# WakeMed Raleigh & WakeMed Cary
## MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE I - INTRODUCTION

1.1 DEFINITIONS

"ADMITTING PHYSICIAN" means the physician/licensed independent practitioner (LIP) responsible for the admitting orders and the completion of the admission history and physical.

"ADVANCE DIRECTIVE" means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions. Advance directives may include a “Declaration of a Desire for a Natural Death,” Health Care Power of Attorney, Do-Not-Resuscitate Orders and similar documents, such as the NC Medical Orders for Scope to Treatment form (MOST) form, expressing the individual’s preferences as specified in the Patient Self-determination Act.

“ALLIED HEALTH PROFESSIONALS” or AHPs (such as medical nurse assistants, dental assistants etc.) are individuals that are employed by a medical staff member who requests that these individuals assist in providing care within a WakeMed facility. These individuals are processed through WakeMed’s Human Resources Department. AHPs are not Providers with Supervised Privileges, such as advanced practice registered nurses or physician assistants.

“ATTENDING PHYSICIAN” means the physician/licensed independent practitioner (LIP) who is primarily responsible for the care of the patient regardless of patient’s status.

“CAPTAIN OF THE SHIP” is the attending physician and is responsible for the coordination of care for the patient.

“CPE” means the Chief Physician Executive.

“CQO” means the Chief Quality Officer.

“CLINICAL PRIVILEGES” means the authorization granted to a practitioner to render patient care and includes access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

“DISCHARGING PHYSICIAN” means the physician/licensed independent practitioner (LIP) who is responsible for discharge orders and discharge summary.

“ELECTRONIC RECORDS AND SIGNATURES”
Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Electronic signature is composed of a statement identifying the signature as electronic, the person’s name, credentials and include the date and time the signature was applied. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

“EMERGENCY” means 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.

“EMD” means the applicable Executive Medical Director.
“HEALTH CARE AGENT” means an individual designated in a health care power of attorney to make health care decisions on behalf of a person who lacks sufficient understanding or capacity to make or communicate decisions relating to health care.

“INVASIVE PROCEDURE” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

“LICENSED INDEPENDENT PRACTITIONER (LIP)” means an appropriately licensed medical physician, osteopathic physician, dentist or podiatrist who has been granted clinical privileges.

“LIFE-PROLONGING MEASURE” means a medical procedure or intervention, which in the judgment of the attending physician, would serve only to postpone artificially the moment of death by sustaining, restoring or supplanting a vital function, including mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and similar forms of treatment. Life-prolonging measures do not include care necessary to provide comfort or to alleviate pain.

“MEDICAL RECORD” means the complete record of the patient’s care maintained within the WakeMed electronic health record (EHR).

“PATIENT” means as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

“PHYSICIAN” means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the North Carolina Medical Board and who has a current valid license to practice medicine and/or surgery in North Carolina.

“PRACTITIONER” means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or Provider with Supervised Privileges who has been granted clinical privileges.

“PROVIDER WITH SUPERVISED PRIVILEGES” or “PSP” means those individuals who are Advanced Practice Registered Nurses (such as Certified Registered Nurse Anesthetists (CRNAs), Anesthesiology Assistants, (AAs), Nurse Practitioners (NPs), Nurse Midwives or Clinical Nurse Specialists) Physician Assistants (PAs) or Anesthesiologist Assistants.

QUALIFIED MEDICAL PERSONNEL” or “QMP” means providers who can act as qualified medical personnel under EMTALA as determined by the Medical Staff and the Hospital. These categories are set forth in the Administrative Policy entitled EMTALA - Qualified Medical Personnel.

“SURGEON/PROCEDURALIST” refers to any practitioner performing any operation or invasive procedure on a patient, and is not limited to members of the Department of Surgery.

“UNABLE TO CONSENT” or “INCOMPETENT” means unable to appreciate the nature and implications of the patient’s condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. Under most circumstances, unless a minor is married or has been determined judicially to be emancipated, a minor cannot consent. The NC statutory exception permits unemancipated/unmarried minors to consent under the following circumstances: medical services for the prevention, diagnosis and treatment of venereal disease and other communicable diseases
reportable under N.C. General Statutes §130A-135, pregnancy (other than for an abortion - see WakeMed’s Administrative-Corporate Policy, Informed Consent), abuse of controlled substances or alcohol, and emotional disturbance. WakeMed system personnel may not discuss these medical services with parent(s), guardian, person standing in loco parentis, or a legal custodian without the permission of the minor unless the physician has determined that the situation in his/her opinion indicates that notification is essential to the life or health of the minor and the physician has notified the parent(s), guardian, person standing in loco parentis/legal custodian. However, if the parent, guardian, or person standing in loco parentis contacts the physician concerning the treatment provided to the minor, the physician may—but is not required to—give information.

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.
1.2 APPLICABILITY
These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff members and other individuals exercising clinical privileges.

1.3 CONFLICT WITH HOSPITAL POLICY
Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

1.4 AMENDMENT
These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.

1.5 ADOPTION
This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

ARTICLE II - ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General
The hospital accepts short term patients for care and treatment provided suitable facilities are available.

A. Admitting Privileges: A patient may be admitted to the hospital only by a Medical Staff member with admitting privileges.

B. Admitting Diagnosis: Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been established and recorded in the medical record. In the case of emergency, such statement will be recorded as soon as possible.

C. Admission Procedure: Planned admissions must be scheduled with the Hospital’s admissions department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the admitting physician/LIP or designee shall contact the Hospital’s admissions department to ascertain whether there is an available bed.

2.1.2 Admission Priority
Admission of scheduled patients may need to be prioritized based on bed availability, consistent with Hospital policy. Pursuant to Hospital policy, admission status (inpatient, outpatient, or observation [a subset of outpatient status]) will be defined by CMS policy, Medicaid rules, or private payer policy, as applicable, and determined by physician/LIP order. Physicians/LIPs must designate admission status in admission orders. Admission status determinations may be reviewed for conformity with applicable requirements, consistent with Hospital policy and the WakeMed Utilization Management Plan.
2.2 ON-CALL EMERGENCY PATIENT RESPONSIBILITIES

2.2.1 EMTALA Requirements
The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

2.2.2 Definition of Unassigned Patient
The patient is unassigned if there is no established patient-physician relationship with a physician with admitting privileges at WakeMed. Patients who present to the Emergency Department and require admission and/or treatment shall have a physician assigned by the Emergency Department physician, based on the call list, if one or more of the following criteria are met:

A. the patient does not have a primary care physician or does not indicate a preference;
B. the patient’s primary care physician does not have admitting privileges;
C. the patient’s injuries or condition fall outside the scope of the patient’s primary care physician and there is no established specialist relationship.

