# PRESBYTERIAN HEALTHCARE

# RULES AND REGULATIONS OF THE MEDICAL STAFF

**Approved by the Board of Trustees**
**July 14, 2010**

# PRESBYTERIAN HEALTHCARE

## Table of Contents

***SECTION I. ADMISSION AND DISCHARGE OF PATIENTS........................................... 1***

***SECTION II. GENERAL CONDUCT OF CARE....................................................................... 3***

***SECTION III. GENERAL RULES AND REGULATIONS REGARDING SURGICAL AND INVASIVE PROCEDURE CARE......................................................................................... 11***

***SECTION IV. MEDICAL RECORDS............................................................................. 14***

***SECTION V. EMERGENCY SERVICES ...................................................................... 18***

***SECTION VI. MEDICAL SCREENING EXAMS AND TRANSFERS – EMTALA............. 19***

***SECTION VII. EMERGENCY ROOM UNASSIGNED CALL .............................................. 25***

***SECTION VIII. MEDICATIONS......................................................................................... 28***

Recognizing that the best interests of the patients are protected by a concerted effort, the physicians and oral surgeons practicing in the Presbyterian Hospitals, set forth the following rules and regulations. If any facility does not provide the unit and/or care referenced in a provision, the provision shall not be applicable to the facility.

## SECTION I. ADMISSION AND DISCHARGE OF PATIENTS

1. Members of the Hospital Medical Staff may admit or treat patients only at those hospitals at which they have been granted clinical privileges. Patients may be admitted only to those facilities which are appropriate to their diagnosis and treatment plan. Medical Staff members may only utilize those privileges which have been granted to them appropriate to the services offered at the facility to which their patient(s) have been admitted. All physicians, except as noted below, who are appointed to the Active, Active Provisional, Courtesy and Courtesy Provisional staff are automatically granted privileges to:

   a. Admit patients - Patients in the "Observation" status will be considered as inpatients for the purposes of admitting privileges.

   b. Perform histories and physicals

   c. Order diagnostic and therapeutic services

   d. Make referrals and request consultations

   e. Provide consultations within the scope of his or her privileges

   f. Use all skills normally learned during medical school or residency

   g. Render any care in a life threatening emergency

   h. Emergency physicians, Radiologists, Pathologists and Anesthesiologists do not have admitting privileges, except as specifically granted by their delineation of privileges. Physicians appointed to the Consulting and Affiliate Staff do not have admitting privileges.

2. The admitting medical staff member shall be responsible for giving information to the Admitting Office or outpatient treatment area relating to the condition of the patient to ensure the protection of other patients and employees whenever said patient might be a source of danger.

3. Medical Staff members, as well as other licensed physicians whose license has been verified by the Medical Staff Office, may refer patients to the Home Care Services and must maintain responsibility for the care of those patients until their discharge from such a service or until the patient's care has been transferred to another physician.

4. A patient may be discharged only by order of the attending medical staff physician or by approved discharge criteria where applicable. If a patient chooses to leave the hospital against the advice of the attending Medical Staff member, a notation of the incident shall be made in the patient's progress notes. The patient will be asked to sign an Against Medical Advice (AMA) form and the attending physician will be notified.

5. Criteria and priority for admissions to a special care unit is established by the respective multi-disciplinary committee and arbitrated by the Medical Director of the respective special care unit.

6. Each member of the admitting Medical Staff will designate at least one member of the Medical Staff to attend his/her patients in his/her absence. This alternate Medical Staff member should be of the same discipline and possess equivalent clinical privileges at the Hospital. In the event that the admitting member of the Medical Staff and his/her designated alternate fail to respond to his/her patient's emergency, (1) the appropriate department chairperson, (2) the Campus Chief of Staff, or (3) the Hospital President/Administrator shall have the authority to call on another member of the active Medical Staff to treat the patient.

7. In circumstances when a hematologist/oncologist is unable to make rounds on his/her own hematology-oncology inpatients and/or consultation patients, he/she will arrange for appropriate coverage for rounds and notation through a hospital-credentialed Hematologist-Oncologist in his/her own group or in an associated group. Appropriate coverage should be arranged for patients with non hematology-oncology problems. The responsibility to arrange for appropriate coverage of patients belongs to the hematologist-oncologist who expects to be absent. In unusual circumstances (expected prolonged absence, coverage through a hematologist-oncologist from a different practice group, etc), the Inpatient Unit Nurse Manager and Emergency Department Nurse Manager should be notified in advance of the expected absence.

8. The Admitting Physician will be named as the Attending unless a physician order by the Admitting Physician directs otherwise.
   EXCEPTIONS:

   a. In the Obstetric Service, the Delivering Physician will be listed as the Attending Physician.

   b. In the Emergency Department, if a patient is admitted, the Emergency Room Physician will list the Admitting Physician or service.

   c. In the Hemby Children's Hospital, the Neonatologist and the Pediatric Intensivist will be listed as the Attending Physician.

9. End stage renal dialysis patients will be admitted by the nephrology service if a patient has a renal related illness (e.g., electrolyte imbalance, fluid overload, access device infection, or ICU

admission, etc). ESRD patients that present with a medical non-nephrological illness will be admitted to the medicine service. Patients that present with a primary surgical problem will be admitted to the appropriate surgical service with nephrology consulting.

