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RULES AND REGULATIONS OF THE MEDICAL STAFF

1. A Medical Staff member in "good standing" as referenced on page 31 of the Bylaws means that the staff member has met the appointment/reappointment requirements during the previous medical staff year, is not in arrears in chart documentation, peer review responsibilities, and dues payments.

2. The Hospital shall admit patients suffering from all types of diseases. All patients shall receive the same level of quality of patient care, regardless of which department, service or practitioner in the Hospital provides the care.

3. A patient may be admitted to Conneaut Medical Center only by members of the Active Medical Staff with admitting privilege. All physicians shall be governed by the official admitting policy of the Hospital. Podiatric service patients shall be admitted only on a Medical Staff Member's service.

4. Each patient shall be the responsibility of a Member of the Medical Staff. Such physician shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another Staff physician a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

5. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated.

6. In any case in which it appears the patient will have to be admitted to the Hospital, the physician shall first contact the appropriate nursing representative to ascertain where there is an available bed.

7. In the case of an emergency admission, patients who do not have a private physician may be assigned in rotation to Members of the Active Staff on duty in a department or service to which the illness of the patient indicates assignment. The admitting physician shall be responsible for giving such information as may be necessary to assure the protection of the patient and to assure protection of others whenever his patients might be a source of danger from any cause whatever. For the protection of patients and the medical and nursing staffs in the Hospital certain principles are to be met in the care of potentially suicidal patients. In the event that a patient admitted to the general service of the Hospital is then or later suspected to be suicidal he should be transferred as soon as practical to the appropriate setting where adequate facilities are available.

8. Admissions to Intensive and Cardiac Care Units:
   If any questions as to the validity of admission to or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Medical Department Chairman.

9. The attending physician is required to document the need for continued hospitalization on an ongoing basis through written progress notes in the patient's medical record. This statement must contain:
   a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
   b. The estimated period of time the patient will need to remain in the hospital.

c. Plans for post hospital care.

10. Patients shall be discharged only on a written order of the attending physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

11. On the day of discharge of a patient, it will be the responsibility of the attending physician to make every effort to discharge said patient by 1:00 p.m. including Obstetric patients.

12. In the event of a hospital death, hospital policy will be followed. An entry must be made in the hospital record documenting the time of death and outcomes of request for autopsy if indicated (see below). This entry may be written or dictated or be part of the discharge summary if the summary is recorded within a few hours of death.

13. It shall be the duty of all Staff Members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with the state law. All autopsies shall be arranged for at an appropriate facility by appropriate personnel in accordance with criteria established by the Medical Staff in coordination with other Hospital Staff. When an autopsy is performed, the deceased patient's attending physician shall be notified of the pending autopsy and its results. A report of the autopsy results shall be made by the attending physician to the Medical Staff for its performance improvement activities. The Medical Staff of BMH should request an autopsy when the following circumstances are evident:
    1. Deaths in which the cause is not known with certainty on clinical grounds.
    2. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death, and provide reassurance to them regarding the same.
    3. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs.
    4. Deaths known or suspected to have resulted from occupational or environmental hazards.
    5. Sudden, unexpected, or unexplained deaths in the hospital which are apparently natural and not subject to a forensic medical jurisdiction.
    6. Deaths resulting from high-risk infections or contagious disease.
    7. Death occurring while the patient is being treated under an experimental regime.
    8. Intra-operative or intra-procedural death.
    9. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
    10. Death incident to pregnancy or within seven days following delivery.
    11. Death where the cause is sufficiently obscure to delay completion of the death certificate.
    12. All suicide deaths.
    13. Death in infants or children.
    14. By Ohio Law: when death was or may have been a result of a criminal act.

MEDICAL RECORDS

I. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current.

This record shall include identification data; chief complaint; personal history, family history; history of present illness; physical examination; statement on course of action planned; diagnostic and therapeutic orders; evidence of informed consent; clinical observations, special reports such as consultations, clinical laboratory, nuclear, and radiology services, and others, provisional diagnosis, medical or surgical treatment; reports of operative and other invasive procedures, tests and their results; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed. All clinical entries in the patient's medical records shall be accurately dated and authenticated.

II. A complete admission history and physical examination shall be completed and recorded within no more than twenty four (24) hours of inpatient admission, must have been completed within 30 days before the patient was admitted or readmitted, and updates to the patient's condition since the assessment(s) are recorded at the time of admission.

This report shall include all pertinent findings resulting from an assessment of all systems of the body. Failure to comply will result in appropriate warning by Administration to complete the history and physical after another twenty-four (24) Hours or face suspension of all admitting privileges. The history and physical may be handwritten but must be legible and identified as such. Surgical (elective) H&P must be completed and recorded at the time preoperative medication is due.

