



***Medical University of South Carolina  
Medical Center***

***Medical Staff  
Rules and Regulations***

***August, 2006***

## **DEFINITIONS:**

1. **Medical Staff** - all persons who are privileged to engage in the evaluation, diagnosis and treatment of patients admitted to the MUSC Medical Center, and includes medical physicians, osteopathic physicians, oral surgeons and dentists.
2. **Board of Trustees** - the Board of Trustees of the Medical University of South Carolina, which also functions as the Board of Trustees for the MUSC Medical Center.
3. **University Executive Administration** - refers to the President of the Medical University of South Carolina and such Vice Presidents and Administrators as the Board directs to act responsibly for the Hospital.
4. **Dean** - the Dean of the appropriate College of the Medical University of South Carolina.
5. **VP for Clinical Operations/ Executive Director, Medical Center** - the individual who is responsible for the overall management of the Hospital.
6. **Executive Medical Director** - the individual who is responsible for the overall management of medical staff functions.
7. **Practitioner** - an appropriately licensed medical physician, osteopathic physician, oral surgeon, dentist, podiatrist, or any other individual who exercises independent judgment within areas of his professional judgment and applicable state practice.
8. **Executive Committee** - the Executive Committee of the Hospital.
9. **House Staff** - any post graduate physician practitioner in specialty or sub-specialty training.
10. **Affiliated Health Professional** - any health professional who is not a licensed medical physician, osteopathic physician or dentist; subject to licensure requirements or other legal limitations; with delineated clinical privileges; exercises independent judgment within areas of his professional competence and, is qualified to render direct or indirect care.
11. **Medical Record** - any/all information, paper and/or computer (consents, OR notes, path, lab & imaging reports, consultations, D/C summary), concerning a single patient that describes the course of the evaluation, treatment and change in condition during a hospital stay, an ambulatory or emergency visit. It is the legal record of care.
12. **Authenticate** - refers to the date and signature by the author of the entry in the medical record; signature is to include full name and the individual's credentials. The signature may be handwritten, by rubber stamp, or by computer key.
13. Whereas herein the word "**Hospital**" is used it refers to the MUSC Medical Center and its component hospitals and outpatient activities.
14. Since the English language contains no singular pronoun which includes both sexes, wherever the word "**he**" appears in this document, it signifies he/she.

# **MEDICAL STAFF RULES AND REGULATIONS**

## **I INTRODUCTION**

It is the duty and responsibility of each member of the medical staff to abide by the Rules and Regulations set forth here within this document. These rules and regulations shall be made a part of the MUSC Medical Staff Bylaws. Such amendments shall become effective when approved by the Board.

## **II ADMISSIONS**

### **Who May Admit Patients**

A patient may be admitted to the Medical Center only by a medical staff member who has been appointed to the staff and who has privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Medical Center has facilities and personnel. When the Medical Center does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the Medical Center, the Medical Center or attending physician, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. Except in an emergency, no patient shall be admitted to the Medical Center unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

### **Admitting Physician Responsibilities**

Each patient shall be the responsibility of a designated attending physician of the medical staff. Such attendings shall be responsible for the

- initial evaluation and assessment of the admitted patient. Such an evaluation must be completed within 24 hours of admission.
- management and coordination of the care, treatment, and services for the patient including direct daily assessment, evaluation and documentation in the medical record by the attending or the designated credentialed provider
- for the prompt completeness and accuracy of the medical record,
- for necessary special instructions, and
- for transmitting reports of the condition of the patient to the referring physician or agency. Whenever these responsibilities are transferred to another medical staff member and service, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

The admitting practitioner shall be responsible for providing the Medical Center with such information concerning the patient as may be necessary to protect the patient, other

patients, or Medical Center personnel from infection, disease, or other harm, and to protect the patient from self-harm.

### **Alternate Coverage**

Each medical staff appointee shall provide assurance of immediate availability of adequate professional care for his patients in the Medical Center by being available or having available, an alternate medical staff appointee with whom prior arrangements have been made and who has clinical privileges at the Medical Center sufficient to care for the patient. Residents may provide coverage only under the direct supervision of an attending physician.

### **Emergency Admissions**

The history and physical examination must clearly justify any admission on an emergency basis and must be recorded on the patient's chart no later than 24 hours after admission. In the case of emergency admission, patients who do not already have a personal admitting physician will be assigned to a medical staff appointee with privileges in the clinical department appropriate to the admitting diagnosis.

