UH Geneva Medical Center

Rules and Regulations of the Medical Staff

University Hospitals
Geneva Medical Center

MEDICAL STAFF RULES AND REGULATIONS

I. Meetings of the Staff

A. A Combined Medical/Surgical Medical meeting shall be conducted no less than two times a year. The last meeting of the year shall be considered the Annual Meeting. This meeting shall be for the purpose of conducting the routine business of the Medical Staff as specified in the Bylaws and for the purpose of electing Medical Staff Officers.

B. The Chief of Staff/and or Department Chairpersons will be able to call special meetings of the General Medical Staff, Medical Department or Surgical Department as needed, as provided in the Bylaws.

II. On-Call Responsibilities

The Medical Staff acknowledges that the Hospital has a legal responsibility to provide call coverage for those services, which Hospital provides inpatient coverage. The Medical Staff further acknowledges that in order for the 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 (set forth in **Appendix A**) 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 the Article XI, Section C of the Hospitals' Medical Staff Bylaws.

As further delineated in the policies and protocols set forth in **Appendix A**, on-call responsibility means that in the event the on-call physician is requested to attend to a patient in the emergency room they 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 Ad Hoc Committee as appointed by the Chief Medical Officer 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 Chief Medical Officer shall appoint the Ad Hoc within one week of being notified of a physician who has failed or appears to have failed to comply with this Section II of the Rules and Regulations. The Ad Hoc Committee must meet to consider the charges, explanations and evidence within two (2) weeks of its appointment. The Committee's findings must be

presented and acted upon by a quorum of the Medical Executive Committee within two (2) weeks of the submission of the recommendations of the Ad Hoc Committee to the Medical Executive Committee. The Medical Executive Committee may enact any of the disciplinary options available to it under the Medical Staff Bylaws, Rules and Regulations.

III. Admission of Patients

A. The Hospital shall accept patients for care; except for acute psychotic patients who are evaluated and treated in the emergency room; wherein a psychiatric evaluation is obtained, and based on that evaluation a plan for referral/transfer to a receiving psychiatric facility and/or arrangements for outpatient follow u*p* psychiatric unit shall be made. If admission is necessitated due to required medical observation and/or lack of a receiving facility, the patient with psychiatric symptoms shall receive care and a consultation shall be ordered with a psychiatrist and/or appropriate community-counseling agency. A family member shall be requested to remain with the patient during hospitalization, although care and treatment of the patient remains the responsibility of the physician and the Hospital and Medical Staff. Inpatient and outpatient alternatives to care shall be provided to the patient and transfer shall be facilitated when a bed is available at a receiving facility as soon as possible.

B. A patient may be admitted to the Hospital only by a member of the Medical Staff having admitting privileges. All Practitioners shall be governed by admitting policies of the Hospital. No patient will be admitted without a provisional diagnosis.

C. No patient will be admitted without prior examination by a physician who shall include a complete history and physical report. If a patient is readmitted for treatment of the same or a related problem within 30 days following discharge from the hospital, an interval history and physical examination report explaining any subsequent changes may be used in the medical record, provided that the original information is included in the record.

D. The physicians on the Emergency Room staff may admit patients after consultation with the patient's choice of physician on the Hospital's Medical Staff who agrees to admit the patient. If the patient is without a private physician, the appropriate Medical Staff member shall be contacted from the current "on-call" schedule. In all cases, the patient can only be admitted under the care of a Medical Staff member with admitting privileges.

E. It is the responsibility of the physician to whom the patient is being admitted to do a complete history and physical on the patient as specified in Section XI of the Rules and Regulations. The Emergency Room doctor is to complete the patient's Emergency Room Record (T-Sheet) and additional physician order/progress sheet when appropriate, and at least the following items must be addressed:

1. Pertinent history of the illness or injury, and physical findings, including the patient's vital signs.

2. Diagnostic and therapeutic orders.

3. Clinical observations, including the results of procedures, tests and treatments.

4. Diagnostic impression.

5. Conclusion at the end of evaluation/treatment, including final disposition, patient's condition on discharge or transfer, and any instructions given to the patient and/or family for follow-up care.

6. A patient leaving against medical advice (with a signed AMA form). If patient refuses, this should be documented.

NOTE: If dental, podiatry, psychological patient, the admitting practitioner (or treating practitioner) must arrange for a physician member of the Medical Staff to monitor medical problems and do a history and physical assessment. For dental patients, dentist performs part of H&P relating to dentistry. For podiatry patients, podiatrist performs part of H&P relating to podiatry.

F. The admission process for patients admitted or transferred to a Skilled ("Swing") bed, is initiated by the admitting physician when he/she determines that a hospitalized patient no longer requires acute care. Patients at the "skilled" level do not require daily physician supervision. At the time orders are written for admission (or transfer) to the Skilled ("Swing") bed the physician must sign the "Certificate and Re-Certification Swing Bed" Form. In signing this form, the physician certifies that post-hospital extended care services are required to be given on an in-patient basis due to the patient's need for skilled services (nursing or rehabilitation) on a continuing basis for the condition which the patient originally received as an acute in-patient prior to the need for skilled ("swing") services. The physician will sign the "Certificate and Re-Certification" Form to re-certify the patient and continue care if needed on or before the 14th day and the 21st day.

IV. Discharge of Patients

A. Patients shall be discharged only on order of the attending physician or physician covering for the attending physician. On the day of discharge of a patient, it will be the responsibility of the attending physician, or physician covering for the attending, to discharge the patient by 11:00 AM. This rule is not applicable to those awaiting special diagnostic reports of work done on the preceding day. The latter will be discharged by 1:00 PM. Patients are expected to leave the hospital prior to 2:00 PM on the day of discharge.

B. All relevant final diagnoses established by the time of discharge, as well as any complications are recorded, authenticated and dated, without the use of symbols and abbreviations, as soon as possible following discharge, but not to exceed a period of fourteen (14) days after discharge.

C. The attending physician is to dictate the final discharge summary within fourteen (14) days following discharge as specified in Section XI of the Rules and Regulations.

D. Dietary instructions shall be given by the attending physician and/or by the dietitian, under the guidelines of the physician, on every patient with an anticipated discharge diet other than a regular diet.

