University Hospitals
Geauga Medical Center

RULES AND REGULATIONS OF THE MEDICAL STAFF

Approved by the Medical Staff on
Feb. 23, 1995, Aug. 24, 1995,
May 23, 1996, August 28, 1997,
April 23, 1998, November 19, 1998,
Feb. 25, 1999, May 27, 1999
August 29, 1999, June 28, 2000,
March 7, 2001, May 23, 2001,
August 22, 2001, November 28, 2001
May 22, 2002, August 28, 2002,
February 26, 2003, August 25, 2004
February 23, 2005, August 24, 2005
November 16, 2005. December 14, 2011;
May 22, 2013; August 27, 2014, September
18, 2019, July 21 2021

Approved by the Board of Trustees on
Mar. 28, 1995, Sept. 26, 1995,
May 28, 1996, September 23, 1997,
April 28, 1998, November 24, 1998,
March 23, 1999, June 22, 1999
September 22, 1999, September 26, 2000
April 4, 2001, June 26, 2001,
September 25, 2001, December 17, 2001
June 25, 2002, September 24, 2002
May 6, 2003, September 28, 2004
June 28, 2005, November 22, 2005;
December 2011; June 18, 2013;
September 18, 2014; November 20, 2019,
July 28 2021

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DEFINITIONS

1. **Board of Directors** refers to the Board of Directors of UH Regional Hospitals.

2. **Hospital** refers to UH Regional Hospitals.

3. **Medical Staff or Staff** refers to duly licensed physicians, dentists, oral and maxillofacial surgeons, psychologists, midwives, podiatrists and other licensed independent practitioners who are members of the active, associate, courtesy and honorary staff and participate in the care of patients at UH Regional Hospitals.

4. **Practitioner** means a member of the medical staff.

ARTICLE I: ADMISSION OF PATIENTS

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

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

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

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

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

1.4 When a dentists admits a patient there will be an M.D. or D.O. who will co-admit these patients as described in the Bylaws. The admitting physician will bear the responsibility for the patient and his/her records and orders from the medical and administrative standpoint. No physicians having admitting privileges will admit to another practitioner's service or in another practitioner's name unless while providing temporary, prearranged coverage or for another physician in good standing. In such case, the admitting order shall be signed as for example, "*Admit to Dr. Smith's Service per Dr. Jones.*" While it is recognized that some physicians may operate their practices as a team, partnership, incorporation, etc., it is necessary that one specific individual be designed as having patient responsibility. This is in no way meant to interfere with the mutual care of the patient by such physicians and their freedom to write orders for patients upon application as specified.

No patient shall be admitted to the hospital, except in an emergency, until after an admitting diagnosis has been stated.

ARTICLE II: PATIENT DISCHARGE

2.1 Patients shall be discharged only upon the written order of the attending practitioner. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the hospital record and the appropriate release form signed by the patient.

2.2 The medical staff member responsible for the care of the patient shall perform or

direct an appropriate member of the hospital staff to perform the following tasks in the event of death.

a) Notify the next of kin.
b) Request permission for an autopsy.
c) Comply with all the administrative details required by the Hospital Administration and/or the County Coroner for the county in which the hospital is located.

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

2.4 The attending physicians for the patient at the time of discharge will be responsible for preparing the discharge summary for the medical records. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following:

a) Reason for hospitalization,
b) The procedure performed
c) The care,
d) Treatment and services provided,
e) The patient's condition and disposition at discharge
f) Information provided to the patient and family and provisions for follow-up care.

For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of hospitalization, all diagnoses, the case disposition, and any provisions for follow-up care.

When a patient is transferred to a different level of care within the hospital and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

ARTICLE III: PATIENT CARE ORDERS

3.1 All orders shall be in writing and/or entered into the Electronic Health Record by the physician. All orders shall be dated and timed. An order shall be considered to be in writing if dictated to a Registered Nurse and signed by the attending practitioner. Licensed Pharmacists, Certified Respiratory Technicians, Registered Respiratory Therapists, Licensed Physical and Occupational Therapists, Licensed Speech-language Pathologists, and Licensed Dietitians, within the scope of their licensure may also receive orders. The staff member receiving the order shall read it back to the practitioner then sign their own name and the name of the ordering practitioner.

