Medical Staff Rules & Regulations

Article I  Delineation of Privileges  2
Article II  Admission, Transfer, and Discharge of Patients  2
Articles III General Conduct of Care  14
Article IV  Rules Regarding Surgical Care  31
Article V  Rules Regarding Obstetrical Care  31
Article VI  Emergency Services  37
Article VII Management of Death and Terminally Ill  44
Article VIII Medical Records  58
Article IX Special Rules and Regulations  69
Article X Committee  73
MEDICAL STAFF RULES AND REGULATIONS

ARTICLE I Delineation of Privileges

Clinical privileges shall be delineated in accordance with the degree of risk to the patient, and denoted by the following classes:

**CLASS 0**
Health-Related Professions Staff. Criteria for classes I, II, III, and IV include, but is not limited to, physicians and dentists with a medical or dental college faculty appointment, and who are board-certified/qualified, or possess equivalent experience per department standards.

**CLASS I**
Diagnosis and therapy of **minor** illnesses, injuries or conditions, and performance of procedures **with no threat to life.**

**CLASS II**
Diagnosis and therapy of **major** illnesses, injuries, or conditions, and performance of procedures **with minimal threat to life.**

**CLASS III**
Diagnosis and therapy of **major** illnesses, injuries, or conditions, and performance of procedures, **with possible serious threat to life.**

**CLASS IV**
Diagnosis and therapy of **unusually complex** illnesses and performance of procedures, **with possible serious threat to life, within area of specialization.**

ARTICLE II

ADMISSION, TRANSFER, AND DISCHARGE OF PATIENTS

1. Admission for Inpatient Care (Hospital policy 02-01, Inpatient Admissions)
A. Relation to the Admitting A patient may be admitted to the Hospital only by a member of the medical staff. Before patients are accepted for admission, Admitting should be contacted. This allows Admitting to obtain registration information, ascertain bed availability, and to assist with patient transfer. This should be done as far in advance of admission as possible to assure smooth functioning and efficient utilization of the Hospital.

B. Priority of Admission (Hospital policy 02-03, Emergent Care and Inter-Hospital Transfer) Individuals will be admitted dependent upon the facility’s capacity and the availability of the required services and will be admitted in one of the following categories:

Category I Emergency. Individuals requiring care that, if not provided without delay (immediately), would endanger life. (Hospital policy 02-09, Precertification Requirements for Elective, Transfer, and Same-Day Clinic Admissions)

Category II Urgent. Individuals who have a medical condition that requires timely care and in whom the delay will worsen the clinical condition
Category II Individuals requiring care not in category I or II who have made prior arrangements regarding payment for service.

This policy applies to all admissions, including patients referred by or seeking transfer from other hospitals or institutions, as well as patients seen in the Emergency Department, Kentucky Clinic, and others seeking admission. (Hospital policies 02-19, Transfer of Patient to Veterans Administration Hospital; 02-21, Transfer of Patient to Psychiatric Facility; 02-23, Patient Transfer to Extended Care Facility)

The requirement of prior arrangements may be met by evidence of (1) applicable insurance coverage, or (2) eligibility and funding availability under programs which assume responsibility for payment (including Medicare and Medicaid), or (3) other sufficient assurance of payment.

C. Provisions Concerning ICU Beds During Periods of High Census (Hospital policies 02-27, ICU Admission Process; 02-29, Admission from OR to Adult Critical Care Units and Pediatric Intensive Care Units)

Assignment of Medical and Surgical ICU Beds: The chair of the ICU committee will, in usual circumstances, be the overall director of all medical and surgical ICUs. When bed shortages are severe, the director or designee will be responsible for assignment of beds in adult ICUs (TICU, CTICU, NSICU, MICU, CCU,
SICU, BURN ICU) and intermediate care unit (6 South). The director of Pediatric ICU will be responsible for pediatric ICU beds. The chair of Anesthesiology will have responsibility for the PACU. The medical director or designee will assume leadership in resolving problems regarding ICU utilization in critical bed situations that extend beyond the 2ICU. Cross assignment, transfer, discharge, and step-down of patients will be in accordance with ICU committee guidelines Hospital bed management policy, and take into consideration service needs and patient care requirements. If problems or questions cannot be resolved by the adult ICU director and the individual unit ICU directors, the chief of staff or designee will be notified to assist with problem resolution.

D. Provisions Concerning Admissions (Hospital policy 02-01, Inpatient Admissions)

1 Emergency Admissions: Within 24 hours following an emergency admission, the medical staff member shall document in the patient’s medical record the need for this admission. Failure to provide the documentation or evidence of willful or continued misuse of this category of admission will be brought to the attention of the Medical Staff Executive Committee for appropriate action.

2 Urgent Admissions: This category includes those so designated by a member of the medical staff and shall be reviewed by the appropriate department concerned to determine priority when all such admissions for a specific day are not possible.

3 Scheduled Admissions: This includes all
scheduled admissions including those already scheduled for surgery. Except for emergency admissions patients for surgery shall not be admitted later than 4:00 p.m.

If it is not possible to handle all such admissions on a service (2 and/or 3), Admitting, with approval of the chief of staff, may decide on the urgency of any specific admissions and may borrow beds from other services if such are available. The medical staff of services that have lent beds shall have priority for subsequent admission in these categories (2 and 3) until the Medical Staff Executive Committee-determined bed allocation for teaching purposes is re-established. The chief of staff shall be held responsible to re-establish this balance.

4. Routine Admissions: This will include elective unscheduled admissions involving all services.

E. Admissions Procedures (Hospital policies 02-01, Inpatient Admissions; 08-03, Patient Rights and Responsibilities)

  a. Admitting must be contacted prior to accepting a patient for admission to determine bed availability/assignment and to facilitate admission/transfer.

  b. A financial counselor shall be responsible for collecting pertinent data to determine the patient’s financial status.
c. Preadmission certification is the responsibility of the clinic for elective admissions.

d. Certification is the responsibility of the Admitting for emergent and urgent admissions.

2. Emergency Department and Clinical Admissions

a. Patients identified as required admissions shall be classified as emergent, urgent, or elective.

b. Patients classified as emergent or urgent who are unable to pay shall require the concurrence of the attending physician or oral surgeon of the service as to the emergent/urgent nature of the patient.

c. Concurrence of the emergent/urgent nature of the patient shall be documented in the medical record within 24 hours of hospitalization.

d. When possible, patients classified as urgent should meet with a financial counselor prior to admission. When urgent patients do not have adequate financial coverage, the admitting attending physician should be notified to determine whether admission should proceed or whether there is time to make other financial arrangements prior to admission.

3. Referred Patients (Hospital policies 02-01, Inpatient Admissions; 08-03, Patient Rights and Responsibilities)

All patients referred to the University Hospital, Inc., must meet the following criteria:

a. Before patients are accepted for
admission, Admitting should be contacted. This allows Admitting to obtain registration information, ascertain bed availability, and to assist with patient transfer.

_b. Prior to the acceptance of the patient by the Hospital, financial arrangements must be made through Admitting (applies only to elective and urgent admissions).

_c. An attending physician or oral surgeon must accept the responsibility for the treatment of the patient.

_F. Responsible Attending Physician/Oral Surgeon (Hospital policy 08-03, Patient Rights and Responsibilities)

A patient to be admitted on an emergency or urgent basis who does not have an attending physician or oral surgeon may select an attending physician or oral surgeon from the medical staff of the applicable department or division. Where no such selection is made a member of the active or associate staff on duty in the department or division may be assigned to the patient on a rotation basis. The chief of each service will provide a schedule for such assignments.

2. Admission for Outpatient Care (Hospital policy 02-11, Registering Outpatients for Hospital Services)

Whenever possible such patient will be seen by the active staff member previously responsible for the patient’s care. If this is not possible, the patient will be seen by available medical staff in the appropriate clinic.
2 Admission for Emergency Care (Hospital policy 02-03, Emergent Care and Inter-Hospital Transfer)

A. Emergency patients referred by a physician or dentist with prior consultation and admission arrangements will be directly admitted for inpatient care by the accepting attending physician or dentist.

B. Non-Refered Emergency Patients: Emergency patients who are not referred under the conditions stated above will be admitted for inpatient care, subject to the availability of beds.

If the Hospital is operating at a maximum capacity, a full-time faculty member or resident designated by the service will assure appropriate disposition of the patient by returning the patient to the referring physician or dentist and medical facility of origin, or arranging for the transfer of the patient to another Lexington hospital after an attending physician or dentist is identified. This should only be required when boarding capacity in overflow areas (ED, PACU) has been exceeded and the care of the patient will, in the judgement of the attending physician, be compromised.

C. Out-of-State Admissions: A patient from out of state is eligible for admission to University Hospital by referral of the patient’s physician or dentist or, in case of emergency, through the Emergency Department.
1 Admission Diagnosis Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon as possible but within 24 hours after admission.

2 Admission of Suicidal Patients (Hospital policies 02-03, Emergent Care and Inter-Hospital Transfer; 02-21, Transfer of Patient to Psychiatric Facility; 06-09, Consent to Treatment)

For the protection of patients, medical staff, and employees of the Hospital, certain principles are to be met in the care of the potentially suicidal patient:
A. Any patient known or suspected to be suicidal in intent and who is to be admitted will ordinarily be admitted to the psychiatric unit of the Hospital. If the patient's physical condition warrants, the patient may be admitted to another unit of the Hospital and a psychiatric consultation requested. If no accommodations are available on the psychiatric unit, the patient may be transferred to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the Hospital where special precautionary measures will be taken.
B. Any patient known or suspected to be suicidal must have consultation by a member of the psychiatry staff.
6. Admissions to or Discharge from Intensive and Cardiac Care Units (Hospital policies 02-27, ICU Admission Process; 02-29, Admission from Operation Room to Adult Critical Care Units and Pediatric Intensive Care Units)

If any question as to the validity of admission to or discharge from an intensive care or cardiac care unit should arise, that decision is to be made through consultation with the respective special care unit designated representative or the chief of staff.

2 Patient Transfers

A. Between Services When a patient is to be transferred between major clinical services (e.g., Medicine, Surgery, etc.) or between major divisions of a service (e.g., Orthopedics, Urology), the patient’s attending physician or dentist and the appropriate accepting attending physician or dentist of the service to which the patient is being transferred must mutually agree upon the written order of the physician or dentist requesting the transfer. Notification of such transfer must be made to Admitting.

B. Between Physicians or Dentists (Hospital policy 08-05, Transfer of Attending Physician/Dentist Responsibility)

When two attending physicians or dentists within a service agree to transfer a patient from one to the other, the physician or dentist from whom the patient is being transferred is responsible for writing a transfer order. The physician or dentist who is accepting responsibility for the patient will
so indicate in the progress notes. In the case of a transfer between two attending physicians or dentists within a service, the absence of a written order will result in the original physician or dentist remaining the responsible physician or dentist of record for legal purposes, for purposes of completing the record, for purposes of setting professional fees, etc. Notification of such transfer will be made to Admitting. When scheduled changes in attendings are made for reason of illness, absence from the city, or teaching purposes notes and notification of these changes are required as above.