V. Transfer of Patients

A. Transfer of patients to another health facility is the responsibility of the attending physician.

B. A standard transfer form must accompany the patient. The transferring physician is responsible for completing the appropriate sections and authenticating, after discussing the case with a receiving physician who agrees to accept the patient.

C. If the patient is transferred from the Emergency Room, the Emergency Room physician will fill out the necessary Emergency Room Transfer Form after conducting an appropriate medical screening evaluation, and discussing the case with a receiving physician who agrees to accept the case. In all cases, prior to patient transfer, the emergency room physician will have provided all necessary stabilizing treatment for the existing emergent medical condition's (including labor).

At times, it may be necessary/appropriate to transfer an unstable patient to another medical facility if,

1) the patient (or person acting on his/her behalf), after being informed of the risks and the hospital's obligations, requests a transfer.
2) the emergency room physician has indicated via the transfer form that, based on the information available at the time of transfer, the benefits of transferring the patient to another medical facility outweigh the risks to the individual or, in the case of a woman in labor, to the woman or the unborn child. The transfer form must indicate a summary of the risks and benefits upon which it was based.

In all cases of patient transfer, all pertinent records, including all available history, diagnostic results, test results, consents, preliminary diagnoses etc., shall accompany the patient during transfer.

VI. Treatment of Patients

A. Patients may be treated only by practitioners who have been granted clinical privileges on the Hospital Medical Staff according to the Bylaws.

B. 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.

C. Every patient in the Hospital must be seen every day by the attending physician, or his designee, authorized to write orders for said patient.
    1. Patients in Skilled ("Swing") beds must be seen at least every seven (7) days (or as needed) by the attending physician.

D. Patients admitted for drug overdose or suicide gesture shall be offered and encouraged to have an appropriate evaluation by a psychiatrist and/or Community Counseling Agency.

E. The Medical Staff is in accordance with and agrees to observe the Hospital Restraint

Reduction Policy #21.4 on the case of "Restraints" which was established to be utilized when restraint of a patient is necessary, due to the patient's physical activities or deficits, which may cause harm to the patient or others.

F. The time frame in which Physicians must see their patients after being notified of a patient's arrival time is as follows:

Critically Ill/Unstable is within one (1) hour; ICCU is within twelve (12) hours, Routine Admission is within twenty-four (24) hours, and Skilled ("Swing") is also within twenty-four (24) hours.

VII. Surgical Care of Patients

A. Except in emergencies, the following must be recorded on the patient's medical record **PRIOR TO** any surgical procedure:

1. preoperative diagnosis;

2. appropriate informed consents for the procedure(s) including documented explanation of risks and alternatives including the potential need to administer blood or blood components; and the informed consent for anesthesia which will include a documented explanation of the risks and benefits for the planned anesthesia;

3. relevant and medically necessary laboratory, radiology, or other diagnostic reports;

4. consultations, when requested;

5. history and physical examination will be dictated and on the chart **PRIOR TO THE START OF SURGERY**, if typing services are available; otherwise, this examination will be handwritten prior to the start of the case;

6. a note written by the surgeon prior to the start of surgery stating the indication for surgery, and what surgery is planned.

NOTE: In the case of an **extreme emergency** (defined as a non-elective procedure with serious threat to life or function,) where any or all of the above entries have not been made in the medical record, the operating surgeon shall state in writing that a delay would be detrimental to the patient (and shall make a comprehensive note in the medical record indicating the patient's condition, and that the patient's condition is deemed to be satisfactory for the planned surgery) prior to induction of anesthesia and the start of surgery.

In all other elective cases the responsible nurse shall notify the operating surgeon, (preferably no later than the night prior to scheduled surgery) of the patient's incomplete record. **PREPARATION FOR SURGERY, INCLUDING PREMEDICATION SHALL NOT BE PERFORMED UNTIL PROPER ENTRIES ARE RECORDED IN THE PATIENT'S MEDICAL RECORD.** If this delay causes a change to be made in the surgery schedule, the operation shall be rescheduled to the next available time.

B. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to involvement of a minor or unconscious patient, and when consent for surgery cannot be immediately obtained from parents, guardian or next of kin. These circumstances should be fully explained in the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

The surgeon is responsible for obtaining the procedure consent. The Anesthesiologist/Nurse Anesthetist is responsible for obtaining the anesthesia consent. Hospital nurses may serve only as witness to signatures on these consents. Refer to the Hospital Consent, Procedure, Sedation and Blood Products Policy #11.4.

C. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled. If a surgeon is repeatedly or flagrantly late, he may be referred to the Chairman of the Surgical Department.

D. In the case of emergency surgery, Anesthesia staff must be available within approximately 30 minutes after notification that anesthesia is deemed necessary.

E. The anesthesiologist/nurse anesthetist is responsible for obtaining informed consent for anesthesia and for recording evidence of this in the medical record.

F. The anesthesiologist/nurse anesthetist will complete a **PRE-ANESTHETIC ASSESSMENT** prior to the patient's transfer to the operating area and before preoperative medication has been administered. This shall indicate an evaluation of the patient, including a review of past and present medical and drug history, previous anesthesia experiences, results of relevant diagnostic studies, ASA physical status, and the plan for anesthesia.

When an anesthesiologist is not present or responsible for the case, the physician performing the procedure must concur with the pre-assessment and with the anesthetic plan. In such cases, the operating physician must place his/her signature, date and time on the pre-anesthetic assessment form as evidence of concurrence and acceptance of responsibility, prior to the start of the procedure.

The anesthesiologist/nurse anesthetist will re-evaluate the patient immediately prior to induction of anesthesia.

G. The Anesthesiologist/Nurse Anesthetist is responsible for maintaining a complete record of the patient's physiological status throughout the procedure. They are also responsible for writing a note after the patient has completed post anesthesia recovery that includes at least a description of the patient's physical status and a notation of the presence or absence of anesthesia-related complications. If post anesthesia complications exist, a plan of care shall be outlined following discussion with the attending surgeon or physician. *(*Each anesthesia entry shall be dated, timed and authenticated by the responsible anesthesiologist/nurse anesthetist.*)*

H. For patients undergoing Moderate Sedation, the physician's signature, date and time evidencing the two pre-anesthetic assessments shall appear on the "monitored vital signs' record. Refer to the Hospital Moderate and Deep Sedation Policy #17.28.

