ADVOCATE CHRIST MEDICAL CENTER
ADVOCATE CHILDREN'S HOSPITAL OAK LAWN

MEDICAL STAFF

RULES AND REGULATIONS

Approved:
01/28/2025: Medical Executive Committee
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MEDICAL STAFF RULES AND REGULATIONS
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CODE OF CONDUCT

DEFINITIONS

DISRUPTIVE BEHAVIOR: means any conduct or behavior which jeopardizes or is inconsistent with quality patient care or with the ability of others to provide quality patient care: verbal abuse includes, but is not limited to yelling, swearing, cursing, humiliating or sexual/gender based inappropriate language.

HARASSMENT: means verbal or physical activity directed against any individual (e.g., patient, family member, physician, house staff, nurse, associate, hospital employee) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical status, marital status, gender or sexual orientation.

SEXUAL HARASSMENT: means unwelcome verbal or physical sexual advances; requests for sexual favors; verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition for employment, advancement or future employment, unwelcome conduct of a sexual nature which has the purpose or effect or unreasonably interfering with a person's work performance or creates an offensive, intimidating or otherwise hostile work environment.

COMMITMENTS

1. Accept and comply with the Medical Staff By-laws, Rules and Regulations Manual, the Medical Staff Conduct Policy, and the Advocate System Policy on Behavioral Expectations and Disruptive Behavior.

2. Understand and accept the Policies and periodic programs that are mandatory to membership:
   a. Business Conduct policy
   b. Culture of Safety policy
   c. Contagious Disease policy
   d. Principles of Partnership with Physician Wellness policy
   e. Universal Protocol policy
   f. Red Rules policy
   g. Medical Staff Conduct Policy

3. Specifically understand and accept the following commitments:
   a. Primacy of patient welfare: to keep patient welfare and interest above self-interest or scientific and institutional interests.
   b. Patient autonomy: to be respectful and honest to empower patient (or surrogates) to make decisions which are paramount as long as they are ethical and not inappropriate
   c. Social justice: to eliminate considerations of any discrimination (social, financial, ethnic, religious, race, gender) in rendering care
   d. Professional competency: to maintain knowledge base and skills appropriate to privileges and to provide quality care
   e. Honesty: to inform patients completely and honestly regarding treatments, procedures, and expectations. To inform patient of mistakes and errors where injury or complications are the result.
   f. Confidentiality: to adhere to HIPPA regulations and other ethical principles with respect to patient's health status
   g. Appropriate relationships: to avoid any physician-patient relationship that can compromise patient autonomy, or raise ethical, social, or business conflicts of interests
   h. Quality improvement and scientific knowledge: to maintain competency and continuing education requirements and to act proactively to minimize error, promote safety and clinical excellence.
   i. Improve access to care: to strive to reduce barriers to care and to commit to the primacy of patient welfare above such barriers
   j. Stewardship of resources: to participate and promote efficiencies that enhance safety, excellence, improved outcomes and reduce wastage of resources, redundancy of testing, and ineffective and inappropriate treatments
   k. Trust: to enhance trust and to disclose/manage relationships (business ownerships, ventures, and stipends/fees, etc.) that may compromise decision making
   l. Collaboration: to maintain ethical, professional, courteous, respectful relationships with all members of the health care team to achieve the best outcomes and satisfaction of all participants

4. Infractions of the code of conduct are subject to mandatory remedial, educational, or disciplinary actions.

PART ONE: ADMISSION OF PATIENTS

1.0 PHYSICIAN-PATIENT RELATIONSHIP AT ACMC

A physician who accepts the inpatient or observation care of a patient shall be responsible for further care of that patient or establishing continuity of care for a minimum of 45 days from the last date of patient's hospital stay during which that physician provided care unless an official termination of care has been documented. For purposes of the foregoing, the phrase "accepts the care of a patient" shall include a physician's actual acceptance of such care, a physician's agreement to accept such care, or the rendering of care to a patient by a physician. Determinations regarding whether a physician should be responsible for care beyond such 45-day period shall be made in accordance with the law governing the physician-patient relationship. Such determinations are the responsibility of each individual physician.

1.1 INDEPENDENT ADMISSION

A patient may be admitted to the Hospital only by a member of the Medical Staff, who has been granted independent admitting privileges, or by a practitioner who has been granted temporary admitting privileges as governed by Article IV of the Medical Staff Bylaws. All practitioners shall be governed by the official admitting policies of the hospital.

1.2 CO-ADMISSION

Podiatrists and dentists may admit patients so long as they have been granted admitting privileges and the patient is also under the care of an attending physician member of the medical staff. The admitting staff member is responsible for the care within their discipline's clinical privileges; the attending physician is responsible for the patients' general medical care. Patients admitted by a dentist or a podiatrist may have their histories and physical examinations performed by the admitting dentist or podiatrist, provided that the dentist or podiatrist is a member of the hospital medical staff, that the dentist or podiatrist has been approved to perform histories and physical examinations by the hospital governing board, and that the history and physical examination are directly related or incident to the dental or podiatrist service, operation, or surgery for which the patient is being admitted.

1.3 TRANSFER OF MEDICAL RESPONSIBILITY

Whenever the responsibilities of the attending physician are transferred to another staff member, the accepting staff member must have privileges appropriate to the level and scope of care required by the patient. A note covering the transfer of responsibility shall be entered in the progress notes and an order written to affect the transfer of responsibility.

1.4 PROVISIONAL ADMITTING DIAGNOSIS

No patient shall be admitted until a provisional diagnosis or reason for admission has been stated for the Admitting Office.

