BAYHEALTH
MEDICAL STAFF
RULES AND REGS

(ADOPTED 7/27/99)

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Revised 09/17/2018	Revised 06/20/2022 Updated Allied Health Practitioner to Advanced Practice Clinician	
Update KGH to Kent Campus And MMH to Sussex Campus 01/17/19		

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1. ADMISSION

1.1 All patients admitted to the Hospital shall be on the service of a member of the Active, Temporary with admitting privileges, or Provisional Active, including qualified Podiatrists and Oral Surgeons.

1.2 No patient shall be admitted as an emergency without having been seen and examined within the previous twelve hours by a member of the Active or Provisional Active Staff or a Qualified Oral Surgeon.

1.3 Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

1.4 Patients shall be admitted on order of the attending physician or verbal concurrence of the attending physician with a Advanced Practice Clinician order, which is confirmed by signature of the attending physician within 24 hours of the admission.

1.5 It shall be the responsibility of the admitting Practitioner to ascertain that appropriate isolation precautions are established and maintained for patients with communicable diseases.

1.6 All elective admissions shall be scheduled by the Admissions Office of the Hospital Campus during its regular work period, except as per emergency bed protocols when in effect.

1.7 Any patient previously seen at the hospital within the last 30 days that is in need of treatment with a related problem/issue will be the responsibility of the previous attending or treating physician.

1.8 Medical/Surgical Admissions. Any Hospital admission through the Emergency Room should be seen by the admitting Physician within the period of time appropriate for the illness or injury incurred but never longer than twelve (12) hours post admission.

1.9 Critical Care Admissions. All admissions to these critical care unit should be thoroughly evaluated in person by the admitting physician either within six (6) hours prior to admission to the unit, or no later than one (1) hour after the admitting orders have been given. This would include transfers of patients from any location, including a medical surgical unit, but not another critical care unit. Patients who are transferred from one level of care to another in the same hospital in a stable condition related to a pending elective procedure would not have to be seen within this timeframe. The definition of critical care units for the purpose of this section includes, the Intensive Care Units (ICU), the Critical and Intensive Care Unit at the Milford Campus (CICU), the Cardiothoracic Surgery/Surgical Intensive Care Unit (CVSICU/SICU), Neuro ICU (NSICU) or any similar units that are implemented at either campus. Patients admitted for telemetry who do not otherwise require critical care unit admission are excluded from this provision, including those who are admitted to a critical care unit because there is no bed elsewhere.

1.9.1 IMC. All admissions should be thoroughly evaluated in person by the admitting physician either within six (6) hours prior to admission to the unit, or no later than six (6) hours after the admitting orders have been given.

1.9.2 Neonatal Intensive Care Unit (NICU). Admissions to the Neonatal Intensive Care Unit (NICU) by neonatal nurse practitioners should be thoroughly evaluated by the supervising neonatologist within sixteen (16) hours of admission. Emergency back-up if needed may be provided by the pediatric hospitalist if response time by the neonatologist exceeds the immediate need.

2. DISCHARGE

2.1 Patients shall be discharged on order of the attending physician or verbal concurrence of the attending physician with a Advanced Practice Clinician order, which is confirmed by signature of the attending physician within 24 hours of the discharge. A discharge diagnosis shall be entered in the medical record upon discharge of the patient.

3. RESPONSIBILITY FOR PATIENT CARE

3.1 Definition of Duty.

3.1.1 Each member of the Active and Provisional Active Medical Staff while "on-call" to provide Emergency Department or inpatient coverage shall be available to respond to the emergent or non-emergent needs of both inpatients and the Emergency Department in accordance with the following standards:

3.1.1.1 A Physician shall be prepared to respond, in person, as medically appropriate and necessary to meet the emergency and non-emergent needs of the Physician's inpatients and the Emergency Department within the time(s) established for such responses by such Physician's Department as approved by the Medical Executive Committee at each Hospital Campus.

3.1.1.2 "In person" response shall mean:

3.1.1.2.1 As to a Physician "on-call", the capability to be present in the Emergency Department to begin examination/treatment of a patient, and

3.1.1.2.2 As to a Physician responsible for the care of an inpatient, the capability to be present, personally or through established coverage arrangements with another member of the Medical Staff, to begin examination or treatment of the patient.

3.1.2 Unassigned Call Requirements

3.1.2.1 Any specialty or subspecialty that has at least five credentialed active and provisional active staff practitioners at a hospital campus must provide continuous (24/7) coverage.

