MEDICAL STAFF
RULES & REGULATIONS

RULES & REGULATIONS OF THE MEDICAL STAFF APPROVALS

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UH AHUJA MEDICAL CENTER
RULES & REGULATIONS

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DEFINITIONS

1. ***Board of Directors*** refers to the Board of Directors of UH Ahuja Medical Center
2. ***Hospital*** refers to UH Ahuja Medical Center.
3. ***Medical Staff or Staff*** refers to duly licensed physicians, dentists, oral and maxillofacial surgeons, psychologists, midwives, podiatrists, and other licensed independent practitioners who are members of the active, associate, courtesy, consulting, and house staff of UH Ahuja Medical Center and participate in the care of patients at UH Ahuja Medical Center.
4. ***Practitioner*** means a member of the medical staff.

ARTICLE I: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

1.1 GENERAL RESPONSIBILITY

A physician member of the medical staff shall be responsible for the medical care including diagnosis and treatment of each patient in the hospital, for the prompt completion and accuracy of those portions of the medical record for which he/she is responsible and for writing orders. Patients and, when appropriate, their designees/legal guardians, are informed about the outcomes of care, including unanticipated outcomes.

Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved patient safety. In order to continually improve the effectiveness of communication among caregivers, a standardized "hand off" communication approach is expected. "Hand off" communications are interactive communications allowing the opportunity for questioning between the giver and receiver of patient information. Examples include but are not limited to: Physicians transferring complete responsibility for patients; physicians transferring on-call responsibilities; anesthesiologist report to PACU nurse; Nursing and Physician hand off from the Emergency Department to inpatient units, different hospitals, nursing homes and Home Health care.

1.2 LEGIBILITY

Any and all information entered into the medical record should be legible. For patient safety, orders will not be carried out unless they are legible. Ordering physician will be contacted for clarification of any illegible orders and entries. The house officer on duty will be contacted to manage critical situations until the ordering physician can be reached. Legibility efforts will be monitored ongoing. In the event an order cannot be implemented because it is not legible and the ordering physician is not physically present, the designated licensed employee (RN, RT, Pharmacist, etc.) will contact the physician to obtain clarification and write a clarification order.

Documentation by practitioners is expected to be consistent with the National Patient Safety Goals as they relate to the use of approved abbreviations. On-going monitoring on the use of non-approved abbreviations will be done on a regular basis and reported to pertinent medical staff committees for appropriate action and considered at reappointment for each practitioner.

1.3 MEDICATION RECONCILIATION

Medication reconciliation is an interdisciplinary process between physicians, nursing and pharmacy to create and evaluate an accurate and complete listing of patient prescribed and over the counter medications, and herbal and supplement products. Medication reconciliation is designed to decrease medication adverse events across the continuum of care by review on admission, transfer or discharge to another setting, service, practitioner or level of care within or outside the organization.

Practitioner participation and documentation is expected in accordance with the National Patient Safety Goals. Ongoing monitoring on participation with the medication reconciliation process will be done on a regular basis and reported to pertinent medical staff committees for appropriate action and considered at reappointment for each practitioner.

1.4 ALTERNATE COVERAGE

Each attending physician must assure timely, adequate professional care for his/her patients in the hospital by being available or designating a qualified alternate physician with whom prior arrangements have been made and who has requisite clinical privileges at this hospital to care for the patient.

In the absence of such designation, the department chair has the authority and responsibility to call any member of the medical staff with requisite clinical privileges to intervene on the patient's behalf. Failure of an attending physician to meet these requirements may result in a recommendation for action as deemed appropriate by the Executive Committee of the Medical Staff.

1.5 DENTISTS, ORAL AND MAXILLOFACIAL SURGEONS, PODIATRISTS, PSYCHOLOGISTS AND OTHER HEALTH PROFESSIONALS

Dentists, oral and maxillofacial surgeons, podiatrists, psychologists and other health professionals may treat patients according to the conditions set forth in the UH Ahuja Medical Center Bylaws. Each such practitioner is responsible for documenting a complete and accurate description of the services provided to the patient.

1.6 CONSULTATIONS

1.6.1 Responsibility for initiating

a) The physician is responsible for initiating consultations and must specify:
   1) Reason for consultation
   2) Timeframe in which to see patient
      a. Routine – within 24 hours
      b. Emergent
   3) Physician requested
   4) Level of management

1.6.2 Guidelines for consultations

a) Indications for consultations shall include:

1) When the patient demonstrates severe psychiatric symptoms including suicidal tendencies and the attending physician is not a psychiatrist;
2) When requested by the patient or next of kin;
3) When there is difficulty in making a diagnosis;
4) When there is difficulty in deciding on appropriate treatment; or
5) When specific skills of other practitioners are needed in unusually complicated situations.

