SOUTHSIDE HOSPITAL
RULES AND REGULATIONS
OF
THE MEDICAL STAFF

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RULES AND REGULATIONS
OF
THE MEDICAL STAFF

A. GENERAL POLICIES – General statement regarding DOH and JCAHO

The actions of the Medical Staff, Allied Health Professional Staff and Graduate Medical Staff shall be governed by these Rules and Regulations, hereinafter set forth, as well as the New York State Hospital Code, all federal, state and local statutory and administrative law pertaining to hospitals and the practice of medicine, dentistry, podiatry and allied health professions, as well as hospital and departmental policies and procedures.

1. If a staff member has been found to have violated these Medical Staff Rules and Regulations that staff member shall be subject to discipline in accordance with the procedure of article VIII and IX of the Bylaws of the Medical Staff.

2. It is required that every practitioner comply with and participate in, the Quality Management/Performance Improvement program which has been established to maintain quality patient care and ensure optimum utilization of hospital beds and medical services.

3. In order to promote the advancement of medical education and thereby improve quality of care, Medical Staff members are expected to participate in the Hospital’s teaching programs if requested by their Department Chair.

B. QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

In addition to satisfying the requirements set forth in Section 3.2 of the Medical Staff Bylaws, applicants to the Medical Staff also shall:

1. Be board certified or board eligible by a board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), subject to the following:

   a) For physicians who are foreign trained and not eligible to take specialty boards, equivalent certification as determined by the Department Chair is an acceptable alternative;

   b) For physicians who are board eligible at the time of initial appointment, board certification is required within 5 years. If board certification is not achieved within the five year period, then, at the time of the next reappointment, the Department Chair shall review the application and recommend to the Credentials Committee whether to approve continuing Medical Staff membership; and
c) The Department Chair may request that the Credentials Committee approve an exception to the requirement of board certification or board eligibility.

2. Applicants to the Medical Staff shall have the burden to document their background, experience, training and demonstrated competence, participation in relevant programs of continuing education, adherence to the ethics of their profession, their good reputations, and their ability to work with and be supervised by others, with sufficient adequacy to assure the Medical Board and the Board of Trustees that all patients treated by them in the Hospital will be given consistently high quality professional care fully consistent with prevailing standards of medical practice and conduct in their specialty, sub-specialty or area of practice; that they will cooperate fully and with sustained interest in the overall functions, activities and responsibilities of the Hospital; and that they will afford all patients all rights guaranteed by applicable statute or regulation and the Medical Staff Bylaws and these Rules and Regulations. These qualifications, criteria, and performance standards are designed to assure the Board of Trustees and the Medical Staff that Hospital patients will receive one level of quality patient care.

3. The process of appointment will be the same for applicants holding or proposed for administrative positions.

4. Practitioners who diagnose or treat patients via telemedicine link are subject to the credentialing process of the Hospital.

5. No practitioners shall be entitled to membership on the Medical Staff or to clinical privileges at the Hospital merely by virtue of the fact that they are licensed to practice their profession, or that they are members of or certified by any professional organization, or that they have or have had professional privileges at other hospitals.

C. ADMISSION AND DISCHARGE OF PATIENTS, INCLUDING EMERGENCY PATIENTS

1. The Hospital shall accept patients for care and treatment appropriate to an acute care hospital, irrespective of their race, color, creed, sex, national origin, sexual orientation, marital status, age, veteran’s status, disability, or the source of payment for their care, except that it may, in non-emergency situations, elect to exclude the prospective patient if:

   a) the capacity of the Hospital has been reached as determined by the Executive Director, or his designee;

   b) the patient requires a type of medical service not authorized by the Hospital’s Operating Certificate; or

2. All patients, regardless of the ability to pay, shall be treated by members of the
Medical Staff and shall be assigned to the Clinical Department concerned with the treatment of the disease or condition which necessitated admission. Members of the Medical Staff may admit patients only to the clinical service to which they are appointed.

3. All patients may be included in the teaching program. A practitioner may exclude a patient from the teaching program when he or she considers such participation to be detrimental to the welfare of the patient or at the request of the patient.

4. A patient shall be admitted to the Hospital only by a member of the Medical Staff with admitting privileges. The admitting practitioner must provide a provisional diagnosis and adhere to the admitting policies and procedures of the Hospital. All admissions are subject to review by the respective Department Chair or Chief of Division or Service.

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

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

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

8. Each practitioner must ensure timely, adequate, professional care for his/her patients in the Hospital by being available or having available to his/her office an eligible alternate practitioner with whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of the attending practitioner to meet these requirements may result in corrective action.