## **III MEDICAL RECORDS**

### **General Guidelines**

- a. The "legal medical record" consists of all authenticated (signed) documentation, handwritten or electronically generated related to the care of an individual patient regardless of storage site or media. Included are all inpatient records from the Medical Center, IOP, Children's Hospital, CMH and their outpatient, provider-based clinics and associated records of patients participating in research projects.
- b. All records are the property of MUSC and shall not be removed except as pursuant to provision of law. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- c. Physicians shall not remove any part of the medical record for any reason. Any physician who purposely removes any document from a medical record will be suspended and/or lose Medical Staff Membership.
- d. The attending Physician shall be held responsible for the preparation of a complete medical record for each patient.
- e. Diagnostic and therapeutic orders given by medical staff members shall be authenticated by the responsible practitioner.

- f. Symbols and abbreviations may be used only when approved by the Medical Staff. The use of unapproved abbreviations as specified in Medical Center Policy #C-21 "Use of Abbreviations" is prohibited.
- g. Progress notes are to be documented daily by the designated attending or his designated credentialed provider for all inpatient and observation patients.
- h. The patient's medical record requires the progress notes, final diagnosis, and discharge summary or final visit note to be completed with authenticated dates and signatures. All final diagnosis, complications, or procedures must be recorded without abbreviations.
- i. Patient progress note entered into the Medical Record by Medical students must be co-signed by either a resident or an attending physician.
- j. Stat dictation shall be limited to urgent situations such as when a patient transfer is pending.

### **History and Physical Requirements**

- a. H&Ps shall be completed no later than twenty-four (24) hours after admission or at the initial visit to an ambulatory clinic.
- b. H&Ps must be completed prior to any operative, invasive, high risk diagnostic or therapeutic procedure, or procedures requiring moderate or deep sedation regardless of setting. For other non- inpatients procedures a focused history and physical may be completed based on the presenting problem.
- c. H&Ps are required in all primary care clinics. On subsequent primary care visits and in specialty clinics, the H&P can be focused, based on the presenting problem(s).
- d. When the H&P examination is not on the chart prior to the surgery or high risk diagnostic or therapeutic procedure, the said procedure shall be delayed until the H&P is completed unless it is an emergency.
- e. When using an H &P that was performed prior to admission or the outpatient procedure, an update to the H&P must be completed within 24 hours for inpatients and prior to the outpatient procedure. This includes intra campus admissions from the Medical Center. (ie, TCU, IOP, )For all outpatient surgeries and other procedures requiring an H&P the update may be completed in combination with the preanesthesia assessment.

- f. A completed H&P (except in circumstances allowing a focused H&P as described in paragraph b above) must include (as information is available):
- chief complaint,
  - details of present illness (history),
  - past history (relevant - includes illnesses, injuries, and operations),
  - social history,
  - allergies and current medications,
  - family history,
  - review of systems pertinent to the diagnosis,
  - physical examination pertinent to the diagnosis,
  - pertinent normal and abnormal findings, and
  - conclusion or a planned course of action.
- g. Dentists are responsible for the part of their patient's H&P that relates to dentistry.
- h. Oral and maxillofacial surgeons may perform a medical H&P examination in order to assess the status and risk of the proposed surgery or procedures.
- i. Podiatrists are responsible for the part of their patient's H&P that relates to podiatry.
- j. Optometrists are responsible for the part of their patient's H&P that relates to optometry.
- k. The attending physician is responsible for the complete H&P.
- l. Residents, advanced nurse practitioners and in some cases physicians assistants, appropriately privileged, may complete the H&P with the attending physician's counter signature. In lieu of a signature the attending physician may complete an additional attestation sheet to confirm or change the initial history and physical.

### **Informed Consent Requirements**

It is the responsibility of the attending physician to assure appropriate informed consent. Is obtained and documented in the medical record and when appropriate, also document the discussion in a progress note .Nursing staff and other personnel may witness patient signature but may not consent the patient.

Informed consent is required for all invasive procedures, for the use of anesthesia including moderate and deep sedation and for the use of blood and blood products.

