# MEDICAL STAFF RULES, REGULATIONS, AND POLICIES
# BEAUMONT HOSPITAL-TRENTON

Beaumont

*May 23, 2023*

SOUTHSHORE MEDICAL CENTER
MEDICAL STAFF RULES AND REGULATIONS

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## ARTICLE I

## CARE OF THE PATIENT

**Section 1.1** Each patient admitted to the hospital shall have laboratory work performed as ordered by the physician. It is expected that in surgical patients, the results of these laboratory examination, with the exception of serological test for syphilis, will be present on the record prior to proceeding with surgery.

**Section 1.1 a** Only one medical staff member may be designated as the attending practitioner responsible for patient care until the patient is transferred or discharged.

EXECUTIVE COMMITTEE APPROVAL: 9-2-08; SSBOT 10-6-08

**Section 1.2** Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever. In case of the physician's failure to meet this responsibility through neglect, lack of knowledge or inaccessibility, the nursing department shall contact the head of the department, the physician on emergency call or the house physician in cases suspected of being contagious. Any of the above physicians has the authority to institute isolation procedures in such cases where the attending physician has failed to order these precautions. The physician ordering isolation procedures shall also notify the attending physician.

**Section 1.3** In the case of a patient applying for admission who has no attending physician he shall be referred to the emergency room for disposition.

**Section 1.4** Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon after as reasonably possible.

**Section 1.5** All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a nurse or other authorized person and signed by the attending physician. Orders dictated over the phone shall be signed by the person to whom dictated, with the name of the physician per his or her own name. At his next visit, the attending/ordering physician shall sign and date such orders.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 5-02, 9-6-05

The Medical Staff delegates to the therapist (Physical Therapist, Occupational Therapist, Speech/Language Pathologist), upon an order for therapy to evaluate the patient, develop a plan of treatment, and initiate the plan of care prior to the physician signing off on the plan.

EXECUTIVE COMMITTEE APPROVAL: 9-6-11

**Section 1.6** When a member of the medical staff is unavailable, he shall obtain prior acceptance of a member of the medical staff to attend his patients, and shall notify the Administrator's Office to this effect. The physician who lives or practices a great distance from the hospital will obtain prior acceptance of a member of the Active Medical Staff who will be available for the immediate care of his patients, either in the hospital or in the emergency room. In case of failure to name an associate, the Chief of Staff of the hospital shall, if necessary, have the authority to call on any member of the staff who, in his judgment, will adequately provide care for the physician's patients.

**Section 1.7** Patients shall be discharged from the hospital only on the order of an attending physician.

**Section 1.8** Standing orders may be developed by any department and submitted to the Executive Committee for its review and approval. Department Standing orders are to be reviewed annually and may be revised at any time. All Revisions will be approved by the Executive Committee. Physicians agreeing to use standing orders are to sign a copy of those standing orders which will be kept in the respective department.

**Section 1.9** An osteopathic musculoskeletal examination is required as an integral part of the H&P performed by osteopathic physicians on their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

EXECUTIVE COMMITTEE APPROVAL: 2-4-03

## ARTICLE II

## MEDICAL RECORDS

**Section 2.1** A medical record shall be maintained on every patient admitted to the hospital. It shall contain sufficient information to justify the diagnosis, to warrant treatment and to explain the end results: Only approved symbols and abbreviations may be used in Medical Records.

EXECUTIVE COMMITTEE APPROVAL: 9-6-05
EXECUTIVE COMMITTEE REVISION: 8-5-08; SSBOT 10-6-08; 2-7-23

**Section 2.2** No medical staff member shall be permitted to complete the medical record of a patient who is unfamiliar to him. No medical record shall be filed until it is completed, unless otherwise ordered by the Health Information Management Committee.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION:12-1-92, 6-93,9-01,5-02, 9-6-05, 2-7-23

**Section 2.3** All medical and dental records must be completed as follows:

History & Physical, Requirements

At a minimum, the History and Physical shall include the chief complaint, details of history of present illness, past medical history, relevant family history and social history, review of systems and relevant physical examination. The physical exam should include an exam specific to the reason for admission and any co-morbid condition.

Inpatient
The physician shall complete the patient's history and physical (H&P) and document it, either by writing legibly in the chart or by dictation, within 24 hours of admission and prior to an invasive procedure which places the patient at significant risk and/or for patients who will be receiving moderate sedation. Failure to do so will result in suspension of admitting and consulting privileges until the H&P is complete. If the H&P is dictated, an entry will be made in the chart that the H&P was dictated and an admission note will be entered that identifies the tentative diagnosis and plan of care. If an H&P has been performed and documented within thirty (30) days of the patient's admission to the hospital or admission for a scheduled operative or invasive procedure, a copy of that H&P examination may be used in the patient's medical record, provided an update is performed by a licensed independent practitioner or designee with privileges to perform H&Ps, and it is documented prior to the procedure or at the time of or within 24 hours of admission. This updated H&P exam must:

(a) Address the patient's current status/any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted).
(b) Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior H&P, or to address any areas where more current data is needed.
(c) Confirm that the necessity for the admission, procedure, or care is still present.
(d) Be written or otherwise recorded on, or attached to, the previous H&P, or written in a progress or consult note.
(e) Be placed in the patient's medical record prior to the procedure or within 24 hours of admission.

Before Surgery

All surgeons shall ensure their patients have a history and physical documented in the chart prior to surgery. If dictated, the transcribed H&P must be on the chart prior to the start of the case. At a minimum, the H&P should include sufficient patient assessment information to ensure clearance of the patient to proceed with surgery. When the history and physical examination are not recorded before surgery or potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states that such delay would be life threatening to the patient. The pre-operative diagnosis shall be recorded prior to surgery.