9. No person who presents for medical care to the Hospital shall be removed, transferred, or discharged for the purpose of effecting a transfer from the Hospital unless such removal or transfer is carried out after a written order made by the attending practitioner that in his or her judgment such removal or transfer will not create a medical hazard to the person, and that such removal or transfer is considered in the person’s best interest, despite the potential hazard of movement. Such removal or transfer shall be made only after prior notification to an appropriate medical facility and only with the consent of the person or other individual authorized to consent on behalf of the person.
10. A discharge summary shall be written or dictated on all medical records of patients hospitalized over 48 hours. However, a final progress note will be sufficient in the case of patients with problems of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetrical deliveries. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The discharge summary must include clinical findings, clinical follow-up, patient's diet, activities and medications. All summaries shall be signed by the responsible practitioner. All discharges must comply with the notice requirement of the New York State Hospital Code and State Law.

An un-emancipated minor under (18) years of age shall be discharged only in the custody of his/her parent(s) or his/her legal guardian unless the parent(s), or guardian, shall otherwise direct in writing.

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

D. INFORMED CONSENT

1. General Requirements

a) Upon admission the patient shall be requested to sign a general admission consent form. If the patient lacks capacity to provide the general admission consent, then the patient’s health care agent (if any), relative, parent (if patient is a minor) or legal guardian shall be requested to sign the general admission consent form.

b) A properly designated health care agent may make any decision that a patient could make if the patient were capable of giving consent. Refer to Hospital Administration Policy and Procedure regarding Health Care Agents and Proxies. Any question concerning a health care proxy document shall be referred to Hospital Administration.

c) Informed consent must be obtained prior to performing a non-emergency surgery, treatment, procedure or invasive diagnostic procedure which bears risk to the life or
health of the patient. Informed consent must be obtained prior to the non-emergency administration of blood and blood products. Informed consent must be obtained by a member of the Medical Staff or an individual credentialed to perform the treatment or procedure.

d) The informed consent discussion should include, but not be limited to, a description of the risks, benefits and alternatives to the proposed procedure or treatment.

e) The Medical Staff member will be responsible for documenting the informed consent discussion and for completing any required hospital forms in the patient’s medical record.

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

i. In the physician’s judgment, an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person’s life or health.

ii. When the Medical Staff member has reason to believe that the patient would suffer immediate and severe harm from a discussion of the patient’s condition and need for treatment.

2. Persons Qualified to Consent to Treatment

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

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

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

a) An adult with the capacity to make health care decisions has the right to refuse treatment. This right includes the ability to refuse or request the withdrawal of lifesaving treatment. A psychiatric consultation should be obtained if there is any doubt about a patient’s capacity to consent or refuse treatment.

b) A person with the capacity to make health care decisions who is under eighteen (18) years of age may also refuse to consent to his/her own medical treatment if that person is a parent, is pregnant, has been married or is married or qualifies as an “emancipated minor,” as described above. A minor may also refuse to consent to his/her own treatment which involves birth control, abortion, sexually transmitted disease or substance abuse treatment.

c) The Medical Staff member must document a patient’s refusal of treatment in the medical record.

d) A Medical Staff member cannot deny lifesaving treatment to a minor even if a parent refuses to consent to the treatment unless there is a valid “do not resuscitate” order or a valid order to withhold treatment.

E. HISTORY AND PHYSICAL EXAMINATION

1. The complete medical history and physical examination must be completed within twenty-four (24) hours of admission. If a complete history and physical examination has been obtained within seven (7) days prior to admission, the requirement of the preceding sentence may be satisfied if a durable, legible copy of this report is placed in the patient’s hospital medical record at the time of, or prior to, any anticipated procedure provided that an update to the patient’s condition or a notation of no change has been recorded at the time of the admission or procedure. The admission history and physical examination, if recorded by a member of the graduate staff, physician’s assistant, or nurse practitioner shall be reviewed by and countersigned by the attending physician within twenty-four (24) hours of admission and prior to any major diagnostic or therapeutic intervention, but no later than twenty-four (24) hours of admission.

1a. Outpatients treated at the Hospital are required to have a physical examination that must contain at least the following information:
- The Patient’s name, date of birth, and medical record number
- The reason the patient is at the hospital and the procedures(s) to be done
- Allergy history
- A brief Medical /Surgical history
- Smoking history
- Addiction/drug abuse history
- Current medications
- If applicable, anesthesia reaction history and ASA score
2. If the admission history and physical for an operative or invasive procedure is performed by a physician who is not a member of the Hospital’s medical staff, the attending physician shall review the history and physical examination and attest to its accuracy by countersigning. Individuals who are not licensed independent practitioners may perform part or all of a patient’s medical history and physical examination under the general supervision of the attending physician. The attending physician shall review and countersign the history and physical examination before the operation or procedure.