2.2.3 Unassigned Call Service
A. Unassigned Call Schedule: Each staff member, consistent with granted clinical privileges, must participate in the on-call coverage of the Emergency Department, or in other hospital coverage programs, as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community. The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Medical Staff Services will coordinate with the Department Chairs to establish a roster of physicians/LIPs responsible for taking Emergency Department call. The time frame for emergency call shall be determined by the Department. If the Department does not define this, the default timeframe is from 0800 to 0800 the following day. It is also noted that the unassigned call list will be used as a default when (inpatient) consultation is requested and no physician/LIP will voluntarily accept the consult.

B. Response Time: It is the responsibility of the on-call physician/LIP to respond in an appropriate time frame. The on-call physician/LIP should respond to calls from the Emergency Department within thirty (30) minutes, and must arrive at the Hospital to evaluate the patient within sixty (60) minutes if clearly requested by the Emergency Department physician. If the on-call physician/LIP does not respond to being called or paged, the physician’s/LIP’s Department Chair or Vice Chair shall be contacted. EMTALA requires an on-call physician/LIP must respond when asked to do so by the Emergency Department physician, or designee. Failure to respond in a timely manner may result in the initiation of disciplinary action.

C. Substitute Coverage: It is the on-call physician’s/LIP’s responsibility to arrange for coverage by a medical staff member with appropriate privileges and to notify the Emergency Department if he is unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.
2.2.4 Patients Not Requiring Admission
In cases where the Emergency Department consults with the on-call physician/LIP and no admission is deemed necessary by both the Emergency Department physician and the on-call physician/LIP, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician’s/LIP’s responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit if indicated. Primary care follow-up will be through a list of available primary care physicians, as appropriate.

2.2.5 Unassigned Patients Returning to the Hospital
Unassigned patients, who present to the Emergency Department, after having been previously discharged from the Emergency Department more than fourteen (14) days after the previous discharge, will be referred to the physician/LIP taking unassigned call that day. Unassigned patients, who have been admitted to the hospital and who return with the same episode of illness to the Emergency Department within fourteen (14) days following discharge, will be the responsibility of the previous admitting physician.

2.2.6 Guidelines for Department Policies on Unassigned Call
Pursuant to the Medical Staff Bylaws, Departments may adopt rules, regulations, and policies that are binding on the members of their Department. The following rules should be used in developing Department policies regarding unassigned emergency call obligations:

A. Unassigned call duties should be based on the medical staff member’s clinical privileges; medical staff members are expected to serve on the unassigned call roster regardless of their staff category.

B. Unassigned call duties shall be apportioned equally among all eligible Department members unless other arrangements have been developed and agreed to and endorsed by the MEC.

C. Unassigned call duties may be divided by division, specialty, or subspecialty. Call schedules that involve different specialties and/or departments shall be coordinated by appropriate department chairs working collaboratively to create an equitable schedule. Inability to agree on an equitable schedule will result in the MEC creating the schedule.

D. Physicians/LIPs may request exemption from unassigned call based on reaching the age of fifty-five (55) and having served at least twenty (20) years of unassigned call. Exemptions are not automatic and must be approved by the Department, the Medical Executive Committee, and the Board. These policies must be consistently applied, and shall not compromise the Department’s ability to fulfill the Hospital’s EMTALA obligations.

E. Any impairment claimed by a medical staff member to limit ability to take unassigned call shall also be considered grounds for limiting their ability to care for all patients.

F. Department rules and regulations concerning unassigned call must be approved by the Medical Executive Committee.

G. The unassigned call list will also be used as a default for inpatient consultations if no one will accept the inpatient consultation voluntarily.
2.2.7 Treating Family Members
WakeMed endorses the North Carolina Medical Board’s position statement regarding self-treatment and treatment of family members. It reads: “It is the Board’s position that it is not appropriate for licensees to write prescriptions for controlled substances or to perform procedures on themselves or their family members. In addition, licensees should not treat their own chronic conditions or those of their immediate family members or others with whom the licensee has a significant emotional relationship. In such situations, professional objectivity may be compromised, and the licensee’s personal feelings may unduly influence his or her professional judgment, thereby interfering with care.

There are, however, certain limited situations in which it may be appropriate for licensees to treat themselves, their family members, or others with whom the licensee has a significant emotional relationship.

1. Emergency Conditions. In an emergency situation, when no other qualified licensee is available, it is acceptable for licensees to treat themselves or their family members until another licensee becomes available.

2. Urgent Situations. There may be instances when licensees or family members do not have their prescribed medications or easy physician access. It may be appropriate for licensees to provide short term prescriptions.

3. Acute Minor Illnesses Within Clinical Competence. While licensees should not serve as primary or regular care providers for themselves or their family members, there are certain situations in which care may be acceptable. Examples would be treatment of antibiotic-induced fungal infections or prescribing ear drops for a family member with external otitis. It is the expectation of the Board that licensees will not treat recurrent acute problems.

4. Over the Counter Medication. This position statement is not intended to prevent licensees from suggesting over the counter medications or other non-prescriptive modalities for themselves or family members, as a lay person might.

This will be the position of the medical staff unless anything described above is disapproved by NC statute, regulation or North Carolina Medical Board position statement. In that event, the Medical Staff Rules & Regulations will automatically conform to the updated language of the statutes, regulations, or North Carolina Medical Board position statement.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities
WakeMed must accept transfers from other facilities if the Hospital has the capability to care for the patient, including the capacity to do so in a safe manner, and the higher level of care offered by WakeMed is needed and requested. Transfers must comply with Hospital policy.

2.3.2 Transports/Transfers within the WakeMed System
Movement of patients for Apex Healthplex and other free-standing facilities under the Cary CMS provider number to Cary Hospital and from WakeMed North, Brier Creek, and other free-standing facilities under the Raleigh CMS provider number to Raleigh Campus is considered internal transport rather than transfer. If a patient is moved between facilities with different CMS provider numbers, then the movement is considered a transfer and must comply with Hospital policy on transfers.

