RULES AND REGULATIONS
OF THE
MEDICAL STAFF
OF
THE UNIVERSITY OF KANSAS HOSPITAL

Revisions approved by Executive Committee of the Medical Staff
April 22, 2004
Revisions approved by the University of Kansas Hospital Authority Board of Directors
July 13, 2004

Revisions approved by Executive Committee of the Medical Staff
April 28, 2005
Revisions approved by the University of Kansas Hospital Authority Board of Directors
September 13, 2005

Revisions approved by Executive Committee of the Medical Staff
September 28, 2006
Revisions approved by the University of Kansas Hospital Authority Board of Directors
November 14, 2006

Revisions approved by Executive Committee of the Medical Staff
January 25, 2007
Revisions approved by the University of Kansas Hospital Authority Board of Directors
February 13, 2007

Revisions approved by Executive Committee of the Medical Staff
February 28, 2008
Revisions approved by the University of Kansas Hospital Authority Board of Directors
August 12, 2008

Revisions approved by Executive Committee of the Medical Staff
November 19, 2009
Revisions approved by the University of Kansas Hospital Authority Board of Directors
January 12, 2010

Revisions approved by Executive Committee of the Medical Staff
April 26, 2012
Revisions approved by the University of Kansas Hospital Authority Board of Directors
July 10, 2012

Revisions approved by Executive Committee of the Medical Staff
November 29, 2012
Amendment approved by the Executive Committee of the Medical Staff
January 24, 2013
Revisions approved by the University of Kansas Hospital Authority Board of Directors
February 12, 2013
DEFINITIONS

ALLIED HEALTH PROFESSIONALS: Health care practitioners, other than physicians and dentists, who are, by academic and clinical training, qualified to exercise certain degrees of independent clinical judgment in the care and treatment of patients, whose professional disciplines are recognized by an appropriate licensing, certifying, registering, or other professional regulatory body in the State of Kansas or by the Authority, and whose disciplines have been approved for practice within the Hospital.

ATTENDING PHYSICIAN: The Member under whose name the patient is admitted to the Hospital or any Special Unit or to whom the patient's care has been permanently transferred.

AUTHORITY: The University of Kansas Hospital Authority.

DO NOT RESUSCITATE (DNR) DIRECTIVE: An individual’s pre-hospital request not to be resuscitated, executed and witnessed in accordance with Kansas law.

DO NOT RESUSCITATE (DNR) ORDER: The written order from a patient’s Attending Physician not to resuscitate a patient who has been admitted to the Hospital, made in accordance with Kansas law and the Hospital’s Policy on Advance Directives and Patient Rights.

HOSPITAL: The general inpatient acute care facility owned by the University of Kansas Hospital Authority and located at 3901 Rainbow Boulevard, Kansas City, Kansas.

HOSPITAL’S POLICIES AND PROCEDURES: Those written policies and procedures adopted by the University of Kansas Hospital Authority and pertaining to the operation of the Hospital, its Special Units, or any department of the Hospital.

HOSPITAL PREMISES: The Hospital, its Special Units, its Emergency Department, and all appurtenant buildings and grounds located at 39th and Rainbow Boulevard in Kansas City, Kansas and the University of Kansas Hospital Dialysis Center, located at 4720 Rainbow Blvd., Westwood, Kansas.

LICENSED INDEPENDENT PRACTITIONER: Those practitioners permitted by the Hospital to provide care, treatment, and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges and category assignment include Doctors of Medicine, Osteopathy, Dentistry, as well as Psychologists.

MEDICAL RECORD: A Medical Record shall consist of medical information that is specific to the patient, that is pertinent to the patient’s care and treatment, and that is in the custody of the Hospital’s Medical Records Department.

MEDICAL-SURGICAL UNIT: Any inpatient care unit, other than a Special Unit, located on the Hospital Premises.
MEMBER: Any member of the Hospital’s medical staff who has been admitted to the Active, Provisional, Courtesy or Volunteer categories of medical staff membership.

OUTSIDE THE HOSPITAL DO NOT RESUSCITATE (OHDNR) ORDER: The written order from a patient’s Attending Physician effective when the patient has not been admitted to or is not being treated within the Hospital, made in accordance with Missouri law and the Hospital’s Policy on Advance Directives and Patient Rights.

PSYCHIATRY UNIT: That inpatient care unit located on the Hospital Premises, dedicated to the rendering of psychiatric services, and possessing its own provider identification number.

REHABILITATION MEDICINE UNIT: That inpatient care unit located on the Hospital Premises, dedicated to the rendering of rehabilitation medicine services, and possessing its own provider identification number.

SKILLED NURSING UNIT: That inpatient care unit located on the Hospital Premises, dedicated to the rendering of skilled nursing services, and possessing its own provider identification number.

SPECIAL UNITS: The Psychiatry Unit, the Rehabilitation Medicine Unit, and the Skilled Nursing Unit (individually, a “Special Unit”).

TRANSPORTABLE PHYSICIAN ORDERS FOR PATIENT PREFERENCE (TPOPP): An OHDNR Order or a chronically ill individual’s instructions regarding medical treatment in the event of rapid health decline, which instructions apply across health care settings.