## SECTION II. GENERAL CONDUCT OF CARE

1. Before any order shall be accepted or carried out, it shall be written in the patient's record by either the individual giving the order or the qualified person to whom the order was dictated. All orders must be timed, dated and authenticated. Verbal orders shall include the name of the ordering practitioner, the date, time and full signature of the person taking the order. Those persons authorized to receive dictated orders appropriate to their fields and enter them into the chart are limited to the following categories of personnel:

    a. Licensed Nurses (Registered Nurses, Registered Nurse First Assistants, and Licensed Practical Nurses)

    b. Certified Registered Nurse Anesthetists

    c. Registered radiologic technologists as authorized by the Director of the Department of Radiology

    d. Registered pharmacists

    e. Physical Therapists

    f. Occupational Therapists

    g. Speech-Language Pathologists

    h. Audiologists

    i. Respiratory Care Practitioners

    j. Licensed social workers

    k. Designated medical technologists as authorized by the Chairperson of the Department of Laboratory and Clinical Pathology

    l. Clinical dietitians/nutritionists

    m. Physicians' assistants

    n. Radiation physicists

    o. Cardiovascular technologists

p. Medical office assistants

q. Psychologists

r. Nurse Practitioners/Certified Nurse Midwives

s. Radiology Technicians

t. Perfusionists/cell saver technologists

3. Therapeutic abortions performed on patients whose pregnancy has progressed beyond twenty (20) weeks must be in compliance with Novant Health's Abortions Policy. The fact that there is substantial risk that the continuance of the pregnancy would threaten the life or gravely impair the health of the woman must be documented.

4. Each appointee to the Medical Staff is expected to attempt to secure autopsies in all deaths that meet criteria adopted by the Medical Staff identifying deaths in which an autopsy should be performed. Findings from autopsies are used as a source of clinical information in quality assessment and improvement activities. North Carolina law requires that the following types of deaths be reported to the Medical Examiner who then accepts or declines the case:

a. Homicide

b. Suicide

c. Accident

d. Trauma

e. Disaster

f. Violence

g. Unknown, unnatural, or suspicious circumstances

h. In police custody, jail or prison

i. Poisoning or suspicion of poisoning

j. Public health hazard (such as acute contagious disease or epidemic)

k. Deaths during surgical or anesthetic procedure

l. Sudden unexpected death which is not reasonably related to known previous disease

m. Death without medical attendance

The Medical Examiner will decide if an autopsy is required. The initial contact and the medical examiner's decision about an autopsy are documented on the "Authorization for Release of Body/Autopsy" form.

Deaths within 24 hours of admission to an inpatient facility do not have to be reported to the Medical Examiner if the death does not meet the criteria listed above.

Additional indications for autopsy established by the SPR Medical Board include

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

b. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may have a bearing on survivors or recipients of transplanted organs.

c. Deaths occurring in patients who have participated in clinical trials (protocols approved by Institutional Review Board).

d. Deaths known or suspected to have resulted from environmental or occupational hazards.

e. All obstetrical deaths.

f. All neonatal and pediatric deaths.

Permission to perform the autopsy must be obtained by a physician and documented on the appropriate hospital forms. Consent for an autopsy required by the Medical Examiner is not necessary. In situations where permission has been obtained to perform an autopsy by someone other than the attending physician, the attending physician should be notified that the autopsy will be performed. The attending physician shall be informed of the results of the autopsy. The pathologist is responsible for the preparation of a descriptive diagnostic report of autopsies performed. The provisional anatomic diagnoses should be recorded in the medical record within three days, with the complete protocol made part of the medical record within 60 days. Autopsy final reports should be available within 60 working days of the autopsy in routine cases. Exceptions may include: (1) Forensic or possible forensic deaths; (2) Congenital or unusual stillbirths; or (3) Unusual medical conditions requiring special studies or external consultants.

5. A consultation with another member of the Medical Staff is encouraged for non-emergent cases in which the diagnosis is obscure, there is doubt as to the best diagnostic or therapeutic measures to use, or the patient demonstrates suicidal

behavior. When called by a referring physician, medical staff listed on the ED unassigned call roster are required to provide inpatient consults during their assigned call period. The following guidelines apply to consultations:

a. A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The selection of the consultant is made on the basis of an individual's training, experience, and competence.

b. A satisfactory consultation includes examination of the patient and the patient's record. A written opinion signed legibly by the Consultant must be included in the medical record following each consultation visit. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation except in situations when the procedure is an integral part of the consultation.

   **i.** The referring physician is responsible for directly contacting the consulting physician or his/her designee*, when a consultation is needed. The only exceptions to this will be routine tests and routine radiological procedures (invasive radiologic procedures would require physician to physician consults). Referring physicians actively participating in invasive procedures may relay information to consulting physicians using intermediaries in these clinical scenarios. Voice mail, pager messages and emails do not constitute a consult. A referring practitioner may use these forms of communication, but the consulting practitioner's responsibility begins only after direct communication from the referring practitioner or his/her designee.

   **ii.** If a specific physician is requested for a consultation but is unavailable, the physician on-call for that physician is responsible for assuring the consultation is completed.

   **iii.** Consultations not designated as urgent/emergent by the requesting physician will be seen within 24 hours of the request for consultation.

   **iv**. The timeliness of response can be decided with the referring physician based on the patient's acuity. In the event of a disagreement regarding appropriate response time, the referring physician's opinion will prevail.

   **v.** Floor unit secretaries and nurses will not assist with contacting the consulting physician. They may give contact information to the referring physician, if it is available.

   * Physician Assistant, nurse practitioner, registered nurse or a certified medical assistant under the direct supervision of the physician, and who have been identified in writing to the hospital by the physician as the physician's designee for the purposes of accepting consultation requests.

c. It is the duty of the Medical Staff, through its Campus Department and Division Chairpersons, to make certain that appointees to the Medical Staff do not fail in the matter of calling consultations as needed.

d. Requested consultations must be accomplished within 24 (twenty-four) hours of the consultation request. If a physician who has been asked to provide a consultation has not seen the patient within 24 (twenty-four) hours, the patient's attending physician shall be notified and asked to select another physician to provide the consultation.

