Medical Staff
Rules & Regulations

11.17.21

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1. **Management of Hospitalized Patients**

1.1. Access to Care

1.1.1. Appointees will arrange coverage for patient care in the System when medical necessity requires an admission, observation stay, or an outpatient invasive or at risk procedure.

1.1.2. The attending Practitioner is responsible for the continuous medical care and treatment of hospitalized patients, the prompt completeness and accuracy of the medical record and a plan of care that includes the patient, family, and System support services

1.1.3. All patients are admitted without regard to race, creed, color, sex, sexual preference, nationality, or source of payment.

1.1.4. Hospitalization is contingent on adequate facilities and personnel being available to care for the patients.

1.1.5. Written Practitioner orders for preliminary care are provided with the patient's arrival to any Department or nursing unit. A daily Practitioner visit with documentation of findings and a plan of treatment is required. More frequent visits and documentation are expected as the patient's condition warrants.

1.2. Consultations

1.2.1. Any qualified Practitioner may be called as a consultant regardless of his or her Medical Staff category assignment. A consultant must have demonstrated the skill and judgment requisite to evaluating and treating the patient's condition or problem and must have been granted the requisite Privileges to do so.

1.2.2. Consultation should be considered when:

a. The patient is high risk for the planned treatment.

b. The diagnosis is obscure after usual diagnostics have been performed.

c. There is reasonable doubt concerning the choice or response to therapeutic measures.

d. Medical or psychiatric conditions are present for which services or expertise are not available.

e. Specific skills of other Practitioners are needed for complex situations.

f. It is requested by the patient, patient's family, or patient's legal representative.

g. Problems of critical illness in which any significant questions exist regarding appropriate procedures or therapy, or non-response to therapy is noted.

h. When required by these Rules and Regulations or other policies of the Medical Staff, any of its clinical units, or the System.

1.2.3. The attending Practitioner is responsible for requesting the consultation. A consultation order will be written as authorization to permit another Practitioner to examine/care for the patient. When requesting consultation, the attending Practitioner must indicate in writing on the order the reason for requesting a consultation and the extent of involvement in the care of the patient expected from the consultant. In all cases, the consultant must make and sign a report of his or her findings, opinions, and recommendations that reflects an actual examination of

the patient and the patient’s medical record. Such report shall become part of the patient’s medical record.

1.3. Transfers

1.3.1. The Practitioner determines the patient required level of care and best location to receive the needed hospital care. A patient shall be transferred to another facility only on the order of a Practitioner, and in compliance with the law.

1.3.2. The patient must receive appropriate care throughout the continuum of entry, transfer from unit to unit, and through discharge or transfer to another facility.

1.3.3. Practitioners as listed under 2.2.3 may conduct a “medical screening” under EMTALA. The Practitioner is responsible for assuring and coordinating this care through proper communications to other Practitioners, nursing care units, receiving health care providers, and the patient/family. EMTALA regulations for transfer to another acute care facility are to be observed and actions are to be documented on the EMTALA Transfer Form.

1.4. Discharge

1.4.1. The patient is able to leave the System when documentation of the patient’s condition indicates stability to the extent that care can be safety provided out of the System or through a transfer to another acute care facility.

1.4.2. A patient may be discharged only by order of the attending Practitioner. The order for the discharge must be written the day of discharge or no sooner than twenty-four (24) hours prior to the day of discharge.

1.5. Leaving Against Medical Advice (AMA)

1.5.1. If a patient demands discharge against medical advice (AMA), the attending Practitioner is notified. The Practitioner may attempt to intervene by having a discussion with the patient to provide information about health risks and barriers in reassessing care. The Practitioner will document all actions in the patient’s medical record, including if the patient leaves against medical advice.

1.5.2. If the patient insists on leaving AMA, the patient will be asked to sign an AMA form. If the patient refuses to sign the form, this fact shall be documented.

2. Coverage for Practitioners’ Services

2.1. Inpatient / Outpatient / Observation

2.1.1. The attending Practitioner must be readily available for consultation and intervention whenever a patient has been hospitalized. All patients are to be seen and evaluated by the attending Practitioner within a reasonable time not to exceed twelve (12) hours of arrival on the nursing units and within thirty (30) minutes for a critical or hemodynamically unstable patient. Normal, term newborns are seen and evaluated within 24 hours.

2.1.2. Each Practitioner must assure timely, adequate professional care for his or her patients in the System by being available or designating a qualified alternate Practitioner with whom prior arrangements have been made and who has the requisite Privileges to care for the patient. Failure of an attending Practitioner to meet these requirements may result in loss of Privileges or such other corrective action as appropriate. An Appointee who will be out of town or unavailable in the case of emergency must enter an order indicating the name of the Practitioner (who

must be an Appointee with comparable Privileges) who will be assuming responsibility for the care of the patient during his or her absence. This requirement is not necessarily if a Practitioner has a regular on-call arrangement for coverage and has indicated that schedule to the System.

