MEDICAL STAFF RULES AND REGULATIONS
EMH REGIONAL MEDICAL CENTER

A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the Hospital only by a member of the Medical Staff. All Staff physicians shall be governed by the official admitting policy of the Hospital.

2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated and the consent of the President or his delegate shall be recorded as soon as possible and always within 24 hours of admission.

3. The Chairman of each Department shall provide a schedule of "on-call" physicians who will be available for consultation for emergency patients who may need to be admitted and do not have a private physician on this Hospital Staff.

4. The Hospital's Admitting Office supervisor or her delegate will admit and transfer patients in accordance with Hospital policies. All patient transfers must be approved by the responsible physician. When a physician requests the transfer of a patient from one floor to another, the Admitting Office is to be notified and will, when appropriate, then request permission from the other attending physician for the transfer.

5. If one physician is covering for another, the absent physician's patients must be admitted on the service of the covering doctor and then transferred by written order when the patient's usual physician returns.

6. The admitting physician shall be responsible for providing all necessary information within his knowledge to assure the protection of the patient from self harm and the protection of others from the patient.

7. A psychiatrist Medical staff member shall admit all patients to the Psychiatric Unit. However, in the psychiatrist's absence or under other unusual circumstances, any physician staff member may admit a patient to the Psychiatric Unit but must obtain a psychiatric consult within 24 hours after such admission. The patient is under the admitting physician's care until the psychiatrist sees the patient and a transfer order is written.

8. The attending physician is required to document the need for continued hospitalization after specific periods of stay as determined by the Utilization Review Committee or applicable legislation and approved by the Medical Executive Committee. The documentation must contain an adequate written record of the reason for continued hospitalization and the estimated period of time the patient will need to remain in the Hospital. This report must be submitted within 24 hours of receipt of such request.

9. Patients shall be discharged only on the order of the attending physician. Should a patient leave the Hospital against the advice of the attending physician or without a proper discharge order, a notation of the incident shall be made on the patient's medical record and the patient shall be asked to sign a Release Against Medical Advice form.

10. The attending physician shall make every effort to discharge his patients by 11:00 AM on the day of discharge, except as other dictated by Hospital policies, and shall endeavor to advise the patient and Nursing Staff of the intended discharge on the day prior to discharge.

11. In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable time and an appropriate entry made on the progress sheet. Policies with respect to release of dead bodies shall conform to local law and Hospital policies.

12. Every member of the Medical Staff is expected to be actively interested in securing meaningful autopsies whenever possible. An autopsy may be performed only with a valid consent, signed in accordance with state law. All autopsies shall be performed by the Hospital's pathologists or by physician delegated this responsibility.

B. MEDICAL RECORDS

1. The attending physician shall be responsible for furnishing a legible, complete, accurate, and scientific medical record which will meet the high standards required by the existing review committees of the Medical Staff. The complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and other; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary; and autopsy report when performed.

2. No medical record shall be filed until it is completed, except on orders of the Medical Records Committee.

3. A complete admission history and physical examination shall be recorded within 24 hours of admission.

4. If a patient is re-admitted within 30 days with the same or related problem with which he was discharged, his medical record may be updated by an interval note and pertinent physical examination. This shall suffice to replace the complete history and physical examination as long as the original information is readily available.

5. Orders may be dictated to a registered nurse. Verbal orders relating to their services may also be given to physical therapists, respiratory therapists, occupational therapists, registered pharmacists, registered dieticians, and x-ray and laboratory technicians. At the next visit the attending physician shall sign such orders. All orders for scheduled drugs, anticoagulants, insulin, cardiac and

vasoactive medications, antibiotics and oxygen shall be authenticated by the responsible practitioner within 24 hours. All verbal and telephone orders should be reviewed by the practitioner, or designated coverage, at the first opportunity to confirm correct transcription. Verbal and telephone orders must be signed and dated within timeframes specified by applicable laws and regulatory standards.

6. Except in extreme emergencies, surgery is performed only after an appropriate history, physical examination, and any indicated laboratory and x-ray examinations have been completed and the preoperative diagnosis has been recorded in the medical record.

7. The attending physician shall review and countersign the history, physical examination, and preoperative note when they have been recorded by a member of the house staff or nurse practitioner. The attending physician shall also write/enter/dictate an admitting note in such cases.

8. Pertinent progress notes shall be recorded at the time of observation, at least every third day. They shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem.

9. Operative reports are dictated or written/entered in the medical record immediately after surgery and describe the findings, the technical procedures used, the specimen removed, the postoperative diagnosis and the name of the primary surgeon and any assistants. When the operative report is not placed in the medical record immediately after surgery, an operative progress note is entered in the medical record immediately following surgery to provide pertinent information for any individual required to attend to the patient.