Note: Unless specifically defined in these Rules and Regulations, all capitalized terms shall have the same meaning as in the Bylaws of the Medical Staff of the University of Kansas Hospital, as revised.

[The remainder of this page left blank intentionally.]
ARTICLE I: ADMISSION AND DISCHARGE OF PATIENTS

Section 1.1 Only those Members authorized in accordance with the Bylaws of the Medical Staff may admit patients to the Hospital.

Section 1.2 Only those Members authorized in accordance with the Bylaws of the Medical Staff or the Hospital’s Policies and Procedures may admit patients to any Special Unit.

Section 1.3 The patient’s Attending Physician shall execute, or cause to be executed, all physician responsibilities as to the admission and discharge of patients as expressed in the Hospital’s Policies and Procedures governing admission and discharge of patients from the Hospital or its Special Units.

Section 1.4 At the time of the patient’s admission to the Hospital or any Special Unit, or as soon as possible thereafter, the patient’s Attending Physician, or a member of the House Staff, under the Attending Physician’s supervision, shall record, either an Admitting Note or a History and Physical Examination in the patient’s Medical Record. If an Admitting Note is recorded, the patient’s Attending Physician, or a member of the House Staff, Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant (PA),* under the Attending Physician’s supervision, shall, within twenty-four hours after the patient’s admission, record an appropriate History and Physical Examination in the patient’s Medical Record. Said History and Physical Examination shall be countersigned by the supervising physician at the time of the next visit or prior to discharge, whichever comes first. *ARNPs and PAs must be approved as Allied Health Professionals.

1.4.1 A history and physical must be available in the medical record on all inpatients within 24 hours of admission and on all patients prior to surgery or procedure.

1.4.2 The history and physical completed before admission is valid for 30 days only. It is acceptable to use up to a 30 day old history and physical as long as it is updated with any changes, or states that no changes have occurred.

1.4.3 The update can be written on the history and physical or in the progress notes. A history and physical greater than 30 days old cannot be updated, or referred to in a current history and physical. It must be re-written.

1.4.4 On a computerized history and physical, the date of the actual assessment (not printing date) is the completion date of the history and physical and must be within 30 days of admission of the procedure.

1.4.5 A complete history and physical should contain the following: a) chief complaint; b) details of the present illness, including, when appropriate, assessment of the patient’s emotional behavioral and social status, c) relevant past, social and family histories, appropriate to the age of the
patient, d) significant past surgical history, e) any remarkable past medical history, f) inventory by body system, g) comprehensive current physical assessment, h) a statement on the conclusions or impression drawn from the admission history and physical examination, i) a statement of the course of action planned for the patient while in the hospital. In services as appropriate, for children and adolescents, the history and physical must include an evaluation of the patient’s growth and development, immunization status, emotional, cognitive, social and daily activities as appropriate, and the family’s and/or guardian’s expectations for, and involvement in the assessment, treatment, and continuous care of the patient.

Section 1.5 Oral and maxillofacial surgeons who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body may perform the medical history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s). Dentists are responsible for the part of their patients’ history and physical examination that relates to dentistry.

Section 1.6 For all patients who have been hospitalized in the Hospital, the patient’s Attending Physician or House Staff shall dictate a Discharge Summary within forty-eight hours following the patient’s discharge. (Exception would be for normal newborns, a handwritten form will be acceptable). The patient’s Attending Physician shall sign or countersign the patient’s Discharge Summary.

[The remainder of this page left blank intentionally.]
ARTICLE II: GENERAL CONDUCT OF CARE

Section 2.1 Responsibility for Care and Treatment.

2.1.1 Each patient admitted to the Hospital shall be under the care and supervision of their Attending Physician. Each Attending Physician shall be responsible for everything in connection with the patient’s hospitalization, including but not limited to the diagnosis and treatment of the patient’s medical condition(s), the use of Consultants (as defined in Section 2.2.1), the appropriate communication with the patient, the referring practitioner, and the patient’s relatives, the conveying of any necessary special instructions to the patient upon discharge, and the accuracy and prompt completion of the patient’s Medical Record.

2.1.2 Whenever the responsibilities of the patient’s Attending Physician are permanently transferred to another Member qualified to act as the patient’s Attending Physician, the outgoing Attending Physician shall clearly note the transfer of responsibility to the new Attending Physician in the patient’s Medical Record.

Section 2.2 Consultations.

2.2.1 Required Consultations:

The following diagnoses/conditions, if not treated by the appropriate specialist, require a consultation by a physician who is credentialed in that field (“Consultant”):

a) All patients who are suicidal require a psychiatric consultation.

b) All patients evaluated for trauma require a trauma consultation as outlined in the Trauma Protocol.

c) All patients 17 years and younger who are on service other than Pediatrics or Family Medicine are required to have an initial consultation with General Pediatrics, a Pediatric subspecialty service, Psychiatry or Family Medicine and follow-up as needed.

d) All patients 18 years of age or older on the Pediatric Service are required to have an initial consultation with General Medicine, an appropriate subspecialty, Family Medicine or another service with adult privileges pertinent to the patient’s diagnosis and follow-up as needed is required.
e) All inpatient antepartum patients with conditions identified as requiring maternal-fetal medicine ("MFM") consultations, as outlined in the MFM Consultation Policy.

