
# Medical Staff
# Rules and Regulations

A Medical Staff Document

Revised: 12/15/2021

**UH PORTAGE MEDICAL CENTER MEDICAL STAFF**

**RULES AND REGULATIONS**

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## ARTICLE I

## ADMISSION PROCEDURES

SECTION 1.

Practitioners admitting patients to the Hospital must document a provisional diagnosis and meet established admitting criteria. In cases of emergency, the provisional diagnosis shall be documented as soon as possible.

SECTION 2.

Emergency admissions from the Physician's office directly to the critical care units (ICU, CCU, SDU) shall meet admission criteria. A discussion with the hospitalist on duty is desirable.

SECTION 3.

Practitioners admitting patients shall provide the Hospital with such information as may be necessary to assure the protection of other patients from those who are a source of danger and/or to assure the protection of the patient from self-harm.

## ARTICLE II

## ANESTHESIA STANDARDS

SECTION 1.

There must be a preanesthesia note in the medical record of all patients for whom an anesthetic is administered which must include specific information relative to the choice of anesthesia for the procedure anticipated in accordance with the applicable Medicare Conditions of Participation.

SECTION 2.

In all cases, the medical record should reflect a post anesthetic visit made after the patient has been moved from the operative area to the designated recovery area, and should describe the presence or absence of anesthesia-related complications in accordance with the applicable Medicare Conditions of Participation.

SECTION 3

Additional requirements with respect to completion and documentation of pre-anesthesia and post anesthesia evaluations shall be set forth in the Anesthesia Evaluation Policy as such policy is amended from time to time.

## ARTICLE III

## AUTOPSY

SECTION 1.

Every Practitioner is expected to be actively interested in securing autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest. Prior to the performance of such autopsy, written consent of the deceased patient's legally-authorized representative shall be obtained and such written consent shall be retained as a part of the deceased patient's medical record. All autopsies shall be performed by the Hospital's pathologists or by a Physician delegated this responsibility by the Director of Laboratories. When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within seven (7) working days, and the complete protocol should be made part of the record within thirty (30) days for routine cases; ninety (90) days for complicated cases. A written detailed autopsy report will be forwarded to the attending Practitioner within forty-five (45) days for routine autopsies. The Hospital shall inform the Medical Staff and attending Practitioner of autopsies that the Hospital intends to perform. Additional information with respect to autopsies including, but not limited to, the Hospital's process for obtaining and documenting permission to perform an autopsy is set forth in the Autopsy Protocol Policy, as such policy may be amended from time to time.

## ARTICLE IV

## CONSULTATION REQUIREMENTS

SECTION 1.

The attending Practitioner is responsible for requesting consultations when indicated. The requesting Practitioner must identify at the time of consultation the particular category of consultation, time frame necessary, if less than twenty-four (24) hours, and the specific reason for requesting consultation. It is the duty of the Medical Staff, through its President and the MEC, to monitor consultative activities.

SECTION 2.

Requests for consultation must be answered within twenty-four (24) hours of the time the Practitioner is notified regarding the consultation request.

Except in an emergency, consultations with another qualified Practitioner are required in cases in which, according to the judgment of the requesting Practitioner:

A. The patient is not a good risk for operation or treatment.

B. The diagnosis is obscure.

C. There is doubt as to the best therapeutic measure to be utilized.

SECTION 3.

A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. The qualifications of the consultant are determined by the Medical Staff on the basis of the individual's training, experience, and competence.

SECTION 4.

A satisfactory consultation includes examination of the patient and the record. A written opinion signed, dated, and timed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

SECTION 5.

All patients admitted to a critical care area (ICU/CCU) must have consultation with or be transferred to the care of a critical care specialist with the exception of post-op care less than twenty-four (24) hours. Critical care specialists will include Practitioners board certified in critical care medicine, pulmonary medicine, or cardiology.

## ARTICLE V

## DENTAL STANDARDS

SECTION 1.

Standards governing dental patients are set forth in Section 6.5 of the Medical Staff Bylaws.

