



Kaleida Health

# **RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF OF KALEIDA HEALTH**

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## Table of Contents

<b>SECTION I</b>		<b>GENERAL RULES OF CONDUCT</b>	
A.	Kaleida Health Policies and Procedures . . . . .	4	
B.	Mandatory Reporting . . . . .	4	
C.	Confidentiality . . . . .	4	
D.	Clinical Service Rules and Regulations . . . . .	4	
E.	Patient Care Responsibilities . . . . .	5	
	1. General Responsibility . . . . .	5	
	2. Transfer of Responsibility . . . . .	5	5
	3. Alternate Coverage . . . . .	5	
	4. Timely Visitation After Admission . . . . .	5	
	5. Infection Control . . . . .	5	
	6. Medical Screening Examination . . . . .	5	
F.	Consent . . . . .	5	
	1. Consent and Treatment . . . . .	5	
	2. Health Information Privacy Consent/Authorization . . . . .	5	
G.	Orders . . . . .	6	
	1. Written Orders . . . . .	6	
	2. Standing Orders . . . . .	6	6
	3. Verbal Orders . . . . .	6	
	4. Do Not Resuscitate Orders . . . . .	6	
	5. Automatic Cancellation of Orders . . . . .	6	
	6. Health Care Declarations . . . . .	6	
H.	Consultations . . . . .	6	
	1. Responsibility . . . . .	6	
	2. Criteria . . . . .	6	
	3. Qualification and Report . . . . .	6	
I.	Research and Use of Investigational Drugs . . . . .	7	
<b>SECTION II</b>		<b>ADMISSION AND DISCHARGE OF PATIENTS</b>	
A.	Non-Discrimination . . . . .	7	
B.	Admission of Patients . . . . .	7	
	1. Authority to Admit . . . . .	7	
	2. Emergency Admissions . . . . .	7	
	3. Protection of Patients and Other Persons . . . . .	7	
C.	Discharge of Patients . . . . .	8	
D.	Transfer of Patients to Other Facilities . . . . .	8	

E.	Leaving Against Medical Advice .....	8
SECTION III DEATHS AND AUTOPSIES		
A	Pronouncement and Reporting of Deaths .....	8
B.	Autopsies .....	8
C.	Organs and Tissue Donation. ....	8
SECTION IV MEDICAL RECORDS		
A.	Responsibility/General Content .....	9
B.	Symbols and Abbreviations .....	9
C.	Documentation .....	9
	1. History and Physical Examination .....	9
	2. Progress Notes .....	10
	3. Pre-Operative Notes/Operative Reports .....	10
	4. Post Operative Documentation .....	10
	5. Entries at Conclusion of Hospitalization. ....	10
D.	Ambulatory Care Services .....	10
E.	Access to Records .....	10
F.	Non-Compliance .....	10
SECTION V SUPERVISION		
A.	Medical/Dental Students .....	10
B.	Residents .....	10
C	Other Students .....	11
AMENDMENTS .....		12

**RULES AND REGULATIONS OF THE  
MEDICAL AND DENTAL STAFF OF KALEIDA HEALTH**

## SECTION I GENERAL RULES OF CONDUCT

### I. A. KALEIDA Health Policies and Procedures

KALEIDA Health has adopted written policies and procedures to govern the conduct of patient care in the Hospital and to assure compliance with Federal and State law. These include, but are not limited to:

1. DNR Orders, Advance Directives
2. Patient Rights
3. Investigational Drugs & Procedures
4. Restraint
5. Harassment
6. Organ & Tissue Procurement
7. Brain Death Criteria
8. Patient Transfers
9. Consents
10. Disaster Plan
11. HIV & AIDS Related Information

A copy of the KALEIDA Health Policy and Procedure Manual is available at all times via KaleidaScope. It is the responsibility of each Staff Member to know the location of the KALEIDA Health Policy and Procedure Manual and to consult and comply with the relevant KALEIDA Health Policy and Procedures in performing patient care activities in the Hospital. All capitalized terms used in these rules and regulations shall have the meanings given to such terms in the Bylaws of the Medical and Dental Staff of KALEIDA Health.

### I. B. Mandatory Reporting

It is the responsibility of each Staff Member, working in collaboration with the appropriate Hospital representatives, to notify the appropriate regulatory agency regarding all reportable conditions. Staff Members are required to comply with all current State, Federal, and KALEIDA Policies and Procedures with regard to reportable conditions.