For Outpatient Procedures Outside of the Operating Room

A brief history and physical is required for outpatients outside of the operating room, who are undergoing invasive procedures which place them at significant risk and/or who will be receiving moderate sedation. The H&P must be completed and on the record prior to the procedure. The history and physical must contain at a minimum, the reason for the procedure, significant medical problems, medications, allergies, vital signs, and examination of the heart, lungs and body system or part where the procedure will be performed.

Admission After Outpatient Procedure

When a patient is admitted to the hospital following an outpatient procedure, the admitting physician shall complete the history and physical (H&P) consistent with the requirement for an inpatient admission.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 4-6-04, 9-6-05

The operative report shall include an account of the findings at operation including the pre-operative diagnosis, post-operative diagnosis, the name of the primary surgeon and any assistants, the procedures performed, specimens removed and the estimated blood loss as well as the details of the surgical technique. Operative Reports must be done within 24 hrs for Outpatients as well as Inpatients, and the report promptly signed by the surgeon and made a part of the patient's current medical record. Physicians who are delinquent in dictation of operative reports for more than 24 hours shall be placed on Full Suspension.

Post–Operative Note: An operative or other high-risk procedure note must be written immediately upon completion of the procedure before the patient is transferred to the next level of care. The note shall include the name of the primary surgeon and assistants, procedures performed, and description of each procedure findings, estimated blood loss, specimens removed, and post-operative diagnosis.

EXECUTIVE COMMITTEE REVISION: 9-6-05

Post Delivery Note and Physician Orders: A post delivery note and physicians' orders must be completed within two hours following completion of a C-Section or vaginal delivery.

EXECUTIVE COMMITTEE APPROVAL: 3-7-06

A detailed discharge summary must be dictated/written within **14 days** of discharge for all patients with a length of stay greater than 48 hours. Discharge summary content should include reason for hospitalization, significant findings, procedures performed, and description of each procedure findings, estimated blood loss, specimens removed, and post-operative notes. For Hospice records an addendum to the original inpatient summary is sufficient. All death records regardless of length of stay require a dictated/written death note/summary.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 12-1-92, 6-93, 5-02, 11-05, 9-6-05, 9-7-10, 11-18-21

The final diagnosis should be recorded in the patient's chart at the time of discharge.

All records shall be completed within fourteen (14) calendar days.

The following steps will be taken for physicians who have not completed records within the 14 day timeframe.

1. 14 days from discharge – each Tuesday, the physician will receive the first communication alert at Epic login with instructions to complete delinquent records. Subsequent Epic communications will be generated for deficient that remain incomplete. Communications will then follow each Tuesday for deficient that remain at 21 days and then 28 days from discharge.

2. 28 days from discharge – Administrative Suspension will occur at this time.

    a. Exceptions to suspension, necessary for patient safety, will be referred to the Chief of the Department, the Chief of Staff, and/or the Chief Medical Officer for consideration.

Administrative Suspension (loss of all hospital privileges) occurs when, after prior notification, incomplete records have reached a minimum of twenty-eight (28) calendar days old in the incomplete medical record system without responsible physician completion activities. The physician may be notified to appear before the Medical Executive Committee.

Physicians on **ADMINISTRATIVE SUSPENSION:**
* cannot exercise clinical privileges, perform procedures, or board new cases
* will be removed from call schedules
* cannot read or supervise test
* will need to transfer care for patients currently in the Hospital to another provider

EXECUTIVE COMMITTEE APPROVAL: 12-22-90
EXECUTIVE COMMITTEE REVISION: 2-11-92, 3-93,6-93,11-93,9-01, 5-02, 12-03, 9-6-05, 3-2-10, 12-16-21

**1.** If the delinquent records are not completed within an additional seven (7) days after Administrative Suspension of privileges as indicated in the above paragraph, the physician may be notified to appear at the next meeting of the Executive Committee.

**2.** If a physician reports an absence from practice of more than five days due to illness or other extenuating circumstances, the physician may receive a five (5) day exemption from suspension due to delinquent medical records at the discretion of the Chief of Department, the Chief of Staff, and/or the Chief Medical Officer.

**Section 2.4** Progress notes shall be written on a daily basis and when any significant change in the patient's condition occurs. Progress notes by the medical staff should give a pertinent, chronological report of the patient's course and should be sufficient to describe the changes in each of the patient's conditions and the results of the treatment. Physicians must place in the patient's medical record the timely, pertinent clinical evaluation of the results of respiratory therapy, physical therapy, and other modalities.

EXECUTIVE COMMITTEE REVISION: 9-6-05, 12-16-21

**Section 2.5** Other than an attending physician or appropriate medical staff committee established by the bylaws, no member of the medical staff, other than the Chief of Staff and the Chiefs of Departments or the emergency room physician or persons delegated by the, shall have the authority to review a patient's medical record. Hospital records, however, may be used for scientific, educational, and statistical purposes and in publications provided the anonymity of the patient is maintained. The use of medical records for these purposes must have the prior approval of the Executive Committee of the Medical Staff.

**Section 2.5a** Accessibility and Confidentiality. The original medical record is the property of the hospital and shall not be removed from the premises without a court order, subpoena, or statute. Unauthorized removal of the records from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee.

Release of information from a medical record shall be made to the patient or to authorized third parties only in accordance with the provisions of applicable State and Federal law and hospital Medical Record policies.

