RULES AND REGULATIONS OF THE
MEDICAL AND DENTAL STAFF OF
STATEN ISLAND UNIVERSITY HOSPITAL

Approved By
Board of Trustees
9/25/2012
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RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF OF
STATEN ISLAND UNIVERSITY HOSPITAL

Article I. - General Policies

Section I.

In addition to the Rules and Regulations hereinafter set forth, the New York State Hospital Code and all federal, State and local statutory and administrative law pertaining to hospitals and the practice of medicine, dentistry and the allied health professions shall also govern the actions of the Medical and Dental Staff. This includes compliance with Title IV regulations regarding The National Practitioner Data Bank as per Article X - Appendix I of these Rules and Regulations.

Section II.

Any staff member who willingly violates the following Rules and Regulations shall be subject to discipline, including restriction or withdrawal of privileges, denial of promotion and or the possibility of failure of reappointment.

Section III.

All staff members must comply with certification of attendance at Infection Control educational inservice (NYS Approved Course).

Article II. - Regular Meetings

The Regular Meeting of the Medical and Dental Staff shall be held on the third Wednesday of March, June, September and December. The June meeting shall also be the Annual Meeting of the Medical and Dental Staff.

Article III. - Admission and Discharge of Patients

Section I.

Staten Island University Hospital may accept patients for care and treatment appropriate to an acute general hospital except that it may elect to exclude a prospective patient:

1. when the capacity of the Hospital has been reached as determined by the President, or his representatives.

2. when the admission of such a case would, in the opinion of the examining practitioner or practitioner, and concurred in by the Chairman of the Department or his representative, endanger other patients.

Section II.

The Transfer Policy is noted in Article X - Appendix II and applies in the case of transfer to another hospital or health facility of a patient who cannot be admitted to Staten Island University Hospital.
Section III.

In transferring a patient from one Practitioner (Attending of Record) to another Practitioner (Accepting Attending Physician) the following steps shall be followed:

1. A discussion must take place between the Attending Physician of record and the Accepting Physician who will accept responsibility for the care of the transferred patient.

2. A short clear transfer summary note must be documented on the progress note by the transferring physician.

3. The Accepting Physician or his/her designee must write the transfer acceptance order on the Transfer Acceptance Order Sheet and any changes to the patient’s orders must also be documented at this time.

4. The Accepting Physician must notify the appropriate house staff or Physician Assistant and document this discussion on the Transfer Acceptance Order Sheet.

5. Only after the completed written acceptance order is placed in the medical record shall the transfer be considered complete. Reference policy: attached.

Section IV.

Except in emergencies, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated and unless admitted by a member of the Medical and Dental Staff with admitting privileges, in accordance with the official admitting policies of the Hospital.

Section V.

A staff member desirous of admitting a patient must first contact the Bed Management Department and state into which of the following categories the patient is to be placed:

1. Emergency admission - An emergency admission is one in which the patient’s condition is such that in the judgment of the admitting practitioner, immediate admission to the Hospital is required. The medical record must clearly justify the patient’s being admitted on an emergency basis. Such findings, including provisional diagnosis, shall be recorded in the patient’s chart as soon as possible after admission.

2. Urgent admission - An urgent admission is one in which the patient’s condition is such that the admission may not be delayed more than twenty-four (24) hours in the judgment of the admitting practitioner.

3. Elective admission - Elective admissions, distinct from emergency and urgent admissions, are classified in one of two ways:

   a. Firm bookings - This is for patients who because of the nature of the services to be performed, require a firm commitment of admission on a particular day so that other services may be suitably scheduled.
b. Tentative Bookings - This is for all other routine admissions. Reservations in this category will be taken in chronological order of receipt of reservation.

c. Elective admissions should not be admitted after 8 PM.

4. Admissions designated by the admitting practitioner as “EMERGENCY” or “URGENT” will be reviewed periodically by the Utilization Management/Case Management Committee and the Executive Committee of the Medical and Dental Staff.

Section VI.

Practitioner or practitioners admitting patients shall be held responsible for giving such information (including signs and symptoms of recent exposure to communicable disease) as may be necessary to the Admitting Office to assure the protection of other patients, hospital personnel and visitors from those who may be a source of danger from any cause whatever to assure protection of the patient from self-harm.

Section VII.

1. All non-referred patients, defined as patients who are not patients of practitioners or practitioners on the Medical and Dental Staff at the time of admission, shall be attended by members of the Medical and Dental Staff. All patients shall be assigned to the department concerned in the treatment of the disease or condition which necessitated admission.

2. Patients shall be attended by their private practitioners. Patients applying for admission who have no private practitioner or practitioner, shall be assigned to a member of the Medical and Dental Staff in accordance with established departmental rules and regulations. The transfer must not occur until the transfer has been approved by the accepting practitioner.

3. Whenever such responsibility is transferred to another staff member, a note covering such transfer shall be entered on the order sheet of the patient’s medical record. The transfer must not occur until the transfer has been approved by the accepting practitioner.

Section VIII.

The policy on Informed Consent is noted in Article X-Appendix.

Section IX.

In the case of patients admitted for induced termination of pregnancy where the determination of blood group and RH type shall not have been made prior to admission, such determination shall be made as soon after admission as practicable and prior to the termination of pregnancy. The patient shall be evaluated for the risk of sensitization to the RHO (d) antigen and if the use of RH immune globulin is indicated and the patient consents, an appropriate dosage thereof shall be administered to her as soon as possible within seventy-two (72) hours after the termination of pregnancy. However, the appropriate dosage shall be administered even after 72 hours (up to approximately 7 days) if the patient should come late to the office or hospital.
Any physician who shall inform a patient that he or she refuses to give advice with respect to, or participate in, any induced termination of pregnancy shall be exempt from liability by the hospital; providing he/she properly refers this patient to another appropriate physician as requested by the patient.

Section X.

1. Each staff member must assure timely, adequate professional care for his patients in the hospital by being available or having available to his office, an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the hospital. Failure of the private practitioner to meet these requirements may result in loss of clinical privileges.