1.5 ADMITTING HISTORY AND PHYSICAL

Members of the Medical Staff admitting patients shall document the circumstances of the admission by an appropriate history and physical or progress note as soon as possible after admission, but within twenty-four (24) hours at the latest. Refer to Part Five, 5.3 History and Physical.

1.6 ASSIGNMENT OF UNATTACHED PATIENT

Any patient who requires admission who does not have a physician who is a member of the Medical Staff, shall have the right to request the services of any consenting member of the Medical Staff with independent admitting privileges as the attending physician. If the patient does not wish to exercise this right, the most appropriate physician on the On-Call schedule shall be assigned as the attending physician. The patient may at any time terminate the services of a physician so assigned and may request the services of any consenting physician member of the Medical Staff with independent admitting privileges.

1.7 DESIGNATION OF ALTERNATES

Each member of the Medical Staff shall furnish the Medical Staff Office with the name of one staff member having equivalent clinical privileges who has agreed to serve as the alternate whenever the physician is not available. In the event that the staff member nor the alternate is not available in an emergency, the President of the Medical Staff, the Chair of the department, or the Hospital Chief Executive shall have the authority to designate a member of the Medical Staff to attend such a case until the attending or the alternate becomes available. Unavailability of a staff member or the alternate within a reasonable period of time may result in remedial action, as appropriate.

1.8 PRIORITIES OF ADMISSIONS

The Admitting Office will admit patients on the following priorities:

1.8-1 EMERGENCY ADMISSIONS

This category includes those so designated by the attending practitioner, who shall document the justification of such designation. Such admissions shall be reviewed, as necessary, by the Care Management Committee. Evidence of willful or continued misuse of the designation will be brought to the attention of the practitioner and corrective action taken, as appropriate.

1.8-2 PRE-OPERATIVE ADMISSIONS

This category includes all patients previously scheduled for surgery. Such patients must have complied with any pre-admission testing protocols in effect. If it is not possible to handle all such admissions, the Chair of the department may decide the priorities of any specific surgical admission.

1.8-3 ROUTINE ADMISSIONS

This category will include elective admissions of all services.

1.9 RESTRICTED BEDS

There will be areas of restricted bed utilization and assignment of patients. Admission or transfer of patients to such restricted areas may be made only after approval of the physician or other person designated in-charge, or in compliance with any established protocols governing the utilization of such restricted areas.

The following are restricted areas:
Intensive Care Units (Surgical, Medical, Neurological, Pediatric, Neonatal); Surgical Heart Unit; Telemetry Cardiac, Medical and Surgical; Labor & Delivery Unit; Psychiatric Unit; Pediatric Unit; Rehabilitation Unit; Oncology Unit; Alcohol Detoxification Unit.

1.10 ISOLATION DESIGNATION

Any diagnosis involving an infectious potential must be designated as requiring an ISOLATION procedure or NO ISOLATION at the time of admission by the attending physician in accordance with current isolation policies.

PART TWO: TRANSFERS OF PATIENT WITHIN THE HOSPITAL

2.1 APPROVAL AND ORDER

All transfers require the approval and specific order of the attending physician or designee.

2.2 RESTRICTED BED APPROVAL

All transfers to a restricted bed unit require unit approval.

2.3 TRANSFER PRIORITIES

Transfer priorities shall be as follows:

a) Emergency Department to appropriate patient bed

b) Obstetrical restricted area to appropriate bed
c) General bed to special care unit
d) Special care unit to general bed

PART THREE: DISCHARGE OF PATIENTS

3.1 APPROVAL AND ORDER

Patients shall be discharged only on a written order of the attending physician, their designee, or advanced practice clinician who is granted appropriate privileges. Consultants may not discharge patients without the consent of the attending physician.

3.2 COMPLETION OF MEDICAL RECORD

All portions of a patient's medical record must be completed within the time frames provided in the bylaws, related manuals, and the Medical Staff Rules and Regulations.

a) A record is considered complete when the contents required by applicable state law, regulatory bodies, and the Medical Staff rules and regulations meet the standards of the Health Information Management (HIM) Department.

b) After special written notice of failure to comply with medical records policies as set forth in 3.2 d), a medical record delinquency (MRD) shall be recorded.

c) The medical record of a hospitalized patient contains mission and time critical information that impacts the care and outcomes of a patient at the next (post-acute) level of care. Therefore, timely completion at the time of hospital discharge is optimal but shall not exceed 72 hours following hospital discharge. If any chart is incomplete four (4) days of discharge, the practitioner responsible for the incomplete status of the chart will be specifically notified by the HIM Department that unless the practitioner completes the chart within eleven (11) days of the discharge, the chart is considered delinquent and a MRD shall be recorded on the eleventh day. If the delinquent medical record provisions are invoked, the practitioner is so informed by special notice from the President of the Medical Staff.

