MEDICAL STAFF
RULES AND REGULATIONS

100 Hospital Road, Prince Frederick, MD 20678

Rules and Regulations of The Medical Staff of Calvert Memorial Hospital
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A. DEFINITIONS: RULES AND REGULATIONS, POLICIES

1. The Medical Staff shall have the power and authority to adopt such Rules and Regulations as may be necessary for the proper conduct of its work consistent with the Medical Staff Bylaws. Such Rules and Regulations shall be a part of the bylaws and may be adopted or amended according to the bylaws. Such Rules and Regulations or amendments thereto shall become effective when approved by the Board of Directors.

2. Policies shall be defined as written statement of medical administrative matters of the Medical Staff, its Departments, and committees. These policies shall be approved by the respective Medical Staff Department or committee, the Medical Executive Committee and the Board of Directors. Policies of hospital services pertinent to the Medical Staff shall be reviewed by an appropriate Medical Staff Department or committee.

B. ADMISSIONS AND DISCHARGE OF PATIENTS

1. The hospital shall accept all patients for care and treatment. If a physician in a specialty is unable to provide care for a particular inpatient, the on-call specialist has the obligation to see that patient to treat, stabilize, and, if appropriate, transfer the patient in a timely manner. For those patients who require the care of a specialist or specialized equipment not available at Calvert Memorial Hospital, or those patients who request transfer to another health care facility, assessment and stabilization will be accomplished until such a transfer can be appropriately arranged.

2. A patient may be admitted to the hospital only by a member of the Active Medical Staff with clinical privileges. All practitioners shall be governed by the official admitting policies of the hospital.

3. The admission of psychiatric patients may be limited by the availability of a suitable room for the protection of the patient. It will be the policy of Calvert Memorial Hospital to use the holding room in the Emergency Department for short-term care of psychiatric patients.

4. Members of the Active Medical Staff with clinical privileges are responsible for the medical care and treatment of each patient in the hospital; for the prompt completeness and accuracy of the medical record; for necessary special instructions; and for transmitting reports of the condition of the patient to the relatives of the patient and as appropriate, to other practitioners. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

5. All patients presenting to the hospital for emergency evaluation shall receive a screening examination sufficient to determine the presence or absence of a medical emergency. Patients presenting to the Emergency Department or Urgent Care Center will be screened by a physician (or a physician extender under the direct supervision of a physician). Patients presenting for a possible obstetric emergency will receive a medical screening by a physician or by a qualified obstetric nurse with the concurrence of a physician. Behavioral Health patients will be medically cleared by an Emergency Department Physician or extender and assessed for psychiatric conditions by a qualified Emergency Psychiatric Services Practitioner in concurrence with the Psychiatrist on call to the Emergency Department..

6. No patient shall be admitted to the hospital until a provisional diagnosis or condition requiring acute medical services has been provided. Provisional diagnosis must be in the nomenclature of accepted diagnosis.

7. In any case in which it appears that a patient will require admission to the hospital, the attending physician will first contact the admitting office to ascertain whether there is an available bed.

8. A patient requiring admission on an emergency basis who does not have a private practitioner may request any practitioner in an applicable Department or service to attend him. When this request for a practitioner of the patient's choice cannot be arranged because:

    a. The practitioner has not seen the patient before, or

    b. The practitioner is not on call for the applicable service;

    Then the requested practitioner shall be given an option to accept the patient.

If the requested practitioner decides not to accept the patient, then the appropriate Medical Staff member on emergency service call will be assigned to the patient. The chief of each Department shall provide a schedule for emergency service call assignments. Failure of the Medical Staff members to appropriately cooperative with this rule may result in corrective action in accordance with Article VIII of the Medical Staff Bylaws.

9. When a practitioner is called by an Emergency Department physician for a specialty consultation, the Medical Staff member must be available within 30 minutes. Initial specialty consultation through two-way voice communication is acceptable.

   Upon completion of the initial consultation, the practitioner can:

   a. Issue admitting order by telephone, or

   b. Attend to the patient in the emergency room within:

      1. Two hours of initial contact for cases deemed emergent by the attending Emergency Department physician, or within;

      2. Six hours of initial contact for cases deemed non-emergent jointly by the attending Emergency Department physician and Consulting practitioner.

