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MEDICAL STAFF

RULES AND REGULATIONS

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ARTICLE 1

DEFINITIONS

Except as specifically defined below, the definitions that apply to the terms used in these Rules and Regulations are set forth in Appendix A of the Medical Staff Bylaws:

(a) "Ambulatory Care" means non-emergency health care services provided to patients without hospitalization, including, but not limited to, day surgeries (with or without general anesthesia), blood transfusions, I.V. therapy, and diagnostic care (laboratory, CV testing, and radiology).

(b) "Ambulatory Care Location" means any department in the Hospital or provider-based site or facility where ambulatory care is provided.

(c) "Attending Physician" means the patient's primary treating physician or his or her designee(s), who shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination after the patient is receiving care or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring practitioner, if any, and the patient's family. For purposes of this definition, a treatment relationship between a patient and a physician begins when the physician or his/her appropriately credentialed designated practitioner (i.e., resident or Advanced Practice Provider) has actually evaluated or treated the patient, or has communicated a treatment plan for the patient to another physician or relevant provider. The mere fact that a patient may have scheduled an appointment with a physician, but has not yet been seen by that physician does not establish a treatment relationship.

(d) "Practitioner" means, unless otherwise expressly limited, any appropriately credentialed physician, resident, dentist, oral surgeon, podiatrist, or Advanced Practice Professional, acting within his or her clinical privileges or scope of practice.

(e) "Responsible Practitioner" means any practitioner who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in these Medical Staff Rules and Regulations. These responsibilities include complete and

legible medical record entries related to the specific care/services he or she provides.

ARTICLE 2

ADMISSIONS, ASSESSMENTS AND

CARE, TREATMENT AND SERVICES

2.1. Admissions:

(a) A patient may only be admitted to the Hospital by order of a Medical Staff member who is granted admitting privileges.

(b) Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.

(c) The admitting physician will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

2.2. Responsibilities of Attending Physician:

(a) The attending physician will be responsible for the following while in the Hospital:

(1) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);

(2) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;

(3) communicating with the patient's third-party payor, if needed;

(4) providing necessary patient instructions;

(5) responding to inquiries from Utilization Review professionals regarding the plan of care in order to justify the need for continued hospitalization; and

(6) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate.

(b) At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record. Whenever the responsibilities of the attending physician are transferred to another physician outside of his or her established call coverage, an order covering the transfer of responsibility will be entered in the patient's medical record. The attending physician will be responsible for verifying the other physician's acceptance of the transfer and updating the attending physician screen in the electronic medical record ("EMR").

(c) For admissions that are 20 days or more, or outlier cases, the attending physician (or a physician designee with knowledge of the patient) will complete the physician certification in compliance with the timing requirements in federal regulations. The physician certification includes, and is evidenced by, the following information:

(1) authentication of the admitting order;

(2) the reason for the continued hospitalization or the special or unusual services for a cost outlier case;

(3) the expected or actual length of stay of the patient; and

(4) the plans for post-Hospital care, when appropriate.

2.3. Care of Unassigned Patients:

All unassigned patients will be assigned to the appropriate on-call Medical Staff member or to the appropriate Hospital service.

2.4. Availability and Alternate Coverage:

(a) The attending physician will provide professional care for his or her patients in the Hospital by being personally available or by making arrangements with an alternate practitioner who has appropriate clinical privileges to care for the patients.

(b) The attending physician (or his or her appropriately credentialed designee) will comply with the following patient care guidelines regarding availability:

(1) Contact from the Emergency Department and/or a Patient Care Unit – must respond within 15 minutes of being contacted and, unless the clinicians involved have determined that another time frame is acceptable, must personally see a patient at the Hospital within 45 minutes of the request (or more quickly based on (i) the acute nature of the patient's condition or (ii) as required for a

particular specialty as recommended by the MEC and approved by the Board);

(2) ICU Patients – must personally see the patient within 12 hours of being admitted to the ICU, unless the patient's condition requires that the physician see him or her sooner; and

(3) Admissions – must personally see the patient within 14 hours of admission, except for newborns delivered at WakeMed who must be seen by the attending within 24 hours.