1.6.3 Documentation of consultation

a) Consultation request - The physician requesting consultation must write an order for the consultation, including the indications for the consultation and the time-frame in which the consultation must take place as outlined in article 1.5.1.

1.7 CONTINUING CARE PLANNING

It is a responsibility of the attending physician to ensure that his/her patients have the benefits of appropriate continuing medical care. Continuing care planning is a coordinated process of activities that involves the patient and health providers working together to facilitate the transition of health care delivery from one environment and/or provider to another. This planning includes decisions about self-care, home health care, unit or facility transfer, ambulatory services, and use of other community resources.

1.8 EMERGENCY MEDICAL SCREENING EXAMINATION – QUALIFIED MEDICAL PERSONNEL

A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under a valid agreement a physician member of the Hospital's medical staff:

- Certified nurse practitioners;
- Certified nurse midwives (obstetrics only);
- Physician Assistants

1.8.1 For non-resident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes and approval set forth in the Medical Staff Bylaws.

1.9 EMERGENCY CARE

The Medical Staff acknowledges that the Hospital has a legal responsibility to provide call coverage for those services for which Hospital provides inpatient coverage. The Medical Staff further acknowledges that in order for Hospital to meet its legal requirements, the Medical Staff must use its best efforts to ensure proper review, monitoring and implementation of a meaningful call-coverage policy which includes, without limitation, ensuring the availability of physicians to take and respond to emergency calls and to implement back-up procedures when physicians are unavailable (due to reasons beyond their control) to take or respond to emergency calls. "On Call" duties come with the

privilege of practicing as an Active Member and/or a Courtesy Staff Member of the Medical Staff. "On Call" physicians must comply with all requirements of the Emergency Medical Treatment and Labor Act ("EMTALA") and the Medical Staff's approved policies and protocols relating to "On Call" coverage and emergency department operations in order to remain an Active Member or a Courtesy Staff Member of the Hospital. Failure to comply with such requirements may be immediate grounds for summary suspension of any non-compliant physician pursuant to Article XI, Section C of the Hospital's Medical Staff Bylaws.

As further delineated in hospital policies and protocols, on call responsibility means that in the event the on-call physician is requested to attend a patient in the emergency room he/she will respond in a timely and appropriate manner. Refusal of an applicable Medical Staff member to comply herewith or to allow himself or herself to be placed on the on-call rotation schedule or refusal (without adequate justification as determined by the Medical Executive Committee and the President of the Hospital) to attend a patient in the emergency room when called to do so, will result in an investigation by an ad hoc committee as appointed by the President of the Medical Staff and, as discussed above, may also be grounds for summary suspension pursuant to Article XI, Section C of the Hospital's Medical Staff Bylaws. The Medical Executive Committee may enact any of the disciplinary options available to it under the Medical Staff Bylaws, Rules and Regulations.

1.10 INPATIENT MEDICAL RECORDS

1.10.1 Required content

a) The attending physician shall be responsible for the preparation of a complete, legible medical record. Medical record entries shall be pertinent, accurate, timely and current. The medical record shall include:
   1) Identification data including the patient's name, address, date of birth, and the name of any legally authorized representatives.
   2) Emergency care provided prior to arrival, if any.
   3) The record and findings of the patient's assessment.
   4) A statement of the conclusions or impressions drawn from the medical history and physical examination.
   5) The diagnosis or diagnostic impression.
   6) The reason or reasons for admission or treatment.
   7) The goals of treatment and the treatment plan.
   8) Determination of the presence or absence of advance directives, and/or DNR status and copies of them if they have been provided.
   9) Evidence of informed consent for surgical procedures or other invasive procedures, anesthesia, sedation and blood/blood components.
   10) Diagnostic and therapeutic orders.
   11) All diagnostic and therapeutic procedures and tests performed and the results.
   12) All operative and other invasive procedures performed using

acceptable disease and operative terminology that include etiology as appropriate.

