New York Eye and Ear Infirmary of Mount Sinai

Rules and Regulations

Reviewed: April 2000, May 2003, June 2015
New York Eye and Ear Infirmary of Mount Sinai
Professional Staff Rules and Regulations

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1.1 MEETINGS
The Annual Meeting of the Professional Staff shall be held in May of each year. At this meeting, the Chair of the Medical Board, the Chairs of the Departments of Ophthalmology, Otolaryngology, and Plastic and Reconstructive Surgery, the Directors of the Departments of Anesthesiology, Radiology, Medicine and Pathology, and the Chairs of the Standing Medical Board committees shall submit comprehensive reports of their year’s work to the Professional Staff. Regular meetings of the Professional Staff shall be held at least annually as designated by the Chair of the Medical Board.

1.2 PRIVILEGES
The procedures for appointment and reappointment to the Professional Staff and the delineation of privileges are set forth in the Professional Staff Bylaws. Surgical privileges shall be delineated for all physicians/dentists performing surgery in accordance with the competencies of each physician/dentist as required by Section 405.4 of the New York Code of Rules and Regulations. Each department shall maintain a roster specifying the surgical privileges of each physician/dentist.

1.2.1 Absence of Privileges
Subject to Article III, Section 1 of the Professional Staff Bylaws, no practitioner shall admit or provide services to patients in the Hospital, including clinic patients, unless that practitioner is a member of the Professional Staff or has been granted Temporary Privileges in accordance with Medical Staff Bylaws.

Exempt from the requirement to obtain medical staff privileges are those practitioners from outside organ procurement organizations designated by the Secretary, U.S. Department of Health and Human Services, engaged solely at NYEE in the harvesting of tissues and/or other body parts for transplantation, therapy, research or educational purposes pursuant to the Federal Anatomical Gift Act and requirements of New York State Codes, Rules and Regulations, 405.

1.2.2 Focused Professional Practice Evaluation (FPPE)
Focused review would be conducted on all newly credentialed applicants, current medical staff members requesting new privileges, and when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care.

The process of evaluation would be conducted by the Chairs or Directors of the Departments of the Professional Staff. The process for FPPE may include any or all of the following: chart reviews, monitoring of clinical practice patterns, simulations, proctoring, external peer review, and discussions with other individuals involved in the
care of each patient including consulting physicians, assistants at surgery, nursing or administrative personnel.

The Chairs/Directors would be responsible for defining a performance monitoring process which will be documented in the Medical Affairs FPPE policy (MA.011). The findings would be submitted to the Quality Department in a necessary document describing the indicators monitored and evaluated.

This process would be applicable to the Professional Staff and the Allied Health Professionals in compliance with the applicable Joint Commission standards.

1.2.3 **Ongoing Professional Practice Evaluation (OPPE)**

Ongoing review would be conducted by the Chairs or Directors of the Department of the Professional Staff. It would be the responsibility of the Chairs or Directors in concert with the Quality Department to identify professional practice trends of the members of the Professional Staff. The Chairs or Directors would provide the Quality Department with necessary documentation based on their established monitoring procedure.

This evaluated information would be used in deciding whether to maintain existing privilege(s), to revise existing privileges, to limit or to revoke an existing privilege(s) prior to or at the time of renewal.

Criteria for evaluation would be department specific. Each Chair or Director will determine the indicators to be monitored and reported to the Quality Department in a timely fashion. Please note that The Joint Commission requires ongoing monitoring be carried out at less than a twelve month interval. Please refer to the Medical affairs OPPE policy MA.010 for the procedures of the review process and the indicators that would be monitored by the Department Chairs or Directors.

This process would be applicable to the Professional Staff and the Allied Health Professionals in compliance with the applicable Joint Commission standards.

1.2.4 **Disruptive Behavior**

According to the AMA, disruptive behavior “generally refers to a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behavior that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care would fall within the definition of disruptive behavior.”

Disruptive behavior includes, but is not limited to:

- Verbal or physical attacks that are personal or go beyond the bounds of fair professional conduct.
• Foul or threatening or disrespectful language.
• Name calling
• Nonverbal behavior, such as facial expressions or manners
• Inappropriate comments or illustrations made within patient medical records or other official documents.
• Non-constructive criticism addressed to its recipient in a manner that intimidates, undermines confidence of, belittles or otherwise harasses.
• Unwillingness to work with, or inability to relate to, other staff in ways that affect patient care.
• Refusal to accept medical staff assignments, or participate in committees as requested by the Governing Body.
• Throwing instruments, charts, other objects
• Criticizing healthcare providers in front of patients or other staff members
• Retaliation against any staff member of New York Eye and Ear Infirmary of Mount Sinai who reports an instance of violation of the code of conduct or who has participated in the investigation of such an incident shall not be tolerated.

Please refer to Medical Affairs policy (MA.009) for guidelines on responding to Disruptive Behavior.

1.3 RESPONSIBILITIES

1.3.1 Admissions

(a) Qualifications

Only a member in good standing of the Professional Staff who has admitting privileges at the Hospital may admit patients, subject to any conditions provided below and to all other admitting policies of the Hospital as may be in effect from time to time. Only a member of the Professional staff with admitting privileges shall assume the principal obligation and responsibility of managing the patient’s medical care.

(b) Dental Patients

Patients admitted for dental services may be admitted under the name of a member of the dental staff. Dental patients with medical co-morbidities or complications present upon admission or arising during hospitalization should be referred to an appropriate Professional Staff member for consultation and/or management. The attending dentist shall be responsible for the admission, management and discharge of dental patients, including all related written documentation.