Reportable conditions include, but are not limited to:

1. Infectious/communicable diseases at the time of clinical diagnosis
2. Child abuse, neglect
3. Incidents

### I. C. Confidentiality and Privacy of Medical Records

All Staff Members and their respective employees and agents shall maintain the confidentiality, privacy, security, and availability of all Protected Health Information maintained by KALEIDA Health, or by business associates of KALEIDA Health, in accordance with any and all health information policies adopted by KALEIDA Health to comply with current federal, state, and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected Health Information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of KALEIDA Health and HIPAA.

### I. D. Clinical Service Rules and Regulations

Each Clinical Service ("Service") shall adopt written rules and regulations governing the operation of the Service and the conduct of patient care activities in the Service. The MEC will approve each Clinical Service Rules and Regulations and any subsequent changes or additions to the Rules and Regulations. These rules shall, at a minimum, include requirements for supervision, as appropriate, of residents, medical students, physicians with limited permits, and Advanced Practice Providers. On-call schedule requirements will be Service specific and stated in the Service rules and regulations. The on call listing must include the doctor's name, contact information and pager number. It is the responsibility of each Staff Member to know and comply with the rules and regulations of the Service to which he/she is assigned and in which he/she conducts patient care activities.

A staff member on call for either Buffalo General Medical Center or Women and Children's Hospital of Buffalo is responsible for providing coverage within their specialty to both campuses. If the on call staff member is not able to

provide a consult, it is their responsibility to obtain a qualified consulting physician and verify that the consult is completed.

I. E. Patient Care Responsibilities

1. General Responsibility. The attending Staff Member is responsible for the medical care and treatment of his/her patient in the Hospital, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician, if any, and to other appropriate persons, subject to all applicable legal requirements regarding the confidentiality of medical information and records.
2. Transfer of Responsibility. If primary responsibility for a patient's care is transferred, a note documenting the transfer of responsibility and acceptance of it must be entered in the patient's medical record. If the patient requests a transfer of care, the attending Staff Member shall cooperate to assure continuity of care.
3. Alternate Coverage. Each Staff Member must insure timely, adequate, professional care for his or her patients in the Hospital by being available to provide such care and by designating an appropriately privileged Staff Member ("Alternate Staff Member") to care for the patient in the absence of the attending Staff Member. If an Alternate Staff Member is unavailable or not designated, the President of the Staff, Chief Executive Officer or applicable Clinical Director may assign any qualified Staff Member to provide necessary care to the patient.
4. Timely Visitation After Admission. An attending Staff Member, or Alternate Staff Member, must see his/her patient within twenty-four (24) hours of admission or within such shorter time period as necessitated by the patient's condition. Thereafter, and throughout the patient's hospital stay, the attending Staff Member or Alternate Staff Member must see his/her acute care patient as often as necessary based upon the patient's condition, but at least once during every twenty-four(24) hour period. Subject to applicable law and regulations, a nurse practitioner or physician's assistant may substitute for the Staff Member on alternate days, but only if the patient is clearly stable (according to standards set by the clinical service) and the nurse practitioner or physician's assistant documents discussion of the plan of care with the Staff Member.
5. Infection Control. Insofar as it is practicable, the admitting Staff Member shall obtain information from the patient concerning signs or symptoms of recent exposure to communicable or infectious disease. It is the attending Staff Member's responsibility to insure that any patient with a known or suspected infectious disease is managed in accordance with the KALEIDA Health Policy and Procedure on infection control.
6. Medical Screening Examination. The initial and on-going evaluation of the presenting patient shall be conducted by Qualified Medical Personnel including Physicians, Physician Assistants, appropriately credentialed and supervised residents, certified advance practice nurses or certified nurse midwives. The medical screening examination includes a history and physical examination/evaluation of the patient, as well as appropriate testing, within the capabilities of the hospital utilizing the facilities routinely available including the use of on-call physicians, as appropriate, to determine whether or not the patient has an emergency medical condition. Completion of appropriate documentation regarding the medical screening examination is also required and must reflect the on-going evaluation of the patient.