   A practitioner, who decides not to come to the Emergency Department and initiates admitting orders by telephone, must see the patient within 24 hours of admission. The exception is an SCU patient who must be seen within four hours. Failure of the attending practitioner to comply with these rules shall result in review by the Department chairman, the chief of staff, or the Medical Executive Committee and may result in corrective action in accordance with Article VIII of the Medical Staff Bylaws. Under no circumstances shall an on-call physician have the right to refuse to see a patient in the E.D., if in the opinion of the E.D. physician; the patient requires an immediate evaluation.

10. In the event a practitioner is to be unavailable, or absent from the area and unable to provide timely professional care for his patients, arrangements must be made with an eligible alternate practitioner who has equivalent clinical privileges at the hospital. A statement identifying the alternate practitioner will be maintained on record with the chief of staff through the Medical Staff coordinator. In case of unavailability of the named practitioner, the Department chairman, chief of staff, or hospital president, respectively and in that order, shall have authority to call the practitioner on emergency service call for the appropriate Department or service.

11. In the case of insufficient beds on a particular service to meet all admission requests, the following order of priorities shall be followed:

    1. Emergency admissions. This includes patients with an imminent danger of losing life, limb or organ.

    2. Urgent admissions. This includes all patients whose condition may change into an emergency if the patient does not have treatment in the hospital within 48 hours.

    3. Pre-Operative admissions or scheduled elective admissions. This includes all patients already scheduled for surgery.

12. The Medical Staff shall recognize areas of restricted bed utilization. It is understood that when deviations are required from assigned areas the Clinical Coordinator will correct these assignments at the earliest possible moment in keeping with transfer priorities. The attending physician will be notified of the transfer; no patient will be transferred without consultation and approval by the attending physician except in the Special Care Unit where appropriate protocol will prevail.

13. Patient transfers will follow the below priorities:

    a. Any patient requiring a Special Care Unit bed;

    b. Emergency room to appropriate bed/

    c. Special Care Unit to appropriate bed;

    d. Obstetrical unit to general medical unit, when medically indicated;

e. From temporary placement in an inappropriate geographic or clinical service to the appropriate area for that patient.

14. The attending practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatsoever. A patient admitted with a known or suspected contagious disease shall be isolated in accordance with the approved policies of the Infection Control Committee.

15. Any patient not admitted to the self-contained psychiatry unit and suspected to be at risk to self or others on the basis of suicidal or homicidal ideation and/or unpredictable behavior will require the following:

    a. Adequate supervision, including provision for the use of restraint; seclusion or protective devices as appropriate and in accordance with hospital policy and state law.

    b. Psychiatric consultation, as appropriate.

16. Admission to the Intensive Care Unit shall be in accordance with approved Medical Staff policy and procedure. If there is any question as to the validity of an admission or discharge from the Intensive Care Unit, consultation with the chairman of the Critical Care Committee, the chief of staff or their designee is required prior to the patient's disposition.

17. The attending physician is required to document the medical necessity or indications for continuing acute care on a daily basis. This documentation must contain: An adequate written record of the reason for continued hospitalization; the estimated period of time the patient will need to remain in the hospital; and plans for post-hospital care.

18. If an attending practitioner is contacted by the utilization review staff regarding a retrospective denial of an admission, he shall promptly coordinate the appeal process with the utilization review staff. Failure to comply with the appeal process will be brought to the attention of the chief of staff and hospital president for action.

19. Patients shall be discharged only on the written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the event shall be made in the patient's medical record.

20. It shall be the responsibility of the attending physician to make every effort to discharge his patients in accordance with the time designated by hospital policies.

21. In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his designee in accordance with hospital policy. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal diseases wherein the patient's course has been adequately documented to with a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

C. MEDICAL RECORDS

1. The attending practitioner, or designee, shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be clinically pertinent and current. This record shall include identification data; history and physical examination; special reports such as consultations, clinical laboratory and radiology services; medical and surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary; and autopsy report when performed. All medical record entries must be dated, timed and signed.