1.3.2 Admitting Responsibilities

The admitting or attending physician/dentist is responsible for the treatment of the patient from the time of admission to the termination of the patient’s Hospital stay. This responsibility cannot be delegated to any other physician/dentist except in writing and
with the written consent of the physician/dentist who accepts the case (who shall be a member of the Professional Staff with appropriate clinical privileges) plus the consent of the patient. If the attending physician/dentist is off or away temporarily, he must notify and familiarize his/her covering physician/dentist with the case of the patient and patient’s condition.

(a) **In Surgical Cases**
In surgical cases, a surgeon may be the admitting or attending physician. If necessary, they should request the assistance of primary care physicians or other consultants who are members of the Professional Staff with the appropriate clinical privileges as the patient’s condition requires.

(b) **Admitting Orders**
The admitting physician/dentist is responsible to ensure that admitting orders are listed on the patient’s chart. All orders including standing orders must appear on the order sheet. All entries in the Medical Record are dated and timed and the author of each medical record entry is identified in the medical record.

1.3.3 **Director of Surgical Services**
The procedures for appointment and reappointment to the Professional Staff and the delineation of privileges are set forth in the Professional Staff Bylaws. Surgical privileges shall be delineated for all physicians/dentists performing surgery in accordance with the competencies of each physician/dentist as required by Section 405.4 of the New York Code of Rules and Regulations. Each department shall maintain a roster specifying the surgical privileges of each physician/dentist. Each surgical service shall be directed by a physician who shall be responsible for the clinical aspects, organization and delivery of all inpatient and ambulatory surgical services provided to the Hospital patients. That physician or another individual qualified by the training and experience shall direct administrative aspects of the service, and shall, in conjunction with the medical staff, monitor the quality and appropriateness of patient care and ensure that identified problems are resolved.

1.3.4 **Attendance in Emergency**
Each member of the Professional Staff shall designate a member of the Active Staff who would be contacted to provide services to his/her patient in an emergency during the absence of the staff member. In case of failure to name and reach such an individual, the President of the Hospital, Chairman/Director of the Department, and/or Chief Medical Officer shall have the authority to call any member of the Professional Staff, should such be considered necessary.

Although NYEE is a specialty hospital, it has a responsibility to the Community to provide first-aid and triage to any person who seeks assistance in an urgent situation. However, as a specialty hospital, NYEE is limited to rendering inpatient care that can be supported by the facility.
On the rare occasion when there is a need to respond to emergencies such as acute myocardial infarction, stab wounds, trauma, etc. from the community, the following procedure is instituted:

(a) Call “Code Blue” for cardiac or respiratory arrest
(b) The on-call residents are to be paged on the Cardiac Arrest pager and are to respond immediately.
(c) In the event that transfer to a general hospital is emergently indicated, the Nursing Supervisor is to call 911.
(d) Medical staff must provide life sustaining emergency care (CPR, administration of oxygen, controlling hemorrhage, etc.) until such time as the patient is stable enough for transport.
(e) All pertinent data including the patient’s identifying information and treatments provided should be recorded.
(f) A summary transfer note must be completed. A summary should accompany all patients who are transferred to another institution.
(g) A summary of the care provided, tests performed and medications administered should be sent with the patient to the receiving facility. A completed transfer form must accompany the patient.
(h) If the patient’s name has not been obtained, the police who responded to the incident are asked to contact NYEE once the patient’s identity has been established.
(i) A note should be made in the patient’s chart documenting the patient’s arrival to the accepting institution and the patient’s treatment plan as determined by the accepting institution’s physicians.

1.3.5 Disaster Plans
Each member of the Professional Staff shall function within the guidelines of New York Eye and Ear Infirmary of Mount Sinai Disaster Plans.

1.4 Supervision
There shall be a licensed and currently registered physician, registered physician’s assistant or a registered specialist’s assistant under the general supervision of a licensed independent physician available on the Hospital premises at all times who shall be responsible for receiving patients for care in accordance with policies established by the Hospital and for the appropriate disposition of requests to admit patients.

1.4.1 Post-Graduate Trainees
(a) Patient Care Services
Patient Care Services may be provided by physicians/dentists in post-graduate training programs accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or an equivalent accrediting agency approved by the New York State Education Department, only if:
(i) All post-graduate trainees have received adequate and appropriate medical education;
(ii) The Professional Staff has reviewed the trainee’s licensure, education, training, physical and mental capacity, and experience; and
(iii) The Professional Staff monitors and supervises such trainees in accordance with a plan developed for such purpose.

(b) Working Hours
In accordance with New York State Regulations, in order that working conditions and working hours of physicians/dentists and post-graduate trainees promote the provision of quality medical care, the Hospital shall establish the limits on working hours for certain members of the Professional Staff and post-graduate trainees. Schedules of post-graduate trainees with inpatient care responsibilities shall meet the following criteria.

(i) The scheduled work week shall not exceed an average of 80 hours per week over a 4 week period;
(ii) Such trainees shall not be scheduled to work for more than 24 consecutive hours;
(iii) For departments other than Anesthesiology, medical, surgical, or other services which have a high volume of acutely ill patients, and where night calls are infrequent and physician rest time is adequate, the Professional Staff may develop scheduling arrangements other than those set forth in clauses (i) and (ii) above;
(iv) The Chairman of every department will develop and implement specific policies related to schedules and limits of responsibility of individual post-graduate trainees during including, but not limited to, new patients.

In determining limits of working hours for post-graduate trainees as set forth above, scheduled rotations shall be separated by not less than 8 non-working hours and post-graduate trainees shall have at least one 24-hour period of non-working time per week.