I. F. Consent

1. Consent and Treatment. A general treatment consent form, signed by each patient or his or her legal representative, must be included in the patient's medical record. Prior to performing specific diagnostic and treatment procedures or services, a Staff Member shall obtain informed consent pursuant to and in compliance with Service rules and regulations and the relevant KALEIDA Health Policy and Procedure. Informed consent must be documented in the patient's medical record.
2. Health Information Privacy Consent/Authorization. Staff members and their respective employees and agents shall cooperate with KALEIDA Health personnel in obtaining and maintaining in the medical record any and all consents and/or patient authorizations required under any and all health information privacy policies adopted by KALEIDA Health to comply with current federal, state, and local laws and regulations, including, but not limited to HIPAA.

I. G. Orders

1. Written Orders. Use of Computerized Physician Order Entry (CPOE) is mandatory. All orders for treatment or diagnostic tests must be accurately entered electronically in the electronic health record (EHR). When the EHR is not available, paper orders must be written legibly and completely and shall include the date, time, title/status (e.g. M.D., D.D.S., D.P.M, resident, medical student, etc) and the signature of the Staff Member or practitioner responsible for the order or an appropriately privileged staff member within the physician practice who is responsible for the care of that patient.

2. Standing Orders. Standing orders may be developed by the appropriate health care teams, in consultation with Staff Members and other practitioners involved in the care of patients, and approved by the Medical Executive Committee in order to standardize certain procedures in a Service or specialty unit. Standing orders are subject to periodic review by the Medical Executive Committee, as appropriate.

3. Verbal Orders. Telephone or other verbal orders should be used sparingly and shall be accepted only by a registered nurse or pharmacist or such other licensed practitioner as permitted by regulation or law. All verbal orders shall be transcribed immediately in a medical record entry, which shall include the date, time, name, title/status (e.g.. M.D., D.D.S., D.P.M., nurse, resident, pharmacist, etc.) and signature of the person transcribing the order and the name of the prescribing practitioner and shall be authenticated by the prescribing practitioner or an appropriately privileged staff member within the physician practice who is responsible for the care of that patient as soon as possible, in accordance with policies and procedure. Verbal orders shall not be accepted when the prescribing practitioner is present and able to write and sign the order, except in an emergency.

4. Do Not Resuscitate Orders. A do not resuscitate order ("DNR Order") shall be made only in conformance with the applicable KALEIDA Health Policy and Procedure. Staff Members should consult the KALEIDA Health Policy and Procedure Manual to determine the circumstances under which a DNR Order may be written and the documentation required for such an order.

5. Automatic Cancellation of Orders. With the exception of a DNR Order, when a patient undergoes an operative procedure, all previous orders are canceled. Orders must be rewritten after each operative procedure. With respect to DNR Orders, Staff Members should consult the applicable KALEIDA Health Policy and Procedure.

6. Health Care Declarations. Each Staff Member shall determine whether his/her patient has executed a living will, advance directive or health care proxy appointing a health care agent or surrogate and shall carefully review any such written declaration and any other relevant evidence of the patient's wishes with respect to treatment. A copy of any such written declaration shall be placed in the patient's medical record or, if unavailable, appropriate notation shall be made in the patient's medical record. Staff Members should consult the KALEIDA Health Policy and Procedure on Health Care Declarations and may request consultation with the Hospital's Ethics Committee and Medical Director if there is disagreement or uncertainty about a patient's wishes with respect to treatment.

#### I. H. Consultations

Responsibility. The attending staff member is primarily responsible for requesting a consultation when indicated or required pursuant to the guidelines herein. Nurse practitioners, physician assistants and residents may order consults. The Medical Staff President, Chief Medical Officer or appropriate Chief of Service may order a needed consult if the attending staff member has failed to do so. The staff member requesting the consult must indicate the reason for which the consult is being requested. A STAT consult requires a personal call from the requesting staff member to the consulting physicians to convey relevant history and verify that the consult is needed on a STAT basis. If it is determined that the patient warrants urgent evaluation, but does not need to be seen within one hours, a mutually acceptable time frame in which the consult must be done will be established.

Criteria. In general consultation is required if significant question exists as to the diagnosis or the best or most appropriate procedure or therapy to utilize; or the necessary treatment falls outside of the attending staff member's privileges.

