MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

OF

UPMC PINNACLE HOSPITALS (Harrisburg, West Shore and Community General Osteopathic)

CLINICAL PRACTICE

RULES AND REGULATIONS

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ARTICLE 1

ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

1.A. GENERAL ADMISSION, TRANSFER AND DISCHARGE POLICIES

1.A.1. Admission

(a) Except in emergency, no Patient shall be admitted to the Hospital unless an admitting (provisional) diagnosis has been made by a qualified Practitioner. In the case of an emergency, the admitting diagnosis shall be documented as soon after admission as possible.

(1) The attending Practitioner or his/her designee (including a resident) shall evaluate a Patient who is admitted to the hospital within a reasonable period of time given the Patient's condition, but in no event later than twelve (12) hours of the Patient's admission to a medical/surgical unit.

(2) Admission orders must be documented in the Patient's record at the time of admission by the attending Practitioner or his/her designee.

(b) Attending Practitioner Evaluation of Patient Prior to Admission of Patient to Hospital from Emergency Department [See Chapter VI. Emergency Services]

1.A.2. Transfer

(a) When the Hospital transfers a Patient from one floor to another or to a specially designated unit (i.e., isolation bed, intensive care unit, etc.), the Patient Registration Office shall notify the Patient's attending Practitioner.

(b) Patients evaluated in the Emergency Department and deemed to be critically ill will not be transferred from the Emergency Department until the attending Practitioner (designee) has made arrangements for the continuity of the Patient's care.

(c) The transfer of care for Patients waiting for admission to the critical care areas from the Emergency Department Practitioner shall be made to the attending Practitioner (designee) upon his/her arrival. This transfer of care would be completed while the Patient was still in the Emergency Department.

(d) A Patient will be transferred to the care of the surgeon upon written order to transfer the Patient to the surgeon's service.

1.A.3. Discharge

(a) Patients shall be discharged only on order of the attending Practitioner or a qualified designee. A qualified designee shall be defined as an Active Medical Staff member or a resident physician acting under the direction of the attending physician.

(b) A deceased Patient shall be pronounced dead by a Physician or an Allied Health Professional, as applicable to his or her privileges.

(1) Every effort should be made to notify a family of a death in a timely fashion.

(2) The medical staff is actively involved in the measurement, assessment, and improvement in the use of developed criteria for autopsies.

(3) No autopsy shall be performed without a legal consent.

(4) All autopsies shall be performed by a Hospital pathologist or by a Practitioner to whom he/she may delegate the duty.

1.B. INFECTION CONTROL

(a) An Infection Control Program will be established to identify and reduce the risk of acquiring and transmitting infections among Patients, Medical Staff, Allied Health Professionals, employees, volunteers and visitors. The Infection Control Program will be implemented by the Infection Control Director and Coordinators under the supervision of the Hospital Epidemiologist, with the assistance of a member of the Infection Control Committee.

(b) Infection Control Policies and Procedures will be maintained in Infection Control Policies and Procedures manuals which will be available on nursing units and in other Patient care areas.

1.C. ADMISSION, DISCHARGE AND TRIAGE POLICIES FOR CRITICAL CARE

1.C.1. General

Admission-discharge-triage policies for critical care areas are contained within Critical Care Policies and Procedures which are located in the respective units.

1.C.2. General Admission Policies/Procedures

(a) Any Practitioner may admit Patients to critical care units if Patients require interventions uniquely available in these units.

(b) Admission shall be on a priority basis, as defined under admission policies.

(c) Attending Practitioners who do not frequently care for critically ill Patients should transfer Patients to an attending Practitioner with critical care expertise.

(d) All Patients will be seen by the attending Practitioner or designee within a four (4) hour period of their admission.

(e) The admitting attending Practitioner, or resident, must have first hand knowledge of the Patient to be admitted and will be responsible for certifying the Patient's need for the special facilities.

(f) The attending Practitioner shall communicate with the appropriate resident as soon as possible.

1.C.3. Routine Transfer Policies

(a) Before a Patient may be transferred from critical care units, all orders will be reconciled by the attending Practitioner or his/her designee.

(b) Patients being transferred from critical care areas will have priority on available beds elsewhere in the Hospital.

1.C.4. Admission of Patients to the Neonatal Intensive Care Unit

All Patients admitted to the Neonatal Intensive Care Unit shall become Patients of a neonatologist unless otherwise provided by written order of the neonatologist.