2. The management of each patient’s care is the responsibility of a qualified licensed independent practitioner with appropriate clinical privileges. The management of a patient’s general medical condition is the responsibility of a qualified physician member of the medical staff.

Section XI.

It is incumbent upon every staff member to comply with the regulations established by the Utilization Management/Case Management Committee and the Performance Improvement Coordinating Group which have been implemented to encourage and maintain high quality patient care and to assist in assuring optimum utilization of hospital beds and medical services, including special care units and special diagnostic services, in accordance with the governmental regulations.

Section XII.

Rules governing sterilization, therapeutic abortion, cesarean section and care of obstetrical patients in this Hospital shall be those contained in the policies and procedures of the Department of Obstetrics and Gynecology.

Section XIII.

DISCHARGE POLICY

“Intent to Discharge in A.M.” where appropriate, should be written by the Practitioner of Record on the day prior to discharge. The patient must be seen by attending or resident physician on the day of discharge, a progress note entered on the medical record and a discharge order form written.

The Discharge Instruction Form must be completed, reviewed by and signed by the attending physician, and the instructions discussed with the patient/family.

Patients shall be discharged on written order of the practitioner or practitioner in attendance. It shall be the responsibility of the practitioner to see that the record is complete, that the final diagnosis has been stated and that the record has been signed as soon as it has been completed. Hospital policy encourages that all discharges be effected prior to 10:00 A.M.

Section XIV.
No adult shall be detained in the hospital against his will, nor shall a minor under eighteen (18) be detained against the will of his parent, legal guardian or custodian except as authorized by law. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest, for the protection of himself or others, pending prompt legal determination of his rights. If a presumably competent patient insists that he be discharged against the advice of a member of the Medical and Dental Staff or the House Staff and efforts to dissuade him are unavailing, the patient (or parent, legal guardian or custodian) shall be required to sign the form entitled “Release for Leaving the Hospital Against Advice.” In the event of refusal to sign such form, this act shall be documented in the patient’s chart. In no event shall a patient be detained solely for non-payment of his hospital bill or practitioner’s statement for medical services.

Section XV.

If a patient wishes to leave the hospital against medical advice, the applicable procedures specified in the Administrative Policy & Procedure Manual should be followed.

Reference policy: attached.

Section XVI.

According to the Patient Self-Determination and Omnibus Budget Reconciliation Act of 1990 (OBRA 90), Medicare and Medicaid certified hospitals, nursing facilities, hospices, and HMO’s must provide all adult individuals with written information about their rights under state law to make health care decisions including the right to accept or refuse treatment and the right to execute advance directives. Facilities must inform patients about their policy on implementing Advance Directives, and document in the patient’s medical record whether he/she has signed an advance directive. It is the hospital’s policy to honor all valid advance directives. If a practitioner cannot, due to moral, ethical, or personal objections then they are obligated to transfer the patient’s care to another practitioner’s service.

For more information, refer to the Hospital’s Policy on Advance Directives.

Section XVII.

It shall be the duty of all Medical and Dental Staff members to secure autopsies whenever possible. No autopsy may be performed within the hospital unless accompanied by a consent executed by the patient’s legal next-of-kin, or one executed by the patient during his lifetime, in accordance with the Public Health Law of the State of New York. Provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours, where feasible. A complete autopsy report shall be made a part of the record.

The medical staff with other appropriate hospital staff has developed and uses criteria that identify deaths in which an autopsy should be performed. (Refer to Appendix II. “Criteria for Autopsy”).

There is a mechanism in place for documenting permission to perform an autopsy. (Refer to Appendix III. “Autopsy Permission”).
There is a system for notifying the medical staff, and specifically the attending practitioner, when an autopsy is being performed. (Refer to Appendix III.A. “Notification of Medical Staff/Attending Physician of Autopsy”).

Section XVIII.

Those practitioners from outside organ procurement organizations designated by the secretary, U.S. Department of Health and Human Services, engaged solely at the hospital in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomic Gift Act and the requirements of section 405.25 of the Health Code are exempt from the requirement to obtain medical staff privileges.

Section XIX.

Treatment of Close Family Members by Physicians: Physicians should not provide care and treatment for close family members at Staten Island University Hospital. This policy reflects AMA guidelines that address the need to protect the rights of patients.

Article IV - Medical Records

Section I.

The physician, dentist or podiatrist of record shall be responsible for the preparation and maintenance of a complete and legible medical record for each patient, the contents of which shall be pertinent and current. A complete medical record is one which includes:

- identification, data,
- the reason(s) for admission for care, treatment and services
- any emergency care treatment and services provided to the patient before his or her arrival
- medical history, including the chief complaint; details of the present illness; relevant past, social and family histories (appropriate to the patient’s age); and an inventory by body system.
- any allergies to food
- any allergies to medication
- a summary of the patient’s psychosocial needs, as appropriate to the patient’s age
- a report of relevant physical examinations
- a statement on the conclusions or impressions drawn from the admission history and physical examination
- a statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate.
- diagnostic and therapeutic orders
- evidence of appropriate informed consent
- clinical observations, including the results of therapy
- progress notes made by the medical staff and other authorized staff
- any medications ordered or prescribed
- any medications administered, including strength, dose and route
- any access site for medication administration devices used, and rate of administration
- any adverse drug reaction
- consultation reports
- reports of operative and other invasive procedures, tests and their results
- reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatments
- records of donation and receipt of transplants or implants
- any medications dispensed or prescribed on discharge
- final diagnosis
- discharge plan and discharge planning
- clinical resumes and discharge summaries
- discharge instructions to the patient or family; and
- when performed, results of autopsy.

There are non-inpatient services, within the hospital, for which a patient must have a history and physical. These services include Ambulatory Surgery and Emergency Department.

1. Progress notes made by the Medical and Dental Staff should give a pertinent chronological report of the patient’s course in the hospital and should reflect any change in condition and the results of treatment. Pertinent progress notes should also be made by others so authorized by the Medical and Dental Staff, such as House Staff Members, individuals who have been granted clinical privileges and specified professional personnel.