6. In order to provide for the best patient safety and continuity of care, the Members of the Medical Staff are expected to communicate in the appropriate form to their colleagues (or other institutions) when patients are transferred, or if there is a change in the physician(s) responsible for the care of the patient. This includes:

   a) Transfers between units within the hospital, such as transfer from a critical care unit to a telemetry unit;

   b) Transfer of call responsibility or covering physician; when multiple physicians are involved in the care of the patient, the attending physician, or the physician covering for the attending physician, is ultimately responsible for patient care issues;

   c) Anesthesiologist's report on transfer from the operating room or post-anesthesia care unit to a critical care unit;

   d) Transfer to an outside facility, i.e. hospital, skilled nursing facility, Hospice care, etc.;

   The transfer communication should include at a minimum: patient identification, patient location, plan of care or changes in care, expected course for the patient, anticipated or potential problems, pending studies (as appropriate), and any special considerations for the patient.

7. Health care providers without admitting privileges recognize that occasionally circumstances may arise requiring inpatient hospital care for their patients. Any healthcare provider practicing at an affiliated ambulatory surgery center will recognize this responsibility and accept duty to arrange for hospital care for a patient as needed.

8. A PA/NP may examine and treat patients in the Emergency Department under the direction of the sponsoring physician, but without the physical presence of the sponsoring physician. At the direction of the sponsoring physician, the PA/NP may admit the patient from the Emergency Department to the sponsoring physician's service. Patients admitted to an acute care setting by the PA/NP whether admitted from the Emergency Department or other locations, must be seen by the sponsoring physician within 24 hours of admission.

9. When a patient is admitted to an inpatient unit other than a critical care unit, it is the responsibility of the attending physician to see the patient within 24 hours of admission.

10. When a change in a patient's medical condition necessitates a transfer to a higher level of care, it is the responsibility of the attending physician to assure that this patient is seen by an appropriate physician within two (2) hours of transfer to evaluate the condition for which the transfer was required. When a patient is admitted to a critical care unit, either by transfer from another institution, or on admission from the Emergency Department; it is the responsibility of the attending physician to assure that the patient is seen by an appropriate physician within two (2) hours of admission to the critical care unit.

11. Each member of the Medical Staff is required to report any suspensions, revocations, limitations or termination of the following within seventy-two (72) hours of the notification:

    a. State Licensure

    b. Malpractice coverage (includes cancellation or non-renewal)

    c. Drug Enforcement Administration registration

    d. Privileges at other hospitals (includes voluntary reduction of privileges)

    e. Restrictions or sanctions by any Professional Review Organization

    f. Change in Medicare Provider Status

12. Each member of the Medical Staff is required to report any award of damages or settlements involving medical malpractice, regardless of the amount, within seventy-two (72) hours of receiving notification.

13. Each member of the Medical Staff is required to report any felony arrests or indictments; any arrest for driving while impaired or driving under the influence; or any arrest or indictment for the possession, use or sale of any controlled substance within seventy-two (72) hours of the notification.

14. Members of the Medical Staff who wish to obtain permission to have professional colleagues, instructors, proctors, visitors, students, interns or residents participate with them as observers or as part of a clinical education experience while carrying out their patient care responsibilities must comply with the requirements of the applicable Novant Health policies. The Medical Staff member will be responsible for the colleague, instructor, proctor, student, intern, or resident while they are in any Healthcare facility. This responsibility shall include the cosigning of any entries into

the medical record, the physician's supervision during any patient examinations and the monitoring of general appearance and behavior. All procedures will be under the direct supervision of a medical staff member who is privileged for such procedure(s).

15. All members of the Medical Staff are expected to participate in the implementation of the Performance Improvement Plan.

16. If a problem regarding the immediate care of a patient is identified by any health care practitioner, the process for resolution of the concern should be handled according to Administrative Policy, Resolution of Patient Care Questions: Chain of Command.

17. The Medical Staff may engage in research if such research projects have been reviewed and approved by the Institutional Review Board. The Medical Staff, if they engage in research protocols within the Hospital or its affiliated institutions and clinics, must conduct/participate in research per the policies and procedures of the Institute for Research and Technology and the Institutional Review Board.

18. All Medical Staff members follow Novant Health policies concerning infection control procedures in order to minimize infection risks to themselves, their patients, and to employees.

19. The Medical Staff shall support the function and operation of a **Physicians' Health and Effectiveness Committee**. Policies and procedures involving this committee shall be approved by the SPR Medical Board.

20. Any outpatient service which meets the definition of "Observation", as set forth in the "Outpatient Observation Policy" approved by the SPR Medical Board, shall be subject to the directions of that policy.

21. Standing Orders may be initiated with regard to Hospital patients in compliance with policies which must be approved by the SPR Medical Board. It is the responsibility of the Attending Physician to provide an order to initiate a specific Order Set or Protocol. To ensure patient safety, order sets submitted by members of the medical staff must be reviewed by a multidisciplinary committee before being approved for entry into the Information Management System. Order Sets may be revised periodically to reflect changes in medical practice or actions taken by the hospital.

22. Members of the Medical Staff are expected to comply with the North Carolina Medical Board's position statement regarding "Self-Treatment and Treatment of Family Members and Others with Whom significant Emotional Relationships Exist" when practicing in the hospital. This position statement says that, "Except for minor illness and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships." It is expected that physicians will delegate the medical and surgical hospital care of themselves, their families, and those with whom they have significant emotional relationships to one or more physicians on the medical staff.

23. Presbyterian Healthcare will maintain a Presbyterian Critical Care Medicine Program guided by evidenced-based outcomes as adopted from national patient safety and quality assessment organizations. The expectations for critical care support, as well as the patient population to which the standards apply are outlined in the Presbyterian Critical Care Management Policy which is approved by the SPR Medical Board. The policy will provide for open access to the critical care units (CCU, ICU, CVRU, and NSICU), for all attending physicians, and maintains and respects the primacy of the attending physician's position as decision-maker for patient care. When a patient is admitted to a critical care unit and meets criteria for the patient population as outlined by the policy, the admitting/attending physician will enter an order for a level of involvement for the critical care provider. The levels are designated as follows:

- Level #1: Attending physician requests transfer of care to the critical care physician for complete evaluation and management. Continued involvement by the attending physician may be appropriate in a consultant role and is not precluded.
- Level #2: Attending physician requests critical care physician consultation for purposes of evaluation and co-management of critical care problems. Co-management may include direct discussion, written recommendations, and written orders as deemed appropriate. Critical/pulmonary care beyond the critical care unit stay will be continued as appropriate at the request of the attending physician.

