



Stony Brook University Hospital
Medical Staff
Rules and Regulations

November 2018

RULES AND REGULATIONS

STONY BROOK UNIVERSITY HOSPITAL STATE UNIVERSITY OF NEW YORK AT STONY BROOK STONY BROOK, NEW YORK

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SECTION 1. PURPOSE

The medical staff shall adopt such rules and regulations as may be deemed necessary for the proper conduct of the professional work of the hospital. Such rules and regulations shall be part of these bylaws and shall be amended following the same process as amendments to the bylaws. Amendments to the Rules and Regulations will become effective after they have been approved by the governing body.

SECTION 2. ADMISSION POLICY

No person shall be denied admission to the hospital because of race, creed, national origin, gender, sexual orientation, source of payment or disability (within the capacity of the hospital to provide treatment). All patients who come to the hospital for evaluation or treatment shall be registered by admitting department personnel whenever possible. Except in emergencies, patients shall be admitted only upon referral and under the care of a currently licensed physician or dentist who shall be a member of the medical staff of the hospital. Except in emergencies, the hospital shall admit as patients only those patients who require the type of medical services authorized by the hospital's operating certificate.

SECTION 3. COMPUTER SYSTEM

Stony Brook University Hospital uses automated information systems for transmittal of all hospital orders and results; and for the maintenance and distribution of patient information. Physicians will have access to these systems. It is the physician's responsibility to use the systems in accordance with the appropriate Stony Brook University Hospital Administrative Policy and Procedures, Section: Information Management (Revised 3/06).

SECTION 4. CONFIDENTIALITY OF PHYSICIAN CREDENTIALING RECORDS

Except as otherwise provided by law, physician credentialing records are confidential except that they may be reviewed by the medical director or designee of Stony Brook University Hospital. A medical staff member may review his/her credentials file by request to the medical director or his/her designee, or to the President of the medical board or his/her designee. The request will be responded to within a reasonable period of time.

SECTION 5. DISASTER ASSIGNMENTS

In case of extreme disaster, all physicians and dentists shall be assigned to posts, either in the hospital or in mobile casualty stations, and it is their responsibility to report to their assigned stations as directed. Coordination of activities shall proceed as outlined in the emergency preparedness plan. In cases of evacuation of patients from one section of the hospital to another, or evacuation from hospital premises, the chiefs of the medical and surgical services shall authorize the movement of patients. All policies concerning patients' care shall be a joint responsibility of the chiefs of the medical and surgical services and the Chief Executive Officer of the hospital or, in their absence, their designees in administration. All members of the medical staff of the hospital specifically agree to relinquish direction of the professional care of their patients to the disaster chiefs of the medical and surgical services in cases of such emergency.

SECTION 6. EMERGENCY CARE

Emergency care will include medical and dental care provided in the Emergency Department.

SECTION 7. INFORMED CONSENT

All patients must give a valid informed consent for all operative and other procedures as per Administrative Policy and Procedures. A written record of such informed consent must be presented to the patient and signed by the patient or his/her legal representative. If the patient is unable to give informed consent, the Associate Director of Nursing (ADN) can be contacted for further advice. When consent is not obtainable, the reason should be documented in the medical record.

SECTION 8. MEDICAL RECORDS

All medical records of both inpatients and outpatients, cared for under the operating certificate of Stony Brook University Hospital, are the property of Stony Brook University Hospital. In-patient medical records and outpatient records of the full and part time (non-voluntary) faculty are accessible by University officials for the purposes of complying with regulatory requirements imposed upon Stony Brook University Hospital by the NYS Department of Health, JCAHO or any other state/federal regulatory or accreditation agency, and quality assurance requirements.

(A) ABBREVIATIONS.

Symbols and abbreviations that may be used in medical records shall be restricted to those that have been approved by the medical board. The official list of such abbreviations can be found in the Administrative Policies and Procedures Manual policy on abbreviations. In addition, certain abbreviations may not be used anywhere in the medical record except on preprinted forms. The names of all medications must also be spelled out when used in medication ordering as per the Administrative Policy and Procedure on abbreviations.

(B) ADDENDUM TO ENTRIES.

Any addendum to the medical record must be entered as a new note in the progress notes and must be dated, timed and signed. No additions may be made to flow sheets or graphs.

(C) AUTOPSY REPORTS.