2. **HISTORY AND PHYSICAL**

    a. A comprehensive admission History and Physical shall be recorded within 24 hours of admission, to be completed by the attending physician or his qualified designee. The admitting physician shall be held responsible for the History and Physical examination. If a complete history has been recorded and the physical examination performed within 30 days prior to the patient's admission to the hospital, a legible copy of these reports may be used in the patient's hospital record provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additional history and any subsequent changes in the physical findings must be recorded. For patients undergoing an operative procedure, the History and Physical will be performed within 30 days and an update note will be performed on the day of and prior to the procedure and must be present in the chart prior to surgery.

b. In the case of patients without medical problems admitted by a qualified oral surgeon or Podiatrist, the History and Physical may be prepared by the provider, who is a member of the Medical Staff.

c. Prior to performing any invasive procedure or any potentially hazardous diagnostic procedure, except an emergency anesthetic or emergency operative procedure, an adequate History and Physical examination must be recorded for both inpatients and outpatients by a qualified member of the Medical Staff. If the H&P is performed by a physician who is not a member of the Medical Staff, it must be co-signed by the attending physician. All required reports, consents and consultations must be completed and attached to the patient's chart. When the History and Physical examination are not recorded before any potentially hazardous procedure, the procedure shall be delayed until the History and Physical is completed unless delaying the procedure would jeopardize "life or limb". In such cases, a note specifying the indication for surgery and urgency must immediately be written by the surgeon. After the procedure is completed, the physician must complete a full History and Physical examination.

d. For obstetrical surgery patients, the pre-operative comprehensive History and Physical examination will be updated on the day of and prior to surgery. The medical record shall include a complete prenatal record.

e. See policy GA-138, Documentation Requirements, for details regarding History and Physician contents.

3. **PATIENT TRANSFER**

The admitting practitioner is responsible for the remainder of the medical record until such time the patient is transferred to another practitioner's service. This practitioner must have admitting privileges and must consent to the transfer. The transfer must be in writing on the chart and be signed by the present attending attesting to the agreement of transfer to the new practitioner.

4. **PROGRESS NOTES**

a. Medical Staff progress notes should provide a pertinent chronological report of the patient's course in the hospital and should reflect significant change in condition and the results of treatment. Pertinent progress notes should also be documented by providers authorized by the Medical Staff, such as consultant staff members and professional personnel

b. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, the patient's clinical problems should be clearly defined and correlated with specific orders as well as the results of test and treatment.

c. The frequency of progress notes must be at least once in each 24-hour period, except progress notes on patients in the Transitional Care Unit shall be written by the responsible practitioner in accordance with TCU policies, procedures and/or state and federal regulations as specified in TCU-18.

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5. **OPERATIVE REPORTS**

a. Operative reports shall be completed for all procedures. This requirement applies to outpatient and inpatient procedures.

b. Operative reports shall be written or dictated upon completion of he procedure**..** A post-procedure note must be written immediately after the procedure and include the name of the primary surgeon and assistant(s), procedure, findings, technical procedures used, specimens removed, estimated blood loss, and post-operative diagnosis. The written report should be promptly dated, timed and signed by the physician and included as part of the patient's current medical record.

6. **ANESTHESIA/SEDATION**

a. All procedures requiring moderate or deep sedation or anesthesia are considered high risk and must include the following documentation in accordance with established standards: History and Physical; Informed Consent for Procedure, Informed Consent for Anesthesia/Sedation, Universal Protocol (Correct Site Surgery Verification), Sedation Assessment/Anesthesia Record, Dictated Operative Report/Procedure Note, Brief Op Note. All should be timed, dated, and signed.

b. A procedure verification must be performed to verify the following required elements: patient name and date of birth, procedure, site, side, special equipment (including implants, radiographs, antibiotic administration and surgical preparation dryness). The procedure verification must include all members of the procedural team in active communication. Procedure verification is required for all procedures except those that are routine and minor such as vein puncture, peripheral intravenous line placement, nasogastric tube insertion or foley catheter insertion. Refer to GA-90: Patient, Procedure and Site Verification Process. (Universal Protocol)

c. For anesthesia procedures: The anesthesiologist will document a pre-anesthesia evaluation, intra-operative anesthesia record, and a post-anesthesia evaluation in accordance with the guidelines of The Anesthesia Society of Anesthesiologists. The pre-anesthesia assessment must include a patient assessment and plan for anesthesia. There must be a re-assessment of the patient immediately prior to induction.