C. Bed Transfer Priority (Hospital policy 02-05, Bed Assignment Rates)
The transfer of a patient from one bed to another requires the approval of the transfer and assignment to the new bed by Admitting.

1. Transfers to increase bed availability

   _a. From Emergency Department to appropriate patient bed.

   _b. From post-operative recovery to an appropriate bed.

   _c. From obstetrical patient care area to general care.

   _d. From intensive care area to general care area.

2. Internal transfer to improve patient care services

   _a. From a bed that is inappropriate for infection control to appropriate assignment for
infection control.

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

_ c. Patient desire for a different room.

8. Patient Discharge (Hospital policy 02-15, Discharge Orders)
A. When the attending physician or dentist (or physician or dentist acting on their behalf) determines an inpatient no longer needs Hospital lodging and care on a continuous daily basis, a written discharge order and discharge diagnosis with appropriate instructions will be entered in the patient’s medical record. When any of the following conditions exist, the attending physician or dentist (or physician or dentist acting on their behalf) will also issue the patient discharge order and discharge diagnosis with appropriate instructions:

1 The patient left the Hospital without a physician’s or dentist’s authorization and failed to return. Discharge order should be written within two hours except where circumstances indicate that the patient left the Hospital unauthorized and, therefore, is being discharged “against medical advice.”

2 The patient leaves the Hospital against medical advice. Discharge order should be written immediately, regardless of whether or not the patient or their responsible agent signed the release form. Writing the discharge order does not in any way relieve the physician or dentist of responsibility to take all reasonable steps to dissuade the patient
from leaving against medical advice or to take any subsequent reasonable steps which the physician or dentist believes to be in the patient’s best interests. (Hospital policies 02-15, Discharge Orders; 06-15, Patient Who Leave the Hospital Against Medical Advice/Without Being Discharge)

B. To the extent possible, the attending physician or dentist should schedule patients for discharge the day prior to the dismissal date so that discharge teaching can proceed, relatives or friends can be notified, and transportation arranged. Discharge orders need to be recorded in the patient’s medical record prior to 8:30 p.m., the night before discharge. Discharges normally will be processed between the hours of 8:00 a.m. and 10:00 a.m., but patients shall be allowed until 11:00 a.m. to check out. Patients awaiting special diagnostic reports on work done on the preceding day shall be discharged by 1:00 p.m. (Hospital policies 02-13, Discharge Planning; 02-15, Discharge Orders)

ARTICLE III GENERAL CONDUCT OF CARE
1. Consent for Care (Hospital policy 06-09, Consent to Treatment)
   A. Informed Consent
   All consent to care and treatment must be
informed. Informed consent is a basic principle of biomedical ethics; it is grounded in respecting the autonomy of the patient as a self-governing individual. When patients seek the benefit of care and treatment, they have a right to know and understand the nature of the care and treatment.

1. The Hospital’s policy 08-03, Patient Rights and Responsibilities, speaks specifically to informed consent: All patients have the right to participate actively in decision regarding their medical care and to decide whether to authorize or refuse procedures recommended by their practitioners. As a result, all patients have the right to an explanation, in understandable terms, of:

   _ _ identity of the physician primarily responsible for the patient’s care;

   _ _ identity of all individuals participating in the patient’s care;

   _ _ description of the nature and purpose of treatment;

   _ _ possible benefits;

   _ _ known serious side effects, risks, or drawbacks;

   _ _ problems related to recovery;

   _ _ likelihood of success;

   _ _ alternative procedures or treatments; and

   _ _ cost.

The *Behavioral Standards in Patient*
Care of the Medical Center also addresses the issue of informed consent (Principle F, Standard 1.1): The attending shall discuss with the patient and family, except in emergencies, the treatment alternatives including procedures, rationales, consequences and significant risks of proposed treatment, and the probable duration of disability. The Hospital's general and special consent policies assume that the consent gained is an informed consent. The criterion applied for a valid informed consent, both morally and legally, is adequate understanding by the patient (or surrogate).

B. General Consent

General consent is obtained by Admitting at the time of a patient's admission, and is designed to cover all procedures in the Hospital that are not of a nature to require a special consent. If it is not possible to obtain the general consent at the time of admission or registration, the responsibility for securing the general consent will rest with the nurse in charge of the division accepting the patient. This includes, but is not limited to, routine Hospital care, laboratory procedures, intravenous feedings, diagnostic X-ray procedures, and most outpatient treatments. It provides protection for procedures done by Hospital personnel, the attending physician or dentist, their assistants, or any other physician or dentist called into the case by the attending physician or dentist. It has the merit of providing
personal coverage for all persons who have a legitimate reason for touching or ministering to the patient, and protects both the Hospital and physician or dentist.

B. Special Consent (Hospital policy 06-09, Consent to Treatment)
A special consent form must be prepared before any of the following procedures are carried out:

- all major and minor surgery that involves an entry into the body, either through an incision or through one of the natural body openings.

- any procedure in which anesthesia is used, whether or not an entry into the body is involved.

- all non-operative procedures that involve more than a slight risk of harm to the patient, or which involve the risk of a change in the patient’s body structure.

- all procedures where radium or X-ray is used in treatment of the patient.

- all procedures which involve electroshock therapy.

- all uses of investigational drugs or procedures on patients.

- all uses of untested blood products when informed consent of the patient can reasonably be obtained.

- all other procedures that, in the physician's or dentist’s judgment, require a special consent; any question as to the necessity of obtaining a special consent from a patient should be resolved in favor of procuring the consent.
Responsibility for securing a special consent will rest with the physician or dentist or person performing the procedure. In all cases the physician, dentist, or person performing the procedure shall be responsible to confirm that a special consent has been signed before the procedure is performed.

C. Special Consent Concerning Minors KRS 214.185 as amended, provides for treatment of minors under the following:

1. The physician is to examine and prescribe treatment for a minor with the minor’s consent only in cases of venereal disease, pregnancy, alcohol, and other drug abuse or addiction.

2. Any emancipated minor or any minor who has contracted a lawful marriage or borne a child may give consent to the furnishing of hospital, medical, dental, or surgical care to the child or self and such consent shall not be subject to disaffirmance because of majority.

3. Health services may be rendered to minors without consent of a parent or legal guardian in an emergency situation. (Hospital policies 06-07, Protection of Children: Reporting Child Abuse/Neglect; 06-09, Consent to Treatment)

4. The consent of a minor who represents that they may give consent for the purpose of receiving health care services but who may not, in fact, do so should be deemed effective without the consent of the minor’s parent or legal guardian if the professional rendering care relied in good faith upon the word of the minor.

5. The professional may inform the parent of the minor patient of any treatment given or needed.
where informing the parent or guardian would benefit the health of the minor.

D. Emergency Consent (Hospital policy 06-09, Consent to Treatment)
Where an emergency exists that requires immediate action of the Hospital and physician or dentist to preserve the patient’s life, or prevent a possible permanent impairment of the patient’s health, and it is impossible to obtain the consent of the patient or someone legally authorized to consent for the patient, the required procedure should be undertaken only under the following two conditions:

1 it can be shown that the emergency is of sufficient magnitude to justify action without consent.

2 it can be shown that under the circumstances there is not sufficient time to obtain consent.

In order to constitute an emergency, the threat of life or health must be immediate. If delay in performance of the procedure would not increase the hazard, then a bona fide emergency does not exist. The Hospital and physician or dentist must make every effort to document the pathological necessity of proceeding with treatment without consent. Consultations should be undertaken and the findings recorded in the patient's medical chart. Notations should clearly indicate the conditions stated above.
When an emergency consent is needed, the Hospital director or the chief of staff must be contacted, informed in detail, and must give approval. This approval must be documented in the medical record at the earliest possible time.

2. Physician Orders (Hospital policy 08-07, Patient Care Orders)
   A. Verbal Orders Verbal orders may be initiated only when the life of a patient would be jeopardized by failure to take immediate action and are applicable only to orders given by the physician or dentist in the presence of a qualified health care professional. Such verbal order(s) shall be recorded on the physician order sheet by the physician or dentist not later than seventy-two (72) hours following the order.
   B. Telephone Orders It is expected that active staff physicians will write, initial, or personally approve orders for the prescribed care of patients in the medical record. However, it is recognized that there may be circumstances where the patient’s medical needs necessitate care that is unanticipated by the active staff physician and should not be delayed until the physician is available on the unit to write orders. If this situation should occur with an active staff physician, qualified health care professionals may accept the physician’s orders by telephone within the following guidelines:
1 Telephone orders may be taken from an active staff physician who is the patient’s physician of record.

2 A telephone order may be taken only by a qualified health care professional who has successfully completed the probationary period.

3 The qualified health care professional receiving the telephone order will write the complete order in the patient’s medical record including the time and date the order was taken, the physician’s name, and title of the health care professional receiving the phone order.

4 If, in the qualified health care professional’s judgment, the patient should be seen by the active staff physician, the health care professional will state the rationale for the request and the physician is expected to come to see the patient immediately. Following this review of the patient the active staff physician or resident will write the appropriate orders.

5. A telephone order must be dated and countersigned within seventy-two (72) hours of the time it is given by the ordering practitioner, and should be limited to orders necessary for management of patient’s difficulties.

C. Telephone Orders for Care of Terminally Ill (Hospital policies 06-17, Withholding/Withdrawing Potentially Life-Sustaining Treatment; 08-07, Patient Care Orders)
Senior residents may take and record a telephone order from an attending to withhold resuscitation procedures on terminally ill patients when a decision is made by an appropriately informed patient’s family or other responsible individual after the attending has left the Hospital or is otherwise unable to write the order personally as defined in the Hospital policy. The required charting activities documenting informed patient, family, or responsible persons must be completed.

D. Written Orders All orders, except in the situations described above, must be signed by staff or resident physician or dentist before being executed.

E. Acting Interns Orders Selected senior students may be appointed as acting interns by the department chair. All students so selected will wear readily visible identification badges during performance of their responsibilities. The department chair will notify Hospital Administration in writing prior to students assuming patient responsibilities. Acting interns may write admission orders and routine patient care orders on the wards of the Hospital. The acting intern will review and obtain approval of these orders with their senior supervising resident (licensed physician) or faculty. The nursing and pharmacy staff will honor these orders when the acting intern has documented the senior supervising resident’s or faculty’s review. The format of documented review should be as follows:
Orders reviewed and approved by Byron Young, M.D. (or) Jane Doe, M.D., PG-3 John Smith, CCIV, Acting Intern

Acting intern orders are not appropriate in intensive care units or critical care settings. Acting intern orders will be countersigned as soon as possible.

F. X-ray and Laboratory Requests All X-ray requests, except in an emergency situation described above, require a completed X-ray request signed by an attending or resident physician or dentist or a validly appointed acting intern. This request must cite the medically appropriate reason for the X-ray.