I. If, in the opinion of the operating surgeon, there is in any surgical procedure an unusual hazard to life, and in major surgery cases as per policy approved by the Surgical Committee, there shall be present and scrubbed in as first assistant, a qualified physician, CRNA, or credentialed surgical assistant **PRIOR TO START OF SURGERY.**

J. A medical staff appointee who is classified in a preceptorship status for specified surgery privileges, must have present their preceptor and/or qualified physician for these specified surgery procedures until that preceptor validates competency for that specific procedure.

K. The attending surgeon shall ensure that all surgical specimens removed during surgery will be submitted for pathological examination, except specimens which by their nature do not

permit meaningful examination, such as cataracts, foreign bodies (including synthetic materials, orthopedic appliances etc.) Any tissue/specimen not forwarded for pathological examination shall be described as "gross pathology review" in the operative report by the surgeon. See **Appendix B**.

Each specimen shall be accompanied by necessary information including the preoperative diagnosis, description of tissue and brief pertinent clinical data, which the surgeon will complete or cause to be completed. The pathologist's report shall be made a part of the patient's medical record.

L. The rules for the **SCHEDULING** of elective or non-emergency surgery will be as follows:

1. Only the Operating surgeon or a member of surgeon's office staff can request a case be scheduled.
2. The schedule is available for posting of cases at all times.
3. A completed Surgery Request Form has been received by the Pre-Certification Review office or Outpatient Surgery Department.
4. The order of cases will be based on the time of the first scheduled case posted, available operating room personnel, room cleaning, etc., as determined by the Manager of Perioperative Services.
5. If cleared in advance with the operating room supervisor, cases may be posted at a specified time for justifiable reason, or they do not interfere with normal operating room schedule. These cases will be scheduled in accordance with rule K.4 and will be done as near to that time as a room is available in the order the case is posted.

The following steps shall be taken when the need to schedule an **EMERGENCY** procedure occurs:

1. The surgeon notifies the Perioperative Services Manager of what procedure is planned.

2. Any "in progress" procedures are completed.

3. The next scheduled elective procedure/s are postponed, and surgeon/s notified of the reason for delay by the surgeon with the emergency case.

4. During off hours, the on-call "team" (including anesthesia) shall not be notified to come in until after the emergency patient has been seen and evaluated by the surgeon who will be performing the case.

M. Except in the case of emergency, all patients undergoing any type of anesthesia should have any **PREOPERATIVE TESTING** that may be warranted based on any/all medical conditions which may be present or suspected.

Any patient of any age who gives a history suggestive of cardiovascular disease pulmonary disease, hepatic and/or gastrointestinal disease, bleeding problems, renal disease, endocrine disorders, neurological disease or musculoskeletal disease shall have relevant medically necessary studies completed prior to surgery.

N. Explicit postoperative orders shall be completed by the surgeon before leaving, and the surgeon shall be available by phone/pager to consult on difficulties, if the need arises. Surgeons are responsible for following the daily surgical aftercare of their patients. Attending physicians are responsible for medical management.

O. The decision to discharge a patient from the PACU and/or from the setting/facility is made either by a qualified licensed independent practitioner or by other appropriately trained personnel utilizing medical staff-approved criteria. In the latter, the surgeon must have written on the record **"Discharge Per Criteria".** See **Appendix C.**

P. Performance monitoring of preoperative judgement, intraoperative skill, and postoperative management shall be included in the hospital's quality management program. Any adverse findings shall be evaluated via the concurrent surgical peer review process under the direction of the Surgical Department Chairman, who ensures timely and appropriate action and follow *up* are taken as warranted. The findings and outcome of the peer review process *are* evaluated along with other factors at the time of individual reappointment and privilege review by the Surgery Committee, and appropriate action taken when warranted. The Surgical Department Chairman reports to the Medical Executive Committee any outcome and actions taken via the concurrent peer review process.

VIII. Patient Care Orders

A. All orders shall be in writing, legible, dated and timed.

B. **VERBAL ORDERS OR TELEPHONE ORDERS** shall be considered to be in writing if dictated to Registered Nurse and authenticated by the attending physician. Licensed Practical Nurses, Licensed Pharmacists, Licensed Physical and Occupational Therapists, Licensed Speech-Language Pathologists, Registered and Licensed Dietitians, Certified and Registered Respiratory Therapy Technicians and Registered Radiographic Technologists within the scope of their competence may also receive verbal orders. The staff member receiving the order shall read it back to the physician then sign their own name and the name of the ordering physician.

1. Verbal orders for respiratory therapy may be accepted or written by a Certified Respiratory Technician or a Registered Respiratory Therapist. Verbal orders for radiological examinations may be accepted or written by Registered Radiographic Technologist. Licensed Dietitians may receive verbal orders for diet instructions or diet changes. Licensed Pharmacists may receive verbal orders for medication. Physical Therapists and Occupational Therapists may receive orders for physical therapy and occupational therapy. Speech-language pathologists may receive verbal orders for barium swallows. Physician Assistant can receive verbal orders. All other verbal orders can only be issued by a Physician, Physician Assistant or an Advanced Practice Nurse.

2 Verbal or telephone orders should be used infrequently and are only acceptable under the following circumstances:

a. During a life-threatening patient care emergency.
b. When an authorized individual contacts the physician to report a change or potential change in the patient's condition, accept a referral, or to clarify orders and the physician determines that immediate changes in orders are necessary.
c. For Admission or Pre-Admission orders.
d. During sterile or procedural conditions where it is not feasible for the physician to write the orders.
e. Telephone DNR orders are only acceptable as outlined in the Hospital *Resuscitative Treatment Policy #21.5* **and must be authenticated, dated and timed within 24 hours.**

All VERBAL OR TELEPHONE ORDERS described above shall be

authenticated and dated by the attending/prescribing physician, or other physician responsible for the patient's care, as soon as possible. In most instances, verbal orders should be **authenticated, dated and timed within 48 hours (unless otherwise stated)**. It is acceptable for a covering physician to co-sign (i.e. authenticate) the verbal order of the ordering physician, which indicates that the covering physician assumes responsibility for his/her colleague's orders as being complete, accurate and final.

C. Orders written postoperatively by CRNA's must be approved and countersigned by the attending physician/surgeon.

D. Orders shall be written only by the attending physician, or other rounding physician from same group practice or by a consulting physician, unless he/she specifies on the order sheet that this responsibility is to be shared with another physician or has notified hospital personnel of substitute coverage through approved mechanisms.