10. All clinical entries in the patient's medical record shall be accurately dated and signed.

11. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations is on file in the Health Information Services.

12. The final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible physician.

13. A discharge summary shall be written or dictated on all patients hospitalized over 48 hours except for normal obstetrical deliveries and newborn infants.

    A final progress note is substituted for the discharge summary in patient s with problems and interventions of a minor nature, who require less than 48 hours hospitalization and in normal newborn infants and uncomplicated obstetric deliveries.

    The discharge summary shall include the following: admission date, discharge date, pertinent history and physical examination laboratory data, hospital course

and treatment, condition at discharge, final diagnosis, discharge instructions, medications, diet and follow-up plans. The discharge summary shall be completed by the physician responsible or his/her designee for the care of the patient at the time of discharge.

14. A legible and appropriate medical record shall be kept for every patient receiving service as an outpatient. The Emergency Room medical record shall be incorporated in the patient's Hospital record if such exists and shall include: adequate patient identification; information concerning the time of the patient's arrival, means of arrival and by who transported; pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital; description of significant clinical, laboratory and roentgenologic finds; diagnosis; treatment given; condition of the patient on discharge or transfer; and final disposition, including instruction given to the patient; and/or his family, relative to necessary follow-up care.

15. Written consent of the patient or his legal agent is required for release of medical information to persons not otherwise authorized to receive this information.

16. Medical records may not be removed from the Hospital premises without a court order or subpoena. Discharged patients' records must be completed in the Medical Records Department, or elsewhere in the Hospital by specific permission of the Medical Records Department.

17. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient be attended by the same physician or by another.

18. Free access to all medical records of all patients shall be afforded to members of the Medical staff for bona fide study, committee work, or research. All such projects shall be approved by the Medical Executive Committee before records can be studied. Confidentiality of personal information concerning the individual patients must be maintained.

19. Standing orders may be formulated by an individual physician or Department. These orders shall be signed by the attending physician.

20. All medical records must be completed within 30 days following patient discharge. If a physician fails to complete records within this time frame his/her hospital privileges to admit and /or schedule surgery for inpatient and outpatients will be temporarily suspended. This suspension will be automatic with formal notice and can occur two times per month.

    When the records are completed, the physician's privileges will be automatically reinstated with notification to the appropriate Hospital departments.

    Physicians will receive sufficient notice of incomplete records prior to being suspended. If requested, records can be available to physicians immediately after discharge.

1. REMINDER LETTERS – Each Thursday physicians will receive a "reminder; letter listing all incomplete records and specifying what is incomplete (i.e.: H&P, operative report, discharge summary . . .).

2. POTENTIAL SUSPENSION NOTIFICATION LETTERS – The suspension cycle will be two times per month. This notification letter may be sent two times per month. On the first and third Tuesday of each month, physicians who have one or more records which have been incomplete greater than 20 days from discharge and/or one or more incomplete H&P or operative reports will receive a "notification" letter informing them of potential suspension of privileges.

   The records 20 days or older and all H&Ps and operative reports must be completed within seven days of the date the notification letter was sent. If the records, H&Ps and operative reports are not completed by the following Tuesday deadline, the physician's privileges to admit and/or schedule surgery will be temporarily suspended.

   This will provide 27 days from discharge to complete records and three days after suspension to complete records, for those physicians who are suspended. A total of 30 days for record completion will be allowed.

3. PHONE CALL REMINDER – Physicians who are at risk of suspension will receive a reminder phone call on the Friday before the Tuesday suspension deadline.

4. CERTIFIED LETTER – A certified letter will be sent to suspended physicians the day the suspension begins.

Physicians who are ill or on vacation will not be suspended. Physicians must notify the Medical Record Department of when they will be on vacation. If physicians receive a notification letter while ill or on vacation, they will be given at least seven days after returning to work to complete records. The seven days will begin on the next first or third Tuesday notification cycle.

A record of temporary suspension of privileges will be maintained in each physician's credentials file. If a physician is suspended three times in a rolling twelve month period, the physician will have his/her hospital privileges totally suspended. In order to be reinstated he/she must justify to the Medical Executive Committee the cause for not completing his records in a timely manner. The Medical Executive Committee shall then recommend to the Board of Directors, through the President, the action regarding the physician's privileges.

21. In the event of the inability of a physician to complete his charts due to death or incapacity, the Medical Records Committee shall review each chart, enter a final diagnosis, and declare that chart complete for filing. If the medical records are not completed by the tenth of the month and he has notified the Record Room Supervisor, he shall not be suspended unless the records have not been completed within 72 hours of his return.