All orders for laboratory studies must cite the reason for the laboratory study.

G. Cancellation of Orders Cancellation of all existing orders for a patient is effected on change in service or when the patient is sent to the operating room or delivery room. An exception may be made if the physician or dentist so indicates in the pre-operative orders.

3. Consultations (Hospital policy 08-11, Consultations)

A. The conduct of good medical practice includes the proper and timely use of consultation. Judgement as to the serious
nature of the illness and the question of doubt as to the diagnosis and treatment rests with the attending medical staff responsible for the care of the patient.
The patient’s attending medical staff is responsible for requesting consultation when indicated, and for calling in a qualified consultant. Consultation requests and the reason for consultation must be documented by the service requesting the consultation. Undocumented consultation requests are not to be undertaken by the consulting service.
The request for consultation and the reason for consultation may be documented in any of the following by the requesting service:

- physician’s order
- consultation requisition form
- progress note

When “Consultation or Consultation Only” is requested, the consultant will evaluate the patient, rendering an opinion and recommendations, but may not write orders on the chart or otherwise participate in the care of the patient.
When “Consult and Co-Manage” is requested, both the attending medical staff and consultant may write orders. The consultant will limit his involvement to the specific entity or procedure requested. Responsibility for other management remains with the attending physician.
The attending medical staff should proceed without consultation in emergency situations when a delay in treatment would endanger the life of the patient. The attending should indicate the nature of the emergency in the patient’s record.
The attending medical staff is recognized as supervising the case. If the attending physician and consultant disagree on the management of the patient, it is desirable for the attending physician to call another consultant. Consultants may request consultation on patients only with the attending physician’s approval.
A satisfactory consultation includes examination of the patient, review of the chart, and a written report of findings and recommendations signed by the consultant and made a part of the patient’s record. Pre-surgical consultation reports, at least in brief form, must be recorded prior to the operation.

B. Required Consultations
Consultations are required in all cases whereby in the judgement of the attending physician:

- patient’s condition requires the specific skills of other practitioners
- it is the request of the patient or the patient’s representative

For therapeutic abortions, medical consultation
is required from two (2) other physicians, and a review by the chief of staff (Hospital policy 08-11, Consultations). If an emergency situation involves a therapeutic abortion, the attending should inform another physician of the situation and the proposed treatment before carrying out the procedure. The informed physician should verify the notification and record their recommendation in the patient’s medical record.

In circumstances of grave urgency, or when there is a disagreement regarding treatment, or when consultation is required by rules of the Hospital, the chief of staff shall at all times have the right to call in a consultant. An earnest attempt should be made to notify the attending medical staff before obtaining consultation.

Additional requirements for consultation may be established by the Hospital as required.

1 Nursing Involvement in Care of Patients If a nurse has any reason to doubt or question the order written on, or the care provided to, any patient or believe that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the patient’s active staff physician or dentist. If the situation is not resolved satisfactorily, the nurse shall contact the nursing divisional director. If warranted, the nursing assistant director may bring the matter to the attention of the chief of service wherein the physician or dentist treating the patient in question has clinical privileges. Where circumstances are such as to justify such action, the chief of service shall personally request a consultation.

2 Drugs, Medications, and Radioactive
Materials

A. General Guidelines

1 Generic Names (Hospital policies 01-34, Formulary System; 08-25, Drug Distribution) Physicians and dentists must use generic names as listed in the Hospital Formulary. Trade names will be accepted on physician or dentist orders if available in Pharmacy. If not available, the physician or dentist will be contacted by Pharmacy to rewrite the orders.

2 Orders in Metric System Drugs will be ordered in the metric system. If the physician or dentist orders a drug in the apothecary system, and the nurse recognizes the error before the physician or dentist leaves the unit, the nurse will ask the physician or dentist to rewrite the order in the metric system. If the order reaches Pharmacy in the apothecary system, a pharmacist will contact the physician or dentist and ask that the order be rewritten in the metric system.

3 Take-Home Drugs (Hospital policies 02-14, Discharge Medication Planning, Education, and Procurement; 02-15, Discharge Orders) All prescriptions for take-home drugs must be signed by a licensed physician or dentist.

B. Ordering Drugs

1. Formulary Drugs Only those drugs approved by the Pharmacy & Therapeutics Committee on the basis of safety, efficacy, and cost to be most advantageous in patient care shall be designated as formulary drugs. These
drugs are listed in the *Formulary*; only formulary drugs are routinely stocked and available from the pharmacy.

2. Restricted Drugs Formulary drugs may be restricted to use, either by medical service (e.g., a drug restricted to use by NICU attending physicians), prescribing criteria (e.g., a drug restricted to use by specific indication), or patient care area (e.g., a drug restricted to use only in NICU). The order for a restricted formulary drug will contain the following:

   _ a. Restriction by a medical service: The attending, fellow, or resident will include the name of their service after their signature (e.g., Dr. J. Jones / attending [e.g., Cardiology]);_

   _ b. Restricted by prescribing criteria: The attending, fellow, or resident will include the indication for use after their signature (e.g., Dr. J. Jones [indication]);_

   _ c. Restriction by patient care area: The attending, fellow, or resident will include the patient care area after the signature (e.g., Dr. J. Jones [e.g., MICU])._

When an order requesting a restricted drug without the above information is received by Pharmacy, the prescribing physician will be contacted to give or obtain authorization. If a physician requests a restricted formulary drug that is not authorized by their service, indication, or patient care area, then they need to comply with one or more of the following:

   _ _ Obtain a consult from an authorized service, call a Pharmacy & Therapeutics Committee
member for special authorization of the new indication, or move the patient to the needed area for proper treatment.

__ If a 23-hour admit patient is admitted on a restricted drug, the patient may be maintained on that drug without the need for proper authorization. However, if the patient is required to stay longer, proper authorization must be obtained. In order to receive restricted medication on a 23-hour admit, the physician will write after the order and signature “(23-hour admit).”

3. Non-Formulary Drugs When a non-formulary drug is prescribed, a pharmacist will contact and inform the prescribing physician that the drug is non-formulary and not stocked. The pharmacist will inform the physician of other formulary alternatives available.

    House Staff Physicians: If the house staff physician feels that the non-formulary drug is still needed, authorization from the attending physician on that service must be obtained. The house staff physician will contact the attending physician, who will authorize the non-formulary drug by writing the order or by calling the pharmacist to give a verbal order (see below).

    Attending Physicians: Attending physicians can authorize non-formulary drug requests, through either verbal or written orders.

    Non-formulary drugs are normally obtained within 24 hours, but may take longer
depending on when the order is received. The Pharmacy should contact the prescribing physician to estimate the time it will take to obtain the drug.

C. Automatic Stop Orders At the time of this printing, drug orders are discontinued automatically according to the following timetable:

Orders for ketorolac will be discontinued automatically after five days. Other drugs may have automatic stop order limits as approved by the Pharmacy & Therapeutics Committee.

Physicians or dentists are encouraged to write for a specific length of therapy on appropriate drugs and to limit their orders for drugs that require frequent monitoring of response such as anticoagulants and cancer chemotherapeutic agents. Daily, the floor pharmacists are provided with a list of all drug orders that are stopping due either to the stated automatic stop policy or to the end of therapy as specified by the physician or dentist.

D. Controlled Substances (Hospital policy 01-33, Drug Control and Security-Controlled Substances) Individual physicians, dentists, and other licensed practitioners must be registered with the DEA in order to write outpatient prescriptions for DEA scheduled controlled substances. Licensed practitioners are eligible for DEA registration if they are licensed in Kentucky. DEA registration is not required to write inpatient drug orders.
E. Investigational Drugs  Investigational drugs shall be used only under direct supervision of the principal investigator who shall be an active member of the medical or dental staff and who shall obtain the informed consent of the patient prior to administration of the drug. To initiate the use of an investigational drug, the principal investigator shall submit a written protocol to the University of Kentucky Institutional Review Board for review. After obtaining Institutional Review Board approval, Pharmacy shall store, label, and dispense all investigational drugs in accordance with the investigator instructions. Pharmacy shall maintain a file of information on investigational drugs being used. Nurses shall not administer investigational drugs until they have some orientation to the study by the principal investigator. It shall be the responsibility of Pharmacy to provide such information as is known at the time the investigational drug is dispensed. (Hospital policy 01-32, Research of Investigational Drugs and FDA Approved Drugs Investigated for Nonapproved Indications)

F. Radioactive Materials (Hospital policies 04-01, Equipment Maintenance Program; 10-30, Decontamination of Patient Rooms That Exceed Acceptable Radiation Levels) All radioactive materials for human use shall be administered only under the direction of a physician approved by the chair of Diagnostic Radiology or chair of Radiation Medicine, and by the Radiation Safety Committee.

ARTICLE IV
RULES REGARDING SURGICAL CARE

Each medical staff member involved in patient care in the operating rooms agrees to practice within the guidelines of the Operating Room Committee. The committee’s rules and regulations are as follows:

1 General Considerations All surgery performed will be under the control of the chair of the department or the attending physician or dentist of the case in question.
2 Surgery Scheduling

The medical director of the Operating Room Services (the anesthesiologist in charge) will be appointed by the chair of Anesthesiology with the approval of the Operating Room Committee. This individual will be responsible for the interpretation and enforcement of these policies and procedures on a day-to-day basis as they relate to the medical aspects of scheduling cases. The medical director of the Operating Room Services in coordination with director of the Operating Room Services shall be responsible for the efficient utilization of operating room resources.

A. All operations must be scheduled with the operating room scheduling office. A total room schedule should not exceed the allotted scheduled time for that room, which will be determined and published on a regular basis by the Operating Room Committee.

B. Information requested on the posting
form must be completed before a case can be scheduled.

C. Final Schedule: The deadline for the final surgical schedule is 13:00 the day prior to surgery, or other times as determined by the Operating Room Committee. The deadline for Monday’s schedule is 13:00 hours on Sunday. Cases can be added, but the order cannot be changed, to the schedule in the KSC until Sunday at 13:00.

D. In-House Queue: Following the deadline for the final schedule, the medical director and nursing supervisor review those cases that are ready for surgery for which there is no scheduled time. Those cases of suitable length to fill the gaps in the schedule will be selected using the split list and placed on the final schedule by 14:00. Priorities within surgical divisions will be determined by the division chiefs. Setting priorities among different divisions will be the prerogative of the medical director.

3. Urgent and Emergency Cases

A. Urgent Cases: All cases that are not strictly elective or emergent in nature are defined as urgent cases. The medical director or designee should be notified by the posting surgeon to acquaint the director with the surgical problems involved in urgent cases. Cases will be done in the order posted, provided the next patient on the list is ready.
for surgery when sent for and that in the judgment of the medical director this constitutes the best use of available operating room resources.