3.1.2.2 Any specialty or subspecialty that has less than five credentialed active and provisional active staff practitioners at a hospital campus, each practitioner will provide coverage one out of five days, except as provided at Section 3.1.2.3 below.

3.1.2.3 In order to assure unassigned call coverage on a continuous (24/7) basis at each hospital campus in those specialties or subspecialties deemed most essential to meeting the emergency care needs of the communities served, each specialty or subspecialty at each hospital shall be evaluated and classified as Tier I (most essential), or non-Tier I specialties. In any Tier I specialty or subspecialty in which there are less than five credentialed active and provisional active staff practitioners at a hospital campus, each practitioner may be required to provide coverage, not to exceed one out of three days, as required to provide continuous (24/7) coverage. The tier classification of specialties and subspecialties at each hospital shall be monitored and evaluated periodically and may be modified from time to time by the Hospital in consultation with the medical staff. Modifications would be based upon reevaluation of the critical needs of the community, relative call burden upon practitioners in the specialty or subspecialty in relation to other specialties or subspecialties, utilization and demand for such services, facility resources, and other relevant factors.

3.2 Department Response Guidelines. Each Department shall establish response times for each specialty or subspecialty practice within the Department and shall report such response times to the Medical Staff Medical Executive Committee for approval. In establishing such response times, each Department shall consider the nature and frequency of emergent conditions affecting each specialty and subspecialty, the capability, and resources of the Emergency Department to address such emergent conditions, and the applicable standards of care for such specialty or subspecialties. Response times as established shall be reasonable under all the circumstances and shall be clinically necessary and appropriate.

3.3 Consultations. Physicians on call are obligated to perform emergency consultations. Non-emergent inpatient consultation shall be completed within twenty-four (24) hours, unless otherwise determined by the Department and accepted by the Medical Executive Committee. Requirements to complete consultations include Sussex Campus (including rehabilitation services), and Kent Campus. If the Practitioner requesting the Consult requires the Consult to be done in less than 24 hours, Physician to Physician communication must occur.

3.4 The attending physician or physician designee must evaluate each inpatient and write or cosign a note every day, except patients admitted to the Sussex Campus Rehabilitation Services. No patient can be admitted or discharged without the verbal concurrence of the admitting physician confirmed by signature within 24 hours of both admission and discharge.

3.4.1 When inpatient care is rendered by a practitioner with Allied Health privileges, it is
the responsibility of the supervising physician or an on-call covering physician to review and cosign chart entries as noted below, unless indicated otherwise by an FPPE or OPPE plan:

Record Element	**Timeframe for Supervising Physician Co-Signature**
Admission orders	Within 24 hours
Discharge order	Within 24 hours
Consults	Within 24 hours
Progress notes	Within 24 hours
History and Physical	Within 24 hours
Operative Reports	Within 24 hours
Discharge Summaries	Within 72 hours of Discharge

4. ORDERS AND DRUGS

4.1 It shall be the general policy that all orders for treatments shall be in writing and signed by the Physician. It is recognized that verbal orders are occasionally necessary and appropriate, but such orders must be dictated by the Physician or appropriately credentialed advance practice nurse or physician's assistant to a registered nurse, licensed practical nurse, pharmacist, physical therapist, occupational therapist, registered dietitian, registered radiology technologist, certified respiratory care technologist, or speech pathologist and signed by the Physician at his/her earliest opportunity, but in no event greater than 48 hours later than the verbal order was given (with the exception of verbal orders for restraint for violent behavior which must be co-signed within 24 hours of the verbal order being given). If the practitioner who placed the verbal order is not available to authenticate the verbal order within the 48 hours then it is acceptable for another practitioner who is responsible for the patient's care to authenticate the verbal order for the ordering practitioner.

4.2 The availability of Pharmaceutical goods and policies concerning automatic stop orders will be as per recommendation of the Pharmacy and Therapeutics Committee based on information that this committee receives from the Medical Staff membership and the Pharmacy support personnel.

5. MEDICAL RECORDS

5.1 The attending Physician, Podiatrist or Qualified Oral Surgeon shall comply with all medical records policies and procedures and is responsible for such compliance by any Physician or Qualified Oral Surgeon who covers for him/her during his/her temporary absence.

5.2 All medical records are the property of Bayhealth and shall not be released, disclosed or distributed without the appropriate legal authorization and through the specific approval of the CEO, COO, or the appropriate physician administrator or by proper court order. In case of readmission of a patient, all previous medical records shall be available for the use of the attending Physician and the other health care practitioners involved with the Patient's medical treatment.