When the completion if not done immediately upon discharge the Hospital Attending physician and related consultants are expected to communicate post-acute plans of care and hand off to the Primary Care Physician or other appropriate team members managing the patient allowing smooth transition and avoidance of post-acute adverse events. Communication will always be HIPAA compliant.

d) The President of the Medical Staff or the designee shall give special notice of a MRD to the practitioner.

e) A copy of the notification of MRD is filed in the practitioner's credentials file in the Medical Staff Office, and a copy is sent to the Department Chair.

f) If a practitioner receives ten (10) or more MRDs during a twelve-month period, the practitioner will immediately be fined $1,000.00 by the Medical Executive Committee, payable to the medical staff within one month of the date of the notice. The fine shall be waived if the practitioner brings all medical records up to date within two weeks from the date of notice of the fine. Further, if the practitioner receives another MRD within six
(6) months from the date of the original notice of the fine, the fine will no longer be waived and will again become due within one (1) month of the notice.

g) Once completed, if the practitioner accumulates ten (10) or more occurrences of delinquent medical records within twelve (12) months of the original notice of the fine, the practitioner May be administratively suspended.

h) If the practitioner gives written or documented verbal notice to the Medical Staff Office prior to absence from the hospital, days of such absence will not be counted toward the permissible fourteen (14) days within which to complete the medical record in relation to the medical record delinquency. If no notice is given of the absence from the hospital, the days will be counted toward the permissible fourteen (14) days.

i) An application for reappointment will not be deemed complete if there are any outstanding fines.

3.3 DISCHARGES AGAINST MEDICAL ADVICE

Should a patient leave the hospital against medical advice of the attending physician, a notation of the circumstances shall be made in the patient's medical record. Every attempt should be made to explain the risks and to have the patient sign a discharge against medical advice form, acknowledging a release from liability of the hospital and physicians.

PART FOUR: DEATH OF PATIENTS

4.1 MEDICAL RECORD DEATH PRONOUNCEMENT NOTE

4.1.1 In the event of a patient death, the deceased shall be pronounced dead by the attending physician or by an appropriate designee. The pronouncement will be completed in a timely fashion, ideally within one hour of notification by nursing of possible patient death.

4.1.2 Appropriate designees include resident physicians and adult and pediatric advanced practice clinicians (APC) who have an active ACLS, PALS, and/or NRP certification. Pronouncement of death by an APC shall not include brain death determination.

4.1.3 If the attending physician or designee is not present, any physician member of the Medical Staff may also perform the pronouncement of death.

4.1.4 The Central Telemetry Center Registered Nurse may pronounce death in an adult patient if the patient's attending physician is unavailable, the death is expected, and a Limitation of Treatment (LET) order is present

4.1.5 Documentation of pronouncement of death shall be documented in the chart by the practitioner who declares the patient dead. The policies with respect to release of dead bodies shall confirm to local law.

4.2 COMPLETION OF DEATH CERTIFICATE

4.2.1 The attending physician is responsible for properly completing the death certificate in a timely manner, in no case later than forty-eight (48) hours after the time of expiration. In the absence of the attending physician, or with the attending physician's approval, the death certificate may be completed and signed by the covering physician, advanced practice registered nurse, physician assistant, the physician who performed an autopsy upon the decedent, or the chief medical officer of the institution in which death occurred (or designee). Failure to complete the death certificate as required by the medical staff rules and regulations and state law may result in a review as a code of conduct violation as outlined in the medical staff rules and regulations and medical staff conduct policy.

4.3 RELEASE OF BODY

Policies with respect to release of the deceased's body shall conform to local law and the policies of the Admitting Office.

4.4 AUTOPSIES

It shall be the duty of all medical staff members to secure meaningful autopsies whenever appropriate. Proper legal authorization for the autopsy is obtained according to existing hospital policy. Any special conditions or limitations of the autopsy should be discussed with the pathologist.

When a death falls under the jurisdiction of the Cook County Medical Examiner's Office, an autopsy will not be performed at Advocate Christ Medical Center unless jurisdiction is relinquished.

PART FIVE: MEDICAL RECORDS

5.1 CONTENT OF MEDICAL RECORDS

The medical record shall contain sufficient information to identify the patient; support the diagnosis/conditions; justify the care, treatment, and service; document the course and results of care, treatment, and service; and promote

continuity of care among providers and shall include information required by accreditation or regulation/law.

5.2 PRACTITIONER RESPONSIBILITY

Every practitioner who attends a patient shall be responsible for that portion of the medical record which involves the services which the practitioner has rendered or supervised.

5.3 HISTORY AND PHYSICAL

a) A complete history and physical examination shall be completed and document in the medical record no more than 30 days before or twenty (24) hours after admission or registration, and prior to any high-risk procedure, surgery, procedures requiring anesthesia or other procedures requiring an H & P. All Licensed Independent Practitioner (LIP) members of the medical staff are privileged to perform H&Ps. Residents and Medical Students may perform part or all of a medical history and physical examination under the supervision or through appropriate delegation by a Licensed Independent Practitioner (LIP). The Resident and Medical Student H&P must be countersigned by a LIP. Advance Practice Nurses and Physician Assistants may perform part or all of an operative patient's medical history and physical examination under the supervision or through appropriate delegation by an LIP member of the medical staff, if the APNs or PAs have been credentialed and privileged to do so. The H&P performed by the Advanced Practice Nurse does not have to be countersigned by a LIP member of the Medical Staff.

b) An appropriate history and physical examination is required for inpatient, observations, and emergency patients prior to any high-risk procedures requiring anesthesia or other procedures requiring an H&P. as well as those undergoing surgical invasive procedures. If an appropriate history and physical examination has been performed and recorded within thirty (30) days prior to the patient's admission to the hospital, a legible copy of this record may be used in lieu of the hospital admission history and physical examination, provided that these reports were recorded by a member of the Medical Staff or an Advance Practice Nurse privileged at the hospital to perform H&P's, and that the form used has been given prior approval by the Health Information Committee as conforming to its requirement for the medical record system. If the history and physical is completed prior to admission, an update note documenting an examination for any changes in the patient's condition is entered into the medical record. At a minimum, in both the inpatient and outpatient setting, the history and physical shall contain a chief complaint/reason for admission/service, history of present illness, , the H&P has been reviewed, and any changes in the patient's condition or that "no change" has occurred in the patient's condition since the H&P was completed, physical examination, and impression or conclusions drawn from the medical history and physical. Additional information contained in the history and physical shall be based upon the clinical setting, the condition of the patient, and the services/treatment provided. It may include pertinent medical, family, and/or social history.