2.3.3 Transfers to Another Hospital
Patients who are transferred to another hospital outside the WakeMed System must comply with the Hospital policy on transfers.
2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS
The practitioner shall provide the Hospital with necessary information about any patients who is a danger to him/herself or others so that reasonable measures can be implemented to prevent the patient from harming self and others. Acute care admissions of suicidal patients will not be accepted except for those patients requiring medical stabilization. Once the patient’s medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility. Observation status may be used temporarily for acutely suicidal patients without medical complications who cannot be placed safely elsewhere.

2.5 PROMPT ASSESSMENT
Patients newly admitted, excluding newborns, must be seen by the physician/LIP or designee (PSP or resident) within twelve (12) hours. Patients newly admitted, excluding newborns, must be personally examined and evaluated by the admitting physician or a designated covering physician/LIP as soon as possible within the first 24 hours of the patient’s admission. Patients admitted to or transferred to the critical care units must be seen by the physician or designee (PSP or resident) within two (2) hours of arrival to the unit.

2.6 DISCHARGE PLANNING
Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.7 DISCHARGE TIME
Patients shall be discharged only by order of the attending physician, or their designees. Discharge should be encouraged as soon as the patient no longer meets inpatient criteria.

ARTICLE III - MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS
The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. An adequate medical record will be maintained for every inpatient, outpatient (including observation patient), or emergency patient. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. The contents will be pertinent, accurate, complete, legible, current, and age specific. Only authorized individuals may have access to and make entries into the medical record.

3.1.1 Electronic Documentation
In order to facilitate access, portability, analysis, and clinical decision support, the medical record will be housed within the organization’s electronic health record (EHR). All entries in the medical record will be entered through the EHR. Handwritten documentation will not be accepted as part of the medical record except when access to the EHR is unavailable (downtime) or in limited defined circumstances (see below).

3.1.1.1 Exception for Pre-procedural History & Physical
Providers who do not use the WakeMed EHR as their office EHR may submit a dictated or office-generated EHR complete pre-procedural history and physical that may be scanned into the EHR.
3.1.2 Dictation
Telephone dictation (without the use of the EHR) will only be accepted for procedural reports.

3.1.3 Downtime Documentation
If the EHR is unavailable, documentation in the medical record should continue. Paper forms will be available for handwritten documentation if needed. Documentation should resume in the EHR as soon as it is available and prior downtime documentation will be scanned for inclusion in the EHR. All handwritten entries in the medical record shall be made in ink and shall be clear, complete, legible, dated, timed, and authenticated.

3.2 AUTHENTICATION
Entries in the electronic medical record are attributed to the user entering them by means of their login credentials. Any entry in the medical record under another user’s credentials is indistinguishable from that user’s true entries, therefore sharing and use of another user’s network credentials is never permitted. Please refer to WakeMed policy “Acceptable Usage of Information Systems.”

3.3 ABBREVIATIONS AND SYMBOLS
The use of abbreviations in the medical record must be consistent with WakeMed’s Unacceptable Abbreviations Policy.

3.4 CORRECTION OF ENTRIES
Once a note has been entered in the EHR and signed, it may not be altered. Errors may be corrected by creating an Addendum for the note, or it may be deleted, after providing a reason for doing so, and re-entered. Paper entries during a down time may be corrected with a single line drawn through the erroneous entry and authenticated with the practitioner’s signature and the date and time.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION
3.5.1 Time Limits
A medical history and appropriate physical examination must be conducted and documented in the medical record no more than thirty (30) days before or twenty-four (24) hours after a hospital inpatient or observation admission or no more than thirty (30) days before a surgical procedure.

3.5.2 Who May Perform and Document the History and Physical Exam
The History and Physical examination shall be performed and recorded by:

A. a doctor of medicine or osteopathy,
B. for patients undergoing dental surgery, by a dentist or an oral and maxillofacial surgeon with history and physical examination privileges,
C. for patients undergoing podiatric surgery, by a podiatrist with history and physical examination privileges, or
D. other qualified PSP in accordance with State law and hospital policy.

3.5.3 Compliance with Documentation Guidelines
A. A complete History and Physical should be documented for all admissions, observations stays, for any high-risk patient undergoing an outpatient interventional procedure or any outpatient undergoing a procedure that requires anesthesia (general, regional or MAC). The History and Physical documentation must include the following information:
1. Chief complaint or reason for the admission or procedure;
2. A description of the present illness;
3. Relevant past (age-appropriate) social and family history;
4. Past medical history, including allergies, current medications, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
5. Relevant review of systems;
6. Relevant physical findings;
7. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care;
8. Clinical impression or diagnosis; and

3.5.4 Responsibility for the History and Physical Examination
Completion of the patient’s history and physical examination is the responsibility of the admitting physician or designee.

3.5.5 Update to the History and Physical Examination
If a History and Physical examination has been performed and documented within thirty (30) days of the patient’s admission or procedure, examination of the patient needs to occur and the results, to include any change to the patient’s condition, must be entered in the medical record no more than 24 hours after admission and immediately prior to surgery/procedure.

3.5.6 Medication Reconciliation
A. Medication Reconciliation* is a requirement for admission, transfer, and discharge whenever meds are administered or prescribed.
   1. Use “Navigators” in Epic to accomplish reconciliation on admission, transfer, and discharge.
   2. Post-procedure, if transfer reconciliation is not done then medications will be placed on "MAR Hold".

B. Post-procedure orders are to be entered after the procedure, not prior to the procedure.

3.6 PREOPERATIVE DOCUMENTATION
3.6.1 Policy
Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:
A. all invasive procedures performed in the Hospital’s surgical suites;
B. certain procedures performed in the Radiology Department and Cath Lab (angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator implantation, electrophysiologic studies, and ablations); and
C. certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).
3.6.2 Procedure

A. **Inpatient/Observation Patient who Subsequently Requires Surgery or Other Invasive Procedure:** The surgeon/proceduralist should enter a preprocedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient’s condition since the History and Physical. If there are no changes in the patient’s condition based on examination, this should be specifically noted. A History and Physical must be conducted and documented prior to the surgery/procedure as described in section 3.6.

B. **New Inpatient/Observation Patient Surgical/Procedural Admission:** The attending physician or other practitioner must document a History and Physical examination as described in section 3.6. If the History and Physical examination is performed by a physician/practitioner other than the surgeon/proceduralist (e.g., the patient’s attending physician or a consulting physician) the surgeon/proceduralist should enter a preprocedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any pertinent changes in the patient’s condition since the History and Physical examination. If there are no changes in the patient’s condition based on examination, this should be specifically noted.