(c) All physicians (or their appropriately credentialed designee) will be expected to comply with the following patient care guidelines regarding consultations:

(1) Urgent Consults – must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner (all such requests for urgent consults – e.g., "stat," "urgent," "today," or similar terminology – must also include provider-to-provider contact by the requesting individual to the consulting physician); and

(2) Routine Consults – must be completed within 24 hours of the request or within a time frame as agreed upon by the requesting and consulting physicians (provider-to-provider contact is encouraged for routine consults, but is not mandated for routine consults).

(d) If an attending physician has a hospitalized inpatient and will be unavailable to care for a patient, or knows that he or she will be out of town for longer than 24 hours, the attending physician will transfer care of the patient as documented in the electronic medical record to the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The attending physician will be responsible for verifying the other physician's acceptance of the transfer.

(e) If, despite the above-referenced provision, neither the attending physician nor his or her covering practitioner is available, the department chair, the President of the Medical Staff, a CMO, and/or the CQO will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.5. Continued Hospitalization:

(a) The attending physician will provide whatever information may be requested by the Utilization Review Department with respect to the continued hospitalization of a patient, including:

(1) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(2) the estimated period of time the patient will need to remain in the Hospital; and

(3) plans for post-Hospital care.

This response will be provided to the Utilization Review Department within 24 hours of the request. Failure to comply with this requirement will be reported to a CMO for appropriate action.

(b) If the Utilization Review Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the attending physician. If the matter cannot be appropriately resolved, a CMO will be consulted.

ARTICLE 3

MEDICAL RECORDS

3.1. General:

(a) The following individuals are authorized to document in the medical record:

(1) attending physicians and responsible practitioners;

(2) medical residents;

(3) nursing providers, including registered nurses ("RNs") and licensed practical nurses ("LPNs");

(4) physicians responding to a request for consultation when the individual has clinical privileges or is an employee or member of the House Staff at the Hospital;

(5) other health care professionals involved in patient care, including, but not limited to, physician assistants, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

(6) students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical students, interns, nursing students) if that documentation is reviewed and attested to by the student's attending physician/supervisor, who must also be authorized to document in the medical record; and

(7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

(b) Entries will be made in the medical record consistent with Hospital policy. Electronic entries will be entered through the EMR. Orders will be entered using Computerized Provider Order Entry ("CPOE"). Handwritten medical record entries will be legibly recorded in blue or preferably black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). All entries, including any handwritten entries, must be timed, dated and signed by the provider who made the entry.

(c) Each practitioner will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(d) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

(e) Any documentation error made in the electronic record should be corrected in accordance with Hospital policy. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed.

3.2. Access to Record:

(a) Access to all medical records of patients will be afforded to members of the Medical Staff or their appropriate designees for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(b) Subject to the discretion of the CEO (or his or her designee), former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

3.3. Content of Record:

(a) For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Medical records will also be kept for every scheduled ambulatory care patient and for every patient receiving emergency services, the content of which is defined further in this Article.

(b) Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital's

policies and procedures. Stamped signatures are not permitted in the medical record.

(c) General Requirements. All medical records for patients receiving care in the Hospital setting or at an ambulatory care location will document the information outlined in this paragraph, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(1) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(2) legal status of any patient receiving behavioral health services;

(3) patient's language and communication needs, including preferred language for discussing health care;

(4) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;

(5) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls) and any patient-generated information;

(6) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(7) admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

(8) allergies to foods and medicines;

(9) reason(s) for admission of care, treatment, and services;

(10) diagnosis, diagnostic impression, or conditions;

(11) goals of the treatment and treatment plan;

(12) diagnostic and therapeutic orders, procedures, tests, and results;

(13) progress notes made by authorized individuals;

(14) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration,

administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(15) consultation reports;

(16) operative procedure reports and/or notes;

(17) any applicable anesthesia evaluations;

(18) response to care, treatment, and services provided;

(19) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(20) reassessments and plan of care revisions;

(21) complications, Hospital-acquired infections, and unfavorable reactions to medications and/or treatments;

(22) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice;

(23) medications dispensed or prescribed on discharge; and

(24) death summary.