B. Emergency Cases: When a surgeon feels that the patient’s deteriorating condition or other reasons warrants jumping the queue of posted urgent cases, the case may be declared an emergency and will be scheduled ahead of urgent cases. Similarly, the surgeon may declare an emergency during the elective daily schedule. This declaration may interrupt the elective schedule. The chair of Surgery or designee has the final authority to resolve all issues related to the declaration of emergency cases. The surgeon declaring an emergency will complete a form indicating the reasons for the declaration of an emergency within 24 hours and submit this to the director of Operating Room Service. Scheduled cases displaced by urgent or emergency cases will take priority over TSA and add-on elective cases.

4. Identification of Patient Neither preparation of the patient for surgery nor surgery shall be initiated until positive identification of the patient is made by checking the armband of the patient against the operating room schedule. A record shall always be made of the positive identification in the patient’s medical record.

1 Preoperative Evaluation and Documentation (Hospital policy 06-09, Consent to Treatment) A
history and physical examination must be recorded within seven (7) days of a surgical procedure or the administration of deep sedation. Prior to preparing the patient for surgery, the medical record will always be examined to see that a consent for the particular surgical procedure to be performed exists. Surgery will not take place without consent except in cases of immediate life-threatening emergency. The preoperative diagnosis and current required laboratory work must be recorded on the patient’s record, except in cases of an immediate life-threatening emergency. If not recorded, the operation will be canceled. In any emergency, the surgeon shall make at least a comprehensive note regarding the patient’s condition prior to initiation of anesthesia and start of surgery.

2 Outpatient Operations The patient undergoing outpatient surgery must always be accompanied by another individual who will transport the patient safely from the Hospital.

3 Care in Transport of Patients All operating room transport personnel shall receive training in first-aid techniques including the ability to immediately recognize the symptoms of cardiac or respiratory arrest.

4 Environment Control of Operating Room

A. Appropriate monitoring will be performed to ensure environmental standards.
B. Radiation Safety Safety of sealed radioactive brachytherapy sources will be the responsibility of the director of Human Safety & Environmental Health of the Medical Center and the chair of the Radiation Medicine. Specific safety control
procedures are outlined in Hospital policies.

9. Tissue Removed (Hospital policy 08-23, Internal Pathology Reports Required for Tissues) Tissue removed during an operation shall be sent to the anatomical laboratories in accordance with current policies so that a pathologist can make such examination as necessary to arrive at a diagnosis. The authenticated report shall be made a part of the patient’s medical record.

1 Operating Room Patient Record (Form H-425) The operation record is the document recording the patient’s surgical experience in the operating room and also is the document used to gather data for efficient use of operating room resources. The circulating nurse has primary responsibility for completing the operating room patient record, and the attending surgeon and anesthesiologist must verify the correctness of this information by signing the record on completion. It is imperative the information on this record be accurate and complete. The operative note will be dictated by the surgeon immediately after completing surgery.

2 Sponge Counts Sponge counts must be obtained for all medical/surgical procedures where one or more sponges are used and an incision is made of sufficient size to permit a sponge to be physically inserted into the wound. In the operating rooms, sponge counts must be done in accordance with Operating room policy and procedures (OR 03-01). For locations outside of the operating room, such as the Emergency Department, ICU, outpatient surgery, cardiac catheterization laboratory, and others, sponge counts should be obtained before
closure of the skin or any cavity in which a sponge could be inserted. Verification of the sponge count should be performed by two individuals, and the results recorded in the procedure note. The note should also signify if the patient leaves the procedure with a sponge in place for packing.

3 Surgical Consent (Hospital policy 06-09, Consent to Treatment) Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient’s life is in jeopardy and suitable signatures 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, these circumstances should be fully explained on the patient’s medical record. Only if time permits, a consultation may be desirable before the emergency operative procedure is undertaken.

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

5 Risk Management (Hospital policy 10-33, Reportable Occurrences) In the event of an incident in the operating room that results in or could have resulted in an injury to a patient, the person witnessing or involved in the event must complete a report and submit it to Risk Management immediately.

ARTICLE V RULES REGARDING OBSTETRICAL CARE
1. Abortions and Sterilizations (Hospital policies 06-11, Abortions; 06-13, Sterilization; 08-11, Consultations)

A. Abortions may be performed when necessary to preserve the life of the mother following the approval of the Therapeutic Abortion Committee.

B. Sterilizations The operation is performed for the sole purpose of sterilization of the patient, whether male or female. Prior to any tubal ligation or hysterectomy being performed, appropriate consent forms and authorization for administration of anesthesia must be completed.

The general rule is that sterilization may be performed under one or more of the following circumstances; however, depending upon payment source, the procedure may not be reimbursed:

_ _ when medical disease complicates pregnancy or may be injurious to the health of the mother or the baby;

_ _ many times, socioeconomic factors may be used to support the sterilization decision; or

_ _ at the request of the patient when informed consent is evident.

The written request for sterilization and the report of the consultant shall be filed in the patient’s medical
C. Sterilization Incident to Therapy A sterilization incident to therapy performed primarily for some other medically valid purpose must be documented in the patient’s medical record.

2. Admission of Non-Obstetrical Patients to Obstetrics Division “Clean” surgical patients with a negative chest X-ray within the last 48 hours may be admitted to the obstetrical division only on the order of the director of Obstetrics or designee, who will review the situation daily with the senior nursing service staff member on duty on the division.

Article VI

EMERGENCY SERVICES

1. Emergency Department Medical Coverage and Responsibilities (Hospital policies HP02-01, Inpatient Admissions; HP08-11, Consultations

Patient care in the Emergency Department is under the direction of the chair of Emergency Medicine. The medical staff of the Emergency Department shall have primary responsibility for the care of all patients in the Emergency Department until such time as the patient is admitted or formally transferred to the care of another physician, dentist, service, or clinic. Attending physicians and dentists and a staff of house officers, who are assigned to the Emergency Department, will personally see each patient and be responsible for:
A. Initiating early and appropriate consultation with the proper service ascertaining the patient has been:

_ treated and released with the indicated instructions for further follow-up by a private physician or dentist or an appointment made for an outpatient visit;

_ accepted by a written note in the chart for care by another service, either on an outpatient basis, or for Hospital admission; or

_ sent to another hospital or another physician or dentist for care after that hospital, physician, or dentist has agreed to assume care.

_ Appropriate documentation of care and treatment rendered will be made by the treating physician or dentist and reviewed by an attending physician or dentist.

_ Limiting treatment of patients who will be referred to other services to emergency measures until the consultant arrives and is delegated responsibility for the patient’s care.

1 Emergency Department Consultation Coverage All clinical departments will furnish the chair of Emergency Medicine with a list of house officers and active staff on Emergency Department call who can be notified by the Emergency Department physicians as soon as it is determined that service should be called for consultation, or when the case might be of teaching interest to them.

2 Admission of Patients from the Emergency Department

A. Admission with consultation An emergency department physician shall ordinarily obtain the consultation and approval of the
appropriate service prior to admitting a patient to the care of that service.

1. Once an emergency department active staff physician in association with emergency department house staff evaluates a patient, determines a need for consultation, and calls for such a consultation for the purpose of the admission or transfer of patient care responsibility; the appropriate resident must see the patient and decide upon admission or render care and arrange for appropriate outpatient care within one hour. If an order to admit is not written, or appropriate emergent management is not initiated within one hour of the call for consultation, the resident’s attending will be called. If the matter is not resolved within another 30 minutes, the chief of the appropriate division or chair of the appropriate department will be called; and if the problem remains unresolved at two hours, the chief of staff will be called. In unusual circumstances, the emergency department attending may extend these intervals for sufficient cause, presuming that admission of a patient depends on justification (medically and in accord with third-party coverage approval), patient willingness, and the availability of a bed. Ordinarily, agreement on these issues is evident and expedites the admission of a patient when appropriate. At very least, agreement between the emergency department attending and the admitting attending is a prerequisite to admission of a patient to the service. The service attending may override the emergency department attending physician's decision to admit, after personally evaluating the patient and arranging appropriate disposition and follow-up. The
emergency department attending will determine a disagreement concerning disposition between consulting services unless the attending of either service can arrange alternative disposition after evaluating the patient.

If it becomes necessary to appeal to higher levels to secure such an agreement, the consulting/admitting resident and attending physician must, within seven (7) working days, justify any delay in the provision of patient care to the director of the resident’s training program and to the chief of staff. If this is not or cannot be done, a report will be placed in their respective files. In the case of residents, three (3) unjustified reports in any twelve-month period will result in a seven-day suspension of training without pay; in the case of faculty, three (3) unjustified reports in any twelve-month period will require the chief of staff to report the matter to the Medical Staff Executive Committee with a request for medical staff discipline up to and including reduction or removal of staff privileges.

2. Following decision to admit a patient from the Emergency Department, further work-up of the patient must be completed from or in the patient’s Hospital room, unless there is an evident delay in obtaining or preparing a bed for the patient.

A. Patients may be transferred to their rooms by way of appropriate laboratories.

B. Direct Admission with Prior
Consultation (Hospital policy HP02-01, Inpatient Admissions)
The chair of Emergency Medicine or the emergency department attending physician may admit any patient at any time if it is manifest that this is a correct disposition of the patient and that failure to admit the patient will likely result in death or serious injury, results in the delay in care for other emergency department patients, or places the Hospital at risk for access block if the patient remains in the Emergency Department. If such an action is contemplated, the physician so admitting must confer with or advise the service to which the patient is to be admitted prior to admitting the patient, to make certain that the service can provide the necessary care. Any disagreement in such a situation must be resolved through the mechanisms outlined above prior to actual admission.

3. Referral to Another Hospital (Hospital policy HP02-03, Emergent Care and Inter-Hospital Transfer)
In the instance where a patient requiring hospital admission must be sent to another hospital, such transfer will only be carried out with the prior approval of the patient’s attending physician.

2 Observation in Emergency Department

There are no designated observation beds in the Emergency Department. Patients needing observation while awaiting admission or awaiting evaluation for diagnosis may be
observed by staff in the Emergency Department provided the following conditions are met:

1 It is anticipated that the period of observation will not extend beyond six (6) hours from time of arrival.

2 The necessary observation can be done adequately. It cannot be assured or assumed that a registered nurse will be available to carry out the observation.

3 The patient for observation must not detract from the care of other patients with emergency conditions present or expected.

4 The Emergency Department attending on duty must be in agreement.

5 The decision to observe may be discontinued at any time by decision of emergency medicine attending physician based on acuity and volume of emergency department patients.

Patients who are direct admits are to be registered by the Emergency Department to assure accurate documentation of any treatments, diagnostic work, and medications. Situations not included above will require that the patient either be admitted or treated and released.

The expected period of observation to facilitate diagnosis is four (4) hours with a maximum of six (6) hours. At this time, the patient is either admitted or discharged. (This may be waived in individual cases, such as when the six (6) hour limit terminates at an early morning hour.) Progress notations are to be entered into the chart every three (3) hours by the physician or dentist caring for the patient.