24. Presbyterian Hospital Charlotte will maintain a Pediatric Critical Care Program guided by evidenced-based outcomes as adopted from national pediatric patient safety and quality assessment organizations. In order to ensure that patients in the Pediatric Intensive Care Unit receive ongoing, consistent monitoring for patient safety and to optimize care, the Pediatric Critical Care Service will evaluate all patients admitted to the Pediatric Critical Care Unit. The admitting/attending physician will request consultative/co-management services from the Pediatric Critical Care Service. The Pediatric Critical Care physician will provide consultation for purposes of evaluation and co-management of critical care problems. Co-management may include direct discussion, written recommendations, and written orders as deemed appropriate. The Pediatric Critical Care physician will provide consultative services after transfer from the critical care unit as deemed appropriate by the attending physician.

25. For new onset chest pain, the telemetry order set can be initiated by a charge nurse prior to notification of the patient's attending physician

## SECTION III. GENERAL RULES AND REGULATIONS REGARDING SURGICAL AND INVASIVE PROCEDURE CARE

1. It is the responsibility of the healthcare practitioner performing the procedure to obtain informed consent from the patient or legally responsible party in accordance with Novant Health's Informed Consent policy (which must be approved by the SPR Medical Board. A valid surgical consent form must be completed prior to an operative and/or invasive procedure and is placed on the medical record. . Emergency treatment without consent may be provided in accordance with Novant Health's Informed Consent policy.

2. Except where there exists an immediate life threatening situation, before anesthesia may be administered to or surgical or endoscopic procedure commenced on any patient, a documented history and physical examination must be entered on the patient's chart.

3. In all cases, at a minimum, the pre-operative diagnosis must be recorded in the Hospital medical record before the start of the surgical and/or invasive procedure.

4. A dated pre-anesthesia evaluation of the patient by a physician shall be recorded in the patient's medical record prior to surgery. This shall include drug allergies, anesthetic risk, medications, previous anesthetic experiences, pertinent medical problems, anesthesia planned, and the signature of the physician who performed the evaluation.

5. Post-operative documentation records the patient's discharge from the postanesthesia care area by the responsible licensed independent practitioner or according to discharge criteria.

6. When an invasive procedure is being performed, there must always be a practitioner available who is capable of performing the procedure in the event of incapacity of the practitioner.

7. A handwritten note or signed report relating specific basic details must be recorded in the medical record_by a surgeon immediately following any operative procedure. Operative progress note must be dated and include the following: findings/description; post-operative diagnosis; procedure(s) performed; name of surgeon and assistant; specimens removed, and estimated blood loss.

8. A report of all operations performed must be dictated by the attending surgeon. All tissues removed at operations must be sent to the Hospital pathologist who shall make such examinations as he considers necessary to arrive at a pathological diagnosis. At the discretion of the surgeon, certain specimens from a list approved by the SPR Medical Board are excluded from this requirement. These exclusions may include: finger nails, toe nails, septum cartilage, cataracts, fat suction, teeth, skin from cosmetic surgery, foreign bodies, kidney stones, foreskin, vaginal mucosa, ribs,

bunions, arthroscopic shavings, foreign materials (hardware, implants, non-tissue foreign bodies, synthetic materials, orthopaedic appliances), residual portions of tissue used as a graft, and normal tissue or bone removed for exposure. At the time total joint tissue or intervertebral disk is removed, the surgeon will have the option of designating "microscopic examination" or if nothing else is designated then gross examination only will be performed. Removed specimens that are not submitted for pathological examination must be described and/or documented in the operative record. Pathology reports are made a part of the record on every patient where a specimen was removed and sent for review. At the request of the attending surgeon, in children under the age of 12 years, gross diagnosis only may be done on tonsils and adenoids removed, with documentation of the findings included in the medical record.

9. All activities of a Physician Assistant/Nurse Practitioner/Certified Registered Nurse First Assistant in the Operating Room must be carried out under the direct supervision of the attending surgeon in the Operating Room Suite. All activities of a Private Surgical Assistant (Operating Room Registered Nurse or Operating Room/Dental technician) in the Operating Room must be carried out under the direct supervision of the attending surgeon who will be present in the Operating Room.

10. All previous orders are considered canceled when the patient goes to surgery. The only exception would be a Do Not Resuscitate status which will remain in effect unless the attending physician, the physician performing the procedure or the anesthesiologist writes an order rescinding the DNR order. The attending physician, the physician performing the procedure, or the anesthesiologist should discuss the patient's wishes concerning resuscitation in the event of a procedure-related cardiac arrest. The mutually agreed upon course of action should be recorded in the patient's chart. Unless an order is written to rescind the DNR, the patient will remain DNR during the procedure. If the physician and patient are unable to agree, then the physician should help the patient find another physician who is able to comply with the patient's wishes.

11. The surgeon must be in the Operating Room Suite and ready to commence the operation at the time scheduled. Any surgeon who requests to be delayed on the schedule shall notify the Charge Nurse of the Operating Room of his situation so that corrections can be made, such as administering pre-medication, sending for the patient and rearranging the schedule if possible for a later time. If not notified and there is more than a 30 minute delay, it shall be the prerogative of the Operating Room coordinator of the surgical schedule to delay the case until the next available time.

12. Visitors shall not be permitted to observe operative or invasive procedures without specific permission from the responsible physician, the patient, and the Operating Room Director.