5.4 PROGRESS NOTES

Progress notes shall be recorded daily to give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and results of treatment sufficient to support continuity of care.

5.5 OPERATIVE REPORTS

A written or dictated operative note is required for any procedure in which informed consent is obtained and moderate or deep sedation is given. An operative note must be dictated/written within 48 hours after the surgery/invasive procedure.

The operative note must include the following elements: Name and hospital identification number of the patient; date and times of the surgery; name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision); pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications; a description of techniques, findings, and tissues removed or altered; estimated blood loss; surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and, prosthetic devices, grafts, tissues, transplants, or devices implanted (if any). The operative note must be signed within (11) days of the procedure.

The ability to schedule surgical cases may be predicated upon operative notes being completed. If a surgeon has two (2) or more operative notes that have not been dictated within the defined 48 hours timeframe, the surgeon will not be able to schedule elective and/or non-emergent cases until the delinquent charts are up to date. If a surgeon has delinquent operative notes occurring three (3) times within a quarter, the surgeon will lose block time for the next quarter.

In the event an operative note cannot be dictated and authenticated prior to the patient being transferred to the next level of care, an immediate post operative note is required to be documented and authenticated and must include: the surgeon and assistants, pre-operative and post-operative diagnosis, procedures performed, specimens removed, estimated blood loss, complications, type of anesthesia administered, and, grafts or implants (may indicate where in chart for detail, if any). This note must be entered and authenticated within the medical record prior to transfer to the next level of care.

5.6 CONSULTATIONS

A consultation shall be called when the care needed exceeds the scope of the physician's privileges/expertise. Documentation of Consultations shall show evidence of a review of the patient's record, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. The report shall be made on an approved form and become part of the permanent record. When operative procedures are involved, the consultation note shall, except in an emergency so stated in the record, be recorded prior to the operation. See 6.4

5.7 OBSTETRICAL AND PRENATAL RECORDS

Obstetrical records shall include a complete prenatal record. The prenatal record may be an original or durable, legible copy of the attending physician's office record, provided that such records are approved by the HIM Department and Health Information Committee as being compatible with the medical record system.

5.8 DATE, TIME, AND AUTHENTICATION OF ALL NOTES

All physician clinical entries including those introduced through transcription or dictation in the patient's medical record shall be dated, timed, and authenticated. All written entries shall be documented in blue or black ink. Authenticated means to establish authorship by means of a written signature, identifiable initials, or computer key.

5.9 ORDERS AUTHENTICATION

All physician cosign and verbal orders should be signed in the electronic medical record within 72 hours of entry. Unsigned orders must be completed within eleven (11) days of discharge, otherwise the order is considered delinquent, and an MRD order shall be recorded on the eleventh day.

5.10 SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when they have been approved by the Health Information Committee. An official record of unacceptable abbreviations/symbols shall be kept on file in the HIM Department and in other areas as may be designated by the Chief Executive or the Medical Executive Committee.

5.11 COMPLETION OF DIAGNOSES AND PROCEDURE NARRATIVES

Final diagnoses, including principal diagnosis, complication or co-morbidities, principal procedure, and other procedures shall be recorded without symbols or abbreviations in the medical record by the attending physician at the time of discharge.

5.12 DISCHARGE SUMMARY

The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and Hospital policy, who is the patient's attending of record is responsible for the patient during the patient's stay in the hospital. This responsibility would include developing and entering the discharge summary.

A discharge summary shall be written/dictated and authenticated within 72 hours of patient discharge/visit. The discharge summary shall include the final diagnoses, reason for hospitalization, significant findings, procedures performed, and care, treatment, and services provided the patient's condition at discharge, and instructions to the patient and family, as appropriate. A final progress note which includes final diagnoses, condition on discharge and any follow-up instructions may be substituted for the discharge summary for uncomplicated obstetrical deliveries, normal newborn infants, and in cases of patients who required forty-eight (48) hours or less in the hospital.

5.13 COMPLETION OF MEDICAL RECORDS

All portions of the medical record must be completed within the time frames provided in the Medical Staff Bylaws, related manuals, and these rules and regulations. Medical record completion and corrective action for delinquencies is specified in 3.2 of the Rules and Regulations.

5.14 ACCESS TO MEDICAL RECORDS

5.13-1 WRITTEN AUTHORIZATION FOR RELEASE OF INFORMATION

Written authorization of the patient or a legally qualified representative is required for the release of medical information to persons not otherwise authorized to receive the information.

5.13-2 REMOVAL OF RECORDS FROM HOSPITAL PREMISES

Medical records may not be removed from the hospital's custody and safekeeping except by court order, subpoena, statute, or administrative policy. All medical records are the property of the hospital. In the case of readmission of a patient, all previous medical records shall be available for use by the attending physician and/or the treatment team. All unauthorized removal of medical records from the hospital, by members of the Medical Staff, shall be grounds for corrective action by the Medical Executive Committee.

5.13-3 INTERNAL PURPOSES WITHOUT AUTHORIZATION

Access to medical records, without written authorization, is permissible for: use in activities concerned with monitoring and evaluation of the quality and appropriateness of patient care; official surveys for hospital compliance with accreditation, licensing, and regulatory standards; educational and research purposes; and automated data processing of designated information. Such access shall be consistent with the preservation of confidentiality of medical and personal information for the individual patient.