Appropriate informed consent shall include at a minimum:

- patient identity,
- date,
- procedure or treatment to be performed,
- name of person performing the procedure or treatment,

- authorization for the proposed procedure
- authorization for anesthesia or moderate sedation if indicated.
- indication that alternate means, risk and complications of the planned procedure and recuperation, and anesthesia have been explained,
- authorization for disposition of any tissue or body parts as indicated,
- risks and complications of blood or blood product usage (if appropriate),
- witnessed signature of the patient or other empowered individual authorizing informed consent, and
- signature, name/identity and pager # of the physician who obtained the consent, (verbal consent may be witnessed by the nurse and indicated on the consent form).
- physician documentation of the consent process in a progress note or on the consent form.

Physician documentation of the consent process and discussion may be accomplished with either an out-patient or in-patient note in the record.

### **Operative and Other Procedure Documentation Requirements**

Immediately after the operation/procedure a progress note will be written and promptly signed by the primary physician/surgeon (this applies to both inpatients and outpatients). This progress note is considered an abbreviated report and will include the pre-operative procedure/diagnosis, the name of the primary physician/surgeon and assistants, findings, procedure performed and a description of the procedure, estimated blood loss, as indicated any specimens/tissues removed, and the postoperative/procedure diagnosis.

For all patients (both inpatient and outpatient) the full operative/procedure report shall be written or dictated and signed by the primary physician/surgeon and entered into the medical record no later than 28 days from the completion of completion of operation/procedure.

Operative/ procedure reports may be completed by residents with supervision by the attending as evidenced by the attending's counter signature authenticating the report. These documentation requirements apply to all procedures billed as such according to a CPT code.

### **Discharge Summary Requirements**

Discharge summary must include reasons for admission, significant findings, procedures performed, treatment given, condition of the patient upon discharge, specific instructions given to patient and/or patient's family in regard to activity, discharge, medications, diet, and follow-up instructions. Residents may complete the discharge summary with attending supervision as evidenced by the attending's counter signature on the report.

### **Complete Medical Records**

The attending physician is responsible for supervising the preparation of a complete medical record for each patient.

- a. Specific record requirements for physicians shall include:
  - identification date, name, address, birth date, next of kin, patient history number, legal status (for behavioral health patients)
  - initial diagnosis
  - history and physical
  - orders
  - clinical observation, progress note, consultations
  - reports of procedures, tests, and results
  - operative reports
  - reports of consultations
  - discharge summary
  - all final diagnoses, complications, or procedures

Medical records for patients with diagnosed cancer must include AJCC staging forms completed by the attending physician.

### **Medical Records Preparation and Completion**

The history and physical, consults, and orders as well as authentications of such will be completed in the time frame specified in these Rules and Regulations. All diagnostic study reports must be dictated and on the medical record within 72 hours of the completion of the study.

The records of all discharged patients (inpatients and ambulatory) not fully completed within twenty-eight (28) days of discharge will be considered delinquent

- a. One week after discharge, if a patient's medical record is not completed the attending physician will receive notification that the chart is incomplete.
- b. The physician will receive a suspension warning if the chart remains incomplete after 21 days post discharge in writing by fax, email, or letter or orally by direct phone call or pager.
- c. If the record remains incomplete at 28 days the physician will receive notice one day prior to suspension of privileges orally by direct phone call or pager.
- d. The suspended physician cannot admit new patients to his or her care.
- e. The suspended physician can continue to provide care for those patients directly under his/her care prior to the suspension.

- f. Three (3) such suspensions in a twelve (12) month period will result in a loss of Medical Staff Membership, according to the MUSC Medical Staff Bylaws.

#### IV. ORDERS

##### General Requirements

- a. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Orders which are illegible or improperly written will not be carried out until they are clarified, rewritten, and are understood. Orders can not be written with abbreviations listed on the prohibited abbreviation list. Scientifically approved chemical symbols for certain drugs are acceptable (i.e., KCL for potassium chloride).
- b. When a practitioner uses a rubber stamp signature, he/she is the only one who uses it and must sign a statement to that effect. It is the responsibility of each practitioner to forward a copy of this statement to the Medical Staff Office. When a practitioner uses an electronic signature, he/she must ensure it is only used in accordance with departmental policies and related regulatory guidelines.
- c. When a patient returns to a patient care unit from the OR all orders must be totally rewritten with the exception of minor procedures as defined by a procedure that could also be performed in a non-OR setting. In that case, the pre-procedure orders are adjusted by the physician postoperatively according to patient condition. When the physician review is completed, a note is entered on the order form which states that the orders have been reviewed and all orders are current.

Patients transferred into or out of an intensive care unit from or to a non intensive care area must have all orders rewritten.

