the next scheduled meeting of the Medical Board, but not later than 60 days. The recommendation of the Medical Board must be presented to the next scheduled meeting of the Board of Directors, but if such meeting is not scheduled for more than 45 days, the executive Committee of the Board of Directors shall be convened to decide on the applicant’s membership and privileges. At each stage, the respective body reserves the right to delay consideration if it is determined that additional information or investigation is required. The minutes of each body shall document the reasons for any delay and the candidate shall be notified.
   e. Any unfavorable information regarding an applicant received subsequent to any step in this process and prior to staff appointment will be brought to the attention of the Medical Director who shall interrupt any further progress of the appointment process and present the information to the Credentials Committee.
   f. Applicants to the Medical Staff must have completed PRISM training before commencing the exercise of clinical privileges.

2. The Application
   a. The following items are to be included in the application.
1. A non-refundable application fee in the amount approved annually by the Medical Board.

2. Statement of nationality and furnishing of appropriate immigration papers, if appropriate.

3. The applicant's educational background, certification and licensure.
   a. Medical school diploma.
   b. Chronological listing of postgraduate training and experience.
   c. New York State license and current registration.
   d. Evidence of certification by any Boards of the American Board of Medical Specialties, with expiration dates if appropriate.
   e. Federal controlled substances license, except House Physician.

4. Current academic appointment, if any.

5. Two references not connected with Phelps Memorial Hospital Center.

6. Completed privileges request form.

7. Names of all hospitals and medical facilities with which the applicant has or had any association, employment, privileges or practice, for the previous 10 years, with relevant dates.

8. Statement whether privileges, association, employment, practice, or training in any hospital or facility have ever been suspended, diminished, restricted, revoked, terminated, or not renewed, voluntarily or involuntarily, and if so, giving details and the reasons for such action.

9. Statement if the applicant has been rejected by any hospital for staff privileges, and description of such action if taken.

10. Evidence of adequate performance of professional and other medical staff responsibilities at former hospitals.

11. Two letters of recommendation from peers and/or faculty (for recent graduates of training programs as to the practitioner’s current medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism.

12. A completed form attesting to the physical and mental soundness of the applicant signed by a physician licensed in the State of New York, based upon an examination completed and documented within the prior six months.

13. Statement whether there are any professional misconduct proceedings presently pending against applicant in any jurisdiction, and if so, giving details including the
substance of the allegations and any findings in any pending proceedings and any additional information that the applicant may deem appropriate.

14. Statement whether there are any pending malpractice actions against applicant or if any have been concluded in any jurisdiction and, if so, giving details including the substance of the allegations and any findings in such actions and any additional information that the applicant may deem appropriate.

15. Proof of required amount of malpractice insurance:
   a. Applicant will submit records of malpractice for previous 10 years, including statement if insurance ever was revoked.

16. Statement whether license to practice medicine in any jurisdiction or any registrations (state, federal, DEA) have ever been challenged in a proceeding, suspended, not renewed or revoked, and if so, details and reasons for such action.

17. Statement that the applicant has not been convicted of a felony in any jurisdiction, United States or otherwise.

18. Waiver of any and all rights and privileges of confidentiality concerning the information requested.

19. Verification by applicant that the information provided in the application is true and accurate.

20. Agreement to appear for interview if requested.

21. Agreement to abide by the Bylaws and Rules of the Medical Staff and the Hospital.

22. Authorization for the Hospital to consult with representatives of former hospitals and with others having information bearing on competency, character, and ethical qualifications.

23. Agreement to release the Hospital and all other institutions and individuals from liability for acts performed in good faith in connection with the application.

24. Proof that the practitioner requesting approval is the same practitioner identified in the credentialing documents by submission of either a current picture hospital ID card from an institution in which primary source verification has been obtained, or a valid picture ID issued by a state or federal agency (e.g., driver license or passport).

3. Criteria to be Considered by the Credentials Committee for Initial Appointment

   a) In addition to all of the information presented to the Credentials Committee under paragraph (2) above, in order to formulate a recommendation to the Medical Board regarding the suitability of the applicant for staff membership and granting of requested privileges, the Credentials Committee will review:

1. Primary source verification of medical school graduation, residency training and licensure.

3. Information provided from applicant’s prior health care facilities and malpractice carriers.

4. Relevant information and explanations regarding:
   ● Challenges to any licensure or registration (see §R.2.a.16).
   ● Voluntary and involuntary relinquishment of any license or registration (see §R.2.a.16).
   ● Voluntary and involuntary termination of medical staff membership (see §R.2.a.8).
   ● Voluntary and involuntary limitation, reduction, or loss of clinical privileges (see §R.2.a.8).
   ● Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant (see §R.2.a.14).
   ● The applicant’s health status (see §R.2.a.12).
   ● Relevant practitioner-specific data as compared to aggregate data, when available.
   ● Morbidity and mortality data, when available.