In the event of autopsy, a provisional anatomic diagnosis should be recorded in the medical record within 3 days. A copy of the entire autopsy report shall be made a part of the patient's medical record within 60 days of the date of autopsy. The physician who attended the patient at the time of death shall record in the medical record any additional clinical diagnoses that are appropriate, considering the results of autopsy.

(D) AUTOPSY RESPONSIBILITIES.

It is the responsibility of the attending physician or his/her designee to obtain consent for autopsy on all deaths. The attempt to obtain this consent must be documented in the medical record by the attending physician or his/her designee. If the attending feels that it would be inappropriate to request a postmortem examination, then a statement expressing this matter must be entered into the medical record.

(E) AVAILABILITY OF RECORDS.

Medical records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. All medical records are the property of the hospital. When the patient returns, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another, provided that certain patients seen by psychiatrists may have their psychiatric history kept permanently in the Department of Psychiatry.

(F) COMPLETION OF RECORDS.

All medical records must be promptly completed. Every medical record must be complete with all documentation of orders, diagnosis, evaluations, treatments, test results, care plans, discharge plans, consents, interventions, discharge summary and care provided along with the patient's response to those treatments, interventions and care. The record must be completed promptly after discharge in accordance with state law and hospital policy but not later than 30 days after discharge.

(G) COMPLICATIONS AND INCIDENTS.

All complications and all incidents which affect patient care must be objectively documented in the progress notes at the time of occurrence.

(H) CONSULTATIONS.

Definitions

Consultation is appropriate in cases in which the diagnosis is obscure, when doubt exists as to the best therapeutic measure to be utilized, and in major surgical cases in which the patient is judged to be a poor surgical risk. Routine consultations must be performed within 24 hours except as noted below.

Urgent consultations must be answered within 4 hours, emergent consultations as soon as possible. When operative procedures are involved, the consultation note shall, except in emergency situations so verified in the record, be recorded prior to the operation. Consultations provided by resident staff must be done in accordance with the hospital policy on supervision of postgraduate trainees.

Physicians on-call to consult in the Emergency Department respond, examine and treat patient with emergency conditions, where stabilization of individuals is necessary, as soon as possible but no longer than 60 minutes (revised 3/15/16)

Qualifications

The consultant must be qualified in the field in which his/her opinion is sought. Attending to attending communication of request for consultation is strongly encouraged but designation of fellow, resident or nurse practitioner to initiate consultation is acceptable.

Contents of a Consult

The consultation shall include examination of the patient and the patient's medical records, and pertinent findings on examination of the patient, and the consultant's written opinion, and recommendations. This report shall be signed by the consultant and is a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. Any member of the medical staff who is requested to be a consultant for a patient should record a note at the time a patient is seen.

Written Report Due

The consultant's final and complete consultation, including a written opinion which reflects an examination of the patient and the patient's medical record must be completed within 24 hours, unless both services agree that it is not necessary to complete the consultation within 24 hours. In this case, the consultant physician will document in the medical record when s/he will be conducting the consultation.

Requirements for Orders

Orders recommended by consultants may be placed by a medical staff member in the service responsible for the patient. Orders may not be directly placed by consultants. Order placement is available to any concurrent care attending/service involved in the patient's care (reference 9J). All requests for consultations must be ordered. The consultant form also needs to be filled out and acknowledged, in writing, by the consulting physician (revised 3/09).

(I) CONCURRENT CARE.

Definition

Concurrent care is that care which occurs when more than one service is providing direct care and writing orders for a patient.

When Needed/How to Obtain

Concurrent care may be sought when, in the opinion of the requesting service, the patient's care will benefit. A request for concurrent care should be made through the usual consultation channels. Both attendings must agree and document which services the concurrent care consultant(s) is (are) providing.

Responsibility

Though a concurrent care attending assumes responsibility for a portion of the patient's management, the attending physician of record is still responsible for overall management of the patient and for coordinating the care rendered by all other practitioners and hospital personnel.

Requirements for Orders

Orders may be written on the chart by both the admitting attending/service and any concurrent care attending/service involved in the patient's care.

Transfer to Another Service

In the course of a patient's hospitalization, if mutually agreed upon by the attendings, and if advantageous for the patient's welfare, the patient's overall management may be transferred to a concurrent care attending's service.

(J) CORRECTIONS TO THE RECORD.