1.4.2 Residents

(a) Privileges
The sponsoring physician/dentist shall recommend to the Chairman or Director of such department who shall delineate in writing, the privileges of each resident at the Hospital. These privileges shall be based on written criteria and shall be related to the resident’s license, education, training, physical and mental capacity, and experience. The privileges shall specify permissible treatments and procedures, and shall be determined in advance of the delivery of patient care services by the resident. Such privileges shall be modified based upon written criteria and individual review and approval.
(b) **Authorized Treatment/Procedures**
   The list of specific authorized treatments/procedures shall specify those treatments/procedures that may be performed under general control and supervision of the patient’s attending physician/dentist or another physician/dentist credentialed to provide the specific treatments/procedures; and those that may only be performed under direct visual supervision of the patient’s attending physician/dentist or another physician/dentist credentialed to provide the specific treatments/procedures. A list of authorized treatment/procedures by residents shall be available in the Nursing Units.

(c) **Provision of Care**
   The Professional Staff shall supervise and continuously monitor patient care services provided by the residents to assure provision of a satisfactory level of patient care services.

(d) **Supervision**
   Residents may perform any procedure under the direct visual supervision of an attending physician/NYEE approved Clinical Adjunct Surgeon (formerly referred to as Clinical Fellow). NYEE Clinical Adjunct Surgeon may supervise residents in the OR with the approval of the Chief of Service and Program Director with the exception to cases in their field of subspecialty training. When the Chief of Service, with the concurrence of the Program Director is assured of the individual (Clinical Adjunct Surgeon) competence in their subspecialty area (towards the latter part of their training) he/she may supervise residents in the Clinical Adjunct Surgeon area of specialty.

(e) **Life Threatening Situations**
   In the event of life threatening situations, a resident may perform any life sustaining procedure. Any emergency action must be documented in the patient’s medical record and the supervising attending physician must be notified.

(f) **Contacting Attending Physician**
   Circumstances under which supervisory attending physicians must be contacted will include but not be limited to:
   
   (i) Significant changes in patient’s condition
   (ii) Change in treatment plan
   (iii) Need for procedures or therapies not detailed in the treatment plan
   (iv) Urgent or emergent admissions to the service
   (v) Fatigue of the house officer
(g) **Fatigue During On-call**

Residents will be immediately relieved from a continuing assignment when fatigue due to an unusually active “on-call” period is observed. The supervising physician will contact the Director of the Resident Training to substitute another house officer. The Director of Resident Training will subsequently investigate the situation to find out why the resident experienced fatigue to avoid recurrence of this problem.

(h) **Moonlighting**

Residents are prohibited from “moonlighting” or working anywhere other than in hospitals scheduled as part of their training program at NYEE.

(i) **Disciplinary Action**

Failure to adhere to the Rules, Regulations and Policies of the Clinical Department, Medical Staff, Medical Board, and the House Staff Manual will result in disciplinary action.

### 1.4.3 Medical Students

All Medical Students rotating through New York Eye and Ear Infirmary of Mount Sinai will be processed by the Director of Medical Student Education in the appropriate Department.

In the course of their educational curriculum, they may take patient histories, perform complete physical examinations and enter findings in the medical record of the patient with the approval of the patient’s attending physician. All medical student entries must be countersigned within 24 hours by an appropriately privileged physician. Medical students may be assigned and directed to provide additional patient care services under the direct in-person supervision of an attending physician or authorized post-graduate trainee in accordance with departmental policy.

The Hospital in cooperation with the Professional Staff and the medical school shall provide appropriate supervision and documentation of all procedures performed by medical students. In addition, specific identified procedures, may be performed by medical students under the general supervision of an attending physician or authorized senior post-graduate trainee provided that the Professional Staff and the medical school affirm in writing each individual student’s competence to perform such procedures.

The Director of Medical Student Education will oversee and document supervision and competence of medical students which shall be incorporated into the quality assurance program of the Hospital and its affiliation agreement with the medical school.
1.4.4 Physician and Specialist Assistants

Professional Staff shall:

(a) Employ or extend privileges only to registered physician assistants and registered specialist assistants who are currently registered with the New York State Education Department;
(b) Designate in writing the licensed and currently registered staff physician or physicians responsible for the supervision and direction of each registered physician and specialist assistant employed or extended privileges;
(c) Employ or extend privileges only to registered physician assistants whose training and experience are within the scope of practice for which the physician or physicians to whom they are assigned are qualified; and
(d) Be approved for providing the specialized medical services for which the registered specialist’s assistant is employed or extended privileges and employ and extend privileges only to registered specialist’s assistants whose training and experience are appropriate to the delivery of specialized service.

1.5 DISCIPLINARY ACTION
Any violation of these Rules and Regulations shall be referred to the Medical Board which shall take such disciplinary action as is deemed necessary.
II
ADMISSION OF PATIENTS

2.1 AVAILABILITY OF BEDS
Within the capacity of NYEE to provide care, patients are admitted without regard to race, creed, national origin, sex, disability, sexual orientation or source of payment.

2.2 FACILITIES AND PERSONNEL
Admission of any patient is contingent on the capacity of NYEE to provide appropriate services.

2.3 PROFESSIONAL STAFF
Only a member in good standing of the Professional Staff who has admitting privileges at the Hospital may admit patients, subject to any conditions provided below and to all other admitting policies of the Hospital as may be in effect from time to time. Only a member of the Professional Staff with admitting privileges shall assume the principal obligation and responsibility of managing the patient’s medical care.