ARTICLE VII
MANAGEMENT OF DEATH AND TERMINALLY ILL
1. Withholding/Withdrawing Potentially Life-Sustaining Treatment (Hospital policy 06-17, Withholding/Withdrawing Potentially Life Sustaining Treatment)

The medical staff at the University of Kentucky Hospital recognizes the dignity of human life as a paramount value, and that the right of all persons to a dignified and peaceful death requires that medical procedures or treatments in the terminally ill should be undertaken only if it furthers one or both of the following goals:

_ the relief of suffering, or

_ the prolongation of a life satisfactory to the patient.

The decision to withhold or withdraw any potentially life-sustaining treatment should be based on the principle that a patient with decisional capacity has the right to reject potentially life-sustaining treatment even when such treatment is medically appropriate. Additionally, life-sustaining treatment should not be attempted or rendered when such treatment would be futile, that is, would not result in a cure, improvement, or amelioration of the patient’s condition; or restoration of a quality of life
satisfactory to the patient; or would only increase or prolong the patient’s suffering. Relief of pain and suffering is central to exemplary patient care. Commitment of the relief of pain and suffering of the dying patient is essential, even if death is unavoidably hastened as a result of effectively relieving the patient’s pain.

A patient with decisional capacity (or proxy) has the right to accept or refuse treatment after being appropriately informed of treatment choices.

A physician has no obligation to render or offer any treatment that violates applicable standards of medical practice.

A patient has a right to change physicians if the patient (or proxy) and physician disagree over the necessity or appropriateness of treatment.

During the care of the dying patient, the medical staff will abide by the principles outlined in Hospital policy 06-17, Withholding/Withdrawing Potentially Life-Sustaining Treatment, which discusses implementation of DNR orders, withholding futile treatment, advanced directives, making end-of-life decisions, and pain management.

2. Guidelines for Determining Death (Hospital policy 06-19, Diagnosis of Death)
In order to ensure appropriate patient care and abide by KRS 446.400 as it defines and applies to a patient’s death, staff physicians should follow these established guidelines in
determining death.

A. Ordinary Circumstances In ordinary circumstances, the signs of death are:

1 unresponsiveness,

2 absence of pulse and heartbeat,

3 absence of spontaneous respiratory movement and all other movement, and

4 absence of all reflexes.

B. Cerebral Death Cerebral death is defined as the absence of cortical and brain stem function. Certification of signs of cerebral death shall be attested to and documented by a member of the active medical staff.

C. Diagnostic Clinical Criteria of Cerebral Death Currently acceptable clinical criteria for determination of cerebral death in the presence of cardiac activity and relatively normal blood pressure, whether or not artificial means are used to maintain the circulation of oxygenated blood, include:

1 Absence of hypothermia (body temperature 32.2ºC) neuromuscular blockade, shock, significant levels of sedative and central nervous system depressants in the patient’s serum; (e.g., phenobarbital, benzodiazepines), and severe metabolic disturbance (e.g., hyperosmolar coma, hepatic encephalopathy).

2 Cerebral unconsciousness and motor unresponsiveness to stimuli that are normally intensely painful. True decerbrate or decorticate
posturing or seizures are inconsistent with the diagnosis of cerebral death.

_ 3. Absence of spontaneous movements for an observation period of at least one (1) hour, except for spinal reflex activity.

2 Absence of reflexes that involve cranial nerves. The pupils must be fixed midpoint or larger in diameter and nonreactive to sharp changes in the intensity of incipient light. No ocular responses or eye movements to head-turning or irrigation of ear with ice water.

2 Absence of corneal reflexes.

2 No gag, cough, or retching reflex in response to bronchial stimulation with suction catheter.

2 No respiratory movements when the patient is disconnected from the mechanical ventilator. Adequate testing for apnea is very important. An accepted method is ventilation with pure oxygen for a ten-minute period before withdrawal of the ventilator followed by passive flow of oxygen. A ten-minute period of apnea is sufficient to attain hypercarbia (60 Torr or greater), which adequately stimulates a respiratory effort. Testing of arterial blood gases can be used to confirm this level. Any spontaneous breathing efforts indicates that part of the brain stem is functioning and that the patient is not brain dead.

In the absence of confirmatory tests, the seven (7) conditions described above must persist unchanged for at least six (6) hours. A confirmatory test may shorten the observation period.

D. Confirmatory Testing for Determination of
Cerebral Death An additional confirmatory test is recommended for determination of cerebral death (a) when the preceding reflexes cannot be adequately assessed and documented, or (b) in children under the age of five (5).

The following are acceptable confirmatory tests under the supervision of a staff physician with appropriate privileges.

1 angiography, which reveals absence of cerebral circulation.

2 cerebral nuclear scan, which demonstrates absence of cerebral circulation.

3 transcranial doppler study, which demonstrates absence of cerebral circulation.

Note: Angiography, cerebral nuclear scan, or a transcranial doppler study that demonstrates the absence of cerebral circulation is a definitive test of cerebral death. A waiting period is not required.

4. An electrocerebral (EEG), which demonstrates isoelectric activity, provided that severe hypothermia, neuromuscular blockade, shock, significant levels of sedative or central nervous system depressants, or severe metabolic disturbance are absent. A waiting period is recommended when an EEG is used as a confirmatory test (See Special Circumstances).

E. Special Circumstances

1 In cases of anoxic brain death, with
demonstrated electrocerebral (EEG) silence but without angiographic, nuclear scan, or
doppler demonstration of absence of cerebral circulation, a six-hour period of
observation and repeat examination, excluding apnea testing, is required.

2 In cases of children under the age of one (1) year, where absence of cerebral
circulation has not been demonstrated, a 72-hour period of observation and
demonstrated isoelectric activity on EEG at the end of the observation period is
required.

3 In cases of children age one (1) through five (5), where absence of cerebral circulation
has not been demonstrated, a 24-hour period of observation and demonstrated
isolectric activity on EEG at the end of the observation period is required.

4 In cases of gross anatomical brain injury, the period of observation for the persistence
of clinical criteria for cerebral death may be reduced to one (1) hour.

Gross anatomical brain damage may be appropriately assessed by physical
examination or craniotomy or by cranial MRI or CT studies, interpreted by a staff
radiologist, that indicate that the brain is irreparably damaged, extruded, divided, or
destroyed.

F. Pronouncing Death in Cases in Which Artificial Ventilation is Employed
In cases in which artificial ventilation is employed, the fact of death and the presumptive
cause of death should be determined by scientific evidence which, in the opinion of the
physicians making the
determination, is current, acceptable, and adequate to demonstrate irreversible cessation of cerebral and brain stem function.

The pronouncement of death in these cases will be made on the basis of the foregoing criteria by no fewer than two (2) active medical staff physicians, one of whom may include the attending physician interpreting the confirmatory test. The time of death will be determined by the physicians who attend the patient death or, if none, by the physicians who certify the death.

When possible, the surrogate legally responsible family members shall be informed before cessation of artificial ventilation.

G. Organ Donation

In the case of potential organ donors:

_ _ Patient must meet the appropriate criteria for cerebral death.

_ _ Legally responsible family member or designated health care surrogate must provide witnessed informed consent for specific donation.

The two (2) physicians determining death must not be involved in determining the suitability of the donor and must not be members of the surgical team performing the transplant.

_ 3. Pronouncing a Patient’s Death
Upon suspicion of death, the observing nurse will ask the physician closest at hand to see the patient. If death is confirmed and the physician is from another service, the nurse will immediately notify the service physician involved, giving the name of the physician who confirmed the death. The physician pronouncing the patient dead shall indicate such pronouncement and the time of death in the patient’s medical record. The formal death note shall be written and signed by the physician pronouncing or confirming death from the service involved before the body will be released from the Hospital.

4. Notification of Next of Kin (Hospital policy 06-29, Notification of Next of Kin that Patient is Being Treated at University of Kentucky Hospital)

Responsibility for providing immediate notices of death to the immediate next of kin rests with the attending physician or dentist or designee.

2 Request for Autopsy (Hospital policy 06-25, Authorization for Autopsy)

A. The duty of every staff member or designee shall be to secure an autopsy whenever possible. Autopsy should be requested, as recommended by the American College of Pathologists (CAP), when:

1 autopsy may help to explain unknown and unanticipated medical complications.

2 cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.

3 autopsy may help to allay concerns of, and provide reassurance to, the family and/or the public regarding the death.
4 unexpected or unexplained death occurs during or following any dental, medical, or surgical
diagnostic procedures and/or therapies.

5 deceased was a participant in a clinical trial (protocols) approved by the Institutional Review Board.

6 unexpected or unexplained death was apparently natural and not subject to forensic medical jurisdiction.

7 person was dead on arrival at the Hospital.

8 death occurred within 24 hours of admission to the Hospital.

9 death in which the patient sustained or apparently sustained an injury while hospitalized.

10 death resulted from high-risk infections and/or contagious disease.

11 obstetric death.

12 perinatal or pediatric death.

13 autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.

14 death known or suspected to have resulted from environmental or occupational hazards.

B. An autopsy may be performed only with a written consent, signed in accordance with state law. The following order of legal authority will generally apply to the procurement
of consent for autopsy authorization in a non-inquest situation in the absence of permission of the decedent:

1 spouse of decedent

2 all children (of at least age 18) of decedent

3 all grandchildren (of at least age 18) of decedent

4 parents of decedent
5 all siblings

6 all grandparents of decedent

7 the person who assumes responsibility to dispose of the body

It is recommended that as many signatures of a given class be obtained as possible or assurances received that there are no contrary indications from members of that class or a prior class. A minor who has married or borne a child is considered to be an adult for purposes of consent to perform an autopsy. Thus, the additional consent of the parents of such minor is not necessary. Questions concerning obtaining authorization for autopsy should be directed to Pathology or the Hospital administrator on call.

C. All autopsies shall be performed by Pathology. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours, and the complete protocol should be made a part of the record within three months of the autopsy.

6. Donation of Organs (Hospital policy 06-21, Willing or Donation of Human Bodies or Parts for Educational or Scientific Purposes)

Bodies or parts thereof will be accepted only if they have not been autopsied. Whole bodies to be accepted may not have served for organ donation. Donation of organs may be accomplished only with a written consent
signed and in accordance with state law. Written consent must be given on the anatomical gift consent form or be initiated by the deceased having previously completed an organ donation form or the consent on the Kentucky driver’s license. If an autopsy is to be performed, the donation of cornea and scleral rims is included in the authorization for autopsy, unless restricted. Separate authorization is required to include the donation of the whole eyes.

The priority for granting permission for an anatomical gift in the absence of an anatomical gift consent form completed by the donor or in the absence of consent on the Kentucky driver’s license or when persons in prior classes are not available at the time of death is as follows:

_ a. Spouse of decedent;

_ b. An adult son or daughter;

_ c. Either parent of decedent;

_ d. An adult brother or sister;

_ e. Legal guardian of the person of the decedent at time of death;

_ f. Any other person authorized or under obligation to dispose of the body (this would include the executor of the estate of the decedent).