(d) Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(1) known significant medical diagnoses and conditions;

(2) known significant operative and invasive procedures;

(3) known adverse and allergic drug reactions; and

(4) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

(e) Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(1) time and means of arrival;

(2) record of care prior to arrival;

(3) results of the Medical Screening Examination;

(4) known medications, including current medications, over-the-counter drugs, and herbal preparations;

(5) conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

(6) if the patient left against medical advice; and

(7) a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

(f) Obstetrics Records.

(1) Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(a) findings during the prenatal period, as available;

(b) the medical and obstetrical history, including documentation (upon admission to labor and delivery) the patient's status of the following (diseases during the current pregnancy): (i) Human immunodeficiency virus ("HIV"), (ii) hepatitis B, (iii) Group B streptococcus ("GBS"), and (iv) syphilis;

(c) gestational age documented in weeks at time of admission and time of delivery;

(d) observations and proceedings during labor, delivery and postpartum period;

(e) documentation of delivery needs to include any procedures performed;

(f) the results of any other tests required by North Carolina law; and

(g) laboratory and imaging findings.

(2) The obstetrical record will also include a complete prenatal record, as available. The prenatal record may be a legible copy of the attending physician's office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

(3) If an obstetrics patient had no prenatal care or the patient's disease status is unknown, testing for the following diseases will be performed and the results documented in the patient's medical record: (i) HIV, (ii) hepatitis B, (iii) GBS, and (iv) syphilis.

(g) Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible practitioners and the Hospital:

(1) history of maternal health and prenatal course, including mother's HIV, hepatitis B, GBS, and syphilis status;

(2) gestational age documented in weeks;

(3) description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;

(4) time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and problems occurring from birth until transfer from the delivery room;

(5) report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining Hospital stay;

(6) physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;

(7) documentation of infant feeding: intake, content, and amount if by formula; and

(8) clinical course during Hospital stay, including treatment rendered, procedures performed, and patient response; clinical note of status at discharge.

3.4. History and Physical:

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Appendix C to the Medical Staff Bylaws.

3.5. Progress Notes:

(a) Progress notes will be entered by the attending physician (or by a resident working with the attending physician or by the attending physician's appropriately credentialed covering practitioner) at least every 24 hours for every known hospitalized patient and as needed to reflect changes in the status of a patient in an ambulatory care setting.

(b) Progress notes will be legible, dated, and timed. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

(c) Progress notes may be entered by Advanced Practice Professionals as permitted by their clinical privileges.

(d) Medical students may also enter information to be utilized in daily progress notes, provided that the attending physician has reviewed and attested to the information.

3.6. Discharge Summary:

(a) A concise, documented discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another physician who agrees to assume this responsibility. All discharge summaries will include the following and must be completed within 48 hours of discharge:

(1) reason for hospitalization;

(2) significant findings;

(3) procedures performed and care, treatment, and services provided;

(4) condition and disposition at discharge;

(5) information provided to the patient and family, as appropriate;

(6) provisions for follow-up care;

(7) discharge medication reconciliation; and

(8) discharge diagnosis, to include complications when applicable.

(b) A discharge progress note may be used to document the discharge summary for uncomplicated obstetrical deliveries, normal newborn infants, and for stays of less than 48 hours, except for deaths.

(c) A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission, and must include the reason for hospitalization, significant findings, procedures performed and care, treatment, and services provided, diagnosis, including complications when applicable, the date and time of death, and the autopsy to be conducted (when applicable).

3.7. Authentication:

(a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the electronic record. Signature stamps are never an acceptable form of authentication for written orders/entries.

(b) The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.

3.8. Informed Consent:

Informed consent will be obtained and documented in accordance with the Hospital's Informed Consent Policy.

3.9. Delinquent Medical Records:

(a) It is the responsibility of any practitioner involved in the care of a hospitalized patient to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies of the Hospital.

(b) Medical records will be completed within 21 days following the patient's discharge or they will be considered delinquent. If the record remains incomplete 21 days following discharge, the practitioner will be notified of the delinquency and that his or her clinical privileges have been automatically relinquished in accordance with Section 6.E of the Credentials Policy. The relinquishment will remain in effect until all of the practitioner's records are no longer delinquent. During automatic relinquishment of privileges, surgery may be only posted and/or a patient admitted in true cases of emergent patient need. If a delinquent practitioner feels that such circumstances exist, the individual must first contact the relevant department chair, the President of the Medical Staff, a CMO, and/or the CQO and one or more of these Medical Staff leaders must specifically grant an exception to the effectiveness of the automatic relinquishment of his or her clinical privileges based on their finding that an emergency situation exists which necessitates the scheduling of the case or admission.