2.2.2 Ordering Consultations:

When ordering a consultation, the referring Member:

a) Must designate the consultation as either routine or emergent;

b) If emergent, the referring Member should directly contact the Consultant personally if possible;

c) Must designate the consultation as: (i) opinion only; (ii) opinion with order-writing privileges; or (iii) request for transfer to Consultant;

d) Must request a consultation as soon as indicated during a patient visit, and except in unusual circumstances, at least one day prior to discharge.

2.2.3 When Consulted:

When consulted, the Consultant must:

a) Fulfill the consultation request as soon as possible for emergent consultations;

b) Fulfill the consultation request within 24 hours for routine consultations;

c) Conduct an appropriate history and physical examination;

d) Complete the consultation form; and

e) Communicate at the Medical Staff level with the referring Member.

2.2.4 A Consultant who agrees to assume any portion of a patient’s care or treatment shall be responsible for that portion of the patient’s care or treatment until the Consultant informs the Attending Physician that the Consultant is returning such responsibility to the Attending Physician and records a written notation of such in the patient’s Medical Record.

Section 2.3 Patient Encounters. Each Attending Physician and each Consultant who has assumed any portion of a patient’s care or treatment, or another Member covering for them in their absence, shall personally assess their patients at least once per day while admitted to the Hospital or Special Unit. At the time of each such assessment, or as soon as possible thereafter, the Attending Physician or Consultant shall record a Progress Note in the patient’s Medical Record.
Section 2.4  **Informed Consent.** No care or treatment shall be rendered to any patient in the Hospital, its Special Units, or its Emergency Department without a written consent signed by the patient. In those situations in which the patient's life is in jeopardy and suitable signatures cannot be obtained, the Member proposing to render care or treatment to the patient shall follow the Hospital's Policies and Procedures and the Hospital’s Ethics Handbook in either proceeding with treatment or obtaining consent from the appropriate surrogate decisionmaker or in obtaining administrative consent before proceeding with treatment. Written consents obtained more than thirty (30) days prior to the initiation of care or treatment will not be valid.

Section 2.5  **Treatment Orders.** Except as otherwise specifically provided herein, all orders for treatment shall be in writing, dated and timed, and signed by the issuing practitioner and should include the issuing practitioner's pager number. Orders written by other than a Member or duly licensed member of the House Staff must be cosigned by the supervising Member if and as provided herein. No Member's co-signature shall be required for the protocol-driven practice of ARNPs so long as such ARNPs are acting within their approved scope of practice as permitted by K.S.A. 65-1130 and approved through the Hospital's credentialing process for Allied Health Professionals. With respect to the practice and orders of PAs pursuant to delegated authority or medically approved protocols as permitted by K.S.A. 65-28a08, the supervising or responsible Member shall comply with all applicable supervision requirements of the State Board of Healing Arts, K.A.R. 100-28a-10, and the Authority, including without limitation the following:

2.5.1  With respect to care provided by a PA during the first ninety (90) days of the supervising Member-PA relationship, the supervising Member shall, at least every fourteen (14) days, review all medical records and charts of patients evaluated or treated by the PA and authenticate such review in the patients' records by signing and dating the medical record or chart;

2.5.2  With respect to care provided by a PA after the first ninety (90) days of the supervising Member-PA relationship, the supervising Member shall, on a periodic basis and at least annually, review, evaluate, and determine whether the PA has performed patient care services with professional competence and reasonable skill and safety. The supervising Member shall document such review in a written report which shall be signed by both the supervising Member and the PA; and

2.5.2  With respect to emergent care provided by a PA that exceeds the authority granted to the PA, the supervising Member shall, within forty-eight (48) hours of the care or treatment provided by the PA, review the patient's records and authenticate such review in such records.

Section 2.6  **Verbal and Telephone Orders.**

2.6.1  Verbal orders may be issued only during face-to-face contact between a
Member, duly licensed member of the House Staff, or duly authorized Allied Health Professional.

2.6.2 Verbal orders shall only be accepted in an emergency where the patient’s condition may be compromised without immediate action or when a procedure is in progress and being performed by a Member or member of the House Staff and the order must be carried out immediately.

2.6.4 Telephone orders shall be issued by a Member or duly licensed member of the House Staff on a limited basis to licensed nursing service personnel (RNs and LPNs), registered pharmacists and registered respiratory therapists.

2.6.3 Telephone orders shall be issued only if the circumstances are such that an immediate order is required and it would be impractical for the issuing prescriber authorized under Section 2.6.4 to do so in writing or for purposes of clarifying existing order. Telephone orders are not appropriate for routine orders.

2.6.5 All verbal and telephone orders shall be transcribed as a complete order and read back in their entirety, including patient identification information, to the ordering practitioner.

2.6.6 All telephonic reporting of critical test results shall be verified by having the person receiving the information record and read back the test results, including patient identification information.

2.6.7 All verbal and telephone orders must be authenticated, dated, and timed by the ordering Member, ordering member of the House Staff, supervising resident, covering physician, or Attending Physician within seventy-two (72) hours of its issuance.