13) Progress notes made by medical staff and the interdisciplinary team.
14) All reassessments when necessary.
15) Clinical observations.
16) The response to the care provided.
17) Consultation reports.
18) Every medication ordered and/or prescribed for an inpatient during the period of hospitalization as well as the indication for each medication, including herbal medications.
19) Every dose of medication administered and any adverse drug reactions.
20) Every medication dispensed to or prescribed for an ambulatory patient or inpatient on discharge.
21) All relevant diagnoses established during the course of care.
22) Any referrals and communications made to external or internal care providers and to community agencies.
23) Documentation of patient education.
24) AJCC Staging Form, as applicable

1.11 IMMUNIZATIONS

All medical staff members and allied health professionals, who provide patient care, must present a statement confirming that they have been tested for tuberculosis and have a negative skin test within the past 12 months, or a recent chest X-ray indicating no active disease, if they have tested positive, have received the BCG vaccine or are allergic. Those physicians providing a chest x-ray for these purposes must also include a statement attesting that they are free and clear of TB symptoms. Hepatitis B vaccination is encouraged for all members of the medical staff.

1.12 ELECTRONIC SIGNATURE

a) Medical Staff members may obtain and utilize electronic signatures provided that all of the following criteria are satisfied:
   1) The confidentiality of the electronic signature and the record or document to which it pertains is ensured
   2) The use of electronic signatures is in compliance with all applicable laws, regulations and hospital policies
   3) The use of the electronic signature is limited to the following:
      a. Approval of history and physical examinations, operative reports, clinical resume/discharge summaries, face sheets/attestation sheets
      b. Approval of Medical Staff policies and procedures
      c. Approval of documents pertaining to Medical Staff and/or hospital committee meetings held in the ordinary course of business
      d. Authentication of procedure reports generated by or pertaining to members of the departments/divisions set forth in

Section 3.3 of the Medical Staff Bylaws.

ARTICLE II: EMERGENCY DEPARTMENT PHYSICIANS

2.1 Qualifications and credentialing for Emergency Department physicians are outlined in the Medical Staff Bylaws.

2.2 At the termination of their services to the Hospital in the capacity of Emergency Department physicians, all of their associations, rights and privileges with the medical staff shall be automatically terminated. This does not preclude the application for medical staff privileges through the established mechanism as outlined in the Bylaws.

2.3 Under special circumstances Emergency Department physicians may assist House Physicians in critical situations with hospital patients.

2.4 Emergency Department physicians shall care for the patients in the Emergency Room and such other duties as determined by the Emergency Room Service.

ARTICLE III: ADMISSION OF PATIENTS

3.1 ADMITTING RIGHTS

Patients may be admitted to the hospital only by members of the medical staff, in good standing, with admitting privileges as defined in the Bylaws of the Medical Staff.

3.2 At times of full hospital occupancy or shortage of hospital beds or other facilities as determined by the Chief Executive Officer or his/her designee, priorities among various patient categories for access to beds, services or facilities shall be in the following order:

a) Acute emergency patients;
b) Transfers out of Intensive Care or Special Care Unit;
c) Same day surgical admissions;
d) Elective medical admissions;
e) Elective surgical admissions

When two or more members of the medical staff have made a reservation for an elective admission, and all such reservations cannot be accommodated, priority is determined by the diagnosis and nature of the procedure. The decision as to preference will be made by the Chief of Staff or in his/her absence, the hospital President.

3.3 Except as outlined below, all admissions will be under the name of one specific member of the medical staff having appropriate privileges and in good standing.

When podiatrists or dentists admit a patient there will be an M.D. or D.O. who will co-admit these patients as described in the Bylaws. The admitting physician will bear the responsibility for the patient and his/her records and orders. No physicians having admitting privileges will admit to another practitioner's service or in another practitioner's name unless while providing temporary, prearranged coverage for another physician in good standing. In such case, the admitting order may be signed as for

example, "*Admit to Dr. Smith's service per Dr. Jones.*" While it is recognized that some physicians may operate their practices as a team, partnership, incorporation, etc., it is necessary that one specific individual be designated as having responsibility for the patient.

3.4 No patient shall be admitted to the hospital, except in an emergency, until after a provisional diagnosis has been stated. In case of an emergency, the provisional diagnosis shall be stated as soon as possible after admission.

3.5 Admission order shall be provided or approved by the attending physician upon admission. If admitting orders cannot be provided within this time frame, the House Officer will then evaluate patient and write orders.

ARTICLE IV: PATIENT CARE ORDERS

4.1 All orders shall be in writing. An order shall be considered to be in writing if dictated to a Nurse and signed by the attending practitioner. Orders may also be dictated to Pharmacists, Respiratory Technicians, Certified Respiratory Therapists, Licensed Physical and Occupational Therapists, licensed Social Workers, Registered Dietitians and Central Registration Clerks, within the scope of their field of expertise as described below.

