RULES AND REGULATIONS
OF THE BYLAWS OF THE MEDICAL STAFF

UNIVERSITY OF NORTH CAROLINA
HOSPITALS

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RULES AND REGULATIONS OF THE BYLAWS OF THE MEDICAL STAFF
THE UNIVERSITY OF NORTH CAROLINA HOSPITALS

1. The meetings of the Medical Staff shall be held as provided in Article XII of the *Bylaws of the Medical Staff*.

2. Patients may be treated only by physicians and dentists who have been duly appointed to membership on the Medical Staff and by Allied Health Professionals with practice privileges. All hospitalized patients shall be attended by a member of the Medical Staff and shall be assigned to the service concerned with the treatment of the patient's disease. The Medical Staff shall be responsible for supervising Housestaff in the provision of care to patients under their care.

3. Each member of the Medical Staff who is not a resident in the city or immediate vicinity shall name a member of the Medical Staff who is a resident of the city or immediate vicinity, who may be called to attend his/her patients in an emergency. In case of failure to name such an associate, the Department Chair involved or the Chief of Staff shall have authority to request any member of the Medical Staff to substitute. In the anticipated absence of a member of the Medical Staff, s/he shall designate another member of the Medical Staff to attend his/her patients. In the case of failure to do so, the Department Chair involved or the Chief of Staff shall have the authority and responsibility to designate a member of the Medical Staff to substitute.

4. Except in emergency situations, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

5. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from potential sources of danger from any causes whatsoever, or to assure protection of the patient from self-harm. All Medical Staff and Housestaff physicians and Allied Health Professionals will practice according to Hospitals policies on restraint and seclusion.

6. Each patient admitted for inpatient care or outpatient surgery shall have a history taken and a comprehensive physical examination (H&P) performed by an attending physician or by a Housestaff physician or Allied Health Professional with such privileges and authenticated by the attending physician. Qualified oral surgeons who admit patients without medical problems may perform the history and physical examination on those patients. An H&P shall be completed for the electronic medical record no more than twenty-four (24) hours prior to a scheduled admission or outpatient surgery or within twenty-four (24) hours after emergency surgery (the "Required Period"). In an emergency when there is no time to record a complete H&P, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery. If all or part of the H&P is dictated, then a brief note shall be written in the record on the progress notes or typed directly in the electronic medical record upon admission to provide pertinent information until the dictated H&P is transcribed. An H&P may be performed outside the Required Period, but within thirty (30) days prior to a scheduled admission or outpatient surgery, if an updated assessment is subsequently both performed and documented during the

Required Period that identifies any changes in the patient's medical status or that no changes have occurred.

7. When a history and physical examination is not recorded before the time stated for a surgical operation, the operation shall be canceled unless the attending surgeon documents in the patient's medical record that such a delay would constitute a hazard to the patient.

8. Standing orders, automatic stop orders, and routine laboratory and x-ray work shall be formulated, approved or modified by the Executive Committee for the Medical Staff upon recommendations by Department Chairs or Medical Staff Committees.

9. All orders for treatment shall be in writing and signed by the physician, dentist, allied health professional with such privileges, or the designated member of the Housestaff responsible for the patient. Signature stamps are prohibited. Entries in the medical record by Housestaff or allied health professionals that require countersigning by supervisory or attending Medical Staff members include: operative reports, procedure notes, admission history and physical, daily progress notes, discharge summaries, 48-hour final progress notes, pre-anesthesia record, anesthesia record, post-anesthesia note, pre-op note, and post-op note if stay is greater than 48 hours. A verbal order shall be considered to be in writing if it is dictated by a licensed physician, dentist, or allied health professional with such privileges to a licensed nurse or other licensed or registered person functioning in his/her sphere of competence; i.e., Occupational Therapist for Occupational Therapy treatment; Physical Therapist for Physical Therapy treatment; Respiratory Therapist for Respiratory Therapy treatment, and signed by an appropriate licensed Practitioner. Orders dictated over the telephone shall be signed by the appropriate authorized person to whom dictated and should indicate the name of the Practitioner who gave the order. The Practitioner giving the order shall authenticate such verbal orders within forty-eight (48) hours. If automated systems are introduced, these requirements shall be considered met if the approved system is used.