2.6.8 All verbal and telephone orders must include the printed pager number of the ordering practitioner.

Section 2.7 DNR, OHDNR and TPOPP

2.7.1 It shall be the responsibility of a patient’s Attending Physician to initiate DNR Orders in accordance with applicable law and the Hospital’s Policy on Advance Directives and Patient Rights.

2.7.2 Conflicts relating to a DNR Order, a DNR Directive, an OHDNR Order or a TPOPP shall be directed to the Hospital Ethics Committee.

2.7.3 When a patient is admitted to the Hospital with a DNR Directive, OHDNR Order, or TPOPP, the Attending Physician or member of the House Staff shall review the DNR Directive, OHDNR Order or TPOPP with the patient or the patient’s surrogate decisionmaker, and shall translate the
DNR Directive, OHDNR Order or TPOPP into the inpatient medical record unless such DNR Directive, OHDNR Order or TPOPP has been revoked. If the patient is incapacitated and there is no surrogate, the DNR Directive, OHDNR Order or TPOPP shall be immediately translated into the patient’s medical record, provided that it has been appropriately completed, as follows:

2.7.3.1 A DNR Directive must be executed by the patient or another person in the patient’s presence and at the patient’s express direction, a qualified witness, and the patient’s physician in accordance with Kansas laws at K.S.A. §§ 65-4942, 4943, as such laws may be amended from time to time.

2.7.3.2 An OHDNR Order must be executed by the patient or surrogate and the patient’s physician in accordance with Missouri law at Mo. Rev. Stat. § 190.603, as such law may be amended from time to time.

2.7.3.3 A TPOPP must be signed by the patient or surrogate and the patient’s physician.

Section 2.8 Drugs and Medications.

2.8.1 Except as otherwise specifically provided herein, all drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Services, A.M.A. Drug Evaluations, or the University of Kansas Hospital Formulary.

2.8.2 An order for medication must comply with the Hospital’s Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted in, medication orders, both generally and for specific types of medications.

2.8.3 Hospital supply shall be used for medications administered to patients. Patients may use their own supply only under the following limited circumstances: (a) the medication is not on the Hospital Formulary and a reasonable therapeutic substitution is not available; (b) the Member, pharmacist and patient determine there is a medically necessary reason for the patient to use a personal supply to meet an individual patient need (and this is documented in the chart); or (c) the medication is an investigational medication provided under protocol as part of the patient’s participation in an investigational study. In all of the foregoing circumstances, the medication must be contained in an original prescription container that allows Hospital staff to verify the content.

2.8.4 If a Member intends that a patient be permitted to use personal medications they bring into the Hospital or Special Unit, that Member
shall write a complete order for that specific medication. Such order shall comply with Section 2.5 and contain the statement that the “patient may use their own supply” or another statement substantially similar thereto.

2.8.5 A Member may order an investigational drug only if the Member is listed as a principal investigator or co-investigator on a research study approved by the Human Subjects Committee of the University of Kansas Medical Center and provides evidence of such to the Department of Pharmacy. Members of the Medical Staff who order an investigational drug shall cause the basic pharmacological information about the drug to be provided to members of the nursing staff prior to any such member of the nursing staff’s administration of the drug to the patient.

Section 2.9 Restraints and Seclusion

2.9.1 General Standards for all Restraints and Seclusion

2.9.1.1 A Member, or duly licensed member of the House Staff, may order a physical restraint (or a drug to be used as a restraint) or seclusion for a patient only when appropriate alternatives have failed and the restraint or seclusion is necessary to protect the safety of the patient or others. Any physical restraint (or drug used as a restraint) employed shall be the least restrictive restraint necessary to achieve the desired level of restraint.

2.9.1.2 Chemical restraint is any medication used to restrict the patient’s freedom of movement which is not standard treatment for the patient’s medical or psychiatric condition. The Member, or duly licensed member of the House Staff will order any specific nursing assessments depending on the chosen medication.

2.9.1.3 All physical restraint and seclusion orders shall include the time limit for the restraint and/or seclusion. No PRN orders shall be written.

2.9.1.4 Different standards for restraint and seclusion care exist for Behavioral restraints in Psychiatry; Behavioral restraints in non-psychiatric areas and Medical-Surgical restraints. See the following sections for those specific standards.

2.9.1.5 Seclusion is only used in the psychiatric areas of the Hospital.

2.9.2 Behavioral (Violent) Patient Restraints in Psychiatry:

2.9.2.1 Any Member or duly licensed member of the House Staff who orders a physical restraint or seclusion for any patient hospitalized on a Psychiatry unit, shall ensure that the patient is examined and evaluated
in a face to face manner by a Member or a duly licensed member of the House Staff within one hour of the patient’s placement in restraints or seclusion, regardless of the length of time the patient is in restraint or seclusion. If the Member who orders the restraint or seclusion is not the patient’s Attending Physician, the Member shall notify the patient’s Attending Physician of the restraint or seclusion as soon as possible.

2.9.2.2 No Member or duly licensed member of the House Staff shall order a physical restraint or seclusion, for a Psychiatry patient, to exceed 3 hours for adults or 1 hour for children and adolescents under 18 years of age.

2.9.2.3 After expiration of the time limit a new order may be issued only after the Member or duly licensed member of the House Staff reevaluates the patient.