3.1.1 Verbal orders for respiratory therapy may be accepted or written by a Certified Respiratory Therapy Technician or a Registered Respiratory Therapist. Licensed Dietitians may receive verbal orders for diet instructions or diet changes. Licensed Pharmacists may receive verbal orders for medication. Physical Therapist or Occupational Therapists may receive verbal orders for physical therapy and occupational therapy. Speech-language Pathologists may receive verbal orders for barium swallows.

3.1.2 Certified Nurse Practitioners, Certified Nurse Midwife and Physician Assistants may write orders within their scope of practice, such order do

not need to be co-signed by the attending physician.

3.2 All verbal orders should be used infrequently and as described above shall be signed with their signature being dated and timed by the prescribing practitioner or other practitioner responsible for patient's care within 48 hours.

3.3 If the attending practitioner desires that a second practitioner, who is not an associate, assist in the care of a patient, then a written order may declare permission for the other practitioner to write orders.

3.3.1 There is an automatic cancellation of all wound care and traction orders for a patient undergoing surgery. The day of surgery will be counted as day one for postoperative orders.

3.3.2 The following drug orders will be discontinued, if not renewed daily: Heparin and intravenous solutions that are not for keep open purposes.

3.3.3 The following drug orders will be discontinued, if not renewed on the third day after the drug is prescribed: intravenous antibiotics, and parenteral pain medications.

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

3.5 There must be an order for food or nutrition products on every patient's medical record.

3.6 Consultations may be ordered by the attending physician when they are appropriate. In general, the consultant should be notified by the attending physician and either the Unit Secretary or a Registered Nurse on the Inpatient Unit. Normally the consultant should respond within 24 hours or notify the hospital staff caring for the patient the reason for the delay.

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

3.8 Laboratory tests ordered to be done daily will be automatically stopped after being done for three days. Protime and APTT ordered to be done daily for patients on anticoagulants will not be subject to an automatic stop order.

3.9 All patient medical records, both inpatient and outpatient must document complication(s), hospital acquired infections, unfavorable reactions to drugs, and unfavorable reactions to anesthesia.

3.11 LEGIBILITY

Any and all information entered into the medical record should be legible. For patient safety, orders will not be carried out unless they are legible. Ordering physician will be contacted for clarification of any illegible orders. The house officer on duty will be contacted to manage critical situations until the ordering

physician can be reached. Legibility efforts will be monitored ongoing. In the event an order cannot be implemented because it is not legible and the ordering physician is not physically present, the designated licensed employee (RN, RT, Pharmacist, etc.) will contact the physician to obtain clarification and write a clarification order.

3.12 AUTHENTICATED

All patient medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided. Authentication of medical record entries may include written signatures or computer key. There shall be no delegation of authentication codes to another individual.

ARTICLE IV: SPECIAL TREATMENT PROCEDURES

4.1 SECLUSION

Seclusion refers to the involuntary confinement of a person alone in a room where the person is physically prevented from leaving. Seclusion is a treatment option available at UH Regional Hospitals based on Section 4.5 below and the Special Treatment Procedure Policy.

4.2 CONVULSIVE THERAPY

Electroconvulsive therapy is not done at UH Regional Hospitals.

4.3 PSYCHOSURGERY

Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental, or behavioral disorder are not done at UH Regional Hospitals.

4.4 BEHAVIOR MODIFICATION

Behavior modification procedures that use aversive conditioning are not done at UH Regional Hospitals.

4.5 RESTRAINT

Restraint is defined as the use of a physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body as a means of controlling physical activities to protect the patient or others from injury. Restraint differs from the use of mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures that are considered a regular part of such procedures. These mechanisms include, but are not limited to, body restraint during surgery, and arm restraint during intravenous administration. Devices such as bed rails, table top chairs, protective nets, helmets, or orthopedic appliances, braces, wheelchairs, or other appliances or devices used for postural support or to assist in obtaining and maintaining normative body functioning, are not considered restraint interventions.