2.1.3. In the event the attending Practitioner is unavailable with no pre-arranged coverage, the nursing supervisor will notify the Department Chair or Medical Staff President or Vice President for assistance with patient disposition. If none are available, the nursing supervisor will determine coverage.

2.1.4. The attending Practitioner has the same responsibilities for coverage as described for inpatient/observation when an outpatient is in the System for an invasive or at risk procedure.

2.2. Emergency Department

2.2.1. The Medical Staff will provide back up for patients without an established Practitioner including timely follow up coverage for Emergency Department patients discharged from the Emergency Department as needed, as well as those admitted to and discharged from the System.

2.2.2. Coverage to assist the ED is provided by active Medical Staff on a rotating basis for the following services:

a. General Surgery
b. OB
c. GYN
d. Pediatrics
e. Anesthesia
f. Radiology
g. Family Practice / Internal Medicine
h. Orthopedics
i. Urology

Exceptions for specific Practitioner coverage include:

a. Practitioners of age greater than sixty (60) who have provided written request for exemption to their Department Chair.
b. Practitioners with an illness or disability who are unable to perform usual medical duties, who have provided written request for exemption to their Department Chair.
c. Request for special consideration submitted to the Department Chair and approved by majority vote of the Service.
d. Single or dual Practitioner sub-specialty services which are requested to provide alternate coverage when they are not available. (Not expected to provide call more than 1/3 of the on call schedule)

2.2.3 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.

3. Practitioners' Orders

3.1. Written / Electronic Orders

All orders for treatment or diagnostic tests must be entered clearly, legibly, and completely, and signed by the Practitioner responsible for them or a Practitioner willing to take responsibility for the care of the patient. Orders that are illegible or improperly entered will not be carried out until entered or understood by the health care provider implementing the order. Orders for diagnostic tests that necessitate the administration of test substances or medications will be considered to include the order for this administration according to approved protocols. When the prescribing Practitioner is not available to promptly sign and date all orders, it is acceptable for the covering Practitioner to co-sign the order. The signature indicates that the covering Practitioner assumes responsibility for his/her colleague's order.

3.2. Telephone or Other Verbal Orders

Telephone or other verbal orders are to be used infrequently and only when necessary. Telephone or other verbal orders may be taken only by a Practitioner, an APP (if within his or her scope of practice), a registered nurse, or a licensed practical nurse approved in accordance with System policy. In addition, a registered pharmacist may transcribe telephone orders pertaining to drugs. Registered respiratory therapists and certified respiratory therapy technicians may take verbal orders for medication, treatment, and/or procedures within their area of competence that they will deliver or perform. Imaging Technologists may take verbal orders for imaging testing within their area of competence that they will perform. All verbal orders shall be transcribed in the proper place in the medical record; shall include the date, time, name, and signature of the person transcribing the order, and the name of the Practitioner issuing the order. The entire verbal order should be repeated back to the Practitioner/APP. All verbal orders must be signed, dated, and timed by the ordering Practitioner/APP or another Practitioner/APP who is responsible for the care of the patient within 30 days of when the order was originally given.

3.3. Continued Orders

All orders must be reconciled for unit to unit transfers and reentered, post-operative, and postpartum care. Previously written orders are considered discontinued for post-operative and postpartum care.

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3.4. Orders by a Physician Assistant or Advanced Practice Nurse

3.4.1. An order by a Physician's Assistant must be within his or her defined scope of practice and must be consistent with the Physician Assistant's supervision agreement and System policies.

3.4.2. An order by an Advance Practice Nurse must be within his or her

defined scope of practice and must be consistent with the standard care arrangement.

4. Medical Records

4.1. Ownership and Removal of Medical Records

All medical records are the property of the System and cannot be removed from the System, except pursuant to a court order, subpoena (in some cases), and statute or by permission of the CEO. Unauthorized copying or removal of medical records by a Practitioner from the System is grounds for corrective action.

4.2. Use of Abbreviations and Symbols

The medical record may incorporate only those abbreviations or symbols that are approved by the MEC. An approved list of such abbreviations and symbols is maintained in the General Policy and Procedure Manual.

4.3. Authentication

All clinical entries in the patient's record must be accurately dated, timed, and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key, or signature stamps. The use of signature stamps or computer key entry is acceptable under the following strict conditions:

4.3.1. The Practitioner who utilizes a signature stamp or computer key is the only one who has possession of the stamp or code for the computer key and is the only one who uses it;

4.3.2. The Practitioner places in the administrative offices of the System a signed statement to the effect that he or she is the only one who has the stamp or code and is the one who will use it.