4.1.1 Verbal orders for respiratory therapy may be accepted or written by a Respiratory Therapy Technician. Registered dietitians may receive verbal orders for diet instructions or diet changes. Registered Pharmacists may receive verbal orders for medication. Physical Therapists and Occupational Therapists may receive verbal orders for physical therapy and occupational therapy. Licensed social workers may receive verbal orders for discharge disposition planning. Central Registration Clerks may receive verbal orders for admission status.

4.2 The staff member receiving the order shall read it back to the practitioner, write the name of the ordering practitioner and then sign their own name and date and time the order. Elements that should be included in any verbal medication order include:

- Name of patient;
- Age and weight of patient, when appropriate;
- Date and time of the order;
- Drug name;
- Dosage form (e.g., tablets, capsules, inhalants);
- Exact strength or concentration;
- Dose, frequency, and route;
- Quantity and/or duration;
- Purpose or indication;
- Specific instructions for use; and
- Name of prescriber

4.2.1 Verbal orders must be documented in the patient's medical record, and be reviewed and countersigned by the prescriber as soon as possible or within 48 hours.

4.2.2 Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

4.2.3 The ordering physician may not be able to authenticate his or her verbal order within 48 hours (e.g., the ordering physician gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time). In such cases, it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final.

4.2.4 A qualified practitioner such as a physician assistant or nurse practitioner may not "co- sign" a physician's verbal order or otherwise authenticate a medical record entry for the physician who gave the verbal order.

4.3 Medications may be ordered using either a medication's non-proprietary (official generic) or proprietary (brand) name. However, the pharmacist has the authority to dispense, and the nurse to administer, a medication under its non-proprietary name although the proprietary (brand) name of the medication may be different from the proprietary name which has been prescribed, unless otherwise stated in the order.

4.4 Telemetry orders must be reordered every third day.

4.5 If the attending practitioner desires that a second practitioner, who is not an associate, assist in the care of a patient, then a written order declare permission for the other practitioner to write orders. Orders for consult shall be deemed permission for that consultant to write orders.

4.6 Drug orders for a patient who is transferred from the Emergency Department into the Intensive Care unit shall be automatically cancelled.

4.7 Antimicrobial medications must be reordered after 5 days.

4.8 If a patient is admitted under the care of a non-surgeon and is scheduled for surgery by a consultant surgeon, then at the time of surgery the patient's attending physician may elect to change the attending physician to that of the surgeon. Any change from the surgeon being listed as the attending physician will require a written order to that effect.

4.9 There must be an order for food or nutrition products on every patient's medical record or the attending physician must document justification for withholding of nutritional products.

4.10 Consultations may be ordered by the attending physician when they are appropriate. The consultant should be notified by the attending physician, the Unit Clerk, or a Registered Nurse on the Inpatient Unit. The consultant should respond within 24 hours or notify the hospital staff caring for the patient the reason for the delay. An urgent consult shall respond as soon as possible and within 12 hours. A stat psychiatric consult should be requested for a suicidal patient to determine competence and decision making capacity.

4.11 Standing orders for treatment may be used in an emergency or as a basis for treatment for patients until the attending physician can write specific orders. Standing orders must be formulated by conference between the medical staff and the president of the hospital in reference to medical treatment. These orders will be considered verbal orders and must be reviewed and approved annually by the Executive Committee of the Medical Staff.

4.12 Laboratory tests ordered to be done daily will be automatically stopped after being done for three days, except for PT and PTT.

4.13 A blanket reinstatement of previous orders for medications is not acceptable, i.e. "resume pre-op medications".

4.14 Diagnostic Testing

a) Diagnostic testing is performed to determine the patient's health care needs. When a test report requires clinical interpretation, relevant information is provided with the request. This diagnostic testing may include histopathology, radiology and/or cardiopulmonary.

ARTICLE V: PROGRESS NOTES

5.1 FREQUENCY

Progress notes shall be entered and dated in the patient's chart on a daily basis by the treating physician/licensed independent practitioner. In some critical situations, more frequent progress notes are appropriate. All progress notes must be signed, dated and timed by the physician/licensed independent practitioner entering the note in the chart. The practitioner who is the admitting physician shall ensure that he/she has visited with the respective patient daily during the patient's inpatient stay of the Hospital or has made other appropriate arrangements for a physician member of the medical staff or a licensed independent practitioner employed by the attending physician to visit the patient in the event that the attending physician is unavailable. However, a physician must see the patient as outlined in Section 5.2 of these Rules and Regulations.