A history & physical report shall include:

1) the chief complaint/reason for admission or treatment;
2) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral, and social status;
3) relevant past, social and family histories appropriate to age of the patient;
4) an inventory of body systems;
5) statement of conclusions or impressions drawn from admission history and physical examination (including diagnosis or diagnostic impression);
6) a statement of the course of action or treatment planned for the patient.

In records for children and adolescents, there must be evidence of:

- evaluation of developmental age
- consideration of educational needs/daily activities
- immunization status
- expectation for and involvement in assessment, treatment and
- continuing care, by the parent or guardian

If a patient has been discharged and readmitted within seven (7) days with the same diagnosis and the complete history and physical examination may be waived in lieu of an interval or progress note denoting what has happened since the patient's

discharge. A copy of the original history and physical shall be included in the record.

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such a delay would be detrimental to the patient.

III Diagnostic and Therapeutic Orders must be legible, authenticated, and dated.

IV Daily progress notes by the attending physician and other authorized individuals as appropriate which update the plan of care and must be pertinent, meaningful observations. Such items to address may include the following and should be legible, authenticated, dated, and timed:

1. reassessment
2. response to care and/or treatment
3. abnormal findings of tests
4. consultation reports
5. medications ordered
6. response to medications given
7. adverse drug reactions
8. medications prescribed at discharge
9. relevant diagnoses during case
10. referrals to external and/or internal provider/agency

A progress note shall be written into the record when a patient is transferred to a different level of care (i.e. ICU to Med/Surg) or to another physician.

V Consultations shall show evidence of a review of the patient's record, by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as 'I concur' does not constitute an acceptable report of consultation.

VI Operative Reports are to be completed and recorded immediately following surgery and shall contain the following:

1. pre-operative diagnosis;
2. a description of the findings;
3. the technical procedures used;
4. the specimens removed;
5. the post-operative diagnosis; and
6. the name of the primary surgeon and any assistants

NOTE: If transcription delays exist, a brief operative progress note must also be entered into the chart (i.e. an emergent, middle of the night procedure).

Any practitioner with undictated operative reports six (6) hours following the procedure shall be automatically suspended from operative privileges except for any inpatients who have already been scheduled for surgery.

VII Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedure results must be entered into the Medical Record as soon as they become available.

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. The attending physician has the responsibility to establish final diagnosis.

VIII A discharge clinical resume shall be written or dictated on all medical records of patients including ambulatory surgery except for normal obstetrical deliveries, normal newborn infants. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant treatment and result. All summaries shall be authenticated by the responsible physician.

The Discharge Summary is to be dictated within twenty-one (21) days of discharge and shall include the following:

1. admitting and final diagnosis
2. the reason for hospitalization;
3. significant findings;
4. procedures performed and treatment rendered;
5. condition and prognosis of the patient on discharge;
6. instructions given to the patient and/or family, which specifically includes: physical activity, diet, medication and follow-up care;

IX When an autopsy is performed, provisional anatomic diagnoses are entered in the medical record within three (3) days, and the complete protocol is made part of the record within sixty (60) days. See #12 of Rules and Regulations of the Medical Staff.

X In the event of patient death, physicians are encouraged to conform to state/regional donor network protocols which are available on all units.

XI Symbols and abbreviations may be used only when they have been approved by the Executive Committee of the Medical Staff. An official record of approved abbreviations and dangerous abbreviations not to be used is on file in Health Information Services. Symbols and abbreviations may not be used in the history and physical, consults, operative reports or discharge summary.

XII Orders, including verbal orders, may be co-signed when there is a signed agreement between the Physicians. This standard agreement shall state that the co-signing Physician agrees to take responsibility for the order he/she is signing. The signed agreement forms are to be kept on file in Medical Records (HIS) Department. This practice is not to be used for dictated reports.

XIII Recognizing that the medical record must be complete within the designated

time frame, the Medical Staff, in cooperation with Coding and Medical Records, will comply with and expect the following:

A. All charts must be completed within 30 days of the patient's discharge as defined in CMS rules of participation for Critical Access hospitals.

B. Coding will complete their analysis of the chart within 5 days of discharge.

C. Medical Records will complete their analysis of the chart within 14 days of discharge.

D. The physician will always have 14 days to complete any deficiencies, including E-sig. The physician will be notified of these deficiencies either by fax and/or the physician mailbox according to the following procedure:
Letter #1 Notification of incomplete charts with 14 days to complete
Letter #2 If the 14 days have passed, a copy of the suspension notice

E. Recognizing that not responding to coding inquiries in a timely manner may result in a process delay or incorrect attestations being filed, coding inquiries will be considered a deficiency and must be answered within 14 days, physicians will be notified of these deficiencies in the same manner.