C. **Outpatient Treatment or Surgery/Procedure:** The physician/practitioner should complete a History and Physical (described in section 3.6) that may include a focused physical examination focused appropriately to correspond to the planned treatment or procedure and include elements in section 3.6.3(B).

D. **Outpatient Surgery/Procedural Patient Subsequently Assigned to Observation Status or Admitted to Inpatient Status:** The surgeon/proceduralist should have already completed a History and Physical. If a focused History and Physical was completed for the surgery/procedure, upon admission to inpatient status, a History and Physical Examination as described in section 3.6 must be documented within 24 hours by the attending physician or designee, specifically addressing changes in the patient’s condition, based on examination, since completion of the Focused Preoperative History and Physical Form. Patients scheduled for surgery via outpatient surgery with planned admission must have a complete history and physical documented prior to surgery.

3.7 **PROGRESS NOTES**

A physician, usually the attending physician, or another practitioner involved in the patient’s care will record a progress note each day (unless patient is awaiting disposition to an alternate level of care), and at the time of each patient encounter on all hospitalized patients. Progress notes should document:

A. the reason for continued hospitalization;

B. the estimated period of time the patient is expected to remain in the hospital, when applicable; and

C. plans for post-hospital care near the time of the anticipated discharge.

It is noted that residents or Providers with Supervised Privileges may make rounds and record daily progress notes. It is expected that the supervising physician will be involved in the initial assessment and as needed throughout the course of hospitalization.

3.8 **OPERATIVE/PROCEDURE REPORTS AND NOTES**

An operative/procedure note must be documented in the EHR immediately following the surgery/procedure. The brief operative/procedure note includes, at minimum:
A. the name of the surgical procedure,
B. a detailed account of the findings at surgery,
C. the technical procedures used,
D. the tissues removed or altered,
E. estimated blood loss,
F. the post-operative diagnosis, and
G. the name of the primary surgeon and any assistants.

If a complete operative/procedure note is created in the EHR, then no further documentation is required. If not, then a complete operative/procedure report including all of the above items, plus a detailed report of the procedure should be dictated immediately before patient arrives at PACU.

3.9 POST ANESTHESIA DOCUMENTATION
A post anesthesia note must be completed within the first forty-eight (48) hours after the conclusion of anesthesia services (including MAC, regional and general anesthesia). This note should be done after the patient has awakened sufficiently to participate in the assessment, if possible. The note must be completed by a person privileged to provide anesthesia services. The post anesthesia note shall contain the following elements:

A. Respiratory function including respiratory rate, airway patency and oxygen saturation;
B. Cardiovascular function including heart rate and blood pressure;
C. Mental status;
D. Temperature;
E. Pain;
F. Nausea and vomiting; and
G. Postoperative hydration status.

3.10 CONSULTATION REPORTS
Consultation reports should be completed within 24 hours, unless mutual agreement between providers, and should answer the question of the requesting physician. See section 4.4 for expectations regarding consultations.

3.11 OBSTETRICAL RECORD
The obstetrical record must include a medical history, including a complete prenatal record, if available, and an appropriate physical examination. Admissions for caesarian-section delivery and vaginal delivery followed by tubal ligation procedure require a History and Physical Examination as described in section 3.5.

3.12 DISCHARGE ORDERS AND INSTRUCTIONS
Patients will be discharged or transferred only upon the order of the attending physician or designee who will complete the following actions in the EHR:

A. Review any pending lab results.
B. Reconcile all hospital and pre-admission medications for discharge.
C. E-prescribe or print any discharge prescriptions (if applicable).
D. Review the discharge medication list for accuracy.
E. Order any additional referrals such as physical therapy and home health services.
F. Order any needed medical equipment or supplies.
G. Review and update the patient’s problem list to indicate the final diagnoses for
which the patient was treated.

H. Complete a discharge summary.
I. Provide (or assist Hospital personnel in providing) any specific instructions for the patient in a form that can be clearly understood by the patient and all caregivers and includes, if applicable:
   1. Dietary instructions and modifications.
   2. Instructions for pain management.
   3. Medical equipment and supplies.
   4. Any restrictions or modifications of activity.
   5. Follow up appointments and continuing care instructions.
   6. Recommended lifestyle changes, such as smoking cessation.

3.13 FINAL DIAGNOSES
The final diagnoses will be recorded in full in a final progress note or discharge summary and updated in the patient’s problem list at the time of discharge, transfer, or death of the patient. In the event that pertinent diagnostic information has not been received at the time the patient is discharged, the practitioner will be required to document such in the patient’s record. Once the pending diagnostic information has been received and a definitive diagnosis has been made, the practitioner will be required to document the diagnostic findings and final diagnosis in the patient’s medical record.

3.14 DISCHARGE SUMMARIES
The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. Discharge summaries are required to be completed in the EHR for inpatients with a complicated stay, with an inpatient-stay greater than 48 hours, for patients who are transferred, or for patients who expire regardless of the length of stay. All discharge summaries will be authenticated by the discharging physician/LIP.

A. **Content:** A clinical summary will be completed in the EHR upon the discharge or transfer of patients described above. The discharge summary is the responsibility of the discharging physician (or designee) and will contain:
   1. Reason for hospitalization;
   2. Summary of hospital course, including significant findings, any procedures performed, consultations performed, and treatment rendered;
   3. Condition of the patient at discharge;
   4. Instructions given to the patient and family, including medications, referrals, and follow-up appointments; and
   5. Final diagnoses.

B. **Short-term Stays:** An abbreviated discharge summary will be completed in the EHR for observation stays and uncomplicated inpatient hospital stays of less than 48 hours, uncomplicated vaginal deliveries, uncomplicated caesarean sections, and normal newborn infants, which includes at least the following:
   1. The condition of the patient at discharge;
   2. Final diagnoses; and
   3. Instructions given to the patient and family, including medications, referrals, and follow-up appointments.

C. **Deaths:** A clinical summary is required on all inpatients or observation patients who expired. The summary will include:
1. Reason for admission;
2. Summary of hospital course;
3. Date and time of death; and
4. Final diagnoses.

D. **Timing:** A Discharge Summary or discharge note should be entered in the medical record within forty-eight (48) hours of discharge or death. A discharge summary must be entered in the completed record prior to a patient’s transfer.