C. GENERAL CONDUCT OF CARE

1. All previous orders are cancelled when patients go to surgery or are transferred to or from the ICU, CCU or PCC.

2. All drugs and medications administered to patients shall be those listed in the latest editions of: United States Pharmacopoeia, Nation Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. A pharmacist who receives a prescription for a brand name drug may dispense any generically equivalent drug that complies with the above unless otherwise specified. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with UH Elyria Medical Center's "Policy and Procedure for the Use of Investigational Drugs" and all regulation of the Federal Drug Administration.

3. The attending physician is primarily responsible for requesting consultations. He must communicate all pertinent information relative to the case to the consultant before the consultant is obligated to perform the consultation. Any qualified physician with clinical privileges at UH Elyria Medical Center can be called for consultation within his area of expertise.

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 between the non-physician practitioner and 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.

5. Except in an emergency, consultation is appropriate in the following: in cases in which the diagnosis is obscure or where there is doubt as to the best therapeutic measures to be utilized; in unusually complicated situations where specific skills of other physicians may be needed; in critical illness in patients who are becoming progressively worse; in major surgical cases in which the patient is not a good risk; in cases where departmental Rules and Regulations require consultation; and in cases where a consultation is requested by the patient or his/her legal representative. A satisfactory consultation includes examination of the patient and the records and a written opinion signed by the consultant's diagnostic impression and important suggestions should be written in the record at the time of the consultation.

6. In cases of disagreement between the attending physician and the consultant, a second qualified consultant may be called by the attending physician. The first consultant shall be notified if this occurs.

7. If any Hospital registered nurse doubts or questions the care provided to any patient or believes that appropriate consultation has not been obtained, the nurse shall so notify his or her superior who in turn may refer the matter to the appropriate Nursing Supervisor. If she feels it is warranted, after discussion with the attending physician the Nursing Supervisor may notify the appropriate Department Chairman. Where circumstances so justify, the Departmental Chairman may require a consultation and/or the appropriate patient care.

8. It is desirable that all members of the Medical Staff be certified in basic life support triennially.

9. One member of the Medical Staff shall be primarily responsible for the medical care and treatment of each patient in the Hospital and for the prompt completeness and accuracy of the medical record. Whenever these responsibilities are transferred to another Staff member, a note covering the transfer shall be entered on the order sheet of the medical record. In surgical cases the primary responsibility automatically transfers to the operating surgeon at the time of surgery.

10. Each physician is responsible for the <u>continuous</u> care of his patients either by himself or by a qualified alternate who has been apprised of this action. The Hospital operator shall likewise be notified if an alternate is taking a physician's calls. The physician or his designee must make daily patient visitations.

11. Regulations for automatic stop orders on drugs, respiratory therapy, physical therapy and occupational therapy shall be established by the Medical Staff on the recommendation of the appropriate committees. Medications and/or treatments not prescribed for a specific number of doses or days will be stopped automatically in accordance with departmental policy.

12. In special conditions the administration of certain medications by registered nurses shall be in accordance with policy as approved by the Medical Executive Committee and the Medical Staff.

13. A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff. Such patient will be admitted under the names of both the dentist and the physician. Both the physician and dentist should be notified after the patient is admitted to the floor. The physician's responsibilities are the medical history pertinent to the patient's condition prior to anesthesia and surgery, and supervision of the patient's general health status when hospitalized. The discharge of the patient shall be on written order of the dentist and the concurrence of the physician. Podiatrist may admit patients and complete H & P's; Podiatrist may consult other specialist as needed.

14. Written, signed, informed, surgical consent shall be obtained prior to any

operative procedure except in those situations wherein the patient's life is in derepress and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken.

15. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post anesthetic follow-up of the patient's condition.

16. All tissue removed during an operation shall be sent to the Hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made for certain reconstructive surgeries as approved by the Medical Executive Committee upon the recommendation of the appropriate department.

17. All Medical Staff members shall abide by and participate in the Hospital's Disaster Plan.

18. Whenever an Emergency Room patient is referred to a Staff member, the physician to whom the patient is referred shall render whatever care is indicated at this Hospital.

19. Appropriate committees may adopt rules and regulations for Hospital units and for special care units such as the Recovery Room, Newborn Nursery, Intensive Care Unit, Coronary Care Unit, etc., subject to final approval by the Medical Executive Committee, the Medical Staff, and the Board. Any such rules and regulations shall conform to, and become a part of, these Medical staff Rules and Regulations and the Medical Staff Bylaws. Any inconsistencies between such rules and regulations (or the Bylaws) shall be resolved in favor of the Bylaws documents.