4.3.3. Outpatient orders on requisition forms require the actual signature of the ordering Practitioner. Signature stamps are not acceptable.

4.4. Documentation Requirements

Criteria for medical record content are described here and in the Outpatient Documentation Policy. The content of the medical record shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers. Each medical record shall include:

4.4.1. Description and history of present complaint and/or illness.

4.4.2. Personal and family medical histories.

4.4.3. Physical examination report.

4.4.4. Diagnostic and therapeutic orders.

4.4.5. Evidence of appropriate informed consent.

4.4.6. Progress notes and other clinical observations, including results of therapy.

4.4.7. Relevant diagnosis/conditions.

4.4.8. Condition on discharge, including instructions relevant to patient's condition at admission, to the patient or patient's legal representative on post-hospital care.

4.5. History and Physical (see Bylaws, section 8)

4.6. Progress Notes

4.6.1. Regular pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending Practitioner. Whenever possible, each of the patient's clinical problems and results of tests and treatments are identified in the progress notes.

4.6.2. The progress note includes date and time of entry, pertinent exam, identified clinical problems and improvements, pertinent test results, plan of care, and the attending Practitioner's signature

4.7. Operative / Procedure Reports

4.7.1. The Practitioner must enter an operative or procedure progress note in the medical record immediately after the procedure providing sufficient information for uninterrupted continuity of patient care to include, at a minimum, the name of the surgeon and assistants, anesthesia, the post-operative diagnosis, the procedure(s), estimated blood loss, remaining tubes, unexpected findings/events, and specimens removed.

4.7.2. Final operative and procedure reports must be completed within twenty-four (24) hours of an operative or other procedure and must record, as applicable, the name of the surgeon and assistant(s), procedure(s), a detailed description of each procedure, the findings, estimated blood loss, the specimens removed, the disposition of each specimen, and the post-operative diagnosis.

4.8. Obstetrical Records

4.8.1. Obstetrical records include the prenatal record, and an interval H&P on admission to reflect pertinent additions and subsequent changes in findings. A completed legible copy from the Practitioner's office or a clinic record is an acceptable prenatal record. Documentation of the labor and delivery includes the progress of labor, medical interventions, and their effectiveness, complications, and maternal/newborn outcomes.

4.9. Discharge Summary

4.9.1. The discharge summary or clinical resume is completed at discharge for all inpatients and observation patients in the System for greater than 24 hours, except for normal newborns.

a. The discharge summary must include all of the following:

i. Preliminary Diagnosis.

ii. Events during the stay: diagnostic testing and significance of results; consultations obtained and their summaries; procedures performed; findings and any complications; treatments; and effectiveness.

iii. Condition at discharge

iv. Instructions for patient, family/caregiver, including discharge medications and plans for follow up care.

v. Final diagnosis.

4.9.2. An interim discharge note will be entered as a progress note on the day of discharge if the discharge summary and discharge note are not immediately available in the record.

4.9.3. The physician must sign the discharge summary if delegated to a Physician Assistant.

4.10. Delinquent Medical Records

4.10.1. The patient's medical record for hospitalized and outpatient visits must be completed with authentications as soon as possible but not later than thirty (30) days from the patient's discharge date. ED records must be completed on the day of the visit and before the patient moves to a higher level of care.

4.10.2. Rules for assuring timely completion of medical records:

a. Based on a quarterly report from the Medical Records Department, more than three (3) delinquent records for timeliness and completeness will result in an intensified review for a six (6) month period.

b. The Practitioner is notified of the intensified review status. During this six (6) month period, a $100.00 fine will be assessed for each additional delinquency and $50.00 fine for each day thereafter until chart is complete. The next delinquency will result in an additional fine of $100.00 and $50.00 for each day thereafter until the chart is complete. The third delinquency will result in an automatic suspension of Privileges consistent with the Medical Staff Bylaws. The suspension will begin within 72 hours of the date set forth in the notice of the delinquency.

c. Nothing in this section is to be construed as precluding referring a matter for corrective action pursuant to the Medical Staff Bylaws.

4.11. Medical Research

4.11.1. Appointees may utilize and have access to patient medical records for the purposes of bona fide studies or research approved by the MEC. All projects using medical record information from patients, whom the Practitioner is not the attending of record, must have prior approval of the MEC.