4.5.1 Orders for Restraint

An order for restraint or seclusion must be obtained from a physician or a Licensed Independent Practitioner (LIP) or Certified Physician Assistant with prescriptive authority. All restraint or seclusion orders are time limited as defined in the hospital restraint policy.

4.5.2 Procedures

The procedures for putting a patient in restraints and monitoring a

patient during a period of restraint is contained in the hospital restraint policy that is incorporated by reference into these Rules and Regulations.

ARTICLE V: AUTOPSIES

5.1 MORTALITY MANAGEMENT

Pronouncing death occurring with UH Regional Hospitals is a responsibility of the physician. Notification of family, coroner's office, if indicated, and request for autopsy must be done by either physician or a nurse who is familiar with the case and be properly documented. The coroner's office should be notified when the circumstances of death is one of those listed as "reportable deaths", established by the Ohio State Coroners Association. The body should be handled with respect. Once the funeral home has been chosen by the family, the body may be released. This is done by the Security staff. All deaths occurring within UH Regional Hospitals, with or without autopsy should be reviewed by the appropriate committee. Findings and recommendations should be documented.

5.2 CRITERIA FOR AUTOPSY

Autopsy should be requested on all deaths occurring within the hospital including those cases the coroner declines to take jurisdiction action, and particularly when it is an unexpected death in a relatively healthy or young person, uncertain diagnosis or cause of death, still born, obstetrical death, or when there is any reasons of concern by the family members or physicians.

5.3 NOTIFICATION OF CORONER'S OFFICE

Once notified, the coroner will investigate and review the case without removing the body from the hospital. After the investigation, if the coroner decides to take jurisdiction over the case and orders a forensic autopsy, the body will be moved from the hospital for that purpose. Refer to "When to Report a Death" published by the Ohio State Coroners Association on their website www.osca.net. Examples of those deaths include but are not limited to: Death within 24 hours of admission to the hospital, death following recent surgery or anesthesia, history of previous injury or accident and death on arrival.

If the Coroner, after investigation, decides that a forensic autopsy is not indicated, it becomes the hospital's responsibility to request an autopsy from the family. Refer to Article 5.8 for responsibility.

5.4 CONSENT FOR AUTOPSY AND DOCUMENTATION

The properly documented consent by the next of kin must be obtained before an autopsy can be performed. Next of kin includes living spouse or living oldest child. The consent must be signed in person and witnessed on the approved form. Telephone consent is not acceptable. All documentation regarding an autopsy should be on the appropriate forms or in the Electronic Health Record. Only the person who is legally allowed to consent for autopsy can decline an autopsy. The family may request and consent for an autopsy before being asked by the hospital staff. The Hospital nor its personnel, including the physician, can decline the request.

5.5 NOTIFICATION OF PHYSICIAN
The attending physician should be notified before and after the autopsy is performed. The pathologist should relay the preliminary findings and diagnosis to the attending physician.

5.6 AUTOPSY REPORT
When an autopsy is performed, provisional diagnoses are recorded in the patient's chart within 2 (two) working days. For usual routine cases, the report should be finished within 30 (thirty) working days. For complicated cases, the report must be completed within 3 (three) months.

5.7 AUTOPSY FINDINGS AND REVIEW
All deaths and findings of all autopsies, hospital's or coroner's (forensic) should be discussed at the appropriate committee meeting as part of quality and mortality review. Unexpected and significant autopsy findings of malignancy or infection control should be reported to the Cancer Registry and/or the Infection Control Committee.

5.8 RESPONSIBILITY AND PROCEDURE
All Departments, Services and Committees mentioned above are responsible and required to maintain current functional procedures and policies according to these Rules and Regulations which are in compliance with the Ohio State Law governing deaths, and other regulatory agencies.