**Section 2.6** The use of the short form medical record shall be used in the following cases.

1. Patients registered as Outpatient Surgeries.

2. Patients registered as Observation Status.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 9-01, 5-02, 2-23

**Section 2.7 - Record Completion for Teaching Patients**
The resident assigned to a teaching patient shall be responsible for completion of the medical record from admission to discharge. Only the

attending physician may place final discharge signature to a chart even though the patient is a teaching patient cared for by a resident.

Co-signatures are required for teaching patients as follows:

1. H&P and progress note by the next daily visit

2. Operative report, L&D Summary, and Discharge summary within 30 days of discharge.

EXECUTIVE COMMITTEE APPROVAL: 11-1-05

**Section 2.8 – Death Certificates, Responsibility for Completion**
The proper preparation of a death certificate is an important role of the Medical Staff.

Responsibility for completing and signing the death certificate rests with the attending physician, or in the absence of the attending physician, their designated covering physician. Certification of the death, i.e., a completed, signed death certificate, should be provided within the 48 hours immediately following pronouncement of death.
As the death certificate is not an autopsy report, the attending physician shall use their sound medical judgment to complete the certificate based on what is known to them. In the event that the patient expired prior to the attending physician seeing the patient, this information may be obtained from the electronic medical record or consultation with the patient's primary care physician (if they are not the attending). It is the responsibility of the attending physician of record to complete the death certificate regardless of whether or not they saw the patient during the hospitalization in which the patient died.

Regardless of where the patient expires, all deaths that meet pre-defined criteria are reported to the Medical Examiner. Depending on the circumstances of the patient's death, the ME may sign the death certificate or they will refer the matter back to the patient's attending physician.

Cases in which the attending physician is available but refuses to sign the death certificate will be immediately referred to the Department Chief. The matter may be escalated up the chain of command, if necessary.

BEAUMONT HEALTH BOARD OF DIRECTORS APPROVAL: 10-24-19

## ARTICLE III

## CONSULTATIONS

**Section 3.1** Consultations shall be dictated or written legibly on a proper form provided for this purpose. A consultation request shall include the indications for the consultation. The consultation report shall contain the consultant's findings on examination and state his opinions and recommendations. Such consultations shall be given by a qualified member of the active or consultant division of the Medical Staff. A physician regularly associated in practice with or employed by a physician requesting the consultation may not act as a consultant in those conditions for which consultation is mandatory. If the attending physician and consultant disagree on management of a patient, a second consultation must be ordered.

EXECUTIVE COMMITTEE REVISION: 9-7-10

**Section 3.2** If the consultant is to assume the entire management and responsibility of the patient following consultation, the patient shall be transferred to him by the attending physician who will write an order on the medical record for such transfer, with the agreement of the consultant.

**Section 3.3** In those instances where the patient's condition merits a consultation, but where a consultation has not been requested, the Chief of the Department may request the attending physician to seek immediate consultation. If the physician refuses, the department chief may either act in the role of a consultant or may secure the services of a physician who, in the chief's judgment, is qualified to serve as a consultant under the circumstances. All instances of this nature must be reported to the Administrator of the hospital.

**Section 3.4** Psychiatric consultation and treatment should be requested for, and/or offered to, all patients who have attempted suicide or have taken a chemical overdose.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 5-02, 9-7-10

**Section 3.5 <u>Timeliness of Consultations</u>:**

*a.* The OHS standard for timely response to requests for physician consultations shall be:

1) STAT and urgent consults: requesting physician to evaluate patient personally prior to requesting STAT or urgent consult. Consulting physician to see patient within a mutually agreed upon timeframe during physician to physician contact.

2) Routine consults: physician to evaluate patient within 24 hours;

***b.*** All STAT and urgent consultation requests should be made by telephone call directly physician to physician to ensure that pertinent history, reason for the consultation, and the timeframe in which the consultant needs to be present at the bedside are clearly communicated. In the event that the requesting physician is engaged in critical patient care management and cannot make the call, the call may be made by a nurse, but must be directly communicated to the consulting physician.

***c.*** All OHS physicians shall ensure that they carry working pagers and/or left contact numbers with hospital switchboards while on call.

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Oakwood Southshore Board of Trustees Approval 4-28-03

**Section 3.6** All consults must be initiated by the admitting/attending physician only.

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Joint Conference Committee Approval 1-5-12

**Section 3.7 Intensive Care**

**Preamble:**

By clarifying the expectations of physician leadership, this rule seeks to improve patient safety and clinical outcomes, increase the efficiency of service, and enhance the quality-of-care environment for patients and all healthcare professionals. It concurrently seeks to foster a collegial atmosphere with administration to achieve these goals.

Board Certification

All intensivists must be board certified/eligible in Critical Care Medicine.

Intensivist Mandatory Consult

All patients admitted to any ICU must have a mandatory intensivist consult and must be managed by a board certified/eligible intensivist. The routine consults must be performed/staffed within 24 hours by the consulting intensivist. Stat consults must be staffed within one (1) hour of notification when clinically indicated. Consultations performed by residents or APPs do not satisfy that requirement.

Intensivist Model of Care

The intensivist shall comply with the following Intensivist Model of Care:

- The intensivist must be involved in providing the equivalent of at least

six weeks of full-time ICU care each year to maintain clinical competency.