(c) Failure to complete the medical records that caused the automatic relinquishment of clinical privileges 60 days from the relinquishment will constitute an automatic resignation of appointment from the Medical Staff and of all clinical privileges.

(d) Medical record delinquencies will be included as part of routine ongoing professional practice evaluation ("OPPE") quality reports and, if confirmed by the department chair, will be referred for review pursuant to the Medical Staff Professionalism Policy.

(e) An incomplete medical record will not be permanently filed until it is completed by the responsible practitioner or it is ordered filed incomplete by the MEC. Except in rare circumstances, and only when approved by the MEC, no practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

(f) When a practitioner is no longer a member of the Medical Staff and his or her medical records are filed as permanently inadequate, this will be recorded in the practitioner's credentials file and the individual will not be considered to have left the Medical Staff "in good standing" for purposes of future reference responses.

(g) Any requests for special exceptions to the above requirements will be submitted by the practitioner and considered by the HIM Department.

ARTICLE 4

MEDICAL ORDERS

4.1. General:

(a) Whenever possible, orders will be entered directly into the EMR by the ordering practitioner. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be entered into Epic in accordance with Hospital policy.

(b) All orders (including verbal/telephone orders) must be:

(1) dated and timed when documented or initiated;

(2) authenticated by the ordering practitioner, with the exception of a verbal order which may be countersigned by another physician who is responsible for the care of a patient. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials, and which must include the date and time; and

(3) documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

(c) Orders for tests and therapies will be accepted only from:

(1) members of the Medical Staff;

(2) residents; and

(3) Advanced Practice Professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges.

Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

(d) The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.

(e) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(f) No order will be discontinued without the knowledge of the attending physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.

(g) All orders for medications administered to patients will be reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is issued when the pharmacy is “closed” or the pharmacist is otherwise unavailable, the medication order will be reviewed by nursing and then by the pharmacist as soon thereafter as possible, preferably within 24 hours.

(h) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All as necessary medication orders (also known as PRN) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(i) Advanced Practice Professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. Admission orders issued by an Advanced Practice Professional on behalf of the Supervising Physician must be countersigned by the Supervising Physician prior to the patient’s discharge.

4.2. Verbal Orders:

Verbal orders shall be accomplished in accordance with the Verbal/Telephone Orders Administrative Policy.

4.3. Standing Orders, Order Sets, and Protocols:

(a) The Order Set Committee must review and approve any standing orders and protocols. All standing orders, order sets, and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

(b) The Order Set Committee will confirm that all approved standing orders and protocols are consistent with nationally recognized and evidence-based guidelines. The Order Set Committee will also take appropriate steps to ensure that such orders and protocols are reviewed periodically.

(c) When used, standing orders and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another responsible practitioner.

(d) The attending physician must also acknowledge and authenticate the initiation of each standing order, order set, or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.

(e) Practitioners can modify, cancel, void, or decline to authenticate standing orders that the practitioner believes were not medically necessary in a given situation. The practitioner's action to modify, cancel, void, or decline to authenticate a standing order must be reflected in the patient's medical record.

(f) Definitions:

(1) Order Set: A "menu" of treatment options, organized to promote best practices and facilitate safe workflows, which is designed to facilitate the creation of a patient-specific set of orders by a practitioner. The practitioner can choose from the available "menu" options to tailor the order to the patient's needs. The resulting order must be authenticated by the practitioner prior to implementation (examples: Admission orders, post-operative orders, and discharge orders);

(2) Protocol: A defined set of orders that is initiated "en bloc" by a practitioner if warranted by the patient's clinical presentation. In some cases, the initiation of a protocol authorizes defined care by

non-practitioner clinical staff. A protocol may not contain alternatives or choices for medications or treatments for the care nurse/other non-practitioner to determine, and must clearly identify the specific clinical situations, patient conditions, or diagnoses under which initiation of the protocol is justified. An authorizing signature is required for initiation of the protocol, but not for every subsequent application of the protocol (example: Potassium Replacement Protocol, which authorizes non-practitioner clinical staff to administer individual potassium dosages as specified by the Potassium Replacement Protocol while the order remains active); and