## ARTICLE VI

## DISASTER PROCEDURES

SECTION 1.

In the event of a disaster, the Medical Staff efforts will be integrated with those of the rest of the Hospital. The procedure for granting disaster Privileges is set forth in Section 6.6.4 of the Medical Staff Bylaws. The responsibility of initiating the disaster plan lies with the Hospital President/Administrator on Call. Coordination of Medical Staff functions shall be the responsibility of the Vice President for Medical Affairs. In his/her absence, these functions shall be performed by the Medical Staff President, the Medical Staff Past-President or the Medical Staff President-Elect, or their designee, in that order.

All Practitioners on the Medical Staff shall initially report to the Hospital cafeteria for assignment as needed.

In the event of a disaster, all decisions regarding triage, evaluation and transfer of patients and medical policies shall be determined as described in the Hospital Emergency Management Plan available at each nursing unit.

## ARTICLE VII

## DISCHARGE PROCEDURES

SECTION 1.

Patients shall be discharged only on the order of the attending Practitioner. If a patient chooses to leave the Hospital against medical advice, the patient or the party responsible for the patient (e.g. the patient's legal representative) shall be requested to sign a "Release Against Medical Advice" form. A full narrative of the incident shall be recorded by the Practitioner in the patient's medical record.

SECTION 2.

The discharge summary is the responsibility of the attending Practitioner, and shall include: the reason for hospitalization; the procedures performed; the care,

treatment, and services provided; the patient's condition and disposition at discharge; information provided to the patient and family (*e.g.* instructions given to the patient and/or family, particularly in regard to physical activity limitations, medications, diet, etc.) and provisions for follow-up care. The final diagnosis and any complications must be spelled out in full without the use of symbols or abbreviations. Additional requirements with respect to discharge summaries are set forth in the Discharge Summary Policy as such policy may be amended from time to time.

## ARTICLE VIII

## INFORMED CONSENT REQUIREMENTS

SECTION 1.

The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. Where the patient is incapacitated or incompetent (physically, mentally, or legally), such informed consent must be obtained in accordance with applicable laws and regulations. These circumstances should be fully documented in the patient's medical record. Requirements with respect to obtaining and documenting informed consent are set forth in the Informed Consent Policy as such policy may be amended from time to time.

SECTION 2.

No photographs, motion pictures, or videotapes shall be taken, or drawings or other form of artwork made, of a patient unless permission in writing has been granted by the patient or his/her legal representative, and such permission shall be filed in the patient's medical record. This requirement pertains to such materials when they are taken or made for the purpose of publication. Such authorization is not necessary where the sole purpose is for inclusion in the patient's medical record or for use in other aspects of the patient's treatment or care. See the Clinical Photography for Documentation of Disruptions in Skin Integrity Policy, as such policy may be amended from time to time, for additional information.

## ARTICLE IX

## MEDICAL RECORDS REQUIREMENTS

SECTION 1.

Entries in the medical record may be made only by individuals given this right as specified in Hospital and Medical Staff policies. All entries in the record must be legible, complete, dated, timed and authenticated.

SECTION 2.

It is the responsibility of all Practitioners and other authorized individuals who document in the medical records to assure that such entries are legible.

SECTION 3.

The basic requirements with respect to completion and documentation of a medical history and physical examination are set forth in Section 14.6 of the Medical Staff Bylaws.

All inpatient records will contain an initial patient assessment with a minimum of a history, physical examination, and patient care assessment within twenty-four (24) hours of admission.

The physical examination shall be comprehensive in nature relating to the patient's medical history and to the Practitioner's clinical judgment. Information relating to this assessment may be found in the following documents:

* the Examination and Treatment Record of the Emergency Department Physician
* the Admitting Note and Progress record
* the Nurse Assessment Record
* the Nurse Clinician Examination Record reviewed and authenticated by the attending Practitioner.

The comprehensive history and physical examination will be obtained prior to all inpatient surgery or procedures requiring anesthesia services. Exceptions include cardiac procedures (e.g. cardioversion, TEE, etc) where anesthesia has been consulted and in an emergency situation when the delay necessitated by this requirement would pose a serious threat to the health of the patient. In such a case, the attending Practitioner must document in the record the emergency and must ensure that a history and physical is performed as soon as possible.