2. “Specified Professional Personnel” are those individuals who are duly licensed practitioners, members of the House Staff and other personnel qualified to render direct patient care under the supervision of a practitioner who has clinical privileges in the hospital and who are capable of effectively communicating with patients, the Medical and Dental Staff and hospital personnel.

3. Attendings shall be required to enter notes on the patient’s chart on a daily basis, with the exception of Rehabilitation Medicine. In the Substance Abuse Unit, these daily notes may be written by a Physician Assistant (and countersigned by the Attending Physician) with the exception of the entering of a comprehensive note written by the Attending on the first day of all new patients’ admissions. It should be noted that an examination and evaluation of the patient is required prior to documentation of the daily note in the medical record.

A Physician or allied health professional who is credentialed under the bylaws and properly trained is a “qualified medical person” who may perform a Medical Screening Examination under EMTALA (Emergency Medical Treatment and Active Labor Act).

Section II.

1. A complete history shall be taken and, together with the findings or physical examination and a provisional diagnosis, shall be recorded within twenty-four (24) hours after admission of the patient. When a patient is discharged from a hospital and then admitted to The Staten Island University Hospital for rehabilitation, an EKG, CBC, urinalysis and BMP or CMP (basic metabolic profile or complete metabolic profile) will be performed.

2. For ambulatory procedures, a history & physical which has been performed by a qualified physician within 30 days before the procedure may be used provided an update of the patient’s condition is recorded in the medical record as noted under Section c. below. A history & physical that is greater than 30 days may not
be used, and a new history & physical must be completed prior to the procedure starting.

3. All histories and physicals must be performed by a Licensed Independent Practitioner (LIP) with privileges to perform H&Ps. In addition, it should be noted that for all histories and physicals, an update to the patient's condition since it was last assessed is required at the time of admission when using an H&P that was performed before admission. An update to the patient's condition will be recorded on the Pre-Procedural Interdisciplinary Assessment Form or in the progress note. The method used to evaluate the patient to identify the type and extent of the update to the condition is a clinically appropriate evaluation by the Licensed Independent Practitioner.

4. It is recognized that the prenatal patient is a special situation in that, of itself, the prenatal course of care is a planned, systematic updating of the history & physical performed at the first visit and throughout the pregnancy. As such, the entire prenatal record can be utilized as the history & physical, provided it is updated to reflect the patient's condition upon admission.

Section III.

1. Except in extreme emergencies, surgery is performed only after an appropriate history, physical examination, and any indicated laboratory and x-ray examinations have been completed and the preoperative diagnosis has been recorded in the medical record.

When such history and physical examination are not completed before an operation or any potentially hazardous diagnostic procedure, such operation or procedure shall be canceled, unless, in the judgment of the surgeon or attending practitioner, it is determined that the risk of delay is greater than the risk of proceeding in the absence of conformity of such requirements, and such determination is recorded on the patient’s chart and signed by such surgeon or attending practitioner.

2. Determining the appropriateness of a procedure for each patient is based in part on a review of the patient’s history, physical status, diagnostic data, the risks and benefits of the procedure and the need to administer blood or blood components.

Section IV.

Whenever possible, each of the patient’s clinical problems should be clearly identified in the progress notes and the Plan of Care shall be clearly identified and documented in the progress notes and correlated with specific orders, as well as results of tests and treatments.

Section V.

All clinical entries in the patient’s medical record should be accurately dated, timed and signed to the extent that such signatures shall consist of the first initial, full last name and professional title of the recording person.

Section VI.
An official record of non-approved abbreviations shall be in accordance with the Administrative Policy and Procedures.

Section VII.

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

Section VIII.

Final diagnosis shall be recorded in full without the use of symbols or abbreviations, dated and signed by the responsible practitioner at the time of discharge of all patients.

Section IX.

Medical records of patients shall not be accessible to any person except to the extent minimally necessary for members of the Medical and Dental Staff concerned with treatment of the patient, hospital officials responsible for payment and operations including ensuring that the Hospital is in compliance with applicable quality of care, license and accreditation standards and the President and Chief Executive Officer, his representative, and the members of the Board of Trustees concerned with operations of the Hospital. Except as permitted by law, including, but not limited to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and as permitted by the Hospital’s Medical Record Access policies and procedures or upon the order of a court having jurisdiction, no copies of or extracts shall be given to any person except upon the written permission of the patient, his legal guardian, custodian or his duly authorized representative, which has been filed with the President and Chief Executive Officer. No records shall be taken from the hospital unless under the order of subpoena of a court having jurisdiction. In the case of readmission of a patient, all previous records shall be available for the use of the attending practitioner or practitioner. (HIPAA)

Section X.

Nothing contained in a patient’s medical record shall be removed from the chart except in accordance with the Hospital’s “Access To Patient Information And The Right To Amend Patient Records” policy. When possible, alterations shall not be made in the chart, but instead a fully explanatory new entry shall be made to correct or alter a previous entry. (HIPAA)

Section XI.

Medical records must accompany the patient, e.g., from the nursing unit to the operating room, from the operating room to the recovery room, etc.

Section XII.

Patient’s medical records must be completed in a timely manner in accordance with regulatory agency requirements. The history and physical must be completed within 24 hours of admission. If the history and physical is recorded in the patient’s medical record by an individual other than the attending practitioner, the history and physical examination shall be reviewed and countersigned by the attending physician of record.

Operative reports must be dictated/written on all surgeries and procedures performed. When the operative and other procedure report is not placed in the medical record
immediately after the operation or procedure, a progress note must be entered immediately. The note must confirm the name of the primary surgeon and associates, findings, technical procedures used, specimens removed and post operative diagnoses. Dictated operative reports must be completed within 14 days post discharge.