ARTICLE VI: PROGRESS NOTES

6.1 FREQUENCY
Normally progress notes should be entered in the patient's chart on a daily basis by the treating physician. In some critical situations more frequent progress notes are appropriate. Progress notes must be dated and timed. All progress notes must be signed by the practitioner entering the note in the chart.

6.2 TIME TO SEE THE PATIENT
When a patient is admitted to a general medical/surgical unit through the Emergency Room he/she should be seen and a progress note entered in the chart within 24 hours.

Elective admissions should be seen and a progress note entered in the chart within 24 hours.

Those patients admitted directly to an Intensive Care Unit or a Special Care Unit or transferred to an Intensive Care Unit or a Special Care Unit from a general medical/surgical unit must be seen and a progress note entered in the chart within 12 hours of admission to the Unit.

6.3 HISTORY AND PHYSICAL
History and physicals must be completed within 24 hours of admission. The history and physical exam must be completed and recorded before any surgery is started.

Generally for elective surgeries this will be done during preadmission testing. When an H & P is completed within 30 days before admission or registration,

there must be an updated entry documenting any changes in the patient's condition within 24 hours after admission or registration. In all cases involving surgery or a procedure requiring anesthesia services, prior to the surgery or procedure an updated H & P must be completed.

If the history and physical exam are performed within 30 days before admission to UH Regional Hospitals or in the office of a physician staff member or, when appropriate, the office of a qualified oral or maxillofacial surgeons staff member, a durable, legible copy of this report may be used in the patient's medical record, provided an update documenting either changes that may have occurred or no changes have occurred is recorded in the medical record at the time of the admission.

Surgery is performed only after a history, physical examination, any indicated diagnostic tests, and the preoperative diagnosis have been completed and recorded in the patient's medical record. In emergency situations in which there is inadequate time to record the full history and physical and diagnosis is recorded before surgery. The Emergency Room record may be used as the history and physical only when the patient is being transferred directly from the Emergency Room to the Operating Room.

6.4 OPERATIVE RECORD

The practitioner documents in the patient's medical record any operative or other procedures and/or the administration of moderate or deep sedation or anesthesia.

A licensed independent practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other procedure is performed.

An operative or other procedure report is written or dictated upon completion of the operative or other procedure before the patient is transferred to the next level of care. When a full operative or other procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, it must be written/dictated within 48 hours. If the practitioner performing the operation or other procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

A progress note must be entered in the medical record immediately after each operation or procedure before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon and assistants, procedures performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

The operative report must contain the following:

6.4.1 The Operative Report must contain: the names of the licensed independent practitioner(s) who performed the procedure and his or her assistants. The name of the procedure(s) performed, a description of the procedure(s), findings of the procedure(s) any estimated blood loss, any specimens removed and the post-operative diagnosis.

The post-operative record must contain the following:

6.4.2 Vital signs and level of consciousness;

6.4.3 Medications (including intravenous fluids) and blood and blood products and blood components;

6.4.4 Any unanticipated events or postoperative complications, including blood transfusion reactions and the management of these events;

6.4.5 The post-operative documentation contains the name of the licensed independent practitioner responsible for discharges;

6.4.6 The patient's discharge from post-sedation or post-anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria;

6.4.7 The medical record contains documentation of the use of approved discharge criteria that determine the patient's readiness for discharge.

ARTICLE VII: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

7.1 GENERALLY

A physician member of the medical staff shall be responsible for the medical care including diagnosis and treatment of each patient in the hospital, for the prompt completion and accuracy of those portions of the Medical Record for which he/she is responsible, for writing orders, and for supplying information to the patient's family as appropriate.

7.2 ALTERNATE COVERAGE

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

In the absence of each designation, the department chair or division chief has the authority and responsibility to call any member of the medical staff with requisite clinical privileges and training. Failure of an attending physician to meet these requirements may result in a recommendation for action as deemed appropriate by the Medical Executive Committee.

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

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

7.4 CONSULTATIONS

7.4.1 Responsibility for initiating:

7.4.1.1 The attending physician is responsible for initiating consultations when indicated or required as set forth in these Rules and Regulations.