d. For sedation procedures: The responsible physician must document the following required elements prior to sedation: history and physical, sedation plan, pre-sedation assessment including an airway assessment and ASA status, and re-assessment immediately prior to sedation.

e. The qualified practitioner administering moderate/deep sedation or anesthesia must document the drug, dosage/concentration, route and time in an approved location of the medical record.

7. **CONSULTATIONS**

a. Consultations shall show evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. .

b. Consultations shall be completed within 24 hours after the initial request by the attending physician unless an extended time limit is specified. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in an emergency situation so verified in the record, be recorded prior to the operation.

c. In cases where the consultant is the principle surgeon, the consultant's report may be substituted for the pre-operative History and Physical if the report meets the Medical Staff's criteria for a History and Physical assessment as specified in MS-044. A consultant's progress notes are appropriate but do not relieve the attending physician of his responsibility for progress notes. If the admitting physician feels that the patient could best be handled by another physician (or consultant), it is recommended that the patient be transferred to the service of that physician. This transfer must be clearly delineated on the order sheet and progress notes.

8. In the case of patients transferred from a medical unit to the psychiatric service, an admission medical evaluation performed by a member of the Medical Staff within 24 hours of transfer will serve as the patient's admitting History and Physical, when seen in conjunction with the psychiatric admission note. If over 24 hours, then the transferring physician must add an update to the H&P.

9. All clinical entries in the patient's medical record shall be accurately dated, timed, and signed by the practitioner.

10. Abbreviations which have been prohibited by hospital policy may not be used.

11. **DISCHARGE DOCUMENTATION**

a. A discharge diagnosis must be given at the time of discharge and shall be recorded in full on the order sheet without the use of symbols and abbreviations. The discharge diagnosis should be dated, timed and signed by the practitioner.

b. The clinical resume or final summary should state the reason(s) for hospitalization, significant findings, procedures performed and treatment rendered, condition of the patient upon discharge and any specific instruction given to the patient and/or the family, as pertinent. Instructions relating to physical activity, medication, diet and follow-up care should be included in the summary. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved."

c. When pre-printed instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the medical record Department. If authorized in writing by the patient or his legally qualified representative, a copy of the clinical resume should be sent to any known medical practitioner and/or medical facility responsible for the subsequent medical care of the patient. A final diagnosis and discharge note may be substituted for the resume in the case of patients admitted for less than 48 hours or for a same day procedure. The final discharge note should include any instructions given to the patient and/or the family.

12. Written consent by the patient in compliance with current state law is required for the release of medical information to persons not otherwise authorized to receive this information.

13. Originals X-rays, copies of digital x-rays, and histological slides may be sent to practitioners or hospitals when required for diagnosis or patient transfer. Medical records may not be removed from the hospital for private use of a practitioner.

14. Open Acess to medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information. All such projects shall be approved by the Institutional Review Board before records are studied. This approval shall be in writing. The identity of the patient researched must be anonymous.

15. A medical record shall not be permanently filed until it is completed by the treating practitioner or his designee. No medical record shall be considered until all recorded material is authenticated by signature. Medical records must be completed within 30 days of a patient discharge.

D. GENERAL CONDUCT OF CARE

1. A general consent form, signed by, or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admission director shall notify the attending physician whenever such consent has not been obtained. When so notified, it shall, with the exception of emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

2. All orders for treatment shall be in writing. A telephone order shall be considered to be in writing if dictated to a duly authorized person functioning within that person's sphere of confidence and signed by the responsible practitioner or appropriate member of the Medical Staff. All orders dictated over the telephone shall be signed by the appropriate authorized person to whom dictated with the name of the practitioner per his or her own name. The responsible practitioner, ~~or~~ the attending physician or associate shall authenticate and date such telephone orders within 48 hours, unless superseded by regulations or hospital policy. Only licensed personnel, in accordance with hospital policy may accept telephone orders.

   a. Telephone orders for restraint or seclusion shall be signed within 24 hours.

   b. Telephone orders received in the Transitional Care Unit (TCU) will be signed by the responsible practitioner in accordance with the TCU policies, procedures and/or state and federal regulations.