13. It is the responsibility of the practitioner performing the procedure to ensure the site-marking and pause policy is implemented. Any practitioner declining or refusing to participate in the pre-procedure pause as outlined in the pause policy, will be subject to immediate disciplinary steps set forth in *Policy on Appointment, Reappointment and Clinical Privileges.*

## SECTION IV. MEDICAL RECORDS

1. A complete history and the findings of a complete physical examination must in all cases be documented on the medical record within 24 hours after admission.

2. The History and Physical Examination report may be dictated, created by an electronic medical record system or handwritten and must contain: chief complaint, history of present illness, relevant past medical history, social and family histories, a relevant physical examination, conclusions or impressions from the H&P exam, the diagnosis or diagnostic impression, the goals of treatment and the treatment plan.

3. One history and physical shall be adequate for a planned course of outpatient therapy with repeated scheduled treatments (e.g., treatment of pain management patients). Progress notes which include any changes in the H&P must be documented at each patient visit.

4. An updated history and physical examination for obstetrical patients includes a current antepartum record and a completed obstetrical admission note. In cases of delivery by cesarean section or bilateral tubal ligation following normal delivery, a current history and physical examination must be written or dictated prior to administering anesthesia.

5. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission to the hospital, a reasonably durable and legible copy of these reports may be used in the patient's medical record, provided these reports were recorded by a Medical Staff Member and are in a form approved by the Medical Board and are authenticated by the admitting physician. For history and physical examinations performed outside the facility, an update to the history and physical examination must be recorded on, or attached to the report and signed within 24 hours after admission. Prior to an invasive procedure or prior to anesthesia administration, an outside history and physical must be updated including any additions or changes to the history or physical.

6. If a patient is readmitted within thirty (30) days for the same or related problem an interval admission note, including all additions to the history and any subsequent changes in the physical findings, must be documented in the medical record and signed by the admitting physician within 24 hours of admission.

7. In the Transitional Care Unit (TCU) at POH, the attending physician or physician extender must perform each resident’s assessment, including a medical history and physical examination, within 72 hours of admission, except when an examination was performed within 24 hours before admission and the findings were recorded in the medical record on admission.

8. Patients must be seen and a progress note written by the attending physician as often as the patient’s condition dictates, but in no case less than:

a. At least once/day for patients on the Critical Care Units and Medical/Surgical units;

b. At least once every other day for patients on the Rehab Unit;

c. At least once every three days for patients whose primary reason for remaining in the hospital is to await placement in an extended care facility; or

d. At least every thirty (30) days for patients admitted to the POH TCU.

Progress notes by the medical staff should give a pertinent chronological report of the patient's course, should be sufficient to describe the changes in each of the patient's conditions and should record the results of treatment, including the patient's response to care provided and to antibiotics or pain medication. Additionally, when specific care goals are developed as part of the initial assessment process, progress or lack of progress toward goal achievement should be documented in the progress notes.

9. A discharge summary must be dictated or legibly written by the physician or licensed Allied Health Professional (upon approval by the department of the physician's specialty), and authenticated by the physician, on all patients hospitalized more than forty-eight (48) hours and shall include all relevant diagnoses established at the time of the discharge, reason for hospitalization, significant findings, procedures performed, treatment rendered, condition of patient on discharge and any specific discharge instructions to the patient and/or family members.

10. A discharge summary is not required on admissions less than forty-eight (48) hours or for normal newborns with uncomplicated deliveries, provided there is an adequate and legible discharge note which documents the patient's condition at discharge and provides specific discharge instructions.

11. A Discharge Summary or an Emergency Report must be dictated in the event of a patient death regardless of the length of the patient's stay in the hospital.

12. a. Every medical record entry should be dated and timed, the author identified and authenticated. Verbal orders shall be authenticated by the prescribing practitioner or other practitioner within 48 hours. Authentication means to establish authorship by a legibly written signature, initials or acceptable hospital identifier. The following medical record entries require authentication by the physician: History and Physical, Consultation Note, Operative Note, Progress Notes and Discharge Summary.

13. Medical Staff members who are engaged in the medical care of a patient shall be allowed access to the records of such patient at the nursing station and in the Medical Records Department.

14. No unapproved symbol or abbreviation may be used in the patient's medical record. There must be an explanatory legend or electronic resource available to identify any symbols and/or abbreviations used in the medical record.

15. All final diagnoses and complications must be recorded in the medical record without the use of symbols and/or abbreviations.

16. All records are the property of the Hospital and shall not be removed from the Hospital's jurisdiction and safekeeping except pursuant to an order of a court of competent jurisdiction. In the case of readmission of a patient, all previous records shall be made available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another physician.

17. A medical record shall not be permanently filed until it is completed by the responsible physician or oral surgeon, or is closed under the policy for Administrative Closure of a Patient Medical Record on order of the SPR Medical Board. No medical staff member is permitted to complete a medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or unavailable permanently or protracted for other reasons.

18. The attending physician shall be held responsible for a complete and legible medical record for each patient treated.

19. Medical Staff members will be notified weekly of records pending delinquent status.

20. All incomplete Medical Records will be considered delinquent thirty (30) days post discharge. If a member of the Medical Staff does not complete their delinquent records within thirty (30) days after the record becomes available, the staff member's privileges will be temporarily suspended. Reinstatement to the original status on the Medical Staff shall occur upon completion of all their medical records. Should a member have four (4) suspensions or a total of ninety (90) days of suspension within a consecutive twelve month period, this shall be considered a voluntary resignation from the medical staff. The practitioner may reapply for medical staff membership after completing all medical records.

21. Medical Staff members with delinquent record status will be reported to the Campus Department/Division Chairperson, Medical Staff Office and Administration.

22. Practitioner signatures are kept on file in the Medical Staff Office. In any situation where a signature on the medical record is questioned, verification of the authenticity of a practitioner's signature may be confirmed by a comparison to the signature on file in the Medical Staff Office. Administrative supervisors have access to the Medical Staff files 24 hours a day in the event verification is needed at a time other than the regular office hours of the Medical Staff Office. In the event verification is needed at sites in the Presbyterian Health Care system outside Presbyterian Hospital Charlotte,

samples of the questioned practitioner's signature can be transmitted by facsimile machine to the site needing verification.