The person(s) signing the authorization for anatomical gift is to certify that no one in a prior class is available and that they are not aware of contrary indications or opposition by others in line (of their same class or a prior class) to make their gift.
The appropriate service to receive the donation must be notified by the staff member obtaining the anatomical gift consent.

7. Notification of Funeral Home (Hospital policy 01-21, Funeral Director Notification)
Admitting is responsible for coordinating with the funeral director relative to the time of body release.

ARTICLE VIII MEDICAL RECORDS

1. General Guidelines (Hospital policy 05-01, Organization of Medical Records)
The attending physician or dentist shall be responsible for the preparation of a complete and legible medical record for each patient. The medical staff member’s medical record documentation will conform to state and federal regulations. The medical record documentation will be pertinent and current. This record shall include identification data; complaint; personal and family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary; and autopsy report, when performed. Radiology films and other records are
considered to be part of the medical record with regard to management, circulation, and control of this material. The retention schedule for radiology films and other records is maintained according to existing Hospital policy.

A. History and Physical A complete admission history and physical examination shall be recorded within 24 hours after the admission of the patient; within seven (7) days of a surgical procedure or the administration of deep sedation. This report should include all pertinent findings resulting from an assessment of all systems of the body. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

B. Progress Notes Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and accurate communication. Whenever possible, each of the patient’s active clinical problems should be clearly identified in the progress notes and correlated with specific findings, assessments, and plans. An attending physician or house officer progress note shall be written at least daily for all patients. For critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem, more frequent notes are expected.

The house
staff progress note, in addition to the above, should document the presence, evaluation, and recommendations of the attending medical staff. All medical student progress notes require countersignature by a house officer, or alternatively, the attending physician. In instances where the attending physician is required to document the need for continued hospitalization, this documentation must contain:

_ _ an adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient’s diagnosis is not sufficient;

_ _ the estimated period of time the patient will need to remain in the Hospital;

_ _ plans for post-hospital care.

C. Operative Reports Operative reports refers to reports of operative and other procedures that place the patient at risk, including invasive and noninvasive procedures such as endoscopic and diagnostic catheterization procedures, radiotherapy, hyperbaric treatment, and radiographic procedures.

A preoperative diagnosis shall be recorded before surgery by the attending physician or house staff.

Operative reports must be dictated immediately following the procedure for outpatients as well as inpatients and for procedures performed in the operating room
as well as other areas. It shall include:

_ _ pre-operative diagnosis

_ _ indications for surgery or procedure

_ _ name of the primary surgeon and assistants

_ _ detailed description of findings

_ _ technical procedures used

_ _ specimens removed

_ _ post-operative diagnosis

The report shall be signed promptly and filed in the medical record as soon as possible. Because of potential delays in dictation and transcription, a post-operative progress note must be recorded immediately after surgery. This note shall include the preoperative diagnosis, indications for surgery or procedure, name of the primary surgeon and assistants, a description of findings, technical procedures used, specimens removed, and post operative diagnosis.

D. Required Anesthesia Records and Reports The following records and reports will be maintained for each patient:

_ _ A pre-anesthesia note will be placed in the patient’s chart indicating the patient’s physical status, special problems, and contemplated surgery;

_ _ An anesthesia record will be maintained during the administration of anesthesia, which will include vital signs and the conduct of anesthesia;
A post-anesthesia discharge note must be placed on the patient’s chart indicating the patient’s status at the time of discharge from post-anesthesia area. The name of the physician
responsible for discharging the patient from the post-anesthesia recovery area will be recorded;

_ _ Within 48 hours after the operation, a post-anesthetic note should be placed on each patient’s chart.

_ _ When inpatients who have had surgery are discharged from the Hospital on the same date of the procedure, the discharging physician or dentist will be responsible for writing the post-operative anesthesia and discharge note. This note should be clearly titled “post-op anesthesia and discharge note.” The note must mention blood pressure, pulse, presence or absence of the swallowing reflex and cyanosis, any post-operative abnormalities or complications, and the general condition of the patient.

_ E. Clinical Entries All clinical entries in the patient’s medical record shall be accurately dated and signed by the responsible physician or dentist. All entries must be written in blue, blue-black, or black ink or ballpoint pen.

_ F. Corrections in Clinical Entries Each entry in the medical record should be made as soon as possible after patient assessment, intervention, order, or procedure to facilitate prompt communication with subsequent care providers. If it is necessary to make a correction to an entry, the following requirements must be followed:

**Concurrent Corrections (made as the entry is being written)**

If a correction is made concurrent with writing the chart entry or other medial documentation, a single line must be drawn through the incorrect information. Correct information must be written above or adjacent to the incorrect information.
The correction must be initialed by the person making the entry.

**Corrections Made at a Later Time**

If a correction is made at a later time (not concurrent with the initial entry), a single line must be drawn through the incorrect information and correct information added above or adjacent to it. The date, time, and signature (at least the first initial and last name) of the person making the later correction must be recorded.

If additional space is needed to record the full corrected text, additional information may be entered elsewhere on the page and labeled as a correction to an earlier entry. This entry must also be dated, timed, and signed with at least the first initial and last name of the person making the later correction.

___

_G. Abbreviations_ Abbreviations are not to be used in recording final diagnosis or operations. Abbreviations and symbols should be limited to those listed in the approved list of the Medical Center located on each inpatient floor and in the online information system.

_H. Final Diagnosis_ Final diagnosis and operative procedures must conform to preferred terminology listed in the *Standard Nomenclature of Diseases and Operations*. The medical disorder of principle importance (the reason for hospitalization) should be named first. Complicating conditions that may have extended the Hospital stay should be listed in order of importance followed by appropriate
other diagnosis. The final diagnosis shall be recorded, signed, and dated by the responsible physician or dentist at the time of discharge of each patient.

I. Discharge Summary (Hospital policy 05-03, Discharge Summaries)
A discharge summary will be dictated promptly upon discharge, preferably on the day of discharge for all patients, including observation patients. A discharge summary on obstetrical patients and normal newborns may be written in an abbreviated format. The OB discharge summary form may be used for obstetrical patients. If this form is not used, a dictated summary is required. For newborns, the newborn progress notes/discharge assessment is considered the discharge document, and shall include weight, physical examination, follow-up instructions, medications, problems list, disposition, and attending physician signature.

J. Release of Medical Information (Hospital policy 05-07, Release of Medical Information/Medical Records – General; 05-09, Release of Medical Records / Direct Patient Care)
Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. Any information released from the medical record should be handled through Medical Records.

K. Removal and Management of Medical
Records (Hospital policy 05-02, Retention and Storage of Medical Records)
The medical records, radiology films, and other records are the property of the Hospital. Under no circumstances shall physicians or dentists remove the medical or radiological records from the Hospital's custody except in accordance with a Hospital policy, court order, subpoena, or statute. The physician or dentist must inform the director of Medical Records or Diagnostic Radiology before removing any record in order to comply with one of these external demands. All physicians and dentists will strictly abide by the policies and procedures for the maintenance and integrity of medical and radiological records.

L. Access to Medical Records (Hospital policy 05-11, Access to Medical Records By or On the Behalf of a Patient) Free access to all 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 concerning the individual patient. All such projects shall be approved by the respective department chair and, where appropriate, the approval of the Human Investigation Subcommittee before records can be studied.

M. Medical Records Deficiencies Operative/procedure reports must be dictated immediately following surgery. In addition, a written progress note must be recorded in the chart immediately following surgery.
All records must be completed by all involved physicians within 30 days of the patient’s discharge or suspension will be initiated. Suspension actions involve removal of all Hospital privileges for faculty and house staff including admitting, operating, writing orders, and rendering treatment. Suspension action shall be initiated in writing under the authority of the director of Medical Records. If any staff member wishes to contest the suspension, they may show cause to the chief of staff within 24 hours of receipt of the suspension notice as to why the staff member has been unable to complete the records. The suspension will last until the deficiencies have been corrected. The resident staff member will be placed on leave without pay for the duration of the suspension. For resident staff, the time period of suspension will be added to the length of internship or residency. Lost time will be made up at the end of the regular period of internship or residency without pay; otherwise, the physician will lose credit for the entire year. For active staff, three (3) such suspensions of admitting privileges within any 12-month period may be sufficient cause for permanent suspension of the privileges of
the Hospital for that practitioner. In such a case, a deficiency report will be submitted by
the chief of staff regarding the matter to the Medical Staff Executive Committee.
Suspension of staff appointment will be considered by the Medical Staff Executive
Committee for the delinquent faculty member.

3. Consultation (Hospital policy 08-11, Consultations) An adequate consultation shall
consist of an examination of the patient and the patient’s record and a written or typed
report entered in the patient’s medical record. Consultation may be performed by
residents, fellows, attending physicians, and dentists. When an intern or medical
student is involved in the consultation, the consulting attending will be indicated on the
report.

A. Requested When consultation from another physician or dentist is desired, the
request must be documented in the patient’s record, and should make clear the
questions being asked of the consultant. It should be initiated as early as possible in the
course of the patient’s hospitalization so that any pertinent findings in the consultation
may be incorporated in the evaluation of the patient and so that action on any
recommendation may be initiated prior to discharge. If a consultation is needed
urgently, e.g., within 24 hours, the consultation request form should be supplemented
by telephone or personal contact with the resident or staff physician or dentist on call.

B. Emergency The responsible physician or dentist shall proceed without consultation in
emergencies when it is their opinion that to delay surgery or treatment in order to obtain
consultation would endanger the life of the patient. In these situations, the responsible
physician or dentist shall make a note in writing in the patient’s medical record of both the
indications for the operation and the nature of the emergency. In those emergency situations in
which the surgery or treatment does involve sterilization or the termination of a known or
suspected pregnancy, the attending physician or dentist will be responsible to inform another
attending physician or dentist of the situation and the treatment or surgery contemplated prior
to carrying out the surgery or treatment. The physician or dentist so informed will be
responsible to confirm such notification at the earliest opportunity by means of a note in
writing in the patient’s medical record.
ARTICLE IX
SPECIAL RULES AND REGULATIONS

1. Clinical Staff Disaster Assignments (Hospital policies 12-11, Mass Casualty Response Plan)

A. All medical staff members shall be assigned to locations in the Hospital,
and it is their responsibility to report to their assigned stations upon notification of a disaster. The chief of staff or designee will coordinate and work with all assignments and specific procedures for a disaster as set forth in the Hospital’s disaster plan. The chiefs of clinical services and the director of the Hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from the Hospital premises, the chiefs of clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be the joint responsibility of the department chair and the director of the Hospital. In their absence, the deputy chair and alternate in administration are next in line of authority respectively. The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergencies and agencies participate. There should be a written evaluation of all drills that must involve the medical staff, house staff, and Hospital employees.