### 3.15 DIAGNOSTIC REPORTS

Inpatient and observation patient diagnostic reports (including but not limited to EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read and reported by the physician scheduled to provide the interpretation service within 24 hours of the test being available to read. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

### 3.16 PROVIDERS WITH SUPERVISED PRIVILEGES

The attending or supervising physician will review the care rendered by all PSPs working with them. No co-signature of orders or medical records entries is required, with the exception of the discharge summary. See section 4.7 of this document for additional information regarding PSP supervision.

### 3.17 ACCESS AND CONFIDENTIALITY

A patient’s medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient. Records will not be removed from the Hospital’s jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

A. **Access to Old Records:** In case of readmission of a patient, all previous records will be made available to the admitting physician whether the patient was attended by the same physician/LIP or by another physician/LIP.

B. **Access for Medical Research:** Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient in compliance with HIPAA regulations. All such projects must have prior approval of the Institutional Review Board. A medical records request form will be presented to the Director of the Health Information Management Department by the study sponsor or their designee prior to records being made available.

C. **Access for Former Members:** Whenever legally appropriate, former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

### 3.18 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed as incomplete by the Medical Executive Committee.

#### 3.18.1 Suspension of Clinical Privileges for Incomplete Records

A. All portions of the medical record of a patient are to be completed by the responsible practitioner within twenty-one (21) days of discharge. A Department Chair may require a record to be prepared within a shorter timeframe, including immediately, if he deems it necessary for the welfare of the patient.
B. A practitioner with an incomplete record(s) will be notified that the record is available for completion.

C. Twenty-one (21) days after discharge, the incomplete medical record is considered a delinquent record. A practitioner with a delinquent medical record is notified via a letter from the CQO or designee, that automatic suspension has occurred in accordance with the Medical Staff Bylaws. Notification of the suspension will be forwarded to the operating room, the Call Center, and the Medical Staff Services office.

D. The CQO or the President of the Medical Staff, for good cause shown, may waive imposition of a suspension by extending the period of completion of a medical record for a defined number of days not to exceed thirty (30) days. Generally, a ‘good cause’ that must be shown by the practitioner is an unexpected, unplanned, exceptional circumstance necessitating the practitioner’s absence from routine practice.

3.18.2 General Rules Regarding Medical Record Delinquency

A. In determining medical record delinquency and enactment of suspension of medical staff privileges, considerations will be given for vacations provided that the Health Information Management Department is notified prior to the date of the vacation and all available records are completed at the time the practitioner gives notice of vacation.

B. Delinquent records will result in the suspension of the physician’s/LIP’s privileges to admit patients, consult on patients or post surgery.

C. It is the responsibility of the delinquent physician/LIP to notify the Health Information Management Department when documentation is completed.

D. During the suspension of privileges, surgery can be posted or a patient can be admitted if the delinquent physician/LIP declares the action is necessary due to the emergent need of the patient. This should be documented in the patient’s medical record.

E. If a physician/LIP demands admission of a patient despite suspension of his or her privileges and appointment, Hospital personnel will direct the physician/LIP to contact his or her Department Chair, the President of the Medical Staff, or the CQO or appropriate EMD, who may consider allowing the admission in an emergency situation.

F. No references will be provided for any practitioner who leaves the staff until all medical records are complete.

ARTICLE IV - STANDARDS OF PRACTICE

4.1 ADMITTING PHYSICIAN
The admitting physician or designee (PSP or resident) is responsible for completing the history and physical within the time frames described in section 3.6.

4.2 ATTENDING PHYSICIAN
4.2.1 Responsibilities
Each patient admitted to the Hospital shall have an attending physician/LIP who is a Medical Staff member with admitting privileges. The attending physician/LIP will be responsible for:

A. the medical care and treatment of each patient in the Hospital;
B. coordinating care among any consulting practitioners;
C. the prompt, complete, and accurate documentation of the medical record; and
D. necessary special instructions regarding the care of the patient.

When appropriate to the patient’s condition and authorized by the supervising physician, a resident or PSP may perform these tasks when privileged or authorized to do so.

4.2.2 Identification of Attending Physician
At all times during a patient’s hospitalization, the identity of the attending physician shall be clearly documented in the medical record. If the attending physician changes during the hospitalization, the medical record must be appropriately updated to reflect the change.

4.2.3 Requests for Transferring Attending Responsibilities
If there is a request for change of attending physician, other than for routine changes of coverage with a group, there must be an order and documentation that the new attending has agreed to assume care of the patient.

4.3 ORDERS
4.3.1 General Principles
A. All orders for treatment will be entered in the electronic health record.
B. Handwritten or faxed orders will not be accepted except under the following conditions:
   1. The electronic record is unavailable for use.
   2. Pre-operative orders from providers who do not use the WakeMed EHR in their office. These must be generated from another EHR or otherwise typewritten/computer-generated.
   3. Chemotherapy.
C. Orders must be clear and unambiguous.
D. All orders must be specifically given by practitioners who have been granted privileges or by residents.
E. Vague or “blanket” orders (such as “continue home medication” or “resume previous orders”) will not be accepted.
F. Instructions should be in plain English. Prohibited abbreviations may not be used.
G. Orders may be received and executed only by an authorized individual as defined by hospital policy.
H. Orders are authenticated and attributed to the provider based on his/her login credentials to the electronic health record. Providers may not share login credentials under any circumstances.

4.3.2 Verbal (including telephone) Orders
Verbal orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it via computer. Verbal orders must comply with the following criteria:
A. The order must be given to an authorized individual per Hospital policy.
B. Verbal orders should be dictated slowly, clearly, without prohibited abbreviations to avoid confusion.
C. The order must be read back to the prescribing practitioner by the authorized person receiving the order.
D. Any alerts generated by the orders must be addressed by the provider.

E. All verbal orders must be signed by the ordering practitioner or another practitioner involved in the patient’s care. Failure to authenticate such orders will cause the record to be incomplete and can lead to suspension.

F. The following orders may not be given verbally:
   1. Orders for cancer chemotherapy;
   2. An order to withhold or withdraw life support.

G. Orders for admission will not be accepted verbally, however approved “Bridging Admission Orders” may be used under the following circumstances:
   1. The provider is in a lengthy OR case.
   2. The provider does not have access to a computer.
      The provider will still perform medication/order reconciliations within two hours for ICU admissions and within eight hours for non-ICU admissions.

4.3.3 Faxed Orders
Orders transmitted by fax shall be considered properly authenticated and executable provided that:
   A. The fax is legible and received as it was originally transmitted by fax or computer;
   B. The order is legible, clear, and complete
   C. The identity of the patient is clearly documented by full name and date of birth;
   D. The fax contains the name of the ordering practitioner, a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;
   E. The original order, as transmitted, is signed, dated, and timed; and
   F. The fax, as received, is signed by the attending physician or ordering practitioner within twenty-one (21) days of discharge.