(3) Standing Order: A set of orders designed to expedite timely, safe, evidence-based, and consistent patient care as part of an emergency response or as part of an evidence-based treatment regimen when it is not practical for nursing staff/other non-practitioners to obtain a verbal or authenticated written order from a practitioner prior to the provision of care. Criteria to initiate standing orders, such as specific clinical situations, patient conditions, or diagnoses, must be clearly specified by medical staff. Nursing staff/other non-practitioners may not choose among treatment or care options unless the choice is explicitly driven by the patient's condition or other parameter, such as demographic variables (age, gender) or laboratory results. Standing orders may be activated by a nurse or other non-practitioner without a prior order for that patient by the practitioner responsible for the patient's care, but must be authenticated properly subsequent to implementation (example: ED Standing Orders for Chest Pain).

4.4. Self-Administration of Medications:

(a) The self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will not be permitted unless the medication or a suitable substitute alternative is not available on the Hospital's formulary and the attending physician has issued an order directing that self-administration of medications be permitted. Under such circumstances, the self-administration of medications will only be permitted if:

(1) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

(2) a practitioner responsible for the care of the patient has issued an order permitting self-administration;

(3) in the case of a patient's own medications, the medications are visually evaluated by a pharmacist to ensure integrity; and

(4) the patient's first self-administration is monitored by nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.

(b) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(c) All self-administered medications (whether Hospital-issued or the patient's own) will be kept secure.

(d) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be packaged, sealed, and returned to the patient or given to the patient's representative at the time of discharge from the Hospital.

4.5. Stop Orders:

A practitioner is permitted to order any medication for a specific length of time so long as the length of time is clearly stated in the orders. Medications not specifically prescribed as to time or number of doses will be subject to "STOP" orders in accordance with Pharmacy policy.

4.6. Orders for Drugs and Biologicals:

(a) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

(b) All orders for medications and biologicals will be dated, timed and authenticated by the responsible practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy after an assessment for contraindications.

4.7. Orders for Radiology and Diagnostic Imaging Services:

(a) Radiology and diagnostic imaging services may only be provided (i) on the order of an individual who has been granted privileges to order the services by the Hospital, or (ii) consistent with state law, from other practitioners authorized by the Hospital to order services.

(b) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the procedure.

4.8. Orders for Outpatient Services:

(a) Orders for outpatient services (e.g., lab tests, diagnostic services, etc.) may also be accepted from practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

(b) Orders for outpatient services must be submitted on a prescription pad, letterhead, or an electronic order form and include: (i) the patient's name; (ii) the name and signature of the ordering individual; (iii) the date and time; and (iv) the type, frequency, and duration of the service, as applicable.

ARTICLE 5

CONSULTATIONS

5.1. Requesting Consultations:

(a) The attending physician shall be responsible for requesting a consultation when indicated and for contacting a qualified consultant.

(b) Requests for consultations shall be entered in the patient's medical record. In addition to documenting the reasons for the consultation request in the medical record, the attending physician is encouraged to personally contact the consulting physician to discuss all consultation requests. However, for urgent consults, the attending physician must personally speak with the consultant or his/her appropriate designee (i.e., resident or Advanced Practice Provider) to provide the patient's clinical history and the specific reason for the consultation request.

(c) Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the Professional Practice Evaluation Policy or other applicable policy.

(d) Where a consultation is required for a patient in accordance with Section 5.3 or is otherwise determined to be in patient's best interest, a CMO, CQO, the President of the Medical Staff, or the appropriate department chair shall have the right to call in a consultant.

5.2. Responding to Consultation Requests:

(a) Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.

(b) For non-urgent consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For urgent consults, the consult must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner.

(c) The physician who is asked to provide the consultation may ask an Advanced Practice Professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an Advanced Practice Professional will not relieve the consulting physician of

his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the Advanced Practice Professional is sufficient.

(d) When providing a consult, the consulting physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the consulting physician will be directly communicated to the attending physician. In addition, any recommendations for additional consultations must be recommended to the attending physician for his or her approval prior to any such consultations being formally requested.