E. Emergency physicians may write initial admitting orders and any subsequent emergency orders.

F. Orders for hazardous drugs must be handwritten by the attending and/or consulting physician. No verbal or telephone orders shall be accepted for Hazardous drugs. Hazardous drugs are defined as any and all chemotherapeutic agents and investigational drugs.

G. Standing orders and/or protocols shall be formulated by conference between all members of the appropriate Department with approval of the Medical Executive Committee.

H. It is the responsibility of all physicians to comply with the Hospital Automatic Stop Order Policy #17.3.

I. Patient care orders must be re-written when one of the following occur:
   a. When a patient returns from surgery;
   b. When medication is resumed after an automatic stop order has been employed;
   c. When a patient is transferred to or from ICU;
   d. When a patient is transferred to or from a Skilled ("Swing") bed.

   It is unacceptable to write, "RENEW", "REPEAT", or "CONTINUE" in the above circumstances or for patients admitted from a Nursing Home.

J. Patient care orders may be written by a resident physician while in an approved clinical rotation at the hospital. All resident physician orders must be countersigned by the supervising teaching attending physician (Refer to Hospital Physician Rotation Policy #7.1.

IX. Diagnostic and therapeutic procedures and test results

It shall be the responsibility of the Hospital to have all reports of clinical laboratory studies, pathologic studies, imaging examinations, other diagnostic studies promptly incorporated in the chart.

X. All Ambulatory Observation records are to include a dictated or legibly written "relevant" history and physical examination, appropriate diagnostic test results, progress notes describing continued need for observations and a dictated or legibly written summary of the

conclusions at termination of hospitalization or evaluation/treatment including final diagnosis, condition on discharge, and any instructions such as diet, medications, activity and follow up provided to patient at the time of discharge.

XI. Medical Records

A. The attending physician shall be responsible for the preparation of a complete and legible medical record for each individual evaluated or treated as an inpatient.

All physicians must have completed Electronic Medical Record training to the satisfaction of the Chief Medical Officer prior to evaluation or treatment of a patient.

Such record shall include:

1. History and Physical Examination **dictated** within 24 hours of admission and/or prior to surgery. This timeframe applies for weekend and holiday admissions, as well as weekday admissions. This report shall include:

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

   In records for children and adolescents, when relevant to reason for admission, 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

   In records of ambulatory/outpatient procedures, the following guidelines for when to conduct a complete H&P verses a brief H&P shall follow:

   • All ambulatory procedures performed in the operating suite require a complete H&P prior to the procedure

     - Ambulatory procedures not performed in the operating suite *that place the patient at significant risk* require a brief H&P consisting of the following Reason for the Procedure
     - Significant past medical history
     - Current medications
     - Allergies
     - Plan for Anesthesia
     - Post-operative plan and, at a minimum, a recording of vital signs
     - Examination of heart, lungs, and part to be invaded

(Example: a CT of the Head does not carry significant risk and so does not need a brief H&P, but a CT-guided biopsy or CT under conscious sedation does carry risk and should have the brief H&P)

- Skilled ("Swing") patients transferred from an Acute Care bed will have a copy of the H&P, discharge summary and other relevant tests, studies, notes placed on the Skilled chart. The physician will write or dictate an addendum to the H&P to update the patient's progress. This is to occur within twenty-four (24) hours.

  hours.

- If the Skilled ("Swing") patient is transferred in from another Acute Care facility, the admitting/attending physician for the Skilled patient will evaluate the patient and dictate or write the H&P within twenty-four (24) hours.

2. Diagnostic and Therapeutic Orders.

3. **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. Progress notes must be dictated or written within 24 hours. Such items to address **may** include:

   a. reassessment
   b. response to care and/or treatment
   c. abnormal findings of tests
   d. consultation reports
   e. medications ordered
   f. response to medications given
   g. adverse drug reactions
   h. medications prescribed at discharge
   i. relevant diagnoses during case
   j. referrals to external and/or internal provider/agency

   A progress note shall be written or dictated into the record when a patient is transferred to a different level of care (i.e. ICCU to Med/Surg).
   - Progress notes on Skilled ("Swing") patients will be written at least every seven (7) days or as needed for assessment and treatment (refer to #3 above).

4. Operative Reports are **dictated** immediately following surgery and shall contain the following:

   a. pre-operative diagnosis;
   b. a description of the findings;
   c. the technical procedures used;
   d. the specimens removed;
   e. the post-operative diagnosis; and
   f. 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).

5. 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.

6. Skilled ("Swing") patients who require rehabilitation services will have such services initiated by the attending physician. This initial Skilled Plan of Care for the relevant therapy (Physical Therapy, Occupational Therapy, Speech Therapy) will be signed by

the physician. The physician and relevant therapist will re-evaluate the plan of care at least every two weeks, or with significant changes in status, and the physician will sign the updated Plan of Care (in the Rehab section of the chart).
of the chart).

7. Clinical Resume (Discharge Summary) which is dictated within fourteen (14) days of discharge and which includes the following:

   a. the reason for hospitalization;
   b. significant findings;
   c. procedures performed and treatment rendered;
   d. condition and prognosis of the patient on discharge;
   e. instructions given to the patient and/or family, which specifically include: physical activity, diet, medication and follow-up care;
   f. final diagnosis

   Please note: For patients being discharged to a nursing home, the discharge summary must be dictated within 24 hours of discharge.

8. 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 **Appendix D**.

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

B. No medical record shall be filed until it is completed except on the recommendation of the Medical Executive Committee.

C. Records not completed within the designated time after being placed in the physician's incomplete file will be declared delinquent and the physician so notified.

1. All records are to be filed complete within thirty (30) days of discharge. Physicians will be notified of those deficiencies, which need to be completed within fourteen (14) days of discharge according to the following approved procedure.

2. Reminder/warning letters will be sent to physicians once a week according to the following time frames:

   LETTER #1 Deficiencies aged to 7-13 days
   A reminder memo from Health Information Services, is sent to physician's office asking for completion of deficiencies as soon as possible.

   LETTER #2 Deficiencies aged to 14-20 days
   A letter from the President of the Hospital (or designee in his/her absence) is sent to the physicians informing them that their record(s) have reached a "delinquent status" and asking them to complete all identified deficiencies within seven (7) days to avoid suspension.