A focused history and physical examination shall be performed on all patients undergoing outpatient surgery or an outpatient procedure requiring anesthesia services. The focused history and physical examination shall be conducted within twenty-four (24) hours of registration but prior to the surgery or procedure and shall document at least the following:

* Reason for the surgery or procedure
* Significant past history
* Current medications
* Allergies
* Pertinent physical examination including vital signs, heart, lungs and involved organ(s), at a minimum.
* Plan for sedation or anesthesia
* Post operative plan

SECTION 4.

The attending Practitioner or designee is responsible for documentation of an appropriate admitting note within twenty-four (24) hours of the patient's admission which must include the following:

A. Reason for admission including admitting diagnosis.

B. Pertinent clinical findings.

C. Plan of treatment.

D. Need for hospitalization including level of care.

SECTION 5.

Progress notes shall give a pertinent chronological report of the patient's course and shall be sufficient to describe the changes in the patient's condition, as well as record the results of care, treatment, and services provided. Progress notes shall be written at least daily by the attending or admitting Practitioner and more frequently if changes occur in patient condition or treatment plan.

SECTION 6.

The responsible Physician must place in the patient's medical record the timely, pertinent clinical evaluation of the results of respiratory therapy and documentation of respiratory care services must include the specifications of the prescription.

SECTION 7.

The medical record of a newborn who received oxygen shall include evidence that the therapy was begun and terminated on the order of a Physician and was recorded in oxygen concentration percentage rather than in liters/minute.

SECTION 8.

The attending Practitioner shall be responsible for the preparation, review and authentication of an appropriate, complete medical record for each patient which shall contain at least the following:

A. Identification data (when not obtainable, the reason shall be documented).

B. Medical history of the patient including the chief complaint; details of the present illness; relevant past, social, and family histories; and an assessment of body systems.

C. Report of relevant physical examination.

D. When a patient is readmitted within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes since the previous history and examination may be used in place of the full history and physical report as long as the prior history and physical is referenced and confirmed by the Practitioner.

E. Diagnostic and therapeutic orders.

F. Evidence of appropriate informed consent (when consent is not obtainable, the reason shall be documented in the record).

G. Clinical observation including results of therapy (including progress notes, consultation reports, etc.).

H. Reports of procedures, tests, and the results thereof.

I. Conclusions at termination of hospitalization or evaluation/treatment.

J. Discharge plan and instructions.

K. Additional information as required by applicable law and accreditation standards as detailed in the Content of Medical Records Policy as such policy may be amended from time to time.

SECTION 9.

All medical records should be completed within two (2) weeks after being made available in the Medical Record Department to the attending or responsible Practitioner.

Records not complete within thirty (30) days of the patient's discharge shall be considered delinquent. Practitioners with delinquent medical records will be notified by the President of the Hospital and the President of the Medical Staff of the automatic suspension of their Hospital Privileges in accordance with Section 10.4.1 (e) and subject to Section 10.4.2 (b) of the Medical Staff Bylaws.

Full Privileges shall be restored only upon the completion of all delinquent records. A Practitioner who has had his/her Privileges suspended four (4) times in any one (1) calendar year shall have his or her appointment and Privileges automatically terminated in accordance with Section 10.5.1 (e) of the Medical Staff Bylaws and must thereafter reapply.

SECTION 10.

The Medical Records Committee shall declare any medical record complete for purposes of filing when the Practitioner responsible for completion of the record is deceased or unavailable permanently or protractedly for other reasons. No Practitioner shall be permitted to complete a medical record on a patient unfamiliar to him/her.

SECTION 11.

Symbols and abbreviations may be used in the medical record only when they have been approved by the Medical Staff. Each abbreviation or symbol shall have only one meaning. An official record of such approved symbols and abbreviations shall be kept on file in the Medical Records Department.

SECTION 12.