5.3 A discharge diagnosis shall be made on all patients before the patient is discharged. This diagnosis will be written by the discharging Physician, Podiatrist or Qualified Oral Surgeon or may be phoned to the nurse or ward clerk by the discharging Physician, Podiatrist or Qualified Oral Surgeon.

5.4 Medical records are required to be completed by the Attending Physician or the authorized Advanced Practice Clinician to perform such duties as follows:

5.4.1 A complete legible history and physical examination shall in all cases be written or dictated within twenty-four (24) hours after admission of the patient. Any surgery, including endoscopic procedures, and any patient admitted or placed into an inpatient bed requires appropriate history and physical. Other patients treated on the hospital campuses will require documentation of evaluation only to the extent determined appropriate by their attending physician.

5.4.2 Progress Notes: A daily progress note shall be entered in the patient's medical record.

5.4.3 Operative Notes

5.4.3.1 There must be an immediate post-operative note placed on the chart that addresses each of the following:

- Date of procedure
- Time of procedure
- Preoperative diagnosis
- Postoperative diagnosis
- Procedure(s) performed
- Surgeon
- Assistant
- Findings
- Surgical Wound Classification
    - Clean
    - Clean-Contaminated
    - Contaminated
    - Dirty, infected
- Packing ____ yes ____no
- Type of anesthesia

- Estimated blood loss
- Tubes and drains
- Specimen removed
- Signature.

5.4.3.2 Formal Operative Note: Must be dictated within twenty-four (24) hours after completion of the procedure, or placed on the chart by the physician within 48 hours.

5.4.4 Discharge Diagnosis: The attending Physician is responsible for completion of the discharge summary and final diagnosis (unless autopsy report is still pending) within 72 hours of the discharge of the patient from the Hospital.

5.4.5 Consultations: Pertinent clinical consultation subjects such as historical information, physical exam, pending questions, suggested interventions, and any plans that the consultant might have for further review should be documented on the chart immediately following completion of the consultation, with any more formal consultation dictation or notation to be completed at the discretion of the consultant.

5.4.6 Diagnostic Imaging/Radiology Reports: The interpretive report by the Radiologist shall be dictated within twenty-four (24) hours after completion of the procedure.

5.4.7 Preliminary autopsy reports by the Pathologist must be dictated within three (3) days and final reports within sixty (60) days.

5.4.8 Records of discharged patients are completed by the physician, consultant, or proceduralist within thirty (30) days following notification by Medical Records that the charts are available for any pending documentation.

5.5 Medical Records Delinquency.

5.5.1 Health Information Services (HIS) personnel must notify practitioners that deficiencies are available for completion. This notification is done via their Epic inbasket. Deficiencies must be completed in the timeframes noted in the Medical Staff Rules and Regulations. After such time, they become delinquent. Practitioners will receive a summary of deficiencies and delinquencies weekly via their Epic inbasket. After a delinquency passes 14 days, the practitioner will be contacted via phone or email to complete the delinquencies. This process will take place weekly.

5.5.2 A delinquency older than 30 days will result in suspension of the practitioner's membership and Clinical Privileges. This action will consist of suspension of elective admissions, consultations, and elective operating privileges. Notification of this action will be sent to the practitioner by the Medical Staff Office and filed in the practitioner's credentialing record. Suspensions will take place weekly after the 30 days has been reached.

5.5.2.1 In any six (6) month period the first such suspension will remain in effect until the delinquency is cured.

5.5.2.2 The second such suspension shall also remain in effect until the delinquency is cured with a notification clearly indicating that this is the second suspension.

5.5.2.3 The third such suspension shall remain in effect until fourteen (14) days following the date that the delinquency is cured.

5.5.2.4 The fourth such occurrence within a six (6) month period will result in automatic revocation of the member's Medical Staff membership and Clinical Privileges.

5.5.3 In extenuating circumstances, institution of the suspension may be delayed or temporarily lifted by the Chief Medical Officer or Chief Operating Officer.

5.6 HIPAA. Organized Health Care Arrangement/Notice of Privacy Practices.

5.6.1 For purposes of compliance with the federal HIPAA privacy regulations, patients obtaining services from Bayhealth Medical Center are provided with a joint notice of privacy practices on behalf of the Hospital and the Medical Staff as an Organized Health Care Arrangement. An Organized Health Care Arrangement is described by the federal privacy standards, 45 C.F.R. Part 164, as a clinically integrated care setting in which individuals typically receive care from more than one health care practitioner. The Hospital and the Medical Staff participate in an Organized Health Care Arrangement.