F. Physicians who are unavailable due to sickness or vacation will be exempted for that time if they have so notified the Medical Staff Office.

G. Certain parts of the medical record may be required to be completed in a shorter time period as defined by various regulations. Examples of this are History and Physicals, which must be completed within 24 hours of admission and Operative Reports must be completed immediately following surgery.

H. A list of suspended physicians will be published each Wednesday and placed in physician mailboxes.

I. To lift suspension, all delinquent charts must be completed.

XIV All records are the property of the Hospital and shall not be removed from the Hospital premises except by subpoena, court order or state statue; or during the normal course of business (i.e. microfilming).

Unauthorized removal of charts from the Hospital is grounds for suspension of the physician for a period to be determined by the Medical Staff Committee.

XV DOCUMENTATION: Any health care worker that is directly involved in the patient's care functioning within his/her sphere or competence may document in the medical record. All documentation will be authenticated and signed by the responsible practitioner.

CHART SUSPENSIONS

I Definitions:

A. Delinquent Medical Record – any patient chart that has not been completed 21 days or more after the patient is discharged, including dictation and signatures.

B. Chronic offender – a medical staff member who has received three (3) letters of suspension within any 12 month period.

II Suspension Procedure:

A. When a physician has any number of incomplete/delinquent medical records (21 days or more after the patient is discharged at the time of chart count) a warning letter and list will be sent.

B. After seven (7) days, if the charts are not completed, a suspension letter will be sent.

C. Every week when chart count is done, another suspension letter will be sent to those that are already suspended and each week thereafter until all medical records are completed.

D. The suspended physician may not be removed from suspension until ALL discharge charts are completed.

E. After receiving a third (3rd) suspension letter within any 12 month period, the physician can be required to re-apply for membership and clinical privileges.

F. Physicians suspended for delinquent charts;

1) will not be allowed ANY admissions, including emergency admissions,
2) will be responsible for finding his/her own replacement with a letter given to the patient informing them of this situation,
3) will not be able to schedule any Special Procedures, and
4) will not be permitted to exercise operating room privileges for elective surgeries except for surgery patients already in-house (scheduled surgeries will be cancelled).

G. A list of suspended physicians is sent to the President and the Chief Medical Officer each week.

H. The suspension list is updated daily and provided to the Nursing Supervisor and Patient Access Services.

I. Physicians are placed in an extension status if they notify HIS of illness, vacation, or being out of town if HIS is notified before the Physician leaves. Physicians in this status cannot be suspended.
Note: A physician currently on suspension will not be removed from the suspension list as a result of being placed on extension.

J. In case of readmission of a patient, all previous records (including outpatient and emergency room) shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another.

K. Written consent of the patient is required for the release of medical information to persons not otherwise authorized to receive this information. Such written authorization of the patient or his legal guardian, must be dated within 60 days of the request.

L. Deficient records for physicians protractedly unavailable to complete will be referred to the Utilization Management Committee for disposition. Upon determination by such committee, the chart(s) will be filed incomplete with a cover sheet documenting the date and action of the

committee's determination stating: "This chart has been filed incomplete by order of the Utilization Management Committee". The incomplete record will then be filed in the patient's unit folder and from that point on will not be counted in the Delinquent Chart Rate calculation.

GENERAL CONDUCT OF CARE

1. Informed consent forms for treatment shall be prepared by the Hospital, taking into account all specific procedures. These are to be adopted by the Medical Staff with the aid of legal counsel. Each permission shall be reasonably specific as to the character of the operation or procedure.

2. All orders for treatment, including verbal orders, shall be taken according to the approved policy regarding Patient Orders, Verbal, Telephone, and Fax.

3. The physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Renew", "Repeat" and "Continue Orders" are not acceptable.

4. All previous orders are cancelled when patients go to surgery. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or the A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration (FDA).

5. Only physicians, podiatrists, or dentists who hold a current DEA certificate and professional license in the State of Ohio may prescribe drugs and medications to patients at the Hospital within the scope of their licensure and privileges and subject to the investigational drug policy of the Hospital. Allied Health Professionals who hold a current DEA and professional license in the State of Ohio may do so as per privileges granted by the Medical Staff.

6. The organized medical staff shall oversee the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process. However, additional clearance may be obtained by a practitioner not privileged through the medical staff process as long as the privileged physician accepts responsibility for it and incorporates it in his/her assessment.

7. Except in an emergency, consultation is required in the following situations:
   a. When the patient is not a good risk for operation or treatment.
   b. When the diagnosis is obscure after ordinary diagnostic procedures have been completed.
   c. Where there is a doubt as to the choice of therapeutic measures to be utilized.

d. In unusually complicated situations where specific skills of other physicians may be needed.
e. In instances in which the patient exhibits severe psychiatric symptoms.
f. When requested by the patient or his family.