4.11.2. Dentists, Podiatrists, and Psychologists may treat patients as provided in the Credential Procedure Manual. Each is responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the medical care provided to the patient. More specifically, Dentists, Podiatrists, and Psychologists are responsible for the following:

a. A detailed dental/podiatric/psychological history and description of the dental/podiatric/psychological problem documenting the reason for hospitalization.

b. A detailed description of the examination of the specialty area must be provided.

c. A complete operative/consultative report, describing the findings, technique, any specimens removed, and postoperative/post-therapeutic diagnosis.

d. Progress notes as are pertinent to the dental/podiatric/psychological condition.

e. Pertinent instructions relative to the dental/podiatric psychological condition for the patient and/or significant other at time of discharge.

f. Discharge summary or final summary note.

5. Clinical Services Quality

5.1. All Clinical Services will establish a mechanism for the evaluation of Medical Staff activities. Policies and procedures to support the functions of the special care units shall be developed in cooperation with the Medical Staff: The quality review process is designed by MSPC, based on data collection of Service indicators utilizing the expertise of Medical Staff Departments and approved by the MEC per the Quality Improvement Program.

5.2. Quality care concerns are brought to the attention of the appropriate Chair of Medicine

or Surgery through review screens or concerns from hospital management or another medical staff member. If not available or the concern relates to the Department Chair, the President of the Medical Staff or designee is notified.

6. Psychiatric Emergency Care

6.1. Psychiatrist services, other than those provided at the System's Behavior Health Unit are limited to situational evaluation, crisis intervention, medical stabilization, and transfer arrangements for timely continuing or follow-up care at an appropriate mental health agency.

6.2. A System social worker or case manager will be consulted for all psychiatric-type hospitalizations to the System.

7. Informed Consent

7.1. Patient Rights

7.1.1. Refer to the Informed Consent Policy in the System's Policy and Procedure Manual.

7.2. Consent for Minors

7.2.1. Refer to the Informed Consent Policy in the System's Policy and Procedure Manual.

8. Surgery Services

8.1 Specific policies for surgical care delivery are maintained by the Department of Surgery. The following general guidelines apply for all scheduled (non-emergency) surgeries:

a. Informed consent is obtained from an authorized individual consistent with Section 9 of these Rules and Regulations and is signed, dated, and witnessed prior to sedation and within thirty (30) days of the procedure.

b. Standard pre-operative testing is not required unless necessary based upon patient's condition. Pre-operative testing guidelines should be followed for elective inpatient and ambulatory surgery and performed within one month of the surgery. No repeat laboratory testing is required for a patient who is scheduled for an additional surgery within thirty (30) days of a previous surgery.

c. Prior to any operation, the surgeon shall note in the patient's record the pre-operative diagnosis and the surgeon's reason and plan for the procedure to be performed. The operating surgeon or anesthesiologist must document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experiences, and any potential anesthetic problems. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating are and before pre-operative medication has been administered.

d. The H&P must be documented in the medical record prior to surgery and shall be performed consistent with Section 8 of the Bylaws.

e. Tissues and other materials removed during surgery will be examined by a pathologist per protocol. The operative findings will be compared to the pathologic diagnosis and documented by the surgeon in the medical record.

f. Prior to the induction of anesthesia, a time out shall occur per policy to verify the patient's identity and the site and side of the body to be operated upon and ascertain that the information required under this Section 8 is in the patient's

record. If the required information is not in the record, the procedure shall be canceled or postponed, unless the operating Practitioner states in writing that such a delay would constitute a danger to the patient.

9. Deaths / Autopsy

a. Only a Physician can pronounce death for hospitalized patients. In cases of expected deaths or when resuscitation is not done and the Physician is not present, the nurse will notify the attending Physician of the signs of death and the physician may pronounce death via the telephone.

b. Reporting of deaths to the Coroner's Office shall be carried out when required by and in conformance with state law.

c. The death certificate must be signed by the attending Physician unless the death is a coroner's case, in which event, only the coroner may issue the death certificate. When the coroner determines that there is "No Jurisdiction" or "Jurisdiction Terminated" by the coroner, the attending Physician is responsible for issuing the death certificate.

d. A Physician's order is required to release the body from the System. In a coroner's case, the body may not be released to anyone other than coroner personnel.

e. The System is required by state law to request donations for organs/tissues where criteria has been met. The Organ Donation Policy is maintained as a System Policy and Procedure.

f. Every Appointee is encouraged to secure autopsies in cases of unusual death or particular medico-legal or educational interest and for other accepted professional reasons. Proper consent for an autopsy shall be obtained consistent with Ohio law. In a coroner's case, an autopsy may be performed only with the authorization of the coroner, regardless of the consent to or objection of the kin. When any suspicion arises during the course of an autopsy in a case not originally believed to be a coroner's case, the autopsy must be stopped immediately and the case reported to the Coroner's Office. All autopsies shall be arranged by the System pathologist or designee.

g. Refer to the Autopsy Criteria Policy in the System's Policy and Procedure Manual.