# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Article</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td><strong>GENERAL RULES</strong></td>
<td>6</td>
</tr>
<tr>
<td>II</td>
<td><strong>MEDICAL RECORDS</strong></td>
<td>8</td>
</tr>
<tr>
<td>III</td>
<td><strong>PHARMACY</strong></td>
<td>13</td>
</tr>
<tr>
<td>IV</td>
<td><strong>PLACEMENT OF OUTSIDE LABORATORY RESULTS ON PATIENTS’ CHARTS</strong></td>
<td>17</td>
</tr>
<tr>
<td>V</td>
<td><strong>RESIDENCY PROGRAMS</strong></td>
<td>18</td>
</tr>
<tr>
<td>VI</td>
<td><strong>CRITERIA AND PROCEDURE FOR AUTOPSIES</strong></td>
<td>19</td>
</tr>
<tr>
<td>VII</td>
<td><strong>TRANSITIONAL CARE FACILITY</strong></td>
<td>21</td>
</tr>
<tr>
<td>VIII</td>
<td><strong>ANESTHESIA</strong></td>
<td>22</td>
</tr>
<tr>
<td>IX</td>
<td><strong>EMERGENCY MEDICINE</strong></td>
<td>27</td>
</tr>
<tr>
<td>X</td>
<td><strong>FAMILY PRACTICE</strong></td>
<td>29</td>
</tr>
<tr>
<td>XI</td>
<td><strong>INTERNAL MEDICINE</strong></td>
<td>31</td>
</tr>
<tr>
<td>XII</td>
<td><strong>OBSTETRICS AND GYNECOLOGY</strong></td>
<td>32</td>
</tr>
<tr>
<td>XIII</td>
<td><strong>PEDIATRICS</strong></td>
<td>40</td>
</tr>
<tr>
<td>XIV</td>
<td><strong>SURGERY</strong></td>
<td>42</td>
</tr>
<tr>
<td></td>
<td><strong>Section 1 – Podiatry Subdivision</strong></td>
<td>43</td>
</tr>
<tr>
<td></td>
<td><strong>Section 2 – Vascular Subdivision</strong></td>
<td>43</td>
</tr>
<tr>
<td></td>
<td><strong>Section 3 – Neurosurgery Subdivision</strong></td>
<td>44</td>
</tr>
<tr>
<td>XV</td>
<td><strong>NEUROSCIENCES</strong></td>
<td>46</td>
</tr>
<tr>
<td>XVI</td>
<td><strong>PSYCHIATRY</strong></td>
<td>47</td>
</tr>
<tr>
<td>XVII</td>
<td><strong>LABORATORY</strong></td>
<td>48</td>
</tr>
<tr>
<td>XVIII</td>
<td><strong>DIAGNOSTIC RADIOLOGY</strong></td>
<td>49</td>
</tr>
<tr>
<td>INDEX OF REVISIONS</td>
<td>REVISED</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td>April 1977</td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td>January 1979</td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td>April 1980</td>
<td></td>
</tr>
<tr>
<td>Revised</td>
<td>1986</td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>March 1986</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>May 1986</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations</td>
<td>November 1986</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Medical Records)</td>
<td>December 1988</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Placement of Outside</td>
<td>June 1989</td>
<td></td>
</tr>
<tr>
<td>Laboratory Results on Patient’s Charts and Residency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesia &amp; Obstetrics/Gynecology</td>
<td>June 1989</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>October 1989</td>
<td></td>
</tr>
<tr>
<td>Laboratory</td>
<td>January 1990</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine &amp; Diagnostic Radiology</td>
<td>April 1990</td>
<td></td>
</tr>
<tr>
<td>Family Practice &amp; Surgery</td>
<td>May 1990</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>July 1990</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Medical Records) &amp;</td>
<td>December 1990</td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records (Oral Orders)</td>
<td>December 1991</td>
<td></td>
</tr>
<tr>
<td>Pharmacy (Automatic Drug Stop Orders)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics Department (Board Certification/Eligibility)</td>
<td>February 1992</td>
<td></td>
</tr>
<tr>
<td>Criteria &amp; Procedure for Autopsies</td>
<td>June 1992</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Emergency Care Unit</td>
<td>September 1992</td>
<td></td>
</tr>
<tr>
<td>Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynecology Department Rule &amp; Regulations</td>
<td>September 1992</td>
<td></td>
</tr>
<tr>
<td>(Deletion of Consultation requirements for Primary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C/Sections)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics Department (Discharge Summary)</td>
<td>September 1992</td>
<td></td>
</tr>
<tr>
<td>Surgery Department (Board Certification/Eligibility)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Family Practice</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Emergency</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Internal</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for OB/GYN</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Pediatrics</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Surgery</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>Change in Department Meeting Agenda for Anesthesia</td>
<td>October 1992</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Delinquent Medical Records)</td>
<td>December 1992</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations (Emergency Care Unit</td>
<td>December 1992</td>
<td></td>
</tr>
<tr>
<td>Coverage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Records (Discharge Summary)</td>
<td>December 1992</td>
<td></td>
</tr>
<tr>
<td>Changes approved by MEC in May 1989 were added to the</td>
<td>December 1992</td>
<td></td>
</tr>
<tr>
<td>General Rules &amp; Regulations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addition of Rules and Regulations pertaining to the</td>
<td>April 1993</td>
<td></td>
</tr>
<tr>
<td>Podiatry Subdivision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Update Emergency Medicine Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Diagnostic Radiology Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update OB/GYN Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Internal Medicine Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Family Practice Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Revision Description</td>
<td>Date</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Update Surgery Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Medical Records Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Pharmacy Department Rules &amp; Regulations</td>
<td>May 1993</td>
<td></td>
</tr>
<tr>
<td>Update Family Practice Department Rules &amp; Regulations (2.2.9.1.A through 2.2.9.3)</td>
<td>July 1993</td>
<td></td>
</tr>
<tr>
<td>Update OB/GYN Department Rules &amp; Regulations (Isolation of Patients)</td>
<td>July 1993</td>
<td></td>
</tr>
<tr>
<td>Addition of Board Certification requirements for the Department of OB/GYN</td>
<td>September 1993</td>
<td></td>
</tr>
<tr>
<td>Addition of Board Certification requirements for the Midwifery Division of the OB/GYN Department</td>
<td>September 1993</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records Department Rules &amp; Regulations re: Oral Orders</td>
<td>February 1994</td>
<td></td>
</tr>
<tr>
<td>Update to OB/GYN Department Rules &amp; Regulations re: Surgical Assistants</td>
<td>July 1994</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records Department Rules &amp; Regulations re: History &amp; Physicals</td>
<td>July 1994</td>
<td></td>
</tr>
<tr>
<td>Addition of the Rules &amp; Regulations for the Transitional Care Facility</td>
<td>July 1994</td>
<td></td>
</tr>
<tr>
<td>Addition of the Rules &amp; Regulation for the Subdivision of Neurosurgery (Department of Surgery)</td>
<td>August 1994</td>
<td></td>
</tr>
<tr>
<td>Update / revision of the Rules &amp; Regulations for the Medical Records Department</td>
<td>October 1994</td>
<td></td>
</tr>
<tr>
<td>Revision of the Rules &amp; Regulations for the Dept. of OB/GYN</td>
<td>February 1995</td>
<td></td>
</tr>
<tr>
<td>Update to Pediatrics Department Rules &amp; Regulations</td>
<td>May 1995</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records Rules &amp; Regulations re: Discharge Summaries</td>
<td>June 1995</td>
<td></td>
</tr>
<tr>
<td>Updates to Medical Records Rules &amp; Regulations re: wording regarding operative procedures, legibility, completion of records</td>
<td>June 1996</td>
<td></td>
</tr>
<tr>
<td>Update to Internal Medicine Rules &amp; Regulations re: General Practice Subdivision</td>
<td>June 1996</td>
<td></td>
</tr>
<tr>
<td>Update of Family Practice Dept. Rules &amp; Regulations</td>
<td>June 1997</td>
<td></td>
</tr>
<tr>
<td>Update re: General Rules re: malpractice limits</td>
<td>June 1997</td>
<td></td>
</tr>
<tr>
<td>Update re: Drug Stop orders</td>
<td>June 1997</td>
<td></td>
</tr>
<tr>
<td>Update re: definition of who may administer drugs in the facility</td>
<td>June 1997</td>
<td></td>
</tr>
<tr>
<td>Update re: Speech Therapists accepting verbal orders</td>
<td>April 1999</td>
<td></td>
</tr>
<tr>
<td>Update to Surgery Rules &amp; Regulations</td>
<td>May 1999</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Update to Verbal Orders, who may accept</td>
<td>December 1999</td>
<td></td>
</tr>
<tr>
<td>Addition of Vascular Subdivision Rules &amp; Regulations to Surgery Department Rules &amp; Regulations</td>
<td>April 2000</td>
<td></td>
</tr>
<tr>
<td>Revision to Family Practice Rules &amp; Regulations</td>
<td>October 2000</td>
<td></td>
</tr>
<tr>
<td>Revision to Anesthesia Rules &amp; Regulations</td>
<td>March 2001</td>
<td></td>
</tr>
<tr>
<td>Revisions to TCF Rules &amp; Regulations</td>
<td>May 2001</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations – On Call Responsibilities</td>
<td>January 2002</td>
<td></td>
</tr>
<tr>
<td>Update to Surgery Rules &amp; Regulations – On Call Responsibilities</td>
<td>January 2002</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: consults, progress Notes and Medical Records suspensions</td>
<td>June 2002</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Discharge summaries</td>
<td>September 2004</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Histories and Physicals</td>
<td>December 2005</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Consultation Requirements</td>
<td>June 2007</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Admitting Physician Responsibilities</td>
<td>December 2008</td>
<td></td>
</tr>
<tr>
<td>Addition of the Rules &amp; Regulations for the Neurobehavioral Sciences Department, Revision to Anesthesia Rules &amp; Regulations, change to General Rules 1.0.4</td>
<td>December 2009</td>
<td></td>
</tr>
<tr>
<td>Update to Neurobehavioral Sciences Department, Addition of 2.8.6 Daily Hospital Visits</td>
<td>February 2010</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records: Addition of Medical Records Queries, Update to Rubber Stamp Signatures, Revisions to Timeliness of Chart Completion</td>
<td>June 2010</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Admitting Physician Responsibilities</td>
<td>June 2011</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: History &amp; Physical Examination</td>
<td>June 2012</td>
<td></td>
</tr>
<tr>
<td>Update to General Rules &amp; Regulations re: Department Meeting Attendance Requirements</td>
<td>June 2012</td>
<td></td>
</tr>
<tr>
<td>Update to Rules and Regulations re: Diagnostic Radiology and Laboratory</td>
<td>June 2013</td>
<td></td>
</tr>
<tr>
<td>Update to Pharmacy Rules and Regulations</td>
<td>June 2014</td>
<td></td>
</tr>
<tr>
<td>Update to Medical Records: Addition of C. Allied Health Professional Documentation</td>
<td>June 2016</td>
<td></td>
</tr>
<tr>
<td>Update to Anesthesia re: Life Support Requirements</td>
<td>June 2016</td>
<td></td>
</tr>
<tr>
<td>Update to Emergency Medicine re: Life Support Requirements</td>
<td>June 2016</td>
<td></td>
</tr>
</tbody>
</table>
MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I – GENERAL RULES

A) All members of the Medical Staff must provide evidence of a minimum amount of malpractice insurance as set by the State of Pennsylvania.