2.9.2.4 Monitoring of the Psychiatry patients, cared for with physical restraint or seclusion, occurs via constant observation of the patient.

2.9.3 Behavioral Restraints in Non-Psychiatric Areas

2.9.3.1 Patients hospitalized on a Medical-Surgical or Rehabilitation unit, who demonstrate aggressive or violent behavior will be examined and evaluated by a Member or a duly licensed member of the House Staff within one hour of the patient’s placement in restraints, regardless of the length of time the patient is in restraint. If the Member who orders the restraint is not the patient’s Attending Physician, the Member shall notify the patient’s Attending Physician of the restraint as soon as possible.

2.9.3.2 No member or duly licensed Member of the House Staff shall order a physical restraint for an aggressive or violent Medical-Surgical or Rehabilitation patient, to exceed 3 hours for adults and 1 hour for children and adolescents under 18 years of age.

2.9.3.3 After expiration of the time limit a new order may be issued through a verbal or written order.

2.9.3.4 Monitoring of the patient shall be ensured and occurs by: observation by a qualified person at least every hour; assessment of the patient at least every two hours for adequacy of restraint, presence of any potential injury, adequacy of circulation, desire to eat, drink, or use the toilet; and release and range of motion at least every four hours.

2.9.4 Medical-Surgical Restraints

2.9.4.1 Patients hospitalized on a Medical-Surgical or Rehabilitation unit, whose
behavior (non-violent) creates safety concerns, may require physical restraint.

2.9.4.2 If a restraint is initiated by a registered nurse in an emergency situation, an order must be obtained within 60 minutes.

2.9.4.3 Members or duly licensed members of the House Staff may renew orders up to a maximum time limit of 24 hours.

2.9.4.4 Monitoring and care shall be ensured and occurs by: observation by a qualified person at least every hour; assessment of the patient at least every two hours for adequacy of restraint, presence of any potential injury, adequacy of circulation, desire to eat, drink, or use the toilet; and release and range of motion at least every four hours.

Section 2.10 Constant Observation.

2.10.1 A Member, or a duly licensed member of the House Staff, may order constant observation for any patient when the patient is actively suicidal, actively homicidal, or when the patient is psychotic, confused, or cognitively impaired with seriously agitated or combative behavior.

2.10.2 Orders for constant observation shall state the dates and times to initiate and discontinue the constant observation.

2.10.3 Any Member or duly licensed member of the House Staff who orders constant observation for a patient must document the reason for the order in the patient’s medical record and reassess the patient and the need for constant observation at least once every 24 hours.

2.10.4 Any Member of the Medical Staff or duly licensed member of the House Staff who believes that a patient requires constant observation for more than 48 hours shall obtain a consultation from a Member in the Department of Psychiatry.

Section 2.11 Diagnostic Procedures. When ordering diagnostic procedures, including but not limited to radiology, lab/pathology, EKG, GI/Endoscopy, echocardiography, and EEG, Members shall include in the written requisition form the appropriate ICD9 code, other appropriate information about the patient’s diagnosis, or the sign or symptom providing the indication for the diagnostic procedure.

Section 2.12 Quality Improvement. Each Member shall cooperate in the Hospital’s quality improvement activities, including responding to reasonable inquiries by any quality improvement or peer review committee of either the Hospital or the Medical Staff regarding the Member’s care and treatment of any patient.

Section 2.13 Allied Health Professionals.
2.13.1 Each Member who agrees to supervise the care rendered by an Allied Health Professional within the Hospital must continuously monitor, oversee and direct the work of the Allied Health Professional and annually evaluate the work of the Allied Health Professional; must accept responsibility for all patient care services provided by the Allied Health Professional; and must possess Clinical Privileges which permit the Member to perform the same patient care services performed by the Allied Health Professional.

2.13.2 For Allied Health Professionals who are ARNPs, the Department Chairs or their designee shall serve as the “responsible physician” for the ARNPs practicing within their respective areas as long as the scope of duties for the ARNP remains the same. If working with another physician would require a change in the ARNP’s scope of practice, this option would not apply and complete paperwork would be required to be on file. Responsibility in this regard shall include authorizing all written protocols for those ARNPs who are delegated the responsibility of prescribing drugs. The foregoing notwithstanding, whenever an ARNP provides care to a patient, the patient’s Attending Physician shall be deemed to be the sponsoring physician of record in regard to services provided by the ARNP, and that physician shall oversee and direct the work of the ARNP.

2.13.3 No Member shall supervise the care rendered by an Allied Health Professional within the Hospital unless the Allied Health Professional has been and remains duly credentialed and approved by the Hospital within the approved scope of practice to perform the patient care services they seek to perform.

Section 2.14 Meeting Requirements

2.14.1 Medical Staff Members assigned to the Active Category are required to attend 50% of the General Medical Staff meetings per year.

[The remainder of this page left blank intentionally.]
ARTICLE III: RULES PERTAINING TO SPECIFIC SPECIALTIES

SURGERY AND PROCEDURAL SPECIALTIES

Section 3.1 Pre-surgical Documentation.

3.1.1 With the exception of emergency surgeries, no Member shall perform a major surgical operation on any patient until a written History and Physical Examination and the results of appropriate studies, as indicated by the patient’s illness or condition, are completed and made a part of the patient’s Medical Record.