5.2 TIME TO SEE THE PATIENT

When a patient is admitted to a general medical/surgical unit he/she should be seen by a physician within 12 hours and a progress note entered in the chart.

Those patients admitted directly to an Intensive Care Unit or a Special Care Unit or transferred to an Intensive Care Unit or a Special Care Unit from a general medical/surgical unit must be seen by a physician within 4 hours and an admission note entered in the chart.

Emergency Department Consults: All response times should be reasonable, generally this means thirty (30) minutes or less, depending on the particular facts and circumstances.

5.3 HISTORY AND PHYSICAL

History and physicals must be completed within 24 hours of admission. When the history

and physical is dictated, a progress note must be dated indicating the history and physical has been completed. They may either be done by the attending physician or a house physician. In the event that the House Physician does not complete the history and physical exam, the responsibility for completing them remains with the attending physician. The history and physical exam must be completed and recorded before any surgery is started. Generally for elective surgeries this will be done during preadmission testing. If the history and physical exam are performed within 30 days before admission to UH Ahuja Medical Center or in the office of a physician staff member or, when appropriate, the office of a qualified oral or maxillofacial surgeon staff member, a durable, legible copy of this report may be used in the patient's medical record, provided whatever changes may have occurred are recorded in the medical record at the time of the admission.

Surgery is performed only after a history, physical examination, any indicated diagnostic tests, and the preoperative diagnosis have been completed and recorded in the patient's medical record. In emergency situations in which there is inadequate time to record the history and physical before surgery, a brief note, including the preoperative diagnosis is recorded before surgery.

Other licensed independent practitioners who are permitted by law to provide patient care services independently may perform all or part of the medical history and physical examination if granted such privileges

5.3.1 The physical exam may be limited to cardiac, respiratory and appropriate regional exam for the following outpatient procedures:

a) All patients scheduled for pain blocks, including but not limited to epidural and paravertebral facet injections whether or not an anesthesia consultant is required.
b) All patients for whom an anesthesia consultation is not required
c) All patients undergoing invasive radiological procedures
d) Endoscopy procedures

5.3.2 If conscious sedation is not being used and the only anesthetic is to be a local anesthetic, the physical exam for outpatients may be limited to an appropriate regional exam.

ARTICLE VI: SPECIAL TREATMENT PROCEDURES

6.1 CONVULSIVE THERAPY

Electroconvulsive and other forms of convulsive therapy are not performed at UH Ahuja Medical Center.

6.2 PSYCHOSURGERY

Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental, or behavioral disorder are not performed at UH Ahuja Medical Center.

6.3 BEHAVIOR MODIFICATION

Behavior modification procedures that use aversive conditioning are not performed at UH

Ahuja Medical Center.

6.4 MECHANICAL RESTRAINT

Restraint is defined as follows: Restraint is any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. Restraint differs from the use of mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular part of such procedures.

These mechanisms include, but are not limited to, body restraint during surgery, and arm restraint during intravenous administration. Devices used to protect the patient such as table top chairs, protective nets, helmets, or mechanisms such as, orthopedic appliances, braces, wheelchairs, or other appliances or devices used for postural support of a patient or to assist the patient in obtaining and maintaining normal body functioning, are not considered restraint interventions.

6.4.1 Orders for Restraint

A Physician must perform and document a patient assessment and write an order for restraints within one hour of application and each 24 hours thereafter when restraints are continued. This assessment and documentation must be repeated with each order renewal. Each restraint order must include time limits of no more than 24 hours (or 8 hours if restrained for psychiatric behavioral reasons) and the reason for restraints.

Preprinted Physician Orders are available to facilitate the process.

6.4.2 Procedures

The procedure for putting a patient in restraints and monitoring a patient during a period of restraint is contained in the Hospital's Administrative Policy and Procedures that is incorporated by reference into these Rules and Regulations.

6.5 VENTILATOR MANAGEMENT:

Patients on ventilator management will require a pulmonary consult after 48 hours.

ARTICLE VII: PROCEDURE REQUIREMENTS

7.1 HISTORY AND PHYSICAL

7.1.1 A history and physical exam must be on the patient's chart for all patients prior to the patient receiving general anesthesia or undergoing an invasive procedure. In an emergency the relevant parts of the physical must be documented prior to the emergency procedure.