B) No patient will be admitted to the hospital without an attending Medical Staff Member. Patients needing admission without an attending Member will be assigned to various Members on a rotational basis developed by the department chairperson with advice from and with the approval of the Medical Executive Committee.

C) Each Member of the Medical Staff shall, with consent, name a Member of the staff who may be called to attend his/her absence or in an emergency. This representative shall be within the same Department and Subdivision (if applicable) and be a Member of the Medical Staff with admitting privileges. The list shall be reviewed at the time of re-application of membership.

D) The Medical Staff dues shall be billed as of the first day of the Medical Staff year (i.e., July 1st) and shall be due within a 60-day period. If no payment is received within that time, reminders will be sent at 60 and 90 days. At 90-days a final reminder, which shall inform the Member of the consequences of not responding positively in the time allotted, will be sent via overnight mail with signature required. Should the Member fail to respond to this reminder within 10 days of its receipt, his or her staff membership and privileges will be terminated. The above correspondence shall be under the supervision and control of the Credentials Committee. The final letter indicating the exact date of termination shall be handled as indicated for such actions in the Bylaws.

Part 1 – Emergency Care Unit Coverage

If a Medical Staff Member is on call for emergency room coverage, he or she is to respond within 15 minutes to a telephone call from the Emergency Care Unit. If, after discussion with the Emergency Care Unit physician, it is deemed that immediate presence is necessary, the Member must be present in the Emergency Care Unit within 30 minutes.

1) It is the responsibility of the Medical Staff Member who is listed on the On Call roster to notify the Emergency Care Unit if they sign out to another member of the Medical Staff.
2) It is the sole discretion of the Emergency Care Unit physician as to which on call specialty or subspecialty Member should be the first doctor called to assess an Emergency Care Unit patient. The Member called must come to the Emergency Room to physically evaluate and assess the patient, regardless of the patient’s medical insurance. If the Member does not respond to the ECU physician’s request by appearing in the ECU within the required 30 minutes, the ECU physician shall contact the Specialty Department Chairperson. The President of the Medical Staff will be contacted to inform him or her of the incident. It will be the President of the Medical Staff’s responsibility to recommend to the CEO of the Hospital that the Member be precautionary suspended in accordance with the Medical Staff Bylaws, Article XII, Section 3, Part 2. When the Member who is called by the ECU arrives to assess the patient, the patient is then his/her responsibility, and that Member can consult whomever he or she feels is most appropriate to assist him or her in handling the case.

**Part 2 – Admitting Physician Responsibilities**

A) Each patient shall be the responsibility of a designated attending physician of the medical staff. Within 24 hours of a patient’s admission or transfer to the inpatient service, the responsible attending of record shall personally examine the patient, establish a personal and identifiable relationship with the patient if such was not established prior to the admission or transfer and record an appropriate history, physical examination, working diagnostic impression(s) and plan for treatment. The attending is responsible for ensuring communication to the patient of the treatment plan and realistic goals of care, as well as subsequent communication about significant variances from expected outcomes that occur during medical treatment of surgery. Critically ill patients must be seen by the attending physician, his/her alternate, a consulting physician, or a qualified Allied Health Professional within 4 hours.

B) The attending physician of record shall be responsible for transmitting reports of the condition of the patient to the referring physician, if applicable. Whenever these responsibilities are transferred to another medical staff member and service, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
ARTICLE II – MEDICAL RECORDS

A) An adequate medical record shall be maintained for every inpatient, SPU patient, outpatient, and patient treated or examined in the emergency unit.

B) The admitting Medical Staff Member is required to have certain parts of the medical record (patient’s chart) completed in an appropriate and timely manner. These parts shall include: the recording of the medical history and physical examination, progress notes of appropriate content and frequency, descriptive reports of procedures performed, a discharge summary, a completed medical record summary sheet (face sheet) and completion of such other forms or statements that may be required by action of the Medical Executive Committee, by these Rules and Regulations or by the Bylaws of the Medical Staff.

C) All documentation of Allied Health Professionals must be countersigned within the time frame specified in these Rules and Regulations unless otherwise requested by the collaborating or supervising Medical Staff Member and approved by the Credentials Committee, Medical Executive Committee and the Board of Directors.

Part 1 – Consultation

A) A consulting Medical Staff Member is required to complete those above-mentioned parts that are relevant to his/her participation in the care of a given patient. If appropriate, such a Member shall also complete a consultation sheet.

B) Timelines of consultation request: all consultation requests must be responded to in no more than 24 hours. Requests for urgent responses require physician to physician communication.

C) Consultation is required in the following circumstances:
   1) In unusually complicated situations where specific skills of Medical Staff Member may be needed.
   2) In instances in which the patient exhibits severe psychiatric symptoms, a psychiatrist must be consulted.
   3) Pediatric patients (up to the age of 18) admitted to the Intensive Care Unit (critical care) will have a mandatory pediatric consultation by a pediatrician or qualified Family Medicine physician.
   4) Pregnant patients requiring surgery will have a mandatory consultation pre-operatively by an obstetrician or qualified Family Medicine physician.

Part 2 – Content of Medical Record

A) The medical record shall contain sufficient information to identify the patient clearly, to justify the diagnosis and treatment, and to document the results accurately.
B) Each medical record shall include the findings and results of any pathological or clinical laboratory examinations, radiology examinations, medical and surgical treatment, and other diagnostic and therapeutic procedures.

C) Each medical record shall include a provisional diagnosis; primary and secondary final diagnoses, the latter if necessary; a clinical resume; and, where appropriate, necropsy reports.

D) Each medical record shall include notes by authorized house staff members and individuals who have been granted clinical privileges, consultation reports, nurses’ notes, and entries by specified professional personnel.

E) Resident house staff may participate in the documentation on and completion of the medical record. The following components must be countersigned by the attending staff member responsible for the patient’s care: history and physicals, consultations, operative reports, and discharge summaries. The face sheet must be signed by the attending staff member.

F) All entries in the record shall be dated and authenticated by the person making the entry.

G) A complete history and physical examination report must be dictated or legibly written on the designated form within 24 hours of the patient’s admission. H&P’s must be performed no earlier than 30 days prior to admission, and countersigned by the attending physician. When an H&P is completed within 30 days before admission or registration, an update must be completed within 24 hours after admission or registration. In all cases involving surgery or a procedure requiring anesthesia services, an update must be completed prior to the surgery or procedure. If medical urgency precludes this requirement, the responsible practitioner shall indicate such in a progress note. Pre-operative medical consults may replace H&P’s if they are in complete form as described below.

H) A complete history and physical will include the following:
   1) Medical history including chief complaint, details of present illness, relevant past, social and family histories (appropriate to the patient’s age) and inventory by body system
   2) Assessment of the patient’s psychosocial needs, as appropriate
   3) A report of relevant physical examinations
   4) A statement on conclusions or impressions drawn from the admission history and physical examination.

I) Obstetrical records must include all prenatal information. A legible original or reproduction of the office/clinic prenatal record is acceptable.

J) A discharge summary is required on all patients admitted to the hospital. A short stay summary or final progress note may be substituted for a discharge summary when the patient is discharged after a short procedure. The discharge summary is completed immediately after patient discharge, but no later than seven (7) days, and should include:
   1) A summary reason for admission
   2) Significant findings
3) Procedures performed
4) Treatment provided
5) Patient’s condition on discharge
6) Discharge instructions

K) Medical Record Queries shall be answered within fifteen (15) days after the date of discharge.

L) Oral orders: Under urgent circumstances when it is impractical for the order to be given in a written manner by the responsible practitioner, oral orders for medication and treatment may be given to one of the following, with restrictions as noted:
   1) A registered nurse;
   2) A pharmacist who may transcribe oral orders pertaining to drugs;
   3) A physical therapist/technician who may transcribe oral orders pertaining to physical therapy regimens; and
   4) A respiratory therapist/technician who may transcribe oral orders pertaining to respiratory therapy treatments.
   5) A speech therapist who may transcribe oral orders pertaining to speech therapy.

Authorized personnel accepting an oral order shall:
   1) Repeat the order back to the physician;
   2) Transcribe the order verbatim in the proper place in the patient’s medical record; and
   3) Include in the order the date, time (military), and full name of the ordering physician, and the signature and credentials of the person taking the order.

The oral order shall be signed within 24 hours by the responsible Medical Staff Member or the Allied Health Professional who gave the order.

M) All progress notes reflect documentation of a pertinent chronological report of the patient’s course in the hospital and reflect any change in condition and the results of treatment. Progress notes are to be entered by the attending and operating surgeon (or their associated allied health professional) on the chart of each patient at least once a day. The operating surgeon should write a daily note until the patient is surgically stable for discharge.