Discharge summaries must be completed on all patients hospitalized more than 48 hours and all expirations within 30 days from discharge. The discharge summary must include:

- the reason for hospitalization
- the procedures performed
- the care, treatment and services provided
- the patient’s condition at discharge
- information provided to the patient and family
- provisions for follow-up care

When the discharge summary is not placed in the medical record at the time of discharge and for patients hospitalized for less than 48 hours with only minor problems, a discharge progress note must be completed. A discharge progress note documents the patient’s condition at the time of discharge, discharge instructions, and required follow-up care.

1. Failure to complete medical records within thirty (30) days after discharge of the patient will result in suspension of privileges. Physicians are notified by phone granting them seven (7) days to complete their delinquent medical records. H.I.M. will follow up with a 24 hour notification fax to their office as well as notification to the applicable Department Chairmen of all that are non-compliant. Department Chairmen shall be notified 24 hours prior to a suspension going into effect, in order to allow Department Chairmen the opportunity to contact practitioners directly, prior to the actual suspension.

2. These records must be completed by the 30th day.

3. If the charts are not completed within that time period, the practitioner’s admitting privileges will be suspended. This will include the suspension of all members in a group with which the suspended member is associated. Practitioners admitting to another service while rendering patient care will be reported to the Ethics Committee of the Medical and Dental Staff for appropriate action.

   a. Practitioners who remain suspended for more than seven (7) days will be reported to the Administrator, the President of the Medical and Dental Staff and their Director of Service.

   b. Failure to complete delinquent records within 30 days from the date of any one suspension will result in termination of staff appointment. H.I.M. Department is responsible to notify the Department of Medical Staff Services of record completion status relevant to the suspension list.

4. Three such suspensions during a period of twelve (12) months will result in termination of the present appointment. Such termination will become effective ninety (90) days from the date of notification. The practitioner may then reapply for staff privileges and, if reappointed, would be appointed at the Adjunct Attending level with a one-year probationary period.
Section XIII.

No medical record shall be filed until it is complete, except upon the order of the Medical Records Administrator.

Section XIV  Utility/Case Management Rules:

Case Management has an Appeals Division whose responsibility is to appeal any utilization denials.

Utilization denials may have any of four types of appeal:

1. ** Expedited Appeal** – in response to concurrent denials of payment for lack of medical necessity for admission and/or continued stay on “HMO’s end of day” reports. Appeals case managers review the chart and contact the attending physician for assistance in appealing the denial. Attending physician may be requested to appeal the denial directly with the physician director of the HMO. Physician advisors may assist in the process.

2. ** Standard Appeals** – in response to post discharge denials of payment. Appeals case manager reviews the medical record and with input from the physician advisor and/or attending physician, formulates a written appeal.

3. ** External Appeals** – for cases that are only eligible for retrospective reviews, as a 2nd level appeal. Meant primarily for consumers when denied a service. However, the provider with the patient’s consent, and a service fee, can appeal HMO’s final determination.

4. ** Arbitration** – done by independent agencies, is available for selected HMO’s as a final level appeal.

The attending physician’s assistance will be requested, as necessary in all the appeals processes. Physician advisors review appeals determination and act as a resource to the case managers.

Attending physicians will be notified of denials that were not appealed or that are upheld (based on lack of documented medical necessity).

Section XV. **Legibility of Progress Notes**

If a member of the Medical and Dental staff is reported to their Chairman/Director to have notes and/or orders that are illegible, a sample of their charts will be reviewed by a Committee consisting of the Chairman/Director, a member of the Quality Management Department, an Officer of the Medical and Dental Staff, a representative of H.I.M., and the Chief Medical Officer. If this Committee agrees that there is a consistent pattern of illegible notes and/or orders the Attending will be required to submit a Corrective Plan of Action to the Committee within 30 days of notification of their deficiency. If they do not submit an acceptable plan in the 30 day timeframe, the Committee shall, with the approval of the Medical Executive Committee, mandate a Corrective Action. Should the member refuse to comply with the Corrective Action the members shall be deemed to have automatically resigned from staff until such time as he/she becomes compliant.

Section XVI. **Medical Students Writing In The Medical Record**
Medical Students may perform a history and physical examination and it may be placed in the medical record, but it must be clearly identified as having been completed by a medical student. While it may remain in the medical record, it does not meet the requirement for the record to contain a medical history and physical examination performed and documented by a Licensed Independent Practitioner. The same policy applies to the writing of a progress note by a medical student. Even where a medical student has recorded a medical history and physical examination, and/or progress note, a LIP must nonetheless record a separate entry of the history, physical exam and/or progress note. (Refer To Appendix XIII For Policy on Requirements With Respect To Medical Students Writing In The Medical Record).

Section XVII. Electronic Signatures

Electronic signatures, passwords and user names may be used only by the individual physician and/or dentist him/herself. It should be noted that breach of this rule and regulation shall be considered a violation of the Bylaws and subject to disciplinary action.

Article V. General Care of Conduct

Section I. Orders

1. All order for treatment shall be in writing; shall be dated, timed; and signed on the Order Sheet. A verbal order shall be considered to be in writing if dictated to another member of the Medical and Dental Staff, Allied Health Professional with privileges in the Hospital, or a member of the House Staff. In situations of emergent patient need, when no physician, or Allied Health Professional with Hospital privileges is available, an RN or Pharmacist may accept, document, and sign a verbal order. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated (and who implemented the read back, in accordance with hospital policy ADM III, B37.0 “Verbal/Telephone Orders”), with the name of the practitioner per his or her name. The responsible practitioner shall authenticate, by countersignature, verbal orders and telephone orders accepted by an RN or pharmacist within twenty-four (24) hours, with the exception of the out-patient chemical dependency units where countersignatures on verbal orders and telephone orders shall be obtained within forty-eight (48) hours; and failure to do so shall be brought to the attention of the appropriate departmental chairman. Countersignature of PA orders is addressed in the attached policy.

2. The Practitioners’ orders must be written clearly, legibly and completely. Orders which are illegible or improperly written should not be carried out until rewritten or understood by the nurses. The use of “renew”, “repeat”, and “continue” are not acceptable unless the drug, dosage, administration time and channel of administration are clearly specified. All orders must be dated, timed and signed.