PART SIX: GENERAL CONDUCT OF CARE

6.1 GENERAL CONSENT TO TREATMENT

A general consent form entitled the Health Care Consent signed by, or on behalf of, every patient admitted to the Hospital must be obtained at the time of admission. In the event that a patient refuses to sign the consent form, the Admitting Office shall notify the attending physician, and it shall be the responsibility of the physician to obtain the patient's signature before the patient will be admitted. This rule does not apply in the case of an emergency, wherein the patient's life is in jeopardy and a legal representative of the patient is not immediately available. The general consent form does not take the place of other specific consent forms, such as for surgical procedures and special procedures.

6.2.1 ORDERS

6.2-1 WRITTEN ORDERS FOR MEDICATION AND TREATMENT

Orders for outpatient services must be ordered by a practitioner who meets the following conditions is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the: all practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients. Orders for medication and treatment for both inpatients and outpatients shall be given only by members of the

Medical Staff or House Staff or APN's and PA's with clinical privileges which are within their scope of service to order and prescriptive authority, for the care and treatment of each patient. During the declared Public Health Emergency in

the State of Illinois due to the surge of Coronavirus Disease 2019 (COVID-19), Orders for REGEN-COV treatment will be accepted from members of the Medical Staff of Advocate South Suburban Hospital or Advocate Trinity Hospital, even if not a member of the Advocate Christ Medical Center medical staff, for patients that meet the clinical guidelines put forth in the Emergency Use Authorization by the U. S. Food and Drug Administration ("FDA"). Such written orders must be within the scope of service of the ordering provider and within the provider's prescriptive authority. Orders for this treatment will not be accepted from non-medical staff members who are not on staff at either Advocate South Suburban Hospital or Advocate Trinity Hospital. This exception shall only be allowed during the declared Public Health Emergency in the State of Illinois.

a) a) All orders and signatures must be written clearly and legibly. Orders which are illegible or improperly written shall not be carried out until re-written or understood by the person responsible for executing the orders. All orders must be dated, timed, and signed. Orders shall be given only to licensed, registered, or certified professional persons who are authorized by law to administer or dispense the medication or treatment in the course of practicing their identified specific discipline

b) A collaborating physician who delegates limited prescriptive authority to an Advanced Practice Nurse and/or physician assistant shall include that delegation in the written collaborative agreement/supervisory agreement. The prescriptive authority may include prescription and dispensing of legend drugs and legend controlled substances categorized as Schedule III, IV, or V controlled substances, as defined in the Illinois Controlled Substances Act (720 ILCS 570.) The authority to prescribe Schedule II controlled substances may not be delegated by the collaborating physician.

c) An APN or a Physician Assistant who has been given controlled substances prescriptive authority shall be required to obtain an Illinois mid-level practitioner controlled substance license in accordance with 77 ILL. Adm. Code 3100. The physician shall file a notice of delegation or prescriptive authority with the Division. The delegation of authority form shall be submitted to the Division prior to the issuance of a controlled substance license.

d) The APN or Physician Assistant may only prescribe and dispense within the scope of practice of the collaborating or supervising physician.

e) All prescriptions written and signed by an Advance Practice Nurse or a Physician Assistant shall indicate the name of the collaborating or supervising physician. The collaborating or supervising physician's signature is not required. The advanced practice nurse or Physician Assistant shall sign their own name.

6.2-2 WRITTEN ORDERS FOR DIAGNOSTIC TESTS AND PROCEDURES, PHYSICAL THERAPY OR REHABILITATION SERVICES/TREATMENT

a) Diagnostic tests and procedures (lab, radiology, or other diagnostic services) and physical therapy and rehabilitation services and treatments may be provided at the request of members of the Medical Staff, House Staff, and physicians (including dentists and podiatrists) and practitioners otherwise eligible to be a medical staff member licensed in Illinois.

b) APNs and PAs may also order these tests and treatments so long as they have clinical privileges and the ability to write such orders is included in their respective collaborative/supervisory agreements. These orders are to be written in the name of the APN or PA.

c) Orders under this section may be given to and accepted by Access/Registration staff.

6.2-3 VERBAL ORDERS

Verbal orders shall be used in emergency situations only. A verbal order shall be given to and recorded by authorized licensed personnel, (i.e., respiratory therapists, nurses, social workers, dietitians, occupational, physical and speech therapists, pharmacists, house staff, other physicians) and signed by the responsible physician before leaving the area. Verbal orders shall be "read-back" to the dictating practitioner by the individual transcribing the order. Verbal orders are acceptable when given in the procedural setting for routine, elective and urgent procedures. The physician who provided the verbal orders during the procedure will authenticate the order prior to leaving the area.

6.2-4 TELEPHONE ORDERS

a) Telephone orders may be taken by licensed personnel enumerated above, providing the person receiving the order signs the name of the responsible physician and affixes their own signature beneath it.

b) Telephone orders shall be "read-back" to the dictating practitioner by the individual transcribing the order. In such cases the responsible physician must sign the dictated order within seventy-two (72) hours unless otherwise indicated by state and/or federal mandates.

6.2-5 ORDERS FOLLOWING SURGERY

All previous orders are canceled when patients go to surgery. Therefore, new orders must be written.

6.2-6 ORDERS FOR DIAGNOSTIC SERVICES

Orders for daily diagnostic services expire after seventy-two (72) hours.