5.6.2 Members of the Medical Staff shall comply with the practices described in the joint notice with respect to health information created or received as part of the Organized Health Care Arrangement between the Hospital and the Medical Staff.

6. ELECTROCARDIOGRAM

6.1 Electrocardiograms (EKGs): An EKG received in the EKG Department will be interpreted within twenty-four (24) hours after being placed in the interpreting Physician’s electronic mailbox. EKGs that are not interpreted within the 24 hour time frame will be placed in the next day's interpreting Physician's electronic mailbox prior to 4:30 pm to assure that the EKG is interpreted and sent to the medical record expeditiously (the technicians will notify this Physician of the need for timely interpretation).

6.2 All electrocardiograms shall be performed by qualified Hospital personnel using the Hospital equipment, except where arrangements have been made with the Hospital administration.

6.3 All such electrocardiograms shall be read and signed by a member of the Medical Staff with appropriate Clinical Privileges.

6.4 Any Physician requesting an electrocardiogram shall designate the Physician who is to interpret the result and record his/her findings.

6.5 Each Physician assuming responsibility for EKG interpretation must ensure that the EKGs assigned to his/her service are interpreted on a daily basis.

6.6 Any finding that appears to require intervention that has not been documented as having been recognized must be immediately reported by the interpreting Physician to the ordering Physician or his/her designee.

6.7 If an interpreting Physician can not provide services every day, he/she must make arrangements for another credentialed physician to cover the EKG obligation within the time constraints noted above and in Article 6 of the Rules and Regulations.

7. DIAGNOSTIC IMAGES

7.1 The diagnostic images report shall be signed by a member of the Hospital Department of

Diagnostic Imaging or an approved, credentialed specialist from another Department who has privileges to interpret images.

7.2 An ongoing Radiation Safety program should be managed by the Radiation Safety Committee with the assistance of a Radiation Safety Officer who shall not act as Chairperson of the committee and who may be a physicist rather than physician.

8. PATHOLOGY

8.1 Anatomic specimens removed at operative procedures should be sent to the laboratory in accordance with the appropriate departmental and interdepartmental policies which define specific requirements, procedures, labeling and transportation methods, specimen types that require examination, and those that do not (i.e B7000.05, B7000.09, B7000.08, B7000.11, B7000.20).

8.2 Anatomic pathology frozen section interpretation must be completed, reported and documented as rapidly as is possible upon receipt of the specimen.

8.3 Non-frozen section anatomic pathology tissue evaluation will have variable turnaround times based on: the size and type of tissue, method and extent of fixation required, radioactive decay time, ancillary testing required, internal or external consultations, and reporting mandate complexity.

8.4 Processing of emergency Laboratory Department clinical specimens must be completed in a timely manner following receipt of the specimen by Laboratory personnel and will be monitored via Laboratory Performance Improvement.

8.5 Routine clinical laboratory samples will be processed in a timely manner and will be monitored via Laboratory Performance Improvement.

9. DEATH

9.1 It is the responsibility of the attending physician or his/her covering physician to pronounce the patient and determine the time of death.

9.2 It is also the responsibility of the attending Physician to notify immediate family in an appropriate manner and to review the circumstances of the death as indicated.

9.3 It is expected that members of the Medical Staff will be familiar with their patients advance directives and related information and to intervene accordingly.

9.4 It is expected that members of the Medical Staff will seek organ or tissue donation where applicable.

9.5 Members of the Medical Staff are also expected to be actively interested in securing autopsies and to assist Hospital staff in completing any consent related information.

9.6 It shall be the responsibility of the attending Physician to notify the office of the Medical Examiner in cases falling under Medical Examiner jurisdiction. The hospital Pathologist may perform an autopsy in a Medical Examiner's case only when there is a documented request by the Medical Examiner's Office.

10. SCREENING EXAMINATION

Medical screening examination and related documentation, within the capability of the hospital, will be performed on all individuals who come to the hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable hospital policies and procedures are defined as:

A. Emergency Department

- Physician members of the medical staff with clinical privileges to practice in the Emergency Department, though not necessarily Emergency Department privileges.
- Nurse Practitioners and Physician Assistants on the Allied Health Staff with clinical privileges to practice in the Emergency Department, though not necessarily Emergency Department privileges.

B. Labor and Delivery

- Physician members of the medical staff with OB/GYN privileges.
- Certified nurse midwives with obstetrical privileges.
- Registered nurses with at least 2 years Labor and Delivery experience and certification in neonatal resuscitation, following telephone consultation with a physician or certified nurse mid-wife.