3. The practitioner's orders must be written clearly and legibly. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

4. All previous orders are canceled when the patient goes to surgery.

5. All drugs and medications administered to the patient shall be those listed in the latest edition of the CMH Formulary, or those approved as non-formulary medications through the Medication Usage and Safety Team procedures. Drugs for bona fide clinical investigations may be exceptions with the approval of the Institutional Review Committee. They shall be used in full accordance with the statement of principles involved in the use of investigational drugs and all regulations of the Federal Drug Administration.

Drugs brought to the hospital by patients must be given to the nurse who will secure them in accordance with hospital policy.

6. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

7. Except in an emergency, consultation is recommended in the following situations:

   a. When the patient is not a good risk for operation or treatment.

   b. When the diagnosis is obscure after ordinary diagnostic procedures have been completed.

   c. Where there is doubt as to the choice of therapeutic measures to be utilized.

   d. An unusually complicated situation where specific skills of other practitioners are needed.

   e. In instances where the patient exhibits severe psychiatric symptoms.

   f. When requested by the patient or his family.

   g. In any case where there is a question of criminal action.

   h. Pediatric cases that meet any of the following criteria:

      - Any critically ill child whether cause of illness is known or not.
      - The patient is not a good risk for surgery.
      - High-risk patients admitted to the services of physicians of surgical specialties who have no admitting privileges in pediatrics. High risk is defined as those pediatric patients with co-morbid medical conditions such as diabetes, seizure disorder, and/or developmental disabilities.

8. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant.

E. GENERAL RULES REGARDING SURGICAL CARE

For other details not found in this set of Rules and Regulations; please refer to the Surgical Department Rules and Regulations.

1. Post-Operative care of a patient must be rendered by the surgeon himself or a designated physician who is equally qualified to attend to the needs of the patient should a post-operative complication arise.

   a. Post-operative care is defined as the care rendered to a patient after or following a surgical procedure until such time that the patient is discharged and/or transferred to the care of another practitioner's service.

   b. Documentation of such care shall follow the policies set forth in Article C: "Medical Record," in the CMH Medical Staff Rules and Regulations.

   c. All patients needing major surgery shall be admitted to the service within which those surgical privileges are held. "Major surgery" shall be defined by Department, either in a protocol or in the delineation of privilege. It is supported that patients who have co-morbidities or complicated medical problems be co-managed by an appropriate provider.

2. A patient admitted for dental care is a dual responsibility involving a dentist and physician member of the Medical Staff.

   a. Responsibility of the dentist.

      1. A detailed dental history justifying hospital admission.

      2. A detailed description of the examination of the affected part and pre-operative diagnosis.

      3. A complete operative report in accordance with section C.5 of these Rules and Regulations.

4. The progress notes as are pertinent to the oral or podiatry condition.

5. Clinical resume or summary statement.

b. Physician's responsibility.

1. Medical history pertinent to the patient's general health, if requested by an oral surgeon or podiatrist.

2. A physical examination to determine the patient's condition prior to anesthesia and surgery, if requested by an oral surgeon or podiatrist.

3. Supervision of the patient's general health status while hospitalized.

c. The discharge of the patient shall be on the written order of the dentist or podiatrist member of the Medical Staff.

d. All of the above functions may be performed by a qualified oral surgeon, or podiatrist who has had training to provide those services..

3. Written, signed, informed, surgical consent shall be obtained prior to an operative procedure except in those situations where the patient's life is in jeopardy and suitable signature cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, those circumstances should be fully explained on the patient's medical record. Consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits. Full compliance with informed consent will be in accordance with hospital policy.