Corrections are to be made by drawing a line through the change(s), dating and initialing the change(s). Obliterations of any kind are not permissible.

(K) DELINQUENT RECORDS.

NO medical record shall be filed until it is complete, except on the order of the Medical Records committee.

Definition

A delinquent medical record is one that, more than **10** days after discharge, has not been **completed** with all required entries and documents-

Delinquent More Than 20 Days

If delinquency of a medical record results from 20 or more days of delay by a physician in completing a required part of the record, then that physician shall be subject to the following disciplinary action:

1. Attending staff and nurse midwives shall have admitting privileges suspended, except for emergency admissions, until the records are complete. Attending physicians will not be able to admit, schedule patients other than current inpatients in the OR, Endoscopy Lab or Cardiac Cath Lab, but will be permitted to care for their current inpatients and perform previously scheduled procedures.
2. In all cases, the attending will be noted as the responsible party to dictate or complete operative reports and/or discharge summaries in the electronic Medical Record (EMR) and to sign those documents. Residents and fellows will not be included in the chart deficiency assignment and tracking process.
3. Suspensions for delinquent medical records shall be in accordance with the following.

Suspension Policy

If the discharge summary or op report has not been completed within 10 days of discharge, The Health Information Management (HIM) department shall appropriately notify the practitioner that his/her privileges to admit patients shall be suspended 10 days from the date of notice. The Chief of Service and the OPPE designee will also be appropriately notified.

Practitioners will be appropriately notified of immediate suspension if any medical record remains delinquent after the warning period. The Chief of Service, OPPE designee, Patient access services, OR Booking office and other necessary departments will also be appropriately notified.

Privileges will not be reinstated until all the delinquent records have been completed.

(L) DICTATION.

All dictated and typed medical record documents shall show the date of the examination or procedure and the date of dictation.

(M) DISCHARGE ORDERS AND FINAL DIAGNOSIS.

No patient will be discharged from the Stony Brook University Hospital until the following items are completed:

1. all orders signed and countersigned
2. discharge order written

Final diagnosis shall be recorded in full and dated and signed by either the resident or attending physician at the time of discharge. This is deemed to be as important as the actual discharge order. This is considered to be an integral part of the discharge order.

(N) DISCHARGE SUMMARIES.

A discharge summary shall be completed in the electronic medical record (EMR) on all inpatients with a length of stay over 48 hours, except for normal vaginal deliveries and normal newborn infants, for whom a comprehensive final discharge progress note by the attending physician shall be sufficient. In the event of death or an external hospital transfer a dictated discharge summary shall always be required regardless of the length of stay. (11/18)

All discharge summaries must be completed and authenticated at the time of discharge or transfer by the discharging health care practitioner (resident, fellow, attending, nurse practitioner, midwife or physician assistant) unless another healthcare provider is specifically and designated in the EMR. The completed report requires the authentication of the attending physician. The ultimate responsibility for the discharge summary lies with the attending physician and midwife.

The discharge summary must include:

- admission diagnosis
- pertinent physical examination findings and laboratory results
- procedures and complications in hospital
- discharge diagnosis
- discharge medications
- active medical problems at discharge
- follow up. (7/06)

(O) EDUCATION OF PATIENT AND FAMILY.

The attending physician of record will be responsible for assuring that patients receive appropriate information and education about their care and treatment.

(P) EXAMS FOR SURGICAL PATIENTS.

For patients requiring surgery, the following must be included (1) preoperative examination and assessment by the attending physician and (2) daily attending postoperative examinations and assessments.

(Q) IDENTIFICATION OF ENTRIES.

All entries in the medical record must contain a signature or be an authorized electronic signature, and legible date, time, hospital ID number and/or name.

(R) LEGIBILITY.

All entries in the medical record must be legible. Any problems with legibility will be referred to the chief of service for appropriate action.

(S) OBSTETRICAL RECORDS.

The current obstetrical record shall include a complete prenatal summary. The prenatal summary may be a legible copy of the attending physician's office record, which must be on file in labor and delivery at 36 weeks of pregnancy. An interval admission note must be written that includes pertinent additions to the history and subsequent changes in the physical findings.

(T) OPERATIVE REPORTS.