7.1.2 Any appropriate or required exam for *outpatients* must also be on the patient's chart prior to the procedure. The physical exam may be limited to cardiac, respiratory, and appropriate regional exam or indication for the following *outpatient* procedures.

a) All patients scheduled for pain blocks, including but not limited to epidural and paravertebral facet injections whether or not an anesthesia consultation is required.

b) All patients for whom an anesthesia consultation is not required
c) All patients undergoing invasive radiological procedures
d) Endoscopy procedures other than Sigmoidoscopy
e) Any other procedures requiring conscious sedation

7.1.3 If conscious sedation is not being used, and the only anesthetic is to be a local anesthetic, the physical exam for *outpatients* may be limited to an appropriate regional exam. For sigmoidoscopy, the physical exam may be limited to an appropriate indication for the procedure.

7.2 PREADMISSION/PREPROCEDURE TESTING

7.2.1 For all *inpatients* and *outpatients*, who need an anesthesia consultation, except emergencies, the following is requested:

a) NPO 8 hours prior to Surgery.
b) If no IV is infusing, insert 20 g or larger IV to Heparin lock. Use Saline Lock if patient is allergic to Heparin.
c) Electrolytes if on diuretic or antihypertensive medications.
d) CBC within 3 weeks prior to surgery.
e) PTT if patient is receiving Heparin.
f) PT if patient is taking Coumadin.
g) Blood ready in Laboratory (if ordered).
h) Chest x-ray (if ordered).
i) Serum Pregnancy Test for female capable of childbearing.
j) EKG if patient is 60 years of age or older.
k) History and Physical report on chart.

7.2.2 Preprocedure testing is at the discretion of the physician performing the procedure for the following *outpatient* and *inpatient* procedures:
a) All patients scheduled for pain blocks, including but not limited to epidural and paravertebral facet injections whether or not an anesthesia consultation is required
b) All patients for whom an anesthesia consultation is not required
c) All patients undergoing invasive radiological procedures
d) Endoscopy procedures

7.3 OBSTETRIC REQUIREMENTS

All pregnant patients, including patients with ectopic pregnancies and abortions should have their ABO/RH group/type status analyzed in the laboratory. When such patients are RH(D) negative and have no immune anti D in their serum, then RH(D) immunoprophylaxis should be routinely be given. If such therapy is offered and refused, refusal of the offered treatment must be documented.

All babies delivered of Rh negative mothers should have cord blood collected and sent for type, Rh, and direct Coombs test.

All babies delivered of O-positive mothers should have cord blood drawn for blood group typing.

7.4 CONSENT

All patients having surgery or other invasive procedures, and those for whom anesthesia or conscious sedation may be used, must have an appropriate consent form signed by the patient and the physician performing the procedure before the procedure. Consent for anesthesia and non-emergency blood transfusions must be documented in the medical record.

ARTICLE VIII: PATIENT DISCHARGE

8.1 Patients shall be discharged only upon the order of the attending practitioner. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, the incident shall be documented in the hospital record and, if possible, the appropriate release form signed by the patient. If the patient refuses to sign the form and leaves, this shall be documented in the medical record.

8.2 The medical staff member responsible for the care of a patient shall perform or direct an appropriate member of the medical staff to perform the following tasks in the event of death.

a) Notify the next of kin.
b) Request permission for an autopsy when it is indicated based on Article V.
c) Comply with all the administrative details required by the Hospital Administration and/or the Cuyahoga County Coroner.

8.3 Discharge planning will be coordinated with the patient, family, community agencies and Hospital staff members to assure appropriate aftercare for patients after discharge.

8.4 The attending physician for the patient at the time of discharge will be responsible for preparing the discharge summary for the medical record.

ARTICLE IX: AUTOPSIES

9.1 CRITERIA

In all cases where there is confusion about diagnosis or highly unusual pathology is suspected, autopsies should be requested. In cases where there may be concern on the part of the family about the cause of death, it is desirable that an autopsy be requested. In cases where foul play or forensic issues are involved the coroner should be consulted to determine whether or not an autopsy is required.

9.2 DOCUMENTATION

Information including consent for autopsies should be documented on the Permit to Perform Autopsy Form 570.

9.3 NOTIFICATION

When an autopsy is scheduled, the autopsy service shall notify the attending.