In the case of readmission of a patient, all records shall be made available to the attending Practitioner. This rule shall apply whether the patient is attended by the same or another/other Practitioner(s).

SECTION 13.

Free access to all medical records of all patients shall be afforded to Practitioners in Good Standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. Subject to the discretion of the President of the Hospital, former Practitioners shall be permitted access to the information contained in the medical records of such Practitioner's patients for such periods during which they attended those patients in the Hospital.

SECTION 14.

No chart is to leave the Medical Records Department or the Doctors' Incomplete Chart Room, unless it is properly signed out by Medical Record Department personnel.

SECTION 15.

All medical records are the property of the Hospital and shall not be taken off of the Hospital premises except in accordance with a court order, subpoena (accompanied by written consent of the patient/legal representative, as necessary), or statute.

SECTION 16.

Written consent of the patient or his/her legal representative is required for release of medical information to persons not otherwise authorized to receive this information. The release of all such information shall be in strict accordance with the policies published in the "Manual for the Release of Patient Information," as such policies may be amended from time to time, on file in the Medical Records Department.

SECTION 17.

Before an attending Practitioner leaves for vacation or personal leave, he/she MUST FINISH all the charts available in his/her computer print-out. A finished chart is one that is totally complete except for signature on the dictated material(s). Before leaving, the attending Practitioner must inform the Medical Records Department of his/her chart status and vacation dates. The time sequence for chart completion will then be frozen until he/she returns. Upon the Practitioner’s return, two (2) weeks are permitted to complete the charts that accumulated while the Practitioner was away.

If ALL charts are NOT COMPLETED before leaving, the time sequence will continue to run normally including carrying out the automatic suspension procedure set forth in §9, even if the attending Practitioner is still away.

SECTION 18.

Group signing of charts shall be permitted in accordance with the requirements set forth in the Group Signing of Charts Policy, as such policy may be amended from time to time, for the following:

a. Consultations
b. Discharge Summary
c. Reports
d. Orders. All orders, including verbal orders, must be dated, timed, and authenticated by either the ordering Practitioner or another Practitioner who is responsible for the care of the patient and who is authorized to write orders by Hospital policy in accordance with State law.

All operative/procedure notes shall be authenticated by the Practitioner performing the procedure.

## ARTICLE X

## ORDERS

SECTION 1.

All requests for radiological services shall contain reasonable information from the requesting Practitioner to justify the need for the examination and to alert the radiologic personnel to any aspects of the patient's condition that may require special handling (e.g., possible fractures, dislocations, etc.).

SECTION 2.

All orders must be in writing. An order shall be considered to be in writing if dictated (by telephone or otherwise) by such persons granted Privileges to do so.

Verbal orders shall indicate the name of the dictating Practitioner and shall include the name, date, time, and signature of the authorized person who received/transcribed/read back such order. Verbal orders shall be dated, timed, and authenticated by the ordering or responsible Practitioner within forty-eight (48) hours.

Practitioner orders may be faxed to Hospital locations.

SECTION 3.

Verbal orders may be transcribed only by the following categories of Hospital personnel and such personnel may transcribe only those orders relative to their respective areas of professional expertise:

A. Registered Nurses
B. Respiratory Therapists
C. Physical Therapists/Occupational Therapists/Speech Therapists
D. Registered Technologists in Radiology Services (Radiology, Nuclear Medicine, Ultrasound, etc.) may make and sign notes on the Physician's Order Sheet commenting that the planned radiological examinations have been rescheduled or canceled (and the reason why) or that they have been completed and may accept verbal orders from Practitioners.
E. Medical students in a Hospital preceptorship from his/her preceptor in accordance with the Residency Training, Medical Education, and Clinical Training Policy as such Policy may be amended from time to time.
F. Pharmacists
G. Clinical Dietitians may take and document verbal orders from Practitioners on the patient chart.

SECTION 4.