4.3.4 Reconciliation of Orders Following Surgery or Transfer
All previous orders must be reconciled when the patient:
   A. goes to surgery (excluding specific procedures as listed in hospital policy),
   B. is transferred to a critical care area,
   C. is transferred to a general medical unit from a critical care area, or
   D. is transferred to, and readmitted from, another hospital or health care facility.

Instructions to “resume previous orders” will not be accepted.

4.3.5 Range Orders
Range orders should be used sparingly. Range orders may only have range of dose with particular conditions in which to use these orders. Range orders greater than two-fold (e.g., 2-4mg) will not be accepted.

4.3.6 Drugs and Medications
   A. Hospital Formulary: To assure the availability of quality pharmaceuticals at a reasonable cost, practitioners shall comply with the formulary system established by the Medical Executive Committee upon the recommendation of the Pharmacy Director, the Pharmacy and Therapeutics Committee, and MSQI Committee. Any practitioner may submit a request for addition of a drug to the Hospital formulary
prior to its need. These requests shall be submitted to the Pharmacy Director. Drug will be added to, or removed from, the formulary based on evidenced-based criteria.

B. **Substitution**: Medication orders written for trade-name drugs may be dispensed as the formulary generic drug unless the physician specifically writes “Do Not Substitute” on the patient order sheet. The Medical Executive Committee shall approve policies concerning automatic therapeutic substitution upon the recommendation of the Pharmacy Director, the Pharmacy and Therapeutics Committee, and MSQI Committee.

C. **Approved Drugs**: Only drugs and medications listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations may be administered to patients in the Hospital, the only exception being drugs for bona fide clinical investigation.

D. **Investigational Drugs**: Investigational drugs shall be used in full accordance with the guidelines established by the Hospital’s Institutional Review Board, and shall comply with all regulations of the US Food and Drug Administration and Drug Enforcement Administration.

E. **Controlled Substances**: Only practitioners holding a currently valid DEA (Drug Enforcement Agency) Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category.

F. **Definition of a Complete Order**: All medication orders shall include the drug name, the dosage, the route of administration, the schedule of administration, and if appropriate, the date and time of discontinuation. If appropriate, a dilution and rate of administration should be specified. All medication orders that are incomplete will be called to the attention of the ordering practitioner for clarification prior to being dispensed.

G. **Nomenclature**: When ordering medications, standard nomenclature must be employed, using the United States Adopted Names-approved generic name, the official name, or the trademarked name (if a specific product is required). Prohibited abbreviated names and symbols should not be used.

H. **Dosing Formats**: SI (metric system) units must be used in medication orders except for therapies that use standard units (such as insulin and vitamins). Exact dosage strengths (such as milligrams) shall be used rather than dosage form units (such as “vials” or “ampules”). Apothecary and avoirdupois system units (i.e., grains, drams, minimis, ounces) shall not be used. A leading “0” must precede a decimal expression of less than one (e.g., 0.5 mL). A terminal “0” (e.g., 5.0 mL) following an integer should not be used. The use of decimals should be avoided when possible (e.g., prescribe 500 mg instead of 0.5 g).

I. **Hold Orders**: Instructions to “hold” a medication should be specific and must include the name of the medication to hold and the number of doses to hold. If it is uncertain that a medication will be resumed, a “stop” or “discontinue” order should be given.

J. **PRN Orders**: “PRN” or “as needed” orders must be qualified by listing the indication for the medication.

K. **Adverse Drug Events**: Significant adverse drug events are reported immediately to the prescribing practitioner and aggregate data is reviewed by the Pharmacy & Therapeutics Committee.

L. **Automatic Stop Orders**: Orders for narcotics expire automatically after seventy-two (72) hours and must be renewed every three (3) days. Orders for all
parenteral antibiotics must be renewed every five (5) days and for all other antibiotics every ten (10) days. This rule does not apply to orders designating a specific number of doses or a termination date. No medications are to be discontinued without the attending physician being notified.

4.3.7 Stat" Orders
“Stat” or “now” orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. “Stat” and “now” orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of “stat” and “now” orders may be grounds for corrective action.

4.4 CONSULTATION
Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges. The attending physician will either request the consultation through provider-to-provider communication or provide authorization requesting the consultation and permitting the consulting practitioner to attend or examine the patient. The consultation request should include the reason for the consultation and the requested timeframe of consultation completion. The consulting practitioner should not request additional consultations unless agreed upon by the attending physician.

4.5 CRITICAL CARE UNITS
4.4.1 Critical Care Unit Admissions
Attending physicians of patients in a critical care unit are responsible for following unit policy regarding appropriateness for continued stay. Any conflicts regarding this will be evaluated by that unit’s medical director.

4.4.2 Prompt Evaluation of Critical Care Patients
Each patient admitted or transferred to a critical care unit shall be examined by a physician or physician’s PSP within two (2) hours.

4.4.3 Critical Care Services
Certain services and procedures may be provided to patients only in critical care units. The Medical Executive Committee will work with Hospital Administration to establish policies that specify which services may only be provided in a critical care unit.

4.6 DEATH IN HOSPITAL
4.5.1 Pronouncing and Certifying the Cause of Death
In the event of a hospital death, the deceased will be pronounced by a physician. For DNR/Hospice patients, the nurses may call the physician with specific signs/symptoms of death and document in the record. The physician may make a determination of death based on the two nurses’ assessments. A member of the organ harvesting team may not pronounce death. The physician pronouncing death will document the date and time of death in the patient’s medical record. The attending physician or designee (PA or NP, when appropriate) at time of death is responsible for certifying the cause of death and completing the Death Certificate within five (5) business days.
4.5.2 Organ Procurement
When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable per the Anatomical Gift Policy.

4.7 AUTOPSY
Refer to WakeMed’s Autopsy and Medical Examiner Policy.

4.8 SUPERVISION OF PROVIDERS WITH SUPERVISED PRIVILEGES

4.8.1 Definition of Dependent Practitioners
Providers with Supervised Privileges (PSPs), including Clinical Psychologists, Advance Practice Registered Nurses (CRNAs, Nurse Midwives, Nurse Practitioners and Clinical Nurse Specialists providing patient care), Anesthesiology Assistants, and Physician Assistants, are licensed or certified health care practitioners. The qualification and prerogatives of PSPs are defined in the Medical Staff Bylaws. PSPs may provide patient care only under the supervision of a Medical Staff member with privileges.