8. The attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending physician to attend or examine his patient, except in an emergency.

9. If a nurse has any reason to doubt or question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior who in turn may refer the matter to the Director of Patient Care Services. If warranted, the Director of Patient Care Services may bring the matter to the attention of the chairman of the department wherein the physician has clinical privileges. Where circumstances are such as to justify such action the chairman of the department may himself request the consultation.

10. Active Staff members shall have an office or residence located in close enough proximity to the hospital to provide continuing care to his/her patients and to that end secures that physicians may be available within a reasonable time period when the patient's condition requires prompt attention, unless otherwise defined by other rules or regulations, contract, or State or Federal laws."

11. All practitioners including but not limited to physicians, CRNA's, or other practitioners who are scheduled for on-call service shall be available to respond within a reasonable time frame, except as specified by federal, state, or local laws, and ACOG or other applicable guidelines.

12. The responsible licensed independent practitioner or his/her designee clearly explain the outcome of any treatments or procedures to the patient, and when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.

13. When a physician transfers care of a patient to another physician, a verbal report is to be given which allows the receiver of information to ask questions and obtain clarification if needed. The physician taking over responsibility for a patient's care is to receive sufficient information to do so safely.

GENERAL SURGICAL RULES

1. The surgeon in charge of the case shall be responsible for recording a preoperative diagnosis using standard nomenclature.

2. All surgical patients will sign the standard operative permit provided by the Hospital which should be witnessed.

3. All cases scheduled for elective surgery must have a completed and recorded history and physical examination and provisional diagnosis at the time the preoperative medication is due. The surgical nurse is to check with the division before taking the patient to surgery to determine that the record is complete. Should the record not be complete, the surgeon in charge of the case shall take adequate steps to see that it is complete prior to transporting the patient to the operating room.

4. Additional clearance may be obtained from a non-staff physician as long as the credentialed physician accepts it and incorporates it in his/her assessment of that patient.

5. The Surgical Department Committee shall determine which operative specimens will be submitted for pathological examination. It shall be the responsibility of the attending surgeon to make certain that such pathological diagnosis is incorporated in the medical record.

6. All operations performed shall be fully described by the operating surgeon immediately following surgery. The operative report should include, besides the technical points of each operation, the following:
    a. Detailed account of the findings at surgery.
    b. Technical procedures used.
    c. Specimen removed.
    d. Preoperative diagnosis.
    e. Postoperative diagnosis.
    f. Name of the procedure performed.
    g. Names of the assistant, the anesthetist, scrub nurse and circulating nurse.

7. The surgeon and his assistant must be in the operating room and ready to be in surgery at the time scheduled and in no case shall the operating room be held longer than 15 minutes after such a time.

8. The use of a Surgical Assistant or an RNFA will be at the discretion of the attending Surgeon.

9. Newly appointed and temporary privileged staff will be precepted at least five (5) times for surgeries requiring an assistant and the physician being precepted is to obtain an appropriate preceptor.

10. Visitors in surgery shall not be permitted except by special permission from the hospital President or Director of Medical Affairs, the Surgical Chairman, the surgeon in charge of the case and the patient. All those attending in surgery must wear the special operating room suit provided by the Hospital. No one but licensed physicians and registered nurses are to be in the operating room during surgical procedures with the exception of medical students, student nurses or others trying to enter the health field who may receive special permission to observe the specific operation with the consent of the patient.

11. The Hospital must provide in the operating rooms conductive flooring, safety features, humidity control, and air conditioning, and explosion-proof electrical connections.

12. All contaminated cases will be placed on the schedule at the end of the elective procedures for the day, unless a situation of immediate life threat exists.

13. Safety straps are to be used in securing all oxygen and gas cylinders in use in the operating room and recovery rooms.

14. A patient admitted for dental care is the dual responsibility involving the dentist and the physician Member of the Medical Staff. In the case of podiatric surgery, the same procedure shall be followed;

    a. Dentists' and podiatrists' responsibilities:

        1) A detailed dental or podiatric history justifying hospital admission.
        2) A detailed description of the examination of the oral cavity and/or feet and a preoperative diagnosis.
        3) A complete operative report, describing the findings and technique. In cases of extraction of the teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues and fragments shall be sent to the Hospital pathologist for examination, or the rationale for no specimen submitted should be documented.
        4) Progress notes as are pertinent to the oral and podiatric condition.
        5) Clinical resume.

    b. Physicians' responsibilities:
        1) Medical history pertinent to the patient's general health.
        2) Physical examination to determine the patient's condition prior to anesthesia and surgery.
        3) Supervision of the patient's general health status when hospitalized.
        4) Countersign patient's chart on summary.

    c. The discharge of the patient shall be on the written order of the dentist member or podiatrist in conjunction with the physician member of the Medical Staff.