- The intensivist must be present 10 hours during the daytime 7 days a week. If an intensivist goes offsite, they must arrange coverage for their patients from an in-house intensivist in order to satisfy the above criteria.
- The intensivist must be dedicated to the care of the ICU patients only.
- After the 10-hour daily coverage, the intensivist is expected to return all pages/call/notifications within 5 minutes at least 95% of the time when not present on site and arrange for residents or APPs to reach ICU patients within 5 minutes
- The intensivist must perform and lead interdisciplinary rounds daily. These rounds must also meet the expectation of being patient and family centered.
- Rounds shall start at a set specific time on each unit in a manner that allows for interdisciplinary rounds and maximizes the patient and family experience.
- The intensivist shall follow ICU protocols that are supported by evidence-based medicine.
- The intensivist is expected to support Beaumont Health standardized protocols that are related to quality metrics and value-based purchasing.
- Support Beaumont Health's mission and values.

Medical Leadership in ICU

The Medical Director of Critical Care Services (or designee) shall provide direction for day-to-day operations, establish and enforce Admitting and Discharge criteria (as endorsed by the Medical Executive Committee), act as the gatekeeper for those functions, provide triage direction for monitored bed utilization, and work with the ICU Nurse Manager to provide quarterly reports to the Chief of Medicine and Chief of Staff.

The Medical Director of Critical Care Services (or designee) shall assume at least co-supervisory responsibility and authority for any residents rotating through the ICU.

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Joint Conference Committee Approval: 10-29-14; 09-26-19

## ARTICLE IV

## OBSERVATION OF STAFF MEMBERS

**Section 4.1** Observation of a physician or dentist may be established at the discretion of the Executive Committee when indicated by a review of

the physician's clinical work, Such review may be conducted by the Tissue, Record, Audit or Professional Review Committees when applicable.

**Section 4.2** The physician under observation or probation will be provided with a statement of the nature of the observation and the departments and procedures to which it applies.

**Section 4.3** An applicant approved for membership on the Active, Courtesy, or Consulting medical staff shall serve an initial provisional staff appointment under observation for a 12 month period. During this appointment he must be assigned to a department where his clinical competence and ethical and moral conduct may be observed by a designated staff member of the Active medical staff.

**Section 4.4** The term of observation will be as noted in the Oakwood Southshore Medical Center Medical Staff By-Laws, Article II, Section 6, which reads as follows:

> **Section 6 - <u>Terms of Appointment</u>**
>
> All initial appointments and reappointment to the Medical Staff shall be for a period of up to three years.

## ARTICLE V

## ORDERS

**Section 5.1** Patients may **not** take any medications, (O.T.C.'s or legend), except on the direct order of the attending physician.

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EXECUTIVE COMMITTEE APPROVAL: 12-11-90

**Section 5.2** Patients may not bring their own personal medicine into the hospital for use therein except for the following situations:

a. Oral type contraceptives that have already been started.
b. Unavailable medication, such as an investigational drug that is used for maintenance.

**Section 5.3** The following policies and procedures apply to the ordering administration of medications**:**

### A. <u>STANDARD PRACTICE FOR WRITING MEDICATION ORDERS</u>

a. Name of drug selected from formulary list.
b. Dosage form and strength.
c. Frequency of administration, number of days old or total doses if known.
d. Route of administration
*e.* Signature, date and time.

## B. POLICIES AFFECTING VALIDITY OF ORDERS

The following policies cover the duration of an effective order.

### 1. STOP ORDERS ON DRUGS:

The following drugs have an automatic stop order period:

**72 HOURS:**

ANTICOAGULANT

**72 HOURS:**

NARCOTICS CONTROLLED SUBSTANCES IN SCHEDULE II INJECTABLE AMINOGLYCOSIDE ANTIBIOTICS

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EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 6-25-96

**7 DAYS**

CONTROLLED SUBSTANCES IN SCHEDULE III, IV
ANTIBIOTICS
CORTICOSTEROIDS
ANTINEOPLASTICS

All post operative antibiotic orders will have a one time automatic stop order period of 48 hours. Once renewed by the physician, normal stop order policies will apply.

All physician orders for those drugs listed above will be automatically discontinued after the stop order period unless:

A. The attending physician rewrites the medication order.

B. The order indicated an exact number of doses to be administered.

C. An exact period of time (Hours or Days) for the medication is specified.

The nursing staff must consult with the physician before a stop order will go into effect. A stop order may be renewed verbally or by phone. The physician shall sign said renewal within 24 hours or on his next visit for the order to be continued as written.

**NO DRUG WILL EXPIRE AT ANY OTHER TIME THAN AT NOON.**

Within reason, all drugs not falling within the above classification of dangerous drugs will be continued until the physician orders them discontinued.

Verbal orders are not acceptable **except** from a physician. Verbal orders for medication may be accepted only by Pharmacists, Registered Nurses, Respiratory Therapists, Nurse Practitioners, Nurse Anesthetists, and Physician Assistants.

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EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 4-06-04

The following procedure will be used to carry out the policy.

If the drug order is not reordered after the physician's notification, the order will be stopped. A daily reminder sheet will be attached to the front of the chart indicating the name of the patient and the drug orders which will expire. The expiration drug list will be posted no later than 8:00 p.m. for drugs which will expire the following noon.

Respiratory therapy will be able to accept verbal or phone orders from physicians, who wish to have their patients seen by Respiratory Therapy.

Dietitians may accept physician's verbal orders for diet and document them in the physician order section of the medical chart.

**2. STAT ORDERS**

A stat order does not automatically discontinue a p.r.n. order for the same day, but merely alters the time of subsequent administration**.**

**3. TIME LIMITATIONS**

All orders for a drug to be administered at designated intervals (i.e., every

4 hours, 3 times a day, etc.) do not require the additional direction of "daily" to make the order valid beyond the initial 72-hour period. If there are time limitations affecting the validity *of an order, they* are to be included in the order.