3. Each order, including the time it is written, shall be made on a separate line.

4. All previous orders for a patient are automatically canceled by transfer of that patient to another service, a special care unit, the operating room or delivery room or upon an operation or delivery, or discharge. After an operation, all preoperative orders are deemed automatically canceled and new postoperative orders must be written immediately after any surgical or obstetrical procedure.
5. Any error or undue delay in the fulfillment of an order shall be reported immediately to the responsible practitioner and to the appropriate chairman of his or her department.

6. PRN medication orders must include the reason for use.

7. Range orders (e.g. 1-2 tablets Q4H) are not permitted unless they contain specific doses for the specific reason indicated (e.g. 1 tab Q6H for mild pain, 2 tabs Q6H for severe pain).

8. Taper orders (orders for tapering doses) must include the specific dose for each dosing period or increments by which the dose is to be changed with each specific interval.

Section II. Pharmacy Services

Hours for Medication Administration

1. Medications are to be given following the schedule listed below.
   - Q24H _____ Daily_________ 1000
   - Q2H _______ Every two hours __________ 0200,0400,0600,0800, 1000,1200,1400 etc.
   - Q4H_______ Every four hours_________ 0200,0600,1000,1400, 1800,2200
   - Q6H______ Every six hours__________ 0600,1200,1800,2400
   - Q8H_______ Every eight hours_________ 0600,1400,2200
   - Q12H______ Every 12 hours___________ 1000,2200
   - A.C.______ Approximately half to one hour before meals_________ 0730,1100,1600
   - P.C.______ Approximately half to one hour after meals___________ 0730,1100,1600
   - H.S._______ Hours of sleep___________ 2200
   - Sleep Medications____________________ 2200

2. Standard Hours for Medication Administration at Inpatient Psychiatry
   - Q24H __________________________ 0900,1300,1700,2100
   - Specific Hours of Administration Written
   - H.S._______________________________ 2200

3. Standard Hours for Medication Administration in Rehabilitation Medicine
   - Q24H __________________________ 0800
   - Q8H_____________________________ 0600,1300,2200
   - Q12H___________________________ 0800,2000
   - Q24H___________________________ 0800
   - Q8H_____________________________ 0600,1300, 2200
   - Q12H___________________________ 0800,2000

4. Chemical Dependency Units
   - Standard Hours for Medication Administration on the
     Chemical Dependency and Alcohol Rehab. Units
     - Methadone Administration___________ 0600
     - Magnesium Gluconate________________ 0900,1300,2100
     - Q12H___________________________ 0900,2100
     - BID_____________________________ 0900,2100
5. Respiratory Inhalation Therapy Administration

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Time (24-hour format)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2H</td>
<td>0800, 1000, 1200, 1400, 1600, 1800, 2000, 2200, 2400, 0200, 0400, 0600</td>
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<tr>
<td>Q4H</td>
<td>0800, 1200, 1600, 2000, 2400, 0400</td>
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<tr>
<td>Q6H</td>
<td>0800, 1400, 2000, 0200</td>
</tr>
<tr>
<td>Q12H</td>
<td>0800, 2000</td>
</tr>
</tbody>
</table>

Expiration Times for All Written Drug Orders

1. Controlled Drug Orders (See Policy 8.1.8, Safe Handling of Controlled Drugs). Exception: Orders for methadone maintenance/detox are valid for 7 days.
   - A schedule II Drug Order is valid for 72 hours i.e.
     - Meperidine 75mg IM q6h.
     - Morphine 8 mg IM q6h PRN
   - A schedule III, IV, or V Drug Order is valid for 7 days i.e.
     - Phenobarbital 15mg p.o. tid and hs
     - Lorazepam 0.5mg p.o. tid prn

2. Antibiotics will follow the schedule time depending which segment the order is written on the Antibiotic Order Sheet.
   - Prophylactic therapy ____________24 hours
   - Empiric therapy __________________72 hours
   - Therapeutic therapy ____________7 days

3. All other drug orders (see policy 8.1.5) are stopped automatically after 30 days (see policy 8.1.5 for exceptions). All large volume parenterals must be renewed daily.

4. Ambulatory Oncology Unit may have up to a 180 day stop order on non-controlled drug orders. Schedule II Narcotic Orders are valid for 7 days. Schedule III-V are valid for 7 days.

5. All standing pre-operative medication orders shall be automatically suspended when a patient undergoes surgery.

Medication Order Writing

- Use ball-point pen
- While it is preferred that medication be prescribed using the generic name, medication orders using the medication brand name are acceptable.
- Date and time all orders
- Parenteral Nutrition orders must be written on the Parenteral Nutrition Daily Order Form. Orders are written daily and must be in the Pharmacy by 1300.
- All Antimicrobial orders must be written on the Antimicrobial Order sheet.
• All Chemotherapy/Antineoplastic orders must be written on the Chemotherapy Order Form.
• Use Hospital approved abbreviations only and leading zeros on doses that are less than one (i.e. 0.1mg.)
• Avoid trailing zeros after whole numbers (i.e. 1.0mg.)
• Use only approved abbreviations.
• All orders must contain route of administration (i.e. PO., IM, IVPB, etc.)
  Example: 6/1/95 1000  Digoxin 0.25mg. p.o. Q24H
• Write beeper # on all orders.
• Continuous Infusions
  The Staten Island University Hospital Continuous Infusion Guide defines the SIUH Standard dilutions.

  When prescribing continuous infusions of medication, the standard concentrations must be utilized. Make dosage adjustments by indicating dosage units per time period.

• Formulary System
  The Hospital pharmacy operates under a closed Formulary system. The Pharmacy & Therapeutics Committee determines what medications are on Formulary taking into account efficacy, indication, side effects, cost and comparison with other drugs in similar class. A copy of the Hospital Formulary is available on each patient unit.

• Restricted Formulary Drugs
  Several drugs are on formulary with restricted indications or Department Chairman Authorization (i.e.: Antibiotics).

  Antibiotic restrictions are imprinted on the back of the Antimicrobial Order Sheet.