N) Operative reports of surgical procedures, and of such other diagnostic and therapeutic procedure as may be specified in these Rules and Regulations, must be dictated immediately following the completion of such procedures. A postoperative note must be documented in the medical record after surgery.

O) Legibility: All documentation must be written clearly and legibly using black ink. Orders, which are illegible, will not be carried out.

P) Corrections: The method of correcting an erroneous entry in the medical record is to draw a single line through the incorrect information; write “ERROR” above; and initial and date the correction.
Q) Symbols and abbreviations may be used only when they have been approved by the medical staff and when there exists a legend to explain them.

R) Rubber-stamp signatures are not acceptable in a medical record.

S) Confidentiality: All records shall be treated as confidential. Only authorized personnel shall have access to the records. The written authorization of the patient must be presented for release of medical information outside the hospital. All legitimate requests for information will be processed according to the hospital policy regarding release of information.

T) Ownership: Medical records are the property of the hospital, and they shall not be removed from the hospital premises, except for court purposes. Copies may be made available for authorized appropriate purposes such as insurance claims, physician review, etc. in accordance with hospital policy regarding release of information.

**Part 3 – Timeliness of Chart Completion**

A) Timely, accurate documentation is important for quality patient care and compliance with licensing standards and other regulations.

B) Any additions or corrections to a patient’s medical record must be made after the new or correct information is available. The information must be clearly identified as a correction or addition and include the date and time of same.

C) Medical Staff Members will satisfy the requirements noted above and sign the medical record. The failure to comply with the requirements noted above (including signature) will result in the suspension of the admitting, consultation and operating privileges of the Member.

D) Notification of delinquent medical records: Each week, a notice will be sent to those Members whose records are incomplete by ten (10) days or longer from the time of discharge. A second notice will be sent to those Members whose records are incomplete by twenty-one (21) days or longer from the time of discharge.

E) Medical Staff Member suspension: when a Member’s charts are delinquent by more than thirty (30) days, the Member’s privileges will be suspended. Notification of such suspension will be sent to the Member. Procedures previously scheduled may proceed. Any surgeries scheduled thereafter shall be postponed until all delinquent records are completed. New admissions or the scheduling of procedures are not permitted. Consultations are not permitted. The suspended Member may not cover Emergency Room call, may not provide coverage for partners or other Members, nor admit under a partner’s or other attending Member’s name. Any exceptions must be approved by the Vice President of Medical Affairs and the CEO or his/her designee.
F) All hospital departments shall be notified of the suspension to enable the enforcement of the suspension.

G) Any Member who remains on suspension for seven (7) calendar days or longer will be referred to the Medical Executive Committee for further action.

H) Any Member who is suspended more than three (3) times within a six (6) month period for delinquent charts will be placed on probation in accordance with the Bylaws of the Medical Staff, Article XII, Section 3, Part 1.

I) In order to expedite the processing of medical charts for Quality Improvement, the following time frames have been established:
   1) Such charts referred to departments, subdivisions, and/or committees for review and comment shall be completed and returned to the originator of the request within eight (8) weeks of receipt of the chart.
   2) Such charts referred to individual Medical Staff Members from the above noted departments, subdivisions, and/or committees for screening and/or other review purposes, shall be completed and returned to that body within two (2) weeks of receipt of the chart by the Member.
   3) Any failure to comply with the above time frames shall be referred to the Medical Executive Committee for further action, including disciplinary measures if indicated, which shall be decided by the Medical Executive Committee.
ARTICLE III – PHARMACY

A) Drugs may be administered only upon the proper order of a practitioner acting within the scope of his or her license. Drugs may be administered directly by a Medical Staff Member, a professional nurse, or a licensed practical nurse who satisfactorily completed a Pennsylvania Board approved education program, Graduate practical nurses, graduate professional nurses, licensed physician assistants, and students in approved schools of nursing may administer drugs, but only under the supervision of a registered professional nurse or Medical Staff Member.

1) The practitioner’s current DEA number is kept on file in the Medical Staff Office and the Pharmacy Department is notified.
2) The practitioner must notify the Medical Staff Office immediately, if there is a change in status regarding their DEA number.
3) The practitioner will abide by the approved policies of the Pharmacy & Therapeutic Committee and Pharmacy Department.

B) Chemical symbols may not be used in ordering a drug – the name must be spelled out.

C) Upon discharge, the patient may be given the following if requested by the attending practitioner:
   1) Reconstituted oral suspension medications. All other unused medications are to be returned to the Pharmacy.
   2) All medications must be properly labeled before they are given to patients.

D) The Pharmacy is given the option of dispensing a generic equivalent drug, when deemed appropriate, unless specifically requested to dispense the brand name product by the ordering practitioner.

E) A pharmacy copy of the practitioner’s order will be reviewed by a pharmacist prior to dispensing and/or administration of a medication unless an urgent situation exists, or the pharmacy is closed, in which case, the order is to be sent to the Pharmacy and reviewed by the Pharmacist as soon as possible.

F) All active drug orders are automatically canceled when a patient goes for general surgery and must re-order by the practitioner post-operatively.

Part 1 – Parenteral Nutrition

A) Parenteral nutrition orders must be re-ordered on a daily basis after the patient has been evaluated by the practitioner.

B) Parenteral nutrition solutions are only to be prepared by the Pharmacy Department in a laminar flow hood.

C) All orders for parenteral nutrition (new and re-order) must be written by 1400 hours each day.
D) Orders written after 1400 hours will not be prepared until the following day.

E) All hyperalimentation solution will be hung at 2000 hours daily.

**Part 2 – Formulary**

The Formulary system is the accepted method whereby the Medical Staff of the Hospital, working through the Pharmacy and Therapeutic Committee, evaluates, appraises, and selects drugs that are considered most useful in patient care.

A) Practitioners are requested to use only “Formulary drugs” whenever possible.

B) Requests for additions to the Formulary will be presented to the Pharmacy and Therapeutic Committee at its regular meeting by the Director of the Pharmacy.

C) In addition to the regular members of the Committee, practitioners who have particular expertise in the usage of a drug may be invited or consulted for informational input.

D) If the Committee decided that a requested drug presents advantages over current medications, or if the drug is unique in its action and may be of benefit to patients, the drug may be accepted at that time.

E) The Committee may also approve the drug for a six (6) month trial if it is undecided on the benefits of a drug but feels strongly enough to give it further consideration.

F) Should a drug be rejected for inclusion in the Formulary, it may be reconsidered at a later date if demand or new information so dictates.

G) When a non-formulary drug is ordered, the Pharmacist will contact the practitioner and make them aware that the drug is not on the Formulary and suggest alternatives.

H) If the practitioner feels the requested drug is still needed, the Pharmacist will obtain the drug through ordinary channels, which could create a delay in therapy of up to 48 hours.

I) The Hospital Formulary will be routinely reviewed and updated by the Pharmacy & Therapeutic Committee and submitted to the Medical Staff Departments for revisions.

J) The approved formulary revisions are submitted to the Medical Executive Committee and to the Medical Staff Departments through established communication mechanisms.
Part 3 – Medication Brought into the Hospital

If a patient or practitioner brings medication into the hospital, it may only be used when all of the following criteria are met:

1) The medication has been ordered by a practitioner.
2) The medication has been identified and re-labeled by the Pharmacy prior to administration.
3) The medication is currently not on the Hospital Formulary; and
4) There are no formulary drugs that may be substituted.
5) No sample medications are permitted to be used in the hospital.

Part 4 – Automatic Drug Stop Orders

A) The following drugs must be reordered after one week (7 days):
   1) Antibiotics. Post-op antibiotic prophylaxis will be stopped within 24 hours unless the surgeon provides an appropriate justification to continue in the medical record.
   2) Steroids (cortico steroids)
   3) Ketorolac 5 days
   4) Sedatives
   5) Hypnotics
   6) Tranquilizers
   7) Anticoagulants (Heparin, LMWF, warfarin)

B) Narcotics must be reordered after seven (7) days.

C) The practitioner will be informed that the drug will be discontinued forty-eight (48) hours prior to its discontinuation.

D) All telephone orders must be repeated by the pharmacist or nurse taking the order and signed within 24 hours.

Part 5 – Pharmacy Standards

A) All drugs are distributed through the Pharmacy, which is supervised by a Registered Pharmacist.

B) Records shall be kept of the transactions of the Pharmacy and correlated with other hospitals’ records when indicated. Such special records as are required by law shall be kept.

C) Drugs dispensed by the Pharmacy shall meet the standards established by the U.S. Pharmacopeia, National Formulary, New and Non-Official Remedies, British Pharmacopeia or Canadian Formulary.

D) Drug samples are never to be used in the hospital.
Part 6 – Adverse and Toxic Reactions

The attending practitioner shall report any adverse or toxic reaction to a drug to the Pharmacy via an Adverse Drug Reaction Report.

Part 7 – Investigational Drugs

A) Investigational drugs can only be researched and administered to patients with the approval of the Institutional Review Committee and the knowledge of the Chief Executive Officer.

B) Requests for use of investigational drugs shall be referred to the Chairperson of the Institutional Review Committee.

C) Upon approval by the Institutional Review Committee, the Director of Pharmacy shall be informed about the decision by the Committee Chairperson.

D) The Director of the Pharmacy will refer the investigational drug to the Pharmacy & Therapeutic Committee for their approval.

E) For further guidelines, see Administrative Policy #280.

Part 8 – Drug Utilization Reviews

A) Each department will perform their own DUR’s in conjunction with the Pharmacy & Therapeutic Committee, who will oversee all DUR studies.

B) The department will be responsible for establishing the type of drugs to be evaluated, purpose of the study, and criteria and thresholds for each DUR.

C) Drug Utilization Reviews will evaluate the appropriateness of empiric, prophylactic, and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice.

D) The Pharmacy Department will assist in any DUR study, when requested by the Medical Staff Department or Pharmacy & Therapeutic Committee.

E) Results of DUR’s will be presented to the department and Pharmacy & Therapeutic Committee on a quarterly basis.

F) DUR evaluation will be available to the Department Chair at time of re-appointment or increase of clinical privileges.