4.8.2 Guidelines for Supervising Providers with Supervised Privileges
A. The physician is responsible for managing the health care of patients in all settings, including care provided by PSPs.
B. Health care services delivered by physicians and by PSPs under their supervision must be within the scope of each practitioner’s granted privileges and licensure.
C. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the PSP, ensuring the quality of health care provided to patients.
D. The role of the PSP in the delivery of care shall be defined through mutually agreed upon practice guidelines developed by the physician and the PSP. The supervising physician and a PSP shall agree in advance upon any procedures that the PSP is authorized to perform without a supervising physician present.
E. The physician must be available for consultation with the PSP at all times, either in person or through telecommunication systems or other means. The supervising physician must see and evaluate patients when requested by the PSP.
F. The extent of the involvement by the PSP in the assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition and the training, experience, and preparation of the PSP, as determined by the physician.
G. PSPs are responsible to clearly identify themselves as PSP.
H. The physician and PSP together should review all delegated patient services on a regular basis, as well as the mutually agreed upon practice guidelines.
I. Each supervising physician is responsible for clarifying and familiarizing the PSP with his or her supervising methods and style of delegating patient care.
J. Each PSP must document the identity of their supervising or collaborating physician and one or more alternate supervising physicians.

4.8.3 Supervising Physician
A PSP may not provide services to patients if the supervising physician is out-of-state or is not available within thirty (30) minutes by telephone or within sixty (60) minutes travel time from the Hospital. A physician may not supervise more than four (4) PSPs at any one point in time.
A Medical Staff member who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of a PSP shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.8.4 Medical Record Documentation
PSPs may enter progress notes and enter orders within the scope of their licensure, clinical privileges, written supervision agreement, and in furtherance of the hospital’s informed consent policy.

4.9 INFECTION PREVENTION AND CONTROL
Practitioners have an important role in the prevention of nosocomial infection. All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties. An essential part of this program incorporates patient infection prevention measures as well as systems of barrier precautions. Universal Precautions and hand washing are to be used by practitioners for contact with blood, moist body substances, and non-intact skin of all patients, regardless of the patient’s diagnosis. It is WakeMed’s policy that all care givers perform appropriate hand hygiene before and after each patient contact.

4.10 CLINICAL PRACTICE GUIDELINES
Clinical practice guidelines provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. Clinical practice guidelines can also be used in designing clinical processes, or checking the design of existing processes.

The Medical Executive Committee may adopt evidenced-based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

The Medical Executive Committee shall consider such sources as the Agency for Health Care Policy and Research, professional medical societies and physician organizations, professional health care organizations, and local organizations. Guidelines shall be adapted to the community, the needs of the patient population, and the resources of the Hospital. Clinical practice guidelines so adopted must anticipate and capture variance.

ARTICLE V - PATIENT RIGHTS

5.1 PATIENT RIGHTS
All practitioners shall respect patient rights as noted in Hospital Policy.

5.2 INFORMED CONSENT
It is the responsibility of the practitioner performing a procedure to obtain informed consent from the patient, although it may be the responsibility of hospital personnel to document this consent through obtaining the patient’s signature. A resident physician with the service performing the procedure may obtain the patient’s informed consent and sign the applicable consent form. A CRNA or AA may obtain informed consent from the patient and sign the applicable consent form for all anesthesia modalities and related procedures that he/she is privileged to manage. Any other PSP is permitted to obtain a patient’s informed consent and sign the applicable consent form for any procedure which he or she is performing or may perform without the supervising physician...
5.3 ADVANCED DIRECTIVES, WITHDRAWING AND WITHHOLDING LIFE-PROLONGING TREATMENT

All patients treated in the Hospital should be provided appropriate care and support, including life-prolonging treatments, absent contrary instructions from the patient or legal representative. There are circumstances when it is appropriate and ethical to withdraw or withhold life-prolonging treatments in accordance with the wishes, directives, or best interests of the patient. The following Hospital policies should be followed: Advanced Directives/Patient Self Determination Act, Patient’s Right to Natural Death-Written Declaration (Living Will), Natural Death in the Absence of a Declaration, Health Care Power of Attorney policies, and policies for compliance with Medical Orders for Scope of Treatment (“MOST”). Orders for advance directives must be initiated by a physician, or designee.

5.4 DO NOT RESUSCITATE ORDERS

Full resuscitation efforts shall be initiated on all persons who suffer a cardiac or pulmonary arrest on Hospital premises unless a DNR order specifies otherwise. Do not resuscitate orders should follow Hospital policy ‘Do Not Resuscitate Orders’.

5.5 DISCLOSURE OF ADVERSE OUTCOMES

An adverse outcome may be a known risk of a treatment or procedure. A complication or other adverse outcome that is explained during the informed consent process does not constitute an “unanticipated outcome”. When adverse outcomes occur, Hospital policy should be followed.

5.6 RESTRAINTS

Hospital policy ‘Restraint of Patient’ should be followed when ordering restraints and/or seclusion.

5.7 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board.

ARTICLE VI - SURGICAL CARE

6.1 SURGICAL PRIVILEGES

Practitioners may only perform surgery or other invasive procedures as their privileges allow. Specific facility policies dictate where these procedures may be performed.

6.2 ANESTHESIA

Moderate sedation may only be provided by qualified practitioners who have been granted clinical privileges to perform these services as designated in the WakeMed Sedation Policy. This policy also describes which physicians may perform deep sedation and anesthesia and their responsibilities thus.

6.3 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Pathology policy shall describe those specimens that do not warrant tissue appraisal. The pathologist’s report will be made a part of the patient’s medical record.
6.4 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE
Time-out and site-marking protocols are delineated in the Hospital policy ‘Universal Protocol for Prevention of Wrong Site, Wrong Procedure, Wrong Person Surgery’. All procedural practitioners must adhere to this policy.

ARTICLE VII - RULES OF CONDUCT

7.1 Disruptive Practitioners

7.1.1 General
It is the objective of WakeMed medical staffs to ensure optimum patient care by promoting a safe, cooperative, and professional health care environment in which to address the concerns of its patients.