5. Proximity of office and home to the hospital in order to be able to respond promptly to an emergency.


7. The recommendation of the Department Director.

4. Criteria to be considered by the Credential Committee for Reappointment

These shall be identical to those required for initial appointment, and in addition: (a) entries in Practice Profiles, (b) continuing education documentation.

5. Delineation of Privileges

The criteria and procedure for granting specific clinical privileges shall be the same for applicants as for current members of the Staff in each Department and/or Section to which the applicant applies; and shall be based on reasonably demonstrated current competence in the requested privileges.

The delineation of privileges shall be generated by the Chief of each department and must be approved consecutively by the Credentials Committee, the Medical Board and the Board of Directors prior to implementation, as defined in the Medical Staff Bylaws.

S. HOUSE STAFF PHYSICIAN

The House Staff Physician, under the supervision of the Medical Director, provides care and treatment to all patients, as circumstances require, during his/her tour of duty.

1. General Rules
   a. Performs those procedures for which he has been granted privileges or which are allowed per hospital policy procedure.
   b. Performs those procedures which would be expected of a House Staff
Physician, i.e. basic life support, advanced life support, etc., in accordance with presently accepted standards.

c. Evaluates and treats patients in a timely fashion appropriate to the presenting problem.

d. Interprets appropriate laboratory tests, X-rays, EKGs, etc. for the presenting problem and consults with patient's attending physician, an attending physician, or an emergency service physician.

e. Documents appropriately on the Medical Record pertinent details of history, physical examination, diagnosis, treatment, condition, and orders (if indicated).

f. Discusses and consults with other appropriate administrative staff, hospital support staff, patients and families, and documents accordingly.

g. Refers problems to proper professional staff for consultation and direction.

h. Maintains a professional attitude and provides a safe, quality patient care.

i. Maintains safe, organized work practices and performs other duties as requested, required.

j. Stabilizes all emergency and acute life threatening injuries/illnesses within the limits of its capabilities.

2. Educational Requirements

a. Must be a graduate, with M.D. or D.O. degree, of a medical college approved by the State Education Department, or, if a graduate of a foreign medical school, hold a valid ECFMG certificate.

b. Must be licensed to practice medicine in New York and have a valid registration.

c. Must present evidence of adequate training to accept the responsibilities in (1).

5. Credentialing

1. House staff shall complete an application for membership on the medical staff and provide information equivalent to that requested of candidates for regular staff membership. They shall submit a request for privileges and their application and qualifications shall be considered by the Credentials Committee.

a. House physicians are covered by the hospital’s malpractice policy and therefore do not have to submit evidence of current malpractice coverage.

b. On the basis of need, applicants for house physician positions may be allowed to work if their application is completed, they have submitted evidence of character and competence and they have been interviewed by the Medical Director. In such cases, Temporary Privileges will be granted according to the Medical Staff Bylaws. The application shall continue to proceed through the routine steps.

8. House physicians shall be supervised by the Medical Director, who shall prepare annual performance evaluations as required.
Revision History
April 2012: Additional language Q.12
September 2012: Modification of D.7
February 2013: New A.16
July 2013: Additional sentence in I.4.f.
October 2013: New A.1.a
November 2013: New Q.18, Q.19
September 2015: Revision of Q.10
APPENDIX A

Phelps Memorial Hospital Center Outpatient Mental Health Department

Clinical Table of Organization

- Medical Director
  Psychiatry
- Assistant VP
  Nursing/Mental Health
  Operations
- Psychiatrist
  Ossining Counseling
- Psychiatrist
  Phelps Counseling
- Psychiatrist
  Echo Hills
- Psychiatrist
  CDT/Threshold
- Psychiatrist
  ATS
- Manager
  Behavioral Health
- Program Director
  PCS/Oss
- Program Director
  Threshold/Echo Hills
- Unit Supervisor
  CDT
- Program Director
  ATS
- Unit Supervisor
  SCM

Phelps Memorial Hospital Center Inpatient Mental Health Department

Clinical Table of Organization

- Medical Director
  Psychiatry
- Assistant VP
  Nursing/Mental Health
  Operations
- Psychiatrist
  ! South
- Psychiatrist
  BRU
- Program Director
  Psychiatrist
  BRU
- Nurse Manager
  BRU/1 South