2.4 TIME OF ADMISSION
Except in emergency cases, the attending physician/dentist shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same day surgery, the attending physician/dentist must comply with Hospital policies concerning pre-surgical laboratory tests, documentation and scheduling.

2.5 ADMISSION INFORMATION
Admission information shall include the following:

1. Date and time of admission
2. Name and Address of Patient
3. Date of Birth
4. Next of kin or sponsor
5. Veteran status (insofar as these are attainable)
6. Admitting diagnosis
7. Patient’s current condition
8. Name of referring practitioner
9. Infirmary’s attending practitioner or service
10. Allergies to food and/or medications
11. Social Security Number (if available)

2.6 PRIVATE PATIENTS
Each private patient will be attended by the physician/dentist of his/her choice provided said physician/dentist is a member of the Professional Staff and has appropriate clinical
privileges. When any patient is attended by two or more members of the Professional Staff, the name of each attending physician/dentist must be entered officially on the Hospital records.

2.7. SERVICE PATIENTS
The Chairman of each department or his/her designee shall, in his/her sole discretion, assign members of the Professional Staff commensurate with delineated clinical privileges to attend patients who are not admitted as private patients. Such assigned physician/dentist shall be the personal physician/dentist to the patient and assume professional responsibility for his/her care in the Hospital and for a proper plan of care to discharge.

2.8 ADMISSION HISTORY AND PHYSICAL EXAMINATION
Every patient shall have a history and physical examination performed by a Licensed Independent Practitioner. If the history and physical examination is performed prior to admission, the history and physical shall be reviewed, updated as appropriate and signed, dated, and timed by a Licensed Independent Practitioner credentialed by the NYEE within 24 hours after inpatient admission or prior to surgery, whichever comes first.

2.9 COMMUNICABLE DISEASE

2.9.1 Query
The admitting physician/dentist shall ask each person being admitted for information concerning signs or symptoms significant infections or of recent exposure to communicable disease.

2.9.2 Isolation
Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending physician/dentist consistent with the principles outlined by the Infection Prevention Committee. These are available on the hospital intranet policy manager MCN. If the attending physician/dentist refuses to order isolation, this information shall be given to the Infection Prevention Manager who will consult with the Chairman or Director of the department involved. Said Chairman or Director shall consult with the attending physician/dentist and make the final decision concerning isolation of the case for the protection of Hospital employees and other patients.

2.9.3 Reporting
All cases of infection and communicable disease must be reported to the Infection Prevention Manager who will report to the Infection Prevention/Control Committee. Those found in special services units must also be reported to the physician/dentist in charge of the unit. Those found in other areas of the Hospital should be reported to the applicable department.
III
ORDERS AND DOCUMENTATION

3.1 ADMITTING ORDERS ON PATIENT RECORD
All entries in the Medical Record are dated and timed and the author of each medical record entry is identified in the medical record. Ongoing review of the Medical Record at the point of care, based on the following indicators: dating, timing, and legible signature of all Medical Record entries.

The admitting physician/dentist is responsible to ensure that admitting orders are listed on the patient’s chart. All orders including standing orders must appear on the order sheet.

3.2 INPATIENT AND OUTPATIENT HISTORY/PHYSICAL EXAMINATION AND MEDICATION HISTORY
The attending physician/dentist shall review, augment (if necessary), and countersign the house officer’s, physician assistant’s, nurse practitioner’s, or medical consultant’s inpatient and outpatient history and physical examination which must include the patient’s medication history, the chief complaint, details of the present illness, all relevant past medical, social and family histories, the patient’s emotional, behavioral and social status when appropriate and all pertinent findings resulting from a comprehensive, current assessment of all body systems.

3.3 TRANSFERS FROM ADMITTING PHYSICIANS
The admitting physician/dentist must be the physician/dentist on record at the time of admission. If the admitting physician/dentist transfers the cases to another member of the Professional Staff, such transfer shall be noted in writing in the medical record by both the transferring and receiving physician/dentist.

3.4 ORDERS FOR TREATMENT
All orders for treatment, including verbal orders, shall be legibly written and properly dated, timed and authenticated by the ordering practitioner on the patient’s order sheet.

3.4.1 Abbreviations
The physician/dentist writing patient orders will refrain from using prohibited abbreviations as designated by NYEE.

3.4.2 Behavioral Information
The admitting physician/dentist is also responsible for providing patient information concerning: behavioral characteristics that would disturb or endanger others; and the need for protecting the patient from self-harm.

3.4.3 Written and Verbal Orders
Verbal Orders or orders dictated over the telephone shall be accepted only by a house officer, medical resident, registered professional nurse, physician’s assistant, or
pharmacist, shall be used sparingly, and shall be signed by the person taking the order who shall also indicate the name of the physician/dentist dictating the order. For verbal or telephone orders or for telephonic reporting of critical test results, the complete order or test result will be verified by having the person receiving the information record and “read back” the complete order or test result.

The physician/dentist dictating such orders shall sign the order in the order sheet no more than twenty-four (24) hours after any such verbal or telephone order is given.

3.4.4 Automatic Stop Orders
Guided by the Pharmacy and Nursing Department policies and procedures which are reviewed at two-year intervals and as indicated, details can be found in the Pharmacy and Nursing policy.

Anticoagulants (warfarin, IV heparin, and Enxaparin orders) all have one (1) day expiration dates. All controlled substances have a 72-hour automatic stop order date. All antibiotics have a seven (7) day automatic stop date.