Qualifications and Report. A consultant must be qualified to give an opinion in the field in which his or her opinion is being sought based upon his or her clinical delineation of privileges. The consultant shall document and sign a report of findings, opinions and recommendations. The consult report must include relevant history and a physical exam

performed by the consultant, documented in sufficient detail to support the consultant's conclusions. The consultant's report shall be completed and placed in the patient's medical record within 24 hours of the request for such consultation. If the report is dictated, but not recorded in the patient's chart, a brief note must be placed in the chart at the time of evaluation to that effect and a note summarizing the consultant's findings must be made in the chart within the 24 hour period. If a consult is requested STAT, the consultant must respond to the call within 30 minutes, and must be physically present to evaluate the patient within one hour. If the consultant is recommending urgent interventions for a patient seen for either a routine or STAT consult, a personal phone call shall be immediately placed to the staff member who requested the consult to convey those recommendations.

**Upon completion of the consultation the CONSULT SERVICE will be responsible for**

1. Direct real time communication (phone call/ encrypted communication) with the referring service to relay their recommendations
2. Ask the referring service if they prefer to enter the order themselves or have the consulting service place them
3. Orders must be placed by either provider as agreed upon at the time of the consultation. Delays in placing orders creates risk for patients.

**Upon receipt of the recommendations the REFERRING SERVICE will be responsible for**

1. Acknowledging receipt of the recommendations
2. Respond if they will place the orders or direct the consulting service to do so after ensuring there are no contraindications or conflicting/interacting orders

**Consulting services must explicitly state when they are signing off on a patient's case,** to make it clear that they will no longer provide further guidance or recommendations

**I. I. Research and Use of Investigational Drugs**

Staff Members who conduct or propose to conduct research on patients or other human subjects, tissue, or medical records, shall comply with the appropriate Institutional Review Board guidelines and with KALEIDA Health Policy and Procedure for the protection of human subjects. Investigational drugs may be used only in accordance with all pertinent Federal and State regulations and current KALEIDA Health Policy and Procedures.

**SECTION II ADMISSION AND DISCHARGE OF PATIENTS**

**II. A. Non-discrimination**

Patients will be admitted without regard to race, creed, color, religion, national origin, sex, sexual orientation, gender identity or expression, physical appearance, source of payment, age or disability within the capacity of the Hospital to accommodate.

**II. B. Admission of Patients**

1. Authority to Admit. Patients may be admitted to the Hospital only by Staff Members with admitting privileges or others who have been granted admitting privileges by the KALEIDA Health Board of Directors. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been established and noted in the patient's medical record. In the case of an emergency, such statement shall be recorded as soon as possible after admission.
2. Emergency Admissions. Emergency patients may be admitted upon the request of the attending Staff Member at any time. A patient to be admitted on an emergency basis, who does not have a personal physician or dentist, may request any Staff Member with admitting privileges of the applicable service to attend him/her. If no such selection is made, or the request is denied, the patient will be assigned to a designated Staff Member with admitting privileges on the appropriate Service.
3. Protection of Patients and Other Persons. Members are responsible for taking such action as may be necessary, and permitted by law, to protect the patient and other persons from a patient who may be a source of danger.

## II. C. Discharge of Patients

Patients may be discharged only on the order of an attending Staff Member or other appropriate practitioner who is privileged to do so.

## II. D. Transfer of Patients to Other Facilities

The transfer of a patient to another facility shall be accomplished in accordance with the provisions of the KALEIDA Health Policy and Procedure on Patient Transfers and Medical Screening and the applicable provisions of Federal and State law. Generally, a patient shall be transferred to another medical care facility only upon the order of the attending Staff Member and only after (i) the patient has received an appropriate medical screening examination (which shall include a history and physical examination/evaluation) conducted by a physician, physician assistant, resident, or certified advance practice nurse; and (ii) the patient is considered sufficiently stabilized for transfer, or as provided in the Policy and Procedure on Patient Transfers and Medical Screening, a transfer is medically necessary; and (iii) reasonable steps have been taken to secure the patient's written informed consent; and (iv) arrangements have been made with the other facility, including communication between the Staff Member and the receiving physician and consent by the receiving physician and facility to accept the patient. All pertinent medical information necessary to insure continuity of care must accompany the patient.