6.3 DRUGS AND MEDICATIONS

6.3-1 HOSPITAL FORMULARY AND INVESTIGATIONAL DRUGS

All drugs and medications administered to patients shall have been approved by the Food and Drug Administration (FDA) and listed in the Hospital Formulary, a copy of which is available at each nursing unit. Drugs not approved by the FDA and used for clinical investigation are permissible only in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals and with approval of the Medical Investigation Committee and in accordance with all applicable Federal or State regulations.

6.3-2 SELF-ADMINISTERED MEDICATION

Medication brought by patients into the Hospital or medication to be self-administered shall not be administered to said patients except by specific order of a physician.

6.3-3 TOXIC OR DANGEROUS DRUGS

All orders for drugs which have been declared toxic or dangerous by the Pharmacy, Therapeutics and Transfusion Committee shall automatically terminate after seventy-two (72) hours, unless the original order specified a longer (stated) period of time or a stated number of doses.

6.4 CONSULTATIONS

6.4-1 INDICATIONS FOR CONSULTATION

The conduct of good medical practice includes the proper and timely use of consultation. Recognizing that not all of the conditions requiring consultation can be delineated precisely, the following conditions generally indicate need for consultation:

a) When the diagnosis is uncertain after ordinary diagnostic procedures have been completed.

b) In unusually complicated situations wherein specific skills of other practitioners may be needed.

c) When the level of care required is outside the scope of the privileges granted to the primary physician or the problem is out of the area of the primary physician's expertise.

d) When required by departmental or special care unit rules, provided such rules have been approved by the Medical Executive Committee.

e) When specifically requested by the patient or the patient's family with concurrence by the attending physician.

f) If, in the judgement of the attending physician, the patient poses a significant risk of harm to self or others, a psychiatric consultation will be sought.

6.4-2 REQUESTS FOR CONSULTATION

The attending physician is primarily responsible for requesting consultation when indicated and for communicating with the consultant. Except in an emergency, it shall be the responsibility of the attending physician (or designee) to provide written authorization for the consultation, the reason for the consultation and to indicate whether the attending physician wishes only a consultation report or that the consultant provides continuing care. In the event that the attending physician wishes to transfer the care of the patient entirely to the consultant, the attending physician shall so indicate in the request and affect such transfer of care with an order. The consultant should not exceed the authority granted in the request for consultation unless the consultant has prior discussion with and approval of the attending physician. Except in an emergency, no consultant shall be permitted to request the services of another consultant without the prior knowledge and approval of the attending physician.

6.4-3 CONSULTANTS

Any member of the Medical Staff may be called into consultation in a case which involves conditions falling within the member's area of expertise as defined by the member's scope of clinical privileges. Recognized consultants who are not members of the Medical Staff may be permitted, on request of the attending physician, to treat patients providing they have been granted temporary privileges as described in Section2.7 of the Medical Staff Bylaws.

PART SEVEN: EMERGENCY MEDICAL CARE SERVICES

7.1 EMERGENCY MEDICAL CARE RECORDS

7.1-1 CONTENT OF RECORDS

An appropriate legible medical record must be made for every patient receiving emergency medical care. Such record shall be incorporated into the Hospital record if the patient is admitted to the Hospital. The emergency services record shall include the following:

- Patient identification data
- Information relevant to the time of arrival, mode of arrival and accompanying persons, if any
- Impression
- Pertinent history of illness or injury, including detail of any pre-hospital care
- Description of significant physical findings and vital signs
- Diagnostic tests ordered and their results
- Consent forms for procedures undertaken
- Treatment given and response
- Condition of patient on discharge, transfer, or admission
- Final disposition, including any medications given or prescribed and any instructions regarding follow-up care
- Whether the patient left against medical advice
- Notation that a copy of the record is available to the practitioner or medical organization providing follow-up care

7.1-2 AUTHENTICATION OF SERVICES

Each medical record must be completed and authenticated by the physician responsible for any patient care services provided by that physician, including consultations.

7.2 DEPARTMENTAL ORGANIZATION

7.2-1 STAFFING

a) The Emergency Services Area will be staffed at all times (24 hours a day) by a member of the Department of Emergency Medicine faculty/attending staff.

b) All members of the Emergency Medicine Department will be appropriately credentialed with delineation of clinical privileges according to the Medical Staff Bylaws and the Rules and Regulations of the Department.

7.2-2 PROCEDURE MANUAL

The Chair of the Emergency Medicine Department, in conjunction with the members of the Departmental Staff shall develop and maintain a procedural manual relating to the services rendered in the Emergency Services Area. Such procedures shall be based upon the policies, that have been approved by the Medical Executive Committee, and shall become operative when approved by the Medical Executive Committee. Such procedures shall be reviewed at least annually and any revision must be approved by the Medical Executive Committee before becoming operative.

7.2-3 PERFORMANCE IMPROVEMENT

Performance Improvement monitoring and review of patient care services are carried out by the Emergency Medicine Department.

7.2-4 DISASTER PLAN COORDINATION

The Department of Emergency Medicine shall maintain liaison with the Disaster Committee and shall be familiar with the written Disaster Plan at all times so as to effectively complement the efforts of the Disaster Committee in the event of an internal or external disaster.

7.3 PATIENT CARE POLICIES

7.3-1 INITIAL EVALUATION BY EMERGENCY MEDICINE DEPARTMENT PHYSICIANS

All patients are initially evaluated by members of the Emergency Medicine staff on duty, unless prior arrangements have been made for the attending physician to be available to render care.

7.3-2 EVALUATION BY NON-EMERGENCY MEDICINE DEPARTMENT PHYSICIANS

Medical staff physicians, other than Emergency Medicine Department members, may attend their patients in the Emergency Services Area and render care within the scope of their delineated clinical privileges. They are responsible for the completion of the medical record of such services.