15. Pre-operative lab studies will be ordered at the discretion of the Surgeon and at the request of Anesthesia.

    Scheduling of preoperative work-up shall be accomplished by the surgeon's office to occur at the minimum of 2-3 days before scheduled date of surgery.

If a patient returns for a second surgery within a two (2) month period, additional pre-operative studies and pre-operative interview is not needed, unless deemed necessary by the surgeon or anesthesia provider. A new H&P is required.

In the event that surgery is postponed, the same work-up may be utilized for two (2) weeks. After two (2) weeks and not more than 30 days, the surgeon shall enter an addendum to the H&P attesting to the continued reliability of the test and maintenance of the health status of the patient.

16. Either the attending surgeon (with the exception of Podiatry and Dental), the Chief of Surgery, or the Chief of Anesthesia is to sign off on the Anesthesia Records when other than an Anesthesiologist provides anesthesia for any surgery.

17. Non-staff Physician orders for SPU procedures will be reviewed with the SPU Director. At the discretion of the SPU Director, referral may be made to the pertinent Department Chair who is willing to take responsibility for the patient. In the absence of the Department Chairperson, the Chief Medical Officer may be contacted.

I. FOCUS REVIEW OF NEW AND/OR HIGH RISK PROCEDURES

Physicians requesting new or high risk procedures (listed in section II) shall provide documented evidence for the pertinent Department Chairperson to determine sufficient experience and current competence to independently perform each procedure. Documented evidence may be requested as follows:

- Letter of recommendation from residency training director verifying training in each procedure requested attesting to sufficient experience and current competence (past 2 years) to independently perform each procedure;
- a case list as evidence of the procedure performed over the last 2 years;
- preceptoring/proctoring of 6 cases by either a member of our medical staff with same privilege or an outside physician that has been granted temporary privilege by the medical staff to do so, with up to 5 cases waived at the discretion of the preceptoring/proctoring physician with agreement by the pertinent Dept. Chair.

II. ONGOING REVIEW OF MAINTAINING COMPETENCY WITH INVASIVE AND/OR HIGH RISK PROCEDURES

Once a physician has been granted privileges to perform surgical, new or high risk procedures listed below, working towards maintaining competency shall be achieved by requiring six (6) procedures during a one-year period, either at this facility or by providing records from another facility. If a physician performs insufficient cases, that privilege will become inactive until documentation has been provided of six (6) preceptored procedures within the current year. The Physician requesting re-instatement of such privileges must arrange for their own preceptor.

Some of the highly technical procedures are listed as follows as well as any other procedures deemed appropriate by the Medical Staff:

Gynecology
Repair of Fallopian Tubes
Salpingo-uterostomy
Diagnostic Hysteroscopy with biopsy
Operative hysteroscopy
Laparoscopy
Retropubic Urethral suspension
Paraurethral Suspension

Podiatry
Insertion of silastic implants into metatarsophalangeal joints

Otorhinolaryngology
Reconstructive and Maxillofacial Surgery
Head and neck cancer surgery

Orthopedics
Hand surgery
Laminectomy
Joint replacement

Surgical
Pancreas Surgery
Thyroidectomy
Thoracotomy
Pulmonary Resection
Esophageal Resection
Hiatal Hernia Repair
Mediastinal Tumor Resection
Chest Wall Resection and Reconstruction
Endoscopy
Laser Surgery

Urology
Endoscopic Examination
Associates elective addition general surgery, i.e., incidental appendectomy, incidental splenectomy, lymph node biopsies
May utilize thoracic abdominal incisions
Endoscopic Surgery
Laser & Ultrasonic Applications & Surgery

III. PRECEPTORING / PROCTORING

The following preceptoring guidelines shall be adhered to on a consistent basis for initial or re-instatement requests for new and/or high risk, technically difficult procedures:

1) preceptoring shall be done by an assigned unbiased member of our medical staff or an outside physician that has been granted temporary privilege to do so.
2) Six (6) cases shall be preceptored for all new and/or high risk/technically difficult procedures unless waived by the pertinent preceptor with agreement by the pertinent Dept. Chair.
3) Documentation shall be provided of preceptoring performed at another facility.
4) Logs of cases performed at another facility that satisfy the pertinent Department Chairperson may be accepted in place of preceptoring.
5) Fewer preceptored cases may be acceptable only when the preceptor documents satisfaction with his/her competence.
6) The proctor shall be responsible to the Credentialing Committee, and not to the patient or to the individual being proctored. Documentation of the proctor's evaluation shall be submitted in writing to the Credentialing Committee. Criteria of competency for each procedure shall be: familiarity with instrumentation and equipment, competency in their use, appropriateness of patient selection, adherence to "Time Out" policy, clarity of dissection, safety time taken to complete the procedure and successful completion of same. Proctoring shall be provided in an unbiased, confidential and objective manner. The mechanism for appeal shall be the same as the appeal process defined in the Medical Staff Bylaws for individuals for whom privileges are denied or granted in a temporary or provisional manner.