ARTICLE 2

MEDICAL RECORDS

2.A. GENERAL RULES AND REGULATIONS

2.A.1. On-line Identification/Filing System

An on-line system of identification and unit filing to insure the prompt retrieval of a Patient's medical record shall be maintained. In the case of readmission of a Patient, the Patient's medical record which includes all previous admissions and emergency service records shall be available upon request.

2.A.2. Access

All medical records in all Hospital departments are the property of the Hospital and shall not be removed from the Hospital except upon subpoena, court order, or statute.

(a) Access to medical records of Patients shall be afforded to Practitioners for approved study and research, consistent with preserving the confidentiality of the personal information concerning the individual Patients. Approval will be through the Practitioner's Department Chair.

(b) Subject to the discretion of the Vice President for Medical Affairs, former Members of the Medical Staff shall be permitted access to information from the medical records of their Patients covering all periods during which they attended such Patients in the Hospital.

(c) In compliance with Commonwealth and federal Regulations, and Hospital Policies and Procedures, Patients shall have access to their medical information with proper authorization.

2.A.3. Content

The medical record shall contain sufficient information to identify the Patient, support the diagnosis, justify the treatment, document the course of treatment and results accurately, and facilitate continuity of care among health care providers.

(a) The attending Practitioner shall be held responsible for the preparations of a complete medical record for each admission of each Patient.

(b) This record shall include:

(1) Identification Data (including name of any legally authorized representative when applicable)

(2) History and Physical Report including Chief Complaint; Present Illness; Past History; Family History; Physical Examination (including pelvic and rectal examination when applicable); Provisional Diagnosis (Admitting Diagnosis)

(3) Reports including Clinical Laboratory Reports; Radiology Reports; Consultations when applicable or requested; Tissue Reports

(4) Treatment [See (III)]

(5) Physician's Order [See (III)]

(6) Progress Notes [See (II)(7)(A)(3)]

(7) Principal Diagnosis

defined as the condition after study to be chiefly responsible for the admission of the Patient.

(8) Co-morbid Conditions/Complications

defined as conditions that coexist upon admission or that develop during the hospitalization that affect treatment received and/or length of stay.

(9) Principal Procedure

defined as the procedure performed for definitive treatment rather than one performed for diagnostic or exploratory purposes; the procedure most related to the principal diagnosis.

(10) Secondary Procedures

defined as additional significant procedures performed during hospitalization.

(11) Discharge Summary

This is a recapitulation of the significant findings and events of the Patient's hospitalization and his/her condition on discharge.

(a) The Discharge Summary shall include reason for hospitalization, significant findings, treatment and/or procedures rendered, brief overview of Patient's progress throughout this hospital stay, condition of the Patient at the time of discharge, and discharge instructions such as type of diet, medications, physical activity, and follow-up care.

(b) The person who completes the discharge summary must have integral knowledge of that Patient's hospital course and discharge plan.

(c) A Discharge Summary will not be mandatory for uncomplicated patients if the hospital stay does not exceed forty-eight (48) hours and the discharge diagnosis is the same as the admitting diagnosis.

(12) Discharge Instructions

At the time of discharge, the Patient's condition, diet, medications, activities, special instructions, and follow-up appointment(s) shall be documented.

(13) Others

Evidence of known advance directives, Powers of attorney and Autopsy Report (when applicable).

(c) In the event of death, the Discharge Summary shall include the events leading to death.

2.A.4. Outpatient Medical Record

The outpatient medical record shall contain sufficient information to confirm the diagnosis, document services provided and treatment received.

(a) The attending Practitioner shall be responsible for the preparation of a complete outpatient medical record (or medical record entry) for each service provided to a Patient.

(b) The outpatient medical record shall include

(1) Identification data

(2) History and physical report or psychiatric exam

(a) A history and physical is required for all Patients who have had an outpatient procedure performed by a Practitioner.

(b) It includes past history, admission diagnosis, chief complaint and history of present illness, physical examination, and treatment plan.

(c) Any Outpatient History and Physical Examination Report performed prior to the day of procedure shall be updated to reflect Patient's current status.

(3) Reports

Laboratory reports, Radiology reports, Tissue reports, Physician's orders and progress notes and dictated operative/invasive procedure report (the only exception being x-ray procedures, provided that the x-ray report documents the same information that would be required on an operative report).

(4) Discharge Instructions

At the time of discharge, the Patient's condition, diet, medications, physical activity and follow up care shall be documented**.**

(5) For any other requirements regarding documentation and/or timeliness on various documents in the outpatient surgery record, please refer to the appropriate section of the Medical Staff Rules and Regulations regarding that particular document.