(e) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the Professional Practice Evaluation Policy or other applicable policy unless one of the following exceptions applies to the physician asked to provide a consultation:

(1) the physician has a valid justification for his or her unavailability (e.g., out of town);

(2) the patient has previously been discharged from the practice of the physician;

(3) the physician has previously been dismissed by the patient;

(4) the patient indicates a preference for another consultant; or

(5) other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria (paragraphs (1)-(5)), then the requesting physician should find an alternate consultant. If the attending is unable to do so, then a CMO, CQO, the President of the Medical Staff, or the appropriate department chair can appoint an alternate consultant.

(f) Once the consulting physician is involved in the care of the patient, the attending physician and consulting physician are expected to review each other's notes in both the electronic and paper charts on a daily basis until

such time as the consultant has signed off on the case or the patient is discharged.

5.3. Mental Health Consultations:

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

5.4. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, appears in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the attending physician states in writing that an emergency situation exists.

5.5. Content of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain the date and time that the consultation occurred, entered in Epic or a legible written form, and shall include recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not constitute an acceptable consultation report. The consultation report will be made a part of the patient's medical record. When necessary, authentication shall include the date and time.

(b) When non-emergency operative procedures are involved, the consultant's report will be recorded in the patient's medical record prior to the surgical procedure. The consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.6. Concerns:

A practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the applicable department chair, the President of the Medical Staff, a CMO, or the CQO, and the concern may be forwarded for review pursuant to the Professionalism Policy.

ARTICLE 6

SURGICAL SERVICES

6.1. Pre-Procedure Protocol:

(a) The physician responsible for the patient's care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination prior to transport to the procedural/operating room, except in emergencies. The history and physical can be conducted within 30 days of registration with a pre-operative assessment completed within 24 hours of admission or prior to surgery, whichever comes first.

(b) Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

(1) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(2) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(3) the attending physician (i.e., surgeon) is in the Hospital; and

(4) the procedure site is marked and a "time out" is conducted immediately before starting the procedure, as described in the Universal Protection Policy.

(c) For hospitalized patients that subsequently require surgery or other invasive procedure, OR when the H&P is performed by a physician/practitioner other than the surgeon/proceduralist, the surgeon/proceduralist should enter a pre-procedure progress note or consultation note.

6.2. Post-Procedure Protocol:

(a) An operative procedure report must be documented by the operating physician immediately after an operative procedure and entered into the record. The operative procedure report shall include:

(1) the patient's name and Hospital identification number;

(2) pre- and post-operative diagnoses;

(3) date and time of the procedure;

(4) the name of the operating physician(s) and assistant surgeon(s) responsible for the patient's operation;

(5) procedure(s) performed and description of the procedure(s);

(6) description of the specific surgical tasks that were conducted by practitioners other than the operating physician;

(7) findings, where appropriate, given the nature of the procedure;

(8) estimated blood loss;

(9) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(10) the type of anesthesia/sedation used and name of the practitioner providing anesthesia;

(11) specimen(s) removed, if any;

(12) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(13) the signature of the operating physician.

(b) If a full report cannot be entered into the record immediately after the operation or procedure, a brief post-op note must be entered by a physician (operating physician or resident only) in the medical record immediately after the procedure. In such situations, the full operative procedure report must be entered or dictated within 24 hours. The brief post-op note will include:

(1) the names of the physician(s) responsible for the patient's care and physician assistants;

(2) the name and description of the procedure(s) performed;

(3) findings, where appropriate, given the nature of the procedure;

(4) estimated blood loss, when applicable or significant;

(5) specimens and tissues removed or altered; and

(6) post-operative diagnosis.

ARTICLE 7

ANESTHESIA SERVICES

7.1. General:

(a) Anesthesia may only be administered by the following qualified practitioners:

(1) an anesthesiologist;

(2) an M.D. or D.O. (other than an anesthesiologist) with appropriate clinical privileges;

(3) a dentist, oral surgeon or podiatrist, in accordance with state law;

(4) a CRNA who is supervised by the operating practitioner or an anesthesiologist who is immediately available; or

(5) an anesthesiologist assistant under the supervision of an anesthesiologist who is immediately available, if needed.