G) The Pharmacy & Therapeutic Committee reports to the Medical Executive Committee on a monthly basis and to the Medical Staff Departments through established communication mechanisms.
ARTICLE IV – PLACEMENT OF OUTSIDE LABORATORY RESULTS ON PATIENTS’ CHARTS

A) Medical reports generated from St. Luke’s Hospital- Allentown Campus, Lehigh Valley Hospital Health Network Laboratories, Muhlenberg Hospital Center, St. Luke’s Hospital, may become a permanent part of the patient’s medical record. These institutions were chosen because of the great degree of crossover of members of the respective Medical Staffs.

B) Acceptable medical reports for inclusion in the medical record include: Non-tissue laboratory results, x-rays, EKG, EEG, and other diagnostic studies.

C) This recommendation does not preclude the use, by members of the Medical Staff, of laboratory results from other hospitals or physicians’ offices in the treatment of their patients. This data may be included in the history and physical (H&P); however, the actual reports will not become a permanent part of the record.

D) All tissue specimens must be reviewed by Sacred Heart Hospital pathologists prior to definitive cancer treatment (i.e., operative procedure, radiation therapy, chemotherapy) in our institution. In emergency situations, timely review by Pathology would suffice.
ARTICLE V – RESIDENCY PROGRAMS

A) As Sacred Heart Hospital is committed to undergraduate and graduate medical education, the Medical Staff of Sacred Heart Hospital has a responsibility to participate in the educational programs.

B) Each Residency Program is under the direct supervision of a designated Program Director as appointed by the Board of Directors.

C) Residents may participate in the care of patients. Supervision of a resident’s care of an individual patient is the direct responsibility of the patient’s attending physician. The Residency Policy Manual for each residency will describe, in detail, the supervisory relationship.

D) Medical Staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone.
ARTICLE VI – CRITERIA AND PROCEDURE FOR AUTOPSIES

A) The Medical Staff of Sacred Heart Hospital recognizes the importance of autopsies in evaluating the quality of care rendered to its patients and encourages autopsies to be requested for all deceased hospital patients. Those deaths on which a potential medico-legal issue is present should be handled according to applicable statutes and laws. The Medical Staff also recognizes requirements of accrediting agencies, specifically The Joint Commission, in the performance of autopsies. The medical staff, with other appropriate hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed. To that end, the Medical Staff adopts the following criteria that identify deaths for which securing autopsy permission should be sought:

1) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician;

2) All deaths in which the cause of death or a major diagnosis is not known with certainty on clinical grounds;

3) Cases in which autopsy may help to allay concerns of and provide reassurance to the family and/or the public regarding the death;

4) Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnosis, procedures and/or therapies;

5) Deaths of patients who have participated in clinical trials (protocols) approved by SHH institutional review boards;

6) Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction;

7) Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospitals; deaths occurring in hospital within 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized;

8) Deaths resulting from high-risk infections and contagious diseases;

9) All obstetric deaths;

10) All neonatal and pediatric deaths;

11) Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs;

12) Deaths known or suspected to have resulted from environmental or occupational hazards;
B) The permission for obtaining an autopsy follows the standards outlined in the SHH Laboratory Handbook. In all hospital deaths which are not “Coroner Cases,” “the authorization for autopsy” form must be completed even if permission for autopsy is denied. As per the Department of Pathology procedures, there is a system for notifying the medical staff, and specifically, the attending physician when an autopsy is being performed.

C) The findings from autopsies are reported to the attending physicians in a timely fashion (preliminary findings within 48 hours; final report within 30 working days for routine cases and 3 months for complicated cases).

D) The autopsy findings are utilized in quality assessment and improvement activities. The final autopsy reports are reviewed by the appropriate medical staff departmental quality assessment committees for clinical and educational value.
ARTICLE VII – TRANSITIONAL CARE FACILITY

A) Transitional Care Facility Policy and Procedure regarding Resident Physicians and also covering Attending Physicians concerning writing and signing orders.

1) As in the accepted policy in the resident training program in the units of Sacred Heart Hospital, if the resident physician is in possession of a valid license to practice medicine in the state of PA, then the resident physician can write and sign orders in the T.C.F. without the countersignature of the head of the residency training program. This, of course, includes the Graduate Training License. There will be times, however, when the head of the program or his/her designates, would want to approve and countersign an order, and will do so at their discretion.

2) If a validly licensed private attending physician, solo or group, is covering for another similarly licensed physician, then the written orders do not have to be countersigned by the actual attending physician, but the latter must follow through with all other regulations as regards to visits, etc.

B) Policy and Procedure regarding Medical Staff Member not fulfilling Transitional Care Facility requirements in reference to Federal, State and Hospital regulations.

1) Initially, T.C.F. staff, to include nursing or ancillary staff, shall notify the Member of any deficiencies on the resident record.

2) If the Member does not respond to the staff’s request within a reasonable period of time, the deficiencies will be reported to the Administrator and/or Medical Director of the T.C.F.

3) After discussion between the Medical Director and Administrator as to the deficiencies, the Medical Director of the T.C.F. shall speak to the Member.

4) If, after discussions with the Member, the record deficiencies are not corrected, then the Member will be reported to the Chair of the department to which he or she is connected.

5) If, after this is done, the deficiencies are still not corrected, the Medical Director, after consulting with the Department Chair, shall report all the facts to the President of the Medical Staff, who will then take further appropriate action. This action shall include whatever measures necessary to solve the problem in accordance with the Medical Staff Rules & Regulations and Medical Staff Bylaws.

C) All physicians attending residents in the T.C.F. will comply with the Policies and Procedures for Attending Physicians in the Sacred Heart Hospital Transitional Care Facility.
ARTICLE VIII – ANESTHESIA

Anesthesiologists are accorded the same general clinical rights, limitations, responsibilities, and privileges granted to members of the Medical Staff assigned to the Hospital's other clinical departments. The policies and conduct of the Hospital and other members of the Medical Staff should not infringe upon their responsibility to exercise independent medical judgment.

Part 1 - Credentialing

A) All members of the Department of Anesthesiology must be duly licensed and must have completed a residency program in Anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology.

B) Each member of the Department of Anesthesiology must demonstrate competency in Anesthesiology by having passed the certifying examination given by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology within five (5) years of completing residency.

C) All registered nurse anesthetists who function within the Department of Anesthesiology must be duly licensed registered nurses and must have completed a training program of nurse anesthesia approved by the American Association of Nurse Anesthetists (AANA) Council of Accreditation.

D) All registered nurse anesthetists shall take and pass the certifying examination given by the American Association of Nurse Anesthetists and therefore, entitled to be Certified Registered Nurse Anesthetists (CRNAs), within one (1) year of completion of their anesthesia training program.

Part 2 - Responsibilities of Physicians

A) All anesthesia at Sacred Heart Hospital will be administered by, or under the supervision of, an anesthesiologist, with the exception of other Medical Staff Members using local anesthesia.

B) Anesthesiologists will accept appropriate referrals and subsequently provide service in the operating room, Birthplace, and other areas within the institution where their services may be required.

C) In addition, they will offer consultative services and, when requested, respond to medical problems referable to the specialty of Anesthesiology; this may include pain relief, cardiopulmonary resuscitation and respiratory care.

D) A minimum of one (1) anesthesiologist will either be rendering anesthesia service in the hospital or otherwise be available to provide services to patients at all times. This coverage is the responsibility of all Active Staff Members. A CRNA will provide anesthesia relief at times when the anesthesiologist on call is occupied on another case.
1) Anyone desiring to exchange specific call assignment must arrange such with other members of the Department who are agreeable to the change.

2) Anyone wishing to have less than a full share of call must make appropriate arrangements with other anesthesiologists willing to accept a portion of the responsibility.

3) When such changes are made, it is the responsibility of the individual initiating the exchange to do all the following:
   a) Change the operating room anesthesia call book;
   b) Notify the OB/GYN Department; and
   c) Notify the hospital operator with the operating room coverage change.

E) An anesthesiologist shall be responsible for determining the medical status of all patients scheduled to receive anesthesia care, developing a plan of anesthesia care, and informing the patient or a responsible adult with the proposed plan and any alternatives that are available. A signed consent shall be obtained for the proposed anesthetic plan. Under extreme emergencies, this rule may be modified. When this is the case, the circumstances shall be documented in the patient’s record. The development of an appropriate plan of anesthesia care is based upon:
   1) Reviewing the medical record;
   2) Interviewing the patient to discuss medical history, previous anesthetic experience and drug therapy;
   3) Examining the patient when necessary to assess those aspects of the physical condition that might affect decisions regarding perioperative risk and management;
   4) Obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia;
   5) Determining the appropriate prescription of pre-operative medications as necessary to the conduct of anesthesia; and,
   6) The responsible anesthesiologist shall verify that the above has been properly performed and documented in the patient’s record.

**Part 3 – Perioperative Responsibility**

Perioperative responsibility includes the following:

A) Identification and re-evaluation of patient immediately prior to induction; this shall include an assessment of the patient’s vital signs and shall be documented on the anesthetic record.

B) Preparation and check of equipment, drugs, fluids, and gas supplies;

C) Appropriate monitoring of patient including, but not limited to, monitoring of oxygenation, ventilation, circulation, and temperature as detailed in the ASA Standards for Basic Monitoring.

D) Selection and administration of anesthetic agents;

E) Support life functions under the areas of anesthetic, surgical, and obstetrical manipulations; and,

F) Recording the events of the procedure on an established anesthetic record.
Part 4 – Post-Anesthetic Care

Post-anesthetic care includes:
A) Remaining with the patient as long as necessary;
B) Assessing whether adequate nursing personnel and necessary equipment are available for safe post-anesthetic care;
C) Informing personnel caring for patients in the immediate post-anesthetic period of any specific problems presented by each patient;
D) Determining when post-anesthetic surveillance may be discontinued and placing a recovery room discharge note on patient’s chart in progress notes; and
E) Complying with the ASA Standards for Post Anesthesia Care.

Part 5 – Medical Direction of CRNA

Anesthesiologists will be required, on occasion, to medically direct certified registered nurse anesthetists (CRNAs).