2.A.5. Medical Record Reports

(a) All reports shall be electronically filed in the legal medical record.

(b) When pathological diagnoses are made outside of the Hospital and the Patient is admitted for treatment, either a copy of the pertinent pathology report will be filed with the Hospital's record, or the slides will be submitted to the pathologists for review.

2.A.6. Abbreviations

(a) Only those abbreviations on the approved Abbreviations List shall be used.

2.B. MEDICAL HISTORY AND PHYSICAL EXAMINATION REPORT (H&P)

2.B.1 When is an H&P Required?

An H&P is required for all inpatient admissions, observation admissions and outpatient procedures other than interventions performed in the Emergency Department.

2.B.2. When does the H&P need to be in the Medical Record?

The H&P must be performed and recorded in the patient’s medical record within twenty four (24) hours after admission and prior to any procedure.

2.B.3 H&P Required and Elements

For inpatient admissions, observation admissions and procedures requiring general/regional anesthesia and procedures using procedural sedation, the H&P must include the following elements (note qualifiers on some elements):

(a) Chief Complaint

(b) History of Present Illness

(c) Past medical and/or Surgical History (when pertinent to the admission and/or procedure)

(d) Medications

(e) Allergies

(f) Family History (when pertinent to the admission and/or procedure)

(g) Social History (when pertinent to the admission and/or procedure)

(h) Review of Systems (when pertinent to the admission and/or procedure)

(i) Physical Examination (extent based on the Practitioner's clinical judgment but must include a heart and lung exam)

(j) Assessment

(k) Plan

For procedures using local anesthesia the only physical exam requirement is to include an examination of the body part the procedure is going to occur on (e.g. the thumb).

If the Hospital delivers infants, the current obstetrical record will include a prenatal record.

2.B.4. H&Ps Performed Prior to Inpatient Admission, Observation Admission or an Admission for a Procedure

All UPMC Pinnacle Hospital employed Practitioners must document such H&P's on-line within the electronic medical record.

H&P's performed in the non-UPMC Pinnacle Hospital employed Practitioner's office prior to an inpatient admission, observation admission or an admission for a procedure can qualify as the required H&P, provided that:

(a) It is a legible, signed and dated.

(b) The H&P is no older than thirty (30) days prior to admission/procedure.

(c) The H&P is still appropriate for the situation surrounding the admission/procedure.

(d) The H&P is compliant with the requirements outlines in this document.

(e) The Practitioner records on-line an appropriate interval note as a part of his/her admission note in the medical record.

(f) If the H&P was performed outside the hospital by a Licensed Practitioners, permitted by law to perform and record a H&P, who is not a member of the UPMC Pinnacle Hospitals Medical or Allied Health Staff, it must be reviewed by and updated by a member of the UPMC Pinnacle Hospitals Medical or Allied Health Staff who has been granted privileges by UPMC Pinnacle Hospitals to perform H& Ps. If reviewed, updated to include all necessary information annotated as such and signed and dated to show that it is current, by a UPMC Pinnacle Hospitals Practitioner, it will be considered a valid H&P as long as it meets the requirements outlined in this document.

(g) Any H&P recorded prior to admission must be updated within twenty-four (24) hours of admission or prior to the performance of a procedure.

2.B.5. Readmission Within Thirty (30) Days for Same Condition

If a Patient is readmitted within thirty (30) days for the same condition, the previous H&P, with addition of an interval note. The interval note must reflect the prior admission and describe what has transpired since discharge the prompt this admission.

2.B.6 Qualified Practitioner who Can Perform and Document H&P

Only H&Ps performed and documented by the following Practitioners will be accepted as valid H&Ps:

(a) Active Medical Staff (if granted privileges by UPMC Pinnacle Hospitals to perform H&Ps)

(b) Allied Health Professional (if granted privileges for UPMC Pinnacle Hospitals to perform H&Ps)

(c) Residents and Fellows performing approved rotations at UPMC Pinnacle Hospitals

(d) Practitioners as detailed in 2B.4

2.B.7. Special H&P's

(a) Children and Adolescents

The History Report of children and adolescent inpatients shall include, where feasible, an evaluation of the Patient's developmental age; length or height, weight, consideration of educational needs and daily activities, as appropriate; the parent's report or other documentation of the Patient's immunization status; and the family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the Patient.