ANESTHESIA RULES

1. General anesthesia shall be administered either in the operating rooms or C-Section room but not in the Emergency Department, Radiology Department or Special Procedures Unit.

2. The anesthesia sheet shall show the pre-op medication, a detailed graph of pulse, respiration and blood pressure taken and charted periodically through the course of the operation. Type and amount of anesthesia used shall also be stated.

3. Operative procedures shall be stated on the anesthesia sheet. Name of surgeon, assistant and anesthetist shall also be included.

4. There shall be a pre and post anesthetic visit made by the anesthetist. The patient's condition on both visits shall be stated on the back of the Recovery Room sheet.

5. Anesthetists are to discuss with the surgeon the pre-op medication to be used and type of anesthesia recommended for the operative procedure.

6. All patients who are to receive an anesthetic must have a pre-anesthesia evaluation including medical, anesthetic and drug histories, physicals and routine blood work prior to onset of anesthesia. This includes dental cases and podiatric cases. Prior to

administration of an anesthetic, the patient's condition shall be reevaluated by the anesthetist, and the anesthetist shall check the equipment, drugs and gas supply to be used.

7. The Preoperative Anesthesia Evaluation record and preop medication orders shall be countersigned by the attending physician when anesthesia care is administered by someone other than an Anesthesiologist. The Chairman of Surgery shall co-sign the same when anesthesia care is administered by someone other than an Anesthesiologist for Podiatry and Dental patients.

EMERGENCY MEDICINE SERVICES

1. Emergency Medicine services are provided by a contracting agency specializing in emergency care. Practitioners who serve under such contract shall be trained and experienced in emergency care.

2. Seriously ill patients or those being admitted to the intensive care unit, are to be seen by their attending physician within eight hours of admission.

3. There will be an on-call physician to represent all clinical departments.

4. 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

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.

ED PHYSICIANS UNDER CONTRACT TO UH CONNEAUT MEDICAL CENTER

1. Emergency Medicine physicians who serve the Hospital through a contracted group shall meet the general qualifications for membership set forth in Section IV. An exception to the Bylaws will exist for emergency medicine physicians who are not Board-certified in emergency medicine, whether or not serving through a contracted group, requiring them to provide proof of current ACLS and ATLS certification. The credentials on each of the physicians must be on file in the Medical Staff office to include:
   a. Complete medical staff application
   b. Two letters of reference
   c. Delineation of privileges

   d. Copy of Ohio state licensure
   e. Copy of DEA
   f. Verification of malpractice insurance
   g. Copy of ACLS & ATLS for those not Board Certified in Emergency Medicine (if applicable)
   h. Documentation of Orientation including provision of ID badge and setting up pertinent computer access programs

2. The contract service shall be responsible for the recruitment, screening, credentialing and scheduling of the physicians. In the event of emergency scheduling problems, it shall be the responsibility of the contract service to find a replacement.
3. Administrative support services to be provided will include:
   a. Emergency Medicine policies and procedures
   b. Delineation of privileges for the emergency department physician
   c. Public relations
      1) Community awareness of Hospital's commitment to quality emergency care
      2) Community's awareness of hours of coverage
   d. Interaction of Emergency Medicine with other ancillary services, ancillary personnel and other hospital departments
4. The contract service will assist Hospital in development of Quality Performance Improvement Program for E.D.
5. The Hospital will conduct pre-accreditation survey of E.D. prior to Joint Commission visit and keep informed of the latest changes in Joint Commission accreditation criteria, government regulations.
6. Contract service will provide the liaison with the Hospital, Medical Staff and E.D. physicians; and periodic on-site visits for the implementation of new programs and quality improvement activities.
7. A physician who is working under contract in the UH Conneaut Medical Center Emergency Medicine Service is not eligible to make application for active medical staff privileges during the tenure of his contract. (A physician under such contract would be obligated to 12 or 24 hour constant duty in the Emergency Medicine Unit and could not be available to administer to private patients.)

CONSULTATION RULES

1. Consultations shall show evidence of a review of the patient's record, by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

2. Except in emergency, consultation with a Member of the Consulting Staff or the Active Medical Staff shall be required in all major cases in which the patient is not a good risk, or in which the diagnosis is obscure. Consultation also shall be required in accordance with state law on termination of life-sustaining treatment. The attending physician shall make request on a consultation blank. The procedure shall

be followed as outlined above. The consultant should not be an associate of the attending physician where possible.