3. All delays and deferrals in the history and/or physical examination must be justified in the patient's medical record.

4. As recommended by the American Board of OB/GYN, the physical examination shall include examination of breast and pelvic and cervical cytology smear on women 21 years and older unless the patient refuses or the examination is medically contraindicated. The cervical cytology smear may be deferred if one has been performed in the last three (3) years. Insofar as it is possible to identify patients who may be at risk for sickle cell anemia, all potentially susceptible patients including infants over six (6) months of age shall be examined for the presence of sickle cell hemoglobin unless testing has been previously performed. Results or refusal of these test and examinations shall be recorded in the medical record. Patients over 35 should also have a rectal examination within one year of admission.

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

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

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

8. The Hospital will accept laboratory results for inpatients from laboratories located in New York State which have a valid laboratory permit issued by either the New York State Department of Health or the New York City Department of Health or from a physician’s office with a CLIA-approved laboratory.

F. MEDICAL RECORDS

1. The practitioner of record shall be responsible for making entries in the medical record that accurately reflect the patient’s medical condition (whether inpatient, outpatient, emergency or home care). The contents of the record shall be pertinent and current.

2. The medical record shall contain in addition to the demographic data, an appropriate history (chief complaint, present illness, past history, family history, review of systems), and physical examination, provisional diagnosis, clinical laboratory reports, x-ray reports, consultations, medical and surgical treatment, tissue report, progress notes, final diagnosis, discharge summary and autopsy findings, if performed.

3. The practitioner of record is responsible for ensuring that the entries in the medical record reflect that he/she is directly involved in the daily overall care of the patient. All practitioners and physician assistants or nurse practitioners, who exam the patient, must document their evaluation at that time. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity and transferability of care. Each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Patients must be seen, and progress notes shall be written daily on all patients and at least every seven days on patients whose status is alternate level of care, including Physical Medicine and Rehabilitation and Brain Injury Units and Psychiatry patients, more often if there is difficulty in diagnosis or management of the clinical problem.

4. Entries in the medical record must demonstrate that the practitioner of record was directly involved in the overall care of the patient. All clinical entries in the patient’s medical record shall be accurately dated, signed and should be timed. Signatures shall consist of the full last name and first initial of the recording person. If the entry reflects a prior encounter with the patient, the date and time of such encounter should be reflected in the medical record.

5. Symbols and abbreviations may be used only when they have been approved by the Medical Board. An official record of approved and unapproved abbreviations shall be kept on file in the Medical Records Department, and on each nursing unit.
6. A practitioner’s routine orders, when applied to a given patient, shall be reproduced in detail on the order sheet of the patient’s record, dated, timed and signed by the practitioner.

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

8. Entries may be made in the progress note of the medical record by medical or dental students and shall be countersigned within twenty-four (24) hours by the attending physician or dentist or by an appropriately credentialed physician.

9. Members of the Graduate Staff, and Allied Health Professional Staff (who are appropriately credentialed and privileged): physician’s assistants, nurse practitioners and may dictate discharge summaries, provided that the summaries are reviewed by the attending physician of record. Nothing contained in this Section shall be interpreted to in any way change the attending physician’s ultimate responsibility for the patient’s care and the completion of the patient’s medical record.

10. Members of the Graduate Staff must be supervised by the attending practitioner of record or a designee. The attending practitioner is responsible for countersigning the history and physical written by a member of the Graduate Staff within twenty-four (24) hours of admission. Further documentation in the medical record must evidence the level of involvement by the attending practitioner of record. Merely countersigning the notes written by a member of the Graduate Staff is not sufficient documentation of the attending’s involvement and supervision.

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

12. The following types of cases do not require a dictated or written discharge summary to complete the medical record:

   - Normal Newborns
   - Normal Deliveries
   - Pediatrics – less than 48 hours stay
   - Cardiac Catheterization – less than 48 hours stay
   - Admissions for less than 48 hours stay, except those involving transfers, death and major morbidity
   - Ambulatory Surgery Cases
   - Ambulatory Endoscopy Cases
   - Lithotripter Cases
   - In-Vitro Fertilization Cases
   - Chemotherapy – less than 48 hours stay
   - Intravenous Gammaglobulin Cases – less than 48 hours stay
   - Uncomplicated Surgery Cases – less than 48 hours stay
Nonetheless, the medical record for such procedures shall not be deemed complete unless it includes an appropriate entry by the responsible physician containing a discharge note with outcome of hospitalization, the disposition of the case, any provisions for follow-up care and a final diagnosis.