7.4.2 Guidelines for Consultations:

Indications for consultations shall include:

7.4.2.1 When the patient evidences severe psychiatric symptoms including suicidal tendencies and the attending physician is not a psychiatrist (Behavioral Health Consultations should be completed within 24 hours of the request);

7.4.2.2 When requested by the patient or next of kin;

7.4.2.3 When there is a difficulty in making a diagnosis;

7.4.2.4 When there is difficulty on deciding on appropriate treatment; or when specific skills of other practitioners are needed in unusually complicated situations;

7.4.2.5 When a patient has been on a ventilator for 24 hours and the attending is not a critical care specialist (intensivist, pulmonologist, or cardiologist);

7.4.2.6 When any patient has been admitted to the ICU for 24 hours or anticipated to be in the ICU for longer than 24 hours and the attending is not a critical care specialist (intensivist, pulmonologist or cardiologist);

7.4.2.7 When a patient is receiving acute dialysis, a nephrologists should be consulted, or

7.4.2.8 When a surgical patient below the age of 13 is admitted, an appropriately credentialed pediatrician or family practice physician consultations should be requested.

7.4.3 Documentation

7.4.3.1 Consultation Request

The attending physician requesting consultation must write an order so requesting and notify the consultant.

7.4.3.2 Consultation Report

The consultant must make and sign a report of his/her findings, opinions and recommendations that reflects, when appropriate, an actual examination of the patient and the patient's record. Such reports shall become a part of the patient's record.

7.4.4 Consultation Request by Department Chair

Where circumstances are such as to justify such actions, the Chair of the Department may request consultations.

7.5 CONTINUING CARE PLANNING

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

7.6 EMERGENCY CARE

Emergency care shall be provided to both inpatient and ambulatory patients as necessary by members of the medical staff. Emergency services panels may be specified by Medical Staff departments or their divisions or by the Medical Executive Committee. If a conflict arises in the establishment of an Emergency Service plan then the Medical Executive Committee decision shall control. If a physician refuses to serve on a properly constituted panel then the provisions of the Bylaws shall be called into play.

The provision of emergency care may not be denied because of the payment source for the care to be provided. Refusal to participate in Medicare, Medicaid or other publicly funded or sponsored programs shall not exclude the practitioner from the requirement for providing emergency care. Emergency care includes referrals from the UH Regional Hospital's Emergency Room when the practitioner is on call.

7.6.1 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 with 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.

7.7 EMERGENCY CARE DOCUMENTATION

The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: the time and means of arrival, indication that the patient left against advice, when applicable, conclusions reached at the termination of care, treatment and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment and services, a copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or services.

7.8 MEDICAL RECORD CONTENT

7.8.1 REQUIRED CONTENT

The attending physician shall be responsible for the preparation of a complete, legible medical record. Medical record entries shall be pertinent, accurate, timely and current. The medical record shall contain the following clinical information:

7.8.1.1 Identification data including the patient's name, address, date of birth, and the name of any legally authorized representatives. The patient's sex, the legal status of any

patient receiving behavioral health care services, the patient's language and communication needs.

7.8.1.2 The reason or reasons for admission for care, treatment, and services.

7.8.1.3 The patient's initial diagnosis, diagnostic impression of conditions.

7.8. 1.4 The record and findings of the patient's assessment and reassessment.

7.8. 1.5 Any allergies to food and medications.

7.8.1.6 Any conclusions or impressions drawn from the medical history and physical examination.

7.8.1.7 Any diagnoses for conditions established during the patient's course of care, treatment and services.

7.8. 1.8 Any consultation reports.

7.8. 1.9 Any observations relevant to care, treatment and services.

7.8. 1.10 The patient's response to care, treatment and services.

7.8. 1.11 Emergency care provided prior to arrival, if any.

7.8.1.12 Progress notes made by medical staff and other authorized individuals

7.8. 1.13 Any medication ordered or prescribed.