**4. CANCELLATION OF CURRENT ORDERS AT OPERATION**

All current orders are automatically canceled and new orders are written as for a new patient when a patient goes to the operating room.

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EXECUTIVE COMMITTEE APPROVAL: 12-11-90
EXECUTIVE COMMITTEE REVISION: 5-02

**Section 5.4** Physician Assistants and Nurse Practitioners may write orders for routine laboratory work, diagnostic tests and medications (as allowed by state licensure) and for appropriate referrals to other health professionals.

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EXECUTIVE COMMITTEE APPROVAL: 4-5-05
EXECUTIVE COMMITTEE REVISION: 8-7-19

**Section 5.5** Order Writing/Co-signing requirements for Physician Employed/Contract Registered Nurse – Physician Employed/Contracted Registered Nurse may write nursing progress notes and act as scribe for sponsoring physician progress notes. Sponsoring physician must sign scribed progress notes at the same visit.

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EXECUTIVE COMMITTEE APPROVAL: 4-5-05

## ARTICLE VI

## AUTOPSIES

**Section 6.1** Autopsies will be performed only with the written consent of the nearest relative of the deceased, or in the absence of a living relative, a responsible friend. Ordinarily, the spouse of the deceased is considered the closest relative, even if the couple is living apart. Legalized divorce dissolves this relationship. Children of the deceased are responsible when the spouse is either deceased or divorced, and all children have an equal voice making unanimous consent advisable if possible to obtain. Generally speaking, however, the signature of the eldest child is acceptable. Parents of the deceased are next in order and the consent of either parent is sufficient to permit examination. Siblings are next considered, and the same rules of equality and unanimity hold as with offspring.

**Section 6.2** Autopsies will be ordered by the attending physician and

performed by the hospital pathologist or by a physician designated by the pathologist. Those autopsies which are ordered by a Medical Examiner should be performed at the Wayne County Morgue or a similar Forensic Pathology facility.

EXECUTIVE COMMITTEE APPROVAL: Revised 4-5-05

**Section 6.3 Medical Staff Autopsy Criteria:** All medical staff should consider asking next of kin for autopsy authorization when autopsy criteria are met:

1. Unanticipated death or unknown complications may have caused death.
2. Deaths of participants in clinical trials or when a patient is being treated under a new therapeutic trial regiment.
3. Intraoperative or intraprocedure death.
4. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
5. All deaths on a psychiatric service.
6. Deaths due to accidents in the hospital.
7. Obstetrical deaths or death incident associated with pregnancy within 7 days following delivery.
8. Neonatal and pediatric deaths, including those with congenital malformations.

EXECUTIVE COMMITTEE APPROVAL: 4-5-05

## ARTICLE VII

## DUES AND ASSESSMENTS

Members of the Medical Staff shall pay such dues as are determined by the Executive Committee of each hospital staff. Funds accumulated from dues will be used as will be determined by the Executive Committee of the Medical Staff. Assessments in addition to the regular dues may be levied on all members of the Medical Staff by action of the Executive Committee for good reason, or by action of the majority of the Medical Staff. Members whose dues or assessments have not been paid after two written notifications shall be recommended by the Secretary of the Staff to the Executive Committee of the Medical Staff for suspension.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90

## ARTICLE VIII

## DISASTER PLAN

Each member of the Medical Staff will be assigned to a specific role in the hospital's Disaster Plan. It is essential that each physician respond promptly in an emergency according to the role assigned to him.

## ARTICLE IX

## DENTAL PATIENTS

**Section 9.1** Dentists and oral surgeons shall be members of the Surgical Department and all patients admitted for dental surgery shall be admitted to the surgical service.

**Section 9.2** The dental care of the patient shall be the responsibility of the dentist. The dentist will assume the responsibility to arrange with a member of the Medical Staff to perform a medical history of the patient prior to oral surgery and to assume medical responsibility pre-operatively and during the post-operative course.

## ARTICLE X

## ADMINISTRATOR'S INVOLVEMENT IN PATIENT CARE

In circumstances of urgency wherein the Administrator or his designate is advised in writing by members of the nursing staff that the patient's condition is serious and where the physician is not taking action which appears indicated, the hospital Administrator shall confer with the attending physician, the departmental chief and/or the Chief of Staff for the purpose of requesting a consultation to review the patient's condition and to make recommendations for treatment if necessary.

EXECUTIVE COMMITTEE APPROVAL: 12-11-90

## ARTICLE XI

## COMPLETED APPLICATION

**Section 11.1** All information requested in the application and delineation of privileges record must be completed according to CVO CR1 policy.

The application, attestation and delineation of privileges must be signed and dated.

The application fee, as determined by Corporate Credentialing Services, must be submitted. References must be verified. National Practitioner Data Bank inquiry made. American Medical Association and/or American Osteopathic Association verification report received.

**Section 11.2** A practitioner granted clinical privileges must complete computer (i.e., EPIC) training within three months of appointment to the Medical Staff or granting of clinical privileges, whichever is sooner. Failure to complete training within the prescribed timeframe will be considered a voluntary resignation from the Medical Staff and relinquishments of all clinical privileges.

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EXECUTIVE COMMITTEE APPROVAL: 12-11-90
REVISED: 06-20-19, 2-7-23

## ARTICLE XII

## QUALIFICATIONS FOR DEPARTMENT CHIEFS

**Section 12.1** The Chief of each medical staff department/service must be certified by a specialty board, or affirmatively established, through the privilege delineation process, that the he/she possesses comparable competence.