(b) Podiatric Case

(1) For any patient who meets the classification of ASA 1 (normal, health patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit such patients, perform a complete admission H&P, and

assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient.

(2) For any patient who meets ASA 3 or 4 classifications, a medical H&P of the patient shall be performed and recorded by a physician who is a member of the Medical Staff before podiatric surgery. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(3) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric H&P as well as all appropriate elements of the patient's record.

(c) Dental Cases

(1) Dental Cases shall include both a dental and medical H&P prepared by appropriately privileged practitioner(s).

2.C. EVIDENCE OF APPROPRIATE INFORMED CONSENT

An invasive/operative informed consent shall be obtained by the Practitioner prior to the procedure. In the case of elective sterilization for medical assistance recipients, consents must be obtained at least thirty (30) days, but no more than one hundred and eighty (180)days, prior to the date of the procedure.

2.D. OPERATIVE/INVASIVE PROCEDURE REPORT

2.D.1. Pathological Review of Specimens

(a) All specimens removed at operation shall be sent to the Hospital pathologist with the exception of those items described on a pathological Review Exception List ("Exception List") which shall be developed and annually reviewed by the Operating Room Committee in conjunction with the Chair of the Department of Pathology (or his/her designee). The Exception List shall conform to all applicable laws, regulations and accreditation standards. The Exception List shall be submitted to the Medical Executive Committee of the Medical Staff on an annual basis for information and the current version of the Exception List shall be maintained in the Operating Room Rules and Regulations.

(b) The pathologist shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis, and he/she shall sign his/her written report.

2.D.2. Required Documentation

(a) An operative or other high-risk procedure report will be written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

Note 1: An exception to this requirement is allowed if an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within twenty-four (24) hours (I am making an assumption here that this the timeframe allowed by the hospital).

Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or are of care.

(b) Operative or other high-risk procedure reports are required for all procedures performed in the Operating Room, Labor and Delivery Room Suites, the G.I. Laboratory, Cystoscopy Laboratory, and Special Procedure Suite.

(c) The required elements in an operative or other high-risk procedure report include:

(1) Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision) to include the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner(significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);

(2) Pre-operative diagnosis;

(3) Post-operative diagnosis;

(4) Name of the specific surgical procedure(s) performed;

(5) Type of anesthesia administered;

(6) A description of the procedure to include surgical techniques used, findings, and tissues removed or altered;

(7) Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;

(8) Complications, if any; and

(9) Estimated blood loss.

(d) The required elements of an operative or other high-risk procedure progress note include:

(1) Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);

(2) Pre-operative diagnosis;

(3) Post-operative diagnosis;

(4) Procedure performed and a description of each procedure finding;

(5) Specimens removed; and

(6) Estimated blood loss.

(e) For procedures that are not performed in the areas designated in [2.D.2. (b)] the documentation regarding the procedure that must be placed into the patient's record does not need to contain all the elements in the operative or other high-risk procedure report or the operative or other high-risk procedure progress note. That documentation may be done in the progress notes, dictated or electronically entered.

2.E. DISCHARGE REGULATIONS

2.E.1. Order for Discharge

Patient shall be discharged only upon written order of the attending Practitioner.

2.E.2. Medical Record Documentation at Discharge

(a) On day of discharge, the attending Practitioner shall document his/her principal diagnosis, co-morbid conditions/complications, principal procedure, secondary procedure, see that the discharge instructions are completed and electronically sign all documentation.

2.E.3. Discharge Summary/Final Progress Note

(a) A discharge summary is required on all admitted Patients.

(b) The final progress note should include any instructions given to the Patient and/or family.

(c) A dictated Discharge Summary will not be mandatory for uncomplicated patients if the hospital stay does not exceed forty-eight (48) hours and the discharge diagnosis is the same as the admitting diagnosis.

2.F. AUTHENTICATION OF MEDICAL RECORDS

2.F.1. Records

Records shall be authenticated and signed by the Practitioner or individual credentialed to do so.

2.F.2. Signatures/Countersignatures

(a) All clinical entries on medical records shall be dated and electronically signed by the author or appropriate designee.

(b) In all instances, the Practitioner should sign all clinical entries made by himself/herself.

2.G. COMPLETION OF MEDICAL RECORDS

2.G.1. Timeliness of Medical Records

(a) A complete history and physical examination shall be recorded within twenty-four (24) hours after admission of the Patient. Failure to do this will result in postponement of the procedure unless the Practitioner documents that such delay would be detrimental to the life or health of the Patient.