7.8.1.14 Any medications administered, including the strength, dose and route and any adverse drug reactions.

7.1.8.15 Any access site for medication, administration devices used, and rate of administration.

7.1.8.16 Treatment goals, plan of care, and revisions to the plan of care.

7.1.8.17 Orders for diagnostic and therapeutic tests and procedures and their results.

7.1.8. 18 Evidence of known advanced directives.

7.1.8.19 Evidence of informed consent for surgical procedures or other invasive procedures.

7.1.8. 20 All operative and other invasive procedures performed using acceptable disease and operative terminology that include etiology as appropriate.

7.1.8. 21 Any medications dispensed or prescribed on discharge.

7.1.8.22 Any records of communication with the patient, such as telephone calls or e-mail.

7.1.8. 23 Any patient-generated information.

7.1.8.24 Any referrals and communications made to external or internal care providers and to community agencies.

7.8 RESIDENT PHYSICIANS

Resident physicians are given patient care responsibility commensurate with the individual's level of training, experience, and capability. In all matters of an individual patient's care, the attending physician maintains the responsibility for the care of the patient and supervises resident physicians. For ancillary medical services, the chief of the service will supervise the resident physician.

A resident physician may be in training at UH Regional Hospitals as a regular part of a clinical rotation. This type information would be established in agreement with the primary training center. In this case the attending physician must countersign the following entries in the medical record: History and Physical, Face Sheet (Attestation Statement), Progress Note, Operative Note and

Discharge Summary.

If the resident does not have a full, unrestricted license in the State of Ohio, then the attending physician must countersign all medical record entries.

If the resident is in training at UH Regional Hospitals as part of an individually arranged clinical rotation, then all medical record entries must be countersigned by the attending physician.

Evidence of the resident's training status, a copy of any agreements documenting the training rotation, evidence of malpractice insurance, a copy of the resident's medical license, and a copy of the resident's DEA registration certificate must be placed in the medical staff office prior to the beginning of the resident's activity at UH Regional Hospitals. Documentation to verify that a back ground check was completed, immunizations and TB test are in compliance is also required. Medical residents may attend all education meetings of the medical staff, but may attend business meetings, service or committee meetings only with the approval of the Committee Chair and the Chief of Staff.

PRIVILEGES:

All resident physician will have the following privileges:

1. Conduct histories and physical exams and document in the patient's chart;
2. Examine assigned patients as required and document the examination in the chart;
3. Change dressings and catheters as directed by the attending physician.
4. Administer medication to and obtain laboratory samples from patients;
5. Perform designated procedures when under the direct personal supervision of an attending physician;
6. Assist in the performance of procedures with an attending physician;
7. Perform emergency privileges as defined in Section 5.9 of the Bylaws; and
8. Perform additional privileges at the specific request of an attending physician with documentation of training and ability. These privileges must be approved by the Department Chair and the Chief of Staff.

7.9 TUBERCULIN TESTING

At the time of their initial appointment and at the time of their reappointment, every member of the medical staff must present the results of a tuberculin skin test within the past year. For those medical staff members with positive skin tests or vaccinations that will cause a conversion, the results of at least one chest x-ray taken after the conversion must be provided. Recent converters are expected to seek treatment from their own physician. Members of the medical staff with privileges in obstetrics or the newborn unit must present the results of a tuberculin skin test on an annual basis.

ARTICLE VIII: MEDICAL RECORD COMPLETION

8.1 GENERAL

Medical records shall be completed within 30 (thirty) days of the patient's discharge from the hospital. A member of the medical staff with 5 (five) or more records, each incomplete for 30 (thirty) or more days after discharge of the patient from the hospital, is subject to suspension of admitting, consulting and surgical scheduling privileges until all incomplete records are completed.