B. Modification of Standing Rules and Regulations during Disasters and other Extenuating Circumstances.

During disaster or other extenuating circumstances, certain standing rules and
regulations of the medical staff may be selectively waived by the chief of staff, director of the Hospital, or chief of clinical service. The following are some of these:

- consents for care
- prohibition against the use of untested blood
- documentation for Hospital privileges

2. Special Care Units
Special rules and regulations are available for each special care unit in the Hospital, which includes:

- Respiratory/Cardiothoracic Intensive Care
- Surgical Intensive Care
- Medical Intensive Care
- Coronary Care
- Pediatric Intensive Care
- Bone Marrow Transplantation Unit
- Neonatal Intensive Care
- Burn Unit
- 3 North Unit
Markey Cancer Center

Please refer to these specific rules and regulations located in each of the above units.

3. Required Pathology Reports (Hospital policy 08-23, Internal Pathology Reports Required for Tissues)

For patients who received oncologic diagnosis at facilities or programs other than the Medical
Center a formal documented consultation and review of tissue and slides by Pathology is required.

The review should, unless there is need for urgent therapy, be accomplished prior to the initiation of definitive therapy. Declaration of urgent need for therapy must be made by two physicians and be subject to retrospective audit.

The physician or dentist providing therapy or surgical management has the responsibility of ensuring that a review of the appropriate tissue has been conducted by Pathology.

**ARTICLE X**

**COMMITTEES**

**SECTION 1. Pharmacy & Therapeutics Committee**

A. Composition Membership shall consist of a chair and at least six (6) representatives of the medical staff, including members from the departments of Surgery and Family Medicine. Physician duties are structured so responsibilities can be carried out on a voluntary basis. Subcommittees include representatives of the College of Pharmacy, Pharmacy, Hospital Administration, and Nursing. A pharmacist from Pharmacy shall act as secretary for the committee.

B. Duties This committee shall be responsible for
the development and surveillance of all drug utilization policies and practices within the Hospital and related outpatient areas in order to assure optimum clinical results and minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, administration, safety procedures, and all other matters relating to drugs in the Medical Center. In the course of performing the following specific functions, the committee shall consider and shall make its recommendations considering the cost-effectiveness of given drugs with the goal of providing effective therapy while controlling costs:

_ _ conduct medication use evaluations to review drug therapy, practice, and drug utilization within the Medical Center at least quarterly.

_ _ make recommendations concerning drugs to be stocked in patient care areas.

_ _ develop, maintain, and review periodically a formulary of accepted drugs for use in the Medical Center.

_ _ recommend policies related to the operation of a formulary system or other matters relating to drugs in the Medical Center.

_ _ prevent unnecessary duplication of formulary drugs and drugs that are generic or therapeutic equivalents.

_ _ establish and promote the use of practice guidelines related to drug therapy, including the implementation of national guidelines and the development and implementation of local guidelines.

_ _ oversee the delivery in the outpatient and home care environments of
medications traditionally delivered in the Hospital, including chemotherapy, antibiotics, parenteral analgesics, etc.

_ _ promote the education of faculty, staff fellows, residents, and students regarding proper drug use, including indications, costs, risks, and monitoring.

_ _ promote the education of faculty, staff fellows, residents and students on appropriate interactions with the pharmaceutical industry and its representatives.

_ _ encourage a public health perspective in the use of drugs, considering the impact on the Medical Center and the local and global community.

_ _ encourage research on drug delivery and drug usage.

_ _ establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

_ _ maintain liaison with the Medical Institutional Review Board.

_ _ assist in the creation, review, and monitoring of critical pathways to optimize medication utilization.

_ _ proactively engage in quality initiatives designed to improve medication use and reduce medication errors throughout the Hospital and related outpatient areas.

C. Meetings
This committee should meet at least six times per year and send timely reports to the chief of staff and Medical Staff Executive Committee regarding its activities.
SECTION 2. Infection Control Committee

A. Composition This committee shall consist of a chair, the Hospital epidemiologist, and at least three representatives from the clinical department, including Pathology. At least one representative Hospital Administration and from the nursing staff shall serve as ex officio members.

B. Duties The Infection Control Committee shall be responsible for the surveillance of Hospital infection potentials, the review and analysis of actual infections, the retrospective and the concurrent review of the use of antibiotics and their effectiveness, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, including:

- __ operating rooms, delivery rooms, recovery rooms, special care units.
- __ sterilization procedures by heat; chemicals or otherwise;
- __ isolation procedures.
- __ prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment.
- __ testing of Hospital personnel for carrier status;
- __ disposal of infectious material.
- __ other situations as requested by the Medical Staff Executive Committee.

C. Meetings This committee shall meet at least ten (10) times a year, shall maintain a record
of its proceedings and activities and shall report to the Medical Staff Executive Committee and chief of staff.

SECTION 3. House Staff/Graduate Medical Education Committee (HS/GMEC).
A. Composition All residency training directors are members *ex officio* of the HS/GMEC. At their discretion and with the concurrence of the associate dean for Extramural and Postgraduate Medical Education, who chairs the committee, some members may elect to designate a faculty member to represent them at some or all meetings of the HS/GMEC but remain available to participate in HS/GMEC functions such as internal reviews or *ad hoc* committees as needed. Members *ex officio* also include the associate chief of staff for Education (ACOSE) at the Veterans Administration Medical Center, the associate deans for Academic Affairs and for Clinical Affairs of the UK College of Medicine, the chiefs of staff of the Veterans Administration Medical Center and of University Hospital, the Hospital director, CEO of and the director of the UK Medical Professions Placement Service. The committee is staffed by the director of the GME Office. All these members may, from time to time or permanently with the concurrence of the associate dean, designate an associate to represent them at some or all meetings of the HS/GMEC but remain available to participate in HS/GMEC functions such as internal reviews or *ad hoc* committees as needed. Members *ex officio* also include the president of the House Staff Association and chief residents. Other
individuals may be appointed to the HS/GMEC by the associate dean for Extramural and Postgraduate Medical Education as needed.

B. Duties The HS/GMEC, consistent with ACGME (Accreditation Council for Graduate Medical Education) requirements, is the entity that provides oversight to the GME enterprise. Its responsibilities include assurance that individual programs operate in a manner consistent with ACGME institutional requirements and assurance that individual programs operate in a manner consistent with ACGME program requirements. In doing this, it recommends policies to govern GME for adoption by the Medical Staff Executive Committee and, through mechanisms of continuous monitoring, assures that these policies, once adopted, are enforced.

C. Meetings The HS/GMEC meets monthly (with the exception of January) and reviews and discusses the reports of its subcommittees and of other committees and other matters relevant to GME. Agenda items may be proposed by any member. Each meeting includes an opportunity for resident input and a report from the Veterans Administration Medical Center. The associate dean for Extramural and Postgraduate Medical Education reports quarterly to the Medical Staff Executive Committee or more often as needed.

SECTION 4. Laboratory Advisory and Transfusion Committees

A. Composition The Transfusion Committee shall
consist of the medical director of the Blood Bank, who shall act as chair, and representatives of the Anesthesiology, OB/GYN, Medicine, Pediatrics, Surgery, and other departments that are major users of the Blood Bank and Laboratory. The representative of Hospital Administration in charge of the Clinical Laboratories shall serve *ex officio* on the committee.

The Laboratory Patient Care Committee shall consist of a faculty member of Pathology, designated by the director of the Hospital Laboratory and approved by the chief of staff, who shall act as chair. It will also consist of representatives of Anesthesiology, OB/GYN, Medicine, Pediatrics, Surgery, Neurology, Family Practice, Hospital Administration, and other faculty from Pathology.

B. Duties

1. The Transfusion Committee shall review blood usage to include the following:

   _a._ Evaluation of the appropriateness of an adequate sample of cases of patients who have been administered transfusions, including the use of whole blood and blood components.

   _b._ The evaluation of all confirmed transfusion reactions.

   _c._ The development or approval of policies and procedures relating to the distribution, handling, use, and administration of blood and blood components.

   _d._ The review of the adequacy of transfusion service to meet the needs of patients.
e. The review of ordering practices for blood and blood products.

2. The Laboratory Patient Care committee shall review and advise on all problems relative to the relationship between the Hospital laboratories and clinical services. It will also advise on the scope of services to be provided, including recommendations for new services and for deletion of unnecessary or inappropriate services.

C. Meetings

1. The committee shall meet at least quarterly.

2. Summary reports of committee deliberations, conclusions, and recommendations shall be maintained and submitted to the Medical Staff Executive Committee on a timely basis.

SECTION 5. Sterilization and Therapeutic Abortions Committee

A. Composition The committee shall consist of the chair of Obstetrics & Gynecology who shall chair the committee and the chair of Urology plus one (1) active staff obstetrician-gynecologist.

B. Duties It shall be the duty of this committee to recommend appropriate rules and regulations concerning sterilization and abortion to the chief of staff and the Medical Staff Executive Committee.

C. Meetings This committee shall meet annually or more often as needed.
SECTION 6. Anatomic Pathology

A. Composition The committee shall be chaired by the director of Surgical Pathology. Committee membership shall include at least four (4) members of the medical staff who represent the major surgical services. The Hospital director or designee shall be represented.

B. Duties and Responsibilities

1 The committee will assure that all tissue removed at a surgical procedure is sent to Pathology, except where exempted by written Hospital policy, and that a report is submitted;

2 study periodically agreement or disagreement among preoperative, post-operative and pathologic diagnosis for the purposes of determining the justification for surgical procedures undertaken in University Hospital, including those procedures where no tissue was removed or submitted; and

3 annually review the necropsy service including physical facilities, equipment, staffing, the reports and performance of the service, its infection control, and radioactive material policies.

C. Meetings The committee shall meet at least monthly and shall report to the chief of staff and the Medical Staff Executive Committee.

SECTION 7. Operating Room Committee

A. Composition The Operating Room Committee shall consist of a chair and representatives from General Surgery, Anesthesiology (both inpatient and outpatient), Obstetrics/Gynecology, the
surgical sub-specialties, Ophthalmology, Surgical Pathology, and Dentistry. The OR director, nursing service managers, and the representative of Hospital Administration in charge of the OR are *ex officio* members.

B. Duties This committee shall oversee proper utilization of the operating rooms and recommend and enforce rules and regulations for the operating room areas to the chief of staff and the Medical Staff Executive Committee.

C. Meetings The committee shall meet at least nine (9) times per year. Summary reports of committee deliberations, conclusions, and recommendations shall be maintained and submitted to the Medical Staff Executive Committee on a timely basis.

SECTION 8. Cancer Committee

The Cancer Committee serves as the oversight committee for all cancer-related activities in the Medical Center. This committee is charged with assuring the appropriate organization, environment, and services required to provide optimal cancer patient care and professional education through a comprehensive cancer program designed to meet the requirements of the JCAHO, the Commission on Cancer of the American College of Surgeons, and the Association of American Medical Colleges.