**Section 12.2** Comparable competence is defined as follows:

- **a.** Graduate of accredited program and Board Eligible.
- **b.** Active practice in their specialty for three years.
- **c.** Active member of Oakwood Southshore Medical Center Medical Staff for three years.
- **d.** Documentation of CME requirements as defined for the state.

**Section 12.3** The Departments have defined the following Boards as justification.

| | | |
|---|---|---|
| Emergency Medicine | * | American Board of Osteopathic Emergency Medicine |
| | * | American Board of Emergency Medicine |
| | | |
| Family Practice | * | American College of General Practice |
| | * | American Board of Preventative Medicine |
| | * | American Osteopathic Board of General |

| | | |
|---|---|---|
| | | Practice |
| | * | American Board of Family Practice |
| | | |
| Medicine | * | American Board of Internal Medicine |
| | * | American Board of Osteopathic Internal Medicine |
| | * | American Board of Allergy and Immunology |
| | * | American Board of Psychiatry and Neurology |
| | * | American Board of Pediatrics |
| | * | American Board of Otolaryngology |
| | * | American Board of Dermatology |
| | * | American Board of Physical Medicine and Rehabilitation |
| | * | American Board of Cardiology |
| | * | American Board of Gastroenterology |
| | | |
| OB/GYN | * | American Board of Obstetrics & Gynecology |
| | * | American Board of Osteopathic Obstetrics & Gynecology |
| | | |
| Pathology | * | American Board of Pathology |
| | | |
| Radiology | * | American Board of Radiology |
| | | |
| Surgery | * | American Board of Anesthesiology |
| | * | American Board of Urology |
| | * | American Board of Surgery |
| | * | American Board of Orthopedic Surgery |
| | * | American Board of Podiatric Surgery |
| | * | American Board of Opthalmology |
| | * | American Board of Osteopathic Surgery |
| | * | American Board of Oral Surgery |
| | * | American Board of Plastic Surgery |
| | * | American Board of Otolaryngology |
| | * | American Board of Thoracic Surgery |

*EXECUTIVE COMMITTEE APPROVAL: 9-1-92*

**Section 12.4** Documentation must be present in the Credentials file on Board Certification.

**Section 12.5 ALTERNATIVES TO CERTIFICATION** Should a Chief not be certified by an appropriate board, he/she must certify that they are as competent as a board certified individual. The medical staff shall determine the knowledge and skills expected of the board(s) is relevant to the individual's responsibilities as department chief**.**

**Section 12.6** If he/she is not board certified, the credentials file must document the determination that he/she possesses the knowledge and skills comparable to those expected of a corresponding diplomat of a relevant board(s).

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EXECUTIVE COMMITTEE APPROVAL: 9-1-92

## ARTICLE XIII

## POLICY ON THE CONFIDENTIALITY OF PEER REVIEW MATERIALS AND INFORMATION

**Section 13.1** As the governing body of a licensed hospital in the state of Michigan, the Oakwood Southshore Medical Center Board of Trustees is responsible for the quality of care rendered in the facility and is obligated by law to assure that the Hospital Medical Staff conducts effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients.

**Section 13.2** In order to encourage the conduct of effective professional practice review activities, it is the policy of Oakwood Southshore Medical Center to conduct peer review and quality assurance activities in such a manner as to qualify for all protections against liability, discovery and admissibility available under the laws of the State of Michigan. Accordingly, the records, data and knowledge collected for or by individuals assigned a professional practice review function under the authority of the Oakwood Southshore Medical Center board of Trustees shall be confidential and shall be used only in connection with professional practice review activities of the Hospital. All individuals assigned a professional practice review function, whether members of the medical staff or employees or agents of the Hospital, shall be advised of their obligations to maintain the confidentiality of professional practice review records, data and knowledge. Disclosure of such information, whether written or oral, shall be made only when and to the extent required by law.

This policy shall not be modified without prior notice to the Executive Committee of the Medical Staff.

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EXECUTIVE COMMITTEE APPROVAL: 2-9-93

## Article XIV

## RESPONSIVENESS TO COMMITTEES

**Section 14.1** All Medical Staff members shall comply with all requests for information from any committee assigned a professional practice review function in order to provide for effective professional practice review activities.

a. An initial request for information shall be sent to the medical staff member and he shall be given thirty (30) days in which to respond in writing to the committee requesting the information.
b. Should the medical staff member fail to respond in writing within thirty (30) days, he shall be sent a second request for information, a copy of which shall be sent to his Department Chief. The medical staff member shall be given fifteen (15) days in which to respond to the second request for information.
c. Should the medical staff member fail to respond in writing to the second request for information, he shall be sent a third request for information by certified mail, return receipt requested or by hand delivery, informing him that he must either respond to the committee by a certain date, as determined by the requesting committee, or appear before the Medical Executive Committee at its next meeting.
d. If the medical staff member fails to respond to the third request for information and does not appear before the Medical Executive Committee as scheduled, his admitting privileges including the ability to perform consultations, surgery and obstetrical procedures shall be automatically suspended. Such suspension shall remain in effect until a sufficient response is provided by the medical staff member.
e. All responses shall be reviewed for sufficiency by the committee requesting the information. Upon review of the response, the committee may determine if the response is sufficient, seek additional information or determine the response to be insufficient. Should additional information be requested, the procedure outlined in a-d above shall be initiated. Should a response be found to be insufficient, proceedings may be initiated to rescind a medical staff member's appointment or reduce, restrict or suspend a medical staff member's appointment or reduce, restrict or suspend a medical staff member's clinical privileges, pursuant to Article V, Section 1 of the Medical Staff Bylaws.

