RULES AND REGULATIONS
OF THE BYLAWS OF THE MEDICAL STAFF

UNIVERSITY OF NORTH CAROLINA HOSPITALS

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THE UNIVERSITY OF NORTH CAROLINA HOSPITALS

NOTE: Capitalized terms shall have the same meaning as set forth in the Bylaws of the Medical Staff.

1. The meetings of the Medical Staff shall be held as provided in the *Bylaws of the Medical Staff* (the "Bylaws").

2. Patients may be treated only by Practitioners[1] with clinical privileges and by residents/subspecialty residents. All hospitalized patients shall be attended by a physician with privileges (or a Certified Nurse Midwife for labor and delivery patients only) and shall be assigned to the service concerned with the treatment of the patient's disease. Practitioners shall be responsible for supervising residents/subspecialty residents in the provision of care to patients under their care.

2a. In accordance with the requirements of the Emergency Medical Treatment and Labor Act ("EMTALA"), all individuals presenting to a UNC Hospitals dedicated emergency department (as defined by law and in policy) for examination or treatment shall be given an appropriate medical screening examination (MSE) by qualified medical personnel (QMP) to determine if an emergency medical condition exists. QMP include physicians, physician assistants, nurse practitioners, and Certified Nurse Midwives (for labor and delivery patients only). The MSE is not an isolated event; it is an ongoing process that begins, but typically does not end, with triage. When the Hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate MSE, it will still assess the individual's condition upon arrival to insure the individual is appropriately prioritized, based on their presenting signs and symptoms, to be seen by a QMP for completion of the MSE.

3. Each member of the Medical Staff who is not a resident in the city or immediate vicinity shall name a member of the Medical Staff who is a resident of the city or immediate vicinity, who may be called to attend his/her patients in an emergency. In case of failure to name such an associate, the Department Chair involved or the CMO shall have authority to request any member of the Medical Staff to substitute. In the anticipated absence of a member of the Medical Staff, s/he shall designate another member of the Medical Staff to attend his/her patients. In the case of failure to do so, the Department Chair involved or the CMO shall have the authority and responsibility to designate a member of the Medical Staff to substitute.

4. Except in emergency situations, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

[1] "Practitioner" is defined in the Bylaws as: 1) a member of the Medical Staff, (2) an individual with Telemedicine, Visiting or Locum Tenens privileges, or (3) an Independent or Dependent Allied Health Professional with clinical or practice privileges at the Hospital.

5. Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from potential sources of danger from any causes whatsoever, or to assure protection of the patient from self-harm. All Practitioners and residents/subspecialty residents will practice according to UNC Hospitals' policies on restraint and seclusion.

6. Each patient admitted for inpatient care or outpatient surgery/procedure requiring anesthesia shall have a history taken and an appropriate physical examination for the procedure being performed or reason for admission (H&P) performed by one of the following individuals with privileges at UNC Hospitals: 1) a physician; 2) a Nurse Practitioner or Physician's Assistant; 3) a resident/subspecialty resident (for residents/subspecialty residents, privileges are not required, just credentials to practice at UNC Hospitals); 4) a Certified Nurse Midwife (for labor and delivery patients only); 5) a dentist (for dental procedures for the sole purpose of determining the fitness of the dentist's patient for the dental procedure only, as authorized by the North Carolina State Board of Dental Examiners); or 6) a Certified Registered Nurse Anesthetist (for preoperative anesthesia only). Such H&P shall be authenticated by the attending physician unless performed by the attending physician, dentist or a Certified Nurse Midwife. Qualified oral surgeons who admit patients without medical problems may perform the H&P examination on those patients. A history and physical (H&P) examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination are completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration but prior to surgery. In an emergency when there is no time to record a complete H&P, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record before surgery/procedure requiring anesthesia. An H&P may be performed outside the time frames set forth above, but within thirty (30) days prior to a scheduled admission or outpatient surgery/procedure requiring anesthesia, if an updated assessment or interval H&P is subsequently both performed and documented during the Required Period that identifies any changes in the patient's medical status or that no changes have occurred.