(b) An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).

(c) "Anesthesia" means general or regional anesthesia (which includes the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks), monitored anesthesia care or deep sedation. "Anesthesia" does not include topical or local anesthesia, minimal or moderate sedation.

(d) Because it is not always possible to predict how an individual patient will respond to moderate sedation, a qualified practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

(e) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(a) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia within 48 hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services.

(b) The evaluation will be recorded in the medical record and will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;

(2) an interview, if possible, pre-procedural education, and examination of the patient;

(3) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

(5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(6) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) and (2) must be performed within the 48-hour time frame. The elements in (3) through (6) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

(c) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

(a) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient's physiological status.

(b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(1) the name and Hospital identification number of the patient;

(2) the name of the practitioner who administered anesthesia and, as applicable, any supervising practitioner;

(3) the name, dosage, route time, and duration of all anesthetic agents;

(4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(5) the name and amounts of IV fluids, including blood or blood products, if applicable;

(6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(7) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations:

(a) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(b) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the

reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).

(c) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(2) cardiovascular function, including pulse rate and blood pressure;

(3) mental status;

(4) temperature;

(5) pain;

(6) nausea and vomiting; and

(7) post-operative hydrations.

(d) Patients will be discharged from the recovery area by a qualified practitioner according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a post-anesthesia recovery scoring system. Post-operative documentation will record the patient's discharge from the post-anesthesia care area.

(e) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

(f) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

7.5. Direction of Anesthesia Services:

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and

- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE 8

PHARMACY

(a) Blood transfusions and intravenous medications will be administered in accordance with state law and approved policies and procedures.

(b) Adverse medication events will be immediately documented in the patient's medical record and reported to the attending physician, or designee. The director of pharmaceutical services and the Hospital's quality assessment and performance improvement program will receive the information through the incident reporting review system.

(c) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.

(d) Except for investigational or experimental drugs in a clinical investigation, all drugs and biologicals administered will be listed in the latest edition of: United States Pharmacopeia, National Formulary, or the American Hospital Formulary Service.

(e) The use of investigational or experimental drugs in clinical investigations will be subject to the rules established by the MEC and the Institutional Review Board.

(f) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, other practitioners and Hospital staff.

ARTICLE 9

EMERGENCY SERVICES

9.1. General:

Emergency services and care will be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

9.2. Medical Screening Examinations:

(a) Medical screening examinations, within the capability of the Hospital, will be performed by qualified medical personnel in accordance with pertinent Hospital EMTALA policies.

(b) The results of the medical screening examination must be documented prior to the patient's discharge from the Emergency Department.

9.3. 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 clinical department chairs to establish a roster of Medical Staff members responsible for taking Emergency Department call. The time frame for emergency call shall be determined by the relevant department. If a particular department does not define the time frame, the default time frame 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 a Medical Staff member has not voluntarily accepted the consult.

(b) Response Time: It is the responsibility of the on-call Medical Staff member to respond, whether to a phone call or personal presence, in accordance with time frames as set forth in the Medical Staff Credentials Policy and these Rules and Regulations. If the on-call Medical Staff member does not respond timely, the relevant department chair or vice chair shall be contacted. Failure to respond in a timely manner may be referred for review pursuant to the Medical Staff Professionalism Policy.

(c) Substitute Coverage: As set forth in the Medical Staff Credentials Policy and these Rules and Regulations, on-call Medical Staff members must arrange for appropriate coverage and notify the Emergency Department if they are unavailable to take call when assigned. Failure to do so may be referred for review pursuant to the Medical Staff Professionalism Policy.

9.4. Patients Not Requiring Admission:

In cases where the Emergency Department consults with the on-call Medical Staff member and no admission is deemed necessary by both the Emergency Department physician and the on-call Medical Staff member, 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 on-call Medical Staff member's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit, if such follow-up care is clinically indicated. Primary care follow-up will be through a list of available primary care physicians, as appropriate.

9.5. Unassigned Patients Returning to the Hospital:

Unassigned patients who have been admitted to the Hospital, and who return with the same episode of illness to the Emergency Department within 14 days following discharge, will be the responsibility of the previous admitting Medical Staff member. Unassigned patients who present to the Emergency Department, after having been previously discharged from the Emergency Department more than 14 days after the previous discharge with a different episode of illness, will be referred to the on-call Medical Staff member taking unassigned call that day.