3.1.2 If a complete history and physical examination has been performed within thirty (30) days prior to the patient’s admission, a durable, legible copy of a written report of such history and physical examination will fulfill this Section’s requirement of a written History and Physical Examination provided any changes, or no changes noted, subsequent to the date the history and physical examination were obtained and/or performed have been recorded in the patient’s Medical Record prior to performing the surgery. A history and physical greater than 30 days old cannot be updated, or referred to in a current admission document.

3.1.2.a The history and physical is good for the entire hospital stay. Any changes in a patient’s condition prior to surgery should be documented in the progress notes. Therefore, the admission history and physical is acceptable to use as the history and physical prior to surgery even if the patient has been in-house for greater than 30 days. Any changes would be documented in the progress notes.

3.1.3 With the exception of emergency surgeries, if a Consultant is to perform a surgery, the Consultant shall enter either a Consultation Report or a Pre-operative Note in the patient’s Medical Record prior to performing the surgery.

3.1.4 With the exception of emergency surgeries, no Member shall perform a major surgical operation on any patient until an anesthesiologist or other qualified anesthetist has performed a pre-anesthesia evaluation of the patient and placed a written record of such evaluation in the patient’s Medical Record.

Section 3.2 Tissue Disposition. All tissues removed at surgery or during any procedure, except those tissues specified in advance by the Authority, shall be sent to the Department of Pathology for examination by a surgical pathologist.

Section 3.3 Post-Surgical Documentation.
3.3.1 Any Member who performs surgery or a procedure on any patient shall prepare or dictate an Operative Report or Procedure Note immediately following such surgery or procedure, whether the surgery or procedure was performed on an inpatient or outpatient basis. When the Operative Report or Procedure Note is not placed in the record immediately after the surgery or procedure, the Member who performed the surgery or procedure shall record a Progress Note in the patient’s Medical Record immediately following the surgery or procedure.

3.3.2 The anesthesiologist or qualified anesthetist who managed the patient’s anesthesia during surgery shall record a complete written anesthesia record and a written record of post-anesthesia follow-up in the patient’s Medical Record.

3.3.3 Notwithstanding the requirement of Section 3.3.1, the writing or dictation of Operative Reports, Procedure Notes, Progress Notes, and anesthesia records required by this Section may be delegated to a member of the House Staff only if they were physically present during the surgery or procedure.

**EMERGENCY**

Section 3.4 Emergency Department Call Eligibility.

3.4.1 Members of the Active and Provisional Staffs shall be required to accept Department call on a rotating basis with other Members of the Active and Provisional Staffs in their Clinical Department on a schedule determined by the applicable Clinical Department Chair in accordance with the Bylaws.

3.4.2 In general, Members of the Courtesy and Volunteer Staffs shall not be required to accept Department call, but may accept such call if requested by the applicable Clinical Department Chair, or the Chief of Staff, or as a substitute for another Member who is unavailable for Emergency Department call as scheduled. Notwithstanding the foregoing, Members of the Courtesy and Volunteer Staffs may be required to perform assigned on-call duties and assignments if deemed necessary by the applicable Clinical Department Chair of the department in which the Courtesy or Volunteer Staff Member is assigned.

Section 3.5 The Emergency Department Physician on duty shall supervise all patient care in the Emergency Department delivered by members of the House Staff not supervised in person by another Member.

Section 3.6 The Emergency Department Physician on duty shall care for all Emergency Department patients. Transfer of care of a patient in the Emergency Department to another Member of the Medical Staff requires a written order and acceptance
by that Member. A trauma patient with an Attending-to-Attending Physician handoff does not require a written order and acceptance by the Attending Physician trauma surgeon.

Section 3.7 Members shall comply with the requirements of any plan for the care of mass casualties at the time developed by the Authority in the event of any major disaster. All Members shall participate in rehearsals of any such plan for the care of mass casualties as requested by the Authority.

Section 3.8 Each Member is responsible for ascertaining the dates they are to be available on-call for the Emergency Department pursuant to a call list provided in advance to the Emergency Department by their Clinical Department Chair in accordance with the Bylaws and/or the Hospital’s Policies and Procedures.

Section 3.9 In the event a Member will be unavailable to be on call for the Emergency Department on any date such call duties have been assigned to them, such Member shall arrange for another Member to substitute for them during the period of their unavailability and shall notify the Emergency Department, Page Operator, and On Call House Staff Team, of the change in the assigned schedule.

Section 3.10 Any Member on call for the Emergency Department, or a member of the House Staff under the Member’s direct supervision, shall be present in the Emergency Department within thirty (30) minutes of being summoned by the Emergency Department, or sooner as dictated by the nature of the patient’s emergent medical condition.

Section 3.11 Any Member, or any member of the House Staff under the Member’s direct supervision, responding to a summons by the Emergency Department in accordance with this Section shall examine, treat, and stabilize the patient for whom they have been summoned.

Section 3.12 Any Member who examines and/or treats a patient in the Emergency Department shall record, or cause a member of the House Staff under the Member’s direct supervision to record, a written note in the patient’s Emergency Department chart describing the examination and treatment provided to the patient in the Emergency Department and the results thereof.