- d. Orders will be rewritten when a patient is transferred between levels of care (i.e. from an intensive care unit to the floor or vice versa.) A reorder for medication or treatment is to be written after an automatic stop order has been employed.
- e. Explicit orders must be written for each action to be taken.
- f. Medications should be ordered within the MUSC formulary.
- g. Blanket orders such as resume pre-op medications as outlined above in c or resume home medications are prohibited.
- h. Illegible Orders. Admitting privileges and surgical or procedures privileges can also be suspended for illegible orders. Illegible is defined as orders that three (3) other individuals cannot read. Suspension will occur after the physician has been notified, either orally or in writing, on three (3) separate occasions regarding legibility.

- i. All medication orders must be written according to Medical Center Policy #C-78 "Medication Orders".

### **Who May Write Orders**

Orders may be written by members of the medical staff and allied health professionals (advanced nurse practitioners, PA's, residents, psychologists) within the scope of their practice, delineated clinical privileges, and approved protocols. All orders must be written clearly, legibly, and completely and must include date, time written, legible authentication, and the ordering practitioner's pager ID. Authenticated electronic signatures for orders are acceptable when available.

### **Orders for Specific Procedures/Circumstances**

- a. All requests for tests such as imaging and labs, etc shall contain a statement of the reason for the examination.
- b. All orders for therapy shall be entered in the patient's record and signed by the ordering practitioner.
- c. Therapeutic diets shall be prescribed by the attending physician in written orders on the patient's chart. Orders for diet must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.
- d. All orders for *restraints* shall include the type of restraint, the reason for the restraint, the length of time (not to exceed 24 hours), and alternatives attempted. Restraints can be ordered by a physician, or an advanced nurse practitioner or psychologist within the scope of their duties. Such orders must be signed and dated by the ordering practitioner at the time restraints are ordered. Emergency verbal orders must be secured within one hour of the nurse initiating restraints. Verbal orders for restraints must be signed by the ordering practitioner within twenty-four (24) hours. PRN orders are not acceptable.
- e. When restraints are used for behavioral reasons, the patient must be seen by an MD within one hour of initiation.
- f. Do Not Resuscitate (DNR) orders may be accepted as a verbal order only when the patient has executed an advance directive and that directive is included in the patient's record. A no-code (DNR) must be written by the attending physician with the progress notes reflecting the patient's mental status, the reasons for the DNR, diagnosis and prognosis, and a statement of the patient's wishes. Medical staff are to follow Medical Center Policy #C-13 "Resuscitation Orders". In all cases the patient has the right to refuse resuscitation verbally or as by written advanced directive.

## Verbal Orders

A verbal order is defined as an urgent or emergent order that has not been written and is relayed verbally from the physician or dentist. The request for and use of verbal orders should be limited to urgent or emergent situations. In all cases a telephone or verbal order will not be considered complete until the individual receiving the order, reads back and verifies the content of the order

- a. The following disciplines may request and accept a verbal order within the scope of their practice when the need for such an order is urgent:
  - Registered Nurse
  - Licensed Practical Nurse (in ambulatory clinics only)
  - Licensed Physicians Assistant
  - Registered Pharmacist
  - Certified Respiratory Care Practitioner
  - Emergency Medical Technician
  - Licensed Physical Therapist
  - Licensed Occupational Therapist
  - Registered Dietician
  - Board Registered or Licensed Nuclear Medicine Technologist
  - Board Registered or Licensed Radiologic Technologist
  - Dental Hygienist
  - Licensed speech language pathologist
- b. Verbal orders must be signed with credentials, dated and timed, read back and verified, and flagged for signature by the person accepting the order.
- c. The name and pager ID of the practitioner who dictated the order must be documented.
- d. All verbal orders (with the exception of verbal orders for restraint or seclusion) must be signed, timed, and dated by the practitioner, or designee (a physician member of the service team) who issued the order within forty-eight (48) hours.
- e. Verbal orders for Schedule II Controlled Substances must be signed, timed and dated **only by the practitioner** who issued the order within 48 hours. (SC Code Ann.Reg 61-4.908 and 909)
- f. Unsigned verbal orders for controlled substances must be discontinued after forty-eight (48) hours.
  - The responsible physician or dentist must be notified by a nurse of the discontinuation.
  - Documentation of notification of the physician or dentist must occur in the medical record.