23. Only the original author of a medical record entry is authorized to correct or alter the entry. Any correction/alteration must be authenticated by the person making the correction/alteration. Original medical record entries should never be erased or otherwise obliterated, including the use of "white out." If correction/alteration is made, the health care provider should cross out the original entry with a single line, ensuring that it is still readable, enter the correct information, sign with legal signature and title and enter the time and date the correction was made. When the correction requires more space than is available, the individual should write "addendum" and enter the correct information into the record.

## SECTION V. EMERGENCY SERVICES

1. Appropriate medical records shall be kept for every patient receiving Emergency Department services in the hospital. This record shall be incorporated into the hospital's medical records. The record should include:

    a. Adequate patient identification.

    b. The time of patient's arrival, and means of transportation.

    c. Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his/her arrival at the hospital.

    d. Description of clinical, laboratory and radiology findings.

    e. Diagnosis.

    f. Treatment given and time of commencement of treatment.

    g. Condition of the patient upon discharge or transfer.

    h. Final disposition including instructions given to the patient and/or his/her family including medications and instructions relative to follow-up care.

2. Members of the Medical Staff should participate in the development and evaluation of a plan for the care of mass casualties at the time of any major disaster based upon the hospital's capabilities in conjunction with other emergency facilities in the community.

3. All patients presenting to the Emergency Department will receive a medical screening exam by an emergency physician or other qualified medical personnel as defined in Section VI, B.2. of these Rules and Regulations, unless the patient's private physician is immediately available at patient's presentation.

## SECTION VI. MEDICAL SCREENING EXAMS AND TRANSFERS – EMTALA

It is Novant's policy to provide care to individuals who come to the dedicated emergency department or present elsewhere with an emergency medical condition in a manner that best meets the needs of those individuals and that complies with applicable state and federal laws. This does not apply to patients who currently are receiving services as either an inpatient or have begun to receive services as part of an outpatient encounter other than encounters covered by this policy.

A. Definitions

1. Definition of Emergency Medical Condition: Either:

    a) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in :

        1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

        2) Serious impairment to bodily functions; or

        3) Serious dysfunction of any bodily organ or part.

    b) With respect to a pregnant woman who is having contractions, either:

        1) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

        2) That transfer may pose a threat to the health or safety of the woman or the unborn child.

    c) Some intoxicated individuals may meet the definition of "emergency medical condition" because the absence of medical treatment may place their health in serious jeopardy, result in serious impairment of bodily functions, or serious dysfunction of a bodily organ. Further it is not unusual for intoxicated individuals to have unrecognized trauma. Likewise, an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an emergency medical condition.

2. Definition of "Dedicated Emergency Department" includes emergency departments and labor and delivery departments.

3. Definition of “Stabilized”: means with respect to an emergency medical condition to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of that individual from a facility or in the case of a woman in labor that the woman has delivered the child and the placenta.

**B. Medical Screening Exam:**

1. In Behavioral Health and the Department of Psychiatry, components of the medical screening exam include:

a) Presence and severity of homicidal and suicidal ideation.

b) Presence and severity of psychotic thinking and behavior.

c) Ability to care for self.

d) Level of orientation.

e) Judgment and insight.

Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols: MSW’s (Masters of Social Work), Licensed Professional Counselors, Registered Nurses. In some circumstances the individual’s condition may warrant another physician’s expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the hospital.

2. In the Emergency Department, components of the medical screening exam include:

a) History and physical examination.

b) Appropriate testing.

c) Completion of appropriate documentation.

d) Evaluation of the patient, within the capabilities of the hospital including the use of indicated on-call physicians as appropriate, to determine whether a patient has an emergency medical condition as defined by law.

Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols: Physician Assistants, Nurse Practitioners, and Registered Nurses. For sexual assault cases, registered nurses and sexual assault nurse examiners may be used. In some circumstances the individual's condition may warrant another physician's expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the hospital.

3. In the Labor and Delivery Department, components of the medical screening exam include:

a) History and physical examination, appropriate testing and completion of appropriate documentation as per ACOG guidelines.

b) If additional clinical information is required to complete the screening exam, the ED will consult the obstetrician and/or Labor and Delivery.

Physicians and the following categories of individuals are designated as qualified medical personnel authorized to perform a medical screening examination to determine the existence of an emergency medical condition, subject to appropriate physician supervision and established protocols: Labor and Delivery Nurses who have passed all competencies and course requirements to work in labor and delivery, and nurse midwives. In some circumstances the individual's condition may warrant another physician's expertise to determine if the individual has an emergency medical condition. In this circumstance, the on-call physician is required to provide all necessary components of the screening exam and stabilizing treatment in the hospital.

## C. Criteria for Transfer

1. Definition of Transfer: The movement (including the discharge) of an individual outside a hospital facility at the direction of a person employed by (or affiliated or associated, directly or indirectly, with) the hospital. A transfer does not include such movement of an individual: (a) who has been declared dead; or (b) who leaves the facility against medical advice or without having been seen.

2. A transfer from a dedicated emergency department to another medical facility will be appropriate only in those cases in which:

a. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and in the case of a woman in labor, the health of the unborn child;

b. The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment;

c. The transferring hospital sends to the receiving facility copies of all medical records related to the emergency condition which are available at the time of the transfer, the consent and certification form and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records not available at the time of transfer must be sent as soon as practicable;

d. The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer;

e. The patient or his/her legally responsible person consents to the transfer or the legal requirements for involuntary commitment have been satisfied.

Additional requirements must be satisfied with respect to the transfer of unstable patients per Novant Health's EMTALA policy.