3. Where staff rules require two consultations, one consultant must either have major privileges or be in a specific classification.

4. Curettement of the uterine cavity shall not be permitted without consultation except in cases where positive evidence of the non-existence of pregnancy is evident. In such cases, the attending surgeon must write diagnosis, reason for curettage, and disproving the existence of possible pregnancy.

TRANSFER OF PATIENTS

I. Internal Transfer: Patients may be transferred to and from the general care divisions and intensive care units, and if necessary, between and within divisions.

   A. Intensive Care Unit Transfers: Patients transferred from an intensive care unit will have priority for placement on a general care division, and shall whenever possible (depending on bed availability) return to the general care division from which they were originally transferred.

   B. Inter-Division Transfers: To promote a patient's continuity of care, a patient should only be transferred between general care divisions for the following reasons: (1) a change in the patient's specialty service; (2) the patient's medical needs; or (3) a change in the attending Medical Staff member. In the event that an inter-division transfer is necessary, the attending Medical Staff member shall make such request and note it in the patient's medical record.

   C. Intra-Division Transfers: The attending Medical Staff member may request a transfer within a patient care division due to medical needs of the patient (i.e., isolation); such request shall take priority over patient request (i.e., private room).

   D. Physician Responsibility for Internal Transfers: The attending medical Staff member at the time of the patient's transfer from a clinical service is ultimately responsible for the completion of the medical records within the scope of his/her clinical privileges.

II. Transfer to Another Facility:

   A. General Requirements:

      1. Order of Attending Medical Staff Member: A patient shall be transferred to another medical care facility on if:
         a) the attending Medical Staff member has ordered such transfer;
         b) arrangements have been completed for admission to such facility, including discussing the case with a receiving physician who agrees to accept the patient, consultation with the patient and/or the patient's family; and
         c) the patient's condition has stabilized.

2. Continuity of Care: All pertinent medical information necessary to provide for continuity of care must accompany the patient. The attending Medical Staff member shall be responsible for completing a referral information form.
3. Ambulance Transfer: If a patient is to be transferred by ambulance or ambulette, an ambulance transport form must be signed by the responsible Medical Staff member and given to the ambulance driver at the time of transfer. The ambulance transport form provides a means for the responsible Medical Staff member to certify that because of the medical condition of the patient, an ambulance is required, and he/she cannot be transported by other means.
4. Documentation: In all such cases when a transfer is made of a patient to another facility or an emergency patient from the Emergency Department to another facility, it is essential that full supporting documentation be made in the patient's medical record.
5. Patient Request: A patient's request for transfer to another facility shall be honored so long as the patient's condition is stable and the other requirements of this section are satisfied.

B. Disaster Requiring Transfer of Patient: In the event of an internal or external disaster requiring the transfer of a large number of patients, patients shall be transferred to facilities having transfer agreements with the Hospital, to the extent patient care beds are available. The patient's medical record or a summary medical information document shall accompany the patient at the time of transfer.

TELEMEDICINE

Telemedicine services will be used/provided as defined in the current Telemedicine Policy approved by the Medical Staff.

ACTIVITIES OF STUDENTS OF MEDICINE

1. Medical Students may serve preceptorships under the auspices of Active or Courtesy Medical Staff members, with admitting privileges if they are in good standing in the third or fourth year of their education at an accredited school of medicine or osteopathic medicine. The staff member must be established as a preceptor at the medical school attended by the student and will adhere to the Rules and Regulations of the medical staff.
2. Their program at UH Conneaut Medical Center is a continuation of their didactic and clinical medicine education. They may attend all educational conferences of the medical staff and make rounds with the attending physician. They have access to all the educational resources available through the medical library.
3. They may obtain a medical history; however, the staff physician must countersign it on the chart. They may conduct a physical examination with the staff physician present. This will enhance the teaching process at the precise moment the exam is being done.