(b) An operative/invasive report shall be dictated immediately after the procedure and, immediately after transcription, included in the medical record and signed by the Practitioner.

(c) A progress note must be entered on the patient's record at least once daily.

(d) Discharge Summaries shall be completed within forty eight (48) hours after Patient discharge.

(e) At the time of discharge, the Patient's condition, diet, medications, activities and follow-up care shall be documented.

(f) All reports or records must be electronically completed within a period consistent with good medical practice and no longer than thirty (30) days following Patient's discharge.

(g) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within three (3) days, and the complete protocol shall be made part of the record within thirty (30) days unless special studies and/or procedures are required.

2.G.2. Filing of Incomplete Medical Record

No medical record shall be filed until it is complete, except on a documented order of the Health Information Committee.

2.H. DELINQUENT MEDICAL RECORDS PROCEDURE FOR MEDICAL STAFF MEMBERS

2.H.1. Definition

A Medical Staff Member shall be considered having 'delinquent' medical records if:

(a) His/Her medical records have components which are outstanding beyond time limitations stipulated in this document; or,

(b) He/She has thirty (30) or more incomplete medical records.

2.H.2. Notification Process

(a) Initial Notice to Medical Staff Member of Delinquent Medical Records

The Health Information Management Department shall provide initial notification to Medical Staff Members with delinquent medical records which identifies:

(1) The medical records and specific record components which are delinquent; and

(2) The time period in which these delinquent medical records must be completed before a suspension procedure is activated.

(b) Notice of Impending Automatic Suspension of Medical Staff Member

(1) If the delinquent medical records remain outstanding, the Vice President for Medical Affairs, having been notified of the continued deficiency by the Health Information Management Department, shall notify the Practitioner of impending automatic suspension of privileges.

(2) Such letter shall include the time and date of the impending suspension should these medical records remain delinquent.

(c) Automatic Suspension

If the delinquent medical records continue to be outstanding, automatic suspension of privileges will be implemented at the time and date specified in the impending suspension letter.

(a) Notification of such suspension shall be transmitted to the Patient Registration Office and to the involved Hospital departments.

(d) Notification/Suspension Schedule

MEDICAL RECORD COMPONENT	TIME REQUIREMENT	FIRST NOTICE	IMPENDING SUSPENSION	SUSPENSION
History and Physical Examination Report	**Twenty-four (24) hours post admission to hospital.**	Allocation Date (Discovery Date)	Same as First Notice.	Following day.
Operative/Invasive Procedure Report	**Immediately post surgery.**	Day after surgery.	Same as First Notice.	4PM day after surgery.
Discharge Summary	**Forty-eight (48) hours post discharge.**	See Delinquent Record.	See Delinquent Record.	See Delinquent Record.
Delinquent Record – Medical Staff Member (Includes Reports/Records)	**Thirty (30) days post discharge; thirty or more incomplete medical records.**	On or about 1st of each month.	On or about 15th of each month.	7th Working day from 15th at 4PM.
Progress Note	Daily – See (II)(7)(A)(3)	Discovery Date	Same as First Notice.	Following day.

(e) Exemptions; Patient Care; Chronic Offender

(1) A temporary exemption will be made for suspension letters and privilege revocation during all holidays, as well as during a Practitioner's vacation or illness. Holidays are defined to be those federally designated.

(2) All Patients who were hospitalized prior to the institution of the suspension may be cared for in the usual manner and their care shall not be affected by the suspension.

(3) Any Practitioner who remains delinquent for fourteen (14) days following the day of suspension shall be deemed to have voluntarily relinquished Membership and will be informed that he/she must reapply as per the Initial Appointment Policy.

(4) A chronic offender is defined as a Medical Staff Member who has had admission privileges suspended three times within a one hundred and eighty (180) day period. A Medical Staff Member suspended three times within a one hundred and eighty (180) day period will be deemed to have voluntarily relinquished Membership and will be informed that he/she must reapply as per the Initial Appointment Policy. A Medical Staff Member will be notified when he/she has been suspended two times within a one hundred and eighty (180) day period.

2.H.3. Restoration of Privileges of Medical Staff Member

Privileges will be restored when the Vice President for Medical Affairs and the Patient Registration Office have been notified by the Health Information Management Department that the delinquent records and/or reports have been completed, except for those outlined in this document.