3. Transfers of unstable patients - If an individual has an emergency medical condition that has not been stabilized, the individual may not be transferred from the dedicated emergency department unless:

A) The transfer is an appropriate transfer as stated in Section C.2 above;

**And**

B) meets one of the following criteria:

1) Individual requests transfer - the individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under law and of the risk of transfer. The request must be in writing and must indicate the reasons for the request, as well as indicate that he or she is aware of the risks and benefits of the transfer; or

2) Physician certification - A physician has signed a certification that, based upon the information available at the time of transfer, the

medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based. If a physician is not physically present in the dedicated emergency department at the time an individual is transferred, a qualified medical person may sign the certification after a physician in consultation with the qualified medical person agrees with the certification and subsequently countersigns the certification. Qualified medical personnel include:

(a) Behavioral Health and Department of Psychiatry: Masters of Social Work, Licensed Professional Counselors, Registered Nurses.

(b) Emergency Department: Physicians Assistants, Nurse Practitioners and Registered nurses.

(c) Labor and Delivery Department: labor and delivery nurses who have passed competencies and course requirements to work in labor and delivery and nurse midwives.

(d) Neonatal Units: Neonatal nurse practitioners.

4. **Certification for Transfer**

A. When a physician is not physically present in Behavioral Health and Department of Psychiatry, the following categories of individuals are designated as qualified medical personnel who are authorized to (a) conduct a medical screening exam, (b) consult by telephone with a physician to determine whether the medical benefits of transferring an individual outweigh the increased risks of transfer, and (c) sign the certification for transfer form after the physician has made the determination to transfer, subject to established protocols and the physician's subsequent countersignature of the certification form: MSW's (Masters of Social Work), Licensed Professional Counselors, Registered Nurses.

B. When a physician is not physically present in the Emergency Department, the following categories of individuals are designated as qualified medical personnel who are authorized to (a) conduct a medical screening exam, (b) consult by telephone with a physician to determine whether the medical benefits of transferring an individual outweigh the increased risks of transfer, and (c) sign the certification for transfer form after the physician has made the determination to transfer, subject to established protocols and the physician's subsequent countersignature of the certification form: Physician Assistants and Nurse Practitioners.

C. When a physician is not physically present in the Labor and Delivery Department, the following categories of individuals are designated as qualified medical personnel who are authorized to (a) conduct a medical screening exam, (b) consult by telephone with a physician to determine whether the medical benefits of transferring an individual outweigh the increased risks of transfer, and (c) sign the certification for transfer form after the physician has made the determination to transfer, subject to established protocols and the physician's subsequent countersignature of the certification form: Labor and Delivery Nurses who have passed all competencies and course requirements to work in labor and delivery, and nurse midwives. Neonatal Nurse Practitioners are designated as qualified medical personnel who are authorized to transfer newborns.

5. **Accepting Transfer:** Individuals authorized by a Department to accept patient transfers may do so subject to physician acceptance of the transfer and established department protocols. Any Novant hospital that has specialized capabilities or facilities shall not refuse to accept an appropriate transfer of an individual with an emergency medical condition who requires specialized capabilities or facilities if the receiving facility has the capacity to treat the individual.

6. Transfer of patients may be made at the request of the patient, which will be documented in the medical record.

## SECTION VII. EMERGENCY ROOM UNASSIGNED CALL

As required by the By-Laws, Section 3.2-2 and 3.2-3, each Active/Provisional member of the Medical Staff is responsible to take unassigned Emergency Room Call in the frequency (daily, weekly, monthly) determined by his/her department. Medical Staff members will not be expected to take unassigned Emergency Room Call at any Hospitals at which they do not maintain clinical privileges. The following regulations define the Medical Staff's responsibilities regarding unassigned call:

1. For Presbyterian Hospital Charlotte: Each Hospital Department and Division, through the Chairperson, shall be responsible for establishing unassigned call lists to provide Emergency Room coverage for Presbyterian Hospital. Every effort should be made to provide coverage on a twenty-four (24) hour per day, seven (7) day per week basis, however there may be occasions when coverage is not available on a continuous basis. Any physician serving on an unassigned call list shall be required to accept a patient assigned to him/her.

2. For all other Campus Hospital Facilities: The Campus Department/Division Chairperson, shall be responsible for maintaining a separate unassigned call list for each specialty/subspecialty represented by at least three (3) members of the Hospital's Active Medical Staff. Members of a specialty/subspecialty represented by three (3) or four (4) members of the Hospital's Active Medical Staff will be required to take a minimum of six call days (24 hours) per month, four of which shall be weekdays and 2 of which shall be weekend days (Saturday and/or Sunday). When the specialty/subspecialty is represented by five (5) or more members of the Hospital's Active Medical Staff, that specialty/subspecialty shall provide 24/7 coverage for unassigned Emergency Room Call. If a particular specialty is unable to provide 24/7 coverage, patients needing care in that specialty may be transferred to Presbyterian Hospital Charlotte or other appropriate facility in accordance with Section VI hereof. Any physician serving on an unassigned call list shall be required to accept a patient assigned to him/her.

3. When, in the opinion of the hospital's administrator and the appropriate chairperson, there are insufficient numbers of physicians/oral surgeons to cover the unassigned call in a specialty/subspecialty at that facility, additional call assignments will be made at the discretion of the Campus Department Chairperson for the specialty/subspecialty in need of support. Additional call criteria may be established by the Hospital President or his designee, the VPMA or Regional CMO and appropriate chairperson to enhance the quality of care provided and will be considered effective once approved by the SPR Medical Board.

4. When a physician anticipates that he/she cannot fulfill his/her assigned date(s) of call, he/she is responsible for providing an alternate physician (on staff in the same specialty) and of notifying the Emergency Department and the Medical Staff Office prior to the call date.

5. Unless otherwise noted, call runs from 7:00 a.m. the first day of call to 6:59 a.m. the last morning of call. The on-call physician responsible for the presenting patient will be the one on-call when the decision is made by the ED physician to refer or consult, not the physician who was on call when the patient arrived.