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EXECUTIVE COMMITTEE APPROVAL: 6-25-96
EXECUTIVE COMMITTEE REVIEW: 5-02-02
***Original 4-24-75 Additions and Revisions***

## Article XV

## DEA REQUIREMENTS

**Section 15.1** All members of the medical staff shall maintain a current Federal Drug Enforcement Agency (DEA) certificate (if applicable) with schedules 2-5, including 2n and 3n.

**Section 15.2** Affiliate staff members shall maintain current Federal Drug Enforcement Agency (DEA) certificate (if applicable), and appropriate to scope of practice.

EXECUTIVE COMMITTEE APPROVAL : 4-5-05

## Article XVI

## PHYSICIAN COVERAGE

When a member of the medical staff is not available for patient coverage, it is the responsibility of the physician to arrange for designated coverage by a physician with equivalent privileges. All admission and specialty preferences must be managed and updated through the Physician Preference Guide (PPG) by the physician or designated site administrator. Vacation and weekend coverage changes are to be made in the BH Connect or by calling the operator.

EXECUTIVE COMMITTEE APPROVAL: 7-5-05, 5-27-21

## Article XVII

## ED ON-CALL AVAILABILITY

**Section 17.1** Physicians providing on-call coverage to the ED shall be expected to perform any and all duties for which they have been credentialed and received privileges at the time of their appointment or re-appointment.

If the physician is out of town on the scheduled date of coverage, it is the responsibility of the physician to arrange for designated coverage by a physician with equivalent privileges. Coverage changes must be submitted to the Medical Staff Office either by phone or in writing Monday through Friday between the hours of 7:30 am and 3:30 pm. Coverage changes outside of these hours should be communicated to the Nursing Supervisor.

**Section 17.2 CALL SCHEDULE/COVERAGE** To qualify for and participate in the Department of Medicine or Family Medicine – ED call schedule, physicians must fulfill the following requirements: be an Active member of the Medical Staff in good standing in one of those departments for a minimum of one year; office must be in the Trenton service area; physician must meet quality metrics (including H&P completion, length of stay, verbal orders), actively participate on at least one committee which is assigned by the Chief of Staff; pay yearly staff dues, Medical records signed and remain off the suspension list, and must attend the minimum meeting requirements for department and general staff meetings.

Failure to comply with any of the above will result in one written warning, followed by permanent removal from the call schedule for two years.

EXECUTIVE COMMITTEE APPROVAL: 7-5-05, 5-27-21, 2-7-23

## Article XVIII

## EMERGENCY MEDICAL SCREENING EXAMINATION – QUALIFIED MEDICAL PERSONEL

A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under the delegation and supervision of a physician member of the Hospital's medical staff:

1. Licensed specialty certified nurse practitioners;
2. Licensed specialty certified nurse midwives (obstetrics only); and
3. Physician Assistants.

For nonresident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes required in the Medical Staff Bylaws specifically to include the appropriate Medical Executive Committee ("MEC") and Board approved clinical delineation of privileges form. Actions on membership and privileges shall be subject to MEC and Board approval. Resident physicians may perform the medical screening examination under the supervision of the Emergency Department physician or pursuant to authority granted by the graduate medical education program as evidenced by the resident's progressive responsibility as provided in the residency program's policies and resident documentation.

EXECUTIVE COMMITTEE APPROVAL: 3-3-15

## Article XIX

## ELECTRONIC MEDICAL RECORD (EMR)

All medical staff members must comply with the Confidentiality & Computer Systems Usage Agreement that is signed upon time of initial appointment and reappointment and comply with the CH Information Security policy, the CH Acceptable Use Policy, and the CH Electronic Communication Standard.

Electronic Medical Record (EMR) users are responsible for all data, information, and orders which are entered into any Corewell Health computer system using only your designation ID and password. Users will not reveal, release, or make accessible any Corewell Health system, identity and access badge, token, or password to any other person. Users will not use anyone else's user badge, token or password to access any Corewell Health systems.

Failure to comply with these policies may be subject to disciplinary action and/or termination.

EXECUTIVE COMMITTEE APPROVAL: 2-7-23

| | | **REVISION/ADDITION** | | |
|---|---|---|---|---|
| a) | 6/26/75 | PCHA BOARD APPROVAL | Revision | Article V |
| b) | 2/26/75 | PCHA BOARD APPROVAL | Revision | Section 2.6 |
| c) | 2/24/77 | PCHA BOARD APPROVAL | New Section | Section 4.4 |
| d) | 2/24/77 | PCHA BOARD APPROVAL | Addition | Section 5.3 B1 |
| e) | 12/14/77 | PCHA BOARD APPROVAL | Addition | Section 1.9 |
| f) | 12/14/77 | PCHA BOARD APPROVAL | Addition | Section 2.1 |
| g) | 12/14/77 | PCHA BOARD APPROVAL | Addition | Section 2.3a |
| h) | 1/25/79 | PCHA BOARD APPROVAL | Revision | Section 2.3a |
| i) | 6/21/79 | PCHA BOARD APPROVAL | Addition | Section 2.4 |
| j) | 6/21/79 | PCHA BOARD APPROVAL | New Section | Section 3.4 |
| k) | 9/27/79 | PCHA BOARD APPROVAL | Revision | Section 1.1 |
| l) | 12/6/79 | PCHA BOARD APPROVAL | Addition | Section 2.6 |
| m) | 10/29/81 | PCHA BOARD APPROVAL | Revision | Section 4.1 |
| n) | 10-29-81 | PCHA BOARD APPROVAL | Revision | Section 4.2 |
| o) | 10/29/81 | PCHA BOARD APPROVAL | Revision | Section 4.3 |
| p) | 10/29/81 | PCHA BOARD APPROVAL | Revision | Section 4.4 |
| q) | 10/29/81 | PCHA BOARD APPROVAL | Addition | Section 5.3 B1 |
| r) | 1/29/87 | PCHA BOARD APPROVAL | Addition | Section 4.3 B1 |
| s) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 2.3b |
| t) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 2.3d |
| u) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 2.3e |