4. The anesthetists shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up on the patient's condition.

5. General rules regarding obstetrical care – see obstetrical protocols and Department Rules and Regulations.

6. General rules regarding medical care – see the medical protocols and Department Rules and Regulations.

7. 7. General rules regarding emergency room care – see the Emergency Department Policy and Procedure Manual.

a. The Medical Staff shall adopt a method of providing backup medical coverage in the emergency services area. This shall be in accordance with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The Medical Executive Committee shall have overall responsibility for medical care. See appropriate section of bylaws for other qualifying privileges.

b. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record if such exists. The record shall include:

1. Adequate patient identification.

2. Information concerning the time of the patient's arrival, and by whom transported.

3. Personal history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.

4. Description of significant clinical, laboratory and radiology findings.

5. Diagnosis.

6. Treatment given.

7. Condition of patient on discharge and transfer.

8. Final disposition including instruction given to the patient and/or his family relative to necessary follow-up care.

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c. Each patient's medical record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy. Access to the medical record will be available to all providers in medical records or electronically.

8. General rules regarding pediatric care – See the pediatric protocols and Department Rules and Regulations.

F. POLICIES REGARDING DISTANCE AND/OR TIME FROM THE HOSPITAL

In order to provide adequate patient care, all Active members of the Medical Staff must have an office within 25 miles of the hospital and comply with the on-call policy.

G. AUTOPSIES

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. Medical Staff are encouraged to obtain autopsies when the demise of the patient was unexpected, where there was a failure of therapy, or the diagnosis was in question. Specific indications for autopsy are outlined in Policy & Procedure MS-008. Autopsies will be performed after written consent of the nearest relative as outlined by statue or court order. All autopsies will be performed by the hospital pathologist or by a physician to whom he/she delegates this responsibility. Provisional anatomic diagnosis shall be recorded on the medical record within 72 hours and a complete report shall be available within 60 days.

H. EMERGENCY MANAGMENT

It shall be the duty of all staff members to assist with the accommodations of disaster victims. The Emergency Operations plan will be called and initiated in accordance with current hospital policy. The Chief of Staff, VP/MA or their designee are part of the incident command and shall be the physician director of any disaster.

I. PRACTITIONER HEALTH

The bi-annual renewal of privileges will include a statement signed by the practitioner documenting current physical and mental status of the practitioner. Health Screenings, vaccinations and testing will be completed in accordance with hospital policy and applicable laws and regulations.

J. FEMALE CANCER EXAMINATION

In accordance with HB 89, a uterine cytologic examination will be offered to every female inpatient 18 years old and over unless the patient refuses or there are orders to the contrary by the attending physician, or if an examination has been performed within the preceding year.

K. BLOOD TRANSFUSION DOCUMENTATION

Justification for blood transfusion must be documented in the patient's progress notes or operative notes by the physician ordering the transfusion to be given (not the physician ordering the units for type and cross match unless it is the same individual). Consent for the transfusion is the responsibility of the physician.

L. DELEGATION OF MEDICAL PRACTICE

The Medical Executive Committee must authorize the delegation of a specific function or the right to perform a specific procedure, which is commonly considered to be a medical act. Such delegation shall specify terms of training, degree of supervision required and any other condition of practice. Duties related to any such delegation must be within the scope of any pertinent professional practice act of the allied health professional affected.

M. CONFIDENTIALITY OF PATIENT INFORMATION

Members of the Medical Staff will at all times observe and protect the patient's rights to confidentiality of his/her medical record information. This ethical principle applies to computerized records as it applies to any other medical record. Failure to comply

with hospital confidentiality policies including the hospital information systems security agreement will be grounds for immediate disciplinary action as appropriately determined by the Medical Executive Committee.

N. MEDICAL STAFF COMMITTEE REPORTS

The parts of the Medical Executive Committee reports of the last regular meeting that do not fall under the confidentiality requirements of Maryland Code 1-401 will be available for review by any member of the staff. This shall be done in order to acquaint this Medical Staff with the general activity of this committee.

SIGNATURES

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CHIEF OF STAFF

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PRESIDENT & CHIEF EXECUTIVE OFFICER

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CHAIR, BOARD OF DIRECTORS

Approved August 2017.

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