3.4.5 Standing Orders
Standing Medication Orders will be documented in the patient’s medical record upon initiation of therapy, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

3.5 HOSPITAL FORMULARY
The medical staff shall prescribe only formulary approved medications listed in the Hospital Formulary. Physicians requesting non-formulary medications will follow existing institutional guidelines for their acquisition. Generic names will be used in preference to proprietary nomenclature.

Medications designated as available for dispensing and/or administration are reviewed at least annually by the Pharmacy & Therapeutics Committee based on emerging safety and efficacy information.
IV
CONSULTATIONS

4.1 DOCUMENTATION OF CONSULT REQUEST
When requesting consultation, the attending physician/dentist must indicate in writing on the consultation record the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

4.2 REQUESTS

4.2.1 By Attending Physician
The patient’s attending physician/dentist is responsible for requesting a consultation when indicated. It is the duty of the Professional Staff, through its Medical Board, to make certain that members of the Professional Staff request consultations as needed.

4.2.2 By Higher Authorities
When a consultation is required under these Rules and Regulations or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable department Chairman or Director or chief of service, the Chairman of the Medical Board or the Chief Medical Officer. If the attending physician/dentist disagrees with the necessity for consultation, the matter shall be brought immediately to the applicable department Chairman for final decision and direction.

4.3 CASES REQUIRING CONSULTATIONS
Unless the attending physician/dentist’s expertise is in the area of the patient’s problem, consultation with a qualified physician/dentist is required in the following cases:

- Any patient known or suspected to be suicidal;
- When these Rules and Regulations or the rules of any clinical unit, including any intensive or special care units, of the staff require it;
- When the patient requires mechanical ventilation;
- When any significant questions exist as to appropriate procedure or therapy;
- When the patient is not a good risk for operation or treatment;
- Cases of difficult or equivocal diagnosis or therapy;
- When required by state law; or
- When requested by the patient or family.

4.4 QUALIFICATIONS FOR CONDUCTION CONSULTATIONS
Any qualified physician/dentist may be called as a consultant regardless of his/her Professional Staff category. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant
must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges. Consultations responded to and completed by house officers must be countersigned in a timely manner with comments as required by an attending physician.

4.5 NOTIFICATION
When requesting consultation, the attending physician/dentist must indicate in writing on the consultation record the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

When an attending physician/dentist requests the services of a consulting physician/dentist, he should notify the patient of his/her intentions, then communicate with such consultant and make out the appropriate consultation request on the patient’s chart in case the attending physician/dentist wishes to transfer the patient to the consulting physician/dentist, he must do so in writing with the consent of the consultant and of the patient.

4.6 CONSULTATION TIMEFRAMES
Consultations are provided within a reasonable time frame, as determined by the patient’s condition. Emergency consultations are initiated immediately, preferably by direct communication with the Consultant. If emergency situations dictate the need for a transfer to a general hospital before a Specialist consultant can see a patient, such transfer will proceed even if the Consultant has not had an opportunity to participate in the care of the patient. Urgent consultations are usually obtained within twenty-four hours. Routine consultations are usually obtained within two days of request.

4.7 FINAL DECISIONS REGARDING CONSULT DIAGNOSIS AND RECOMMENDATIONS
In the event that the attending physician/dentist disagrees with the diagnosis rendered and/or recommendations for treatment made by a consulting physician/dentist, the Chairman or Director of the applicable department should be called to discuss the case with the consulting and the attending physicians/dentists. The attending physician/dentist maintains the responsibility to make the final decision regarding his/her patient.

4.8 CONSULTANT’S NOTES
The consulting physician/dentist shall record his/her examination, findings and recommendations on the consultation sheet including the date and time of his/her visit and his/her signature. The consultation sheet shall become part of the patient’s medical record.

4.8.1 Timing
The consultant shall communicate the results of such consultation to the attending physician/dentist as rapidly as possible.

4.8.2 Sequence
When operative procedures are involved, consultation notes, except in emergency, shall be recorded prior to the operation.
V
MEDICAL RECORDS

5.1 COMPLETE MEDICAL RECORD
A complete medical record shall be created for each patient. The Chair/Designee of the service shall be responsible for seeing that this is done. Medical records shall be legibly and accurately written, complete, properly filed, retained and accessible in a manner that does not compromise the security and confidentiality of the records. The physician/dentist responsible for each individual patient shall record in the medical record notes of his/her own examination, opinion and recommend treatment. A complete medical record shall include: identification data, chief complaint, personal and family history, history of the present illness, admitting diagnosis, physical examination, all practitioners’ diagnostic and therapeutic orders, nursing documentation and care plans, reports of treatments, medication records, radiology, and laboratory reports including gross and microscopic findings, vital signs and other information necessary to monitor the patient's condition, consultants notes, provisional working diagnosis, reports on medical and surgical treatment, progress notes, complications including hospital acquired infections and adverse reactions to drugs and anesthesia, properly executed consent forms for procedures, treatments, and anesthesia, discharge summary including final diagnosis and condition on discharge, and, in case of death, autopsy findings if post-mortem examination was performed.

5.2 CARE OF RECORDS
All original medical records are the property of NYEE and are not released unless NYEE is responding to Federal or State laws, court orders or subpoenas.

Care shall be taken to insure the security of both open and closed patient records; that unauthorized individuals cannot gain access to patient records; and that patient records cannot be altered.

The patient has the right to access information contained in his or her clinical records within a reasonable timeframe.

Medical records shall be retained in their original or legally reproduced form for a period of at least six (6) years from the date of the discharge or three (3) years after the patient’s age of majority (18) years, whichever is longer, or at least six (6) months after death, as required by Section 405.10 of the New York Code of Rules and Regulations. In case of readmission of a patient, all previous records shall be made available for use by his/her current physician/dentist regardless of whether the patient is attended by the same physician/dentist or another.