3.12.1 If the patient is released from the Emergency Department in stable condition, the note shall specifically so state.

3.12.2 If the patient is admitted from the Emergency Department to the Hospital or any Special Unit, the Admitting Note and History and Physical Examination may be used in lieu of a note in the patient’s Emergency Department chart.

Section 3.13 A Member may transfer an unstabilized patient in the Emergency Department to another facility only if:
3.13.1 The Member determines that, based upon the information available at the time of the proposed transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual and, in the case of a laboring patient, to the unborn child, from effecting the transfer; and

3.13.2 The Member, or another qualified person, on the Member's behalf, informs the patient, or other responsible party, of the Hospital's obligations and the risks of transfer and the patient requests such a transfer in writing.

Section 3.14 Any Member electing to transfer an unstabilized patient in the Emergency Department to another medical facility shall complete and sign a "transfer statement" in a form approved by the Authority.

Section 3.15 In the event of a disagreement between the Emergency Department Physician and the Member(s) summoned to consult on the patient whether a patient has an emergency medical condition and/or should be admitted to the Hospital or any Special Unit, the Member(s) and the Emergency Department Physician shall attempt to resolve the disagreement among themselves. If the disagreement cannot be resolved, the Member(s) and the Emergency Department Physician shall immediately contact the Chief of the Medical Staff or his designee, who shall resolve the dispute.

ARTICLE IV: MEDICAL RECORDS

Section 4.1 General.

4.1.1 All Medical Records, and any copies or other reproductions thereof (unless provided directly to the patient), are the property of the Hospital and shall not be removed from the Hospital Premises for any reason (including research studies or other academic purposes) except as specifically authorized by an appropriate representative of the Authority.

4.1.2 All Medical Records, the information contained therein, and any other patient-specific information shall be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information and shall be released only in accordance with the Hospital's Policies and Procedures governing medical records.

4.1.3 Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's Medical Record shall be as stated in the Hospital's Policies and Procedures governing medical records.

4.1.4 Standardized symbols and abbreviations may be used when they have been through the approval process. Those approved are listed in the
Hospital Formulary.

4.1.5 All Members shall record their entries in a patient’s Medical Record legibly. All physicians will be required to participate in the use of the Electronic Medical Record when available.

4.1.6 The patient’s Attending Physician shall be responsible for the timely preparation and completion of the patient’s Medical Record. Following discharge of the patient, the Medical Record will be completed within 30 days.

4.1.7 Any Consultant who is consulted as to any patient shall be responsible for the timely preparation and addition to the patient’s Medical Record of a Consultation Report and any other notes, orders and other written entries describing the Consultant’s examination and impressions of the patient, any diagnosis made by the Consultant, any recommended testing and/or course of treatment for the patient, and any testing and/or treatment of the patient undertaken directly by the Consultant.

4.1.8 When recording a History and Physical Examination, Consultation Report, or Progress Note in a patient’s medical record, a Member may reference elements of properly recorded House Staff or medical student histories and physical examinations only if the Member was present for the portion of the history, physical examination, or other patient encounter the Member proposes to reference or has personally verified the information recorded by the member of the House Staff or medical student.

4.1.9 All clinical entries in the patient’s Medical Record shall be accurately dated and authenticated by the individual making the entry. The method of acceptable authentication used shall be either:

a. A handwritten signature; or

b. An electronic signature, but only if the Member, member of the House Staff or Licensed Independent Practitioner (as applicable) has signed a Hospital “CONFIDENTIALITY AGREEMENT/SIGNATURE ATTESTATION” form agreeing that the user log on and password will not be shared with anyone.

The use of rubber stamp signatures is strictly prohibited.

4.1.10 Unless otherwise stated in these Rules and Regulations, all Medical Record entries required of any Member may be written or dictated by a member of the House Staff under the Member’s direct supervision.

Section 4.2  Content of Entries.
4.2.1 **Admitting Notes.** If utilized, Admitting Notes shall contain, at a minimum, the admitting diagnosis, the reason or reasons for admission to the Hospital or Special Unit, pertinent findings, and the course of treatment contemplated.

4.2.3 **Progress Notes.** Progress Notes shall include, at a minimum, a description of the patient’s status, including any changes since the last Progress Note, an assessment of the patient’s disease process or injury and its response to treatment, and any changes in the diagnosis and/or treatment plan.

4.2.4 **Operative Reports and Procedure Notes.** All Operative Reports and Procedure Notes shall indicate the primary physician and assistants involved and include a detailed account of the findings during the surgery or procedure, the details of the surgical or procedural technique used, any specimens obtained, and the post-operative diagnosis.

4.2.5 **Pre-Operative Notes.** Pre-Operative Notes shall contain the patient’s diagnosis and a general statement of the planned surgical procedure.

4.2.6 **Post-Operative Notes.** Post-Operative Notes shall record the patient’s vital signs and level of consciousness, medications, blood and blood components used post-operatively, any unusual post-operative events or complications, and the management of such events or complications.

4.2.7 **Consultation Reports.** Consultation Reports shall show evidence of a review of the patient’s record by the Consultant, pertinent findings on the Consultant’s examination of the patient, and the Consultant’s opinions and recommendations. If the Consultation Report contains a recommendation that the patient undergo surgery or other invasive procedure, the Consultation Report shall contain a statement of the indications for the surgery or procedure and a general description of the planned surgery or procedure.