2.H.4. Delinquent Medical Records Procedure for Residents

See Policy for Resident Completion of Medical Records

ARTICLE 3

TREATMENT AND ORDERS

3.A. TREATMENT

3.A.1. Practitioner Care Designation

In case of the inability to locate a designated Practitioner, the Department Chair or designee may authorize any qualified Member of the Medical Staff to provide care should such be necessary.

3.A.2 Surgical Care

Refer to Operating Room Policies and Procedures

3.A.3. Levels of Intensity of Care

Refer to Hospital Policies and Procedures on Level of Intensity of Care

3.A.4 Physicians or Allied Health Professionals (AHP) Ordering Diagnostic Tests, Therapeutic Regiments and/or Performing Procedures for/on Family Members

(a) As a general rule, physicians are discouraged from ordering diagnostic test, therapeutic regiments and/or performing procedures for/on themselves or for/on family members, however, in particular situations, performing such procedures may be appropriate (see below Code of Medical Ethics Opinion 1.2.1- Treating Self or Family).

(b) In circumstance where a physician or AHP orders diagnostic tests and/or therapeutic regiments, validation of the physician's or AHP's licensure must be done prior to executing the order. If prior authorization is required, this will be done before execution of the orders.

(c) Any physician or AHP who wishes to perform a procedure on themselves or on a family member, except in an emergency, should discuss the matter with the Vice President of Medical Affairs prior to performing it.

Code of Medical Ethics Opinion 1.2.1 - Treating Self or Family

In general, physicians should not treat themselves or members of their own families.

Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly

influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

3.A.5. Clinically Significant Allergies

The documentation of clinically significant allergies should be recorded with the Patient's admission orders.

(a) If the Patient has no known allergies, "NKA" (No Known Allergies) must be electronically documented.

(b) The record shall display in a prominent manner a notice of any clinically significant allergies.

3.B. ORDERS

3.B.1. General Regulations

(a) All orders for treatment shall be electronically available.

(b) An order for a medication or a drug requiring a DEA (Drug Enforcement Agency) number must be either signed or countersigned by a Practitioner holding a DEA Number.

3.B.2. Verbal Orders

(a) Oral Orders (verbal and telephone) should only be used in emergency situations or in instances in which the practitioner is involved in a procedure and is unable to electronically enter orders.

(b) Providers cannot give entire admission orders over the phone. In emergency situations, they can give a few orders (i.e., admit order, diet, pain medication and fluid) to admit the patient. Remaining admission orders must be entered electronically.

(c) An oral order shall be authorized if dictated, to the following individuals:

(1) Registered nurse (including CNM) for any patient intervention,

(2) Licensed Practical Nurse, as defined by scope of practice,

(3) Medical or osteopathic doctor for any patient intervention,

(4) Resident or Fellow for any patient intervention,

(5) Physician Assistant for any patient intervention,

(6) Certified Registered Nurse Practitioner for any patient intervention,

(7) Registered Pharmacist for pharmaceuticals,

(8) Physical therapists, occupational therapists, and speech therapists for rehabilitative interventions,

(9) Respiratory therapists for respiratory interventions, and

(10) Paramedics employed by the Hospitals for treatment of patients in emergency situations only in the Emergency Department.

(d) Oral Orders shall be entered by the person to whom dictated with the name of the Practitioner from whom the order was received, followed by the name and role of individual receiving the order.

(e) The responsible Practitioner or designee shall authenticate Oral orders within seven (7) days.

(f) Oral orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for the orders to be given electronically by the responsible practitioner. “Urgent” is defined as based on the patient’s perspective of having pain, discomfort or heightened concern regarding his/her condition. “Impractical” is defined as practitioner is off site, involved in an invasive procedure or unavailable due to sleeping hours. Unless immediate patient safety is jeopardized or extreme circumstances do not allow the use of electronic orders, verbal orders should never be used for patient admission orders.

3.B.3. Orders

Orders must be reviewed:

(a) When a Patient has major surgery; and,

(b) When a Patient is transferred to and from an intensive/critical care unit.

3.B.4. Automatic Stop Orders

(a) The Medical Staff through the Pharmacy and Therapeutics Committee, establishes and promulgates written policies concerning the use of Automatic Stop Orders for selected medications (see Department of Pharmacy Policy MG-24).

3.B.5. Tissue/Cytology Requests

The Practitioner or his/her designee must include appropriate history on all tissue/cytology requests and must also ensure that the surgical specimen(s) is/are appropriately identified.