9.4 AUTOPSY FINDINGS

Autopsy findings should be discussed at either Medical QC, Surgical QC or OB/GYN

QC committee meetings for comparison with clinical data in the medical record.

9.5 AUTOPSY REPORT

When an autopsy is performed, provisional anatomical diagnoses are recorded in the medical record within two working days. The complete report is included in the record within thirty working days for usual cases. For complicated cases, the complete report must be included in the record within three months.

ARTICLE X: MEDICAL RECORD COMPLETION

10.1 GENERAL

Medical records shall be completed within 30 days of the patient's discharge from the hospital. A member of the medical staff with incomplete records for 30 days or more after discharge of the patient from the hospital is subject to suspension of admitting and surgical privileges until there are no deficiencies. Physicians may not transfer patients to their service while they are on suspension for delinquent medical records.

10.2 OPERATIVE REPORT

Immediately after surgery an operative note must be entered in the chart documenting the procedure and any major finding and complications. Also a complete operative report must be dictated immediately after surgery.

Privileges may be suspended if an operative report is not dictated within 48 hours. Any practitioner with undictated operative reports shall be automatically suspended from operative privileges except for any patients who have already been scheduled for surgery. The only exception is for emergencies admitted through the Emergency Room.

10.3 VACATION AND ILLNESS

The suspension shall be delayed if a physician is on vacation, ill, or out of town on the day that his/her suspension becomes effective, due to either incomplete medical records or because of nondictated Operative Reports. The suspension delay shall expire three days after the physician returns. If the suspension begins prior to the physician becoming unavailable as described above, then the suspension shall continue during the physician's absence. Delays due to lost records or inadvertent erasure of dictated material shall not be counted in the determination of suspension status.

10.4 HISTORY AND PHYSICAL

Histories and physicals are to be completed within 24 hours of admission. If the History and Physical is dictated, an admission note should be written for every patient. If a History and Physical are available for the period of up to 30 days prior to admission, then a legible copy plus a notation about any interval changes is acceptable.

ARTICLE XI: DELINEATION AND GRANTING PRIVILEGES FOR CONTRACTED HOUSE PHYSICIANS

11.1 House Physicians

The Hospital may employ or contract for House Physicians to provide supplementary or

special clinical services to hospital patients other than emergency department service. Such physicians shall be assigned to the appropriate department for administrative purposes. They shall be eligible for medical staff membership as House Staff. In attending patients, they shall be under the supervision of the respective attending physician(s) and Department Chairmen and Chiefs of Divisions involved with such patients.

11.2 Credentialing of such physicians shall follow the pattern outlined in the Bylaws.

11.3 House physicians must also meet the following qualifications:

a) Have a minimum of two years of postgraduate training

b) Be certified in Advanced Cardiac Life Support (ACLS). House officers covering evenings and weekends must be NRP certified as well.

11.4 Such physicians shall submit a completed application on the approved form for privileges as House Physicians. Prior to the physician being assigned duties at the hospital, the application must be approved by the medical staff Credentials Committee, Medical Executive Committee, and the Board of Directors. In extenuating circumstances, temporary privileges as outlined in the Medical Staff Bylaws may be granted for a period not to exceed 120 days.

11.5 At the termination of their services at UH Ahuja Medical Center in the capacity of House Physician, all other associations, rights, and privileges with the medical staff shall be automatically terminated. This does not preclude the application for medical staff privileges through the established mechanism as outlined in the Bylaws.

11.6 Under special circumstances, House Physicians may supplement the work of Emergency Department physicians under the direct supervision of the Emergency Department physician.

11.7 House physicians may attend all educational meetings of the medical staff, but may attend business meetings, service, or committee meetings only with the approval of the Committee Chair and the Chief of Staff.

11.8 Responsibilities shall include but not be limited to:

a) Care for acutely ill patients as long as the crisis continues in accordance with the direction of the attending physician.

b) Placement of intravenous lines, arterial lines**,** nasogastric tubes, and urinary catheters.

c) Insert central lines, and perform endotracheal intubation as indicated in the absence of an anesthesiologist. Place soft feeding tubes and confirm placement via x-ray as appropriate.

d) When there is tube placement into the chest, the house physician will review films for confirmation of placement. If there is question regarding the films, they will be reviewed by a radiologist either in person (during day shift) or via teleradiography.

e) Notify the attending physician of any significant change in patient's status or transfer to critical care.

f) Lead the code team according to ACLS protocol for all cardiopulmonary arrests. Once the patient is intubated and in the absence of an adequate peripheral line, the house physician/hospitalist should insert a central line.