10(a) Before a patient may be transferred from one inpatient service (i.e. physician care team) to another, whether or not there is a change in acuity level of care, either the transferring team or the accepting team must write a new, full set of treatment orders. Which team will write transfer orders should be determined on a case-by-case basis, after considering the needs of both the patient being transferred and any patient known to need the vacated bed. In those instances when orders are written by the transferring team, when the patient arrives on the receiving Hospital unit the nursing staff of that unit will promptly notify a physician on the accepting team. The accepting team is expected to countersign, and/or amend as deemed appropriate, the treatment orders in a timely manner that meets the care needs of the transferred patient. The accepting team will notify the nursing staff as soon as it has countersigned the orders. Until the accepting team countersigns the treatment orders, the transferring team will remain responsible for the patient's orders and will remain the first point of contact for the receiving unit nursing staff. EXCEPTION: In those instances when a patient is transferred from one inpatient service (i.e. physician care team) to another AND both the prior Hospital unit and the receiving Hospital unit use the computerized provider order entry (CPOE) system the accepting care team may simply enter a transfer order. It is expected that this accepting care team will amend orders as appropriate. This exception applies whether or not there is a concomitant change in acuity level of care.

10(b) In those instances when a patient is transferred from one acuity level to another but continues to receive care from the same service, the care team must write a new, full set of treatment orders, UNLESS both the prior Hospital unit and the receiving Hospital unit use the computerized provider order entry (CPOE) system. In that case the care team may simply enter a transfer order. It is expected that the team will amend orders as appropriate in the context of the change in acuity level.

11. In all cases, except as noted below, surgical procedures shall be performed only with the prior informed written consent of the patient or his/her legal representative. Obtaining such consent shall be the responsibility of the surgeon. Generally, such consent shall be in writing. However, consent may be obtained by witnessed telephone authorization. In cases of emergency operations, when consent cannot be obtained, such operations will be performed only in accordance with the Hospital's policy on *Consent for Emergency Surgical and/or Medical Treatment.* The surgeon shall record in writing in the patient's medical record the reasons why consent could not be obtained and the need for the operation, with the need concurred with by one (1) other attending physician and so documented in the patient's medical record.

12. All operations performed shall be fully described in writing by the operating surgeon. All specimens removed during a surgical procedure, or tissue passed vaginally in the case of a miscarriage, shall be properly labeled and shall be sent to the pathologist (except as covered in "a-g" below), who shall make such examinations as are considered necessary and record his/her observations and interpretations in a signed report. In certain cases where special studies are indicated, arrangements will be made between the pathologist, surgeon, and special laboratory concerned, with appropriate notation made in the medical record. A signed copy of the pathology report shall be filed timely in the medical record. Exceptions to the requirement of pathologic examination of specimens removed during a surgical procedure are made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used, and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from pathologic examination include, but are not necessarily limited to, the following: (It should be noted that any specimen on which pathologic examination is requested will be examined by Surgical Pathology irrespective of the exclusions).

    a. Specimens that by their nature or condition do not permit fruitful examination, such as an orthopedic or other exogenous appliance, foreign body, or portion of bone or cartilage removed only to enhance operative exposure; (however, it is strongly recommended that where such specimen(s) constitute a component(s) of a specimen requiring pathologic examination, all of this material should be submitted);

    b. Therapeutic radioactive sources, the removal of which should be guided by radiation safety monitoring requirements;

    c. Foreign bodies (e.g., bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

d. Certain specimens known rarely, if ever, to show pathological change, and the removal of which is highly visible post-operative, (e.g., foreskin from circumcision of newborn infants, tissue removed during nasal septoplasty, cosmetic surgery involving removal of essentially non-pathologic material);

e. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;

f. Teeth, provided the number, including fragments, are recorded in the medical record; and

g. Crystalline lenses removed following either intracapsular or extracapsular cataract removal; and in cases where no specimen was removed, the surgical case review is the responsibility of the individual department. Documentation should include the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative diagnosis.