8.2 SUSPENSION OF PRIVILEGES

Every other Wednesday either a Reminder Letter or a letter of Impending Suspension will be sent to members of the Medical staff that have incomplete medical records. Once a physician has received the Letter of Impending Suspension, they have until the following Wednesday to complete all medical records that are deficient greater than 28 (twenty-eight) days from discharge. Failure to complete all records deficient greater than 28 (twenty-eight) days from discharge will result in the physician being placed on Suspension. The suspension of clinical privileges includes admitting privileges, scheduling surgical procedures and consulting. Medical staff members would continue to care for patients already hospitalized, patients scheduled prior to suspension for an inpatient or outpatient surgery and the medical staff members must continue to fulfill their on-call coverage responsibilities. Once suspended all incomplete medical records must be completed to be cleared from suspension. See HIS Policy #GM-49.

8.3 OPERATIVE REPORT

Immediately after surgery an operative note containing the names of the licensed independent practitioner(s) who performed the procedure and his or assistants, the name of the procedure(s) performed, a description of the procedure(s), findings of the procedure(s), any estimated blood loss, any specimens removed and the postoperative diagnosis must be entered in the chart. Also a complete operative report must be dictated immediately after surgery.

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

8.4 DISCHARGE SUMMARY

The attending physician for the patient at the time of discharge will be responsible for preparing for discharge summary for the medical record. In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the following: 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 and provisions for follow-up care.

For patient stays under 48 hours, the final progress notes may serve as the discharge summary and must contain the outcome of the hospitalization, all diagnoses, the case disposition, and any provisions for follow-up care.

When a patient is transferred to a different level of care within the hospital and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.

8.5 VACATION AND ILLNESS

The suspension shall be delayed if a physician is on vacation, ill, or out of town on the day that his/her suspension becomes effective, due to either incomplete

medical records or because of non-dictated Operative Reports. The suspension delay shall expire 3 (three) days after the physician returns. If the suspension begins prior to the physician becoming unavailable as described above, then the suspension shall continue during the physician's absence. Delays due to lost records or inadvertent erasure of dictated material shall not be counted in the determination of suspension status.

8.6 HISTORY AND PHYSICAL

Histories and physicals are to be completed within 24 hours of admission. If a History and Physical is available for the period of up to 30 (thirty) days prior to admission, then a legible copy may be used, provided an update documenting the specific changes that have occurred or that no changes have occurred is recorded in the medical record at the time of the admission.

ARTICLE IX: ACTIVITIES OF STUDENTS OF MEDICINE

9.1 Medical students may serve preceptorships under the auspices of Active, Associate or Courtesy Medical Staff members, if they are in good standing in the third or fourth year of their education at an accredited school of medicine or osteopathic medicine. The staff member must be established as a preceptor at the medical school attended by the student.

9.2 Their program at UH Regional Hospitals is a continuation of their didactic and clinical medical education. They may attend all educational conferences of the medical staff and make round with the attending physician. They have access to all the education recourses available through the medical library.

9.3 They may obtain a medical history; however, the preceptor must countersign it on the chart. They may conduct a physical examination with the preceptor present. This will enhance the teaching process at the precise moment the exam is being done. However, the physical exam and/or the medical history obtained by the medical student will not be the primary history and physical in the medical record and may not be used for treatment purposes.

9.4 The medical student cannot, unless in the presence of a licensed physician, carry out any procedure that would fall within the definition of delivering health care or medical services to the patient.

9.5 Whenever a medical student scrubs in or assists in obstetric or operative cases, it will be permissible for the name to appear on the record. This record should indicate for example – *2nd assist, 3 assist, etc.*

9.6 All medical student entries in the medical record (orders, histories and physicals, progress notes, etc.) must be countersigned by the preceptor. However the physical exam and/or the medical history obtained by the medical student will not be the primary history and physical in the medical record and may not be used for treatment purposes.

9.7 It is imperative that all the medical student's clinical activities be subject to the above guidelines. Any violation of these guidelines should be reported immediately to the attending physician or preceptor to whom he/she is assigned.

9.8 No physician shall have more than two such students under his preceptorship at

a time.

9.9 Medical students may attend business meetings, service, or committee meetings only with the approval of the Committee Chair and the Chief of Staff.

9.10 Neither UH Regional Hospitals, nor its medical staff, makes any implication herewith of its approval of, or formal participation in, such a program or of the content of or jurisdiction over such preceptorships, other than allowing the activities above described, under the supervision and responsibility of the Medical Staff member initiating such program.