6a. The required elements of an H&P include relevant components of each of the following: history of present illness, medications, allergies, past medical history, surgical history, and an appropriate physical examination for the procedure being performed or reason for admission, and an assessment and plan of care.

7. When an H&P is not recorded before the time stated for a surgical operation/procedure requiring anesthesia, the operation/procedure shall be canceled unless the attending surgeon documents in the patient's medical record that such a delay would constitute a hazard to the patient.

8. Standing orders are pre-approved physician orders to address specific clinical scenarios involving the administration of medications, biologicals, procedures and/or tests which have been approved as meeting nationally recognized evidence-based guidelines by MSEC. Upon implementation of a standing order by appropriate healthcare personnel, a Practitioner responsible for the patient shall be notified, and a physician (or a Certified Nurse Midwife for labor and delivery patients only) must authenticate the order with

signature, date, and time within the timeframe required by Hospital policy, but in all cases no later than thirty (30) days of implementation. Exceptions to authentication are standing orders for influenza, pneumococcal and COVID-19 vaccines.

9. Standing orders for patients receiving care at the Hospital shall be developed, approved or modified by MSEC upon recommendations by Department Chairs or Medical Staff Committees. Standing orders require authentication by the patient's treating Practitioner or resident/subspecialty resident. The only exceptions to this requirement are: a) influenza, pneumococcal, and COVD-19 vaccines; b) COVID-19 diagnostic testing; and c) screening mammograms (patients self-refer). In addition, and in consultation with Pharmacy personnel, MSEC must establish, monitor and enforce automatic stop orders for drugs and biologicals that are not specifically prescribed to end at a certain time or number of doses. Physician protocols and order sets need not receive MSEC approval and may be performed by appropriate healthcare personnel as initiated by the Practitioner or resident/subspecialty resident.

9a. UNC Hospitals and its Practitioners may provide radiologic services upon: 1) the order of Practitioners with privileges at UNC Hospitals, or 2) upon the order of physicians, Nurse Practitioners or Physician Assistants who are licensed in the state of North Carolina and whose scope of practice permits them to order such radiologic services.

10. All orders for treatment shall be documented and signed by the responsible Practitioner with such privileges or resident/subspecialty resident.

11. Signature stamps are prohibited for authentication of entries within the medical record.

12. Entries in the medical record in the acute care settings (inpatient, extended recovery, day ops, observations, and hospital procedural areas but excluding the Emergency Department) by residents/subspecialty residents or Allied Health Professionals that require countersigning by an attending Practitioner include: admission orders, operative reports, procedure notes, admission history and physical, discharge summaries, pre-anesthesia record, anesthesia record, post-anesthesia note, pre-op note, post-op note, and discharge orders. Daily progress notes and consult notes authored by residents/subspecialty residents also require countersigning by an attending physician (or a Certified Nurse Midwife for labor and delivery patients only). Countersigning is not required for Certified Nurse Midwives on obstetrical units except for admission and discharge orders.

13. A verbal order shall be considered to be documented if it is dictated by a Practitioner with such privileges or a resident/subspecialty resident to a licensed nurse or other licensed or registered person functioning in his/her sphere of competence (e.g., Occupational Therapist for Occupational Therapy treatment; Physical Therapist for Physical Therapy treatment; Respiratory Therapist for Respiratory Therapy treatment, etc.) and documented in accordance with this rule. Orders dictated over the telephone shall be authenticated by the licensed or registered person functioning in his/her sphere of competence to whom dictated, and they should indicate the name of the Practitioner or resident/subspecialty resident who gave the order. The Practitioner or resident/ subspecialty resident giving the order shall authenticate such verbal orders within the timeframe set by Hospital policy. If automated systems are introduced, these requirements shall be considered met if the approved system is used.