Section 4.3 **Standing Orders.**

4.3.1 Any Member may utilize preprinted standing orders provided such standing orders, and any revisions thereto, have been approved in advance by the Medical Records Committee and the Executive Committee of the Medical Staff.

4.3.2 Any Member wishing to utilize preprinted standing orders approved in accordance with this Section must, on a case-by-case basis, specifically order that such standing orders be applied.

Section 4.4 **Discharge Summaries.** All Discharge Summaries shall identify the patient, and contain sufficient information to support the diagnosis, justify the treatment,
document the course and results of the treatment, and permit adequate continuity of care among health care providers. Discharge Summaries shall also contain instructions given to the patient relating to physical activity, medication, diet and follow-up care.

Section 4.5 Use of Medical Records for Research.

4.5.1 A Member shall be allowed access to a patient’s Medical Record for the purpose of bona fide study and research only if the Member is listed as a principal investigator or co-investigator on a research study approved by the Human Subjects Committee of the University of Kansas Medical Center and provides evidence of such to the Medical Records Department.

4.5.2 Any Medical Record utilized pursuant to this Section shall be checked out from and returned to the Medical Records Department in accordance with the Hospital’s Policies and Procedures governing medical records.

4.5.3 No Medical Record or copy thereof utilized pursuant to this Section shall be removed from the Hospital Premises except as authorized by an appropriate representative of the Authority.

ARTICLE V: AUTOPSIES

Section 5.1 Unless otherwise required by the County Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. All Medical Staff Members shall request and secure written consents for autopsies whenever possible.

Section 5.2 Deaths in which an autopsy should be especially encouraged are:

a) Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.

b) All deaths in which the cause of death is not known with certainty on clinical grounds.

c) Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.

d) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.

e) Deaths of patients who have participated in clinical trials protocols approved by the institutional review committee.

f) Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.

g) Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at the hospital, (b) deaths occurring in the hospital within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
h) Deaths resulting from high-risk infectious and contagious diseases.
i) All obstetric deaths.
j) All neonatal and pediatric deaths.
k) Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients or transplant organs.
l) Deaths known or suspected to have resulted from environmental or occupational hazards.

Section 5.3 All autopsies shall be performed by a hospital pathologist with appropriate clinical privileges at the University of Kansas Hospital. Attending Staff Member shall be notified as to the time and date of autopsy by the Department of Pathology. Unless special circumstances justify variance, provisional anatomic diagnoses shall be recorded on the decedent’s medical record within two working days of the autopsy and shall record a final diagnosis in the decedent’s medical records within thirty (30) working days for routine cases; three months for complicated cases.

ARTICLE VI: AMENDMENTS

These Rules and Regulations may be amended by a majority vote of the Executive Committee. Any such amendment shall become effective upon approval of the Board.

Approved:

Bob Page, President and CEO
University of Kansas Hospital Authority

H. William Barkman, MD, MSPH
Chief of Staff
Conditions Requiring MFM Consultation for Inpatient Antepartum Patients

Mandatory MFM Consults in Family Medicine:
1. Diabetes requiring hypoglycemic therapy
2. PTL or PPROM <36w
3. Chronic maternal illness requiring medical treatment or with end organ disease, including chronic HTN, SLE, severe asthma, hyperthyroidism, renal, hepatic, and cardiovascular disease.
4. Vascular disease, including DVT, PE
5. Fetal malformation
6. Intrauterine growth restriction
7. Abnormal antenatal surveillance
8. Severe pre eclampsia or unexplained hypertension

Mandatory Consults in Family Medicine (in house OB attending is sufficient in the following situations):
1. Dysfunctional labor *
2. < 1cm/h progress x 3h after 4cm dilation
3. Second stage >2h
4. Mild pre-eclampsia
5. Multiple gestation
6. Operative vaginal delivery
7. Repair of 4th degree or other extensive laceration
8. Suspected placenta previa or placental abruption
9. Non-vertex presentation
10. Planned VBAC
11. Fever in labor
12. Concerning fetal heart rate tracing on the Labor floor

Notification of In House Attending (as opposed to formal consultation MAY suffice under appropriate circumstances for the following at ≤36 weeks):
1. PROM ≥ 36w
2. Mild pre eclampsia ≥ 36 weeks
3. Intrapartum or postpartum hemorrhage > 500cc
4. Suspected macrosomia

Mandatory MFM Consults in General Obstetrics:
1. Diabetes requiring hypoglycemic agents
2. PTL or PPROM <34w
3. Chronic maternal illness requiring medical treatment or with end organ disease, including chronic HTN, SLE, severe asthma, hyperthyroidism, renal, hepatic, and cardiovascular disease.
4. Connective tissue disorder remote from term
5. Vascular disease including CVT and PE
6. Fetal malformation
7. Intrauterine growth restriction
8. Abnormal antenatal surveillance
9. Severe preeclampsia/Eclampsia/HELLP
10. Any condition requiring non-emergent delivery < 34 weeks.

Other Specialties without Obstetric Privileges:
1. Any pregnant women hospitalized off the obstetric service

Presented 4/23/09 ECMS.