Brief operative reports must be recorded in the progress notes immediately upon completion of an operation. The handwritten operative note must contain the information delineated in the SBUH Administrative Policy on Operative Reports. Operative reports should be dictated or completed in the EMR immediately after the surgery and must include the information described in the policy as well as a detailed description of the operation and technical procedures used. This report must be dictated or completed in the EMR either by a resident or attending surgeon. It must be reviewed and authenticated by the attending surgeon

(U) ORDERS FOR TREATMENT.

All orders for treatment shall be authenticated electronically or written signature by the authorized prescriber. Documentation of house staff supervision, must be in the medical record. All orders for treatment must be in accordance with standard formats and ordering practices as set by hospital administration and the medical board. In an emergency, an order shall be considered to be in writing if dictated to a registered nurse, or other authorized personnel, but such an order must be countersigned by a physician within 24 hours. Except in an emergency, orders will be carried out only when written or countersigned and dated by an appropriate member of the care team, except in the case of an operative patient, when orders written by the anesthesiologist may be accepted. In an emergency, verbal and telephone orders will be accepted as per EE Verbal Orders.

(V) PATHOLOGY REPORTS.

The pathologist shall submit a written report on all biopsy and surgical specimens. This report shall be made a part of the patient's current medical record, ordinarily within 5 days of the date of the specimen in the event of routine examination, or as soon as reasonably possible in the event of special examinations.

(W) PERMISSION TO WRITE IN RECORD.

Entries in medical records may only be made by individuals given this right as specified in hospital and medical staff policies.

1. Third and fourth year medical and dental students will be permitted to write notes in medical records, but a countersignature will be required. It will be the responsibility of the chief of service to decide who can countersign for that service.
2. Staff chaplains, social workers, dieticians and pharmacists will be allowed to write in the medical record.

(X) PROCEDURE NOTES.

Procedure notes must be written in the progress notes in all cases. Each clinical service is to identify those procedures for which a note is required. Procedure notes must contain the following information: date, time, indications, procedure team, complications, findings/specimens, technique, comments, signature, and ID number.

(Y) PROGRESS NOTES.

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes shall be recorded in a manner so that they are legible. Each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders and results of tests and treatment. The responsible practitioner shall write progress notes on a daily basis and within 24 hours of discharge. The attending physician shall document in the chart on a daily basis that the patient's care was reviewed and patient was examined by the attending and discussed with the house officer or physician extender or that management is proceeding as planned.

(Z) RELEASE OF RECORD.

Written consent of the patient is required for release of medical information to persons not authorized to receive this information.

(AA) ELECTRONIC SIGNATURES.

When electronic signatures are authorized, the individual whose signature the referenced code represents shall be the only user of the reference code. Use of the reference code and/or password shall not be delegated to another individual. The practitioner shall sign a statement to the effect that s/he agrees to view, document, sign and/or alter only those documents to which s/he has legitimate access within the scope of his/her duties; that confidentiality of patient information will be maintained; and that patient information will not be disclosed outside the bounds of applicable law and hospital policies. Upon termination of employment, the respective department shall notify the medical staff office and the medical records department who will inactive the practitioner's access to the computer.

(BB) SUPERVISION OF RESIDENTS/DOCUMENTATION.

The medical record must contain evidence of supervision of the residents and fellows by the attending physicians. This requirement can be fulfilled by including phrases such as "case discussed with attending" and "notes and orders reviewed" in the entries. Countersignature of notes and orders by the attending physician is also acceptable. Such documentation should appear at the time of admission of a patient, daily thereafter [every 24 hours] and, when there is a significant change in the condition of the patient or the plan of treatment, and at regular intervals during the hospital stay.

(CC) VERBAL ORDERS.

Verbal or telephone orders must be carried out in accordance with hospital policy. Verbal or telephone orders must be dated, timed and identified by the name(s) of the authorized prescriber(s) who gave it. Verbal or telephone orders may only be accepted by an authorized prescriber, a registered nurse (RN) or a licensed pharmacist. The verbal or telephone order must be immediately transcribed and read back to the prescriber. Verbal or telephone orders must be signed within 48 (GB 7/09) hours by the issuing prescriber or another prescribing member of the treatment team. The authenticating signature must be dated and timed. All signatures must be accompanied by the unique identifier number which must be legible in the patient's medical record.

SECTION 9. DIVISIONS AND SECTIONS WITHIN A CLINICAL SERVICE.

(A) DIVISION

1. DEFINITION

A division within a service shall be a major sub-unit within that service as required to carry out the patient care responsibilities of the organizational unit.