## II. E. Leaving Against Medical Advice

If a patient desires to leave the Hospital against the advice of the attending Staff Member or without proper discharge or transfer instructions, the patient will be requested to sign an appropriate release attested by the patient or legal representative and witnessed by a third party. A notation of the incident must be made in the patient's medical record including documentation of the advice given and the refusal to comply.

# SECTION III DEATHS AND AUTOPSIES

## III. A. Pronouncement and Reporting of Deaths

In the event of the death of a patient in the Hospital, the patient shall be pronounced dead within a reasonable period of time by a Nurse Practitioner, Physician Assistant or the attending Staff Member (or his or her designee,) except that in the case of brain death, the patient shall be pronounced dead by a physician with privileges to determine brain death. If necessary, the death shall be reported to the medical examiner's/coroner's office in accordance with the provisions of KALEIDA Health Policy and Procedure on this issue. A death certificate must be signed by a Nurse Practitioner, Physician Assistant, an attending Staff Member or an appropriately privileged physician acting on his/her behalf, except in those cases where such a certificate is issued by the medical examiner/coroner. A death certificate must be promptly signed in accordance with the legal requirement that such certificate must be filed with the appropriate governmental authority within 72 hours of death. A body may not be released from the Hospital until an entry verifying death has been made in the medical record of the deceased patient and signed by a Staff Member.

## III. B. Autopsies

It is the responsibility of every Staff Member to attempt to secure permission for autopsies in all cases of unusual death or where an autopsy would be of medical/legal or educational value. Proper consent for an autopsy shall be obtained and documented in accordance with the KALEIDA Health Policy and Procedure on autopsies and applicable law.

## III. C. Organs and Tissue Donation

KALEIDA Health has a legal obligation to notify a federally designated Organ Procurement Organization of all imminent or actual deaths in the Hospital. It is the responsibility of every Staff Member to consult and comply with the provisions of the KALEIDA Health Policy and Procedure on organ and tissue donations.



## SECTION IV MEDICAL RECORDS

### IV. A. Responsibility/General Content

The attending Staff Member is responsible for the prompt preparation of a complete, accurate and legible medical record for each patient. The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify admission and continued hospitalization and treatment, describe the patient's progress and response to medications and services, and promote continuity of care among health care providers. All medical record entries must be dated, timed and authenticated by their authors. The author of each entry shall be identified by name and status/title (e.g. M.D., D.D.S., D.P.M., resident, medical student, etc.).

### IV. B. Symbols and Abbreviations

Symbols and abbreviations may be used in a medical record only when they have been approved by the Medical Executive Committee.

### IV. C. Documentation

1. History and Physical Examination: Every inpatient or ambulatory surgery patient shall have a history taken and physical examination performed by an appropriately credentialed practitioner (includes Physicians, Physician Assistants, appropriately credentialed and supervised residents, advance practice nurses, or certified nurse midwives (who admits under the auspices of a medical staff member)) within seven (7) days before or within twenty-four (24) hours after admission. History and physical exams recorded by a Physician Assistant, resident, advance practice nurses or certified nurse midwife (who admits under the auspices of a medical staff member) must be co-signed or attested to in the medical record by the attending medical staff member or alternate staff member. If the history and physical examination findings have been dictated but are not yet available in the chart, a statement to that effect and a note summarizing the pertinent facts and findings, provisional diagnosis and treatment plan must be made in the chart within twenty-four (24) hours following admission.

If the findings of a history and physical examination performed more than seven (7) days before admission accurately reflect the patient's condition at admission, such prior history and physical examination may be utilized for that admission so long as a copy of such prior history and physical examination is immediately placed in the patient's chart and a note which confirms that the information is current and accurate is made in the chart by the attending Staff Member. If a patient is readmitted within thirty (30) days, an interval history and physical examination reflecting subsequent history and changes in physical findings may be used, provided the original history and physical examination is readily available.