14. When transferring a patient from one primary treatment team (i.e. physician care team) to another or when transferring a patient from one acuity level to another, it is expected that the new primary treatment team will review the existing full order set and amend as deemed appropriate in a timely manner to meet the care needs of the patient. In the event a patient transfers to a new primary treatment team and the new primary treatment team has yet to review and amend orders in a timely manner, the nursing staff will promptly notify the new primary treatment team.

15. In all cases, except as noted below, surgical procedures shall be performed only with the prior informed written consent of the patient or his/her authorized representative. Obtaining such consent shall be the responsibility of a Practitioner or resident/subspecialty resident qualified to perform the procedure. Generally, such consent shall be in writing. However, consent may be obtained by witnessed telephone authorization as set forth in Hospital policy. In cases of emergency operations, when consent cannot be obtained, such operations will be performed only in accordance with Hospital policy.

16. All specimens removed during a surgical procedure, or tissue passed vaginally in the case of a miscarriage, shall be properly labeled and shall be sent to the pathologist (except as covered in "a-g" below), who shall make such examinations as are considered necessary and record his/her observations and interpretations in a signed report. In certain cases where special studies are indicated, arrangements will be made between the pathologist, surgeon, and special laboratory concerned, with appropriate notation made in the medical record. A signed copy of the pathology report shall be filed timely in the medical record. Exceptions to the requirement of pathologic examination of specimens removed during a surgical procedure are made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used, and when there is an authenticated operative or other official report that documents the removal. The limited categories of specimens that may be exempted from pathologic examination include, but are not necessarily limited to, the following (It should be noted that any specimen on which pathologic examination is requested will be examined by Surgical Pathology irrespective of the exclusions):

    a. Specimens that by their nature or condition do not permit fruitful examination, such as an orthopedic or other exogenous appliance, foreign body, or portion of bone or cartilage removed only to enhance operative exposure; (however, it is strongly recommended that where such specimen(s) constitute a component(s) of a specimen requiring pathologic examination, all of this material should be submitted);

    b. Therapeutic radioactive sources, the removal of which should be guided by radiation safety monitoring requirements;

    c. Foreign bodies (e.g., bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

    d. Certain specimens known rarely, if ever, to show pathological change, and the removal of which is highly visible post-operative, (e.g., foreskin from circumcision of newborn infants, tissue removed during nasal septoplasty, cosmetic surgery involving removal of essentially non-pathologic material);

e. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;

f. Teeth, provided the number, including fragments, are recorded in the medical record; and

g. Crystalline lenses removed following either intracapsular or extracapsular cataract removal; and in cases where no specimen was removed, the surgical case review is the responsibility of the individual department. Documentation should include the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative diagnosis.

17. Surgeons and all other personnel involved must be in the operating rooms and ready to begin operating at the time scheduled. The operating room will not be held longer than fifteen (15) minutes after the time scheduled.

18. Patients shall be discharged only on documented order of a Practitioner with such privileges who is responsible for the patient. At the time of discharge, the attending Practitioner or his/her designee shall take appropriate action to resolve all active orders, see that the record is complete, state the final diagnosis, and sign the record.

19. All inpatients must be seen by an attending physician (or a Certified Nurse Midwife for labor and delivery patients only) within 24 hours of admission and then daily by a Practitioner or resident/subspecialty resident. Inpatients who continue to require acute care must be seen and a progress note entered daily by a Practitioner or resident/subspecialty resident. On appropriate subacute services, if an inpatient is medically cleared for discharge to home or an extended care facility (as documented by the attending physician) but discharge has been delayed because of inadequate home support or placement at an appropriate facility, the patient must be seen and a progress note entered by a Practitioner or resident/subspecialty resident as needed based on the patient's condition but no less frequently than every 72 hours. A progress note shall be entered within the timeframe set by Hospital policy and countersigned by the attending physician if authored by a resident/subspecialty resident. The note should include the plan of care and reflect the active involvement of the attending Practitioner.