2. CREATION/DELETION

A division may be created or deleted upon the recommendation of the chief of service to the Dean, School of Medicine (Revised 3/06). It shall be based upon some or all of the following criteria:

1. Recognition by specialty board examination and certification;
2. Recognition traditionally as a clinical subspecialty;
3. Pertaining to an organ system or scientific discipline and not limited to one disease process;
4. Inclusion of all clinical functions traditionally incumbent on a specialty, including patient care, teaching, and research activities; and
5. Size alone shall not be a determining factor.

3. ORGANIZATION

1. Each division shall have an operational head who shall report to the chief of service;
2. Titles such as: physician-in-charge or chief, shall be used upon the recommendation of the chief of service to the Dean, School of Medicine or designee (Revised 3/06) and the approval of the medical board;
3. Criteria for a division chief should be at least:
 - i. peer recognition as being of consultant caliber in the specialty field;
 - ii. certification by sub-specialty boards, if any;
 - iii. responsibility for the operation of a divisional program such as a residency or fellowship training program.

(B) SECTION

1. DEFINITION

A section shall be a sub-unit of a service or of a division within a service as required to carry out the patient care responsibilities of the organizational unit.

2. CREATION/DELETION

A section may be created or deleted upon the recommendation of the chief of service to the Dean, School of Medicine (Revised 3/06).

3. ORGANIZATION

a) The Head of a section shall report to the operational head of the organizational unit within which the section is created.

b) Titles such as "Head of...", shall be used upon the recommendation of the chief of service to the Dean, School of Medicine (Revised 3/06).

SECTION 10. ORGANS FOR TRANSPLANT: RIGHTS TO HARVEST

Practitioners from outside transplant centers, tissue banks or organ procurement centers who come to the hospital for the purpose of harvesting organs for transplant, therapy or research shall be excluded from any requirement for membership in the medical staff.

SECTION 11. PATIENT PROTECTION

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, and to assure protection of the patient from self-harm. All patients shall be assigned to the service or specialty division concerned in the treatment of the disease which necessitated admission.

SECTION 12. PATIENTS FOR TEACHING PURPOSES

All patients, including semiprivate and private with their approval, shall be available for undergraduate and graduate teaching purposes. Exceptions shall be recognized upon the personal request of the patient, or on the advice of the attending physician, with the approval of the chief of service.

SECTION 13. PATIENTS WITH LAB TESTS ONLY

A separate medical record will not be created for patients who are referred to the Stony Brook University Hospital for lab tests only.

SECTION 14 - PEER REVIEW

Stony Brook University Hospital and its medical staff are responsible for the quality of care provided to the patient population seen throughout the institution. Therefore, it is the policy of Stony Brook University Hospital to support the medical staff peer review process. The peer review process (PRP) is a non-biased activity performed organization-wide to measure, assess and, where necessary, improve performance. All peer review proceedings are confidential under Public Health Code 2805, j, k, l, and m, except as referenced below for those who actually participated in the care of the patient in question and are also the objects of litigation.

Procedure

Peer Review Components. The PRP performed by the medical staff contains the following components:

Definitions of circumstances requiring peer review are listed below. Revision of this list is at the discretion of the Medical Quality Assurance Committee, with the advice of the Medical Center Quality Council, with final approval by the Medical Executive Committee. Circumstances leading to peer review include:

All mortalities of inpatients and ambulatory patients while physically on premises.

All sentinel events (as defined in the Sentinel Event Policy) or incidents (as defined in the NYPORTS system) that are deemed physician attributable by the Medical QA Subcommittee that reviews such events.

All transfusion reactions.

Patient complaints and/or grievances related to medical staff management of patient care.

Staff complaints, grievances or concerns against a medical staff member or members related to the management of patient care.

Issues of patient care attributable to a medical staff member or members arising from notice of litigation or actual litigation.

Reviews of resident-supervision.

Issues of physician-attributable patient cross-referenced from one division/department's PRP to another's.

Other complaints/issues that may arise that are referred by the President of the Medical Board, the Chair of the Medical Executive Committee, the Medical Director or Associate Medical Director for Quality Management.

Service specific indicators as defined by the service in question, the Medical QA committee, the Medical Executive Committee and/or the Medical Center Quality Council, including those collected by the Medical Care Review Department as part of its QA/Utilization Review function.