• Drug Information
  Pharmacists are available to assist in all inquiries on drug therapy. If you have a question, don’t hesitate to contact the satellite pharmacist in the patient care areas or call the main pharmacy, North (ext. 9232), South (ext. 2160).

Section III. Surgical Services
1. Surgeons must be in the operating room and ready to commence operation at the scheduled time.

2. The physician performing the procedure and the anesthesia provider, along with the clinical team member(s) will participate in the surgical/procedural safety checklist which includes verification of the correct patient, correct procedure and correct site/side/level as indicated.

3. The individual responsible for administering anesthesia, or, if an anesthetic is not to be administered, the surgeon shall, prior to commencing surgery, verify the patient’s identity, the site of the side of body to be operated upon and ascertain that a record of the following appears in the patient’s chart:
a. A medical history and physical examination shall be performed and recorded within a timely period, but no more than 30 days for all ambulatory surgery patients;

b. A preoperative diagnosis, blood count, urinalysis and any indicated lab and x-ray exams;

c. A written signed informed consent consistent with the Hospital’s Informed Consent Policy & Procedure (refer to policy: attached). Such consent shall be obtained prior to the operative procedure except in those situations wherein the patient’s life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from the parent, guardian or next-of-kin, these circumstances shall be fully explained on the patient’s medical record. Efforts to reach the parent/guardian shall be continued until they have been contacted. A consultation in such instance may be desirable before the emergency operative procedure is undertaken, if time permits.

d. Should a second operation be required during the patient’s stay in the Hospital, a second specifically worded consent should be obtained. Consent for a continuing course of treatment should be obtained in the manner described in the Hospital’s Informed Consent Policy and Procedure.

4. The surgeon shall be responsible that a record is maintained in the Operating Room Suite for each operation performed, indicating compliance with the procedures established by the Hospital to assure that foreign objects are not inadvertently left in the patient’s abdominal or other cavities.

5. The Hospital’s separate specific regulations for preoperative prep and scrub techniques shall be strictly observed.

a. All pre-operative medical evaluations conducted by an individual other than the attending physician (e.g. P.A., N.P.) shall be reviewed and countersigned by an attending physician within 24 hours and prior to the performance of the surgical procedure.

b. All preoperative orders are automatically canceled upon operation and new postoperative orders must be written immediately. (It should be noted that this requirement pertains solely to operative procedures performed in the O.R. and thus invasive procedures performed under Intravenous Conscious Sedation are excluded from this requirement).

6. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and new post-anesthetic follow up of the patient’s condition.

7. a. The Operating Room Manager is responsible for the booking of all cases after consulting with the Manager/Associate Vice President of Perioperative Services.
b. Operations may be scheduled in the name of the Operating Surgeon after receiving a faxed copy of the Informed Consent signed by the surgeon.

8. An operative report shall include the name of the primary surgeon and assistants findings, techniques, complications, tissue removed or altered, post operative diagnosis and general condition of the patient shall be written immediately following surgery and signed by the surgeon. It is the responsibility of the department to define “surgeon.” When the operative report is not immediately placed in the medical record, a progress note must be entered with the above information documented and signed by the surgeon.

9. All anatomical parts and tissues removed at the operation shall be delivered to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnoses. A signed report shall be filed in the patient’s chart and a copy of such report shall be available to the Surgical Case Review Committee.

10. The surgeon is responsible for proper reporting of all wound infections, as well as another infection of his patient to the Infection Control Department.

11. All definitive treatment procedures done at SIUH must have the Pathology Slides reviewed by an In-House Pathologist.

Section IV. Dental Patients

1. A patient admitted for dental care is a dual responsibility involving the practitioner and a practitioner member of the Medical Staff.

2. Dentists are responsible for the part of their patient’s history and physical exam that relates to dentistry. This shall include, but shall not be limited to:
   a. A detailed dental history to justify hospital admission;
   b. A detailed description of the oral cavity and a preoperative diagnosis;
   c. A complete operative report describing the findings and technique. In cases of extraction of teeth, the practitioner shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments, shall be sent to the Hospital pathologist for examination;
   d. Progress notes are pertinent to the oral condition;
   e. Clinical resume or summary statement.

3. The responsibilities of the practitioner shall include, but shall be limited to:
   a. Medical history pertinent to the patient’s general health;
   b. A physical examination to determine the patients’ condition prior to anesthesia and surgery;
   c. Supervision of the patient’s general health status while hospitalized.
4. The discharge of the patient shall be on written order of the practitioner member of the Medical and Dental Staff.

5. Qualified oral and maxillofacial surgeons may perform the medical history and physical exam if they have such privileges, in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

Section V. Consultations

1. In addition to member of the Consulting Staff, any qualified practitioner or practitioner with clinical privileges in SIUH can be called for consultation within his area of expertise.

2. All Emergent Consults
   a. The requesting attending or designated house officer/physician assistant must speak directly with the consulting physician and must complete consultation request form completely.

3. Except in emergency, consultation is indicated in the following situations, but shall not be limited thereto:
   a. Primary cesarean sections;
   b. For cases in which, according to the judgment of the practitioner or the Chairman of the Department where the patient is receiving care, the patient is not a good risk for operation or treatment, or the diagnosis is obscure or there is doubt about the best therapeutic measures to be utilized;
   c. In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms;
   d. For conditions recommended by the Bureau of Maternal and Child Health of the State Department of Health;
   e. When requested by the patient or his family;
   f. Those situations specifically designated elsewhere in these Rules and Regulations of the various clinical departments, or special care units.
   g. For Pediatric Surgical patients (in-patients) up to 12 years of age, there shall be a mandatory Pediatric consultation.

4. Consultations by practitioners not on the Medical and Dental Staff must have prior permission of the pertinent Department Chairman and the President. Such permission must appear in the patient’s record.