A) This medical direction will never exceed a 1-M.D.:2-4 CRNA ratio or, at maximum, a 1-M.D.:4-CRNA ratio.

B) Medical direction is anesthesia direction and management provided by an anesthesiologist whose responsibilities include:
   1) Pre-anesthesia evaluation of a patient;
   2) Prescription of anesthesia plan;
   3) Personal participation in the most demanding procedures in this plan, especially the induction of and emergence from anesthesia;
   4) Follow the course of anesthesia administration at frequent intervals;
   5) Remaining physically available for the immediate diagnosis and treatment of emergencies. Supervising anesthesiologists must be certain another anesthesiologist is available to cover rooms when leaving the O.R. for lunch or rounds (pre-op) in the hospital;
   6) Providing indicated post-anesthesia care; and,
   7) An anesthesiologist engaged in medical direction shall not be administering another anesthetic.

C) An anesthesiologist may engage in the following activities during medical direction:
   1) Address an emergency of short duration in the immediate area
   2) Administer an epidural for labor analgesia
   3) Periodic monitoring of an obstetrical patient
   4) Receive patients entering the O.R. suite for the next surgery
   5) Check on or discharge patients from the PACU
   6) Coordinate scheduling matters.
Part 6 – Other Anesthesiologist Responsibilities

In addition to clinical responsibilities, anesthesiologists must:

7) Attend twenty-five percent (25%) of all department monthly meetings;
8) Attend staff meetings as required by the Bylaws of the Medical Staff;
9) Participate in assigned departmental duties such as quality improvement and other duties from time to time as directed by the Departmental Chairperson;
10) Fulfill continuing medical education requirements established by the American Medical Association, American Osteopathic Association and the Pennsylvania Medical Society;
11) Supervise and teach, as directed by the Departmental Chairperson, interested practitioners rotating through the department (Anesthesia residents, Dental residents, Family Practice residents, and medical students); and,
12) Be currently certified in ACLS, PALS, and Neonatal resuscitation.

Part 6 – Responsibilities of CRNAs

A) All anesthetics administered by CRNAs will be medically directed by a staff anesthesiologist.

B) CRNAs will participate in anesthetic care as directed in the operating room, delivery room, code blues, critical care units, and other areas within the hospital.

C) Prior to each anesthetic, CRNA will discuss patient’s medical history with directing and supervising anesthesiologist and discuss anesthetic plan.

D) CRNAs will identify each patient prior to the onset of an anesthetic.

E) CRNAs will request that supervising and medically directing anesthesiologist be present during induction and emergence.

F) CRNAs will maintain anesthesia at prescribed levels utilizing proper monitoring.

G) CRNAs will record all events of procedure on an established anesthesia record.

H) CRNAs will notify medically directing physician of any alteration of patient’s condition and/or intra-operative emergencies.

I) When placing patient in recovery room, CRNAs will notify recovery room personnel of patients’ surgery, medical problems, intra-anesthetic or operative problems, anticipated problems, and supervising anesthesiologist.

J) CRNAs will attend monthly Anesthesia Department meetings.

K) CRNAs will participate in departmental functions and continuing education programs as directed by Departmental Chairperson.

L) CRNAs will fulfill continuing education requirements as mandated by the American Association of Nurse Anesthetists (AANA).
Part 7 – Chairperson, Department of Anesthesiology

A) Shall be a member of the Medical Staff in good standing, appointed in accordance with the Bylaws of Sacred Heart Hospital.

B) Shall have demonstrated clinical competence and be a Diplomat of the American Board of Anesthesiology.

C) Shall have demonstrated leadership and organizational skills.

D) Clinical and administrative duties include, but are not necessarily limited to, the following:
   1) Make recommendations regarding clinical privileges of anesthesiologists;
   2) Evaluate CRNAs for membership on the Allied Health Professional Staff;
   3) Evaluate the performance of each CRNA at the time of their reappointment to the Allied Health Professional Staff;
   4) Assure that anesthesia services are consistent with patient needs and current anesthesia practices;
   5) Assure that the mechanisms and practices of daily case assignments are conducted in an appropriate manner, do not lead to undue disruption of the schedule, and enable it to be completed efficiently;
   6) Assure the effective monitoring and evaluation of the quality and appropriateness of anesthesia care within the institution;
   7) Develop guidelines for anesthetic safety;
   8) Assure that a program of continuing education is available for all individuals who provide anesthesia services;
   9) Participate in the development of policies that relate to:
      a) The activities of individuals providing anesthesia;
      b) Daily functioning of members of the Anesthesia Department – physicians and CRNAs (call schedules, work schedules, and room assignments);
      c) Determine maximum number of physicians and CRNAs that may be on vacation at a given time. This number may change from time to time based on manpower or staffing needs.
      d) Administration of anesthesia in other departments/services of the hospital (i.e., G.I. Lab, Radiology); and,
      e) The hospitals’ program of cardiopulmonary resuscitation.

E) Shall be responsible for the development and review of the departmental quality improvement program.

F) Shall be responsible for the development of an annual budget.

G) Shall act as a liaison between the Department and Hospital Administration and Board of Directors.

H) Shall be the Chairperson of the departmental meetings.

I) Shall be a member of the Medical Executive Committee and the Operating Room Committee.
ARTICLE IX – EMERGENCY MEDICINE

A) The Emergency Medicine Staff shall consist of physicians on the Active, Courtesy, Honorary, and Consulting Staff contracted to provide care in the Emergency Care Unit of the hospital.

B) Privileges are to be delineated according to the Delineation of Privilege form. All privileges will be delineated according to a standard format set by the Department Chairperson with referral to the Credentials Committee.

C) The Emergency Care Unit will be open 24 hours a day, every day.

D) The Department will meet monthly at a regularly scheduled time.

E) There will be a minimum of one (1) physician and one (1) registered nurse on duty at all times.

Part 1 – Required Qualifications for Emergency Department Physicians

A) The Chairperson of the Department shall have the following qualifications:
   1) Graduation from an approved residency in Emergency medicine, and,
   2) Board certification in Emergency Medicine by ABEM (American Board of Emergency Medicine) or AOBEM (American Osteopathic Board of Emergency Medicine), and,
   3) Ability to administer a Department.

B) Staff physicians shall have the following qualifications:
   1) Completion of two (2) years in an approved Emergency Medicine program with intent to complete the program, an unrestricted medical license, and a letter of recommendation from the Program Director, or,
   2) Board certification in Emergency Medicine by ABEM or AOBEM, or,
   3) Graduation from an approved residency in Emergency Medicine, or,
   4) Board certification in a primary care specialty (Internal Medicine, Family Practice, Pediatrics, or Surgery) and three (3) years (5000) hours Emergency Medicine experience, or,
   5) Fulfillment of the practice requirement of the American Board of Emergency Medicine (5 years – 7000 hours) and intent to pursue board certification.

C) All department physicians shall also have the following qualifications:
   1) Current ACLS, ATLS and PALS (physicians board certified by ABEM or AOBEM and EM board eligible physicians are exempt from ACLS and PALS requirement); and,
   2) Willingness to complete a medical command course and satisfy requirements to give medical command in the EMS System.

D) Exceptions to the above qualifications should be made only in special circumstances, if determined by the Board of Directors.
Part 2 – Patient Treatment

A) All patients presenting themselves for care will be seen by the registered nurse and the consent for treatment signed.

B) Patient will be given the choice of having their private practitioner called or being seen by the practitioner on duty.

C) Emergency treatment, when needed, will be given immediately by physician on duty.

D) Oral orders for treatment will be accepted by the registered nurse on duty after repeating the order back to the practitioner for confirmation. These orders must be signed by the practitioner on his/her arrival.

E) No medications may be dispensed to relatives or friends for patients’ use unless patient is examined in Emergency Care Unit. Emergency Department Physicians are not to prescribe for patients they have not seen.

F) All patients are to be treated with discretion and all attempts are to be made to preserve the dignity of the patient.

Part 3 – Patient Records

A) A record will be kept on all patients seen in the Emergency Care Unit.

B) Patient, parent or guardian must sign consent except in cases where delay will endanger life of patient.

C) Record is to include history, pertinent positive and negative physical findings, treatment, instructions given to the patient and disposition of care in addition to non-clinical data.

D) Record is to be completed before patient is discharged.

E) Record is to be kept where recall is possible at any time.

F) Record review of quality of care will be provided on a daily basis with identification of problems and on a monthly basis through criteria development.

G) Each member shall provide for the maintenance of quality care in assigned areas by monitoring the quality and providing in-service programs for the physician and nursing staffs. He or she shall be knowledgeable of the latest methodologies in his/her area.
ARTICLE X – FAMILY PRACTICE

A) The Department of Family Practice will meet quarterly or as required by the Department Chairperson.

B) All Department business will be decided by a majority vote.

C) Active members must attend at least 25% of the business meetings of the Department.

D) The Staff Secretary will take attendance and minutes at the meetings, transcribe them for the approval of the Chairperson and distribute the minutes to the members.

E) The rules and regulations can be amended, deleted or modified at any regular departmental meeting subject to final approval of the Board of Directors.

F) Any member who is delinquent in his/her department attendance or who is otherwise failing to comply with the rules and regulations will be referred to the Credentials Committee, and disciplinary action will be taken only with the approval of the Family Practice Chairperson.

G) Courtesy members will be limited to twelve (12) patient contacts per hospital year.

H) In order to be considered for Staff Privileges in the Family Practice Department, a new applicant must meet the following criteria:
   1) Must have graduated from an AMA/AOA accredited College of Medicine or Osteopathy or completed a two (2) or three (3) year approved Family Practice Residency Program; and,
   2) Must currently and actively be engaged in the discipline of Family Practice either in direct patient care, teaching or administration; and,
   3) Must show evidence of CME credit to satisfy the American Board of Family Practice/American Osteopathic Board of Family Practice for the past three years, or be a recent (36 months) graduate of an approved Family Practice Residency Program.
   4) Must have performed in-patient care for at least three (3) years in the past; or
   5) Must be a graduate of an approved Family Practice Residency Program.