   LETTER #3 Deficiencies aged to twenty-one (21) days
   Formal letter, from the Chief of Staff, will be mailed informing the physician that they are in violation of the Medical Staff rules and regulations and that their privileges are now suspended and that upon completion of all identified deficiencies, their privileges would be reinstated.

3. As part of ongoing, open record review, history and physical and operative notes will

be reviewed for timeliness of completion. H&P's must be dictated within the first 24 hours of admission, Operative reports must be dictated immediately following surgery.

4. If through the ongoing, open record review process a delinquency occurs in regard to these reports, the physician will be notified that he/she has until midnight the next day to complete the dictation or admitting privileges will be suspended.

D. At the time of appointment/reappointment physicians must have on file in the Health Information Services Department a signed "Author Identification" cards so that authorship of all entries can be determined.

E. At the time of initial appointment, physicians must sign and date "Physician Acknowledgment Statement" indicating they have read the Medicare notice to Physicians about Medicare payment to Hospitals based on accurate information attested to by the patient's attending physician.

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

G. In case of readmission of a patient, all previous records (including outpatient and emergency room) shall be made available for the use by the attending physician.

H. Access to all medical records of all patients shall be afforded the staff physicians in good standing for bona fide study and research, or department or committee duties, consistent with preserving the confidentiality of personal information concerning the individual patients.

XII. Consultation

A. Except in an emergency, consultation will be required in the following cases:

1. Any major surgical procedure under grave circumstances.

2. Any medical/surgical high-risk patient as determined by the attending physician.

3. When a patient is admitted to the ICCU by a physician other than an internist, consultation must be made with an internist or appropriate specialist, according to the policy and procedure in the ICCU.

B. The consultant will examine the patient and dictate, or legibly record findings and recommendations in every case, prior to patient going to surgery. This shall become part of the patient's record.

C. A consultation will be completed within 24 hours of the request. If the patient requires consultation earlier due to increased acuity, a direct conversation between the attending and consultant should occur.

D. EKG's, Echocardiograms, pulmonary function tests, stress tests *etc.* ***shall be read within 24 hours***.

XIII. House Physicians - Granting Privileges for Contracted House Physicians

The Hospital may employ or contract for House Physicians to provide supplementary or special clinical services to hospital patients. Such physicians shall be assigned to the appropriate department for administrative purposes. They shall be eligible for medical staff membership as House Physician. In attending patients, they shall be under the supervision of the respective attending physician(s) and Department Chairperson involved with such patients.

Credentialing of such physicians shall follow the pattern outlined in the Bylaws. House physicians must also meet the following qualifications:

A. Have completed a minimum of two years of postgraduate training
B. Be certified in Advanced Cardiac Life Support (ACLS).
C. Have Ohio Medical License
D. Malpractice Carrier

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 Executive Committee and the Board of Trustees. In extenuating circumstances, temporary privileges as outlined in the Medical Staff Bylaws may be granted for a period not to exceed 120 days.

At the termination of their services at UH Geneva 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.

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 Medical Officer.

Responsibilities shall include but not be limited to:

(a) 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.
(b) Monitor lab results of newly admitted patients and consult with the attending physician about abnormal values as appropriate.
(c) Care for acutely ill patients as long as the crisis continues in accordance with the direction of the attending physician.
(d) Invasive procedures such as central lines, elective intubations, insertion of any tubes or lines are only performed under the presence and direct supervision of an attending physician.
(e) Supervise under direction of attending physician patient transfers to tertiary facilities.
(f) Notify the attending physician of any significant change in patient's status or transfer to critical care.
(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 Pharmacist on call 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 legible progress note in the chart for each activity (e.g. assessment and intervention of a patient for any reason) performed.
(k) Assist laboratory technicians in obtaining unusual or difficult specimens for inpatients; 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.

(l) Will assist in documentation of DNR status following communication with the attending physician, family and patient.
(m) Will round each AM and PM any newly admitted patient and any unstable patients.
(n) Will perform an in-person patient assessment before prescribing drugs, which have the potential to reduce the patient's level of consciousness.
(o) Verbal orders should be limited to emergency situations and when necessary must be signed off before leaving for the day.
(p) 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.
(q) When patients are transferred to another unit within the hospital, this must be communicated to the primary care/attending physician.
(r) Obtain informed consent from a patient when blood transfusions are needed and the attending physician is not present in the hospital to do so.
(s) Medical records must be completed according to established parameters and delinquencies will lead to suspension of privileges.

Specific areas that are not House Physician responsibilities, unless otherwise specified:
(a) Discharge summaries, and routine dressing changes.

XIV. Drills

A. The Medical Staff shall cooperate with Hospital Administration in the establishment and practice of an Internal/External Disaster Plan as provided in the Hospital Safety Manual.

XV. Ohio Department of Health and OSHA regulations

The Medical Staff shall adhere to all hospital policies and procedures regarding:

A. HIV and/or HBV Infected Health Care Workers

B. Bloodborne Pathogen Standard

C. Preventing Transmission of TB in Health Care Facility

XVI. Definition of Terms

A. ATTENDING PHYSICIAN: Insofar as Hospital in-patient care is concerned, an attending physician is a duly authorized agent of the patient, acceptable to the Hospital, to conduct the medical care of the patient and purchase services and commodities for him. Since the patient has selected the physician, the Hospital is committed to honor the orders of that physician in prescribing for that patient. In other words, the medical management of the patient is vested in the attending physician.

B. MEDICAL MANAGEMENT: Medical management consists of the authority to order and perform diagnostic and therapeutic procedures on behalf of the patient. Such authority carries commensurate responsibilities, including:

-Timely completion of the history and physical and provisional diagnosis.
-Daily visits to the patient and progress notes.
-Timely completion of operative reports when applicable.
-Provision for discharge of the patient incorporating adequate discharge instructions.
-Timely completion of the discharge summary and discharge diagnosis.

Medical management of the patient's care rests with the attending physician. Responsibility for medical management may be vested in the following ways:

1. Partnerships/Group Practices

   Two or more physicians interchanging in written orders and treating the patient is acceptable when the physicians have a legally constituted partnership or group practice. Such an arrangement must apply to all patients admitted by any or all of the members of the practicing group. The partnership or group becomes the attending physician. The Hospital Administration should be so notified of such intent.