13. All practitioners shall comply with the Health Insurance Portability and Accountability Act (HIPAA) and the Hospital’s policies and procedures governing patient confidentiality and the release of patient information. (See H, Regulatory Requirements - HIPAA)

14. Medical records may be removed from the Hospital’s jurisdiction and safe-keeping only as required or authorized by law. All records are the property of the Hospital and shall not be removed from the Hospital without permission of the Executive Director, or his designee. The patient has a right to a copy of the medical record after appropriate request to Health Information Management. Unauthorized removal of medical records from the Hospital by Medical Staff members shall be grounds for corrective action.

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

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

17. Each member of the Medical Staff, Graduate Staff and Allied Health Professional Staff shall be given a password or other means of user identification, which will allow the practitioner access to the Hospital’s information systems. No practitioner shall give or disclose to another person, or allow another person to use the practitioner’s password(s) to access protected health information unless requested by the Information Services Department, whether or not such other person is an authorized user on the Hospital’s information system. The assigned personal password constitutes the practitioner’s legal signature and the practitioner accepts full responsibility for all actions taken as a result of the use of the practitioner’s password. In the event that any practitioner reasonably suspects or becomes aware of any unauthorized disclosure or use of the practitioner’s password, the practitioner shall immediately report such unauthorized use or disclosure to the Chief Information Officer or Compliance Officer of the Hospital who shall take appropriate action. Each member of the Medical Staff and Allied Health Professional Staff shall log-off the Hospital’s information systems, or password protect the computer screen, to ensure that a computer session cannot be accessed by any other individual when the computer is left unattended or at the conclusion of the computer session.
18. No practitioner shall print, copy or download patient information from the Hospital’s information systems to any hard drive, diskette, tape, or other storage device or otherwise copy any paper record for purposes other than to provide medical care to the patient or for Hospital/Health System Institutional Review Board (IRB) approved research or educational purposes. Such practitioners shall be solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded.

19. The Medical Staff Departments where electronic and computer transactions and authentications are utilized will work in conjunction with the Information Services Department of the North Shore-Long Island Jewish Health System and the Health Information Management Department of the Hospital to develop and implement criteria and procedures that ensure appropriate and confidential use of electronic or computer transactions and authentications, including the identification of those categories of practitioners and hospital personnel who are authorized to utilize electronic or computer generated transmissions.

20. Delinquent Medical Records

a) If a medical record remains incomplete fourteen (14) days after the patient has been discharged, the Medical Record Director shall notify the physician by ordinary mail that his/her medical records are incomplete. If the medical record is not completed within the ensuing sixteen (16) days, the Medical Records Director shall notify the Admitting Department, the Executive Director, the President of the Medical Staff, and Medical Director of the delinquency. If the medical record is incomplete more than thirty days after discharge, the medical record shall be deemed delinquent. The physician shall be suspended and shall not be allowed to schedule or participate in any of the Hospital services, including but not limited to surgery, delivery, special procedures, attending or admitting patients or performing consultations until such time as he/she completes his/her delinquent records.

b) Any physician who is on suspension sixty (60) days or for a period of more than one hundred seventy-five (175) days in any twelve month period will be automatically terminated from the Medical Staff, and must re-apply for appointment pursuant to the provisions of Article III of these Bylaws.

c) Any suspension or other corrective action taken pursuant to this Section shall not give rise to the due process right granted to Medical Staff members under Article VIII and IX of the Medical Staff Bylaws.

G. GENERAL CONDUCT OF CARE

1. Orders

a) All orders for treatment shall be in writing, dated, signed and should be timed on the Order Sheet by an appropriately credentialed practitioner. Medication orders shall include the name of the drug, the strength expressed in the metric system, the
dosage frequency, the route of administration and the duration of therapy or number of doses to be administered. Written orders may be issued by a Medical Staff member, a graduate staff member, a physician’s assistant, nurse practitioner, certified registered nurse anesthetist and nurse midwife.