I) Requests for Category II or IIB or IIC privileges require certification by either the American Board of Family Practice or the American Osteopathic Board of Family Practice and completion of an approved three (3) year Family Practice Residency Program (for osteopathic physicians, a 1 year rotating internship coupled with a 2-year residency training program will satisfy this criteria). Recent graduates of an approved residency must be Board certified within 2 years of application. In order for Category II, IIB and/or IIC privileges to continue, re-applicants must maintain re-certification by their respective boards.
J) Individuals requesting Category II, IIB, and IIC privileges must have experience in similar duties for at least two (2) of the past five (5) years or have completed additional training to insure proficiency.

K) Family Practice Obstetric Privileges:
   1) Individuals requesting core OB privileges must document practice experience or supplemental elective OB training in addition to the required core OB curriculum and performance of at least 100 vaginal deliveries during their training period or subsequent practice.
   2) All Family Practice physicians requesting obstetric privileges must be proctored by a staff obstetrician for the first ten (10) cases at Sacred Heart Hospital. If the cases are deemed acceptable, then the Family Practice physician may proceed independently within the limit of the delineation of privileges. If specific deficiencies are uncovered during the proctoring, the Chairperson of Obstetrics and the Chairperson of Family Practice will review the delineation of privileges and suggest review or remediation. An additional period of targeted proctoring may be recommended at the discretion of the two chairpersons.
   3) All Family Practice physicians must list an obstetric staff member backup as an alternate physician on the Medical Staff application.

L) Third Year Family Practice Residents engaged in an approved Family Practice Residency Program may apply for membership in the Department of Family Practice provided they work at times that do not conflict with resident duties and provided they have the approval of the director of their program. They must work under the supervision of a Sacred Heart Hospital Family Practice physician who holds Active membership in the Department of Family Practice and who has admitting and treating privileges. All patients treated by the resident must be seen and reviewed by the attending within 72 hours. Residents may request only Category I and IIB privileges.
ARTICLE XI – INTERNAL MEDICINE

A) The Internal Medicine Staff shall consist of members of the Medical Staff qualified to practice Internal Medicine or any subspecialty of medicine.

B) All practitioners shall have their privileges delineated according to education, training, experience, demonstrated competence and judgment, references and other relevant information.

C) The Internal Medicine Department’s responsibility shall be to assure that all patients assigned to that service (In-patient or Ambulatory Patients) are adequately cared for at all times. This responsibility will be monitored by means of concurrent and retroactive review of patient care.

D) It will also be the responsibility of the Internal Medicine Department to adequately staff all the services related to the Department.

E) The chairperson will have professional supervision over the department and is responsible for the proper functioning of the same.

Part 1 – Post-graduate Educational Requirements

A) General Practice Subdivision: A minimum of two (2) years post-graduate education is required to be eligible for the General Practice Subdivision. If the physician has completed at least one (1) year of an American Osteopathic Association (AOA) approved General Practice Residency training program prior to July 1, 1989, and is Board Certified by the AOA Board of General Practice, he or she is also eligible for membership in the General Practice Subdivision. Any physician completing AOA training after July 1, 1989, must complete at least two (2) years of post-graduate education.

B) General Internal Medicine and All Other Subdivisions: A minimum of three (3) years post-graduate education in Internal Medicine is required to be eligible for the General Internal Medicine Subdivision and all other Subdivisions.

Part 2 – Meetings

A) Departmental meetings are held quarterly.
B) Delinquency in meeting attendance will be reported to the Credentials Committee.
ARTICLE XII – OBSTETRICS AND GYNECOLOGY

A) General – Policies are those of the American College of Obstetrics and Gynecology and the ethical religious directives of Catholic Health Facilities.

B) In addition to full-term pregnancies, the following patients may be admitted to the Obstetrical Unit:

1) Threatened abortions and incomplete abortions.
2) Patients with hyperemesis gravidarum.
3) Patients who delivered at home and who are free of communicable and infectious diseases may be admitted to the postpartum Obstetrical Unit.
4) Patients with toxemia.
5) Patients with pyelitis of pregnancy
6) Patients with any medical complications, for example: diabetes, heart disease, etc.
7) Uncomplicated, self-care, gynecologic patients Stage 0 and 1 Gyn malignancies, non-malignant and non-infectious patients. These patients are not to be mixed with the postpartum obstetrical patients, but should be kept in some area of the unit which can be increased and decreased in capacity as the needs dictate. These patients, should they develop an infectious complication, are to be moved immediately from the Unit.
8) Patients with infectious disease are not to be admitted to the Obstetrical Unit.

C) The privileges of Obstetrics and Gynecology may be extended to new applicants who have obtained certification by the American College of Obstetrics and Gynecology or who have completed their subscribed time in training and are eligible for Board Examination. The candidate must successfully pass the written and oral board exam within three (3) years of being accepted to the staff. In order to maintain privileges, he or she must continue to be Board certified as the American Board of OB/GYN mandates.

D) All Obstetrics and Gynecology physicians who perform deliveries at Sacred Heart Hospital are required to be currently certified in Neonatal Resuscitation.

E) All major abdominal surgery, excluding laparoscopy, require an assisting physician.

F) All members of the Department of Obstetrics and Gynecology are expected to attend meetings and postgraduate courses each year. It is expected that they will meet, at least, the basic education requirements of the Pennsylvania State Medical Society.

Part 1 – Labor

A) The father and significant other mature adult may stay with the patient in the Labor Room.

B) If the patient in active labor is found to have an infection, she is managed in that Labor Room using isolation techniques.
Part 2 – Visitors

A) In the postpartum area the visiting hours are:
   1) 11:00am to 8:00pm, except feeding times. Only husbands or significant other and immediate family of parents may visit during feeding times as long as they are free of any active infection. Before entering room, they must wash their hands and wear a sterile gown.
   2) Clergymen are permitted to visit members of their congregation at any time except if infant is nursing.

B) In the Gynecology area the visiting hours are:
   1) 11:00am to 8:00pm. Postpartum and GYN Unit request only two (2) visitors at the bedside at one time.

C) Mothers are permitted to leave the Maternity Department only for in-hospital diagnostic studies.

D) Immediate family of parents includes only the following:
   1) Other children if any;
   2) Their own parents; and,
   3) Their own brothers and sisters.

E) Visitors, nurses, or practitioners may not sit on the patient’s bed.

Part 3 – Labor Progress Record

All patients are to be adequately monitored. If a cardiotocograph is available, the Labor Room nurse is responsible for carefully and adequately applying the external transducers, to obtain a record of a fetal heart pattern and labor contraction pattern. All internal monitoring is to be applied by the practitioner.

Part 4 – Oxytocins

A) Oxytocins must be by Medical Staff Member order only.

B) Oxytoxics may be administered by the Labor & Deliver Nurse.

C) The attending Member or OB/GYN House Officer must remain in the hospital while the Oxytocin is running, or the Oxytocin will be discontinued.
Part 5 – Obstetrical Consultations

A) All consultations must be done by an obstetrician on the Medical Staff. The consultant shall record his/her conclusions on the consultation sheet.
   1) Patients in active labor over four hours without progress.
   2) Hysterotomies.
   3) Major medical and surgical complications – appropriate consultant.
   4) Pre-term induction of labor (before 36 weeks).

B) Consultation requirements of Family Practice and General Practitioners doing Obstetrics:
   1) Any patient who has been admitted in labor and has not been delivered within 18 hours of admission.
   2) Any operative delivery other than low forceps (caput must be visible).
   3) Any abnormal presentation including all breeches over 24 weeks gestation.
   4) All toxemia cases with blood pressure elevated over 145/90, ante, intra, and postpartum of patients with previous history of eclampsia.
   5) Excessive bleeding – ante, intra, and postpartum.
   6) Primigravidas, 35 years old and/or older, in labor.
   7) Patient in premature labor – gestation 35 weeks or less.
   8) Patients who are to be given oxytocin before delivery.
   9) Retained placenta – more than 30 minutes.
  10) Ruptured membranes over 12 hours.
  11) Prolapsed cord.
  12) Second Stage of labor greater than two (2) hours duration.
  13) Patient who has had a previous Cesarean Section, myomectomy or other major genital tract surgery, e.g., vaginal repair.
  14) Multiple pregnancy.
  15) Medical or surgical complications are to be seen by appropriate specialist.
  16) Laceration or extension of episiotomy into sphincter or rectum.
  17) RH sensitization – all patients with a positive titer.

Part 6 – Discharge of Undelivered Patients

When a patient is discharged who has been admitted for some complication of pregnancy or “false labor”, her chart is completed and sent to the Record Office and a new chart is started when she returns to the labor floor. Her prenatal record should be copied and returned to the labor floor for inclusion in the new chart.

Part 7 – Delivery

Fathers or Supportive Adults may be allowed in the Delivery Room at the discretion of the Obstetrician and the Anesthesiologist.
Part 8—Anesthesia

Anesthesia for delivery is provided by anesthesiologists. It is the obstetrician’s responsibility to notify anesthesiology of a need for their services.

Part 9—Obstetrical Emergencies

A) A placenta which is not expressed one hour following delivery is considered a “retained placenta.”

B) All Cesarean Sections are done in the delivery room. The operating room technician will act as the scrub nurse along with the circulating nurse to record the time of the delivery and take care of the baby.

C) Oxygen and resuscitation equipment is available in all delivery rooms and nurseries.

Part 10—Placental Collection

All placentas are collected and the obstetrician may send to the lab at his/her own discretion.

Part 11—Record of Delivery

A) A complete and accurate record of delivery is kept in the delivery room book.

B) Complete identification of mother and baby by means of footprints, thumbprints, and bracelets is done before either the mother or baby leave the delivery room.

Part 12—Immediate Care of the Newborn

A) The State of Pennsylvania requires the following treatment for the prevention of ophthalmia neonatorum: Two drops of 1% silver nitrate or erythromycin .5 mgm ophthalmic ointment is to be instilled into each eye of the infant. If the patient should refuse, then a refusal consent form must be signed.