20. For each outpatient clinic visit, a Practitioner is responsible for the preparation of a complete visit record for each patient in accordance with Hospital policy. The attending Practitioner will ensure that s/he and all residents/subspecialty residents under the attending Practitioner's supervision have completed all chart requirements within the timeframes set by Hospital policy. Allied Health Professionals are also responsible for completing all chart requirements within the designated timeframes set by Hospital policy.

21. The attending Practitioner shall be held responsible for the preparation of a complete medical record for each patient in accordance with the completion requirements established by the Clinical Documentation Committee. The attending Practitioner shall ensure that s/he and all residents/subspecialty residents under his/her supervision have completed all chart requirements within the timeframe set by Hospital policy. Allied Health Professionals are also responsible for completing charts within the timeframe set by Hospital policy.

22. A discharge summary shall be documented for each patient in the medical record within the timeframe set by Hospital policy by a Practitioner with such privileges who is responsible for the patient, except as specified below. A Final Progress Note may be substituted for a discharge summary in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization and in the case of newborn infants and uncomplicated obstetrical deliveries. It will be the responsibility of the Clinical Documentation Committee to determine those specific situations which may be considered to be in this minor category.

23. All operations performed shall be fully documented by the operating surgeon. Operative reports shall be dictated or documented in the medical record within the timeframe set by Hospital policy and contain a description of the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants. If the report is not done, the Department Chair or Division Chief will be notified. A brief Operative Note shall be entered in the medical record within the timeframe set by Hospital policy if the full Operative Note is not completed prior to the next level of care, in order to provide pertinent information until the full Operative Note is completed.

24. A post-anesthesia evaluation shall be completed and documented by a Practitioner qualified to administer anesthesia within the time frame set by Hospital policy.

25. When an autopsy is performed, a provisional anatomic diagnosis is entered in the medical record within the timeframe set by Hospital policy. The final autopsy report will be considered delinquent if it has not been entered and signed, dated, and timed by the responsible pathologist within the time frame set by Hospital policy.

26. Each clinical Department Chair may administratively reassign the clinical duties of Practitioners and residents/subspecialty residents in that Department to enable those Practitioners and residents/subspecialty residents with delinquent medical records, as defined by the Clinical Documentation Committee, to complete such delinquent records. Each clinical Department Chair, or his/her designee, may also administratively reassign the clinical duties of Practitioners and resident/subspecialty residents to enable those Practitioners and residents/subspecialty residents who have not demonstrated compliance with OSHA, CDC or other Hospital safety requirements to demonstrate such compliance, or who have not maintained an individual DEA license. This procedure is an administrative mechanism, distinct from corrective action as authorized by the Bylaws. Such administrative reassignment shall not be considered Corrective Action or disciplinary action (as appropriate) against Practitioners or disciplinary action against a resident/subspecialty resident. However, repeated administrative reassignments that have the effect of being detrimental to the operations of the Hospital may subject a Practitioner to Corrective Action or disciplinary action (as appropriate) or a resident/subspecialty resident to disciplinary action. Pursuant to an administrative reassignment, Practitioners shall not be permitted to schedule new elective surgical procedures or to use the Emergency Department until all delinquent medical records are completed. A resident/subspecialty resident shall, among other appropriate actions, be removed from all clinical activities (subject to ACGME requirements) and be required to utilize annual leave (subject to ACGME requirements) until all delinquent medical records are completed.

27. No autopsy shall be performed without consent of the legally authorized individual. Generally, such permission should be in writing. However, consent may be obtained by telephone in accordance with Hospital policy. The Chair of the Department of Pathology and Laboratory Medicine, or his/her designated assistant, shall be responsible for the performance of all autopsies on patients dying in the Hospital, except in those cases where the Medical Examiner has jurisdiction.