A. Composition The Cancer Committee will be composed of College of Medicine teaching faculty and other board-certified physicians and representatives of associated patient care
services involved in the care of cancer patients. Medical staff membership must include representatives from Surgery, Internal Medicine, Gynecology, Diagnostic Radiology, Radiation Medicine, Pathology, and Rehabilitation Medicine. Administrative and other representation will include Pharmacy, Nursing, Social Services, Tumor Registry, Quality Assurance, and the basic science departments. Other ex officio membership will include University of Kentucky Cancer liaison physicians of the American College of Surgeons. The director of the Markey Cancer Center or designee shall service as chair of the Cancer Committee.

B. Duties

A. General Quality Assurance

1 Encourage, coordinate, and review Medical Center basic research, clinical investigations, clinical services, and educational programs in cancer.

2 Organize, publicize, implement, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, Medical Center-wide, and patient/problem oriented.

3 Act to stimulate the generation of multidisciplinary program grants and program projects.

4 Make certain that consultative services from all major disciplines are available to all patients.

5 Plan and conduct a quality care program that conforms to institutional and JCAHO standards. This program will include at least two patient care evaluation studies annually, one to include survival data and, if available, comparison data. When
appropriate, confidentiality will be maintained. Quality care activities shall be communicated to the Quality Improvement Council.

6 Assure the availability and use of cancer rehabilitation services

7 Encourage a supportive care system for all patients with cancer.

8 Determine the opportunities for cancer prevention programs as well as for educational programs on the early diagnosis of specific malignancies.

9 Assure that pretreatment workup and staging are appropriate as compared to national or regional experience.

10 Review patient management practices to determine the need for, or the impact of, specific professional educational programs.

1 Analyze patient survival by stage of disease and treatment as compared with national or regional experiences.

2 Document patterns of recurrence of specific malignancies and the occurrence of multiple primary malignancies.

3 Encourage systematic, lifelong surveillance of all patients with cancer.

4 Encourage studies using registry data.

5 Develop, sustain, and enrich relationships as most appropriate with other colleges of the University and with community activities.
B. Cancer Program Responsibilities In accordance with the requirement of an approved and nationally certified cancer program, the Cancer Committee must:

1 assure patient access to consultative services in all major disciplines.

2 assure that educational program, conferences, and other clinical activities include the major cancer sites seen at the Medical Center.

3 monitor and evaluate patient care, either directly or by interaction with and review of audit data from other committees.

4 supervise the cancer data system for quality control of abstracting, staging, and annual reporting. Assure that the tumor registry is assisted in achieving physician audits.

5 appoint Cancer Committee members to act as registry physician advisors.

6 monitor mandatory primary treating physician staging of all newly diagnosed cancer patients.

C. Meetings The committee shall meet bi-monthly, as a policy advisory and administrative body, with documentation of activities and attendance. Minutes and recommendations shall be communicated to the Hospital director and Medical Staff Executive Committee.

SECTION 9. Transplantation Service Committee
A. Composition The Transplantation Committee shall consist of the chairs of the Medicine, Surgery, and Pediatrics or their representatives, the medical director of Transplantation Programs, and organ or tissue procurement organizations, banks, and laboratories. There shall also be representation of Hospital
management and Hospital services such as nursing and social services.

B. Duties This committee shall review the programs, minutes, and activities of the individual transplant programs, procurement organization, bank and labs; assuring high quality care and institutional and professional communication. The committee will also recommend procedures, protocols, rules, regulations, training programs for operation and organization of transplant programs to the Hospital directory, chief of staff, and the Medical Staff Executive Committee. The committee will recommend programs for acceptance, for enlargement, retraction, or cessation clinically and financially.

C. Meetings The committee shall meet at least quarterly. All minutes shall be communicated to the Hospital director and Medical Staff Executive Committee.

D. Organ Procurement Committee

1 Composition The Organ Procurement Committee is a subcommittee of the Transplantation Services Committee. Membership should include representatives from Surgery, Neurosurgery, Pediatrics, Medicine, Critical Care, Nursing, Pastoral Care, Social Services, Hospital Administration, and KODA as an external guest representation.

2 Duties The duties of the committee will be to develop recommendations for procedures for communication mechanisms, for educational programs that would optimize the process of organ donation and procurement, quality of interpersonal
relationships, and understanding of the organ procurement program.

3 Meetings The committee should meet at least bi-monthly. All meetings shall be communicated to the Transplantation Services Committee.

SECTION 10. Ethics Committee
The Ethics Committee shall be a standing committee, appointed jointly by the director of the Hospital and the vice chancellor for Clinical Services, according to stated Hospital policy. It shall be multidisciplinary in character, shall meet as prescribed in Hospital policy, and shall serve as a resource for the medical staff, the Medical Center and its several colleges, and the community, addressing issues of medical ethics. The Ethics Committee should meet at least monthly or more frequently to discharge its responsibilities.

SECTION 11. Nutrition Committee
A. Composition Membership shall consist of a chair and at least three (3) representatives of the medical staff. One of the medical staff members should be the physician responsible for the Nutrition Support Service. The director of Dietetics & Nutrition and the assistant director for Clinical Dietetics should be members as well as the coordinator of Nutrition Support. There should be at least one representative from the nursing staff, Hospital Administration, and one representative from Pharmacy.
B. Duties The committee shall be responsible for
review and analysis of clinical nutrition care of hospitalized patients including nutrition by the oral, enteral, or parenteral route. The committee will develop and recommend methods of nutritional assessment and evaluation, nutrition care products and services used, and nutrition quality assurance monitors, and serve as the review and approval body for various clinical nutrition-related operational and educational manuals.

C. Meetings The committee will meet monthly at least ten (10) times per year and send quarterly reports to the chief of staff and Medical Staff Executive Committee regarding its activities.

SECTION 12. Emergency Care Committee

A. Composition This committee shall consist of the chair of Emergency Medicine, director of Trauma Service, director of Emergency and Trauma Services and Hospital administrator designated for emergency services, and representation of departments utilizing emergency services; Medicine, Surgery, Pediatrics, OB/GYN, Diagnostic Radiology, Neurology, and Pathology (Clinical Laboratory).

B. Duties This committee shall review all patient care functions of the Emergency Department and make appropriate recommendations to assure efficient and proper functioning of the emergency services of the University Hospital. They shall ensure effective interaction between the various services functioning in the emergency services. The committee shall
develop and recommend appropriate policies and procedures to assure appropriate functioning emergency services. The committee shall maintain ongoing review of the quality of care of services rendered. This program will meet appropriate JCAHO format. The committee will institute programs to improve quality of care where appropriate.

C. Meetings The committee shall meet at least six (6) times per year. Summary reports of committee deliberations, conclusions, and recommendations shall be maintained and submitted to the Medical Staff Executive Committee on a timely basis.

SECTION 13. ICU Committee

A. Composition Membership of the Intensive Care Committee shall consist of the medical director of each intensive care unit, the chief of staff or designee who shall serve as chair of the committee, divisional directors of nursing for each area, associate Hospital director, clinical pharmacist, and the director of Respiratory Therapy. Secretarial service will be arranged by the associate Hospital director.

B. Duties The duties of the ICU Committee will include coordination and leadership of the activities of the various units and supporting programs to ensure that each patient receives the best possible care; supervision of the quality of care programs of the units and ICU program; and to monitor, document, and continually
improve the care provided at the University Hospital. The committee may consult any and all persons or entities within the Medical Center and University in pursuit of effective patient care and management including medical staff and Hospital committees; medical staff members, divisions, and departments; and Hospital departments and administrators.

C. Meetings The committee shall meet every other month, at least four (4) times per year. Minutes of the meetings and recommendations shall be transmitted to the Hospital director, Medical Staff Executive Committee. Appropriate correspondence regarding quality of care shall be made to those responsible for taking corrective action(s) as recommended by the committee.

Section 14. Credentials Committee
A. Composition The committee shall be chaired by a member of the medical staff appointed by the chief of staff. Committee membership shall also be appointed by the chief of staff and consist of active medical staff members, whose representation shall include, but not be limited to, Internal Medicine, Surgery, Pediatrics, and a Hospital-based service.

B. Duties Duties of the Credentials Committee include review of any and all records, letters of recommendation, performance improvement data, or other materials regarding the appointment/reappointment of medical staff and all other licensed independent practitioners and
the delineation of their clinical privileges.

The committee will also make recommendations to the chief of staff regarding decisions on the appointment/reappointment of all medical staff and all other licensed independent practitioners and the delineation of their clinical privileges; and review and recommend procedures to the chief of staff for the appointment/reappointment of medical staff and other licensed independent practitioners, and the delineation of their clinical privileges.

C. Meetings The committee shall meet at least twice annually, or as often as required to process all appointment/reappointment applications for approval by the Hospital Board of Directors within 180 days of submission to the chief of staff’s office.

SECTION 15. Practitioner Effectiveness Committee

A. Purpose The Hospital recognizes the importance of early recognition of possible effectiveness problems caused by impairment of practitioners because of alcohol, substance abuse, or physical/mental health reasons and the need to encourage practitioners to obtain appropriate care and treatment without fear of embarrassment or punishment. Consequently, it is in the best interest of the Hospital, the medical staff, patients, and practitioners for there to be a Practitioner Effectiveness Committee, which shall be advisory in nature and charged with the responsibility of identifying potential
effectiveness problems and assisting practitioners receive appropriate care and treatment.

B. Composition The Practitioner Effectiveness Committee shall be composed of two (2) members of the active staff appointed by the chief of staff, who will serve terms of three (3) years. No member of the Practitioner Effectiveness Committee shall be a member of the Medical Staff Executive Committee or serve on any disciplinary or corrective action panel. Committee members may include individuals not on active medical staff who, in the opinion of the chair, bring needed skills to the committee.

C. Duties and Responsibilities

1 To be the identified point within the Hospital where information and concern about the physical/mental health of a practitioner can be received for investigation and possible intervention.

2 To meet with the practitioner about whom concern has been expressed and to provide advice, encouragement, assistance, recommendations, including education, counseling, and treatment opportunities, as warranted, in a confidential, dignified, and sensitive manner.

1 To monitor compliance with treatment plans, counseling, and aftercare agreements.

2 To serve as a liaison with any local or state agency, including the Kentucky Medical Licensing Board.
D. Action by the Practitioner Effectiveness Committee shall be separate from disciplinary or corrective action. Meetings may be informal, and there is no requirement that minutes be kept.

E. Notwithstanding, if a practitioner who has been identified as impaired refuses to cooperate and/or who poses a reasonable risk of harm to self, patients, and others, the Practitioner Effectiveness Committee may communicate its concern to the chief of staff, the Hospital director, or the Medical Staff Executive Committee, which may then initiate appropriate corrective action, including, without limitation, summary suspension.

F. Meetings The committee shall meet at least twice annually, or as often as required to discharge its responsibilities.