B) A Hollister Cord Clamp is applied to the umbilical cord under sterile conditions before dividing the cord.

C) Stillborn infants and infants in danger of death are baptized according to ethical and religious directives for Catholic hospitals.

Part 13—Cesarean Sections

A) Cesarean Sections are done by obstetricians.

B) An assisting physician or surgical assistant is required when a Cesarean Section is performed.
Part 14 - Recovery Room

After delivery the patient is taken to the recovery room and observed for at least two hours. During this time her blood pressure and fundus are periodically checked.

Part 15 – Infections

Patients showing any sign of postpartum infection are treated according to the Universal Precautions, Isolation section as defined in the current Environment & Infection Control Policy #202-A226 and the OB/GYN Department Policy #21.

Part 16 – Birthing Room Rules & Regulations

A) The patient must have an uncomplicated prenatal course and be expected to deliver a mature baby.

B) The patient must be in active labor and must be checked by a practitioner.

C) It is advised that the patient have attended a prepared childbirth class or orientation to the Birthing Room.

D) Analgesics, intravenous fluids and electronic fetal monitoring will be ordered at the discretion of the practitioner.

E) Vital signs will be taken and recorded per labor policy.

F) Anesthetics will be utilized at the discretion of the Obstetrician and Anesthesiologist.

G) The use of outlet forceps and/or vacuum extraction will be at the discretion of the practitioner.

H) The patient may take orally ice chips or suck on hard candies.

I) The patient may ambulate in the Birthing Room.

J) The patient may have her husband or coach, and any of her children with her during the labor and delivery process up to a maximum of three (3) people in the room at any time.

K) The practitioner maintains the right to have removed from the Birthing Room any family members or coach he or she deems necessary in order to administer adequate medical care to his/her patient.

L) The mother may breast feed after delivery in the Birthing Room.

M) After two (2) hours, the mother and infant shall be transferred from the Birthing Room.
N) The use of the Birthing Room is strictly on a first come, first serve basis, and patients actively using the Birthing Room will not be displaced to accommodate newly incoming patients into labor.

O) Once the patient has been transferred out of the Birthing Room to the Labor Room, she may not be re-admitted to the Birthing Room.

P) No smoking or eating meals in the Birthing Room.

Q) Participants will dress in appropriate hospital attire.

Section 1 – Division of Nurse/Midwifery

A) The division of nurse/midwifery will function as part of the Department of Obstetrics and Gynecology and will be the responsibility of the department chairperson, subject to ultimate approval by the hospital staff and the Board of Directors, and subject to the bylaws and rules and regulations of the professional staff. A division head will be appointed by the department chairperson for a term of two (2) years and this nurse/midwife will:
   1) Function as a liaison between nurse/midwives, the department chairperson, and other departments and offices within the hospital;
   2) Conduct monthly division meetings at which problems and other timely items will be discussed;
   3) Attend monthly OB/GYN Department meetings;
   4) Submit to the department chairperson minutes of the monthly division meetings including:
      a) A statement of each item discussed
      b) Recommended action, if any
      c) Recommended follow-up, if any

Part 1 – Credentialing

A) All nurse midwives who function with the Department of Obstetrics must be duly licensed registered nurses and must have completed a training program of nurse midwifery accredited by the American College of Nurse Midwives (ACNM).

B) All registered nurse-midwives shall pass the certifying exam given by the ACNM and, therefore, be titled Certified Nurse Midwife, and shall be licensed as a professional midwife by the State of Pennsylvania.

C) All Certified Nurse Midwives shall have entered into a collaborative agreement with a licensed physician, who is an active member of the OB/GYN Department.

D) All Certified Nurse Midwives shall have privileges delineated in accordance with hospital policy.
E) All Certified Nurse Midwives are required to be Board Re-Certified every five (5) years.

F) Neonatal Resuscitation certification is required from the Nurse Midwives in order to have their privileges approved at Sacred Heart Hospital.

**Part 2 - Responsibilities of the Collaborating Physician**

A) The collaborating physician agrees to be available for consultation by the Certified Nurse Midwife, and to assume management of complicated patients when requested by the nurse midwife.

B) The physician shall review the medical records of all nurse midwifery patients, and shall co-sign all orders, History & Physicals, face sheet and discharge summary.

**Part 3 - Responsibilities of the Certified Nurse Midwife**

A) All medications and/or treatments administered by the Certified Nurse Midwives will be medically directed in the Certified Nurse Midwife protocols which have been signed by each individual Certified Nurse Midwife and the collaborating physician.

B) The Certified Nurse Midwife may admit and discharge patients to the hospital under the collaborating physician’s direction/service.

C) The Certified Nurse Midwife will be responsible for completing all the pertinent medical records and documenting all midwifery care provided.

D) The Certified Nurse Midwife shall be responsible for management of the essentially healthy woman through her childbearing years.

E) The Certified Nurse Midwife shall be responsible for evaluating the patient for eligibility midwifery care based on the established risk criteria.

F) Consultation between the Certified Nurse Midwife and the physician shall occur when the client develops a condition which deviates from normal, but which can be managed by the Certified Nurse Midwife. Under such circumstances, the Certified Nurse Midwife shall indicate the occurrence of the consultation and decide management on the patient record.

G) Co-Management shall occur when a nurse midwife patient develops a condition which deviated from normal and requires frequent and/or continuing management by a physician, but some aspects of care remain with the scope of nurse-midwifery management. Each case shall be decided by the individual Certified Nurse Midwife and her/his collaborating physician.

H) Nurse-midwife patient may require transfer to physician care if that patient becomes high risk based on the risk criteria. Upon transfer of patient care to the collaborating physician, the Certified Nurse Midwife shall document this in the medical record.
I) Certified Nurse Midwives will attend monthly OB/GYN Department meetings.

J) Certified Nurse Midwives will participate in quality assurance activities as directed by the department chairperson.

K) Certified Nurse Midwives will fulfill continuing education requirements as mandated by the American College of Nurse-Midwives.
ARTICLE XIII – PEDIATRICS

A) Admission to this department includes patients 18 years of age or younger.

B) All qualified pediatricians on the Active Staff are expected to participate in ward and/or clinic duties. Failure to do so will automatically cause forfeiture of admission and consultation privileges.

C) Ward duties in the Pediatric Department and Nursery will be assigned by the chairperson of the department.

D) General Teaching Ward Rounds will be made daily by the ward practitioner.

E) Departmental meetings will be held at least quarterly.

F) There are no “required” consultations in the Pediatric Department. It is the discretion of the practitioner to request consultative services when needed.

G) In order to provide the best of care to all patients, the nurse in charge along with the head of the department will at times:
   1) Suggest bed transfer to facilitate care and to avoid cross contamination.
   2) Request delay in admission of elective medical or surgical patient in order to allow a certain number of emergency beds.

H) All members of the department shall have their privileges delineated according to the delineation of privileges.

I) In order to be considered for Staff Privileges in the Pediatrics Department, a new applicant must meet the following criteria:
   1) Any new physician approved to the Department of Pediatrics will be required to be Board eligible at the time of joining and Board Certified, as per the definition of American Board of Pediatrics or American Osteopathic Board of Pediatrics within three (3) years after acceptance to the Hospital staff. In order to maintain privileges, he or she must continue to be Board certified as the American Board of Pediatrics mandates. All members of the Pediatrics Department prior to 1992 are to be grandfathered to maintain privileges.
**Part 1 – Newborn Service Regulations**

A) Neonatology consult should be obtained by attending physician when deemed necessary.

B) If the nurse caring for the newborn cannot contact the infant’s attending physician in a reasonable period of time, it will be his/her responsibility to inform the pediatrician on call who will then assume responsibility for the care. In no case is the baby in distress to be left unattended.

**Part 2 – Medical Records Within the Pediatrics Department**

There will be a written or dictated Discharge Summary or transfer note on all Pediatric patients admitted. This does not apply to newborns except those newborns who are detained after their mothers are discharged.
ARTICLE XIV – SURGERY

A) The Surgical Department shall consist of all members of the Active, Courtesy, Honorary and Consulting Medical and Dental Staff qualified to practice surgery and so privileged.

B) The Surgical Department’s responsibility will be to see that the quality of surgical care within the hospital is maintained at a high level at all times, and that all in-patients as well as out-patients are adequately cared for at all times. The Surgery Department has the responsibility for inpatient and outpatient care for indigent patients related to that department.

C) The recommendation for Medical Staff privileges for new members will be made solely by the Chairperson of the Department after consultation with the Chief of the Subdivision based upon education, training, experience, demonstrated competence and judgment, references and other relevant information and interest in the Surgery Department.

D) Medical Staff reappointment is recommended after review of quality of work, attendance at meetings, participation in clinical and mortality conferences and general interest in Sacred Heart Hospital.

E) Dental Teaching privileges may be granted to qualified Medical Staff Members to perform procedures in the Outpatient Dental Unit only and credentialed as outlined in the Medical Staff Bylaws, Article V, Section 6, Part 3 and Article X, Section 4. The Subdivision Chief and Department Chairperson will make their recommendations to the Credentials Committee.

F) The privileges of doing major surgery in this hospital will be extended to new applicants who have obtained certification by the American Board of Surgery or subspecialty Board, or who have completed their prescribed time in training as approved by the Board in question and are eligible for examination by that Board. The rule shall be retroactive to 1952.

G) Any new Medical Staff Member approved to the Department of Surgery will be required to be Board eligible at the time of joining and Board Certified, as per the definition of American Board of Surgery or American Osteopathic Board of Surgery, within three (3) years after acceptance to the Hospital staff. All members of the Surgery Department prior to 1992 are to be grandfathered.

H) All surgeons in their practice at Sacred Heart Hospital shall be governed by the Catholic Ethical and Religious Directives.

I) No operation shall be performed without the consent of the patient or his/her legal representative except emergency where there is a life threatening condition.