28. Postmortem tissue and organ donation will be conducted in accordance with applicable law and Hospital policy. When a tissue or organ of the donor is to be removed for transplantation, and the death of the donor is established by a determination that the person has suffered a total and irreversible cessation of brain function, the pronouncement of death is made in accordance with Hospital policy. The Practitioners or residents/subspecialty residents making the determination of death shall not participate in the procedures for removing or transplanting a tissue or organ.

29. Consultation with the Obstetrical service is required when a known pregnant woman is admitted to a service other than Family Medicine or Obstetrics and Gynecology. A preoperative consultation with the Obstetrical service is also required when an inpatient or outpatient operative or other interventional procedure requiring moderate or deep sedation or anesthesia is planned for a known pregnant woman. This consultation should be requested at the time of surgical/procedure scheduling.

30. Except in an emergency or as otherwise stated in Hospital policy, consultations with another qualified physician are required in cases in which, according to the judgment of the physician:

    a. The patient is not a good candidate for operation or treatment;

    b. The diagnosis is obscure; or

    c. There is doubt as to the best therapeutic measure to be utilized. In general, only physicians who are members of the Medical Staff of the Hospital or properly supervised designees shall serve as consultants. However, in special situations, qualified physicians not on the Medical Staff of this Hospital may be invited to visit a patient, as well as observe the course of treatment, provided the Chair of the appropriate Department, the CMO, gives permission, and applicable Hospital policy is followed. Such a consultant shall not assume responsibilities for the patient. A member of the Medical Staff inviting such a consultant shall notify the Chair of the appropriate Department or the CMO in each case and shall assume responsibility for adherence to this rule.

    The patient's Practitioner is responsible for requesting consultations when indicated. It is the duty of the Medical Staff through its Department Chairs or Service Heads and MSEC to make certain that Practitioners do not fail in the matter of requesting consultations when needed.

    All patients for whom an inpatient consultation is requested shall be seen and examined by a Practitioner or resident/subspecialty resident. A consultation note must be documented in the medical record within the timeframe set by Hospital policy. The consultant's assessment should reflect the active involvement of the attending Practitioner, which may be in person or by phone. When operative procedures are

involved, the consultation note, except in emergency, shall be documented in the medical record prior to the operation.

31. Each Clinical Department must ensure the availability of schedules or instructions in WebXchange or equivalent that inform all members of the health care team of attending Practitioners and residents/subspecialty residents currently responsible for each patient's care.

32. Drugs used shall be among those listed in the Hospital Formulary as amended by the Pharmacy and Therapeutics Committee, with the exception of drugs for bona fide clinical investigations. Deviation from this rule shall be well justified and shall be reported to the Pharmacy and Therapeutics Committee for review. The metric system shall be used in prescription and drug orders. Nonproprietary (generic) rather than trade and proprietary nomenclature shall be used. However, certain products of multiple composition are metered in the Formulary under a recognized generic or trade name titled with the composition listed. The Department of Pharmacy may dispense the exact chemical equivalent (labeled in nonproprietary terms) for those drugs ordered under a trade or proprietary name in the treatment of inpatients and outpatients. However, if any Practitioner or resident/subspecialty resident considers an exception to this policy is indicated for a particular patient, s/he should consult with the senior pharmacist on duty. No abbreviations on the List of Prohibited Abbreviations shall be used in medication orders.

33. All Schedule II controlled substances and other drugs as recommended by the Pharmacy and Therapeutics Committee that are ordered without time limitations of dosage shall be automatically discontinued after seven (7) days. Drugs should not be discontinued without notifying the Practitioner or resident/subspecialty resident. If the order expires in the night, it should be continued until the next morning and called to the attention of the Practitioner or resident/subspecialty resident the following morning.

34. Mass Casualty Assignments. Practitioners and residents/subspecialty residents shall be assigned responsibilities as defined in the Hospital's Disaster Plan.

35. Other rules which have been adopted by MSEC will be found in the Hospital Policy Manual.

Amendments

These *Rules and Regulations* may be amended as provided in the Medical Staff Bylaws.