- g. Verbal orders must not be accepted for chemotherapy agents, investigational drugs or Do Not Resuscitate Orders. Immunosuppressants may not be initiated with verbal orders, however a verbal order for subsequent dose modifications may be accepted.
- h. Non-licensed/certified personnel (i.e., unit secretaries, pharmacy technicians) may not give or accept verbal orders from either physicians or dentists under any circumstances.
- i. The above applies to both paper and electronic medical record verbal order entry.
- j. When using the electronic system, the appropriate physician must select the verbal order within the sign tab and then submit the order.

## **V CONSULTATIONS**

### **Who May Give Consultations**

Any qualified practitioner with clinical privileges in the Medical Center can be asked for consultation within his area of expertise. In circumstances of grave urgency, or where consultation is required by the rules of the medical staff as stated below, the President of the Medical Staff, or the appropriate department chair, or the designee of either of the above, shall at all times have the right to call in a consultant or consultants.

### **Required Consultations**

- a. Consultation shall be required in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent. Consultations are also required in all cases in which, in the judgment of the attending physician:
  - 1. the diagnosis is obscure after ordinary diagnostic procedures have been completed,
  - 2. there is doubt as to the choice of therapeutic measures to be utilized,
  - 3. unusually complicated situations are present that may require specific skills of other practitioners,
  - 4. the patient exhibits severe symptoms of mental illness or psychosis.
- b. The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant.
- c. It shall be the responsibility of all individuals exercising clinical privileges, to obtain any required consultations, and requests for a consultation shall be entered on an appropriate form in the medical record. If the history and physical are not on the chart and the consultation form has not been completed, it shall be the

responsibility of the practitioner requesting the consultation to provide this information to the consultant.

- d. It is the duty of the Credentials Committee, the Department Chair, and the Medical Executive Committee, to make certain that appointees to the staff request consultations when needed.

### **Contents of Consultation Report**

Consultations will be completed within 24 hours for inpatients. Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's record within 24 hours of completion of the consultation. While the consultant may acknowledge data gathered by a member of the house staff, a limited statement, such as "I concur" alone does not constitute an acceptable consultation report. When operative or invasive procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date and time of the consultation and the signature of the consultant.

### **Emergency Department Consultations**

Specialists who are requested as consultants to the Emergency Department (ED) must respond in a timely fashion. In addition, any specialist who provides a consultation in the ED for a patient with an urgent condition is responsible for providing or arranging follow-up care. It is the policy of the ED that all patients are seen by an attending physician physically present in the ED. House staff evaluating patients in the ED for the purpose of consultation will confer with the responsible attending within their given specialty who is physically present in the ED. When such an attending is not physically present, the attending physician responsible for overseeing the patient's care will default to the ED attending physician while in the ED.

## **VI SUBSTANCE ABUSE/PSYCHIATRIC PATIENTS**

Any patient known to be suicidal in intent or with a primary diagnosis of substance abuse or psychiatric disorder shall be admitted to the appropriate psychiatric unit. If there are no accommodations available in this area, the patient shall be referred to another institution where suitable facilities are available. In the event that the patient has a non-psychiatric condition which requires treatment at the Medical Center and no accommodations are available in the Institute of Psychiatry, the patient may be admitted to another unit of the Medical Center only after consultation with the Executive Medical Director or his designee and the assigned Medical Director of the relevant service. Explicit orders regarding precautionary measures are required.

Any patient known or suspected to be suicidal or with a primary diagnosis of substance abuse or psychiatric disorder who is admitted to a non-psychiatric unit must have consultation by a Medical Staff member of the psychiatric staff.

All patients admitted to a non-psychiatric unit while awaiting transfer will be medically assessed and stabilized before transfer. The care of such patients will remain with the attending MD until transfer or discharge.

Patients exhibiting symptoms of a psychiatric disorder or substance abuse while hospitalized with a medical/surgical diagnosis will have a consultation by a physician or a member of the Department of Psychiatry.

## **VII MODERATE AND DEEP SEDATION**

Moderate sedation will be administered under the immediate direct supervision of a physician, dentist, or other practitioner who is clinically privileged to perform moderate sedation. Moderate sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/Analgesia"

Deep sedation/analgesia will be administered only by an anesthesiologist, CRNA or a physician holding appropriate clinical privileges. Deep sedation will be administered ONLY in areas of the medical center where trained, qualified staff and appropriate equipment are present, according to Medical Center Policy #C-44 "Moderate Sedation/ Analgesia".