5.3 FAILURE TO COMPLETE RECORDS
A suspension or termination of admitting and/or clinical, operating room, admitting and booking privileges will be initiated at the discretion of the President of the Hospital or designee if a practitioner fails to complete medical records in a proper and timely fashion, as prescribed below:

- all hospital forms and reports must be electronically signed or manually signed over a legibly printed name, dated and timed
• operative reports must be dictated within twenty-four hours of the time of completion of surgery and signed within 30 days
• inpatient hospital discharge summaries must be completed within 48 hours of discharge and signed within 30 days
• all other relevant hospital forms and reports must be signed within 30 days

Notification of failure to comply shall be provided to the practitioner by the President of the Hospital or designee. Notification shall be documented as by person to person phone contact, acknowledged email or certified letter.

Notification of suspension of privileges shall be provided to the practitioner by the President of the Hospital or designee. Notification of suspension shall be documented as by person to person phone contact, acknowledged email or certified letter.

Notification of termination of privileges shall be provided to the practitioner by the President of the Hospital or designee. Notification of termination shall be documented by certified letter.

Suspension, for the first offense shall begin 48 hours after notification of the practitioner by the President of the Hospital or designee and shall remain in effect until the records are completed.

A second instance of failure to complete medical records within 48 hours of notification of the practitioner by the President of the Hospital or designee, within a six month period, shall result in suspension of admitting and/or clinical, operating room, admitting and booking privileges for a period of 14 days after completion of the records.

A third instance of failure to complete medical records on a timely basis within 48 hours of notification of the practitioner by the President of the Hospital or designee, within a six month period, shall result in suspension of admitting and/or clinical, operating room, admitting and booking privileges for a period of 30 days after completion of the records.

A fourth instance of failure to complete medical records on a timely basis, within a six month period, shall result in termination of staff privileges. Such privileges will only be restored upon submission and acceptance of a new application for staff privileges, as stipulated in Article III, Section 5.

Suspension pursuant to this Section shall be in addition to, not in lieu of, any corrective action pursuant to Article 5, Section 1. Appeal of suspension or termination will be as per Article VI.

Any clinician who has admitting privileges suspended for 30 days on two occasions (as described above) will, upon a third such notification of 30 day suspension, regardless of the time period over which such suspensions have occurred, automatically have staff privileges terminated.

Any clinician who has been suspended for 90 days or more continuously will have their staff privileges terminated.

5.4 OPERATIVE REPORTS
Operative reports should be dictated immediately following surgery; no later than 24 hours after surgery. For those inpatients longer than 24 hours, a discharge summary is required.

5.4.1 Information
All operations performed shall be fully described, dictated immediately following the termination of the operation, and will include the names of licensed independent practitioner(s) who performed the procedure and his or her assistant(s); name of
procedure performed, with concise and adequate descriptions of techniques employed and pathology and complications encountered; estimated blood loss; findings of the procedure and postoperative diagnosis.

5.4.2 Signature
The operative report will be signed by the operating surgeon/dentist.

5.4.3 Tissues, Foreign Bodies
All tissues, foreign bodies, artifacts and prostheses removed or altered during a procedure and requiring laboratory analysis, shall be properly labeled, packaged in preservatives as designated, identified as to patient and source in the operating room suite at the time of removal and sent to the pathologist. All tissue shall remain the property of the Hospital.

5.4.4 Pathologist Examination
The pathologist shall document receipt and make such examination as is necessary. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnosis. A report of the pathologist examination shall be made a part of the medical record and unusual findings will be reported to the patient’s attending practitioner or surgeon.

5.4.5 Infection Control
All infections of clean surgical cases shall be recorded and reported to the Infection Prevention Manager and Quality Department.

5.5 POSTOPERATIVE DOCUMENTATION
A qualified licensed independent practitioner will discharge the patient from the recovery area or from the hospital. The medical record will contain documentation that the patient was discharged from the post-sedation or post-anesthesia area and the name of the licensed independent practitioner responsible for the discharge.

5.6 PROGRESS NOTES
Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. The final responsibility for an accurate description in the medical record of the patient’s progress rests with the attending physician/dentist. The attending physician/dentist must countersign all notes by house officers recommending surgical procedures. Progress notes written by a physician–directed allied health professional must be countersigned within twenty-four (24) hours by the responsible supervising physician/dentist.
VI
SURGICAL PROCEDURES

6.1 PREOPERATIVE REQUIREMENTS

6.1.1 Patient Identifiers
Each member of the health care team, who has contact with the patient, will confirm patient identity, prior to delivering care and/or performing any tests/procedures.

Two identifiers will be used to identify every patient. When a third patient identifier is required, the patient’s mother’s maiden name will be used.

6.1.2 Documentation
There shall be a complete history and physical work-up in the chart of every patient prior to any surgery except emergency surgery. Each record shall document a review of the patient’s overall condition and health status prior to any surgery including provisional diagnosis and the identification of any potential surgical problems and cardiac problems.