7.3-3 PATIENTS REQUIRING ADMISSION

a) Patients who require admission and have a physician on the Medical Staff of the Hospital are admitted only after notification and approval of the attending physician or designated alternate.

b) Patients who require admission and do not have a physician on the Medical Staff of the Hospital are admitted after notification and approval of the appropriate physician on the On-Call Roster.

7.3-4 PATIENTS NOT REQUIRING ADMISSION

a) Patients who do not require admission and have a private physician will be referred to their physician for follow-up care.

b) Patients who do not require admission and do not have a private physician but require follow-up care will be referred to the clinics of the Hospital on an equitable basis or will be referred to the appropriate physician on the On-Call Roster.

7.4 ON-CALL ROSTER

Each clinical department and division, as necessary, must supply the Emergency Services Area with an On-Call Roster on a timely basis. Physicians or dentists who cannot be available at the time assigned can provide for an equivalent substitute, provided the Emergency Services Area is notified in advance. It is the responsibility of the physician or dentist to notify the Emergency Services area and primary department of any change in the ER Call Schedule. All physicians are expected to return a phone call from the Emergency Room within thirty (30) minutes.

PART EIGHT: SURGICAL CARE SERVICES

8.1 SURGICAL MEDICAL RECORDS

8.1-1 INFORMED CONSENT FOR SURGICAL, INVASIVE AND DIAGNOSTIC PROCEDURE

Prior to the initiation of anesthesia for any operative, invasive, or non-invasive procedure, the physician and the anesthesiologist shall discuss the risks, alternatives, and benefits of the surgery and use of anesthesia with the patient or the patient's legally authorized representative (guardian, parent, agent appointed by Durable Power of Attorney for Health Care, or health care surrogate). Subsequently, the patient or representative must sign a form consenting to the surgery/procedure and anesthesia. Informed consent is obtained and documents the nature of the proposed procedures; potential benefits, risks, or side effects including potential problems related to recuperation; the likelihood of achieving the desired outcome(s) of the procedure; the relevant risks, benefits, and side effects related to the alternative, including the possible results of not receiving the procedure.

These requirements do not apply in emergencies where the patient's life is in jeopardy and consent cannot be obtained due to lack of time, inability of the patient to give consent, or unavailability of a legal representative. The circumstances of any emergency where consent is not obtained shall be fully documented in the medical record by the physician performing the procedure.

Procedures Requiring Informed Consent:

1. An informed consent is required for all invasive procedures performed under non-emergent conditions.

2. Invasive procedures are defined as those procedures involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to:
    a. percutaneous aspirations and biopsies
    b. cardiac and vascular catheterizations
    c. endoscopies
    d. angioplasties
    e. Implantations
    f. Lumbar puncture
    g. Placement of central lines and central catheters, including peripherally inserted central catheters
    h. Chest tube insertion
    i. Thora-and paracentesis
    j. Placement of invasive pressure monitors
    k. Circumcision
    l. Sterilization
    m. Regional or spinal pain blocks
    n. Joint aspirations
    o. Therapeutic apheresis

3. Excluded are procedures such as, but not limited to:

    a. venipuncture
    b. placement of urinary catheters
    c. placement of nasogastric tube
    d. placement of peripheral IV lines
    e. arterial blood gases
    f. replacement of a PEG tube
    g. insertion of a rectal tube
    h. arterial puncture

4. High-risk non-invasive procedures that require an informed consent include but are not limited to:

    a. Electro-convulsive therapy
    b. Cardioversion
    c. Radiosurgery (at the initiation of treatment)
    d. Treatments involving radiation/radiotherapy (at the initiation of treatment)
    e. Transesophageal echocardiogram

5. An informed consent is required for all procedures involving anesthesia and procedural sedation, exclusive of local anesthesia or medications administered for anxiolysis.

6. Additionally, it is the responsibility of the physician or other Licensed Independent Practitioner to determine whether the nature of a specific procedure is so complex, high risk or unique that informed consent is necessary.

8.1-2 CONTENT OF RECORD BEFORE SURGERY

a) The medical record must include evidence of pre-operative evaluation and documentation, including a medical history and physical examination or consultation, appropriate test results, and surgical consent forms authenticated by the practitioner performing the procedure and patient when appropriate.

b) The pre-operative evaluation and documentation must be recorded on the patient's record prior to any procedure, except in an emergency. In such an emergency, the medical record must document the patient's condition prior to surgery.

8.1-3 ANESTHESIA RECORDS

The anesthesiologist must maintain an appropriate anesthesia record to show pre-operative evaluation, intra-operative condition, and post-operative follow-up of the patient in compliance with the Department's Rules and Regulations.

8.1-4 OPERATIVE REPORTS

A written or dictated operative note is required for any procedure in which informed consent is obtained and moderate or deep sedation is given. An operative note must be dictated/written within 48 hours after the surgery/invasive procedure.

The operative note must include the following elements: Name and hospital identification number of the patient; date and times of the surgery; name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision); pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications; a description of techniques, findings, and tissues removed or altered; estimated blood loss; surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and, prosthetic devices, grafts, tissues, transplants, or devices implanted (if any). The operative note must be signed within (11) days of the procedure.

The ability to schedule surgical cases may be predicated upon operative notes being completed. If a surgeon has two (2) or more operative notes that have not been dictated within the defined 48 hours timeframe, the surgeon will not be able to schedule elective and/or non-emergent cases until the delinquent charts are up to date. If a surgeon has delinquent operative notes occurring three (3) times within a quarter, the surgeon will lose block time for the next quarter.