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

c) Other than in an emergency, telephone/verbal orders shall be used sparingly. Practitioners who are authorized to issue verbal or telephone orders shall include medical staff members, graduate staff members, certified registered nurse anesthetists, physician’s assistants, nurse practitioners, and nurse midwives. A registered professional nurse, pharmacist, respiratory therapist, physical therapist, occupational therapist or a member of the Allied Health Profession’s Adjunct Staff can carry out and record a verbal order or telephone order when the order is within the scope of their practice or clinical privileges. Staff members receiving a verbal order should repeat back the order to assure its accuracy. The practitioner giving a telephone order must request that the order be read back by the person taking the order after the order has been transcribed to assure its accuracy.

d) Telephone/Verbal orders for treatment other than the administration of controlled substances must be authenticated by the prescribing practitioner as soon as possible, but no later than 48 hours after the order is given. A covering physician may authenticate the order given by the prescribing practitioner. Telephone/verbal orders for the administration of controlled substances must be authenticated by the prescribing practitioner within 48 hours of issuing the order, except that all such orders issued by a physician’s assistant (whether or not a controlled substance) must be countersigned within 24 hours.

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

f) The Pharmacy is authorized to therapeutically interchange a product when such request for an interchange is received and approved by the Medical Board.

g) The Department of Anesthesiology is responsible for preanesthesia medication orders directly related to the anesthesia care of patients receiving general anesthesia, major regional anesthesia and monitored anesthesia care. The Department of Anesthesiology is not responsible for preoperative medication orders which are unrelated to the anesthetic management of the patient.
h) Requisitions for blood and blood products for transfusion shall include the indications for transfusion.

i) All drugs used for investigational purposes shall have the prior approval of the Department Chair (or Chief of a Division) and of the IRB.

j) Medication orders are subject to the Hospital’s “Automatic Stop Order Policy.”

k) In the event that the attending physician, dentist or podiatrist will not be available, he/she must provide adequate coverage to provide continuity of care for the patient and give the covering practitioner’s contact information to the Hospital staff.

2. Surgical Services

a) The Surgeon shall ascertain that a record of the following appears in the patient’s medical record.

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

ii) A preoperative diagnosis and appropriate diagnostic tests.

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

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

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

c) The surgeon shall, prior to commencing surgery, verify the patient’s identity, procedure and the site and side of the body to be operated on by completing the Patient Identification Procedure and Surgical Site Verification check list.
d) All preoperative orders are automatically canceled upon operation and new postoperative orders must be written immediately except DNR orders.

e) The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of preanesthetic evaluation, intra-operative management, and post anesthetic follow-up of the patient’s condition.

f) All operative and other high-risk procedure reports and progress notes shall be dictated and written in the medical record by the operating surgeon immediately (upon completion of the operation or procedure, before the patient is transferred to the next level of care) following surgery. Operative or other high-risk procedure reports shall contain the name of the primary surgeon and assistants, indications for surgery, technical procedure(s) performed and description of the procedure(s), findings, estimated blood loss, complications, specimens removed or altered condition of the patient and postoperative diagnosis.

g) All anatomical parts, tissues and devices removed during a procedure shall be delivered to the Hospital Pathologist who shall make such examination as he or she may consider necessary to arrive at a diagnosis. The operating surgeon shall be responsible for completing the required forms that identify removed tissue and which must accompany tissue to the Pathology Department. A report of the Pathologist’s findings shall be filed in the patient’s medical record and copy of the report shall be available to the Surgical Case Review Committee.

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

i) The anesthesiologist shall have overall responsibility for patient supervision in the Post Anesthesia Care Unit, subject to the post-operative orders of the patient’s surgeon, who is responsible for being on call for any emergency complications. The anesthesiologist is responsible for determining when a patient is sufficiently recovered to permit the patient’s transfer to the next level of care, e.g. ICU, step down unit, or floor bed.

3. Dental Patients

   a) All general dentistry patients shall be admitted by and under the supervision of a physician who is a member of the Medical Staff. The discharge of the patient shall be on the written concurrence of both the dentist and physician involved.

   b) The dentist’s responsibilities shall include, but shall not be limited to:
i) A detailed dental history.

ii) A detailed description of the examination of the oral cavity and a preoperative diagnosis.

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

iv) Progress notes as are pertinent.

v) Clinical resume or summary statement.

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

   i) Medical history pertinent to the patient’s general health.

   ii) A physical examination to determine the patient’s condition prior to anesthesia and surgery.

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

d) An oral surgeon may admit and discharge patients directly from the oral surgery service. Oral surgery patients are to be cared for according to all the rules and regulations promulgated for surgical services.

4. Podiatric Patients

   a) All podiatric patients shall be admitted by and under the supervision of a physician member of the Medical Staff, but the discharge of the patient shall be on the written concurrence of both the podiatrist and the physician involved.