13. Surgeons and all other personnel involved must be in the operating rooms and ready to begin operating at the time scheduled. The operating room will not be held longer than fifteen (15) minutes after the time scheduled.

14. Patients shall be discharged only on written order of the responsible physician or his/her designee. At the time of discharge the attending physician or his/her designee shall take appropriate action to resolve all active orders, see that the record is complete, state the final diagnosis, and sign the record.

15. All inpatients must be seen and reevaluated within 24 hours of admission and then daily by a Licensed Independent Practitioner (LIP) (e.g., attending physician, resident physician, nurse practitioner, physician assistant). A progress note shall be entered in the medical record daily, and countersigned by the attending physician. The note should include the plan of care and reflect the active involvement of the attending physician.

16. For each outpatient clinic visit, the attending physician or Allied Health Professional is responsible for the preparation of a complete visit record for each patient in accordance with the completion requirements established by the Clinical Documentation Committee (CDC). The attending physician will ensure that s/he and all Housestaff under the attending physician's supervision have completed all chart requirements within fourteen (14) days after the date of service. The Allied Health Professional will complete all chart requirements within fourteen (14) days after the date of service.

17. The attending physician shall be held responsible for the preparation of a complete medical record for each patient in accordance with the completion requirements established by the Clinical Documentation Committee. The attending physician shall insure that s/he and all Housestaff under his/her supervision have completed all chart requirements within at most twenty-eight (28) days after discharge. The Clinical Documentation Committee may institute time requirements for the completion of medical records which define delinquent records at a time prior to twenty-eight (28) days after discharge. A clinical summary shall be dictated in the medical record at discharge by the responsible physician for all patients, except as specified below. A Final Progress Note may be substituted for a discharge summary in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization and in

the case of newborn infants and uncomplicated obstetrical deliveries. It will be the responsibility of the Clinical Documentation Committee to determine those specific situations which may be considered to be in this minor category. Operative reports shall be dictated or written in the medical record immediately after surgery and contain a description of the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. If the dictation is not done, the Department Chair or Division Chief will be notified. A brief Operative Note shall be written in the Progress Notes immediately after surgery to provide pertinent information until the dictated Operative Report is transcribed. When an autopsy is performed, a provisional anatomic diagnosis is forwarded within two (2) working days to the Medical Information Management Department for inclusion in the medical record. The final autopsy report will be considered delinquent if it has not been dictated and signed by the responsible pathologist within sixty (60) days after the death of the patient.

18. Each clinical Department Chair, or his/her designee, may administratively reassign the clinical duties of Medical Staff and Housestaff physicians and Allied Health Professionals to enable those Practitioners with delinquent medical records, as defined by the Medical Information Management Committee, to complete such delinquent records. Each Clinical Department Chair, or his/her designee, may also administratively reassign the clinical duties of Medical Staff and Housestaff physicians and Allied Health Professionals to enable those Practitioners who have not demonstrated compliance with OSHA, CDC or other Hospital safety requirements to demonstrate such compliance. This procedure is an administrative mechanism, distinct from corrective action as authorized by Article V of the Policy on Appointment and Corrective Action. Such administrative reassignment shall not be considered Corrective Action against Medical Staff physicians, or disciplinary action against a Housestaff physician or Allied Health Professional. However, repeated administrative reassignments which have the effect of being detrimental to the operations of the Hospital may subject a Medical Staff physician to Corrective Action or a Housestaff physician or Allied Health Professional to disciplinary action. Pursuant to an administrative reassignment, Medical Staff and Housestaff physicians and Allied Health Professionals shall not be permitted to schedule new clinic appointments and admissions, to schedule new surgical procedures or to use the Emergency Department until all delinquent medical records are completed. A Housestaff physician shall, among other appropriate actions, be removed from all clinical activities and be required to utilize annual leave until all delinquent medical records are completed.

19. No autopsy shall be performed without consent of the legally authorized individual. Generally, such permission should be in writing. However, consent may be obtained by recorded and witnessed telephone authorization. The Chair of the Department of Pathology and Laboratory Medicine, or his/her designated assistant, shall be responsible for the performance of all autopsies on patients dying in the Hospital, except in those cases where the Medical Examiner has jurisdiction.