6.1.3 Site Marking
For all procedures involving incision or Percutaneous puncture or insertion, the intended procedure site is marked by a licensed independent practitioner or other provider who is privileged or permitted by the hospital to perform the intended surgical or nonsurgical invasive procedure before the patient is moved to the location where the procedure will be performed and takes place with the patient involved, awake and aware, if possible. The marking takes into consideration laterality, the surface (flexor, extensor), the level (spine), or specific digit or lesion to be treated. The NYEE No Mark-No Surgery Policy is adhered to for all cases involving left/right laterality. The physician will mark the site of surgery, immediately following the pre-operative examination and the site marking will have the following characteristics:

(a) It will be made at or near the procedure site or the incision site.
(b) It will include the surgeon’s or proceduralist’s initials, with or without a line representing the proposed incision.
(c) It will be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping. Adhesive site markers will not be used as the sole means of marking the site.

6.1.4 Cancellation of Surgery
Except in emergencies, when history and physical examination, laboratory tests, pre-anesthetic note, required consultation reports, and signed operative consent
are not present in the patient’s record at time slated for operation, the operation shall be canceled unless the operating surgeon states in writing that delay would constitute a hazard to the patient.

6.2  INFORMED CONSENTS

6.2.1  Evidence
Each patient’s medical record must contain evidence of the patient’s or his/her legal representative’s general informed consent for treatment during hospitalization. Except in an emergency, operations will be performed on adults only with the informed consent of the patient or his/her legal representative and on minors only with the written consent of the parent or guardian.

Informed consent shall include, as a minimum, the specific procedure or treatment or both, the reasons for it, the reasonably foreseeable risks and benefits involved, and the alternatives for care or treatment, if any, as a reasonable practitioner under similar circumstances would disclose.

Informed consent shall be obtained from the patient, and a properly executed informed consent form for the operation including the identification of the practitioner(s) performing the surgical procedure(s) shall be in the patient’s chart before surgery except in emergencies in accordance with Section 405.7 of 10 NYCRR.

6.2.2  Anesthesia Informed Consents
Each patient’s medical record must contain evidence of the patient’s or his/her legal representative’s general informed consent for treatment during hospitalization. Except in an emergency, operations will be performed on adults only with the informed consent of the patient or his/her legal representative and on minors only with the written consent of the parent or guardian.

Informed consent shall include, as a minimum, the specific procedure or treatment or both, the reasons for it, the reasonably foreseeable risks and benefits involved, and the alternatives for care or treatment, if any, as a reasonable practitioner under similar circumstances would disclose.

Informed consent shall be obtained from the patient, and a properly executed informed consent form for the operation including the identification of the practitioner(s) performing the surgical procedure(s) shall be in the patient’s chart before surgery except in emergencies in accordance with Section 405.7 of 10 NYCRR.
6.2.3 Procedures Requiring Consultation
The performing physician/dentist is responsible for obtaining the patient’s or his/her legal representative’s informed consent for all procedures and treatments other than non-invasive diagnostic procedures, such procedures and treatments include, without limitation:

(a) Anesthesia
(b) Surgical and other invasive and special procedures
(c) Use of experimental drugs
(d) Radiation or chemotherapy

6.2.4 Documentation
Documented evidence of such informed consent filed in the patient’s medical record shall include, as a minimum the following information:

(a) Name of Hospital
(b) Patient Identity
(c) Name of Practitioner
(d) Date and time when patient signed the informed consent form
(e) Specific procedure or treatment or both and the reasons for it
(f) Indication that the risks and complications of the procedure or treatment and of the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient’s legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment.
(g) Authorization for any required anesthesia
(h) Authorization for disposition of any tissue of body parts as indicated; and
(i) Name of physician/dentist and translator, if applicable, who informs the patient and obtains the consent.

6.2.5 Signature
Except in an emergency, operations will be performed on adults only with the consent of the patient and on minors only with the written consent of the parent or guardian.

An informed consent must be signed by the patient (or on the patient’s behalf by the patient’s authorized representative) and witnessed by a legally competent third party.

If circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment without first obtaining informed consent as required therein, such circumstances must be explained in the patient’s medical record, and it must also be documented that appropriate Hospital administrators were so
informed and granted permission to proceed. Where possible, two physicians/dentists shall document the medical advisability of proceeding without informed consent.

6.3 **COMMENCEMENT OF SURGERY**
Surgeons scheduled for operations shall be in the operation room ready to commence at the time scheduled. The chief of service or the supervisor of the operating room may cancel any operation, except those of emergency nature, wherein the surgeon has not appeared within 15 minutes of the scheduled time.

6.4 **TIME OUT IN THE OPERATING ROOM**
Prior to starting the procedure or surgery, and when possible, prior to the introduction of the anesthesia process, a time-out is conducted. Other activities are suspended, to the extent possible so that all relevant members of the team are focused on the active confirmation of the correct patient, procedure, site, and other critical elements. Components of the time-out are clearly documented in the Medical Record.

6.5 **FIRST ASSISTANT IN SURGERY**
In any procedure presenting unusual hazard to life based on the individual patient risk factors and complexity of the procedure, a physician with the requisite privileges at NYEE shall be present and acting as first assistant.

6.6 **ANESTHESIA**

6.6.1 **Pre-Operative**
A pre-anesthesia evaluation is completed and documented by a licensed independent practitioner qualified to administer anesthesia within 48 hours prior to operative or other high-risk procedures or before moderate or deep sedation or anesthesia is administered.

6.6.2 **Intra-Operative**
During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient’s oxygenation, ventilation, and circulation are monitored continuously.

6.6.3 **Post-Operative**
A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital. A post-anesthesia evaluation will be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

6.7 **VENDOR’S ROLE DURING SURGERY INVOLVING IMPLANTS**
A manufacturer’s representative’s presence in an operating room shall only be allowed if the product cannot be demonstrated outside of the OR. Representatives are never to
“scrub in,” touch the patient, or adjust any instrumentation during a procedure. Under no circumstances is a representative permitted to participate in a procedure. Prior approval must be obtained from the attending physician and Division Director or designee. Representatives must check in with the Purchasing Department (or at the Security desk before 9:00 AM) before going to a floor. They will be given a dated VISITOR PASS that will be surrendered to the NCC or ANCC on the floor.