9.6. Guidelines for Department Policies on Unassigned Call:

Clinical departments are responsible for developing an appropriate on-call schedule to address unassigned emergency call obligations, subject to the approval of the MEC. The following guidelines should be used in the development of the schedule:

(a) 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.

(b) 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.

(c) Medical Staff members may request exemption from unassigned call based on reaching the age of 55 and having served at least 20 years of unassigned call. Exemptions are not automatic and must be recommended by the relevant department and approved by the MEC and the Board. The grant of exemptions must be consistently applied and may not compromise the department's ability to fulfill the Hospital's EMTALA obligations. Once granted, exemptions may be modified if the MEC, after considering the recommendation of the clinical department, determines that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities.

(d) The unassigned call list will also be used as a default for inpatient consultations if no one will accept the inpatient consultation voluntarily.

ARTICLE 10

TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

10.1. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

(a) assessing the reason(s) for transfer;

(b) establishing the conditions under which transfer can occur;

(c) evaluating the mode of transfer/transport to assure the patient's safety; and

(d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient's care after arrival at that facility.

10.2. Procedures:

(a) Patients will be transferred to another hospital or facility based on the patient's needs and the Hospital's capabilities. The responsible practitioner, in conjunction with the Case Management Department, will take the following steps as appropriate under the circumstances:

(1) identify the patient's need for continuing care in order to meet the patient's physical and psychosocial needs;

(2) inform patients and their family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;

(3) involve the patient and all appropriate practitioners, Hospital staff, and family members involved in the patient's care, treatment, and services in the planning for transfer; and

(4) provide the following information to the patient whenever the patient is transferred:

(i) the reason for the transfer;
(ii) the risks and benefits of the transfer; and
(iii) available alternatives to the transfer.

(b) When patients are transferred, appropriate information will be provided to the accepting practitioner/facility, including:

(1) reason for transfer;

(2) significant findings;

(3) a summary of the procedures performed and care, treatment and services provided;

(4) condition at discharge;

(5) information provided to the patient and family, as appropriate; and

(6) working diagnosis.

(c) When a patient requests a transfer to another facility, the responsible practitioner will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (b) above.

10.3. EMTALA Transfers:

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable EMTALA policy.

ARTICLE 11

MISCELLANEOUS

11.1. Self-Treatment and Treatment of Family Members:

Members of the Medical Staff must abide by the North Carolina Medical Board Rules and Position Statements on the treatment of self and family members. The Position Statement may be found at:

https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/self-treatment_and_treatment_of_family_members

11.2. Guidelines for Treatment of Coworkers:

Medical Staff members should refrain from:

(a) treating any individual without first performing an appropriate assessment and creating a proper medical record; or

(b) writing a prescription for any individual in the absence of a formal physician-patient relationship.

11.3. Orientation of New Physicians:

Each new physician will be provided an overview of the Hospital and its operations. As a part of this orientation, the relevant CMO(s) and Information Services will orient new physicians as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

11.4. HIPAA Requirements:

All members of the Medical Staff and Advanced Practice Professionals will adhere to the security and privacy requirements of HIPAA, meaning that only a responsible practitioner may access, utilize, or disclose protected health information.

ARTICLE 12

AMENDMENTS

(a) Proposed amendments to these Rules and Regulations shall be presented to the MECs of both WakeMed Raleigh and WakeMed Cary.

(b) The Rules and Regulations may then be amended by a majority vote of the members of each MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be provided to each voting staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any voting staff member may submit written comments to the MEC.

(c) If there is any disagreement between the MECs for the two Hospitals with respect to an amendment(s), a joint meeting shall be scheduled to discuss and resolve the disagreement.

(d) No amendment shall be effective unless and until it has been approved by the Board of each Hospital.

ARTICLE 13

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

WakeMed Cary

Adopted by the Medical Staff: February 3, 2019

Approved by the Board: March 5, 2019

WakeMed Raleigh

Adopted by the Medical Staff: February 3, 2019

Approved by the Board: March 5, 2019