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

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

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

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

      i) Medical history pertinent to the patient’s general health.
ii) A physical examination to determine the patient’s condition prior to the podiatric procedure or treatment.

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

5. Consultations

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

b) The attending practitioner is primarily responsible for requesting the consultation when indicated and for calling in a qualified consultant. The request for consultation and the consultation report shall then be incorporated into the patient’s medical record.

c) Consultation is indicated in the following situations:

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

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

iii) In instances in which patients on non-psychiatric units exhibit suicidal tendencies or other severe psychiatric symptoms; e.g. drug or alcohol withdrawal.

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

v) When requested by the attending, patient or the patient’s family.

vi) Physicians or dentists with non-emergent patients going into the OR with an ASA of 3 or more should request a pre-operative medical consultation.

vii) Those situations specifically designated elsewhere in these Rules and Regulations, or in the Policies and Procedures of the various Clinical Departments or Special Care Units.

d) Consultations by physicians or dentists not on the Medical Staff must have (i) the prior permission of the pertinent Department Chair (or designee thereof), (ii) provided the required documentation to the Medical Board and (iii) have been granted temporary privileges as provided for in the Medical Staff By-Laws. Such permis-
6. Clinical and Basic Science Research

The Research, Clinical Investigation and Publications Committee of North Shore University Hospital (the “NSUH RCIPC”) shall function as the institutional review board for the Hospital for the protection of human subjects in research in compliance with applicable Federal and State statutes and regulations. All research programs (including clinical investigation activities) undertaken or to be undertaken at the Hospital and all applications for research grants by members of the Hospital's Medical Staff or any Adjunct Staff of the Hospital shall require the approval of the NSUH RCIPC. The NSUH RCIPC shall also clear before publication all Hospital-associated manuscripts prepared by members of the Hospital's Medical Staff/Adjunct Staff in such manner not to unduly delay the publication thereof. All such research programs (including clinical investigation activities), applications for research grants, and Hospital-associated manuscripts shall first be submitted by the Medical Staff or Adjunct Staff member to Department Chair for review and shall require the Department Chair’s and/or the Chair of the Ethics Committee approval prior to being submitted to the NSUH RCIPC. All rules, regulations, policies and procedures of North Shore University Hospital with respect to clinical investigation and scientific research shall apply to clinical investigation and scientific research undertaken by members of the Hospital's Medical Staff and Adjunct Staff, except that references in the rules, regulations, policies and procedures of North Shore University Hospital to "Administration" or "President" or "Medical Board" for purposes hereof shall be deemed to refer to Administration, President or the Medical Board, as the case may be, of the Hospital.

H. REGULATORY REQUIREMENTS

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

**Infection Control.** The New York State Department of Health and the U.S. Centers for Disease Control and Prevention mandate reporting of infectious diseases which pose a risk to the health of the public. Members of the Medical Staff, the Graduate Staff, and the Allied Health Professional Staff shall comply with all infection control regulations to prevent the transmission of infection. The Division of Infectious Diseases/Infection
Control serves as a resource to the Medical Staff to facilitate mandated reporting. The Division of Infectious Diseases/Infection Control is responsible for meeting the infection control requirements of regulatory agencies for the Hospital.

**Department of Health Incident Reporting.** The members of the Medical Staff, the Graduate Staff and the Allied Health Professional Staff will assist the Department of Quality Management to ensure compliance with all New York State (NYS) Dept. of Health Code requirements that incidents fulfilling the NY Patient Occurrence Reporting Tracking System (NYPORTS) criteria be reported to the NYS Department of Health.

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

**Safe Medical Device Reporting.** The members of the Medical Staff, the Graduate Staff and the Allied Health Professional Staff will comply with the Medical Device Reporting Program, which was established by the Hospital to identify medical device related incidents in order to initiate corrective action and comply with the reporting requirements of the Safe Medical Devices Act of 1990. The members of the Medical Staff, the Graduate Staff and the Allied Health Professional Staff shall report any such potentially reportable incident to the Department of Quality Management.

**EMTALA.** The Emergency Treatment and Active Labor Act (EMTALA) (along with corresponding regulations) is a Federal statute, which applies to all Medicare participating hospitals. The Hospital shall comply with EMTALA in accordance with the Hospital’s EMTALA Policy and Procedure.

**HIPAA.**

1. All members of the Medical Staff, Graduate Staff and Allied Health Professional Staff (and their respective employees and agents), shall maintain the confidentiality, privacy, security and availability of all protected health information (PHI) in records maintained by the Hospital in accordance with any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Protected health information (PHI) shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the Hospital.