In the event an operative note cannot be dictated and authenticated prior to the patient being transferred to the next level of care, an immediate post operative note is required to be documented and authenticated and must include: the surgeon and assistants, pre-operative and post-operative diagnosis, procedures performed, specimens removed, estimated blood loss, complications, type of anesthesia administered, and, grafts or implants (may indicate where in chart for detail, if any). This note must be entered and authenticated within

the medical record prior to transfer to the next level of care.

8.2 PATIENT CARE POLICIES

8.2-1 TRANSPORTATION

Transportation of patients to and from the surgical area and within the surgical area shall be controlled by personnel from the surgical area.

8.2-2 PREPARATION PRIOR TO SURGERY

a) The patient shall have been adequately prepared, in accordance with the guidelines established by the Infection Control Committee.

b) Requirements prior to induction of anesthesia or surgery include the following:

The patient shall be properly identified by means of a wrist bracelet by asking the patient's name, attending doctor's name and the type of operation is to undergo, including the surgical site and laterality.

8.3 GENERAL POLICIES

8.3-1 SURGICAL PRIVILEGES

All practitioners wishing to perform surgical procedures must obtain specific surgical privileges from the Department of Surgery or other department which has been approved by the Medical Executive Committee to exercise the privileges. Physicians requesting surgical privileges for which their assigned department is not approved to exercise must obtain approval from the department which is allowed to exercise the specific surgical privilege. Such privileges are approved through the regular privilege delineation process.

8.3-2 OPERATING ROOM SCHEDULE

Except for emergency cases, all surgical operations must be scheduled in advance. Basic information regarding patient data, type of operation and estimated time, etc. and the procedure for changing the schedule must be in accordance with the rules and regulations approved by the Operating Room Utilization Committee and the Medical Executive Committee.

8.3-3 ATTENDANCE REQUIREMENTS IN SURGERY

All practitioners participating in the surgical procedure are expected to be present and ready well in advance of the scheduled time of the operation. Starting time will be the time the patient is brought into the operating room. No case can be started without all members of the team present in the operating room except in dire emergencies where the most senior resident of that particular service may start the case in the absence of the attending surgeon.

Failure to be present for elective cases within twenty (20) minutes of the scheduled time or after notification shall result in loss of priority and the operation may be canceled.

Surgeons must check in with the patient 20 minutes prior to surgery and 35 minutes prior to surgery for nerve block cases.

The following occurrence based penalty system will be followed if a surgeon is late:

Occurrence #1: Department chair notified by email
Occurrence #2: First letter to Surgeon from the Chief of Surgery
Occurrence #3: Second letter sent to the surgeon from the Chief of Surgery
Occurrence #4: Required to attend the Surgical Executive Committee Meeting to present the case for privileges.

*Please note each time a surgeon is late; an email will be sent to their respective department chair notifying of the occurrence.

8.3-4 PATHOLOGICAL SPECIMENS

All tissues and foreign materials removed at operation shall be sent to the Department of Pathology. The pathologist's report is included in the patient's medical record.

8.3-5 PERSONNEL ALLOWED ACCESS TO SURGERY

No lay visitor shall be given access to the O.R. during surgery. Only individuals in the categories authorized herein and individuals authorized in accordance with hospital policy shall be allowed access to the operating rooms during surgery. Individuals authorized herein shall be members of the medical staff, persons employed by the hospital and assigned to the operating room, and persons participating in residency or clinical training programs.

Only designated surgical personnel should wear and have access to surgical scrub suits. Appropriate attire inside and outside of the surgical suite is in accordance with guidelines established by the Infection Control Committee.

PART NINE: GRADUATE MEDICAL EDUCATION PROGRAMS

9.1 APPROVED ACTIVITIES

A. House Staff members of approved graduate medical education programs of the Medical Center can render patient care services and write patient care orders.

B. Only Licensed Independent Practitioners may write orders to place a patient in restraints or seclusion. The House Staff/Resident physicians are deemed licensed independent practitioners for the purpose of writing orders to place patients in restraints/seclusion provided the following has taken place:

1. The *residency program director or department chair* verifies that the resident physician has a valid Illinois temporary or permanent license to practice medicine which covers activity in the training program.

2. The *residency program director or department chair* determines that writing orders to place a patient in restraints is a part of the training program.
3. The residency program description includes a description of the clinical skills and abilities a resident physician must possess to write orders for restraints and the degree of supervision required.

4. Activity of restraint usage by resident physician is tracked by the QI department or residency program or program director.

5. The ability to order restraints by the resident physician is reviewed annually by the residency program director or department chair to assess the resident physician's ability to write restraint orders and to make any needed changes in required supervision.

6. Orders placing a patient in restraints cannot be written on an "as needed" or PRN basis.

7. The resident physician consults with the treating physician as soon as possible after writing an order placing a patient in restraints.

9.2 SUPERVISION

Such patient care services, and patient care orders are supervised by the attending physician or the consultant if the house staff member is rotating on a consultant service. Those who participate in the teaching program follow ACGME guidelines and supervision of residents is governed by Christ Medical Center Policy. Clinical Departments that have residency training programs will include the procedures for supervision of the residents in their department rules and regulations.

PART TEN: ADOPTION AND AMENDMENT

The procedures outlined in Article Ten of the Medical Staff Bylaws shall be followed in the adoption and amendment of the Medical Staff Rules and Regulations.

Approved:
12/24/2022: Medical Executive Committee
01/16/2023: Governing Council