3.B.6. Use of Restraints

Refer to Hospital Policies and Procedures

ARTICLE 4

CONSULTATIONS

4.A. CONSULTATION REQUESTS

Any Practitioner on the Staff may request a consultation with the approval of his/her Patient with any other licensed Practitioner. If the consultant requested is not a Member, the requesting Practitioner must request permission from the Vice President for Medical Affairs, or his/her designee, for the consultant to answer the consult.

4.B. CONSULTANT

A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought.

4.C. ESSENTIALS OF A CONSULTATION

(a) A satisfactory consultation includes examination of the Patient and the record.

(b) A documented opinion signed by the consultant must be included in the medical record with the date and time.

(c) Consultations must be answered within forty-eight (48) hours of request unless otherwise specified. If the consultation needs to be answered more expeditiously, it is the responsibility of the requesting Practitioner to personally contact the consultant.

4.D. DOCUMENTATION OF CONSULTATION REQUESTS

The attending Practitioner is responsible for requesting consultation, when indicated, including documentation of the reason, extent (consult and treat unless otherwise specified), and date and time.

4.E. CONSULTATION REQUESTS FOR ANCILLARY HEALTH PROFESSIONALS

Other ancillary health professionals (e.g., nutritionist, physical therapist, etc.) employed by the Hospital may be consulted.

ARTICLE 5

UTILIZATION

5.A. ADMISSION REVIEW

(a) The Nurse Case Manager will review records of all categories of Patients within one working day of admission to determine the need for the services of the Hospital.

(b) If, in the opinion of the Nurse Case Manager, a diagnostic admission, preoperative overstay or other type of inappropriate utilization exists, the Nurse Case Manager will contact the admitting Practitioner for more information.

(c) If misutilization still appears likely, the physician advisor engaged by the Outcomes Management Department will be notified.

5.B. THIRD PARTY PAYOR ACTIONS

In those cases where the Hospital has incurred or may incur loss through denial of payment or disapproval of days by any third party payor, the attending Practitioner shall reasonably cooperate by providing information to the Hospital.

5.C. MEDICAL EXECUTIVE COMMITTEE REVIEW

Practitioners who fail to cooperate in providing information to the Hospital as provided in this Section, or who otherwise exhibit a pattern of inappropriate utilization, may be required to appear before the Medical Executive Committee in accordance with the Medical Staff Bylaws.

ARTICLE 6

EMERGENCY SERVICES

6.A. PROVISION OF EMERGENCY MEDICAL SERVICES

The Hospital and its Medical Staff have assumed the responsibility for providing emergency medical services to the residents of its service area as part of a regional emergency medical services system.

6.B. PRACTITIONER STAFFING

Because of the broad nature of clinical problems that are seen and treated in an Emergency Department setting, it is necessary for the Hospital and individual Members of the Medical Staff to share in the responsibility for providing the necessary and appropriate Practitioner staffing. The responsibility for staffing shall be delegated as follows:

(a) The Hospital will arrange for twenty-four (24) hour coverage in the Emergency Department by Practitioners with special training and/or expertise in Emergency Medicine. Said staffing shall be sufficient to handle the normal case load in a reasonable and cost efficient manner.

(b) The Medical Staff through its clinical departments/sections shall provide specialty and subspecialty coverage as needed, on an "on-call" basis. Each department or section shall develop an "on-call" schedule which will provide adequate Emergency Department coverage.

(c) A Departmental schedule designating Emergency Department coverage shall be developed on an equitable basis and shall not exclude any qualified Practitioner who desires to provide coverage.

(d) Any conflicts or disputes related to on call coverage, may be forwarded to the Medical Executive Committee for resolution.

6.C. GENERAL RULES REGARDING EMERGENCY CARE

The duties and responsibilities of all Practitioners and personnel serving Patients within the Emergency Department shall be defined in an Emergency Department Policies and Procedures Manual.

6.D. TIME LIMITS TO BE OBSERVED IN ATTENDING PRIVATE PATIENTS IN THE EMERGENCY DEPARTMENT

(a) If the attending Practitioner or his/her designee has not seen the (non-emergency) Patient within a reasonable time of Patient's arrival in the Emergency Department, the Patient may be seen by the Emergency Department Practitioner. A qualified designee shall be defined as an Active Medical Staff Member or a resident physician or individual credentialed to do so, acting under the direction of the attending physician.

(b) If a Patient is seen and/or treated by a resident on behalf of an attending Practitioner in the Emergency Department, the attending Practitioner shall countersign the Emergency Department record. If a Patient is seen and/or treated by a resident on behalf of an Emergency Department Practitioner in the Emergency Department, the Emergency Department Practitioner shall countersign the Emergency Department record.