2. Limited Consultation

   When the attending physician requests the consultation of another physician in order to provide proper medical care of the patient, he may so specify in writing on the physicians' order sheet, the consulting physician and any limitations he may desire to place on the consultation. This is most common when a specialist, e.g. a surgeon, admits a patient who may need the services of an internist as well. The responsibility of the medical management rests with the attending physician; he has only delegated limited authority to another for certain services on a given patient.

3. Specialty Services

   When, in the treatment of a patient, a specialized procedure may be necessary, a specialist qualified to perform that task joins the attending physician. For example, the anesthesiologist renders a special service necessary for surgery. Certain radiological procedures, especially X-Ray therapy, require delegation of some management authority to another physician.

4. Transfer of Care

   When the attending physician determines that the medical management of the patient would better be served by a physician in a specified field or specialty, he may transfer the medical management of the patient's care to a designated physician. Such transfer shall be initiated by the attending physician writing a request on the physician's order sheet. The responsibility for that patient shall not transfer until the receiving physician's acceptance of that patient in writing on the chart (exception: individual physicians sharing a documented call schedule or a physician covering for another physician has the right to transfer as deemed necessary).

C. CONSULTATION: A consultant is an advisor. A consultation occurs when the attending physician seeks advice from other physicians. A limited consultation in no way effects overall responsibility of the attending physician for the medical management of the patient. The consultant is authorized to write orders or proceed with treatment of the patient in regard to his specialty.

D. REFERRAL: See "Transfer of Care". In case of emergency, the Hospital or a physician has the right to act as necessary if delay would endanger the patient. Such action should not exceed treatment of the emergent condition.

Revised 2-28-06, 2-19-08, 4-21-09, 2-26-10;10-17-10

Revisions approved by the: Medical Executive Committee on 06/25/2021; Full Staff 4/18/2022 and Board of Trustees on 5-27-2022.

Please note: All references to Hospital Policies in these Rules & Regulations are available at the UH Geneva Medical Center intranet.

UH GENEVA MEDICAL CENTER

ON-CALL COVERAGE POLICIES AND PROTOCOLS

PURPOSE

The purpose of the following policies and protocols is to define the appropriate protocols for establishing an effective On-Call Rotation Schedule and Back-up Guidelines and for accessing the appropriate On-Call Physicians and Attending Physicians in the Emergency Department of UH Geneva Medical Center ("Hospital").

POLICY #1 – WHEN TO REFER TO ON-CALL ROTATION SCHEDULE (Availability/Non-Availability of Attending Physician)

A. No Attending Physician. When a patient presents to the Hospital Emergency Department and does not have an Attending Physician, or the Emergency Department cannot otherwise reasonably determine within a reasonable amount of time of patient's arrival at the Emergency Department whether such Attending Physician exists or is available to respond, promptly refer to the On-Call Rotation Schedule (posted in the Emergency Department). The designated physician on-call shall be immediately contacted as determined appropriate by the Emergency Department Physician. Determination of whether a patient has an Attending Physician shall be made as soon possible, but in no way shall such determination (or lack thereof) delay or interfere with the Emergency Departments efforts to screen and stabilize the patient.

B. Attending Physician Available. If a patient presents to the Emergency Department and notifies the Emergency Department that he/she has an Attending Physician on staff at UH Geneva Medical Center, such Attending Physician will be called to assist in managing the patient's care if upon request of the patient or as determined appropriate by the Emergency Department physician. The Emergency Department's efforts to screen and stabilize the patient shall not, however, be delayed or interrupted to wait for the Attending Physician to present to the Emergency Department or the Hospital. Notwithstanding the foregoing, reasonable efforts must be used to contact the Attending Physician to assist in: (1) selecting patient's surgeon, orthopedic, cardiologist and/or other consultant. Notwithstanding the foregoing, the patient (and if applicable, his/her legal guardian) has the right to select his/her own consultant. Reasonable attempts must also be made to contact the Attending Physician to inform him/her and obtain his/her agreement with respect to any decision to transfer the patient. If an Attending Physician is known to be available, do not automatically contact the in-house surgeon, a physician and/or cardiologist without first consulting with the Attending Physician. The Attending Physician is responsible for being (or, if such Attending Physician is a member of a group practice, for making alternative coverage arrangements in compliance with Hospital's On-Call Coverage Policies and Protocols) and if appropriate, presenting to the Emergency Department to respond, examine and treat patients with emergency medical conditions who have identified the Attending Physician as such patient's primary physician or physician of record.

POLICY #2 –PREPARING AND ESTABLISHING THE ON-CALL ROTATION SCHEDULE

Preparing and Disseminating On-Call Rotation Schedule and Call Coverage Policies & Protocols The hospital's Medical Staff Coordinator shall be responsible for preparing and establishing the On-Call Rotation Schedule (the "Schedule") and shall use best efforts to prepare the same at least two (2) weeks in advance of the month to which it will apply. The Hospital's Medical Staff Coordinator shall further ensure that the Schedule is properly posted in the Emergency Department and that copies are disseminated in advance to the following individuals on a monthly basis (and at any time that there is any material change made to the Schedule): (1) the President of the Hospital; (2) the Chief Medical Officer of the Hospital; (3) President of the Medical Staff (4) the Chairperson of each Clinical Department; (5) Emergency Room Department ; and (6) each Physician who is listed on the Schedule as being on-call (if more than one physician from the same physician group or corporation is listed, then each physician must receive his/her own copy of the Schedule, do not just send one copy of the Schedule to the group/corporation).

Obligations of On-Call Physicians To Notify Of Schedule Changes. The Physician must provide a written notice that he/she will be unavailable to participate in the Schedule for the respective month. The letter should also make reference to the On-Call Coverage Policies and Procedures and require that the physician consult his/her copy of the same (or immediately notify Hospital if physician does not have a copy) for further guidance with respect to On-Call obligations of the physician. Every physician scheduled to be On-Call should be responsible for securing in advance an appropriate substitute physician to take call if such original physician cannot meet his/her call coverage obligation in compliance with the Hospital's On-Call Coverage Policies and Procedures. Any substitute physician must be an Active or Courtesy member in good standing on the Hospital's medical staff. Physician must promptly notify the Medical Staff Coordinator and the respective Department Chairperson of the name, telephone number, specialty and availability (and any other information reasonably requested by Hospital) of any substitute physician.