At a minimum, the history and physical must include:

- a. Chief Complaint (CC) – The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, which may be stated in the patient's own words.
- b. History of Present Illness (HPI) – The HPI is a chronological description of the development of the patient's present illness to include signs/symptoms or recent changes from the previous encounter to the present.
- c. Past Medical History (PMH) – The patient's past experiences with illnesses, operations, injuries, and treatments.
- d. Medications – All medications on admission are listed on the Medication Reconciliation Form. The provider is not required to re-write the list in the H&P.
- e. Allergies – All allergies are to be documented on the reconciliation form. The provider is not required to re-write the list in the H&P, but must reconcile the H&P list with the admission Medication Reconciliation Form.
- f. Physical Examination – The type and context of the examination are selected by the examining LIP is based upon clinical judgment, the patient's history and the nature of the presenting problem(s)
- g. Assessment – Document the list of problems and differential diagnosis.
- h. Plan of Care – Documentation is to include the plan for laboratory and radiology investigations and consultations as appropriate.

The extent of history of present illness, review of systems and past, family and/or social history that is obtained and documented is dependent on the clinical judgment and nature of the presenting problem(s). The content of a history and physical examination for the purpose of providing minor procedural care or moderate sedation will contain the elements listed above, with relevance to the nature of the planned intervention.

2. Progress Notes: Progress notes shall be written at least daily on acute care patients and at a frequency as required by law for other patients. Pertinent progress notes shall reflect attention to clinical and laboratory findings and shall be recorded at the time of observation by the attending physician or designee. Clinical problems, interpretations of tests, and treatment plans shall be recorded.

3. Pre-Operative Notes/Operative Reports: The medical record will thoroughly document all operative and other procedures and the use of anesthesia. A pre-operative diagnosis will be recorded prior to surgery by the attending Staff Member responsible for the patient. Operative reports shall be dictated or written immediately after surgery and shall record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed and post-operative diagnosis. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. In case of an emergency, when the operative report is not placed in the medical record immediately after surgery, a progress note must be entered immediately.

4. Post-Operative Documentation: Post-operative documentation shall include the patient's vital signs, level of consciousness, medications (including intravenous fluids), blood, and blood components, any unusual events or post-operative complications, and management of such events.

5. Entries at Conclusion of Hospitalization: The medical record must note the final diagnosis, final disposition, condition at discharge, and instructions for follow-up care, and must be completed by the attending Staff Member within thirty (30) days following the date of discharge. When emergency care is provided, the time and means of arrival are also to be documented in the medical record.

#### IV. D. Ambulatory Care Services

For patients receiving continuing ambulatory care services, the medical record must contain a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications with this list being initiated for each patient by the third visit and maintained thereafter.

#### IV. E. Access to Records

All medical records are the property of KALEIDA Health. Access to such records shall be in accordance with KALEIDA Health Policy and Procedure, which shall reflect the requirements of applicable State and Federal statutes and regulations.

#### IV. F. Non-Compliance

Failure to maintain appropriate medical records will subject the responsible Staff Member to possible disciplinary action according to the KALEIDA Health Policy and Procedure on medical records approved by the Medical Executive Committee.

### SECTION V SUPERVISION

#### V. A. Medical/Dental Students

Medical/Dental students may take patient histories, perform complete physical examinations and enter findings in the medical record of the patient with the approval of the patient's attending Staff Member. All medical/dental student entries in the medical record must be countersigned within twenty-four(24) hours by an appropriately privileged Staff Member.

Student privileges shall be limited to those delineated and conferred by the University designee, under the auspices of the School of Medicine and Biomedical Sciences or School of Dental Medicine, State University of New York at Buffalo. The patient shall be informed that the individual performing a procedure is a student in all such cases. All Medical/Dental student activity must conform to applicable KALEIDA Health Policies and Procedures.

#### V. B. Residents

Residents will function under the supervision of a Staff Member. Decisions in regard to patient care management will be under the supervision of the attending Staff Member. Overall coordination of resident activity will be provided by the residency program director or designee. Participation of residents will be in conformance with the policies and

regulations of the Graduate Medical/Dental Education Consortium of Buffalo, the KALEIDA Health, and all relevant regulatory agencies.

Documentation of attending Staff Member supervision of the patient care provided by residents must include as a minimum:

Documentation of attending Staff Member supervision of the patient care provided by residents must include at a minimum: (a) the teaching physician was present at the time the service was furnished; (b) the presence of the teaching physician during procedures is documented by the physician or resident in the procedure record or an addendum to the procedure record; and (c) in evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical record (42 CFR 415.172(b)).

#### V. C. Other Students

Staff Members may be requested to participate and provide supervision to students in health related professions. All such student activity must comply with applicable KALEIDA Health Policies and Procedures.