2. All members of the Medical Staff, Graduate Staff and Allied Health Professional Staff shall cooperate with Hospital personnel in obtaining and maintaining in the medical record any and all patient authorizations required under any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, HIPAA.
Emergency Management. Hospital Emergency Incident Command System [HEICS] A HEICS Activation for the purpose of the Hospital/Health System, is an event or situation that disrupts or overwhelms the resources of the facility or staff in providing medical care. This may take the form of an internal or external event, which may include a mass casualty incident in the community, power failure, flooding or overcrowding in the Emergency Department. The Medical Staff plays an integral role in the institution’s plan to respond to these situations.

Preparation. Emergency Management Committee reports to the Medical Board. Its membership includes physician and non-physician representatives from many departments and divisions including medicine, emergency medicine, surgery, psychiatry, nursing, pharmacy, administration, security, engineering, materials operations, and others that reflect the institution-wide impact of a disaster. The committee meets regularly to discuss contingency plans for a planned and unplanned event that may impact Southside Hospital.

Response. The emergency management plan is based on the Hospital Emergency Incident Command System (HEICS). HEICS features a logical management structure with forty-nine positions grouped into one of four sections. The cornerstone of HEICS is 1) a clear division of tasks, 2) a defined set of responsibilities for each manager, and 3) a set of common terminology to enhance communication and improve documentation. The aim of the model is to improve accountability, efficiency, and communication within the hospital and with other emergency responders. It also provides a framework for critique and is flexible enough to allow experience-based enhancements.

Role of the Medical Staff during an Emergency. The medical staff is an essential part of the hospital’s disaster response capability. If an emergency is declared, the Medical Director, working with the Incident Commander, in the Emergency Operation Center will decide whether and which full-time and voluntary generalists and specialists are needed to assist with medical care based on the number and type of incident. It is requested that the medical staff bear in mind the following:

- Maintain and regularly update contact information with 1) your Department Head, 2) the Medical Staff Office, and 3) your housestaff. Home, mobile, pager, office, and fax numbers should be available.

- If an incident occurs in the region, stay within reach should your assistance be requested.

- If you are able and willing to assist during a disaster, contact your Department Head for further instructions prior to coming to the hospital. This will prevent confusion and misallocation of resources.
If evacuation, transfer or rapid discharge of inpatients from the facility becomes necessary during an emergency, be able to assist in this process and plan for continuing care.

ADOPTIONS

No physician shall, by himself, undertake the placement of a child for adoption without the involvement of the Department of Social Work. Involvement in non-agency adoptions in which physician remuneration is above and beyond the usual and customary obstetric fee for newborns delivered at the Hospital will be cause for dismissal from the Medical Staff

I. SUPERVISION OF THE GRADUATE STAFF

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

2. Attending practitioners and members of the Graduate Staff who are in their third year of graduate training shall provide supervision to the Graduate Staff Members in the same specialty as such attendings or senior Graduate Staff Members. There shall be a sufficient number of such supervising physicians present in person in the Hospital twenty-four (24) hours per day, seven (7) days per week to supervise the Graduate Staff and to meet reasonable and expected demand. When it can be documented that the patient’s attending physician is immediately available by telephone and readily available in person when needed, the on-site supervision of routine hospital care and procedures may be carried out by members of the Graduate Staff who are in their penultimate year of post-graduate training, or who have completed at least three (3) years of post-graduate training.

3. The attending is responsible to ensure that all decisions and determinations as to patient care are reflected in the treatment plan as written in the progress notes of the patient’s medical record. The treatment plan is the written vehicle through which communication among those attendings and the members of the Graduate Staff involved in the patient’s care is enabled. Therefore, all relevant information must be clearly and thoroughly documented. The following additional requirements apply to treatment plans:

   a) The treatment plan and any significant modifications must be discussed with the members of the Graduate Staff responsible for the patient’s care and approved by the attending. This approval shall be documented in the patient’s medical record.
b) The treatment plan must be reviewed in accordance with the patient’s condition and can only be amended by the written authorization of the attending. A member of the Graduate Staff may only amend the treatment plan without consulting with the responsible attending when he or she determines that an emergency exists. The amendment must be documented in the medical record and the attending notified as soon as possible.

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

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

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

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

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

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

(ii) at the conclusion of the period of coverage, the covering attending/dentist must document that all pertinent information regarding the patient’s care and status has been relayed to the primary attending upon that attending’s resumption of the care of the patient.