Obligations of Department Chairpersons: In order to properly prepare the Schedule, the Medical Staff Coordinator shall require that the Chairperson of each Clinical Department supply the names of those Active Staff members who will be on-call during the applicable month in each of the following respective specialty rotations regularly provided at the Hospital on an inpatient basis:

Surgery	Orthopedic Surgery	Podiatry
Medicine	Pediatrics	
Gastroenterology	Gynecology	
Cardiology	Urology	

If no Active with admitting staff members are available to take call in an applicable specialty for the respective month, than the Chairperson of the applicable Clinical Department shall supply the names of those Active without admitting members who will be on-call during the applicable month. Each Chairperson must communicate to his/her respective Department physicians the requirement that Active Staff with and without admitting privileges) members be available to take call and the expectation that Active with admitting Staff members (and in their absence) Active without admitting Staff members will take call for no less than ten (10) twenty-four hour periods every month or as otherwise required by the respective Department Chairperson after consultation with the President of the Medical Staff, (if the physician covers more than one hospital, then the number of calls will be at the discretion of the Medical Staff).

Advance Notice of Lack of Availability of Physicians In Particular Specialty. If, in preparing the Schedule, the Medical Staff Coordinator determines that no physician is available to take call in a specialty for which the Hospital regularly provides inpatient consultations, then the Medical Staff Coordinator shall immediately notify; (1) the President of the Hospital; (2) the Chief Operating Officer of the Hospital; (3) the President of the Medical Staff; and (4) the applicable Department Chairperson. When it is determined in advance that no physician is available to take call in a particular specialty, then the Schedule shall properly reflect such unavailability and shall further set forth the following

- The specialty for which no physician is available to take call
- The time period for which no such physician is available (e.g. March 1st through March 7th)
- A requirement that the Emergency Department implement the "Back-Up Call Coverage Guidelines" (see Policy #3, below).

Failure of On-Call Physician To Properly Respond To Emergency. If a physician whose name is listed on the Schedule is called to respond to an emergency, it is unavailable to respond or otherwise fails to respond within thirty (30) minutes of time after first being called (or after three documented attempts to reach the physician, whichever occurs first), then the Emergency Department, subject to the final authority of the Emergency Department Physician in light of the particular facts and circumstances, shall immediately do the following and immediately proceed to implement the "Back Up Call Coverage Guidelines (Policy 3):

- REMEMBER: Any physician whose name is listed on the Schedule has a legal duty to respond to call except for circumstances beyond his/her control (e.g. such physician is simultaneously responding to an emergency at a different hospital or inclement weather makes it extremely dangerous for such physician to present to the hospital to respond to the emergency call)
- NOTE All response times should be reasonable, generally this means thirty (30) minutes or less, depending on the particular facts and circumstances. If a response is not received within a reasonable amount of time (or after three documented attempts to reach the physician, whichever occurs first), immediately proceed to the next step.

POLICY #3 - BACK-UP CALL COVERAGE GUIDELINES
(No Physician Available In Particular Specialty To Participate In Call Coverage Rotation Schedule)

A. Implementation of "Back-Up" Guidelines. If, in preparing the Call Coverage Rotation Schedule, the Medical Staff Coordinator determines in advance that there is no physician (e.g. no Active Staff with or without admitting member) in a particular specialty available to participate in the next month's Call Coverage Rotation Schedule, then the following steps should be taken by the Medical Staff Coordinator in consultation with the President of the Hospital and/or the Chief Operating Officer of the Hospital, the President of the Medical Staff and the respective Department Chairpersons.

If no backup is available and appropriate to provide "back-up" call for a particular specialty, then, the Hospital shall arrange in writing with the closest appropriate hospital (the "Transferee Hospital") that provides emergency call coverage in the particular specialty to prepare to take transfer (subject to the discretion of the applicable Emergency Department Physician and the instructions of the respective patient and his/her family or legal guardian) of applicable patients after appropriate screening and

stabilization., Such transfer arrangements shall be clearly noted and identified on the Schedule. Transfer Agreement shall set forth the duration of the arrangement and shall explain the reason(s) for the arrangement (e.g. Hospital is facing a shortage of physicians in a particular specialty and cannot expect a particular specialist to remain on-call twenty-four hours a day, seven days a week for 365 days a year).

- Generally, Transfer Agreement should be entered into on a temporary basis. The Hospital may however, enter into a longer term Transfer Agreement with an appropriate Transferee Hospital if the Hospital knows in advance that due to County-wide or other shortages of physicians in a particular specialty (the "Shortage Specialty"), that Hospital will need to transfer patients who present with emergency medical conditions requiring the services of a specialist who practice in a Shortage Specialty.

- Notwithstanding any Transfer Agreement, and subject to all applicable laws and regulations, at the time any patient is *actually transferred* from the Emergency Department to another acute care hospital, the Emergency Department shall comply with the applicable Hospital policies governing transfers to acute care facilities. The Emergency Department Physician shall complete the Hospital's "Transfer to Acute Care Facility Form' and shall certify his/her responses on the Form.

POLICY #4 - OBLIGATION OF EMERGENCY DEPARTMENT IN EVENT PATIENT IS TRANSFERRED DUE TO FAILURE OF ON-CALL PHYSICIAN TO RESPOND AND/OR APPEAR; OTHER OBLIGATIONS IN EVENT OF TRANSFER

A. Notification To Receiving Hospital Of Name & Address of On-Call Physician(s). In addition to any other obligations of the Emergency Department, in the event a patient is transferred to another hospital due to the failure or refusal of the designated "On-Call" physician(s) (Attending Physician and/or specialty physician) to appear, the Emergency Department Physician must give the On-Call physician(s) name(s) and address(es) to the receiving hospital. Failure to provide this information may violate the Emergency Medical Treatment And Labor Act and its regulations. All attempts to contact and/or requests for the Attending Physician and any On-Call physician to respond to an emergency (or an apparent emergency) shall be properly documented.

B. **Decisions To Transfer Are Subject To Discretion Of Emergency Department Physician.** Subject to the patient's request (or the request of the patient's family or legal guardian) transfer of an Emergency Department patient to another hospital may occur only at the discretion of the Emergency Department Physician or the On-Call (or Attending) Physician.