PRP Participants

The nature of a peer is defined elsewhere in these policies/procedures. Opinions of others on the Medical Staff, not a peer by this definition, may be solicited where that opinion is relevant to a specific management issue for the case under review, but these others must be a part of the reviewing committee (either standing or as ad hoc members). The peer reviewer will not have been a participant in the care of the patient under review. Opinions and information may be obtained from those who participated in the patient's care, recognizing that such expressions may not be protected by confidentiality should these participants be the object of litigation. In addition to standing peer review (quality assurance) committees, ad hoc committees or members may be selected where additional medical expertise is thought necessary. In those instances in which the Chief of Service's care is being reviewed the Medical Director or designee will be responsible for ensuring that the peer reviewers and the process utilized are able to exercise unbiased judgment.

PRP Time Frames

Cases forwarded to Medical Staff Committees for peer review are to be reviewed within 3 months of referral unless, in the judgment of the referring person or group, more immediate review is thought necessary. This will be communicated via the Medical Director or designee.

External Peer Review

Circumstances requiring external peer review include, but are not limited to:

Need for specialty (or subspecialty) expertise when there are no medical staff members with that expertise within the institution. This judgment will be made by the Chief of Service, the Medical Director or designee.

The peer review committee cannot make a determination and requests external review

The individual whose case is under review requests external peer review, gives a basis for that request and it is agreed to by the Medical Director or designee.

The Medical Executive Committee or the Medical Quality Assurance Committee requests external review.

Participation in the PRP by the Practitioner whose Performance is Under Review.

The individual whose case is under review has the right to present his or her information regarding case management to the committee performing peer review and may sit on that committee during the time the case is being reviewed and discussed.

Such individuals will be notified as soon as practicable of the date of the peer review meeting but no less than two weeks prior unless immediate review is required. If the latter, then notice will be given as soon as the meeting date is determined.

Peer Review Program Methodology

Peer review shall be consistent, i.e., all cases for peer review shall adhere to the above.

The relevant time frames shall be adhered to in a reasonable fashion. If there are delays such delays shall be documented in the appropriate committee minutes.

Conclusions of the review are defensible and are a result of a well-balanced approach. The basis for the conclusion is listed and reflects the review of all relevant opinions on the committee including where offered, the opinion of the person whose case is under review.

Results of peer review will be utilized at the time of medical staff reappointment, being aggregated in the QA folder maintained by the Medical Care Review Department and incorporated into the Medical Staff Office credentialing file.

Aggregated or individual peer review activities will be utilized for hospital-wide performance improvement (PI) activities by reporting to the Medical QA Committee and, without attribution and where necessary, to the appropriate Quality Council(s).

The peer review program is an ongoing component of the hospital-wide PI program. Its conclusions, outcomes and actions will be monitored semi-annually by review at the Medical QA Committee and at the relevant Quality Council(s) for numbers, actions taken and, where appropriate, follow-up for effectiveness. The Medical QA Committee shall report semi-annually to the Medical Executive Committee the results of its peer review monitoring.

SECTION 15. PHARMACY

Medical staff, post graduate trainees, and licensed/registered practitioners may prescribe drugs which have been approved for general use by the Pharmacy and Therapeutics Committee and the medical board and thus are listed in the hospital formulary. Only medications needed to treat the patient's condition are to be ordered (MM3.10). Medication orders are to be written clearly and transcribed accurately in accordance with the hospital's order writing policy (MM3.20). High-risk medications, as defined in the hospital's policies, must be presented in accordance with those policies. In some instances only certain groups of physicians will be allowed to prescribe selected high-risk medications, such as chemotherapy (MM7.10).