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

a) personal supervision of all surgical procedures performed by members of the Graduate Staff requiring general anesthesia or an operating room procedure; and

b) pre-operative examination and assessment by the attending surgeon; and

5. Within the context of the residency training program, documentation in the patient’s medical record shall reflect the following requirements;
a) When surgery or high risk procedures are performed by members of the Graduate Staff, documentation by the attending surgeon in the medical record must reflect that the attending surgeon was physically present during the key portion of the performance of the surgery or high risk procedure. Documentation must also reflect that the attending surgeon was immediately available to furnish services during the entire surgery or procedure.

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

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

3. The Program Directors of the Hospital’s Graduate Medical Education programs are responsible for:

- ensuring compliance by Medical Staff members with the supervision requirements of these Rules and Regulations and with the Regulations applicable to supervision of Graduate Staff members.
- monitoring the quality and appropriateness of patient care services provided by graduate trainees according to their level of training.
- directing corrective measures or disciplinary actions with Graduate Staff members.
- remaining continuously responsible and accountable to the Department Chair for all aspects of the Graduate Medical Education Program.
- Any questions regarding this Section I should be referred to the appropriate Department Chair.

J. HOME CARE PROGRAM

1. Medical Staff members are expected to refer their patients who may need social service assistance, alternate level of care placement or home care assistance to the Social Services Department.

2. A written plan of care shall be developed for each patient who is a candidate to receive home care services after hospital discharge. This plan will be based upon assessment of the patient’s post hospital care needs by the Hospital’s discharge planning staff and the physician who has primary responsibility for the patient.

3. During the patient’s hospital stay, this plan shall be periodically re-evaluated by staff in collaboration with the patient’s primary physician. The essentials of the written plan of care shall be made part of the patient’s medical record.
4. Patients may choose to receive home care services from a provider other than the Hospital’s Home Care Department for reasons of preference, insurance coverage, or residence outside of the Home Care Department’s catchment area. The assigned clinical care coordinator shall make the necessary home care arrangements to reflect the patient’s choice.

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

K. MISCELLANEOUS HOSPITAL AND PATIENT CARE REGULATIONS

1. PATIENT RIGHTS
   Consistent with the hospital’s policy of respect for the individuality and dignity of patients, the Medical Staff endorses the “Patients Bills of Rights” which have been promulgated by the NY State Department of Health and NY State Office of Mental Health.

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

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

2. ENVIRONMENT OF CARE
   The Hospital has been designated as a “Smoke Free” hospital. All members of the Medical Staff shall observe the rules of the Hospital in regard to “No Smoking”.

3. ETHICS
   The primary mechanism to address patients’ and staff needs for resolution of issues relating to the ethical and caring treatment of the patient shall be with the responsible Medical Staff member in consultation with the patient and/or family and, when necessary, with his or her Department Chair. Additional counsel of the Ethics Committee may be sought at the discretion of the Medical Staff member or Department Chair via the “Ethics on Call” mechanism.

   No physician shall be required to give advice regarding pregnancy prevention and/or termination of pregnancy nor shall the physician be required to participate in the performance of this procedure. However, the physician shall be required to assist in transferring the patient to another physician who will provide the requested care.
4. **DEATH/AUTOPSY**

When a patient dies, the patient shall be pronounced dead by the attending practitioner or designee. The attending practitioner, or designee, is responsible for making the appropriate entry in the patient’s medical record and for notifying the next of kin. If the attending practitioner, or designee, is unable to contact the next of kin within eight (8) hours of the patient’s death, the attending shall notify Hospital Administration. The attending physician or a physician designated by the attending physician must complete the death certificate.

It shall be the duty of all Medical Staff members to attempt to obtain permission for an autopsy in all deaths except:

- when an autopsy is legally prohibited.
- when a patient’s known wishes prohibit autopsy.
- when a patient’s known religion prohibits autopsy.

An autopsy can only be performed after appropriately obtained informed consent. In Medical Examiner cases consent for hospital performed autopsy can only be obtained after the Medical Examiner has released jurisdiction. A notation should be made in the medical record whether or not permission for an autopsy was obtained.

L. **ADDITIONAL REFERENCE MATERIALS**

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

   a) Administration Policy and Procedure Manual
   b) Patient Care Policy and Procedure Manual
   c) Infection Control Policy and Procedure Manual
   d) Safety Manual
   e) Fire and Disaster Plans
   f) Clinical and Ancillary Department Manuals, i.e., Pharmacy, Dietary
   g) Policy on Impaired Physician