4. The medical student cannot, unless in the presence of a licensed physician who is a staff member, carry out any procedure that would fall within the definition of delivering health care or medical services to a patient.
5. Whenever a medical student scrubs in or assists in obstetric or operative cases, it will be permissible for the name to appear on the record. This record should indicate for example - 2nd assist, 3rd assist, etc.
6. The medical student may change dressings, remove sutures, etc., providing he/she has shown proficiency and the preceptor has so notified the nursing staff.
7. Medical Students may not write orders except under the direct and present supervision of the attending physician. Further, these will not be considered as valid until reviewed and signed by the attending physician. All such chart entries should be further identified, as for example, MS-4 (medical student, 4th year).
8. All medical student entries in the medical record (orders, histories and physicals, progress notes, etc.) must be countersigned by the staff physician.
9. It is imperative that all the medical student's clinical activities be subject to the above guidelines. Any violation of these guidelines should be reported immediately to the staff physician or preceptor to whom he/she is assigned.
10 No alcohol/drugs on campus, use of illegal substances will result in termination of rotation and will be reported to the medical student's medical school and the appropriate authorities.
11 The medical student will wear an ID at all times identifying status as Student Doctor.
12 No physician shall have more than two (2) such students under his/her preceptorship at a time.
13 Each student participating in such rotations and preceptorships at this hospital must be approved by the CEO, Medical Staff President, and/or the Chief Medical Officer and will be responsible to the CEO of the hospital, Chief Medical Officer, Department Chairman, and Preceptor.
14 Medical students 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 Medical Staff President.
15 Neither Conneaut Medical Center, nor its medical staff, makes any implication herewith of its approval of, or formal participation in, such a program or of the content of or jurisdiction over such preceptorships, other than allowing the activities above described, under the supervision and responsibility of the Medical Staff member initiating such program.
16 Medical Students must provide the following to be kept on file in the Medical Staff Office:
    a. A current school affiliation agreement
    b. TB records
    c. Liability insurance
    d. Release of liability waiver and confidentiality statement
    e. Orientation with signed documentation of such
    f. Documentation of proficiencies

RESIDENT PHYSICIANS

Preparation/Paper
In order for a resident physician to participate in patient care activities at UH Conneaut Medical Center, a written agreement with the educational facility is required. A copy of the agreement must be submitted to the Medical Staff Office sixty (60) days prior to the resident physician's arrival at CMC.

a. The written agreement with the educational facility must be completed using the UH approved format and may be a standing agreement or only for the purposes of an individual resident physician. The preceptor must be a Medical Staff practitioner in good standing on the Staff of CMC.

The resident physician shall function under the supervision and control of the preceptor. Supervision requires the availability of the preceptor for consultation and direction of the actions of the resident physician, but does not necessarily require the personal presence of the preceptor at the place where services are rendered. The resident physician may provide services only to patients of the preceptor. He/she may function in any setting within which the preceptor routinely practices.

Resident physicians must confirm that they have sufficient malpractice coverage,

Resident physicians must meet the identification, dress and ethical codes of conduct of BMH.

Use of Facility:

Resident physicians will have full use of the hospital. Medical Staff parking may be used. The Core Library may be accessed through the Medical Staff Secretary or through the UH Intranet. The hospital dictating system may be used. Resident physician dictation must be countersigned by the preceptor.

Attendance at appropriate CME events is encouraged

Clinical Activities:

Resident Physicians will have full access to the charts of the patients of the preceptor(s) appropriate to the teaching program. Access to the charts of patients of other staff members in only with permission of the staff member and patient.

Patient preference should be honored with regard to participation in the teaching program.

Resident physicians may write orders within the limits of the clinical privileges granted through usual medical staff/administrative channels. Orders may be carried out immediately, but countersigning by the preceptor is required for completion of the chart.

Privileges:

All resident physicians will have the following privileges:

1) Conduct histories and physical exams and document in the patient's chart;
2) Examine assigned patients as required and document the examination in the chart;
3) Change dressings and catheters as directed by an attending physician;
4) Administer medication to and obtain laboratory samples from patients;
5) Perform designated procedures when under the direct personal supervision of an attending physician;
6) Assist in the performance of procedures with an attending physician;
7) All residents have emergency privileges as defined in Article IV, Section 9 (b) (iv) regarding Disaster Privileges or Section 9 (e)of the Medical Staff Bylaws.
8) The resident may be granted additional privileges at the specific request of an attending physician with documentation of training and ability. These privileges must be approved by the Department Head plus the Medical Director.

APPROVAL OF MEDICAL STAFF RULES, REGULATIONS, AND POLICIES

The undersigned hereby signify the adoption and approval of all rules, regulations and policies and all modifications thereto of the Medical Staff.

DocuSigned by: Jessica Milliman, DPM
049FB2002DBE4C2...
Medical Staff President
Date: 6/15/2022

DocuSigned by: Kevin Andryc
27EF2B3B7E734F9...
Chief Medical Officer
Date: 6/18/2022

DocuSigned by: Alan Papa
C054C8C0AFDB407...
Chief Operating Officer - UH East Market
Date: 6/15/2022

DocuSigned by: Donald DeCarlo, MD
470C3C1258FC421...
Chief Medical Officer - UH East Market
Date: 6/15/2022

Revised/Approved 4/10; Revised/Approved 11/09; Revised/Approved 8/11; Revised/Approved 5/2022