| | | | | |
|---|---|---|---|---|
| v) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 2.3f |
| w) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 5.3 B1 |
| x) | 9/29/88 | PCHA BOARD APPROVAL | Revision | Section 2.4 |
| y) | 2/11/92 | MEC APPROVAL | Revision | Article II Section 2.3 f2 |
| z) | 12/1/92 | MEC APPROVAL | Revision | Article II Section 2.3a |
| a) | 9/1/92 | MEC APPROVAL | Addition | Article III Section 1.1, 1.2, 2.1, 2.2, 3.1, 3.2 |
| b) | 2/9/93 | MEC APPROVAL | Addition | Article XIII Section 1.1, 1.2 |
| c) | 3/9/93 | MEC APPROVAL | Revision | Article II Section 2.3 |
| d) | 6/8/93 | MEC APPROVAL | Revision | Article III Section 2.3 a,b,f |
| e) | 11/3/93 | MEC APPROVAL | Revision | Article II Section 2.3 |
| f) | 6/25/96 | MEC APPROVAL | Addition | Article XIV |
| g) | 6/25/96 | MEC APPROVAL | Revision | Article V Section 5.3 |
| h) | 9/11/01 | MEC APPROVAL | Addition | Article II 2.3 f |
| i) | 5/02 | MEC APPROVAL | Revision | |
| j) | 2/4/03 | MEC APPROVAL | Addition | Article I Section 1.9 |
| k) | 4/6/04 | MEC APPROVAL | Revision | Article II Section 2.3a, Article V Section 5.3 B |
| l) | 4/5/05 | MEC APPROVAL | Addition | Article XV, Article V Section 5.4, Article VI |
| m) | 7/05/05 | MEC APPROVAL | Addition | Article XVII |
| | | | Addition | Article XVIII |
| n) | 9/6/05 | MEC APPROVAL | Revision | Article I-Section 1.5, Article II-Section 2.1, Article II-Section 2.2, Article II-Section 2.3 b c, Article II-Section 2.4 |
| | | | Delete | Article II-Section 2.3 f1 |
| | | | Addition | Article 2.7 |
| o) | 3/7/06 | MEC APPROVAL | Addition | Article II, Section 2.3-Post Delivery Note & Physician Orders |
| p) | 8/5/08 | MEC APPROVAL; 10/6/08 SSBOT | Revision | Article II, Section 2.1 |
| q) | 9/2/08 | MEC APPROVAL; 10/6/08 SSBOT | Addition | Article I, Section 1.1a |
| r) | 9/2/08 | MEC APPROVAL; 10/6/08 SSBOT | Deletion | Article XI-Dept r&r's |
| s) | 9/7/10 | MEC APPROVAL 12/14/10 SSBOT | Revision | Article II, Section 2.3 (d/c summary) |
| t) | 9/7/10 | MEC APPROVAL 12/14/10 SSBOT | Revision | Article III, Section 3.1 |

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|---|---|---|---|---|
| u) | 9/7/10 | MEC APPROVAL<br>12/14/10 SSBOT | Deletion | Article III, Section 3.4 |
| v) | 9/7/10 | MEC APPROVAL<br>12/14/10 SSBOT | Typo | Article III, Section 3.5 b. |
| w) | 9/6/11 | MEC APPROVAL<br>11/9/11 JCC | Addition | Article I, Section 1.5 |
| x) | 11/1/11 | MEC APPROVAL<br>1/5/12 JCC | Addition | Article III, Section 3.6 |
| z) | 3/3/15 | MEC APPROVAL<br>4/29/15 JCC | Addition | Article XVIII |
| aa) | 4/2/19 | MEC APPROVAL<br>6/20/19 BHBOD | Addition | Article XI, Section 11.2 |
| ab) | 8/6/19 | MEC APPROVAL<br>10/24/19 BHBOD | Addition<br>Revision<br>Revision | Article II, Section 2.8<br>Article III, Section 3.7<br>Article V, Section 5.4 |
| ac) | | 06/29/21 BHBOD | Revision | Article XVI, Article XVII |
| ad) | | 12/16/21 BHBOD | Revision | Article II, Section 2.3 |
| ae) | 2/7/23 | MEC APPROVAL | Revision | Article II, Section 2.1, 2.1a<br>Article IV, Section 6<br>Article XI, Section 11.1<br>Article XVIII<br>Article XIX - New |
| | | **REVIEWED** | | |
| | 6/1/83 | RULES & REGULATION COMMITTEE | | |
| | 9/13/83 | MEC | | |
| | 12/11/90 | MEC | | |
| | 2/9/93 | MEC | | |
| | 6/25/96 | MEC | | |
| | 7/9/96 | MEC | | |
| | 5/00/02 | MEC | | |
| | 7/05/05 | MEC | | |
| | 3/2/10 | MEC | | |
| | 10/7/14 | MEC | | |
| | | **RETYPED** | | |
| | | 6/75, 2/76, 2/77, 12/77, | | |
| | | 1/79, 6/79, 9/79, 12/79, | | |
| | | 10/81, 2/87, 5/88, | | |
| | | 12/90, 5/02, 6/05, | | |
| | | 7/05, 9/05 | | |