20. Postmortem tissue and organ donation will be conducted in accordance with the Uniform Anatomical Gift Act. When a tissue or organ of the donor is to be removed for transplantation pursuant to the Uniform Anatomical Gift Act, and the death of the donor is established by a determination that the person has suffered a total and irreversible cessation of brain function, the pronouncement of death is made by the patient's attending physician, or his/her substitute attending physician, or the Housestaff in

consultation with an attending physician. The physicians making the determination of death shall not participate in the procedures for removing or transplanting a tissue or organ.

21. Consultation with the Obstetrical service is required when a known pregnant woman is admitted to a service other than Family Medicine or Obstetrics and Gynecology. A preoperative consultation with the Obstetrical service is also required when an inpatient or outpatient operative or other interventional procedure requiring moderate or deep sedation or anesthesia is planned for a known pregnant woman. This consultation should be requested at the time of surgical scheduling.

22. Except in an emergency, consultations with another qualified physician are required in:

    a. Curettages or other procedures by which a known or suspected pregnancy of greater than 20 weeks duration from the last menstrual cycle may be interrupted;

    b. Cases in which according to the judgment of the physician:

        (1) The patient is not a good risk for operation or treatment;
        (2) The diagnosis is obscure; or
        (3) There is doubt as to the best therapeutic measure to be utilized. In general, only physicians who are members of the Medical Staff of the Hospital or properly supervised designees shall serve as consultants. However, in special situations, qualified physicians not on the Medical Staff of this Hospital may be invited to visit a patient, as well as observe the course of treatment, provided the Chair of the appropriate Department, the Chief of Staff or his/her designee, gives permission. Such a consultant shall not assume responsibilities for the patient. A member of the Medical Staff inviting such a consultant shall notify the Chair of the appropriate Department or the Chief of Staff in each case and shall assume responsibility for adherence to this rule.

    The patient's physician is responsible for requesting consultations when indicated. It is the duty of the Medical Staff through its Department Chairs or Service Heads and Executive Committee to make certain that members of the Staff do not fail in the matter of requesting consultations when needed.

    All patients for whom an inpatient consultation is requested shall be seen and examined by a Licensed Independent Practitioner (LIP) (e.g., attending physician, resident physician, nurse practitioner, physician assistant). A written opinion must be documented in the medical record within 24 hours of the request. The consultant's assessment should reflect the active involvement of the attending physician, which may be in person or by phone. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

23. Each Clinical Department must ensure the availability of schedules or instructions in WebXchange that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

24. Drugs used shall be among those listed in the Hospital Formulary as amended by the Pharmacy and Therapeutics Committee, with the exception of drugs for bona fide clinical

investigations. Deviation from this rule shall be well justified and shall be reported to the Pharmacy and Therapeutics Committee for review. The metric system shall be used in prescription and drug orders. Nonproprietary (generic) rather than trade and proprietary nomenclature shall be used. However, certain products of multiple composition are metered in the Formulary under a recognized generic or trade name titled with the composition listed. The Department of Pharmacy may dispense the exact chemical equivalent (labeled in non proprietary terms) for those drugs ordered under a trade or proprietary name in the treatment of inpatients and outpatients. However, if any physician or dentist considers an exception to this policy is indicated for a particular patient, s/he should consult with the senior pharmacist on duty. Only those abbreviations which have been approved by the Clinical Documentation Committee shall be used in medication orders.

25. All Schedule II controlled substances and other drugs as recommended by the Pharmacy and Therapeutics Committee that are ordered without time limitations of dosage shall be automatically discontinued after seven (7) days. Drugs should not be discontinued without notifying the physician or dentist. If the order expires in the night, it should be continued until the next morning and called to the attention of the physician or dentist the following morning.

26. Mass Casualty Assignments. Physicians shall be assigned responsibilities as defined in the Hospital's Disaster Plan.

27. Other rules which have been adopted by the Executive Committee of the Medical Staff will be found in the Hospital Policy Manual.

Amendments

These *Rules and Regulations* may be amended as provided in Article XVI of the Medical Staff Bylaws.