5. Attendings who are on call or called for consultation must comply with the following rules:
   a. While on call, the practitioner must be located within 30 minutes of the hospital.
b. While on call, the practitioner must be able to respond to a call (but need not be present) within 10 minutes.

c. If a request is made by the attending in charge that the attending on call come in, he/she must do so in no more than 30 minutes.

d. If the attending in charge determines that the consultation is routine, the consultation must be completed within 24 hours.

e. If the consultation is determined to be emergent by the attending on site, then items (b) and (a) apply.

f. Triage shall be done by the attending on site and his/her determination shall be the final one.

g. The attending on site shall determine what the timely manner shall be for the consultation.

h. These rules shall apply to all services. However, exceptions to the 24 hour rule for routine consults include:
   ➢ Rehabilitation Medicine
   ➢ Dermatology
   ➢ Nutrition
   ➢ Pain Management

6. Consultations called by Emergency Medicine physicians shall comply with EMTALA (Emergency Medical Treatment And Active Labor Act) as follows:

a. Lists of the on call physicians of each specialty or subspecialty service shall be provided on a monthly basis, by the section chiefs or their designee.

b. If a particular specialty or subspecialty is not available at SIUH, the patient, in abidance with transfer policies and procedures, shall be transferred to a facility where that service can be provided.

 c. Should for any reason, the on call physician not be able to be reached or to respond to the requested consult, the referring physician should contact the section chief and/or applicable Department Chairman who will arrange for appropriate consultation by delegating another specialist.

d. Any on call physician unable to respond to the request for consultation must provide written supportive documentation as to the reason for unavailability (a copy of which will be forwarded to that physician’s Department Chairman).

Article VI. General Patient Care and Staff Regulations

Section I. Scope of Assessment

Practitioner responsibility for various aspects of patients initial and ongoing assessment may be delegated to appropriate members of the Allied Health Professional Staff, as defined in the Medical and Dental Staff Bylaws (Physician Assistant, Nurse Practitioner,
Nurse Midwife). Minimally this scope of assessment will include a physical, psychosocial status and health history that address patient’s pertinent history, pertinent physical findings including any signs and symptoms of communicable disease, reference to available radiology, laboratory and diagnostic data, tentative diagnosis and a tentative plan for further diagnostic efforts and treatment. Additional population specific information is required for behavioral science patients as well as pediatric patients due to their age. In pediatric cases, immunization status shall be obtained on initial contact; and on inpatient admissions, evaluation of the child’s growth and development status shall be noted. Changes in the patients’ condition, diagnosis and response to care/interventions would be indications for reassessment of the patient’s status.

It should be noted that Physician Assistants, Nurse Practitioners and Nurse Midwives are Licensed Independent Practitioners, each with a different scope of practice under their individual licenses. It should further be noted that Physician Assistants provide services under the direction and supervision of a Supervising Physician, whereas Nurse Practitioners provide services in collaboration with a Collaborating Physician and Nurse Midwives provide services in coordination with a Back-Up Physician.

It should be noted that Podiatrists are responsible for the part of their patient’s history and physical exam that relates to podiatry.

Reassessment of inpatients and consultations will occur as frequently as necessary to ensure appropriate medical care. Reassessment is documented by a legible written note within the medical record.

The findings, conclusions, and assessment of risk are confirmed or endorsed by a qualified physician prior to major high-risk diagnostic or therapeutic interventions.

Patients recovering from anesthesia and/or sedation will be discharged by a qualified licensed independent practitioner or by the approved medical staff discharge criteria – Aldrete Scoring System.

Section II. General Conduct

1. The Hospital requires that its Staff members and personnel, in dealing with patients, take proper precautions to insure the correct identification of patients in order to prevent errors in the provision of patient services. As an additional precautionary measure, a plastic band containing an addressograph printed insert with identifying information is placed on every patient, including newborns. In addition to checking a patient’s identification by every standard method, it is also mandatory hospital routine to check the plastic band for identification.

2. a. Identification of Quality of Care Issues is the responsibility of every member of the Medical and Dental Staff. Quality of Care Issues are immediately reported to the Department Chairman, Vice President of Quality/Risk Management, Chief Medical Officer and to the President or his representative. There is a process in place, which is applied uniformly, for collecting, investigating and addressing clinical practice concerns regarding a privileged practitioner’s professional practice. (Reference: Article VII of the Constitution and Bylaws of the Medical and Dental Staff – “Corrective Action”)
b. The Hospital has established a complaint resolution process – which details the manner in which patient complaints are received, reviewed and resolved. (Reference: Appendix XVI – Policy on Complaints/Grievances of Patients and/or Patients’ Companions)

3. Witness of destruction to hospital property should be reported immediately to the Head of the Department concerned and to the President or his representative.

4. Every member of the Medical and Dental Staff who observes a break in technique, or observes an act or condition which may endanger the life of a patient, or destruction of hospital property, shall report the circumstances to the head of the department concerned and to the President or his representative.

5. Medical and Dental Staff members have a duty to appropriately inform patients and/or their next-of-kin or other legal surrogate when an adverse event has occurred. All accidents and occurrences which might be a source of liability to the Hospital must be reported immediately, in writing, to the President or his representative.

6. Patients shall not be exposed unnecessarily during examination, but shall be protected by screens, curtains or drapes. No vaginal or rectal examination of a female patient shall be made except in the presence of a female staff member.

7. Medical and Dental Staff members are expected to refer their patients who may need social services assistance to the Social Work Department and the Case Management Department.

8. New York State Social Service Law Section 413 requires that whenever a medical and dental staff member has reasonable cause to suspect that a patient under eighteen (18) years of age, before him in his professional capacity, is an abused or maltreated child, he shall report the matter to the New York State Central Register of Child Abuse and Maltreatment (1-800-635-1522). The staff member should refer to the Hospital’s “Reporting of Suspected Child Abuse/Neglect Cases” Policy (#IIIA 1.0) located in the Administrative Policy and Procedure Manual for Guidance.

9. It is the policy of the Hospital that no patient shall be permitted to leave the Hospital on pass except under extraordinary circumstances, e.g. to attend the funeral of an immediate member of his family, etc., any such exception must be referred to and approved by Administration. Exceptions to this policy exist within the Department of Rehabilitation Medicine.