9.11 Evidence of malpractice insurance, documentation of immunizations and TB test compliance, photo ID and background check, letter of good standing from medical school and affiliation agreement must be on file in the Medical Staff Office prior to rotation.

ARTICLE X: DEPARTMENT MANUALS

10.1 GENERAL

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

The exercise of clinical privileges within any department is subject to the rules and regulations of that department and to the authority of the department chair.

10.2 CREDENTIALS MANUALS

A separate manual may contain specific rules and regulations for granting credentials and privileges.

10.3 COMMITTEE MANUAL

A separate committee manual shall list those committees that are not included in the Medical Staff Bylaws.

ARTICLE XII: EMERGENCY ROOM PHYSICIANS

12.1 Qualifications for Emergency Room physicians are outlined in Section 2.2 (Qualifications for Membership) of the Bylaws of the Medical Staff of UH Regional Hospitals.

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

12.3 Emergency Room physicians may provide emergency care to hospitalized patients.

12.4 Emergency Room physicians shall attend all patients in the Emergency Room and perform other duties a determine by the Emergency Room Services.

ARTICLE XIII: PROCEDURE REQUIREMENTS

13.1 HISTORY AND PHYSICAL

The history and physical exam must be completed and recorded before any surgery is started. Generally for elective surgeries this will be done during preadmission testing. If the history and physical exam are performed within 30 days before admission to UH Regional Hospitals or in the office of a physician staff member or, when appropriate, the office of a qualified oral or maxillofacial surgeon staff member, a durable, legible copy of this report may be used in the patient's medical record provided an update documenting changes that have occurred or that no changes have occurred is recorded in the medical record at the time of the admission. In an emergency the relevant parts of the physical must be documented prior to the emergency procedure.

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

a. Pain blocks, including but not limited to epidural and paravertebral facet injections,
b. Endoscopy procedures,
c. Invasive imaging procedures, and
d. All other procedures for which an anesthesia consultation is not requested or indicated.

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

13.2 PRE-PROCEDURE TESTING

13.21 For all inpatients and outpatients, who need an anesthesia consultation, except emergencies, the following is recommended:

a. Chest x-ray if medically indicated
b. Anyone over the age of 40 should have an EKG within the past 12 months.
c. Complete blood count (CBC) for any patient when the need for blood or significant blood loss is anticipated.
d. Serum BUN, glucose, and electrolytes for patients as medically indicated, especially for patients on diuretics.
e. The patient's medical condition and the nature of the procedure or surgery planned should be used to determine if any other testing is indicated.
f. Weight should be obtained for all patients.

13.22 Serum BUN and creatinine should be obtained for all patients prior to invasive imaging studies when the use of contrast medium is anticipated.

13.3 OBSTETRIC REQUIREMENTS

All patients admitted for obstetrical delivery, including abortion cases in various stages, must have a complete blood count (CBC), blood type, and Rh factor ordered. When such patients are Rh negative, further testing for Rh immune

globulin therapy (RhoGAM screen, etc.) should be considered by the attending physician. If such therapy is not indicated due to previous sensitization (by known erythoblastic offspring, etc.) these tests can be withheld, but circumstances should be documented in the medical record. If such therapy is offered and refused, a release form is to be signed by the patient.

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

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

13.4 CONSENT

All patients having surgery or other invasive procedures, and those for whom anesthesia or conscious sedation may be used, must have an appropriate consent form signed before procedure or surgery.

13.5 TELEMEDICINE

No clinical service will be provided at UH Regional Hospitals via the telemedicine service except by credentialed radiologists utilizing teleradiology while providing on-call coverage.

ARTICLE XIV: ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

14.1 PROCEDURE

Adoption and amendment of Rules and Regulations shall follow the procedures in section 13.A of the Medical Staff Bylaws.

14.2 DISTRIBUTION OF THE RULES AND REGULATIONS

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

14.3 REVIEW

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