- a. Exceptions to the above rule include drugs approved for bona fide clinical investigation and FDA approved drugs prescribed in accordance with non-formulary drug procedures.
- b. Medical students may prescribe medications if such orders are countersigned by a resident or attending physician prior to implementation. Other health professionals may prescribe medication pursuant to specific protocols approved by the medical staff.
- c. Stop date. All medication orders shall be assigned an automatic stop date, as determined by the medical staff, at which time the order must be renewed or it will no longer be valid.
- d. All adverse drug reactions must be reported to the appropriate attending physician and an Adverse Drug Reaction Report completed and forwarded to the pharmacy. Alternatively, the reaction may be entered into the Patient Safety Net, the online patient event reporting system. If indicated, the pharmacy will coordinate submission of an FDA Drug Experience Report.
- e. The following patient-specific information must be available to the prescriber and accessible to other healthcare workers for all patients for whom medication is ordered: age; sex; current medications; diagnoses; co morbidities and concurrently occurring conditions; relevant laboratory values; and allergies and sensitivities. In addition, as appropriate, the following information must also be available: weight and height; pregnancy and lactation status and any other information required by the hospital for safe medication management. {MM1.10}
- f. The patient's own medications may be used but only in accordance with hospital policies. In particular, the medication must be reviewed for use by the pharmacy prior to its being dispensed. It may be dispensed only upon the specific order of the responsible prescriber. {MM2.40}

- g. The effects of all medications must be monitored by appropriate review and documentation of the: patients' perceptions about: side effects and, as appropriate, efficacy; laboratory results; clinical response; and medication prescribed.

SECTION 16. PROFESSIONAL CONDUCT & ETHICAL BEHAVIOR

All members of the medical staff shall conduct their professional activities in accordance with the ethical code of their organized professional associations, in accordance with the New York State Education Law and the Public Health Law covering professional practice, and in accordance with the Bylaws, Rules and Regulations and mission of the Stony Brook University Hospital. This includes, but is not limited to:

1. participating in and abiding by the quality assurance process to assure excellence in patient care.
2. conducting themselves in a professional, courteous and collegial manner in interactions with all others, treating them with respect and dignity.
3. respecting the rights of patients and others to confidentiality.
4. accepting reasonable medical staff assignments.
5. participating in education and teaching assignments.
6. not engaging in any discrimination or harassment based on race, creed, age, color, disability, national origin, sex or marital status.

However, physicians who shall inform a patient that s/he refuses to give advice with respect to, or participate in, any induced termination of pregnancy are exempt from liability by the hospital.

Reporting Responsibilities

Additionally, practitioners have the obligation to report any possible professional misconduct (*i.e.* alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare] to their respective chief of service. [AMA's Code of Medical Ethics, Article 28, Public Health Law, 2803-e]

SECTION 17. RESIDENT EDUCATION

All attending physicians will participate in resident education, including in-house supervision, on a scheduled basis, as required by their chief of service.

SECTION 18. RESTRAINT AND SECLUSION

Restraint and seclusion shall only be used to prevent patients from seriously injuring themselves or others and only when less restrictive interventions are first attempted, and they are authorized in writing by a physician for a specified and limited period of time. Restraints may be used in either the course or routine medical care or behavioral health care (6/05).

For purposes of this policy, physical restraints are defined as any type of physical or mechanical devices used to limit the patient's ability to move in order to protect the patient or others from injury. This does not include those devices customarily used in conjunction with medical diagnostics, surgical procedures/treatments or movement/transfer of patients that are considered a regular or usual part of such treatment or procedure.

In an emergency, the restraint may be applied by a professional nurse who shall set forth in writing the circumstances requiring the use of restraints. In such emergencies, a physician shall be immediately summoned and will be expected to arrive within one hour for Medical Care Restraints and 30 minutes for

Behavioral health Care Restraints. Pending the arrival of a physician, the patient shall be kept under continuous supervision as warranted by the patient's physical condition and emotional state. (6/05)

At frequent intervals while restraints are in use, the patient's physical needs, comfort and safety shall be monitored. An assessment of the patient's condition shall be made at least once every 30 minutes or at more frequent intervals if directed by a physician; orders for restraint shall be rewritten daily and only after a personal examination by a physician. For Behavioral Health Care Restraint, orders for restraint must be renewed after a face-to-face assessment by a physician every one (12 years or younger) or two hours (adolescents and adults). (6/05)

All patients will be reassessed for release from restraint at least every two (2) hours. (6/05)

SECTION 19. SUPERVISION OF HOUSE STAFF AND STUDENTS

Each patient's identified attending physician shall participate in or supervise treatment provided by interns, residents and others to assure that all aspects of patient care meet proper quality levels; and shall assure that there is a meaningful learning experience for any house officer or student who interacts with the attending faculty member in the care of the patient.

Resident function is guided by the Essentials of Accredited Residencies in Graduate Medical Education, both the Institutional and Program Requirements. In addition, the program director will take into account the New York State Health Code 405.4 and the level of responsibility achieved by the resident.