Pre-printed and electronic standing orders, order sets, and protocols for patient orders may only be used if: (i) such orders and protocols have been reviewed and approved by the Medical Staff and the Hospital's nursing and pharmacy leadership; (ii) such orders and protocols are consistent with nationally recognized and evidence-based guidelines; (iii) periodic and regular review of such orders and protocols is conducted by the Medical Staff and the Hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and, (iv) such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering Practitioner or by another Practitioner responsible for the care of the patient and acting in accordance with State law, including scope-of-practice laws, Hospital policies, and Medical Staff Bylaws, Rules and Regulations.

Standing orders/protocols to initiate or adjust medications are only permitted in three situations: (i) emergency; (ii) administration of biologicals for the purpose of preventing disease; and (iii) administration of vaccines for the purpose of preventing diseases. For all other situations, all medication orders must be patient specific with well-defined parameters for administration (i.e., intended recipient(s), drug name and strength, specific instructions of how to administer

the drug, dosage, frequency, and signatures of authorized prescriber) and authorized by the prescriber prior to implementation.

SECTION 5.

Patients who are transferred from one Practitioner's service to the service of another Practitioner require that permission be received from the Practitioner receiving the patient to his/her service prior to the transfer being authorized.

SECTION 6.

Hospital outpatient services may be ordered (and patients may be referred for Hospital outpatient services) by a Practitioner who is (i) responsible for the care of the patient (ii) licensed in, or holds a license recognized in, the jurisdiction where he/she sees the patient; (iii) acting within his/her scope of practice under State law; and (iv) authorized by the Medical Staff to order the applicable outpatient services under a written Hospital policy that is approved by the Board.

The Hospital may accept orders for diagnostic testing from Practitioners regardless of whether they are Appointees to the Medical Staff. If there are any questions as to the validity of the Practitioner's license or scope of practice, the employee may validate the physician's current licensure status for Ohio online at https://license.ohio.gov/lookup/default.asp. If the physician practices outside of Ohio, the licensure status can be confirmed at that states medical license verification website. If you are unable to confirm the licensure status, Medical Staff Services should be contacted to make appropriate verifications. (***Revised 1/26/2014)***

The Hospital does not accept orders for outpatient treatment from Practitioners who are not Appointees unless the Practitioner has provided Medical Staff Services with the name of one (1) or more Appointees who has agreed to act as a designated back up Practitioner for the non-appointed Practitioner during the time that the patient is receiving treatment.

## ARTICLE XI

## PODIATRIC STANDARDS

SECTION 1.

Standards governing podiatric patients are set forth in Section 6.5 of the Medical Staff Bylaws.

## ARTICLE XII

## EXPENDITURE OF FUNDS

SECTION 1.

The expenditure of funds exceeding $100 requires the approval of the Medical Executive Committee and shall be presented by the Secretary/Treasurer.

## ARTICLE XIII

## SURGERY STANDARDS

SECTION 1.

The operating surgeon shall have a qualified assistant at all major operations.

SECTION 2.

All operations performed in the Hospital shall be fully described by the surgeon. Such operative reports shall be dictated or written on a prescribed form in the medical record immediately after surgery and shall contain the name of the Practitioner(s) who performed the procedure and his/her assistant(s), the name of the procedure performed, a description of the procedure/the technical procedures used, findings of the procedure, any estimated blood loss, the specimens removed (if any), and the postoperative diagnosis. When a full operative report cannot be entered immediately into the patient's medical record after the operation, a progress note is entered in the medical record before the patient is transferred to the next level of care. Such progress note shall include the name of the Practitioner(s) who performed the procedure and his/her assistant(s), the procedure performed, a description of each procedure finding, estimated blood loss, specimens removed, and the post-operative diagnosis.

SECTION 3.

Tissue removed during surgery may be sent to the Hospital pathologist who shall make such examination as may be considered necessary to arrive at a pathological diagnosis. Such reports shall be authenticated, dated, and timed by said pathologist and shall be filed in the patient's medical record within twenty-four (24) hours of completion unless further consultation is required.

## ARTICLE XIV

## MISCELLANEOUS

SECTION 1.

The definitions set forth in the Medical Staff Bylaws shall apply to these Rules & Regulations unless otherwise provided herein.

SECTION 2.

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 and registered nurses (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.