g) Pronounce date and time of death for deceased if attending physician is not in the Hospital.

h) Will supervise all potent drug administrations and will consult with Pharmacy when appropriate for method of administration of the potent drug.

i) Will prescribe patient medications (e.g., sedatives, laxatives, etc.) consulting attending as appropriate.

j) Place a progress note in the chart for each activity (e.g. assessment and intervention of a patient for any reason) performed.

k) Obstetric patients will be seen by the Obstetric House Physician.

l) Assist laboratory technicians in obtaining unusual or difficult specimens for inpatients and outpatients; e.g., cultures, and procedures normally not done by laboratory technicians, blood specimens when they cannot be procured, such as on hypovolemic or dehydrated patients, or infants. [Also, overseeing of therapeutic phlebotomies, insulin tolerance tests, lactose tolerance tests, etc.]

m) House Officers will perform a brief assessment on all newly admitted patients; review current labs and if necessary, contact the attending physician to provide current patient condition to help facilitate placing patients on appropriate care paths, expedite diagnostics; provide timely interventions and urgent orders.

n) Will perform History and Physicals, including rectal examination, on all patients admitted to the Hospital or when attending has not done so within 24 hours of the patient's admission.

o) Monitor lab results of newly admitted patients and consult with the attending physician about abnormal values.

p) Care for outpatients who become ill in ancillary service areas such as outpatient laboratory, physical therapy, etc. and notify attending.

q) Will assist in documentation of DNR status following communication with the attending physician, family and patient.

r) Will write admission orders for patients if there is no answer from the attending physician within one hour. These orders will be basic and include such things as vital signs, diet, IV fluids, pain control and activity.

s) Will round each AM and PM after change of shift to the ICU to be prepared for changes in patient status.

t) Will perform an in-person patient assessment before prescribing drugs which have the potential to reduce the patient's level of consciousness.

u) Verbal orders should be limited to emergency situations and when necessary must be signed off before leaving for the day.

v) Will write discharge prescriptions for patients if the attending is not available to do so. Documentation will be made in the record regarding discussion with the attending regarding the reasons for the prescriptions.

w) When patients are transferred to another unit within the hospital, this must be communicated to the primary care/attending physician.

x) Obtain informed consent from a patient when blood transfusions are needed and the attending physician is not present in the hospital to do so.

y) Medical records must be completed according to established parameters and

delinquencies will lead to suspension of privileges.

11.9 Specific areas that are not House Physician responsibilities, unless otherwise specified:
a) Neonatal invasive procedures except venipunctures.
b) Operating room responsibilities except in life threatening situations.
c) Discharge summaries, and routine dressing changes.

ARTICLE XII: [RESERVED]

ARTICLE XIII: DEPARTMENT MANUALS

13.1 GENERAL

Individual departments and divisions may have their own rules and regulations. If an individual set of rules and regulations differ from these Rules and Regulations, then the Medical Staff Rules and Regulations shall be considered primary. However, when a department or service or division must follow the rules and regulations of a regulatory agency or governmental agency, then they become primary.

The exercise of clinical privileges within any department is subject to the rules and regulations of that department and to the authority of the department's director, as defined by the Medical Staff Bylaws.

Department manuals shall be approved by the Medical Executive Committee by a majority vote at a regularly scheduled meeting.

13.2 CREDENTIALS MANUAL

A separate manual may contain specific rules and regulations for granting credentials and privileges.
The credentials manual shall be approved by the Medical Executive Committee by a majority vote at a regularly scheduled meeting.

13.3 COMMITTEE MANUAL

A separate committee manual shall list those committees that are not included in the Medical Staff Bylaws. The Committee manual shall be approved by the Medical Executive Committee by a majority vote at a regularly scheduled meeting.

ARTICLE XIV: ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

14.1 PROCEDURE

Initial adoption of the Rules and Regulations shall require approval by the Board of Directors, followed by a majority vote of the Medical Executive Committee.

Thereafter, any amendment of Rules and Regulations shall require approval by a majority vote the Medical Executive Committee at a regular or special meeting. Any amendment or adoption will become effective after approval by the Board of Directors.

14.2 DISTRIBUTION OF THE RULES AND REGULATIONS

All current and new medical staff members shall be given a copy of these Rules and Regulations and asked to acknowledge that they have received, read, understood, and agreed to abide by them.

14.3 REVIEW

A standing or special committee shall review these Rules and Regulations every two years.