6.7.1 To Ensure Patient Privacy and Proper Infection Control Practices:

(a) The observation of surgery by non-medical personnel is NOT encouraged.
(b) The patient must be informed of the presence of observer(s) and give his/her consent prior to the administration of any mind-altering drug.
(c) The names of all observers must be documented in the Intraoperative Nursing Record.
(d) All visitors must wear proper surgical attire before entering the OR suite.
(e) All visitors must wear a hospital-supplied VISITOR badge.
(f) A log is kept with the visitor’s name, date, time, and attending physician’s name.

6.7.2 Approved Personnel

(a) May observe only
(b) May not enter other operating rooms
(c) May not solicit on premises
(d) Must leave the OR suite after the procedure(s) are completed
(e) May not exceed two in any one room unless allowed by Division Director under unusual circumstances.

6.8 ORGAN DONATION AND TISSUE TRANSPLANTS
This section is not applicable to NYEE. As a specialty hospital our operation is primarily ambulatory surgeries.

6.9 PERFORMING INVASIVE PROCEDURES ON FAMILY MEMBERS
It is the policy of New York Eye and Ear Infirmary of Mount Sinai that physicians, surgeons, and other health care providers will not perform invasive procedures in the operating rooms of New York Eye and Ear Infirmary of Mount Sinai on their own family members. “Family member” is understood to be a first or second degree relative of the physician including a physician’s parents, grandparents, siblings, children, grandchildren and/or any close family relation. If a member of the Professional Staff wishes to perform an invasive procedure in the operating room on a family member, prior approval must be obtained from the appropriate Department Chairman. If a Chairman wishes to perform an invasive procedure in the operating room on a family member, prior approval must be obtained from the Chief Medical Officer. In a true medical or surgical emergency, a physician may intervene on behalf of any patient, regardless of any relationship.
VII
DISCHARGE

The discharge planning process begins early in the patient’s episode of care, treatment and services.

7.1 ORDER
A patient may be discharged only on the written order of the attending physician/dentist. Such discharge shall be made only after explaining the need for discharge to the patient. When the patient leaves the hospital, the current list of medications should be reconciled against the list on admission provided and explained to the patient and, as needed, their family and this interaction is documented in the medical record.

7.2 AGAINST MEDICAL ADVICE
If a patient desires to leave the Hospital against the advice of the attending physician/dentist or without proper discharge, the attending physician/dentist shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his/her legal representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending physician/dentist or without proper discharge, a notation of the incident must be made in the patient’s medical record.

7.3 PROCEDURE
Each patient must have a discharge plan and be given discharge instructions which meets said patients post-hospital care needs. The attending physician/dentist should provide input to the discharge planning coordinator in connection with the post-discharge needs of his/her patients.

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction.

7.4 TRANSFERS TO ANOTHER FACILITY

7.4.1 Consent
When it is determined that a patient’s need for transfer exists, the patient is promptly informed, reasons for the transfer are discussed along with alternatives to the transfer.

A patient shall be transferred to another medical care facility only upon the consent of the patient or authorized guardian, and the order of the attending physician/dentist, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. In emergency situations
where patient consent is unable to be obtained, a patient may be transferred without receipt of such consents, in accordance with applicable law. All pertinent medical information necessary to insure continuity of care must accompany the patient or guardian.

7.4.2 Orders
A record of the transfer, including date and time of the hospital admission, name, sex, age, address, presumptive diagnosis, treatment provided, current medication list, clinical condition, reason for transfer and destination shall accompany any person transferred to a health care facility or certified or licensed home care services agency and, a copy of this information will be retained as part of the patient’s medical record.

7.4.3 Conditions
Each transfer shall be carried out after a physician has determined that such transfer will not create a medical hazard to the person or that such transfer is in the patient’s best interest.
VIII
HOSPITAL DEATHS

8.1 PRONOUNCEMENT
In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician/dentist or his/her designee. All identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection are managed as sentinel events. The root cause analysis addresses the management of the patient before and after the identification of infection.

8.2 REPORTING
Reporting of deaths to the Medical Examiner’s Office shall be carried out when required by and in conformance with local law.

8.3 DEATH CERTIFICATE
The death certificate must be signed by the attending physician/dentist unless the death is a Medical Examiner’s case in which event the death certificate may be issued only by the Medical Examiner.

8.4 DOCUMENTATION IN MEDICAL RECORD
The body may not be released to an authorized individual until an entry has been made and signed in the deceased’s medical record by a physician member of the Professional Staff.

8.5 RELEASE OF BODY
A dead body, including a stillborn infant or fetus estimated by an attending to have completed 20 weeks of gestation, shall be delivered only to a licensed funeral director or undertaker or his/her agent. If, at the time of death, the patient was diagnosed as having a specific communicable disease, a written report of such disease shall accompany the body when it is released to the funeral director or his/her agent.

In a Medical Examiner’s case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an “Order to Release Body” form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.

8.6 AUTOPSIES
The Professional Staff shall attempt to secure permission for autopsies in all cases of deaths that meet the criteria set forth in the Hospital’s autopsy policy. No autopsy shall be performed without proper written consent. All autopsies will be performed by a staff pathologist. The patient’s attending physician, shall be notified when an autopsy is to be performed.