## **VIII PATIENT DISCHARGE**

### **Who May Discharge**

Patients shall be discharged only on the order of the attending/covering physician. Should a patient leave the Medical Center against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient will be asked to sign the Medical Center's hospital release form.

### **Discharge of Minors and Other Incompetent Patients**

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

### **Transfer of Patient**

Patients may be transferred to another medical care facility after arrangements for transfer and admission to the facility have been made. Clinical records of sufficient content to ensure continuity of care shall accompany the patient.

### **Death of Patient**

Should a patient die while being treated at the Medical Center, the attending physician should be notified immediately. A practitioner will pronounce the patient dead, notify the family ASAP, and request and document permission to perform an autopsy, when applicable.

### **Methods for Obtaining an Autopsy**

Methods for obtaining an autopsy shall include:

- a. The family requests an autopsy
- b. The death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County
  - The attending physician requests an autopsy based on the College of American Pathologists criteria and Medical Center #C-16 "Decedent Care Program".
- c. No autopsy shall be performed without written consent of a responsible relative or authorized person unless ordered by the Coroner/Medical Examiner of Charleston County.

### **Duties of the Physician for Obtaining an Autopsy**

- a. Determine whether the death falls within the jurisdiction of the Coroner/Medical Examiner of Charleston County. (Refer to "A Guide to the Autopsy for Physicians and Nurses.")
- b. Obtain permits for organ donation when applicable according to the Organ Procurement, Medical Center Policy #C-17 "Organ/Tissue Donation".
- c. Documentation of request for autopsy must be completed, authenticated, and placed in the medical record.

### **Scope of Autopsy**

- a. The scope of the autopsy should be sufficiently completed in order to answer all questions posed by the attending physician and by the pathologist, upon review of the clinical database.
- b. The autopsy report should include: a summary of the clinical history, diagnoses, gross descriptions, microscopic descriptions, and a final summary that includes a clinicopathologic correlation.
- c. The autopsy findings should be promptly communicated to the attending physician along with all additional information the pathologist considers relevant to the case
- d. The results of autopsies will be monitored as a part of performance improvement.

### **IX MAYDAY PROCEDURE**

In the event that a clinical emergency situation arises within the Medical Center or within any University area designated in the Medical Center Policy #C-14 "Medical Emergency Response". Medical Staff are to follow specific duties as outlined in the policy.

### **IX EMERGENCY MEDICAL SCREENING**

Any individual who presents in the Emergency Department or other department of the Medical Center either by him or herself, or by way of an accompanied party, and requests an examination for treatment of a medical condition must be screened by an appropriate practitioner to determine whether or not an emergency medical condition exists. Individuals qualified to provide this medical screen include attending physicians, house staff, nurse practitioners, and physician assistants.

### **X PATIENT SAFETY INITIATIVES**

All members of the medical staff are required to follow all guidelines/policies related the National Patient Safety Goals and other patient safety initiatives. These policies include but are not limited to:

- Patient Safety C-76
- Verbal Orders - C-56
- Notification of Critical Values - C-80
- Wrong Site, Wrong Procedure, Wrong Person Surgery/Procedure C-25
- Use of Abbreviations C-21
- Sentinel Events C-49
- Patient Identification C-58
- Hand Hygiene IC-27
- Medication reconciliation

## **XI HOUSE STAFF/RESIDENT PHYSICIANS**

House staff (post graduate physician practitioners in specialty or sub-specialty training) at the MUSC Medical Center shall not be eligible to become appointees of the active medical staff and shall not be eligible to admit patients. They are authorized to carry out those duties and functions normally engaged in by house staff according to their defined job descriptions and/or scope of practice under the supervision of an appointee of the active medical staff. Supervision of residents is required. Supervision includes but is not limited to counter signature in the medical record by the attending, participation by the resident in rounds, one on one conference between the resident and attending, and the attending physician's observation of care being delivered by the resident. Active medical staff members are required to supervise students as specified in Medical Center policy C-74, Resident Supervision.

## **XII PEER REVIEW**

All members of the medical staff will be included in the medical staff's peer review process.

Approved by majority vote of the Medical Staff on July 25, 2006.

Approved by the Board of Trustees as of this 11th day of August, 2006.

By: \_\_\_\_\_  
Charles B. Thomas, Jr., MD

Its: Chairman, Board of Trustees  
Medical University Hospital Authority