10. Research projects, publications or exhibits which are identified with the Hospital in any manner must be forwarded to the Institutional Review Committee through the Director of the pertinent department. Members of the Medical and Dental Staff are to use their hospital titles in all publications, program notices, etc.

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

12. Members of the Medical and Dental Staff are expected to cooperate with the Hospital Emergency Preparedness Plan in any emergency or local disaster.
requiring the presence of Medical Staff. Copies of the Emergency Plan are available in the Medical Staff Office.

13. Members of the Medical and Dental Staff are encouraged to participate in educational programs offered by the Hospital. A copy of the videotape on Mandatory Education for hospital employees is available in the Department of Medical Staff Services.

14. Diagnosis or other clinical data shall not be discussed in elevators, corridors, or any of the public places where such conversations may be observed.

15. The rules of the Hospital in regard to “No Smoking” shall be observed by all members of the Medical and Dental Staff.

16. Consistent with the Hospital’s policy of respect for the individuality and dignity of its patients, the members of the Medical and Dental Staff shall familiarize themselves with and be guided by the documents entitled “Patient’s Bill of Rights”, “Advanced Directives and Health Care Proxies” as promulgated by the American Hospital Association, copies of which are obtainable from the Department of Patient Representation.

17. Appropriate subspecialty availability as demanded by the case mix shall be provided promptly in accordance with patient needs. For hospitals with less than 15,000 unscheduled emergency visits per year, the supervising or an attending practitioner need not be present but shall be available within 20 minutes.

Section III. Supervision of Residents/House Staff

The supervision of residents/house staff is monitored in each patient care area.

In the Operating Room, an attending surgeon must be present at each operative procedure performed by a resident/house staff and all operative reports are countersigned.

In the Obstetrical Suite, there is a 24 hour attending practitioner coverage in-house. All deliveries (normal or operative) are supervised when performed by a resident/house staff. All resident notes are countersigned.

In the Emergency Department each patient examined by a resident/house staff is reviewed with the full-time medical staff and the patient’s record is countersigned.

In the in-patient service, each patient is examined on a daily basis and the patient care plan reviewed by the attending staff. The attending staff is responsible to write a daily progress note and document the appropriate diagnostic and therapeutic plan. Communication with the resident for teaching supervision and quality patient care is essential, accomplished either by direct communication or appropriate progress notes.

In addition to the daily bedside evaluation and progress notes on each patient by the attending teaching staff, there is a system in place in the departments to guarantee teaching supervision when the attending practitioner of record is not present in the hospital. There is always a senior resident in the hospital 24 hours a day to supervise the first year residents. As well, there is 24 hour in-house coverage by an attending intensivist and cardiology fellow. The residents have been instructed to notify the attending practitioner of record on all new admissions, transfer to intensive care units,
significant change in status, or the patient’s demise. The attending practitioner must be available by telephone within 10 minutes and to be physically within the hospital within 30 minutes when emergency situations occur. The availability of the attending staff in these circumstances is monitored in the following manner:

1. Whenever the attending practitioner of record is not available, the senior resident on duty is notified. The senior resident on duty is then instructed to contact the chief resident who is on 24 hour beeper call to the hospital.

2. The chief resident will attempt to establish contact with the primary practitioner of record. Simultaneously he/she will contact the on-site intensivist and request assistance in management of the emergency. In addition, there is a department teaching staff on-call list which is readily available throughout the institution. The department attending practitioner on-call will then be asked to come in and evaluate the patient with the resident staff, if the primary practitioner of record is unavailable.

3. Within 24 hours after this occurrence, i.e., the unavailability of the primary practitioner of record, the chief resident and/or the attending practitioner on-call will make the department director aware of the difficulty in communicating with the teaching staff attending of record. This matter is then discussed with the attending practitioner of record and is trended.

The department teaching staff is aware that their continued privileges in the department is dependent upon their daily teaching supervision during teaching rounds and their ability to be readily available when they are on-call to the hospital and the residents.

**Article VII. Policies on Adoptions**

An “agency adoption” shall refer to those circumstances in which a child is to be legally surrendered to an authorized agency approved to place children for adoption by the New York State Department of Social Services. A “private placement adoption” shall refer to those circumstances in which the natural parent or parents of a child consent to the placement of their child to a person or persons other than an authorized agency approved by the New York State Department of Social Services. Both agency adoptions and private placement adoptions shall be permitted at the Hospital, subject to applicable administrative policies and procedures as may be promulgated and amended from time to time and as recommended by the Medical and Dental Staff.

**Article VIII. Patents**

1. All personal applications for patents by any member of the Medical and Dental Staff who has actively participated in research in the Hospital, or who have a contractual agreement with the Hospital, shall require the prior consideration and approval by the Medical and Dental Staff.

2. If such approval is given for the application of a patent, the patent shall be assigned to the Hospital and any royalties that accrue shall be paid to the Hospital and retained in a designated fund which will benefit activities within the Hospital.
3. A member of the Medical and Dental Staff who is not under a contractual agreement or who is not engaged in research in the Hospital may seek a patent on any product or device which he has perfected; however, said patent may not in any way involve the Hospital by name or inference.

Article IX - Smoking Regulations

The Hospital supports wellness promotion and follows guideline as documented in the Hospital’s administrative policy and procedure on “Smoking Regulations” (refer to policy: attached).

Article X. Interpretation

Whenever there is any question as to the proper interpretation of any Rules and Regulations of the Hospital, the matter shall be referred to the President and Chief Executive Officer for Decision.

Article XI. Board Certification

Staten Island University Hospital accepts as board certification, only those boards recognized by ABMS, ADA (American Dental Association) and ABOMS (Osteopathic Board). This applies to all members of the medical and dental staff – current and new.

DEFINITIONS

Practitioner - Any health care provider with clinical privileges, who went through the credentialing process.

His - This refers to “His/Her” and is not meant to be gender specific.
APPENDIX III
APPENDIX V
APPENDIX VI
APPENDIX VII
APPENDIX VIII
APPENDIX XII