J) All operations performed shall be fully described by the attending practitioner and dictated to include pre-operative diagnosis, operation performed, what was found and what was done, immediately following the procedure.
Section 1 – Podiatry Subdivision

In compliance with the Rules and Regulations concerning operating privileges in the Department of Surgery/Subdivision of Podiatry and the guidelines set up by the American Podiatric Medical Association for competency in foot surgery, an applicant must have completed an approved surgical residency program (PSR 12) in order to have privileges to operate at Sacred Heart Hospital. This will allow the performance of the first category of procedures on the Delineation of Surgical Privileges Sheet. More training and documentation is necessary to show competence in the second category of procedures (rear foot and ankle procedures) indicated on the Delineation of Privileges.

Section 2- Vascular Subdivision

A) To be eligible for membership in the Subdivision of Vascular Surgery, the applicant must have completed an approved fellowship and be eligible for board certification in Vascular Surgery.

B) The applicant must obtain board certification in Vascular Surgery within five (5) years of completion of the approved vascular fellowship.

C) Vascular surgeons who are members of the Medical Staff prior to April 25, 2000, and who have performed ten (10) endovascular procedures at Sacred Heart Hospital, will be grandfathered to have full privileges.

D) Members of the subdivision must perform fifty (50) vascular surgical cases per year.

E) Those members who do not actively perform their surgery at Sacred Heart Hospital must provide the number of cases and a letter from the Chairperson of their primary hospital regarding their competency to obtain and to continue having privileges at Sacred Heart Hospital.

F) Endovascular surgery remains an integral part of vascular surgery.

G) Members who want to perform endovascular surgery must take the didactic as well as the practical instructional courses regarding the basics as well as advanced techniques for endovascular surgery and must perform twenty (20) cases per year, either as primary surgeon or first assistant. The first five (5) cases must be done under the supervision of a member of the subdivision who does have privileges at Sacred Heart Hospital.

H) Endovascular procedures done at Sacred Heart Hospital by a physician other than a vascular surgeon must have a vascular surgeon standby.
Section 3 – Neurosurgery Subdivision

A) Each applicant shall have the prerequisite training required for certification by the American Board of Neurological Surgery and shall obtain such certification in accordance with the Department of Surgery Rules and Regulations board certification requirements.

B) Each member within the Subdivision must:
   A) Provide documentation of continuing medical education in the field of Neurological Surgery sufficient to qualify for the AANS/CNS certificate of continuing education.
   B) Fully participate in departmental and divisional committees as designated by the Chairperson of the Department of Surgery and the Chief of the Subdivision of Neurosurgery, as a citizenship obligation to the Department/Division.

C) Each physician within the Subdivision must provide an equal share of neurological surgery coverage for the Sacred Heart Hospital Emergency Room and Clinics. A schedule for such coverage will be provided to the Chairperson of the Department of Surgery by the Chief of the Subdivision of Neurosurgery.

D) Failure to fulfill eligibility/membership requirements will result in action as governed by the Medical Staff Bylaws of the Sacred Heart Hospital.

Part 1 – Organization

A) There will be one Chief of the Subdivision of the Neurosurgery appointed by the Board of Directors.

B) There will be one Associate Division Chief of Neurosurgery appointed by the Board of Directors.

C) The Subdivision of Neurosurgery may, from time to time, elect to establish subsections of special expertise within the subdivision. The establishment of such subsections will be subject to the recommendation of the Chairperson of the Department of Surgery and the approval of the Board of Directors.

Part 2 - Delineation of Privileges

A) Clinical privileges are recommended by the Chairperson of the Department of Surgery following review and advice from the Chief of the Subdivision of Neurosurgery and granted by the Board of Directors of the Sacred Heart Hospital.

B) Operative privileges for Neurosurgery shall include those procedures necessary for the diagnosis and treatment of disorders affecting the brain, spinal cord, peripheral nerves, and their surrounding protective and support structures. These privileges shall be practiced in concert with the American Association of Neurological Surgeons Code of Ethics.
C) All neurological surgery clinical practice at the Sacred Heart Hospital will be carried out under the quality assessment programs as established by the Sacred Heart Board of Directors, Department of Surgery and Subdivision of Neurosurgery.

**Part 3 - Criteria for Performing Cranial Surgery**

A) The surgeon must be board certified or board eligible for certification by the American Board of Neurological Surgery as outlined in the Department of Surgery Rules and Regulations board certification requirements.

B) The patient must meet the Indications for Procedure as set forth in the AANS Criteria for Review of Neurosurgical Procedures.

C) The surgeon must fully cooperate in providing patient information for the Neurosurgery Operative Outcome database.
ARTICLE XV - NEUROSCIENCES

A) The Neurosciences Department shall provide a forum for Staff involved in Neurobehavioral practice to plan, develop, and implement components of the Neurosciences:
   1) Establish and evaluate standards, protocols, policies and practices that facilitate decision-making, problem solving, and evaluation of existing services within the Neurosciences;
   2) Review and measure quality as it pertains to Neurosciences;
   3) Assess material and capital needs;
   4) Evaluate cost per case data;
   5) Review outcome information;
   6) Program enhancement and development; and,
   7) Effect service change as need is determined.

Part 1 – Membership

Neurobehavioral Science Department membership shall consist of staff that practice in Neuroscience related fields. Physician members of the Neurobehavioral Science Department shall hold primary membership in the Neurobehavioral Science Department. Additional members include the Neuroscience Allied Health Personnel including, but not limited to, CRNP, Clinical Coordinators of Neurobehavioral patient care areas, and MRI representatives.

Part 2 – Credentialing

All Medical Staff Members shall have their privileges delineated in accordance with their medical specialty.

Part 3 – Leadership

Leadership of the department shall consist of a Chairperson and Associate Chairperson, who are appointed according to the process delineated in the Medical Staff Bylaws. Chair and Associate Chair positions will not be held by members of the same subspecialty group. Department Chair responsibilities are outlined in the Medical Staff Bylaws.
ARTICLE XVI – PSYCHIATRY

Part 1 – Meetings

The department will meet at least quarterly at a regularly scheduled time.

Part 2 – Daily Hospital Visits by the Psychiatrists on the Inpatient Psychiatry Unit

A) Attending psychiatrists will see their inpatients on the psychiatric units daily, Monday through Friday.

B) The attending psychiatrists will co-sign, date and time all medical chart entries made by their Allied Health Professionals.

C) The attending psychiatrists will arrange a covering rotation schedule to ensure that all inpatients are seen by a psychiatrist at least once each weekend.

D) On the weekend day that the patient is NOT seen by the psychiatrist, the patient will be seen by the Allied Health Professional.

E) All Allied Health Professional chart entries must be co-signed, dated and time within one working day.
ARTICLE XVII – LABORATORY

A) The administering and technical functions of the Laboratory are the direct responsibility of the pathologist. All medical staff matters pertaining to the Laboratory shall be directed to the pathologist.

B) Each member of the Medical Staff shall secure autopsies whenever appropriate. The autopsy permit is the responsibility of the attending practitioner. Autopsies shall not be performed without the written consent of the legal next of kin or by order of the coroner. Autopsies requested at the insistence of the family will only be performed if the attending physician also desires an autopsy. Otherwise, the deceased’s legal next of kin may request that an autopsy be performed by an outside pathologist at the expense of the family. All Sacred Heart Hospital autopsies requested by the attending physician and consented by the deceased’s legal next of kin shall be performed by the hospital pathologist or by a practitioner to whom he or she may delegate the duty.
ARTICLE XVIII – DIAGNOSTIC RADIOLOGY

A) All requests for radiologic services shall contain concise reasons for the examination. This information shall be provided by the requesting medical staff member, house staff member or other authorized practitioner whose name should be clearly indicated on the request form.

B) All physician staff members of the Radiology Department shall be members of the Medical Staff of Sacred Heart Hospital and are required to maintain their professional expertise as outlined by the American College of Radiology and the American Medical Association.

C) Parenteral administration of diagnostic contrast agents is permissible only by a physician or certain radiographers (as defined below):
   1) Radiographer must be registered.
   2) A Staff Radiologist must be in the X-Ray Department, his/her whereabouts known, and is/her availability immediate.
   3) The patient has no major contraindications to contrast administration, i.e., significant allergic history, asthma, etc.

D) Radiologic consultation is available on a 24 hours a day, 7 days a week basis.

E) Physicians on the staff of the Diagnostic Radiology Department shall be board certified or board eligible in either Diagnostic Radiology or General Radiology. Radiographers on the Diagnostic Radiology Department staff must achieve board certification within three (3) consecutive attempts.

F) To be retained as a staff member of the Diagnostic Radiology Department, physicians on its staff who are board eligible, must achieve board certification within three (3) years of initial Medical Staff membership. Radiographers on the Diagnostic Radiology Department staff must achieve board certification within three (3) consecutive attempts.

G) All members of the Diagnostic Radiology Department will fulfill continuing medical education requirements as outlined by the American College of Radiology.

H) While the Diagnostic Radiology Department strongly feels that all radiologic procedures be done by a radiologist, it is aware that under some circumstances a non-radiologist Medical Staff Member may wish to perform the surgical portion of certain invasive special studies. These studies would include angiography, myelography, bronchography, arthrography, percutaneous cholangiography, etc.
I) The Guidelines are as follows:

1) Physicians who have performed the surgical component of an invasive special procedure prior to October 1983, to the satisfaction of the Chairperson of the Department of Radiology, and is a member of the Medical Staff at Sacred Heart Hospital, may continue to perform procedures similar to those performed in the past.

2) All other physicians wishing privileges to perform invasive special procedures must document in writing to the Director of Radiology his or her training and subsequent clinical experience with respect to the specific special procedure he or she desires to perform. Recommendations from the director of the physician’s training program must be included. Documentation of the number of procedures he or she has performed must be presented also.

3) Privileges to perform specific special studies in this Radiology Department will be contingent upon the approval of the Director of the Department following consultation with the Director of the Department to which the non-radiologist physician belongs plus the Credentials and Medical Executive Committee.

4) Special procedures to be performed by the radiologist will be scheduled following appropriate consultation with the physician referring the case.

J) The Director of Radiology or his/her designee will be responsible for radiation safety in all radiation emitting devices under his/her control.

K) The Department of Radiology will be responsible for teaching medical students and residents in Radiology. Residents in other specialties will receive teaching services as time allows.