6. On-call physicians shall respond to calls from the Emergency Department within fifteen (15) minutes. If the physician is unable to reach the physician on first call within fifteen (15) minutes, a second call will be made. If the physician on first call has not responded within thirty (30) minutes the nursing supervisor will be contacted to provide alternate contact numbers for the physician on first call. If the physician on first call can not be contacted at that time, the physician on second call will be called. If the physician is unable to reach the second call physician or if no second call physician has been designated by the Department, the Campus Chief of the Department or Service will be called. It is the responsibility of the Campus Chief of the Department or Service to designate a physician who will assume the Administrative responsibilities of the Chief in the event the Chief is not available.

7. The physician attending the patient in the Emergency Department may believe that he/she needs assistance in determining the existence of an emergency medical condition or in providing stabilizing treatment for such a condition. Unless the attending physician provides an alternate timeframe, the on-call physician must present to the facility within sixty (60) minutes of the request being made.

8. On-call physicians who chose to schedule elective surgery while on call or who take call simultaneously for more than one hospital are responsible for notifying the Emergency Department regarding back-up coverage or other arrangements that should be made in the event the on-call physician is needed. The Chairperson of the appropriate Campus Department or Division will be notified and consulted when a question arises within the Emergency Department concerning the responsibilities or medical intervention of the particular physician on-call. The Chairperson shall have the authority to decide the disposition of the patient when such a question arises.

9. Should a physician request transfer to a less active category, i.e., from Active to Courtesy staff, he/she shall be responsible for the next ninety (90) days of any call rotation already published and distributed. He/she may arrange with another physician on staff in the same specialty to take the call. Following such a request the physician’s hospital activity shall be monitored for ninety (90) days to ensure that continued hospital activity will be appropriate for the less active staff category. Ongoing monitoring of hospital activity and adjustment of medical staff category is described in the Medical Staff Bylaws, Section 3.2-1(b).

10. Practice groups who lose a physician(s) named on a published and distributed call schedule will be required to take the call, unless the physician(s) leaving the group remains on staff (either as a solo practitioner or joining another group), then the physician is responsible for the call. When a group physician(s) leaves the staff, the group may choose to arrange for another physician on staff in the same specialty, but not in their group, to take the call.

11. Notification of any call change must be made to the Emergency department prior to the date of call to be effective.

12. Only physicians or Allied Health Professionals who have been granted Emergency Room Privileges and who are sponsored by a physician on the Medical Staff of the Presbyterian Hospitals may treat patients in the Emergency Department.

13. Visiting physicians who are interested in observing the Emergency Department in operation must have authorization from Administration prior to arriving in the department. Patient(s) authorization/permission shall be obtained when necessary.

14. Assigned call schedule rotations are defined and assigned by the individual departments, but documented and distributed to those on-call by the Medical Staff Office.

15. Patients that are seen in the Emergency Department and are admitted to the hospital by the on call physician, and present to the Emergency Department with the same or related condition(s) within thirty (30) days of discharge will be the responsibility of the original admitting physician. If follow-up as an outpatient is necessary, it is expected that the on call physician assigned to the patient will see the patient within the appropriate time period, not to exceed 30 days.

16. Patients screened, treated and discharged from the Emergency Department and referred to the on call physician for follow-up of a non-emergency medical condition are entitled to one follow-up visit in the office of the physician on call. Following this visit the physician may refer the patient to another physician or clinic.

17. If the patient who was screened, treated and released from the Emergency Department returns to the ED within 30 days for the same or directly related condition, the original physician-on-call is still responsible for assisting in the patient's care.

## SECTION IX. MEDICATIONS

1. The hospital formulary is developed by the Pharmacy department in cooperation with the medical staff and includes the use of generic substitutions and therapeutic equivalents. The pharmacy department will undertake automatic substitution of medications so approved. However, these substitutions may be overridden by the physician writing "Do not substitute" or "Dispense as written" as part of the order. (Pharmacy Policy and Procedure 8.1 Medication Formulary).

2. Non-formulary medications are obtained when prescribed but may result in a delay in initiating therapy as the product may need to be obtained and may not be stocked in the pharmacy. Physicians may request that the product be reviewed for formulary inclusion. (Pharmacy Policy and Procedure 8.1 Medication Formulary).

3. All medications given to patients are to be obtained through the Pharmacy. Professional samples will not be used without Pharmacy approval and appropriate documentation. Under certain circumstances, patients will be allowed to take medications from home with a written order in the medical record. (Pharmacy Policy and Procedure 4.9 Self-Administration of Medications).

4. Medical staff members must adhere to approved restrictions on limited prescribing of medications to specifically credentialed members of the medical staff.

5. Medication orders must be legible and include: the patient's name, location and other necessary identifying information such as a medical records number, medication name (generic or trade name), strength, dosage form, route of and directions for administration, the date the order was written and the prescriber's name. Unapproved abbreviations may not be used. (Medical Staff Policy on Approved and Unapproved Abbreviations.)

6. Medical staff members must adhere to established standards for automatic review and termination of medications. Current standards as defined by the Therapeutics Committee and as approved by the medical staff include, but are not limited to:

    a. All Schedule II, III, IV, and V controlled substances, hypnotics, and barbiturates are to be automatically terminated unless reinstated by the physician no later than fourteen (14) days after the physician order is written. Nursing Services shall verify with the attending physician that discontinuation is appropriate prior to termination.

    b. The use of oxytocic drugs parenterally for induction of labor shall be ordered by the attending physician only when he/she is in the hospital in

attendance of his/her patient or promptly available should he/she leave the hospital during the course of administration of such medications.

c. All other medication orders shall be reviewed no later than fourteen (14) days after the physician order is written to determine that the medication is still needed.

7. Products that are considered to be "nutrition supplements" or herbal products (not approved by the U.S. Pharmacopeia, National Formulary) may be prescribed by the physician and provided by the patient or family (Pharmacy Policy and Procedure 8.8 Nutrition Supplements).