(c) If a Practitioner cannot be contacted within one hour in order to discuss the Patient's problem,

(1) Where the Patient is able to be discharged, the Emergency Department Practitioner will discharge him/her with follow-up care by his private Practitioner.

(2) Where a Patient needs to be admitted and the attending Practitioner is not available within one hour, the Emergency Department Practitioner will call the following order of Practitioners to determine who will admit the Patient:

(a) On call Practitioner

(b) Hospitalist

(c) Chief of Section

(d) Chair of Department

(e) Vice President for Medical Affairs

6.E. ON CALL SERVICES

The duties and responsibility of a Medical Staff Member who is providing specialty and sub- specialty on-call services shall, at a minimum, include the following:

(a) When the on-call specialist or sub-specialist is specifically requested by a physician to see a patient in the Emergency Department, the on-call specialist or sub-specialists shall respond in person (or by approved telemedicine link) and in a timely manner.

(b) The on-call specialist or sub-specialist must provide services, when requested, without regard to the patient’s ability to pay for the services rendered.

(c) After an appropriate medical screening, when a patient with an emergency medical condition requires the services of an on-call specialist or sub-specialist to examine and stabilize the patient, those services must be rendered in the Emergency Department.

(1) An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions (d) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (e) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(d) The current month's on-call physician list is maintained in the Emergency Department.

6.F. MEDICAL SCREENING FOR PATIENTS PRESENTING TO THE HOSPITALS

(a) All patients coming to the Hospitals requesting emergency services will receive an appropriate medical screening examination as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.§1395dd.

(b) Health care personnel approved to perform a medical screening examination includes physicians, physician assistants, certified registered nurse practitioners and appropriately trained Labor and Delivery Nurses.

(1) A triage assessment does not constitute a medical screening examination.

ARTICLE 7

MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR ACT REQUIREMENTS

7.A. REPORT OF A SERIOUS EVENT OR INCIDENT

A Practitioner who reasonably believes that a serious event or incident has occurred shall report the serious event or incident to the Patient Safety Officer of the Hospital. The report shall be made immediately or as soon thereafter as is reasonably practicable, but no later than twenty-four (24) hours after the occurrence or discovery of the serious event or incident.

7.B. DISCLOSURE OF A SERIOUS EVENT OR INCIDENT

The attending Practitioner should be central to the notification and discussion of serious events and incidents with patients and, as appropriate, family members. If the attending Practitioner does not feel capable of the responsibility, the attending Practitioner should immediately contact the Vice President of Medical Affairs or the Patient Safety Officer of the Hospital to pursue the initial discussion.

ARTICLE 8

IMPAIRED MEDICAL & ALLIED HEALTH STAFF MEMBER

8.A. SELF-REFERRAL

A member of the Medical Staff or the Allied Health Staff may refer himself or herself for treatment of a physical illness, psychiatric or emotional illness, or for drug and alcohol abuse. A self-referral may be made by contacting the Vice President of Medical Affairs or the President of the Medical Staff who shall provide the member with a referral to sources for diagnosis, treatment and rehabilitation.

8.B. REPORT OF IMPAIRMENT BY STAFF

An employee of the Hospital or member of the Medical Staff or Allied Health Staff may report suspected impairment due to physical illness, psychiatric or emotional illness, or drugs or alcohol by contacting the Vice President of Medical Affairs or the President of the Medical Staff.

If the Vice President of Medical Affairs or the President of the Medical staff believes that there exists sufficient grounds to investigate the report he or she shall meet with the Medical Staff or Allied Health Staff member about whom the report is made to review the report and the circumstances giving rise to the report. When impairment is found an appropriate referral shall be made in accordance with this document.

Nothing in this document shall be deemed to suspend or in any way interfere with the provisions of the Medical Staff Bylaws and other Governing Documents regarding the imposition of a precautionary suspension or corrective action should circumstances warrant the same.

Nothing in this document shall be deemed to suspend or in any way interfere with the Hospital's policies and procedures regarding employee impairment as they pertain to Medical Staff and Allied Health Staff members who are employed by the Hospitals or by subsidiaries of the UPMC Pinnacle Hospitals.

Revised 09/2015

09/2016

09/2017

02/2018

10/2018

5/2019

12/2019

6/2020

9/2020

Last Revisions – 12/20/2019, 6/23/2020, 9/22/2020, 9/29/2020