Approved by the Medical Executive Committee on March 8, 2001; Revised: 2-26-10; 2-26-10
Approved by the Board of Trustees on 3-20-01;4-15-10

UH GENEVA MEDICAL CENTER

POLICY: TISSUES AND INVASIVE MATERIALS REMOVED FROM PATIENTS

Definitions

I. Tissues:
Any portion of a human body

II. Invasive Materials:
Any materials implanted in a patient (e.g., Broviac catheter, pacemaker). invasive materials may or may not include forensic materials.

III. Forensic Materials:
Bullets, knives, and other invasive materials that may be used as evidence in legal proceedings**.**

Policy

I. All tissues and invasive materials removed from patients will be sent to the University Hospitals of Cleveland Anatomical Pathology Department for evaluation, verification, and documentation. Specimens will be properly identified, labeled using a Surgical Pathology requisition, and accompanied by pertinent clinical information.

II. Any tissue/specimen not forwarded for pathological examination shall be described as "gross pathology review" in the operative report by the surgeon.

III. Exemptions

A. The following specimens are exempted from the policy, but may be sent for pathological examination when the surgeon determines it is necessary for diagnosis:

1. Kidneys and other organs removed for direct human transplantation.
2. Eyes donated for transplantation
3. Bone for bone banking (Pathology receives a specimen from the Bone Bank and a report is generated).
4. Stapes bone removed during stapedectomy
5. Skin specimens sent to Dermatopathology Laboratory
6. Forensic materials
7. Normal placentas
8. Teeth with no concomitant pathology
9. Calculi sent to Reference Laboratory by Urology
10. Lenses removed during cataract surgery

11. Pacemaker generators or batteries, which are returned to the manufacturer by the Department of Perioperative Services
12. Foreskins from routine pediatric circumcisions
13. Normal skin removed during blepharoplast, septoplasty, abdominoplasty, or lipoplasty
14. Bone or soft tissue removed to gain access for surgical procedures such as lamina, spinous processes, and ribs.
15. Excess bone or soft tissue removed during the correction of skeletal deformities such as bunions, and bone fragments, or for cosmetic/functional reasons.
16. Peritoneal venous shunts, peritoneal dialysis catheters, Broviac catheters, subclavian catheters, Mediports, and similar devices.
17. Ventilation (ear) tubes
18. Skin tract from an otherwise normal tracheocutaneous fistula
19. Liposuction materials
20. Veins ligated during varicocele ligation procedures
21. Sperm samples removed via microscopic epididymal sperm aspiration and electro-ejaculation
22. Intervertebral disks

IV. The guidelines below will be followed when handling forensic material that has been removed from a patient.

A. Forensic material will be appropriately contained and handed to the circulating nurse in the Operating Room or the charge nurse in the Emergency Department.
B. To maintain the chain or evidence, the circulating nurse or charge Nurse will complete a Chain of Evidence from which must be signed by the external police or law enforcement officer before the forensic material can be released to the external officer.
C. The forensic material shall be released to the external law enforcement officer upon receipt of the signed Chain of Evidence form.

APPROVAL	
Surgical Department	November 10, 1999
Medical Executive Committee	November 16, 1999

UH GENEVA MEDICAL CENTER

DISCHARGE OF PATIENTS FROM POST-ANESTHESIA RECOVERY AREA AND/OR SETTINGS/FACILITY

1. The post-procedure status of all patients is assessed on admission to the post-anesthesia recovery area and before discharge for either the post-anesthesia recovery area and/or from the setting/facility. Assessment of the patient's physiologic status and outcomes of anesthesia and/or operative or other invasive procedures are fully documented in the record. The PACU scoring system Aldrete is used on all patients upon admission and at the time of discharge from Post-anesthesia Recovery Area.

2. Documentation includes at least a record of:

   Vital signs and level of consciousness:
   Intravenous fluids and drugs – including blood and blood products administered;
   An unusual event or postoperative complication and the management of events;
   When discharge criteria is used, the patient's status that indicates compliance with the criteria.

3. The decision to discharge a patient from the post-anesthesia recovery area and/or from the setting/facility is made either by a qualified licensed independent practitioner **OR** by other appropriately trained personnel by utilizing the following medical staff criteria.

4. Discharge criteria to be used include the following:

   A. From Post-anesthesia Recovery Area:

      Patient is awake – vital signs are stable'
      Any dressing is dry with no active bleeding;
      Patient's plan is managed

   B. From the Outpatient Surgery Unit:

      Patient is awake – vital signs are stable;
      Any dressing is dry with no active bleeding;
      Patient's pain is managed
      Any nausea/vomiting is controlled/treated;
      Patients who have undergone procedures with significant risk or urinary retention are able to void;
      Patient's gait is steady;
      Responsible adult is present;
      Patient and responsible party is understanding of instructions for follow up, and patient is provided with an emergency phone number

5. When appropriate personnel, other than a licensed independent practitioner, utilize the above criteria to assess the patient's ability to be discharged from the post-anesthesia recovery area and/or setting/facility, an order by the attending surgeon must first be entered on the chart. Example: "**Discharge per Criteria**"

Review and approved by the Surgical Department November 10, 1999
Revised by the Surgical Department on November 8, 2000
Revisions approved by the MEC Committee on December 8, 2000.

UH GENEVA MEDICAL CENTER

POLICY: CRITERIA FOR CONSIDERING AUTOPSIES

The following are among the criteria for the Medical Staff to follow when considering autopsies.

1. Unanticipated death
2. Death during treatment of a new therapeutic trial regime.
3. Intraoperative or intra procedural death.
4. Death occurring within 48 hours after surgery or an invasive diagnostic procedure.
5. Death incident to pregnancy or seven days following delivery.
6. Deaths in infants/children with congenital malformations.
7. Death where the cause is sufficiently obscure to delay completion of the Death Certificate.

NOTE:

If a death occurs and an autopsy may be necessary to determine cause of death or beneficial for Quality/Performance Improvement purposes the physician is responsible for obtaining permission for the autopsy from the patient's family or guardian. Documentation of verbal consent must be incorporated into the physician's progress notes and a signed authorization form is placed in the chart.

When an autopsy is performed, the pathologist will communicate the results to the attending physician and the results will be presented at the appropriate Medical Staff Committee.

APPROVALS	
Surgical Department	November 10, 1999
Medical Executive Committee	November 16, 1999