Disruptive behavior includes, but is not limited to, the following:

A. Impertinent or inappropriate comments to patients or entries in the medical record or other official documents that impugn the quality of care delivered by other healthcare professionals and otherwise go beyond the bounds of fair professional conduct;
B. Sexual, ethnic, or other types of harassment, whether verbal or physical in nature;
C. Criticism presented in such a way as to intimidate, humiliate, belittle, and impute stupidity of others;
D. Unprofessional, pejorative, or abusive behavior toward patients, members of their families, nurses, colleagues, and other employees;
E. Imposing requirements on nursing and other staff that have nothing to do with better patient care;
F. Any other behavior that represents an egregious disruption of operations, policies, or medical staff rules.

7.1.2 Reporting of Disruptive Behavior
All reports of disruptive behavior should be submitted in writing as soon as possible after the incident to the appropriate EMD, or designee, and the Department Chair. Once received, a report of disruptive behavior shall then be evaluated by the appropriate Department Chair and EMD or designated representative. The EMD may request the assistance of others (e.g., the CQO, CPE, Senior Vice President of Human Resources, or designee) in performing this evaluation. If an allegation is found to be without merit, it will be dismissed and all records relating to the alleged event shall not become part of the practitioner's file. The individual filing the report and the practitioner in question shall be notified of this decision. Particularly serious offenses may warrant immediate suspension of privileges by those empowered to do so. Furthermore, it may be appropriate to proceed to higher or lower levels of interaction, as described below, with the offending practitioner, or seek recourse as otherwise set forth in the Bylaws and related manuals, at the discretion of the Department Chair, President of the Medical Staff and/or the Administration, depending on the nature or frequency of the alleged offenses. Otherwise, the process shall proceed as follows:

A. First Intervention
If the report is found to be credible, the Department Chair and EMD, or designated representative, should speak privately and informally with the alleged offender. The initial approach should be collegial and designed to be helpful and informative to the alleged offender. It should emphasize that such conduct is inappropriate and therefore must cease. All meetings should be documented using the Intervention
Documentation Form and maintained in the medical staff member’s confidential peer review file.

The following guidelines should be observed with regard to the communication between the medical staff member and the Department Chair and EMD, or designee:

1. Emphasize that if such behavior persists, formal action will be taken to stop it.
2. Document the meeting in the practitioner’s peer review file.
3. Inform the medical staff member that he may submit a rebuttal to the charge. Such rebuttal shall be submitted in writing and will be maintained as part of the physician’s permanent record.
4. Send a follow-up letter to the medical staff member stating the nature of the problem and the need to correct the behavior. This should include a reminder to the medical staff member that he is required to behave in a cooperative, professional manner within the Hospital according to the Medical Staff Bylaws.

B. Second Intervention

If the disruptive behavior continues and is substantiated, the EMD and CQO, Department Chair, and the President of the Medical Staff shall meet with the practitioner to advise that such conduct is intolerable and must stop.

The following guidelines should be observed with regard to the meeting between the medical staff member, the EMD, Department Chair and the President of the Medical Staff:

1. Emphasize that if such behavior persists, formal action will be taken to stop it.
2. Document the meeting in the practitioner’s peer review file.
3. Inform the medical staff member that he may submit a rebuttal to the charge. Such rebuttal shall be submitted in writing and will be maintained as part of the physician’s permanent record.
4. Send a follow-up letter to the medical staff member stating the nature of the problem and the need to correct the behavior. This should include a reminder to the medical staff member that he is required to behave in a cooperative, professional manner with the Hospital according to the Medical Staff Bylaws.

C. Third Intervention

If the disruptive behavior continues and is substantiated, the EMD CQO, Department Chair, the President of the Medical Staff and the WakeMed President or designated representative shall meet with the medical staff member to advise that such conduct is intolerable and must stop. This is not meant to be a discussion but simply a final warning. It shall be followed by a letter from the President of the Medical Staff reiterating the warning. It should be made clear to the offending physician that the next substantiated infraction will result in corrective action, as determined by the MEC, up to and including termination of medical staff membership and privileges.
D. **Fourth Intervention**
Summary suspension of medical staff privileges may result if the pattern of disruptive behavior continues or if a single event is so egregious that it warrants immediate intervention. Corrective action against the practitioner may be initiated as outlined in the Medical Staff Bylaws under ‘Summary Suspension’. The physician shall be entitled to procedural rights as set forth in the Fair Hearing Plan.

7.2 **IMPAIRED PRACTITIONER PROGRAM**

7.2.1 **General**
WakeMed and its medical staff are committed to providing patients with quality care and are aware of their obligation to protect patients from harm. It is recognized that the quality of patient care could potentially be compromised if a member of the medical staff is suffering from impairment. Impairment may result from a physical, psychiatric, or emotional condition. It is the intent of WakeMed and its medical staff to facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.

The purpose of this process is assistance and rehabilitation rather than discipline. The goal is to aid the practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients. Any practitioner shall have the right to refer him/herself to the appropriate EMD or directly to the North Carolina Physician Health Program.

Education of the medical staff and other organization staff about illness and impairment recognition issues specific to physicians shall be conducted periodically.

7.2.2 **Procedure**

A. If any individual has a concern that a member of the medical staff may be impaired in any way that may affect his or her practice at the hospital, a report shall be given to the EMD and/or the Department Chair. The report shall include a factual description of the incident(s) that led to the concern. Every effort shall be made to preserve the confidentiality of the practitioner referred and the referring individual, except as limited by law, ethical obligations, or when the safety of a patient is threatened.

B. Once received, a report shall then be evaluated by the EMD or designated representative. The EMD may request the assistance of others in performing the evaluation.

C. If the report is found to be without merit, it will be dismissed and all records relating to the alleged event shall not become part of the practitioner’s file. The individual filing the report and the practitioner in question shall be notified of this decision.

D. If the report is found to have merit, the EMD will refer the matter to the North Carolina Physician Health Program (NCPHP), or equivalent programs for other licensing boards, for formal evaluation and development of a plan of care. The involved practitioner will be notified of this referral. The involved practitioner will be required to sign a written release allowing NCPHP to provide written confidential monitoring reports to the Director of WakeMed Medical Staff Services at least quarterly. If the involved practitioner does not voluntarily sign a release, the matter may be referred for corrective action pursuant to the Medical Staff Bylaws.

E. If at any time in this process, it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter will be
forwarded to the medical staff leadership for appropriate corrective action pursuant to the Medical Staff Bylaws that includes strict adherence to any state or federally mandated reporting requirements.

Approved by Board of Directors 9/1/2015